ASD Parent guidelines: Informed conversations at the IEP Table

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EDME 541 Master’s Thesis

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Abstract

This criterion-based study was conducted on research of an autism spectrum disorder diagnosis, the different severity levels now included in the DSM5, and evidence-based accommodations that allow students with autism to have a successful educational experience, in order to create Parent Guidelines: Informed Conversations at the IEP Table. The guide provides descriptions and examples of the criteria used to make an ASD diagnosis and the different severity levels. The accommodations found were categorized into four areas that address common deficits for students with autism: behavior, social-communication, academic, and sensory. The information was gathered and presented in a guide for parents of children with autism. The guide informs parents how to use and interpret the language established within a spectrum diagnosis and to articulate best practices regarding accommodations that have been proven to increase the possibility of behavioral, social, and academic success for their child. The parent guide could be used to give parents a sense of where their child is on the spectrum. In addition, the parents can use the description and examples of the three levels of severity, to properly target the areas of deficit when deciding on accommodations. As parents determine what deficits might become a barrier for their child's educational experience, the guide will provide accommodations to overcome those areas. Having this knowledge will give parents the tools so that they can make the best decisions for their child, allowing them to play an integral role in their child's education during Individual Education Plan (IEP) meetings.

Key words: Autism diagnostic criteria, ASD severity levels, IEP accommodations
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Chapter 1

Overview of the Chapter

This chapter provides an overview of a criterion-based research study that explores the levels of autism and educational outcomes for children with autism. The study focuses, in particular, on the language and characteristics of each level of an autism spectrum. In addition, the study explores the educational outcomes of students at the various levels. Because this is a research study that is close to my heart, I thought it appropriate to begin with a narrative of how I became interested in the study. This chapter, then, provides a background to the problem, the purpose of this study, an overview of the methodology, and a consideration of the limitations. The chapter ends with a definition of terms that will be referred to throughout the thesis project.

Forging a Research Topic: My Narrative

The journey began on a late Tuesday afternoon in December 2014. The Assistant Special Education Director for the school district in which I worked as a paraprofessional called me and asked if I would be interested in a long-term substitute job for the middle/high school autistic support teacher. She would be out on emergency maternity leave, and they needed a certified teacher to cover for her. I did not have much experience with children with autism, so I told her I would think about it. I went home, discussed it with my husband, and I prayed for guidance. I felt the Lord leading me to take the challenge. It was a difficult class of eight students who were very low-functioning. I called her the next morning and told her I would do it. I started the next day. There were many challenges and new learning experiences throughout the four months I was there. I learned to lean on the Lord in every situation. As soon as the teacher returned from her maternity leave, the autistic support teacher at the fourth- through sixth-grade level went on maternity leave. Since I had done a great job in the first position, the special education directors
asked if I was interested in moving over to the intermediate school. After 4 months working day-in and day-out with these students, I had fallen in love with working with students with autism. I was sure that God had put these opportunities in my path for whatever it was that he had in store for me. Jeremiah 29:11 says, “For I know the plans I have for you,’ declares the LORD, ‘plans to prosper you and not to harm you, plans to give you hope and a future’” (NIV). I worked in the intermediate autistic support classroom from the day I left the middle/high school classroom until the end of the year. I gained more experience and encountered many other difficult situations. However, I knew on that last day that special education, specifically students with autism, was where my heart was.

I began my studies at Messiah College to earn my special education certification, get an endorsement in autism spectrum disorder, and complete my master’s degree in special education. The following September 2015, the kindergarten through third grade autistic support teacher went out on maternity leave. I did not hesitate; I knew that this was in God’s plan for me. The teacher ended up moving out of the state for her husband’s job and I remained the rest of the year. With almost an entire year of working in the classroom, I developed relationships not only with my students, but also their families. I conducted Individualized Education Plan (IEP) meetings and held conferences. I communicated through phone calls, emails, communication notebooks, and face-to-face meetings. I realized many of the families did not truly understand their child’s diagnosis, potential, and educational opportunities that were available. Many of the parents relied on the teacher, principal, or other administration to make those decisions. Due to the fact that my special education certification would not be final until October of the following year, I was not a candidate for the position I was working in when they went to hire for the 2016-2017 school year. I was crushed, but I knew the Lord had bigger plans and I had to trust Him. 2
Corinthians 1:3-4a says, “Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles” (NIV). It comforted me to know that the God of all creation knew my hurt and was crying along with me. I had been sure that was where God wanted me, but it was not my plan—it was His. Proverbs 3: 5-6 says, “Trust in the LORD with all your heart and lean not on your own understanding; in all your ways submit to him, and he will make your paths straight” (NIV). I knew I had to trust the Lord.

God did have something else in store for me. At the beginning of the 2016-2017 school year, I was offered a job in another school district as a year-long substitute as the fourth through sixth grade emotional support teacher. In this position, I had the opportunity to not only work with students with emotional needs but also with a few students who had higher-functioning autism. The district did not have an autistic support program, so these students were put in the emotional support program. I was able to gain a new level of experiences and understanding of children with autism. I was blessed with getting the job for the 2017-2018 school year as my first full-time teaching position. As I have created many IEPs, and held many IEP meetings, I noticed that, often, the parents were not an active part of the process. It is often assumed that the parent will go along with whatever is suggested by the rest of the IEP team. Their job is to sign the appropriate paper work. Having developed lasting relationships with the families of the students that I have worked with over the years, it bothered me that they were not more involved.

When thinking about what I could contribute to the world of special education, I knew it had to involve the education of students with autism and their families. Through prayer and research, I decided that a guide for parents that would equip them to make informed decisions and be an active participant in the decisions for their child’s education was the direction in which I was meant to go. Psalm 32:8 says, “I will instruct you and teach you in the way you should go;
I will counsel you with my loving eye on you” (NIV). I know God will lead me to create something that will benefit many families of children with autism. In addition, the guide will allow those children to have an educational experience that best meets their needs because the people that know them best—their family—have the tools to be essentially involved in their educational decisions.

**Contextualizing the Problem**

The number of people with autism spectrum disorder (ASD) in our world is increasing. According to Autism Society (2016), 1% of the population in our world is on the spectrum. In the United States, the prevalence of autism increased 119.4% from 2000 to 2010 (Facts and Statistics, 2016). With the increase in population, schools are required to meet the needs of children with autism. According to the National Center for Educational Statistics (2016), “In fall 2013, some 95 percent of 6- to 21-year-old students with disabilities were served in regular schools; 3 percent were served in a separate school for students with disabilities” (para. 3). In the fall of 2013, the percentage of students with autism in public schools that spent 80% or more of their day in regular education classrooms was 61.8% (considered itinerant), 40-79% of their day was 19.4% (considered supplemental), and less than 40% of their day was only 13.8% (considered full time) (NCES, 2016). Students with autism are included in our school, whether it is all or part of the day, and many have an IEP to meet their education needs. Parents are an integral part of the IEP for their children. This product would allow the parents to make more informed decisions for their child’s education. Parents need to understand the levels of functioning for diagnosing people with autism spectrum disorder in order to advocate for their child’s education and appropriate accommodations.
Purpose of the Project

The purpose of the project is to provide a guide for parents of children with autism on the different severity levels in order to empower parents with quality input at IEP meetings and best meet the education needs of their child. The guide will serve two purposes. First, it will inform parents on how to use and interpret the language established within the spectrum. Second, it will articulate best practices regarding accommodations most promising for student success for their child.

Methodology

The focus of this project is to create a guide for parents on the different levels of autism using a criterion-based research analysis. According to Cooper, Hedges, and Valentine (2009):

Another goal for literature reviews can be to critically analyze the existing literature. Unlike a review that seeks to integrate existing work, a review that involves a critical assessment does not necessarily summate conclusions or compare the covered works to one another. Instead, it holds each work up against a criterion and finds it more or less acceptable. Most often, the criterion will include issues related to the methodological quality of empirical studies, the logical rigor, the completeness or breadth of explanation if theories are involved, or comparison of the ideal treatment, when practices or policies or applications are involved. (p. 5)

Using this type of criterion-based analysis allowed for critical analyzation of research on the three levels of autism, characteristics within those levels, and possible educational outcomes when best practices in accommodations are implemented. The definitions of the levels of autism, characteristics, and diagnostic research examples have been examined and brought together to create a cohesive and comprehensive guide for parents to use when advocating for their child’s
Limitations to the Study

In any study, there are always limitations. It is important to recognize those limitations so the audience is informed. One limitation to a criterion-based analysis of the different levels of severity for children on the autism spectrum is that many of the authors of the studies are not parents of children with autism. Parents of children with autism have the most insight into what their child is like on an everyday basis. A researcher may only have access to the child at certain times of the day. Children with autism have a difficult time with change. For example, according to Burner (2013),

When change occurs, children with ASD may respond in a variety of ways, including exhibiting withdrawal, repetitive behaviors, tantrums, or even aggression. It is important to remember that these behaviors are typically the result of extreme anxiety and/or inability to communicate their emotions/desires. (para. 1)

Since a researcher is not part of the child’s everyday routine, the children with autism may respond to them in a manner that is not typical for the child. The researcher may be seeing only the behaviors that occur because of a change in their routine or typical daily situation.

Another limitation to a criterion-based analysis of the different levels of severity for children on the autism spectrum is having the levels of functioning in everyday language for parents. The information that is often included in research on the severity levels of children on the spectrum are written in language meant for doctors, clinicians, or educators. Research is often meant for the use of doctors or educators, but not for the parents. Therefore, careful attention needed to be made on the use of language provided in the guide.
**Definition of Terms**

The following are definitions of terms to allow readers to better understand the study on the severity levels and functioning of students with autism spectrum disorder.

1. **Asperger’s Syndrome**: Asperger’s syndrome is often recognized as a high-level of functioning for students with autism. Autism Society (2016) defines Asperger’s Syndrome as, “What distinguishes Asperger’s Disorder from classic autism are its less severe symptoms and the absence of language delays. Children with Asperger’s Disorder may be only mildly affected, and they frequently have good language and cognitive skills” (para. 1). The American Psychiatric Association (APA) developed a new diagnostic manual (*DSM-5*) in 2013. Gottbetter (2013) reported, “In the new DSM-V, the diagnosis of Asperger’s Disorder no longer exists and has been absorbed into the diagnosis of Autism Spectrum Disorder (ASD)” (para. 3).

2. **Autism Levels**: When diagnosing autism, the DSM-5 uses three levels to help define the severity and functioning levels of the person with autism. Rudy (2017) described the reasoning, “The autism spectrum is incredibly wide and varied. Some people are brilliant while others are intellectually disabled. Some have severe communication problems while others are authors and public speakers. Without descriptive diagnoses like ‘Asperger syndrome’ (usually defined as very high functioning) and ‘autistic disorder,’ (often thought of as lower functioning) how would clinicians be able to describe the severity of any individual patient’s autism? To address this issue, the DSM-5 diagnostic criteria include three ‘functional levels,’ each of which is defined based on the amount of ‘support’ an individual requires to function in the general community. By providing an autism spectrum diagnosis with a functional level, at
least in theory, it should be possible to draw a clear picture of an individual’s abilities and needs” (para. 2).

3. Autism Level 1: The first level of autism can be described as the highest level of functioning of an autism diagnosis. This Level is described by the DSM-5 as “Requiring Support.” North Shore Pediatric Therapy (2017) defined Level 1 as, “Individuals with level 1 autism spectrum disorder experience deficits in social communication which causes noticeable impairments when supports are not present” (para. 3).

4. Autism Level 2: The second level of autism is described by the DSM-5 as “requiring substantial support.” North Shore Pediatric Therapy (2017) defined Level 2 as, “Individuals with level 2 autism spectrum disorder experience marked deficits in verbal and nonverbal social communication skills. Their social impairments are apparent even with supports in place” (para. 2).

5. Autism Level 3: The third level of autism can be described as being the most severe and described “Requiring very substantial support.” North Shore Pediatric Therapy (2017) defined Level 3 as, “Individuals with level 3 autism spectrum disorder experience severe deficits in verbal and nonverbal social communication skills which cause severe impairments in functioning, very limited initiation of social interaction, and minimal response to social advances of others” (para. 1).

6. DSM-5: The APA’s *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.)

7. Full-Time Special Education: When a student with an IEP spends at least 80% of their day in special education classrooms and no more than 20% in regular education classrooms.
8. IEP: An IEP is an Individual Education Plan. The University of Washington (2017) defined an IEP as “a plan or program developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives specialized instruction and related services” (para. 1). A child with autism that attends school will have an IEP that will outline the specific accommodation and goals that work best for the child. An IEP is renewed yearly.

9. Itinerant Special Education: When a student with an IEP spends less than 20% in special education classrooms and at least 80% of a student’s day in regular education classrooms.

10. Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS): PDD-NOS was a term used prior to the DSM-5 to describe a child that had some but not all the symptoms of autism. It is the diagnosis they use for someone who has some but not all characteristics of autism or who has relatively mild symptoms. For instance, a person may have significant autism symptoms in one core area such as social deficits, but mild or no symptoms in another core area such as restricted, repetitive behaviors (Autism Society, 2018, para. 4).

11. Restrictive, Repetitive Patterns of Behavior: Restrictive, repetitive patterns of behavior are used by clinicians to help diagnose people with autism. The Kennedy Krieger Institute (2017) described restrictive, repetitive patterns of behavior as:
One of the hallmark features of an autism spectrum disorder is the presence of restrictive and repetitive behaviors (RRBs), interests, and activities. Individuals may engage in stereotyped and repetitive motor movements (e.g., hand flapping or lining up items) or speech (e.g., echolalia). They may have an insistence on sameness, such
as needing to take the same route to school every day or requiring that activities be completed in exactly the same order each time. (para. 1)

12. Social Communication Impairment: Social communication impairment is a tool used to help diagnose people with autism. The American Speech-Language-Hearing Association (2018) defined social communication impairment as, “Social communication disorder is characterized by difficulties with the use of verbal and nonverbal language for social purposes. Primary difficulties are in social interaction, social cognition, and pragmatics” (para. 1).

13. Social-Emotional Reciprocity: Social-emotional reciprocity is the back-and-forth relationship between two individuals. This is often difficult for people with autism and can be used to help with diagnosis and level of severity of autism. Autism Speaks (2018) reported on the DSM-5 definition of social-emotional reciprocity, “Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions” (para. 2).

14. Supplemental Special Education: When a student with an IEP spends more than 20% and less than 80% of their day in a special education classroom and the rest of their day in regular education classrooms.
Chapter 2
LITERATURE REVIEW

Overview of the Chapter

This chapter is a review of the literature on the methods of diagnosis of autism spectrum disorder and the school accommodations that can be made based on different problem areas. The chapter is divided into six main sections. The first section is a discussion on the theoretical framework based on the change in the APA’s diagnostic manual in 2013, changing the way autism is diagnosed. The second section presents research on the characteristics of an autism diagnosis, including the severity levels. The third section reviews research on accommodation, starting with strategies that deal with behavior. In the fourth section considers research on social accommodations, including sections on inclusion, peer interventions and school connectedness. The fifth section reviews the research done on academic accommodations. The final section gives a review into the research on strategies for sensory accommodation.

Theoretical Framework: ASD Diagnosis and Accommodations

In 2013, the APA released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. One of the major changes from the fourth to the fifth edition was the criteria for autism spectrum disorders. Huerta, Bishop, Duncan, Hus, and Lord (2012) state:

The proposed changes to the DSM-IV diagnostic criteria for pervasive developmental disorders (PDDs) include shifting from a multicaegorical model to a single diagnostic category of autism spectrum disorder (ASD), replacing the three-domain model with a two-domain model, relaxing the criteria for age of onset, and adding symptoms not previously included in DSM-IV, such as sensory, interests and aversions. (p. 1056)

It was found that the *DSM-5* would allow many children, who had been previously diagnosed as
PDD, to continue to qualify under an ASD umbrella. It was also indicated that the DSM-5 produces less misclassifications (Huerta et al., 2012). Due to the changes made to the DSM-5, a review on the diagnostic criteria has been conducted to include the changes made, the diagnostic criteria, and the definitions of the levels of severity. In addition, a review of the literature on successful accommodations for behavior, social and communication, academic, and sensory issues have been conducted.

**Capturing the Essence of a Physician’s Diagnosis**

![Autistic Spectrum Conditions](https://www.dealwithautism.com/types-of-autism/)

*Figure 1: Autism spectrum – the rainbow effect. Reprinted from Autimag. 2014. Retrieved from https://www.dealwithautism.com/types-of-autism/

**DSM-5**

It is important for parents to understand the criteria that qualifies children to be diagnosed with autism spectrum disorder. The changes to the DSM-5 also include the severity and support levels according to each diagnostic category. Bitsika and Sharpley (2018) stated, “The prevalence of autism spectrum disorder (ASD) among children has increased 20-fold to 30-fold since the earliest epidemiologic studies were conducted in the late 1960s and early 1970s” (p. 22). The increase in prevalence has created interest in research to more accurately diagnose children with ASD. In the DSM-5, an individual must present symptoms of ASD from early childhood, whether or not those symptoms are recognized later in life. The change in criteria allows for
diagnosis in younger children (APA, 2013). Kantzer et al. (2018) presented the need for earlier
detection of ASD: “Autism very often co-occurs with other neuropsychiatric and
neurodevelopment disorders” (p. 298). Among these disorders are attention hyperactivity
disorder (ADHD), language disorders, tic disorders, epilepsy, and others. Therefore, earlier
detection can help these other disorders be targeted for interventions (Kantzer et al., 2018). In
their study of the classification system of functioning, Craig et al. (2017) stated, “The new
manual outlines two criteria that must be present for an autism diagnosis. It includes deficits in
social skills and social communication and unusual patterns of behaviors and interests” (p. 1249).
It is important to look at the DSM-5 criteria for autism spectrum disorders in order to fully
understand how clinicians come up with a diagnostic result. Carpenter (2013) gave general
guidelines when looking at diagnostic criteria, including the need for more than one example in a
specific criteria to qualify that criteria as being present, avoiding the use of the same behavior for
more than one criteria, and although a behavior is not currently present it still can be considered
(p. 1). The first criteria for an autism diagnosis listed in the DSM-5 is “persistent deficits in social
communication and social interaction across contexts, not accounted for by general
developmental delays and manifest by 3 of 3 symptoms” (Carpenter, 2013). Reynolds and
Kamphaus (2013) listed the symptoms to qualify in this area; the individual must present
problems with communication in social settings, including social-emotional exchange, non-
verbal communication, and developing and maintaining age-appropriate relationships. Brock,
Dueker, and Barczak (2017) stated, “These characteristics are especially evident on the
playground where many students with ASD struggle to appropriately interact with peers” (p. 1).
A basic social-communicative impairment, according to Pruett and Pavinelli (2016), is “reduced
viewing of eyes, gaze following, and joint attention” and “failure of normal back-and-forth
conversation and failure to initiate or respond to social interactions” (p. 1238). The second criteria for an autism diagnosis, according to the DSM-5, is “restricted, repetitive patterns of behavior, interests, or activities as manifested by at least 2 of 4 symptoms” (Carpenter, 2013). The symptoms to be considered are stereotyped or repetitive motor movements whether in speech or with objects. This can include lining up toys, repetition of others people’s words or phrases, or flipping objects. The child may become anxious or upset when there are changes in schedule or during transitions. Another symptom can be obsession with particular interests that go beyond a typical developing child. The child may have an excessive preoccupation with a particular subject. A child may also be over or under sensitive to aspects of the environment, such as noise, taste, smells, textures, lights, etc. (Reynolds & Kamphaus, 2013). In addition to the two major categories of diagnostic criteria, “Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities)” and “Symptoms together limit and impair everyday functioning” (Carpenter, 2013, p. 5). In addition to the diagnosis in the DSM-5, levels of severity are given “based on social communication impairments and restricted, repetitive patterns of behavior” (Reynolds & Kamphaus, 2013, p. 2).

**Level of Severity**

An important addition to the DSM-5 is the description of the levels of functioning according to the amount of support and individual requires to function in the community. There are three functioning levels for both the major diagnostic criteria: social communication and restricted, repetitive behaviors. Bal, Farmer, and Thurm (2017) discussed the reason for describing function in the DSM-5, “In this case, ‘functioning’ does not refer to quantification of ability or symptom, but rather how those symptoms affect an individual’s age-appropriate ability to responds to the demands of daily life” (p. 2939). The severity of the diagnosis can help
clinicians, teachers, and parents predict the rate of goal achievements. In their study on the predictors of growth, Tiura, Kim, Detmers, and Baldi (2017) found, “Children with ASD diagnosis indicating higher severity tended to improve at a slower pace than those with lower severity diagnosis” (p. 195). It is important to look at the categories of severity in each of the criterion. The DSM-5 rates the severity levels from Level 3 “Requiring very substantial support” to Level 1 “Requiring support.” At the most severe level, Level 3, in social communication characteristics are described as, “Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions, and minimal response to social overtures from others” (Carpenter, 2013, p. 6; Reynolds & Kamphaus, 2013, p. 2). Examples could be a child that approaches people in an usual manner only with the intention of meeting their own needs, speech with only a few words or may not be understood, or the individual may only respond to direct social approaches (Reynolds & Kamphaus, 2013). Level 3 for restricted, repetitive behaviors are listed as, “Preoccupations, fixated rituals and/or repetitive behaviors markedly interfere with functioning in all spheres; Marked distress when rituals or routines are interrupted; very difficult to redirect form fixated interest or returns to it quickly” (Carpenter, 2013, p. 2). An example would be a child who becomes very upset with a change in their schedule or may have a hard time moving to another activity when they are focused on their own interests. Level 2 is described as “requiring substantial support.” A child that in this level of severity does not require quite as much support as Level 3 but does need a significant amount of support to function in daily activities. The deficits in social communication are marked as “verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others” (Carpenter, 2013,
A child with this severity level may speak with very simple sentences, have abnormal nonverbal communication, and interactions with others are limited to their own interests (Reynolds & Kamphaus, 2013). In the category of restricted, repetitive behaviors include “Inflexibility of behavior, difficulty coping with change, or other restrictive/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts; distress and/or difficulty changing focus or action” (Reynolds & Kamphaus, 2013, p. 2). The differences between Levels 3 and 2 in this area are that severity of the reaction to change and the intensity of interference with daily activities.

The final category of support, Level 1 “requiring support” is described for social communication as, “Without supports in place, deficits in social communication cause noticeable impairments; has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others; may appear to have decreased interests in social interactions” (Carpenter, 2013, p. 6; Reynolds & Kamphaus, 2013, p. 2). A child at this level may speak clearly and in full sentences but have problems with back-and-forth conversations and may have difficulty making friends (Reynolds & Kamphaus, 2013). Level 1 restricted, repetitive behaviors are when “inflexibility of behavior causes significant interference with functioning in one or more contexts; difficulty switching between activities” (Reynolds & Kamphaus, 2013, p. 2). A child at this level may have behavioral problems at school and not at home or vice versa. The child may have problems transitioning to different activities but not to the extent that affects functioning as in Levels 2 and 3. Rudy (2017) stated, “By providing an autism spectrum diagnosis with a functional level, at least in theory, it should be possible to draw a clear picture of an individual’s abilities and needs” (p. 2). The importance of understanding the diagnostic criteria and the levels of severity is so that children are able to get the interventions
that they need. Bitsika and Sharpley (2018) stated, “Following the initial diagnosis, clinicians then need to plan for treatment that is based upon the specific symptoms that are exhibited by a child in particular settings” (p. 23). Since parents know their children best, it is important that they are aware of the research-based accommodations, so that they can work with clinicians and teachers to best meet the individual needs of their child.

Table 1.

**DSM-5 Table of Severity Descriptors**

<table>
<thead>
<tr>
<th>Severity Level for ASD</th>
<th>Social Communication</th>
<th>Restricted interests &amp; repetitive behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 3 - 'Requiring very substantial support'</strong></td>
<td>Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others</td>
<td>Preoccupations, fixed rituals and/or repetitive behaviours markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixed interest or returns to it quickly.</td>
</tr>
<tr>
<td><strong>Level 2 - 'Requiring substantial support'</strong></td>
<td>Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others</td>
<td>RRBs and/or preoccupations or fixed interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRB’s are interrupted; difficult to redirect from fixed interest.</td>
</tr>
<tr>
<td><strong>Level 1 - 'Requiring support'</strong></td>
<td>Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions</td>
<td>Rituals and repetitive behaviours (RRB’s) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB’s or to be redirected from fixed interest.</td>
</tr>
</tbody>
</table>

Discovered through the diagnostic criteria and the levels of severity, individuals with autism need support in order to function in daily life. Each child with autism is unique in the way characteristics of autism present themselves. Accommodations should be made according to the individual’s needs (Rudy, 2017). Ezzamel and Bond (2017) stated, “Tailoring interventions for children with ASD is important due to the lack of homogeneity in their presentation” (p. 37). The first set of accommodations addressed is to meet the needs of the behavioral challenges that often accompany a child with autism. Goodall (2015) recognized, “There is a misconception that because many autistic children are academically able, they can cope within the mainstream school environment” (p. 307). Due to the multiple moving parts within a classroom and school environment and the sensory overload in many classrooms, the environment can become very confusing and stressful to the student with ASD, resulting in challenging behaviors (Goodall, 2015). A strategy that can be used to help students with behavior across severity levels is being proactive. Using preventative strategies before the behavior occurs to help the student acclimatise to the classroom and school environment (Aller, 2017; Bevan-Brown, 2010). Bitsika and Sharpley (2018) suggest that the ASD Behaviour Checklist (ASDBC) and the Social Responsiveness Scale (SRS) could be used to help target areas of need. Another strategy that is
helpful is the use of positive reinforcement (Bevan-Brown, 2010; Simpson & Bui, 2016). When using positive reinforcement, students are given preferred items, a favorite toy, candy, or a kind word, immediately after a desired behavior has occurred. Positive reinforcement is often used for all severity levels and can be used with applied behavior analysis (ABA). Tiura et al. (2017) reported that ABA is an effective treatment for ASD. According to Tiura et al. (2017), the reason that ABA works for behavior for all levels of therapy is that its focus is on many areas of development, including cognition, communication, physical motor skills, adaptive skills and social skills. These skills are taught through simple tasks in which children are given the least amount of support necessary to be successful, while using a system of rewards to encourage correct behaviors. Such methods are firmly rooted in behavior and cognitive behavior theories. (p. 186)

Aller (2017) found, “Benefits of ABA being located in a school setting including opportunities to socialize with typically developing peers and teachers as well as exposure to ABA to general education teachers” (p. 9). In other words, ABA can be used in conjunction with multiple school setting depending on where the child is placed, and it has been found beneficial in those different settings. Aller’s (2017) research showed the benefit of utilizing behavior strategies within the regular education setting. Langton and Frederickson (2015) presented one of the educational difficulties presented for students with ASD is that they “experience elevated rates of exclusion from school” (p. 254), which is often due to behavioral difficulties. Langton and Frederickson (2015) stated that parents of children with autism suggested that the learning outcomes come second, while making sure that their child could be in school without being excluded came first when their child’s emotional well-being is supported. Some accommodations that can be made—that can help students to remain as part of the school—are teachers or teaching assistants
supporting emotional regulation, balancing out demands, providing supports in social skills, speech, play, language, and occupational therapies (Langton & Frederickson, 2015). Parents describe a successful placement as one that they can be included as much as possible (Langton & Frederickson, 2015). Cook, Ogden, and Winstone (2016) pointed out the importance of school community not only for behavior, but for social benefits as well.

**Social and Communication Accommodations**

One of the criteria for an autism diagnosis is deficits in social-communication across multiple settings. Hwang, Kim, Koh, and Leventhal (2018) stated, “Children and adolescents with autism spectrum disorder (ASD) show a myriad of atypical behaviors, including restrictive and repetitive behaviors and interests, as well as spoken language and content that may be substantially socially inappropriate” (p. 225). Therefore, exploration into the research about accommodations that meet this need is essential.

![Figure 2. Competing needs by Gilless (2016). Retrieved from http://schoolofdoubt.com/2016/04/15/competing-needs/](http://schoolofdoubt.com/2016/04/15/competing-needs/)

**Inclusion**

Inclusion has been found to improve social interaction and communication for students
with ASD. Rotheram-Fuller, Kasari, Chamberlain, and Locke (2010) investigated social involvement of children with autism in elementary classrooms. They discovered that shared activities with typically developing peers in the early elementary school years helped to protect social relationships in the later elementary school years (Rotheram-Fuller, p. 1228). Rotheram-Fuller et al. (2011) stated, “Children with ASD who are included in typical classrooms show improvement in their social initiations, and the ability to generalize learned social skills in school” (p. 1228). Falkmer, Anderson, Joosten, and Falkmer (2015) researched parents’ perspectives on inclusion for their children with autism and found, “The school was considered important in creating an environment that enabled inclusion, particularly through positive peer relations, prevention of bullying and help from support staff” (p. 1). Other accommodations that were found to be successful for inclusion in the regular education classroom were the positive relationships developed between parents and teachers, the regular education teacher’s understanding that child’s behavior is a condition of their autism, and activities that enhanced peer relationships (Falkmer et al., 2015). Peer relationships and peer mediation have been shown to be an effective accommodation for pro-social behaviors. The National Research Council (2001) declared:

Studies have demonstrated that interactions established between children with autism and adults do not easily generalize to peer partners. However, typical peers have been shown to be effective intervention agents for young children with autism. In these approaches, the peers are taught particular strategies for eliciting social, play, and communicative responses from a young child with autism. Most of these procedures have also been demonstrated to be effective when used in an inclusive setting, in which most of the children present are typically developing. (p. 138)
In an inclusive setting, students can benefit from other strategies, as well. Craig et al. (2017) suggested the use of a personal communication device to help students with autism improve social functioning. Parents have found that having a place where a student with autism can take a “break” when they are feeling scared and having a trusted person to talk to encourages positive social interactions (Bevan-Brown, 2010). Within the inclusive school setting, students with autism need the individual accommodations that best meets their specific need to ensure their success.

**Peer Interventions**

The use of peer modeling and intervention is a well-researched based strategy that has been proven to help students with autism become more socially successful. Al-Qaryouti, Nachabe, and Leeder (2017) did a case study on a kindergarten student with autism at a child care center at Sultan Qaboos University. They found that the mainstream setting provided opportunities to be taught social skills in a way that would not be as successful in a self-contained classroom. Al-Qaryouti et al. (2017) found that there is some evidence to suggest that a child centered, rather than teacher led approach, is more effective in facilitating play. Typically developing peers can also be paired with the autistic child, and encouraged to follow the lead of the autistic child. This type of less structured and more naturalistic approach has shown promising signs of improving the
Peer-mediated interventions (PMI) have been found to help the student with ASD generalize social interactions across multiple settings. Schmidt and Stichter (2012) wrote, “Although adults were successful in teaching skills to children with PDD, these skills were not generalized once the intervention was concluded” (p. 96). The generalization of skills is important for students with autism. Emily Aller (2017) stated, “To provide the best outcome for the growing number of children with ASD being placed in inclusive settings, PMI can help increase social interactions between children with and without ASD thus, promoting full inclusion” (p. 21). Peer interventions have been thoroughly researched and found to be very successful for promoting social interactions for students with autism (Ezzamel & Bond, 2017; Schmidt & Stitcher, 2012; Simpson & Bui, 2016).

**School-Connectedness**

School culture and connections have found to enhance the social-communication of students on the autism spectrum. Goodall (2015) made the statement, “Belongingness, as one of the hallmarks of a community, depends on many environmental and social factors, such as teachers and pupils developing trusting relationships whereby they are engaged in ‘joint enterprise,’ working together in ‘co-agency’ with peer support” (p. 323). Teachers and school administrators have an important role in creating a school environment where all students, regardless of their ability or disability, are included. Hebron (2017) researched the importance of school connectedness when children with autism begin the transition from primary to secondary schooling. She found that students that had consistent connections with their school during the primary years, had positive experiences as they transitioned into the secondary school (Hebron, 2017). The accommodations for social-communication can help students with autism to be more
Students with autism are entitled to an educational experience in the least restrictive environment possible. Autism Speaks (2012) reported:

IDEA provides that students with disabilities are entitled to experience the “least restrictive environment.” School districts are required to educate students with disabilities in regular classrooms with non-disabled peers, in the school they would attend if not disabled, to the maximum extent appropriate, supported with the aids and services required to make this possible. (p. 72)
To provide the least restrictive environment, students need academic accommodations based on their individual needs. The general education setting is one place where appropriate accommodations can be made. Kurth and Mastergeorge (2010) looked at the impact of classroom placement on academic and cognitive achievement and they determined that “inclusion is associated with significant academic gains for students with autism” (p. 12). Other studies have found similar results. Kim, Bal, and Lord (2017) conducted a study on the academic achievements of children with autism from ages 2 to 18. Kim et al. (2017) discovered, “Children who stayed in general education or inclusive classrooms showed significantly higher academic achievement and IQ scores at both age 9 and 18 compared to those who moved from general education or inclusion classrooms to special education classrooms” (p. 9). Students within the inclusive setting have been found to not only have higher academic achievement than students in self-contained classrooms but also have progressed faster (Aller, 2017). One way that has been found to be an effective accommodation is Universal Design for Learning (UDL). The definition of UDL, according to the National Center on Universal Design for Learning (2014), is “UDL provides a blueprint for creating instructional goals, methods, materials, and assessments that work for everyone--not a single, one-size-fits-all solution but rather flexible approaches that can be customized and adjusted for individual needs” (para. 2). Goodall (2015) found that UDL is an effective way to meet the individual needs of students with autism:

A range of needs can be supported within the diverse classroom when practice is premised on the UDL principle of multiple means of representation (what we learn), expression (how we learn) and engagement (why we learn). Providing greater support ensures high standards are preserved whereby difference is not denied. (p. 310)

Designing learning that meets the needs of the individual requires that accommodations to be
made not only for the students with autism but also every student within the classroom. Some accommodations that have been found effective within the inclusive setting are one-to-one support (Bevan-Brown, 2010; Gore Langton & Frederickson, 2016), identifying students interests and strengths to ensure motivation for learning (Bevan-Brown, 2010), adapting instruction when appropriate (Falkmer et al., 2015), chunking instruction (Goodall, 2015), and the use of visual aids (Al-Qaryouti et al., 2017). Shared reading is another strategy that has been found to have both social and academic benefits. Simpson and Bui (2016) observed that shared reading provides “an opportunity to improve reading skills, such as fluency, vocabulary, and comprehension while also supporting the development of social skills, such as turn-taking and interacting with peers” (p. 163). Shared reading activities were found to enhance learning in students with low-functioning autism (LFA), as well. “The Reading buddies intervention provided an opportunity to participate in a shared reading activity and hear stories read by peers – an activity most typically-developing students engage in on a regular basis in their classrooms” (Simpson & Bui, 2016, pp. 174-175). Appropriate accommodations for standardized tests have been associated with achievement on those tests. Bouck (2017) revealed accommodations that have been found to be successful, such as a reader for instructions, additional time, and checking for clarification. It is necessary to make sure that all accommodations are listed in the student’s Individual Education Plan (IEP) (Bouck, 2017). Meeting the student’s educational needs requires the academic accommodations that is best for each child.

Sensory Accommodations
Sensory accommodations are important when looking at the needs of students with autism. Chan, Sudirman, and Omar (2017) stated, “Sensory response is declared as feature of diagnostic conditions. Sensory responses are important for the human brain to analyze and produce knowledge, perception and awareness” (p. 53). Sensory problems can be a barrier for students with autism to meet their behavioral, social, and academic goals. Ashburner, Ziviani, and Rodger (2008) studied sensory processing and the behavioral, educational, and emotional outcomes for children with ASD. Ashburner et al. (2008) learned that “people with ASD frequently present with combinations of sensory under- and overactivity and sensory-seeking behaviors that might also be explained by hypersensitivity and aversion to rapid, changing, or underpredictable sensory input coupled with preference for predictable, repetitive sensory input” (p. 565). Classrooms are complicated sensory environments, including a lot of visual, auditory and tactile input (Ashburner et al., 2008). Due to the complex sensory nature of our typical classrooms, appropriate accommodations should be made. One of the most common and successful accommodation is maintaining a structured environment (Al-Qaryouti et al., 2017; Ashburer et al., 2008; Bevan-Brown, 2010; Falkmer et al., 2015; Goodall, 2015). Structured
learning environments are not the only accommodation that will work for multiple students with autism. Goodall (2015) also suggested

room to move around within well-ventilated classrooms, lit by natural light; quiet spaces to go to when stressed to reduce over-stimulation (such as small seating areas set into classroom or corridor recessess); surfaces having simple colour palettes with matt finishes and the use of curved walls. Any areas of support, such as “quiet refuges” or “safe havens” need to be positioned for easy access, negating the need to navigate complex busy corridors. (p. 322)

For appropriate accommodations to be made, parents need to be involved (Goodall, 2015, p. 322). Structured environments along with other sensory accommodations can promote the best learning environment possible for students with autism spectrum disorder.

**Conclusions**

Regarding a child with autism, it is important to understand the diagnostic criteria and the severity levels included within the diagnosis. Appropriate behavior, social-communication, academic, and sensory accommodations can make all the difference when the child goes to school. Parents are an integral part of the decision-making team when developing those accommodations and listing them in a child’s IEP. Nevertheless, an informed parent will make informed decisions. Thus, they will then share those informed decisions with the Individual Education team. Informed decisions will yield accommodations inevitably strengthening socialization behaviors, communication skills, academic achievement and sensory outcomes enhancing, in the big picture, their child’s school success.
Chapter 3
Project Design
Overview of the Chapter

This chapter presents the design for my thesis project, Parent guidelines: Informed conversations at the IEP table. The project is designed to assist parents of children with autism to become an integral part of the Individual Education Plan (IEP) team. In order to empower parents with quality input at IEP meetings, to best meet the education needs of their child. The guide informs parents how to use and interpret the language established within a spectrum diagnosis and to articulate best practices regarding accommodations that have been proven to increase the possibility of behavioral, social, and academic success for their child. The first section of the guide explains the diagnostic criteria for an autism diagnosis. A table with the criteria and examples are given. The second section of the guide lays out the three levels of severity, including characteristics that fit within each level. The final sections in the guide provide evidence-based strategies for accommodations for students with autism in the areas of behavior, social-communication, academic, and sensory. Having this knowledge will give parents the tools so that they can make the best decisions for their child, allowing them to play an integral role in their child's education.
Parent Guidelines:

Informed Conversations at the IEP table
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Capturing the Essence of a Physician's Diagnosis


Autism spectrum disorder can show itself in many different ways, much like this rainbow. Every individual that is diagnosed with being on the autism spectrum can present with different characteristics. In 2013 the American Psychiatric Association released the fifth edition of the Diagnostic and Statistical Manual of Mental disorders (DSM-5). One of the major changes from the fourth to the fifth edition was the criteria for Autism Spectrum Disorders. Bal, Farmer, and Thurn (2017) stated, “The autism spectrum is manifest in a variety of symptom presentations, and comprises the full range of cognitive and language abilities” (p. 2940). It is important as parents of children with autism to understand the criteria that qualifies children to be diagnosed with autism spectrum disorder. There are two categories that clinicians look at when exploring a possible autism diagnosis. The first category is “Persistent deficits in social communication and social interaction across multiple contexts” (American Psychiatric Association, 2013). All three characteristics listed under this category must be present. The second category is “Restrictive, repetitive patterns of behavior, interests, or activities” (American Psychiatric Association, 2013). Two out of the four characteristics listed under this category must be present. In addition, symptoms must have occurred since early development and they must cause serious problems
with work-related, social, or any other important area of current functioning. Table 1 below describes the characteristics with examples under each category.

**Table 1.**

*Autism Spectrum Disorder Diagnostic Table with Examples*

| 1. Problems with back-and-forth social-emotional exchange with another individual. | • Meddlesome touch, licking etc.  
• Unable to start or maintain conversations  
• Does not want to share, doesn't point things out to others, lack of shared attention  
• Does not respond to others' emotions (smile, frown, crying, etc.)  
• Only interacts with others when they want help or need something  
• Difficulty imitating social play |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Image" /></td>
<td><img src="image2.png" alt="Image" /></td>
</tr>
</tbody>
</table>
| 2. Problems with non-verbal communication used when interacting with others socially. | • Lack of eye contact  
• Trouble understanding and using body language (may face away from speaker)  
• Trouble understanding gestures (nodding, waving, pointing)  
• Speech that is not at a normal volume or rhythm  
• Trouble connecting their verbal and non-verbal communication (connecting eye contact with words or gestures) |
| ![Image](image3.png) | ![Image](image4.png) |
| 3. Problems with creating and keeping friendship with peers. | • Trouble understanding other people's perspectives  
• Trouble matching their behavior to the social situation that they are in (not understanding that peers have lost interest, not realizing when they are not welcome in play or conversation, doesn't understand other's emotions)  
• Problems engaging with peers in imaginative play |
<p>| <img src="image5.png" alt="Image" /> | <img src="image6.png" alt="Image" /> |</p>
<table>
<thead>
<tr>
<th>MASTERS THESIS</th>
<th>38</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Restricted, Repetitive Patterns of Behavior, Interests, or Activities (Must present with 2 out of the 4)</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **1. Stereotyped or repeated motor movements, speech, or use of objects.** | **•** Repeating other people's words or phrases  
**•** “Scripting” - Repeating lines from movies, TV shows, books, songs, etc.  
**•** Talking jibberish after they are 2 years old  
**•** Misuse of pronouns (You for I, he for she)  
**•** Repetitive hand movements (flapping, clapping, finger flicking)  
**•** Repetitive use of objects (lining up toys, dropping items, opening and closing doors, turning lights on and off) |
| ![Image](image1.png) | ![Image](image2.png) |
| **2. Extreme need to stick to routines, patterns of behavior, and extreme resistance to change.** | **•** Insistence on sticking to the routine, could be an unusual routine  
**•** Repetitive questioning on a specific topic  
**•** Verbal rituals (need to say the same thing in the same way)  
**•** Compulsions  
**•** Difficulty with transitions  
**•** Overreaction to a minor change  
**•** Not able to understand humor, implied meaning, or sarcasm |
| ![Image](image3.png) | ![Image](image4.png) |
| **3. Extremely, fixated interests that are not normal in focus or intensity.** | **•** Obsessions, preoccupations  
**•** Interested in only a few things  
**•** Interests that are very intense  
**•** Preoccupation with numbers, letters, symbols, colors, etc.  
**•** Unusual fears |
<p>| <img src="image5.png" alt="Image" /> | <img src="image6.png" alt="Image" /> |</p>
<table>
<thead>
<tr>
<th>4. Over-sensitivity or Under-sensitivity to sensory conditions in the environment</th>
<th>● Attachment to an inanimate object that is unusual (string, rubber band, pencil, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>● High pain tolerance</td>
<td></td>
</tr>
<tr>
<td>● Preoccupation with touch or texture</td>
<td></td>
</tr>
<tr>
<td>● Fascination with watching movement</td>
<td></td>
</tr>
<tr>
<td>● Watching people out of the corner of their eye, unusual squinting</td>
<td></td>
</tr>
<tr>
<td>● Unusual responses to sight, sound, taste, touch, smell</td>
<td></td>
</tr>
<tr>
<td>● Unusual sensory exploration with objects (smelling, sniffing, licking)</td>
<td></td>
</tr>
</tbody>
</table>

**Level of Severity**

An important edition to the DSM-5 is the description of the levels of functioning according to the amount of support and individual requires to function in the community. There are three functioning levels for both the major diagnostic criteria: Social communication and Restricted, repetitive behaviors. Bal, Farmer, and Thurm (2017) discussed the reason for describing function in the DSM-5, “In this case, 'functioning' does not refer to quantification of ability or symptom, but rather how those symptoms affect an individuals' age-appropriate ability to responds to the demands of daily life” (p. 2939). The table below helps to describe the severity levels within each type of support.

Table 2.
### DSM-5 Table of Severity Descriptors

<table>
<thead>
<tr>
<th>Severity Level for ASD</th>
<th>Social Communication</th>
<th>Restricted interests &amp; repetitive behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 3 - ‘Requiring very substantial support’</strong></td>
<td>Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others</td>
<td>Preoccupations, fixated rituals and/or repetitive behaviours markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.</td>
</tr>
<tr>
<td><strong>Level 2 - ‘Requiring substantial support’</strong></td>
<td>Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others</td>
<td>RRBs and/or preoccupations or fixated interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRB’s are interrupted; difficult to redirect from fixated interest.</td>
</tr>
<tr>
<td><strong>Level 1 - ‘Requiring support’</strong></td>
<td>Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions</td>
<td>Rituals and repetitive behaviours (RRB’s) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB’s or to be redirected from fixated interest.</td>
</tr>
</tbody>
</table>


In order to better understand the table, examples of the characteristics within each level of support are given below in their own table below.

**Level 3:** **Requiring very substantial support.** Children at this level require a considerable amount of support to be able to function socially, within the classroom, work environment, or other daily activities.
Table 3.

Level 3: Requiring very substantial support

<table>
<thead>
<tr>
<th>Social Communication</th>
<th>Restrictive, Repetitive Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Child approaches others in an unusual manner only to meet their needs</td>
<td></td>
</tr>
<tr>
<td>● Speech with only few words that may not be understood by others or completely Non-verbal</td>
<td></td>
</tr>
<tr>
<td>● Child may only respond to direct social approaches</td>
<td></td>
</tr>
<tr>
<td>● Behavior is affected greatly when change occurs</td>
<td></td>
</tr>
<tr>
<td>● Repetitive behaviors that interfere with functioning in all areas of the child's life (school, home, playground, etc.)</td>
<td></td>
</tr>
<tr>
<td>● Behavior is very rigid</td>
<td></td>
</tr>
<tr>
<td>● Becomes extremely upset if he/she needs to change their focus or action</td>
<td></td>
</tr>
</tbody>
</table>

Level 2: Requiring substantial support. Children at this level of severity do not require quite as much support as level 3 but do need a significant amount of support in order to function in daily activities.

Table 4.

Level 2: Requiring substantial support

<table>
<thead>
<tr>
<th>Social Communication</th>
<th>Restrictive, Repetitive Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Difficulty understanding verbal and nonverbal communication</td>
<td></td>
</tr>
<tr>
<td>● Social difficulties, even with support</td>
<td></td>
</tr>
<tr>
<td>● Initiating social interactions is very limited and often to their own interests</td>
<td></td>
</tr>
<tr>
<td>● Unusual responses to others</td>
<td></td>
</tr>
<tr>
<td>● Speech in simple sentences</td>
<td></td>
</tr>
<tr>
<td>● Hard time dealing with change, but does not cause as much distress as a child in level 3</td>
<td></td>
</tr>
<tr>
<td>● Repetitive behaviors are noticeable and may interfere with functioning in a variety of places (school and in public places but not at home)</td>
<td></td>
</tr>
<tr>
<td>● Hard time becoming redirected from their focus or action</td>
<td></td>
</tr>
</tbody>
</table>

Level 1: Requiring support. Children at this level of severity need support. However, with that support the individual can function in a more typical manner.
Table 5.

Level 1: Requiring support

<table>
<thead>
<tr>
<th>Social Communication</th>
<th>Restrictive, Repetitive Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Without support social communication is impaired</td>
<td>• Behavioral problems may only occur in one place (school and not at home)</td>
</tr>
<tr>
<td>• Hard time initiating conversation</td>
<td>• Problems with transitioning to new activities, but not to the extent that it affects functioning</td>
</tr>
<tr>
<td>• Difficulty responding to the social cues from others</td>
<td>• Problems with organization and planning</td>
</tr>
<tr>
<td>• May speak in full sentences and can be easily understood, but have a hard time with back-and-forth conversation</td>
<td></td>
</tr>
<tr>
<td>• Difficulty making friends</td>
<td></td>
</tr>
</tbody>
</table>

The importance of understanding the diagnostic criteria and the levels of severity is so that children are able to get the interventions that they need. Children with autism can fit into multiple categories within the levels of support. A child may need level 2 support for a restrictive repetitive behavior, but only need level 1 support for social communication. Since parents know their children best, it is important that they are aware of the research-based accommodations, so that they can work with clinicians and teachers to best meet the individual needs of their child.

**Accommodations**

As children enter school, it is important that parents become an active participant in the educational decisions that are made for their child. Knowledge of the different evidence-based strategies that have been proven effective for children with autism will empower parents with quality input at IEP meetings, to best meet the education needs of their child.

**Behavior Accommodations**

Children with autism often need assistance to maintain appropriate classroom behavior. Each child with autism is unique in the way characteristics of autism present themselves. A number of behavior accommodations have been found to be effective for children with autism.
Table 6.

*Behavior Accommodations*

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>How it works</th>
</tr>
</thead>
</table>
| **Prevention Strategies**     | • Used before the behavior occurs to help the student get acclimated to their class and school  
                                 | • Find what triggers the behavior  
                                 | • Look for ways to alleviate the trigger  
                                 | • For triggers that are unavoidable (fire drills, transitions, etc.) work on a plan to help the child work through the issue  
                                 | • Structure the child's day to support them as they get acclimated |
| **Positive Reinforcement**    | • Student is rewarded with a preferred item for displaying proper behavior  
                                 | • Could be a kind word, toy, candy, music, etc.  
                                 | • To be effective, reinforcement needs to be delivered immediately after the desired behavior occurs  
                                 | • Finding what motivates the child is key to the success of positive reinforcement |
| **Applied Behavior Analysis** | • Skills are taught through simple tasks that are broken down into steps  
                                 | • Students are given the least amount of support to make them successful  
                                 | • Positive reinforcement is used to encourage correct behaviors  
<pre><code>                             | • As students master skills support and frequency of reinforcement is reduced. |
</code></pre>
<table>
<thead>
<tr>
<th>Teaching assistant Support</th>
<th>Support in other areas of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Supports the student in the classroom to help maintain behavior</td>
<td>- Speech/Language</td>
</tr>
<tr>
<td>- Delivers reinforcement</td>
<td>- Occupational therapy</td>
</tr>
<tr>
<td>- Support only when needed</td>
<td>- Physical therapy</td>
</tr>
<tr>
<td></td>
<td>- Social skills</td>
</tr>
<tr>
<td></td>
<td>- Having support in other areas of need helps to alleviate the stress of those issues during instruction</td>
</tr>
</tbody>
</table>

| “Break” area                                                                               |                                                                                             |
|                                                                                           | - Having a place that the student can go when they feel frustrated or scared                  |
|                                                                                           | - In a well-established area                                                                  |
Social and Communication Accommodations

Children with autism have deficits in social and communication, as we learned when looking at the criteria for diagnosis. It is important to look at evidence-based accommodations to help children with autism overcome these difficulties. This section is broken down into three main strategies that have been proven effective. Accommodations within each strategy are given.

Inclusion

![Figure 2: Competing Needs by Gillell. 2016. Retrieved from http://schoolofdoubt.com/2016/04/15/competing-needs/](http://schoolofdoubt.com/2016/04/15/competing-needs/)

Inclusion has been found to improve social interaction and communication for students with ASD. As the graphic illustration shows, inclusion has a mix of students with and without disabilities within the general education classroom; as opposed to in a separate school (exclusion), being pulled out into their own classroom (segregation), or in the classroom but participating only with students with disabilities (integration). Students can be included in many ways, during instruction, part of the day, recess, lunch, specials, or all day. Rotheram-Fuller, Kasari, Chamberlain, and Locke (2010) investigated social involvement of children with autism in elementary classrooms. They discovered that shared activities with typically developing peers in the early elementary school years helped to protect social relationships in the later elementary
school years (p. 1228). Rotheram-Fuller et al. (2010) made the statement, “children with ASD who are included in typical classrooms show improvement in their social initiations, and the ability to generalize learned social skills in school” (p. 1228). In order to make inclusion a success, there are different accommodations to assist the student with autism.

Table 7.

*Social-communication Accommodations: Inclusion*

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching assistant support</td>
<td>- Helps prompt for appropriate social interactions for both the student with autism and the regular education student</td>
</tr>
<tr>
<td></td>
<td>- Delivers reinforcement</td>
</tr>
<tr>
<td></td>
<td>- Support only when needed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Activities</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Finding activities that all students will enjoy</td>
</tr>
<tr>
<td></td>
<td>- Activities that promote social interactions and enhance peer relationships</td>
</tr>
</tbody>
</table>
### Positive relationships between teacher and family

- Open communication
- Updates on progress
- Bridging the gap between school and home to help generalize skills
- Regular education teacher's understanding of autism

### Personal Communication device

- For students that struggle with communication so that they can still interact with their peers
- Helps non-verbal students to communicate needs

### Peer Interventions

The use of peer modeling and intervention is a well researched based strategy that has been proven to help students with autism become more socially successful. Peer modeling and intervention strategies can be used in or outside the classroom setting. Ezzamel & Bond (2016) describe Peer-mediated interventions, “Peer-mediated interventions (PMI) involve teaching typically developing children to engage with children with ASD often using direct informative messages” (p. 28). Peer modeling and intervention strategies have been found to help the student
with ASD generalize social interactions across multiple settings. Being able to transfer a learned skill from one setting to another is difficult for students with autism, therefore the use of peers is important to promote generalization. Schmidt and Stichter (2012) reported that peer-mediated interventions, “have been shown to be beneficial in promoting both generalization and maintenance of skills learned during intervention” (p. 96). There are a few different types of peer accommodations that can be made.

Table 8.

**Social-communication Accommodations: Peer-mediated modeling and intervention**

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>How it works</th>
</tr>
</thead>
</table>
| Peer-mediated modeling and intervention | • Peers are given training on how to work with students with autism  
• Students and peers work together  
• Peers provide support within the students natural environment  
• Peers provide cues and prompts that will eventually faded out  
• Peers are used as a model |
| Personalized intervention            | • Intervention strategies should be made based on the needs of the individual child  
• Input on social struggles, sensitivities, and motivational activities are needed |
Shared reading

- Students participate together in reading activities
- Both students are given the opportunity to read and listen
- Supports social skills: turn-taking and appropriate peer interactions

**School-connectedness**

School culture and connections have found to enhance the social-communication of students on the autism spectrum. Goodall (2015) made the statement, “Belongingness, as one of the hallmark of a community, depends on many environmental and social factors, such as teachers and pupils developing trusting relationships whereby they are engaged in 'joint enterprise', working together in 'co-agency' with peer support” (p. 323). It is important that students regardless of ability are included in their school environment. All students should have the opportunity to fully participate in school-wide activities. Hebron (2017) researched the importance of school connectedness, she found that students that had consistent connections with their school during the primary years, had positive experiences as they transitioned into the secondary school (Hebron, 2017, p. 11). Assuring that your child has the opportunity to be involved in the school-wide activities can have a lasting effect.

**Academic Accommodations**

Students with autism are entitled to an educational experience in the least restrictive environment possible. The general education setting is one place where appropriate accommodations can be made. Kurth and Mastergeorge (2010) found, “inclusion is associated with significant academic gains for students with autism” (p. 12). Other studies have found
similar results. Kim, Bal, and Lord (2017) discovered, “Children who stayed in general education or inclusive classrooms showed significantly higher academic achievement and IQ scores at both age 9 and 18 compared to those who moved from general education or inclusion classrooms to special education classrooms” (p. 9). Not only have students within the inclusive setting been found to have higher academic achievement than students in self-contained classrooms, but those students have progressed faster (Aller, 2017, p. 7). In order to provide the least restrictive environment, students need academic accommodations based on their individual needs.

Table 9.

*Academic Accommodations*

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Design for Learning (UDL)</td>
<td>• Creates instructional assessments, goals, materials, and methods that meet all students needs</td>
</tr>
<tr>
<td></td>
<td>• Adjusted for every student</td>
</tr>
<tr>
<td></td>
<td>• Used within a diverse classroom</td>
</tr>
<tr>
<td></td>
<td>• Multiple ways to demonstrate what, how and why we learn</td>
</tr>
<tr>
<td></td>
<td>• Preserves high standards</td>
</tr>
<tr>
<td></td>
<td>• Meets the needs of the individual</td>
</tr>
<tr>
<td>Identifying students strengths</td>
<td>• Using the interests of students to promote motivation for learning</td>
</tr>
<tr>
<td></td>
<td>• Using students strengths to create successful learning environments</td>
</tr>
</tbody>
</table>
Visual Aids

- Use of visual cues in the classrooms
  - Daily Schedule
  - Classroom schedule
  - Lesson structure
  - Reminders
  - Helps to alleviate frustration and anxiety
- Visual cues based on the need of the student
  - Pictures
  - Words
  - Types of schedule

Chunking instruction

- Breaking down instruction and directions into smaller sections
- Important to find the balance of how much the student can handle at one time

Teaching assistant Support

- Supports the student in the regular education classroom
- Delivers reinforcement
- Support only when needed
Sensory Accommodations

Sensory accommodations are important when looking at the needs of students with autism. Ashburner, Ziviani, and Rodger (2008) learned, “people with ASD frequently present with combinations of sensory under- and overactivity and sensory-seeking behaviors that might also be explained by hypersensitivity and aversion to rapid, changing, or underpredictable sensory input coupled with preference for predictable, repetitive sensory input” (p. 565).

Classrooms are complicated sensory environments, including a lot of visual, auditory and tactile input. Accommodations to the classroom should be made to help with behaviors caused by sensory sensitivities.

Table 10.

*Sensory Accommodations*

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured Environment</td>
<td>• The classroom should be set up in a way that minimizes the child's behaviors due to sensory issues</td>
</tr>
<tr>
<td></td>
<td>• Input on sensory sensitivity is crucial</td>
</tr>
<tr>
<td></td>
<td>• Some suggestions to create a structured environment:</td>
</tr>
<tr>
<td></td>
<td>◦ room to move around</td>
</tr>
<tr>
<td></td>
<td>◦ well-ventilated</td>
</tr>
<tr>
<td></td>
<td>◦ natural light</td>
</tr>
<tr>
<td></td>
<td>• Maintaining a consistent classroom set up</td>
</tr>
</tbody>
</table>
“Break” area

- Having a place that the student can go when they feel frustrated or scared
- In a well-established area

Surfaces within the classroom

- Smooth
- Simple colors

Conclusions

As a parent of a child with autism, it is important to understand the diagnostic criteria and the severity levels included within the diagnosis. Appropriate behavior, social-communication, academic, and sensory accommodations can make all the difference when the child goes to school. Parents are an integral part of the decision making team when developing those accommodations and listing them in a child's IEP. An informed parent can share their knowledge with the Individual Education team to assist in making decisions that are best for their child. Informed decisions will yield accommodations inevitably strengthening socialization behaviors, communication skills, academic achievement and sensory outcomes enhancing, in the big picture, their child’s school success.
References


Chapter 4

Discussion

This chapter is a reflection on the process of creating a guide for parents of children with autism that included diagnostic criteria, the different severity levels, and evidence-based accommodations to empower parents to give quality input at IEP meetings. The chapter is divided into four sections. The first section is Implications for Theory. This section provides a description of how the project evolved and the ways the project can be used theoretically. The next section, Implications for Practice, is an explanation of ways the guide can be used to improve methods in the field of special education. The third section, Implications for Future Research, includes possible areas of research that would strengthen the potential impact this guide has on parents with autism. Lastly, in the epilogue thoughts and knowledge are shared that were gained from this experience.

Implications for Theory

Implications to theory are made on how the project evolved from a parent guide on the advantages and disadvantages of inclusion for students with autism to Parent Guidelines: Informed Conversations at the IEP Table. Originally the project started as a guide for parents on the advantages and disadvantages of inclusion for students with autism. Once research began on the literature for the Master's proposal, it became apparent that that there was a need for more parent input at IEP meetings. Aller (2017) stated:

Parents have a perspective on their child that nobody else does therefore, having input from them regarding benefits and disadvantages of the educational setting on development is crucial. It would also be a good idea to explore what role parents have in deciding the educational setting for their child. (p. 28)
When IEP meetings are generally conducted; teachers and administrators determine placement, goals, and accommodations for children with autism; and the expectation is that parents come and sign the paperwork. It would be advantageous to have genuine input from parents—those who know their child best—when developing a child’s IEP. For parents to fully participate, they need to have a grounded understanding of the criteria for an autism diagnosis and the range of severity levels. In addition, having knowledge of evidence-based strategies and accommodations would assist parents in choosing the accommodations that best fit their child. Therefore, *Parent Guidelines: Informed Conversations at the IEP Table* was developed.

The theoretical implications for how this project can be used in the field of special education are that parents would use this guide to equip themselves to bring quality information about what will work best for their child to an IEP meeting. The guide begins by breaking down the criteria for an autism diagnosis into the two main categories of problems: social communication and restricted, repetitive behaviors. Each characteristic within the categories is explained and examples are given. The update to the *DSM-5* included three levels of severity. The guide provides a chart with examples and descriptions at each level. The theory is that parents can use the examples within the guide to best align their child’s abilities to where they may fall on the autism spectrum. For parents to align their child’s needs to the appropriate accommodations, the guide places the modifications within the deficits that are common for students with autism: behavioral, social-communicative, academic, and sensory. In theory, by providing the information included in the guide, parents will bring quality information to the IEP table. As a result of the implementation of appropriate modifications/accommodations, the child will likely benefit or improve in one of the developmental domains listed above, namely academic, behavioral and/or social-communicative.
Implications for Practice

This section provides ways to use *Parent Guidelines: Informed Conversations at the IEP* for practice in the field of special education. The guide is designed to assist parents of children with autism to become an integral part of the IEP team by empowering parents with quality input. The guide informs parents how to use and interpret the language established within an autism spectrum diagnosis and to articulate best practices on accommodations that have been proven to increase the possibility of behavioral, social, and academic success for their child.

Making the decision about goals and designing instructional accommodations for students is one of the most challenging parts of creating a student’s IEP. When the student is new to the special education teacher's caseload, it becomes even more problematic. The parent guide could be used to give parents a sense of where their child is on the spectrum. Bal, Farmer, and Thurn (2017) stated, “The autism spectrum is manifest in a variety of symptom presentations and comprises the full range of cognitive and language abilities” (p. 2940). It is important that parents of children with autism understand the criteria that qualifies children to be diagnosed with autism spectrum disorder. In addition, the parents can use the descriptions and examples of the three levels of severity to properly target the deficit areas when deciding on accommodations. As parents determine what deficits might become a barrier for their child’s educational experience, the guide will provide an overview of accommodations that could help the child to overcome those areas.

The guide provides a list of accommodations that have been proven to help with behavioral, social-communicative, academic, and sensory problems. Having informed parents at the IEP meeting will help to bridge the gap between what the teacher knows and does not know about the student, so that a unique educational plan can be created to provide the greatest chance for success. Accommodations should be made according to the individual’s needs (Rudy, 2017).
Ezzamel and Bond (2017) stated that, “Tailoring interventions for children with ASD is important due to the lack of homogeneity in their presentation” (p. 37). Preparing parents to fully participate in the development of their child’s IEP can save special education teachers from having to guess about what accommodations may work best for those students. Also, accommodations, determined during an IEP meeting to best suit the child’s needs, can be followed through at home as well because parents have acquired a more informed understanding of their child’s learning modalities.

Autism is a spectrum, and each child is unique—not only in how autism presents itself, but also in what accommodations will work the best. It is necessary that all parties involved in the IEP team have knowledge of the research and resources that are available to them when creating a student’s IEP. Having professional development opportunities for teachers on what the district has available and ways to promote positive parent-teacher relationships would be beneficial. Falkmer et al. (2015) claimed, “The child's school experiences, and thus the parents’ perception of the inclusiveness of the school, were heavily affected by their everyday relationship with the child’s teacher” (p. 15). Parents have a perspective and knowledge about their child that, when met with the experience and expertise of the special education teacher, will provide an opportunity to for the child to best achieve their goals. The guide, *Parent Guidelines: Informed Conversations at the IEP Table*, could have a positive influence in the field of special education by promoting informed collaboration between parents and teachers to create an educational plan where the child will have the greatest benefit.

**Implications for Future Research**

This project offers guidelines to parents on the language and criteria used in an autism diagnosis, along with descriptions of the levels of severity and evidence-based accommodations.
There were limitations to the research that were determined. As research was conducted to create this project, it would have been helpful to have more input from parents and teachers on the benefits of and hindrances to their collaborative experiences. Future research would also be beneficial on what effect the informed parents have on their child’s educational experience by coming to the IEP table informed. Another aspect of research that would be helpful is both the teachers’ and parents’ perspectives on the collaboration process and how that relationship has changed the way an IEP meeting is conducted. Future research should be done on the risks and benefits that parent input has on targeting accommodation strategies to align with their child’s specific deficits. Having first-hand accounts from parents and teachers on the advantages and disadvantages of specific accommodations would provide the parents with a window into what a successful collaborative IEP meeting looks, feels, and sounds like.

**Epilogue**

As I reflect on the experience of conducting research and creating my project, there are important things that I can take away as a Christian and as a parent and a teacher. Through this experience, I have developed a better understanding of the importance of prayer. As I took on this challenge, I prayed for the Lord’s guidance throughout the entire process. The Lord brought me through every challenge, anxiety, and stress-filled situation. In addition, this experience has reminded me of the importance of prayer throughout the IEP process. I need to remember to pray throughout the creation of the IEP, as I invite parents to become involved, and during the IEP meeting. Realizing that God knows what will be most beneficial for the student, prayer allows me to look for guidance and to trust Him to help me get the student there.

As a parent, this experience has allowed me to understand the important role I have in my children’s education. Having two boys with 504 plans, an educational plan that is managed by
the classroom teacher due to a diagnosed disability, I have information about my boys that can help their guidance counselors and teachers find the best way to help them be successful. It is important I reach out for more collaboration with their schools.

Many of the jewels I have taken from this experience are applicable to me as a special education teacher. It has made me aware of how I involve the parents of my students in the IEP process. Currently, parents are given a form to fill out that is included in one section of the IEP. I am feeling led to propose a document that will allow parents to have greater input into the goals and accommodations that will be included in their child’s IEP. Along with that, it is imperative I develop positive relationships with the parents. I believe Couros (2015), author of the book *The Innovator's Mindset*, said it best: “The three most important words in education are: Relationships, relationships, relationships. Without them, we have nothing” (p. 68). I need to bear in mind whether or not I agree with a parent, they want what is best for their child, and I need to value their opinion. Finally, I am taking away the importance of individualizing the IEP. It is common to use the same or similar goals for students within a specific disability category. This project has helped me refocus when developing an IEP for a student, so that the IEP is indeed an *Individualized* Education Plan.
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