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Parents’ Perspectives on Early Intervention for Children With Autism

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MA, Kaplan University, 2016

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Dissertation Submitted in Partial Fulfillment

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Abstract

The purpose of this study was to analyze parent perspectives on early intervention services for children with autism. Research has shown a significant positive impact of early intervention on children with autism. A total of eight parents participated in this basic qualitative study guided by social cognitive theory. Participating parents were those whose child had an autism diagnosis and were receiving or had received early intervention services in Southeast Michigan. Data analysis included establishing themes and codes to organize the data into categories. Thematic analysis was applied by analyzing interview transcripts. The research questions used to collect data addressed parents' perspectives on early intervention, facilitators of and barriers to early intervention, and improving the effectiveness of intervention programs. Results indicated four themes from parents' perspectives on early intervention for children with autism. The findings of this study indicated that the parents thought that teachers were interactive and had good communication, that their children received individually tailored programs and therapies, that parents struggled with transportation due to expenses and having to take off work, that the teachers 'availability through phone and in person provided good communication, and that parents lacked outside resource information. Findings from this study could be used to improve parent involvement and delivery of early intervention. The study may also continue to support positive social change for health educators and children by improving early intervention programs along with starting new programs.

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Dedication

I would like to dedicate this work to my children, Penelope, Michael, Rosalie, and Scott, for being my inspiration. I would also like to dedicate this work to my sister, Brooke; my husband, Eric; my brother, Lenny; Dad; Mom; and Grandma and Grandpa Schmidt for always supporting me and encouraging me throughout my life. I would also like to dedicate this work to my best friends, Nicole, Brian, Erin, and Audy, for sticking by my side and providing constant encouragement.

Acknowledgments

I have to acknowledge my wonderful committee members, especially my committee chair, Dr. Nolan. Thank you for all the support and guidance throughout this journey. Your encouragement and guidance made it possible for me to reach my goals. Thank you for believing in me.

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Chapter 1: Introduction to the Study

Introduction

The purpose of this study was to analyze the perspectives of parents of children with autism receiving early intervention services. Input from parents whose children receive these services may allow for improvement to be made to existing therapies, which include speech and language therapy, physical therapy, developmental therapy, psychological services, and occupational therapy (Centers for Disease Control and Prevention [CDC], 2019d). These services are vital to health promotion, as they help some of the most vulnerable individuals in the population acquire skills during formative years that will result in improved health across the lifespan. Parent perspectives on early education programs can determine the overall benefits that children receive from the provision of these services. The potential social implications of this study include a significant positive impact on the delivery of services toward increasing effective communication with parents, gaining insights into the experiences of parents of children with autism using intervention services, and providing information to improve health for children with autism and their families. In this chapter, I review the background of early intervention and autism and provide the study's problem statement, purpose, theoretical and conceptual frameworks, nature, definitions, assumptions, scope and delimitations, limitations, and significance.

Background

Early intervention services support babies and toddlers with developmental delays and disabilities and support their families as well. These services include speech and language therapy, physical therapy, developmental therapy, psychological services, and occupational therapy (CDC, 2019b). Autism encompasses a broad range of conditions that include challenges with social skills, nonverbal communication, speech, and repetitive behaviors. This disability is accompanied by gastrointestinal disorders, seizures, sleep disorders, and sensory sensitivities (Kuhlthau et al., 2017). Children who receive early intervention services are able to maintain developmental growth and integrate into general education services. In a study that collected data on adults living with autism who participated in early intervention services while growing up, the results showed that participants were doing better in verbal functioning, educational levels, social functions, and independent factors compared to adults who did not receive intervention services (Abatzoglou et al., 2019). Thus, the health promotion benefits received from these services have been demonstrated with longitudinal analysis (Kuhlthau et al., 2017). Every case involving autism is different and varies per the individual.

In 2018, 1 in 44 children was diagnosed with autism spectrum disorder (ASD), whereas in 2002, only 1 in every 150 children was affected (CDC, 2019a). Early intervention is for children from birth to 3 years old. These programs provide services to children with autism and other developmental delays (Bellini et al., 2016). These services can promote better language skills, motor skills, and health across the lifespan.

In Michigan, by 2019, 20,959 children had been diagnosed with autism (Michigan Department of Health and Human Services, 2020). This number represented quite an increase compared to 2015, when the number of children diagnosed was 15,976

(Michigan Department of Health and Human Services, 2020). The geographical area of focus for this study was Southeast Michigan. County-level rates could not be determined. Common trends seen throughout Michigan are impaired communication, impaired social interaction, restrictive and/or repetitive interests, and sensory issues (Autism Alliance of Michigan, 2020). The Modified Checklist of Autism in Toddlers (MCHAT) is a 23-question screening tool used to diagnose children throughout the state of Michigan. The questions asked on the MCHAT pertain to developmental delays (Autism Alliance of Michigan, 2020).

Parents are presented thorough information about autism and the signs, symptoms, and behaviors to look for but rarely get detailed information on early intervention services (Abatzoglou et al., 2019). Service delivery modes such as specialized therapies and interventions are not always used to engage families in the process (Brebner et al., 2016). Early intervention is a crucial time for children with autism to learn skills that are delayed or nonexistent (Abatzoglou et al., 2019). Transitioning from early intervention to general education classes can be extremely difficult for a child with autism (Fontil et al., 2019). Parent involvement is crucial when it comes to the services being beneficial (Abatzoglou et al., 2019).

Early detection and diagnosis of autism are usually not initiated by doctors but dependent on parents who have concerns with their children (Imai et al., 2019). Warning signs and certain behaviors that are unexplained can cause a parent to seek help through early intervention diagnosis services to find the proper answers (Imai et al., 2019). Parent input is vital for successful intervention in two ways: specifying which intervention outcomes are of utmost importance by setting success criteria and reporting on the measures of outcomes during the services by interacting regularly with the teachers and therapists (Leadbitter et al., 2017). An integral part of evaluating early intervention is the measurement of patient care and parent input (Imai et al., 2019). Early childhood education helps create positive socioemotional, behavioral, and educational outcomes (Morrissey, 2019). While all services provided through early intervention have a direct impact on health promotion, health education specifically is provided to help a child's development during these programs (Leadbitter et al., 2017).

Early intervention and parent perspectives represent an underexplored area. Sources such as Zheng et al. (2016) and Sheldrick et al. (2019) have concluded that early intervention and parent perspectives have been understudied. Early developmental opportunities, such as early intervention, can provide the child with academic success, health, and well-being (CDC, 2019a). The following are some of the few studies that provide information on parents' perspectives and early intervention experiences: Edwards et al. (2017), Jennings (2017), Lee (2015), and Singler (2018). Parents play a vital role in early intervention. They can become informed advocates, and the family must grant written consent for a child to be evaluated and receive treatment (Special Education Guide, 2020). Parents are also required to implement many interventions at home; thus, educating parents on specific techniques to improve child health and functioning is essential to intervention success (Morrissey, 2019). To successfully promote the health of children in these programs, parent perspectives are vital to this area of research. This study is needed to gain a better understanding of the early intervention process and how children with autism benefit from these services.

Problem Statement

Early intervention programs provide services to children under the age of 3 with developmental delays and disabilities (CDC, 2019b). Early intervention is a combination of services such as behavioral health, developmental therapy, occupational therapy, physical therapy, speech and language therapy, social work services, and psychological services that collectively serve to promote the health of children with special needs (Larcombe et al., 2019). These services can have a remarkable impact on the child's ability to overcome difficulties and learn new skills (CDC, 2019a). Early intervention provides long-lasting improvements to a child's behavioral health and creates customized plans that will adapt to the child as they change (Larcombe et al., 2019).

Research on early intervention has demonstrated crucial long-term positive effects on the health and education of autistic children (National Institutes of Health [NIH], 2017). Early intervention is critical, with 1 in 59 children being diagnosed with autism and boys being 4 times more likely to be diagnosed than girls (CDC, 2019c). Children with autism who attend these services, compared to children who wait, have been shown to have a higher intelligence quotient and better language and motor skills children (National Institutes of Health [NIH], 2017). Parents play a vital role in their children's overall achievement. Early interventions are play based and parent facilitated, so therapists can interact and observe children in an environment in which they feel comfortable and act naturally (Kaczmarek, 2018). This allows time for the parents to engage in observational learning of service techniques and allows them to adopt the same system at home.

Early intervention services can be held at specialized centers or in a natural setting child (National Institutes of Health [NIH], 2017). Community centers or specialized schools have programs where the child can attend and receive therapies pertaining to their disability (Stuart, 2019). A natural setting may be a child’s home, a relative’s household, a playground, or even a park. The therapist meets the family at a specific location to allow the child to feel comfortable (Stuart, 2019). Natural settings are convenient for parents who work during the day and need specific appointment dates and times.

Parental input on early education programs can determine the overall benefits that children receive during health education services (Knierim et al., 2018). Interventions for behavioral health issues can be addressed and improved through play-based techniques (Gordon, 2017). Floor-time is a play-based technique that is commonly used, in which skills are built upon by incorporating the child’s own interests (Gordon, 2017).

Services held at specific locations can cause time conflicts for some families, which can lead to some children not being able to attend all services (Smith, 2017). This can lead to a lack of support for the children and the parents. Other barriers include lack of staff, lack of coordination, and parents not understanding the full benefits that their child is eligible for (Knierim et al., 2018). By identifying specific barriers and facilitators, it is possible to improve outcomes.

Parental input allows special education teachers to specialize early intervention services and prepare Individualized Education Programs (IEPs; Edwards et al., 2017). Involving families to participate in therapies can improve the success of health and education services (Smith, 2017). These services can significantly impact the overall health and quality of the child’s life. Proper education provided to parents on topics such as benefits of therapy services, qualifying services, and parental support can persuade them to enroll their child (Smith, 2017). Health education services provided during early intervention can help a child with issues such as anxiety, depression, and physical fitness (Gordon, 2017). Studies have shown that when evidence is presented to parents on the overall success rate of achievement by utilizing early intervention services, parents are more willing to enroll their child (Edwards et al., 2017). The earlier a child is enrolled, the more time they will be given to receive therapies and health education services.

The family-centered approach helps build relationships between families and educators. Parents and teachers can learn from each other concerning the needs of the child and allow the child to receive enhanced care (Roddy, 2016). Involving families allows them to have an improved understanding of developmental science, explore the influential potential of family resources, and have an understanding of critical family pattern interactions such as parent–child transactions and family-orchestrated child interactions, as well as how the parent is able to promote the child’s health and safety (Guralnick, 2019).

A strong parent–teacher relationship is almost equally important as the child–teacher relationship to maintain effective communication and build trust (Patton, 2015).

Parents who feel as if they are involved throughout the process have a more suitable understanding of exactly what services their child is receiving and the reasons for the services (Williams, 2019). Setting goals and involving the parents is one way that a parent is capable of feeling included and able to voice their opinions on any concerns that they may have (Patton, 2015). Many parents feel an array of emotions when finding out that their child has autism and needs therapies as soon as possible to help improve symptoms (Grafton Integrated Health Network, 2016). Williams (2019) reported that of all the parents who fully participated in early intervention services, 70% continued to practice these services at home and saw a significant overall improvement. Improving self-efficacy and enabling observational learning allow parents to learn and adopt new at-home therapies to improve the rate at which their child is progressing.

There is a gap in research regarding parents' perspectives on early intervention services and how they feel that their child benefits or does not benefit from these programs (Baglama & Demirok, 2016; Ben-Itzchak & Zachor, 2017; Edwards et al., 2017; Estes et al., 2019; Fuller & Kaiser, 2019; Mottron, 2017). The majority of research emphasizes the importance of the role of parents, but there is very little data on parent perspectives on these services.

Parent perspectives can help improve programs and the delivery of information being given to parents. Early developmental opportunities, such as early intervention, can provide the child with academic success, health, and well-being (CDC, 2019d). Early childhood education that incorporates health education provides positive outcomes for a child's developmental readiness (Morrissey, 2019). The problem is that parents have little understanding of how early education classes work (Kirkland, 2016). It would be beneficial to know how parents view this process and how to improve parent self-efficacy, expectations, and observational learning. Some parents do not understand how to help their child and are unaware of the developmental practices used during early intervention (Kirkland, 2016). With current rates of autism and the success of these therapies, finding ways to increase success and understand barriers can have a positive impact on the health of children with autism and their families across the lifespan.

Purpose

The purpose of this basic qualitative study was to understand parents' perspectives and experiences in early intervention services to improve health and service delivery for individuals with autism. Parents' perspectives can help to increase rates of success and adherence to treatment, thus improving health outcomes across the lifespan. If communication is lacking throughout the early intervention program, between the staff and the parents, this could lead to low parent confidence, low expectations, and no observational learning, which could result in little to no training techniques being used at home (Edwards et al., 2017).

Parents' perspectives will be able to better inform delivery of services to help identify ways to serve families during early intervention. This may allow parents to utilize routines and activities used during early intervention at home to continue to help their child grow (CDC, 2019a). Children learn differently from one another, and when a standard method of teaching is used during these services, not all children may benefit in the same way. By providing parents’ perspectives on the intervention, more children will receive effective intervention (Morrissey, 2019).

Research Questions

- Research Question 1: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence social cognitive theory (SCT) constructs of self-efficacy, expectations, and observational learning in early intervention?
- Research Question 2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention?
- Research Question 3: What do parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build the parents' self-efficacy?

Theoretical Framework

This study was conducted as a basic qualitative study utilizing SCT. Basic qualitative research was first identified in 1925 by psychologist Paul Lazarsfeld. Lazarsfeld stressed the importance of three points: having a reliable audit trail, possessing interviewer skills, and being able to interpret findings (Bailey, 2014).

SCT is a learning theory created by a Stanford psychology professor, Albert Bandura (Bandura, 1986). This theory has a major component of observational learning and focuses on how individuals are influenced by and influence others (Bandura, 1986). SCT refers to how the social environment affects an individual's behavior (Bandura, 1986). This theory helps explain how behavior is maintained rather than just regulated. SCT consists of five constructs: reciprocal determinism, observational learning, reinforcement, expectations, and self-efficacy (LaMorte, 2019). This helps health educators understand why an individual engages in certain behaviors.

Reciprocal determinism is composed of three factors: the individual, the environment, and the behavior itself (Pourmovahed et al., 2018). A person's behavior is influenced through social stimuli and cognitive processes. Behaviors can be either rewarded or punished, which will result in the child enjoying or disliking a behavior or situation (Cherry, 2020). If a child is placed in an environment tailored to their needs and likes, they will be more amenable to enjoying the experience.

Observational learning is acquired through modeling behaviors (LaMorte, 2019). During early intervention, a therapist is able to demonstrate a behavior or task and the child will then mimic the task. Parents are able to watch the therapist perform intervention activities and learn from them and then replicate them at home. This leads to reinforcement, which can be either positive or negative (Pourmovahed et al., 2018). This closely ties to the child's behavior and the environment.

Expectations refer to outcomes and anticipated consequences (LaMorte, 2019). A value is placed on the outcome of the experience and the individual. Performing tasks and actions can lead to improved behavior and increased development (Thorne, 2016). Parents need to have positive expectations of outcomes, or their dedication to treatment may be low. Practicing these tasks in therapy sessions will increase confidence in the parent's ability to do the task at home, which will increase the child's confidence in performing tasks and challenges (LaMorte, 2019).

Self-efficacy emphasizes an individual's attitudes, abilities, and cognitive skills (Pourmovahed et al., 2018). A person's beliefs in their own ability stem from four sources of influence: mastery experiences, vicarious experiences, social persuasion, and emotional states (Lopez-Gariddo, 2020). Parental confidence is essential for successful at-home interventions. If a parent is not confident in their ability to follow through on these interventions at home, they will not do them. A parent who has a strong self-efficacy will have the confidence and abilities to succeed in therapeutic techniques required at home (Pourmovahed et al., 2018).

This framework is used to understand parents' perspectives pertaining to play experiences and self-efficacy for children with autism. Previous studies have shown a high satisfaction rate for parents with the communication between themselves and the professionals, but they felt frustrated with the delivery of services (Crane et al., 2018).

Nature of the Study

This study used a basic qualitative analysis approach. In utilizing this approach, the goal was to gain insights into the parents' perspectives (Dew, 2007). This allows researchers to understand a situation through another person's experiences. Because the interviews were semistructured, each interview was coded accordingly depending on the questions and responses. This allowed for organization of the data based on codes and categories created through the research questions. Semistructured interviews were conducted with parents from Southeast Michigan whose child had been diagnosed with autism and attended or had attended an early intervention program. This allowed me to conduct interviews with parents regarding their child's experiences prior to, during, and post early intervention. Input from parents throughout the process can allow changes to be made to programs and address concerns on the process.

This study used a basic qualitative analysis approach. Qualitative research focuses understanding human behavior and the reasons for behavior. The goals of basic qualitative research are to reduce data into meaningful themes that focus on the experiences and understandings of the participants (Yousey-Elsener & Masek, 2010).

Based on reviews of scientific journals and research studies, methods of early intervention delivery have been scientifically proven to increase a child's developmental growth (Mottron, 2017). The more effective delivery of these therapies is through face-to-face interaction with the child's parents present in a natural setting. SCT predicts that learning occurs in a social context with a dynamic interaction with the person, environment, and behavior (LaMorte, 2019). Due to the essential role that parents play in early childhood intervention, it is extremely important to explore their perspectives and identify factors that influence their self-efficacy, expectation, and observational learning. By identifying common factors that improve each of these constructs, it will be possible to create better intervention services and hopefully increase successful outcomes.

The occurrence being investigated was parents' perspectives on their experience with early intervention services for their autistic child. Parents whose children had been diagnosed with autism and attended early intervention services were interviewed. Parents were recruited through an intermediate school district. This service provided early intervention services for any family living within Monroe County, Michigan. Data were collected through interviews over the phone or through a Zoom meeting. Analysis of data was conducted by using NVivo software.

The current study benefited from a basic qualitative framework by allowing parents to voice their opinions on early intervention systems, which mainly use play techniques in order to engage with children. Parents' perspectives can allow health promotion professionals to utilize their feedback when creating interventions. This approach related to the research questions and study approach by interviewing parents on their child's experiences with early intervention services. This information retrieved on parents' perspectives can help improve awareness, health education, public health strategies, and therapy techniques.

Definitions

I used the following key terms throughout my study, making it necessary to define their meanings:

Autism spectrum disorder (ASD): A developmental disorder that affects communication and behavior. Symptoms generally appear within the first 2 years of life and include having difficulty with communication and interaction with other people, exhibiting restricted interests and repetitive behaviors, making little to no eye contact, rarely sharing enjoyment or objects or activities, failing or being slow to respond to someone calling their name, having facial expressions that do not match what is being said, and not meeting milestones (National Institute of Mental Health, 2020).

Early intervention services: Services that support babies and toddlers with developmental delays/disabilities and support their families as well. These services include speech and language therapy, physical therapy, developmental therapy, psychological services, and occupational therapy (CDC, 2019c).

Developmental therapy: A service that uses fun and spontaneity of play to help a child develop skills such as language and speech, gross motor skills, and self-help skills (MileStone Clinic, 2016).

Health education: Health education educates people about behaviors that promote wellness in a variety of ways, using health-focused strategies to improve the well-being of community members. Health education is used to create, implement, oversee, and analyze programs and strategies that promote health and well-being (National Commission for Health Education Credentialing, 2021).

Individualized educational plan (IEP): A written document that outlines a child's education. The educational program is tailored to the individual student. It identifies the services that a child needs in order to receive the maximum benefit to allow them to grow and learn during the school year. To develop an IEP, by law, one or both of the child's parents, the child's teacher or prospective teacher, and a representative of the local education agency must be present (Autism Society, 2020).

Intermediate school district (ISD): An educational agency for individuals from birth through age 26 that provides specialized education services and resources in schools and community settings (Monroe County ISD, 2020).

Occupational therapy: Helps individuals across their lifespan through the therapeutic use of daily activities to promote health and prevent, or live better with, an injury, illness, or disability (American Occupational Therapy Association, 2020).

Physical therapy: Includes activities and exercises that help build motor skills and improve strength, posture, and balance children (National Institutes of Health [NIH], 2017).

Speech and language therapy: These services help improve abilities to communicate and interact with others. Verbal skills include correctly naming people and things, better explaining feelings and emotions, using words and sentences better, and improving the rate and rhythm of speech. Nonverbal communication includes using hand signals or sign language and using picture symbols children (National Institutes of Health [NIH], 2017).

Assumptions

There were several assumptions for this research study. The participants had the option to choose over-the-phone or Zoom interviews to answer the questions; therefore, it was assumed that all participants fully understood the questions and were able to read and write in English. Another assumption was that the parents allowed their children to attend early intervention services to the full extent and did not stop therapies early. Another assumption was that the parents answered truthfully and based their answers solely on their child's experience. Lastly, we assumed that parents want what is best for their child and are willing to work for that to the extent that they are able. These assumptions were necessary in the context of the study to receive honest and truthful answers to analyze the information and create credible data to benefit early intervention services.

Scope and Delimitations

To improve health education and positive development in the autistic population, it is necessary to maximize the impact of early intervention. While it is well established that early intervention is effective, it is also known that parent participation is a critical component (CDC, 2019d). Thus, identifying parent perspectives can provide needed information to improve the delivery of early intervention. By gathering parents' perspectives, it is possible to improve interventions and create more therapeutic deliveries.

Parents of children who did not need early intervention and parents of children who were receiving early intervention but did not have autism were excluded from this study. Race and gender do not affect whether a parent can provide their perspective on early intervention services. The qualifications needed in order to be involved in the study were for the child to have a medical or educational diagnosis of autism and have participated in an early intervention program in a specified region. Potential transferability is applicable to all parents of children in early intervention, even those without autism.

Limitations

Weaknesses of using a basic qualitative design include the following: It is a time-consuming process, it is not possible to verify the results because participants have more control over the content, it is labor intensive, it is difficult to investigate causality, and the design is not statistically representative (Merriam, 2009). Questions during the interviews were chosen carefully in order to avoid upsetting any parent. Autism can be a sensitive subject, so data collection was conducted over the phone or by video conferencing. Considerations were made to address potential issues with parents being in denial about the autism diagnosis. There was a risk for sampling bias due to the participants coming from the same early intervention organization. This could have led to a response and desirability bias. Parents were reassured of confidentiality, and rapport was established.

Transferability provides readers with evidence on the study such as time, population, situations, and context (Merriam, 2009). To allow judgments on transferability to be made by the reader, detailed descriptions of the data were collected (Merriam, 2009). Dependability involves evaluation of the quality of data analysis, data collection, and theory generation and was established by allowing participants to read their transcripts (Given, 2008). To support dependability, I captured changing conditions that appeared within the setting (Given, 2008). Findings were applicable to parents of children with ASD in Southeastern Michigan who had been receiving early intervention services. Transferability and dependability allowed for trustworthiness to be established for the reader.

Sampling bias can occur when members of a population are more likely to be selected. There are different types of sampling bias: Self-selection bias is when people with specific characteristics are more like to agree to the study than others; nonresponse bias occurs when people refuse to participate or drop out of a study; under coverage occurs when some members are inadequately represented; survivorship is when people and objects are more likely to be represented in the sample than unsuccessful ones; and prescreening is when participants are prescreened (Crane et al., 2018). To avoid sampling bias, the target population should be defined, and the researcher should match the sampling frame to the target population. The population was defined as parents whose children had been diagnosed with autism and enrolled or recently enrolled in early intervention. In order to match the sampling frame, parents who met the criteria were approached for screening by recruiting through the early intervention center. The individuals who wanted to participate became the actual sampled population (Crane et al., 2018). Not encouraging a specific outcome can decrease the chances of a study being considered biased.

Desirability bias indicates that the subjects are chosen based on the responses that they believe will be desirable. To eliminate any desirability bias, I chose participants without knowing whether they had a positive or negative experience concerning the topic. A properly designed interview can mitigate the problem (Grimm, 2010). The interview questions were read to all participants in the same order, and open-ended questions provided detailed answers. Honest answers from participants can help improve programs through positive and negative feedback.

Significance

This study could bring positive social change by improving early intervention programs, along with starting new programs. Positive social change results in the improvement of human conditions, and findings from this study could help those seeking to improve intervention services for children living with autism. Some children with autism do not see the correct therapists due to lack of staffing or improper diagnosis. Parent perspectives will provide insight for providers to know common issues and increase involvement. Improving early intervention programs can improve the overall performance rate of children with autism and allow providers to have a better understanding of common parent issues. Understanding factors that can improve self-efficacy, expectations, and observational learning for parents of children with ASD who are receiving early intervention services can help the field of health promotion by identifying factors that will aid in improved health service delivery.

Health educators can benefit from parent perspectives by gaining insight on a diverse range of therapies used outside of the classroom. Health education and health promotion have a close relationship and can be used together (Wright et al., 2016). The results of this study can allow health educators to create new educational learning techniques tailored to certain behaviors and areas of struggle. The Extension for Community Healthcare Outcomes Autism Transition program allows parents to meet with health educators for 1 hour a week for 12 weeks to gain insight and knowledge on the complex healthcare needs of individuals with autism (Mazurek et al., 2020). The collaboration of health educators and parents can help determine which types of involvement are most desired and effective (Spencer et al., 2018). Health issues can begin at school or home; thus, interventions should take place in both settings (Spencer et al., 2018).

Health educators can incorporate SCT with learning techniques to improve the self-efficacy of parents and help maintain health goals inside and outside of the classroom. SCT helps use knowledge such as perceived self-efficacy, outcome expectations, health goals, and health risks and benefits and educates individuals on their own lifestyles (Bandura, 1986). The outcome expectations can influence overall health behavior and regulate behaviors through self-evaluation and interventions (Bandura, 1986). The promotion of health education can create opportunities for growth at a younger age.

Summary

Early intervention has been able to help children with autism increase their overall development through therapies and interventions. Early intervention is a combination of services such as behavioral health, developmental therapy, occupational therapy, physical therapy, speech and language therapy, social work services, and psychological services (Larcombe et al., 2019). Parents' perspectives can help to increase rates of success and adherence to treatment. This input could improve the success of early intervention and identify facilitators of and barriers to a successful early intervention experience.

Autism is a lifelong condition with traits such delayed speech, obsessive interests, and repeating of words and phrases. Children who receive services have been shown to maintain developmental progress throughout adulthood (Ma, 2015). Parents' perspectives were collected and analyzed by using a qualitative approach based on SCT. This method allows for researchers to recover data from individual perspectives.

Chapter 2 includes a literature review pertaining to the key concepts of the study. It also includes detailed descriptions of SCT. I also provide detailed information on autism, autism outcomes, early intervention, and the prevalence of autism. This chapter concludes with a review of qualitative methodology.

Chapter 2: Literature Review

Introduction

Children diagnosed with autism often utilize services through early intervention (Park et al., 2019). In this chapter, I review the theoretical constructs of SCT, outline the literature search strategy, and then review relevant literature in the following areas: prevalence of autism, early intervention, parent's impact on diagnosis and services, and effective communication. Early intervention services are equipped for children under the age of 3 years with neurodevelopment disorders (Park et al., 2019). Parents and caregivers are the first form of playmates in a child's life, meaning that they help develop the basics of social interaction (Waters et al., 2018). Parents are able to participate in meetings to discuss and decide upon the proper treatments for their child (Park et al., 2019). A parent's perspective is taken into consideration because they are with their child daily (Waters et al., 2018). Parents are usually the first individuals to notice unusual behaviors in their children.

Early intervention has been shown to be very effective at helping children maintain their progress, goals, and abilities (Sevaslidou et al., 2019). Addressing developmental delays early on can allow the child to transition into general education and integrate into a more independent lifestyle as they grow older (Waters et al., 2018). Involving parents allows health educators to have a better understanding of where the child has strengths and weaknesses (Wright et al., 2016).

The purpose of this study was to analyze parents' perspectives and experiences related to early intervention services. All children learn differently, and when a standard method of teaching is used during these services, not all children may benefit in the same way (Waters et al., 2018). Providing parent perspectives on the intervention can improve the experience of parents in program delivery, which will ultimately make intervention more successful. Doing this may help more children to receive effective intervention. Early intervention services that involved parents showed improvement in the child's social interaction, reduced parental stress, and an increase in the child's self-efficacy (Park et al., 2019). Parents with high self-efficacy form a stronger sense of commitment to their activities (Pourmovahed et al., 2018). Parents have proven to be key figures in helping their children through the early intervention process (Sevaslidou et al., 2019).

The prevalence of autism is continuing to rise. In 2018, 1 in 44 children was diagnosed with ASD (CDC, 2019a). Some early signs and symptoms of autism are not making eye contact, exhibiting abnormal body posture or facial expressions, and not responding to one's name (CDC, 2019d). A child will undergo testing prior to receiving early intervention. These tests can determine if the child is showing developmental delays and can also provide evidence that the child has autism (Ma, 2015). Studies have shown that children who receive intervention as soon as delays are noticed are able to make a significant amount of developmental progress and maintain the progression (Ma, 2015). Early detection allows for the child to receive services for a longer period of time.

This chapter includes a literature review pertaining to the key concepts of the study. It also includes detailed descriptions of SCT. I provide detailed information on autism, autism outcomes, early intervention, and the prevalence of autism. This chapter concludes with a review of qualitative methodology.

Literature Search Strategy

Literature searches were performed in the Walden Library, EBSCO, CDC, National Center for Biotechnology Information, and SAGE databases from 2015–2021. Research engines included PubMed, Research Autism, Medline, PLOS ONE, ProQuest, and Wiley Online Library. Keywords and terms that were searched included the following: *autism*, *autism spectrum disorder*, *autism and health education*, *autism and early intervention*, *health education*, *dissertations on early intervention*, *qualitative studies on early intervention and parents' perspectives*, *early intervention*, *autism and early intervention*, *parents' perspectives on early intervention*, *parents' perspectives on early intervention and autism*, *children with autism enrolled in early intervention*, and *early intervention communication.*

I identified peer-reviewed literature with a focus on studies involving children with autism enrolled or previously enrolled in early intervention services and parents' perspectives on early intervention services. I searched using phrases such as *early intervention and parents' perspectives* (886,704 results), *early intervention and autism* (147,137 results), *autism and parents' perspectives* (116,882 results), and *parents with children with autism* (309,231 results). Simultaneously, I searched for key terms. I added filters by selecting keywords such as *perspectives*, *autism*, and *early intervention*.

Theoretical Framework

SCT was developed by psychology professor Albert Bandura. This theory originated through the Bobo experiments, in which preschool children were exposed to aggressive or nonaggressive adults to see if the children would mimic their behaviors

(Bandura, 1986). The children experienced the adult verbally and physically being aggressive toward a Bobo doll, and when the children were placed into a room to play with the doll, they also showed aggressive behavior toward it LaMorte, 2019). This experiment allowed for the basis of observational learning to be incorporated into teaching techniques. The autism spectrum is broad, and every child lands differently on the spectrum (LaMorte, 2019). This means that different levels and techniques of teaching are required in order for the child to receive the proper education.

SCT has an emphasis on social influence and interactions with people, environments, and behaviors. An individual's behaviors are acquired through social environments (LaMorte, 2019). There are six constructs to SCT: reciprocal determinism, behavioral capability, observational learning, reinforcements, expectations, and self-efficacy (Larango, 2016). Reciprocal determination consists of the individual's set of learned experiences, external social context, and responses to stimuli to achieve goals (LaMorte, 2019). This illustrates that not all children learn the same way, and educational plans and interventions need to be tailored to the child's needs. This theory takes into consideration a child's past experiences to incorporate positive outcomes (LaMorte, 2019). This allows the child to feel at home and more relaxed in an intervention setting (Bandura, 1990).

Self-efficacy refers to people's beliefs about their capabilities to exercise control over their own activities (Pourmovahed et al., 2018). Strong parent self-efficacy allows the parent to view challenging problems and tasks with a positive attitude and outlook (Pourmovahed et al., 2018). Self-efficacy can be learned through observation and experiences (Lopez-Garrido, 2020). Involving a parent during early intervention services allows the parent to build their confidence in performing these therapies at home with their child. Positive affirmation from therapists and the child will continue to help the parent learn more therapeutic skills and boost their confidence (Pourmovahed et al., 2018). Parent self-efficacy can be more important than child self-efficacy because it determines the sustainability of these interventions at home (Pourmovahed et al., 2018).

Reinforcements refer to internal and external responses to a child's behavior (LaMorte, 2019). A parent positively reinforcing a child due to progressive actions and behaviors during intervention can encourage the child to continue the desired behavior. Behavioral capability can be adopted through learning through skills training (LaMorte, 2019). A parent can learn techniques and have a better understanding what works best for their child and help them adapt to new learning techniques to achieve the desired behavior.

Collective efficacy can be used to boost the confidence of a child in their belief in their ability to perform certain actions to achieve a desired change (Bandura, 1990). A child is most likely to mimic the behavior of an adult they look up to in group activity settings and play-like environments (Bandura, 1990). Parent self-efficacy is the belief that a child will perform tasks successfully through positive reinforcement during at-home therapies (Pourmovahed et al., 2018). A child's personal factors, environmental factors, and behavior can all influence each other in positive or negative ways (Bandura, 1990). Incentive motivation and providing credible role models can help a child during therapies in order to achieve the desired behaviors.

Research has shown that parent self-efficacy is associated with increased quality of parent–child interactions, increased parental responsiveness, and parental involvement (Pourmovahed et al., 2018). Programs and interventions are tailored to a child and allow the parents to continue treatments at home with specific plans that benefit the child. Parents are provided with instructions on parenting skills to respond to different behaviors (Pourmovahed et al., 2018).

SCT related to the current study because children with autism learn differently depending on the severity of their disability and the learning environment that suits them best. ASD is divided into three levels of severity: Level 1, Level 2, and Level 3 (Holland, 2018). Level 1 severity means that the individual has mild symptoms that barely interfere much with work, school, and relationships. In Level 2, individuals require support and therapy, and in Level 3, individuals require the most support and need intensive therapies and full-time aides (Holland, 2018). Different techniques are needed in order for the child to meet developmental milestones, and with children at a young age not being able to express their learning environmental needs, parental input is needed (McMahon & Cullinan, 2016). Parents are provided with age-appropriate child development education to teach parents effective strategies to improve a child's overall behavior (Pourmovahed et al., 2018). The research questions helped build onto this study by proving that knowledge is acquired through specified learning techniques, prior knowledge, and individual experiences.

SCT is directly related to observing others socially, experiences, and outside influences (Koskey, 2016). Early intervention allows children to work together and compare their findings and understanding of situations. A child is able to explore different options and possibilities for multiple scenarios, which allows the teacher to accommodate activities and different learning techniques depending on the child (Dalcour, 2020). More techniques can be used so that the child can observe different experiences; this allows parents and educators to maintain and create more learning techniques (Kosky, 2016). Observational learning can be used for the child to model behaviors and to manipulate the expectation or anticipated behavior of the child (LaMorte, 2019). Parents can participate in observational learning and then use these techniques and skills at home to provide more assistance to their child. A child with ASD will influence their environment and be influenced by their environment.

Promotion of conventional learning techniques can lead to new intervention therapies. A study conducted on early intervention curriculums showed that learning is an active process; knowledge is invented, not discovered; all knowledge is personal; and all knowledge is socially constructed (Mcmahon & Cullinan, 2016). Learning is an essential process of making sense of the world, which allows for meaningful, open-ended, and challenging problems for the learner to solve (McMahon & Cullinan, 2016). The diagnosis of autism has challenged the usefulness of constructivist-formed methodologies (McMahon & Cullinan, 2016). Children with autism already focus on the big picture, which can help children with this disability focus on learning as a whole (McMahon & Cullinan, 2016). Children with autism usually respond less to environmental stimuli and fail to explore new options on their own (McMahon & Cullinan, 2016). This is where new teaching methods, observations, and parental perspectives come into play to create an environment where the child will learn successfully.

In a previous study, the basic qualitative method was used to understand the perspectives of parents with children with autism on play experiences and self-efficacy (Oyola et al., 2018). The Skard and Bundy model was used to evaluate the child's playfulness. The characteristics used in this model are framing, intrinsic motivation, internal control, and freedom to suspend reality (Oyola et al., 2018). After analysis and coding were completed, the researchers were able to conclude that the general context of the play experience included parents being satisfied, happy, and trusting. Parents explained that they felt that the most effective interactions were intrinsically motivated rather than the disrupting the child's play preference (Oyola et al., 2018). Parents wanted to prolong play encounters, and many of them would show the child a preferred toy or game to initiate more playing (Oyola et al., 2018). Parents' perspectives can allow for more information to be obtained to influence new interventions and therapy techniques.

This study used a basic qualitative analysis method. This study design is used to understand the perspectives of the participants (Merriam, 2009). Interviews were the main method of data collection in order to understand the subjects' point of view. This information can help in the development of new theories by helping to address new issues and ideas as they emerge (Dudovskiy, 2019). Events, situations, and experiences differ per individual.

The current study benefited from this framework by allowing parents to voice their opinions on early intervention systems, which mainly use play techniques in order to engage with children. Learning environments that involve parent interaction and playtime allow for the child to feel more relaxed and comfortable (CDC, 2019b). Observing a child while they play can help therapists keep the child engaged during the whole intervention.

Autism

Autism encompasses a broad range of conditions that include challenges with social skills, nonverbal communication, speech, and repetitive behaviors (Lyall et al., 2017). This disability is accompanied by gastrointestinal disorders, seizures, sleep disorders, and sensory sensitivities (Kuhlthau et al., 2017). Autism has had a significant public health impact (Lyall et al., 2017). In the United States, total annual costs associated with ASD are approximately $250 billion; lifetime individual associated costs are estimated to be around $1.5–2.5 million (Kuhlthau et al., 2017). Autism impairments are lifelong and associated with increased risk of nonbehavioral health outcomes, injuries, and elevated mortality rate (Lyall et al., 2017). Some individuals with autism integrate into independent adulthood more easily than others. Psychiatric disorders are common in individuals living with autism (Rosa et al., 2016). Comorbid psychiatric disorders that are common are attention-deficit/hyperactivity disorder, anxiety disorder, and mood disorders (Rosa et al., 2016). These disorders can mean prolonged therapies and difficulty living independently.

Signs and Symptoms

Parents are often the first individuals to notice atypical behaviors (Cafasso, 2016). Autism differs from person to person, with a range of abilities and characteristics (Spanoil, 2018). Characteristics fall into two categories: social interaction and communication problems and restricted and repetitive patterns of behaviors, interests, or activities (Spanoil, 2018). Characteristic behaviors include not making eye contact, abnormal body posture or facial expressions, not responding to their name, abnormal tone of voice, not babbling by 1 year of age, inappropriate social interaction, lack of understanding of social cues, self-abusive behaviors, repetitive movements, not smiling by 6 months, social withdrawal, not using any gestures or copying gestures such as waving or pointing by age 1, not uttering or attempting to say phrases by 2 years old, and any loss of speech or language skills (Cafasso, 2016). Severity of symptoms vary per the individual.

Prevalence and Risk Factors

The rate of autism has continued to rise over the years. In 2018, 1 in 44 children was diagnosed with ASD, whereas in 2002, only 1 in every 150 children was affected (CDC, 2019a). There is no cure for autism, and the reason that some children have this disability is still unknown (CDC, 2019c). Scientists believe that a combination of environmental and genetic factors play a role in the early brain development of the child, which can lead to autism (Boat & Wu, 2015). Health disparities increase the likelihood of a child being diagnosed with autism and hold a barrier to being properly diagnosed (Wiggins et al., 2019). Certain health disparities that are linked to autism diagnosis are poor access to healthcare, low socioeconomic status, language barriers, and concerns about immigration status. These disparities may cause a child to have a late diagnosis and delayed therapy treatment options (CDC, 2019c).

Boys are four times more likely to have autism than girls (CDC, 2019c). One in 34 boys and 1 in 150 girls are diagnosed (CDC, 2019a). Health disparities of the parents and complications during pregnancy can contribute to the child being born with this disability (CDC, 2019d). If the parents are older, the child is born at an extremely low birth rate, premature births, infections during pregnancy, and genetic mutations of unknown causes can possibly be linked to autism (Boat & Wu, 2015). Studies have shown parental age is a consistent finding in the epidemiology of autism. Men in their 30s are 1.6 times more likely to have a child born with autism compared to men in their 20s (Deweerdt, 2020). When a male becomes 40 his chances increase to 6 times more likely than another male under the age of 30 (Deweerdt, 2020). Fewer studies have been conducted on maternal age and autism since women have children over a narrower age range (Deweerdt, 2020). Studies have shown that the chances of a woman having a child with autism slowly increases with age (Deweerdt, 2020). There is no test to determine if a child will be born with autism but it is important to know signs and symptoms of this disability.

Long-Term Outcomes

As the child grows older and becomes an adult, they may also face challenges. A longitudinal study conducted in Greece interviewed 69 parents whose children were diagnosed with autism during childhood (Sevaslidou et al., 2019). Now that the children have become adults the findings showed that 22.6% were doing very poor, 24.5% poor, 18.9% good, and 22.6% very good (Sevaslidou et al., 2019). Data was collected on age, severity of the diagnosis, developmental milestones, and present outcomes. The present outcomes that the researchers questioned were how well the individuals were verbally functioning, educational level, social functioning, and independent factors such as occupational status and independent living (Sevaslidou et al., 2019). Adapting to a new way of life can be more difficult to some individuals but adapting can potentially help gain independence.

Having goals and being independent are two factors that many adults aspire to. Gaining independence, postsecondary education, and employment are the three most common independent goals recorded by adults living with autism (Wehmeyer & Shogren, 2017). In general adults diagnosed with autism reported to be functioning poorer than their same-age peers when it came to their mental health, relationships, independent living, and employment (Wehmeyer & Shogren, 2017). When compared to their same-age peers on verbal functioning they showed similar comparison (Sevaslidou et al., 2019). Furthermore, every case involving autism is different and varies per the individual, resulting in a need for specialized early intervention programs.

Early Intervention

Early intervention provides services and support to babies and young children under the age of 3 that have developmental delays and disabilities (CDC, 2019d). These services also include support for family members. These programs are usually state funded and provide services for free or at a reduced cost for any child who is eligible (CDC, 2019b). Evaluations of the child's skills and abilities will determine if the child is eligible to participate in the program (CDC, 2019b). A child with a disability can greatly benefit from these interventions to increase their development.

Interventions are play-based and parent-facilitated so therapists can interact and observe children in a habitat they feel comfortable in and will act naturally (Kaczmarek, 2018). This allows time for the parents to be educated on service techniques and allow them to adopt the same system at home. Natural settings such as at the child's home, a playground, or park can allow the child to feel more comfortable and be more willing to learn and retain information (Kaczmarek, 2018).

Early intervention provides services to children with autism and other developmental delays from birth to 3 years old (Bellini et al., 2016). The effectiveness of early intervention has been proven through various outcomes. A systematic review of 343 quantitative studies was able to provide comprehensive evidence that early intervention is effective (Puthussery et al., 2018). A total score of 11 represented the highest possible points. The scores were put into three categories: 8-11 being high quality, 4-7 medium quality, and 0-3 low quality. Specific early interventions that were analyzed were Creating Opportunities for Parent Empowerment (COPE), Early Intervention (EI), Hospital to Home (H-HOPE), Kangaroo Care (KC), Modified Mother Infant Transaction Programme (M-MITP), Nursing Systems Towards Effective Parenting-Preterm (NSTEP-P), Parent-Baby Interaction Programme (PBIP), and Traditional Holding (TH). The top three recorded programs were Kangaroo Kare (n=8), Mother Infant Transaction Programme (n=7), and Infant Health and Development Program (n=5). Parents recorded feeling as if the programs were family based, allowed skin to skin contact, accepted breastfeeding, and designed to enhance behavioral, health, and cognitive development

(Puthussery et al., 2018). Furthermore, enhancing a child's development can lead to enhanced outcomes and improved program delivery.

Early intervention is widely regarded as an effective method to improve developmental outcomes children (National Institutes of Health [NIH], 2017). A quantitative study was conducted by using a questionnaire given to 180 teachers to determine the views of special education teachers working in an early intervention program (Baglama & Demirok, 2016). This questionnaire was used to identify opinions and recommendations to improve the quality of education policies and programs. The majority believed that early childhood programs are prepared to get information about developmental levels of children, programs are generally developed for child with autism, programs are curriculum based, application programs can be planned based on the activities which children show interest, appropriate programs are prepared based on the child's needs, programs involve regular follow up assessments of the children, early intervention might include different activities, programs require collaborations between different groups of people, agree instructive counseling provided families with the ability to make decisions based on their child's needs (Baglama & Demirok, 2016). These recommendations could provide improved programs and interventions in the future.

Early Intervention With Autism

Early intervention provides diagnosis and treatment options for children with autism (CDC, 2019c). Some children do not have developmental regression until the age of 2 while others are unable to meet their milestones from a younger age children (National Institutes of Health [NIH], 2017). Both of these are warning signs and should be addressed immediately to receive early intervention services. Integrated developmental and behavioral intervention can promote better language and motor skills children (National Institutes of Health [NIH], 2017). Typical early intervention programs for children with autism include: Family training, speech therapy, hearing impairment services, physical therapy, and nutrition services children (National Institutes of Health [NIH], 2017). Progress plans can be made annually, and new goals can be set depending on how much advancement has been made.

When a child enters services, the main goal is for the child to gain so much progress that they are no longer on the autism spectrum when they are older (Monnier, 2020). Early intervention helps children obtain goals early in life such as: A higher intelligence quotient, better language and motor skills, physical skills, thinking skills, communication skills, social skills, and emotional skills children (National Institutes of Health [NIH], 2017). These skills are needed to live an independent life and obtain new life skills.

Specific therapies offered to children with autism during early intervention are applied behavioral analysis (ABA) therapy and pivotal response therapy (PRT) (Monnier, 2020). ABA therapy involves hours of different therapeutic techniques throughout the day and the child is rewarded for certain behaviors and discouraged from others children (National Institutes of Health [NIH], 2017). PRT is applied during playtime. This type of therapy targets areas of developmental such as motivation and self-management (Monnier, 2020). This approach helps children respond to verbal cues (Monnier, 2020). Additionally, these therapies can lead to beneficial outcomes in a child’s development.

ABA therapy helps teach autistic children social and behavioral skills (Kuhlthau et al., 2017). When a child properly pronounces a word, they are reinforced with a reward and the reward is withheld until the child properly completes the tasks (Kuhlthau et al., 2017). This type of therapy helps children distinguish between desired and undesired behavior (Rudy, 2019). PRT therapy is initiated by the child and is play based and focused on motivation, response to multiple cues, self-management, and initiation of social interaction (Rudy, 2019). The goals of this approach are to: develop communication and language skills, increase positive social behaviors, and relief from disruptive self-stimulatory behaviors (Kuhlthau et al., 2017). Both of these therapy techniques have proven to provide significant outcomes for children with autism.

Early Intervention Outcomes for Autism

Acting early with intervention can have a significant impact on a child's ability to learn new skills (Kuhlthau et al., 2017). A child's brain is most adaptable in the first three years of their life (Kuhlthau et al., 2017). This makes it crucial for children to receive therapies as soon as developmental delays are noticed (CDC, 2019c). Children with autism who receive early intervention tend to have better outcomes. A study conducted in Denver, Colorado observed children with autism between 18-30 months of age who were receiving early intervention services (Ma, 2015). These children were then observed two years after completing early intervention to see if the children were able to maintain their goals, abilities, and progression. After the two-year mark, the children showed an increase in IQ, adaptive functioning, motivation, and communication. The comparison group was children within the same age group that were diagnosed with autism and not receiving early intervention services or had received early intervention services for a short time but did not follow through with the whole program (Ma, 2015). Therefore, intervening early and actively participating in these programs can make a difference in a child's life.

Another study by Noyes-Grosser and colleagues (2018) involved children actively participating in early intervention and diagnosed with autism. A total of 193 children were observed and at the end of the services none of the children were rated as having made “No Progress”. The children received services involving social emotional skills, knowledge, and behavioral development. A total of 32% were rated as little progress, 59% moderate progress, and 9% a great deal of progress (Noyes-Grosser et al., 2018). Additionally, early intervention can increase a child's overall developmental growth, which can also lead to a healthier life and better communication skills.

A meta-analysis by Fuller and Kaiser (2019) examined 1442 children (mean age 3.55 years) in 29 different studies. This study proved the social communication can be improved through early intervention by participating 10 hours a week for 45 weeks. Out of all the children 84% showed a significant increase in social communication through applied behavioral application, speech therapy, and language therapy (Fuller & Kaiser, 2019). Early intervention has shown to be crucial to low and high functioning children with autism.

Many variables can affect the outcome of early intervention. Autism severity, cognitive ability, and adaptive behavioral skills influence the outcome (Ben-Itzchak & Zachor, 2017). A study by Ben-Itzchak and Zachor, (2017) showed that standardized testing provides little evidence regarding changes in autism severity. Changes in autism severity through algorithm scores are predicted through baseline cognitive ability and autism symptoms severity, baseline receptive language, receptive and expressive language, and baseline nonverbal IQ (Ben-Itzchak & Zachor, 2017). Autism severity and the child's age best predicted cognitive gains. Factors that influenced cognitive gains and a higher level of intervention were older maternal age and higher maternal education level. For adaptive behavior, only maternal age was determined to influence the amount of intensity of early intervention needed (Ben-Itzchak & Zachor, 2017). Every child learns differently depending on the learning techniques used per variable. This information highlights the importance of identifying all relevant information to make early intervention as successful as possible.

Public Health Education and Promotion Impact of Early Intervention

Childhood development is a vital determinant of the overall health of an individual throughout their lifetime (CDC, 2019d). A child's brain has achieved 90% of their adult brain volume by the age of 6, making early intervention extremely important (CDC, 2019d). The lifetime individual associated costs estimated to be around $1.5-2.5 million (Lyall et al., 2017). Autism impairments are lifelong and associated with increased risk of non-behavioral health outcomes, injuries, and elevated mortality rate (Lyall et al., 2017). The physiological growth a child experiences during their childhood allows them to develop skills such as processing, comprehension, language, emotional regulation, and motor skills (CDC, 2019a). Early intervention is a free service that helps a child meet their milestones and maintain developmental growth.

Early intervention is state funded and free to most families in order to provide for all families apart from their socioeconomic status (Healthy People, 2020). This helps eliminate the negative influence of poverty on the academic achievement of children with autism (CDC, 2019b). Early intervention programs allow for a low student-teacher ratio, focus on basic skills, creation of school-parent liaisons, provide snacks and meals, health care services, home visitation, and supportive social services (Healthy People, 2020). This gives all families an equal opportunity to receive the best services available.

In order to receive services a child must be evaluated and diagnosed with autism (Parsons, 2018). Many insurance companies do not cover medical evaluations and parents end up spending $700-$2,000 out of pocket for the initial evaluation and diagnosis (Parsons, 2018). Depending on other symptoms and issues the child has they can be placed on medication, which often requires copayments. A typical ABA therapy session ranges from $80-$150 an hour (Parsons, 2018). Some children need these therapy sessions 2-3 times per week (Parsons, 2018). With not all expenses being covered through insurance many parents have to pay for these services by themselves (Parsons, 2018). By investing early, it saves public health dollars across the lifespan of the individual.

Integrating health education into early intervention can benefit a child's overall development. The Department of Health/Department of Children, Schools, and Families [DH/DCSF] provide universal service frameworks to schools that includes services for health and education (Spencer et al., 2018). This framework looks beyond a broad approach and acknowledges the importance of family incorporation to health education

(Spencer et al., 2018). Children with autism can tend to be picky eaters, which can lead to malnutrition (World Health Organization, 2020). Health education can help parents develop healthy meal plans during food shortages, low-income families, and for children that will only eat foods of certain textures (Worlds Health Organization, 2020).

Parental engagement in school health events and engaging with the community has helped acknowledge desired and undesired activities that are effective in children achievement proper health and educational goals (Spencer et al., 2018). Children with autism struggle with overstimulation, which can make expanding the palate difficult (Parsons, 2018). Delayed oral motor function can cause a child to have difficulty moving food around in their mouth, which can cause an aversion to textures (Parsons, 2018). School and parental engagement form a relationship between the school and home environment (Spencer et al., 2018). Barriers such as certain foods and textures the child can't eat can be discussed and replacement options offered. Health education is a vital asset to early childhood education.

Parents' Impact on Diagnosis and Services

Early intervention is becoming more family oriented and involving parents in the process and making changes to services as needed because of adequate feedback (Bellini et al., 2016). Parents are being provided with information through videos, conversations, printed materials, and support groups (Edwards et al., 2016). Parents are also included in meetings involving the child's progress to discuss if changes are needed and if improvements are being made (Jennings, 2017). Programs are individualized for the child to fully benefit from the services (Edwards et al., 2016). Parents play a critical role in addressing their child's needs including the implementation and supporting early intervention services (Jennings, 2017). Parents experience direct and indirect impact of these services through interaction with the healthcare workers and accelerated or slower progress their child is experiencing.

Parents can be overwhelmed with the amount of information they receive when their child is first diagnosed (Bellini et al., 2016). Early intervention helps parents have a better understanding on the services provided and what services are best suited to their child, how many hours of service their child will receive weekly, where they decide to have the interventions take place since some therapies are available at the child's home, and any questions that may arise (Bellini et al., 2016). Making the child feel comfortable can allow for better engagement during intervention services (Lopez-Garrido, 2020). In order to ensure the child feels comfortable, the parent must have confidence in their ability to perform at home therapies and engage in invention sessions with the therapists (Lopez-Garrido, 2020). A parent can allow the child to learn from them through observational learning, verbal persuasion, and positive psychological feedback (Lopez-Garrido, 2020).

Early detection and diagnosis of autism is usually not initiated by doctors but dependent on parents who observe concerns with their children (Healthy People, 2020). Warning signs and certain behaviors that are unexplained can cause a parent to seek help through early intervention diagnosis services in order to find the proper answers. Researchers stress that since the children utilizing the early intervention services are under the age of 3, parent involvement is crucial when it comes to the services being beneficial (Iwasa et al., 2019). Usually concerns arise when the child is between the ages of 1 and 2 years old (Bellini et al., 2016).

Early intervention includes a range of services, but the most common ones requested for children with autism are speech therapy and occupational therapy (Edwards et al., 2016). Surveys were sent out to parents of children with autism who are currently or recently enrolled in early intervention (Bellini et al., 2016). Surveys were conducted by Bellini et al., (2016) in 50 counties throughout Indiana. Out of 586 surveys sent out 198 were fully completed and returned. The ages of children who were recorded on the survey were 2-8 years old and the average age of the children being 5.77. The settings and services varied from 73.8% of children attending public early intervention programs and 16.4% receiving services at home. The two most requested services were speech therapy and occupational therapy (Bellini et al., 2016). Parental input allows early intervention therapists to acknowledge which services parents feel as if their children need the most and gives them a way to advocate for their child.

Parents play a vital role in early intervention (Luelmo & Kasari, 2021). First, they become an informed advocate and the family must grant written consent for the children to be evaluated and receive treatment (Special Education Guide, 2020). Parents are assisted with guidance to increase their knowledge on autism advocacy and help with advocacy empowerment (Luelmo & Kasari, 2021). The parents are typically provided a copy of the regulations and procedures allowing them to understand their rights and protections. The parents may also attend all Individualized Family Service Plan (ISFP) meetings (Special Education Guide, 2020). During these meetings any concerns or issues the parents or therapists have can be addressed along with revising the child's individualized plan as needed. During early intervention services the parents will also participate and can ask questions when needed (Special Education Guide, 2020). Parental participation is a major part of the early intervention process.

There are no medical tests to determine if a child has autism. Healthcare professionals such as developmental pediatricians, psychologists, neurologists, speech and language pathologists, and occupational therapists will perform developmental screenings to decide if a child should be diagnosed with ASD (Wetherby et al., 2021). Developmental screenings begin at birth through routine visits (Estes et al., 2019). A child may be referred to a specialist for testing if delays are present. Before services can begin parents often fill out an assessment called, M-CHAT or Modified Checklist for Autism in Toddlers. This assessment helps healthcare workers understand the child's strengths and weaknesses and can help determine which services will be needed (Estes et al., 2019). Being diagnosed with autism is a key moment for individuals and parents who have been searching for answers.

Health Education in Autism

Health education for children with autism is important for them to be able to reach their full potential. The Individuals with Disabilities Education Act (IDEA) was reauthorized in 2004 to ensure that children with disabilities are provided with free health education (Claypool & McLaughlin, 2017). This act helps children receive the proper health education, so they can reach their full potential. This allows public schools to provide and engage in health education with children with autism based on how they want to learn rather than providing a general learning experience (Vanguard, 2019).

The current issue is that health education being provided to children with autism is no longer keeping up with social and scientific changes (Claypool & McLaughlin, 2017). Lifting structural and environmental barriers can help improve health education delivery services. Incorporating quality care and parents' perspectives can drastically increase the effectiveness of health education services by providing new learning techniques and better system navigation (Gipson, 2021).

Health Education and Early Intervention

Early Intervention provides children with individualistic and general health education through classroom and one on one setting (Ison, 2020). Diverse circumstances are taken into consideration when creating a health education curriculum for children with autism. Every child with autism is different and individualized plans are put into place to allow the child to receive the proper education materials (Ison, 2020). The Children and Parents Services (CAPS), is a parental choice program that allows parents to choose the type of care their child is provided. By incorporating this program parents are involved in the intervention therapy choices their child receives (Ison, 2020).

Importance of Communication

Professionals such as therapists, special education teachers, health educators, teacher aids, and doctors play a vital role in the child and parent's life during the early intervention stages (Lee, 2015). Effective communication between the professionals and the parents can prevent unnecessary confusion (Lee, 2015). Early intervention can be a difficult process if the parents do not fully understand what it all entails and how the process works (Lee, 2015). This can result in a lack of confidence in the parent's performance and leave many unanswered questions and lack of support at home for the child (Lee, 2015). A lack of support can lead to the child not making any progress (Crane et al., 2018).

Communication is extremely important from the planning stages (Edwards et al., 2016). A phenomenological study was conducted by Lee (2015) using an ethnography approach over a 6-month period. Semistructured interviews and observations were used to collect data. The overall results concluded that the parents had a high satisfaction rate with the communication between themselves and the professionals but felt frustrated with the early intervention planning process (Crane et al., 2018). The parents felt as if they were obligated to use the providers the professionals wanted them to and gave them very little options elsewhere.

Communication is an essential component of both autism diagnosis and early intervention (Edwards et al., 2016). One study found that once a diagnosis was reached not all parents felt as if they had the proper information on what to do next and what types of therapies their child would be receiving (Crane et al., 2018). Lack of communication can cause many issues throughout the early intervention process (Crane et al., 2018). This can result in children plateauing in progress since parents did not understand how to help their child outside of the therapies and services they were receiving.

A qualitative study was conducted by Crane, et al., (2018) utilizing structured over the phone interviews. There were 10 parents who had children enrolled in early intervention that participated in the study (Crane et al., 2018). Codes were formed from the data to create themes. The three themes that were created to analyze the data were: The process of understanding and accepting autism, barriers to satisfaction with the diagnosis process, and inadequate post diagnostic support provision. Theme one reported a range of initial concerns and routes to a subsequent diagnosis. Many of the issue's parents showed concerns for were delays in reaching milestones, tantrums and behaviors, and developmental delays such as toilet training. Parents stated they were not fully aware of the key signs and symptoms to look for and felt naïve during the whole intervention process due to lack of information and resources (Crane et al., 2018). Theme two was based on a major barrier that all parents felt as if there was a lack of autism awareness amongst professionals. The professionals involved in this process focused more heavily on the negatives than the positives and have the parents very little hope for the future when it came to their children succeeding. The parents felt as if the professionals were not educated properly. The third theme was based off parents feeling directionless. They were left were many unanswered questions and did not know where to find more help or where to go from the initial diagnosis (Crane et al., 2018).

Another study was conducted by Edwards, et al., (2016) using semistructured interviews involving 14 individuals from 12 different families. Coding was used to create 3 central themes: parents 'initial perceptions of early intervention following their child's autism diagnosis with autism, the consequences (both positives and negatives) of the early intervention message, and parents' perspectives on life after early intervention. The results concluded that parents were aware of the importance of early intervention, professionals communicated thoroughly to the parents during the whole process, and parents experienced stress post early intervention (Edwards et al., 2016). The healthcare needs of people with ASD and their caregivers are complex and require a range of integrated services, including health promotion (World Health Organization, 2020). Learning more about the experiences of parents whose children receive early intervention for autism will provide valuable information that can be used to improve treatment outcomes.

Summary

The rate of autism has continued to rise over the years with 1 in 44 children being diagnosed with ASD and boys are 4 times more likely to be diagnosed with autism than girls (CDC, 2019a). Early intervention has been proven to help children with autism and improve their developmental delays. A child's brain is most adaptable in the first three years of their life. This makes it crucial for children to receive therapies as soon as developmental delays are noticed (CDC, 2019c). Parent's perspectives and high self-efficacy are vital to early intervention therapies because they know their child the best and in what areas they are struggling in (Edwards et al., 2016).

A greater understanding of parents' perspectives on early intervention will allow for positive changes to programs and specialized plans for children with autism. Autism has no cure and professionals are still not certain what causes this disability (CDC, 2019b). Therefore, improving the lives of children with autism is of high importance.

Effective communication between all parties involved will increase the likelihood of the children receiving the proper services to succeed (CDC, 2019c). By understanding the perspectives of parents whose children receive early intervention services for autism, there will be increased understanding on how to improve services.

An individual will have autism his/her whole life, but symptoms can become non-apparent as they get older if the proper steps are taken (Boat & Wu, 2015). The diagnosis of children with autism under the age of 17 has climbed drastically over the past 10 years (Boat & Wu, 2015). Parent perspectives are important for understanding signs and symptoms of autism, improving early intervention, and increasing communication with the health educators.

To address the lack of knowledge of parent perspectives on early intervention, this study explored the communication between the parents and early intervention professionals throughout the process. This information can inform future research and practice for children with autism in early intervention. SCT was applied using a basic qualitative approach to understand the experiences of the process through the perspectives of the parents with children with autism.

Chapter 3 includes detailed information on the theoretical framework, autism, signs and symptoms, prevalence and risk factors, long-term outcomes, early intervention, early intervention with autism, early intervention outcomes for autism, public health education and promotion impact of early intervention, parents’ impact on diagnosis and services, and the importance of communication.

Chapter 3: Research Method

Introduction

The purpose of this study was to analyze parents' perspectives and experiences related to early intervention services for children with autism. Parents' perspectives can help to increase rates of success and adherence to treatment (Crane et al., 2018). If communication is lacking throughout the early intervention program between the staff and the parents, this could lead to a less-than-pleasant experience and little to no training techniques being used at home (Larcombe et al., 2019). Parents' perspectives can better inform the delivery of services to help identify ways to serve families during early intervention.

In Chapter 3, I focus on the basic qualitative approach, provide a review of the research design and rationale, and describe my role as the researcher, the methodology, and issues of trustworthiness. The basic qualitative approach facilitated researcher understanding of parent perspectives on factors in early intervention that influence self-efficacy, expectations, and observational learning. As the researcher, I aimed to set aside all biases and prejudgments to obtain honest answers. I conclude with ethical procedures that were in compliance with the Institutional Review Board (IRB).

Research Design and Rationale

Early intervention therapies are important, and parents have an essential role in the effectiveness of early intervention therapies. There is a need to know more about parent perspectives to maximize the impact of these interventions. This study was a qualitative research study that examined parents' perspectives and experiences related to early intervention among children with autism. SCT was applied using a basic qualitative approach. A qualitative methodology was chosen over a quantitative methodology because the purpose of this study was to gain insight and understanding (Larcombe et al., 2019). With an understanding of what parents go through, therapies can be used to create the perfect learning environment. A therapy technique can cause stress for one child and create a fun learning environment for another (Autism Society, 2020). Interviews were the main method of data collection in order to understand the subjects' point of view.

A basic qualitative approach was chosen instead of a case study, ethnography, or phenomenological approach. A case study describes an experience, person, event, or place and analyzes the experience of the individual through observation and interaction with the individual (Thorne et al., 2004). The ethnography method identifies cultural aspects and variables by getting involved through observation and interacting with the participants (Thorne et al., 2004). The phenomenological approach describes individuals' lived experiences through their viewpoint (Thorne et al., 2004). A basic qualitative approach explores an individual's reasons and opinions (Thorne et al., 2004). This approach was chosen over the others in order to use SCT and better understand parents' perspectives on early intervention. SCT uses the individual, their behavior, and the external environment to create a system where the individual is empowered to influence their environments (Merrifield, 2015).

The following research questions guided this research study to explore parent perspectives on early intervention:

- Research Question 1: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention?
- Research Question 2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention?
- Research Question 3: What do parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build the parents' self-efficacy?

Role of the Researcher

My role as the researcher included interviewing parents of children with autism who were attending or had recently attended early intervention services. I had no personal or professional relationships with any of the participants. Two of my children did attend this program/intervention from June 2017–February 2018 and from May 2018–August 2018. To reduce any positive or negative influence, I did not personally know any of the participants in this study.

As the researcher, I made sure that there were no ethical issues that might arise and that the data collection methods were within compliance with the facility and state rules/regulations (Walden University, n.d.). All parents signed consent forms prior to starting the study so that they would know exactly what the study entailed and that no identifying information would be shared. Because the children were not directly involved in this study, there was no need for any additional forms or approvals. I had no contact with the children during this study, just the parents. To reduce opportunities for biased opinions that could arise, I also asked the parents about any negative experiences during their child's time in early intervention. This was done to help eliminate any bias to create honest results. If the parents did not like the program or found it to be ineffective, this was an opportunity to voice their opinion.

Methodology

Participant Selection

This study focused on parents whose child had autism and was attending or had recently attended early intervention. Early intervention programs provide services to children under the age of 3 with developmental delays and disabilities. Early intervention is a combination of services such as behavioral health, developmental therapy, occupational therapy, physical therapy, speech and language therapy, social work services, and psychological services (Larcombe et al., 2019). Parents could participate in the study as long as their child had been professionally diagnosed with autism and was receiving services based on their diagnosis.

A total of 8 parents were recruited to participate in this study. A total of 11 participants replied, and three of them were ineligible. The first two participants who contacted me through phone were a husband and wife who had taken a flyer with them but had recently moved to Canada and started using a Canadian early intervention program. The third participant contacted me through phone but was not consistently attending early intervention services. Eight participants allowed for a sufficient amount of information to be obtained and the research questions to be addressed (Merriam, 2009). A small number of informative interviews can be more helpful than dozens of short interviews in qualitative studies (Merriam, 2009). By using an established theory with a sufficient amount of theoretical perspectives, a smaller sample size provided adequate information (Malterud, et al., 2015). Data source triangulation was used to evaluate the consistency of findings (Cohen & Crabtree, 2006). Data triangulation was the most effective form of triangulation for the study and was chosen over investigator, theory, and methodological triangulation. Investigator triangulation involves multiple researchers, theory triangulation involves more than one scheme to explain a phenomenon, and methodological triangulation involves using more than one way to gather information (Grant, 2018). Because only one investigator was conducting the study and only one option was being using to gather information, data triangulation was the most effective choice.

Due to recruitment being out of one specific county, recruitment was done through social media and the early intervention center. Therapists and early intervention teachers placed flyers out in the classroom about the study. If parents were interested and wanted to participate, the providers collected their email or contact information for me to contact them. Parents were then contacted through email to ask whether they would like to participate in a study involving autism and early education (see Appendix A). Recruitment of participants was done with the help of the facility and through social media platforms and pages aimed toward Monroe County early intervention. Facility staff helped by placing flyers in the early intervention classroom for the parents to see, and a social media post was made on a Southeast Michigan Early Intervention Autism page on Facebook. Due to COVID-19, interviews were conducted over the phone or through a Zoom meeting, depending on parent preference. Communication was done through email.

Nonprobability convenience sampling was used in order to obtain data from individuals who successfully met all the criteria to participate. The parents needed to have a child who had been diagnosed with autism and was currently attending early intervention classes one to two times a week in Southeast Michigan. Sampling consisted of a set of individuals or objects selected from a population by a defined procedure (Statistical Solutions, 2020). The parents answered a questionnaire asking them if they met all the requirements in order to participate in this study. The questions included the following: Is the child currently enrolled or was the child recently enrolled in an early intervention program? If so, for how long? Did the child actively participate 1–2 times a week in the program? Has the child ever had a diagnosis of ASD? (See Appendix C.) Nonprobability sampling involves nonrandom selection based on convenience or other criteria, specified by the researcher, allowing the researcher to collect initial data (Haenssgen, 2019). This allowed for easy participant selection based on eligibility.

Instrumentation

To collect data, the parents were asked about the different therapies that each child received. Some children were receiving different therapies than others, and I kept track through interview questions of which therapies were used per child (Appendix F). The data were collected through semistructured interviews, and an interview protocol and recording device were used in order to obtain data for analysis. SCT was used as a guide to develop the interview questions. This theory encourages and accepts different perspectives and initiatives, allows for the researcher to build on and use parental responses using cognitive terminology, and encourages critical thinking during open-ended questioning (Brooks & Brooks, 1993). The guiding questions to the research questions are located in Appendix B. The guiding questions were created based on the research questions. A face validity assessment was completed with experts in the field.

Multiple sources of data were used for data triangulation, including member checking and transcript review to help in gaining an in-depth understanding of participant experiences and perspectives (Bloomberg & Volpe, 2008). The data sources that were used were a checklist of all possible interventions (Appendix F), alignment of research questions (Appendix I), and preliminary and interview questions (Appendix B). Data triangulation helps in organizing data and adds strength to a study by lending credibility to the study (Bloomberg & Volpe, 2008).

Researcher-Developed Instruments

The semistructured interview questions were developed by following the theoretical framework and methods used during the study. The questions were also based on the research questions in order to gain insightful information on early intervention services. This allowed for open-ended interview questions to be asked and the honest opinions of the participants to be recorded. Trustworthiness was ensured through data source triangulation, member checking, and an audit trail. A letter of consent was signed by all participants. I recorded all interviews and transcribed them into a Word document. The interview protocol was reviewed by three experts within the qualitative field (Castillo-Montoya, 2016). Face validity was assessed by having three health education experts evaluate the questionnaire. Three questions were used for face validity, which prompted participants to rate whether they believed that the interview protocol was appropriate, to rate the alignment of the research questions with the interview protocol, and to rate the alignment of the interview protocol with the theoretical constructs (see Appendix E). I met with Walden University qualitative methodologist Dr. Bidjerano. He suggested that I create a table with all the codes (Appendix G) and create a table with a few selected codes and create subcategories (Table 2). This table is incorporated in Chapter 4. Appendix I highlights the alignment of the research questions with theoretical constructs and interview questions.

To ensure face validity, three experts on qualitative research in health education reviewed the instrument and rated it on alignment between the interview questions and research questions with theoretical constructs (Appendix E). An assessment tool was sent to three experts on January 7, 2021. They were asked to rate the instrument on a Likert-type scale for appropriateness of the interview protocol, alignment of the research questions with the interview protocol, and alignment of the interview protocol with theoretical constructs. All experts rated the study between 5 and 7 and recommended the following changes: Make changes to Research Questions 2 and 4, make sure that the interview questions pertain to health education, and incorporate self-efficacy constructs. I asked three experts to provide feedback to the Construct Table (Appendix E) and supply any changes needed. Dr. Holly Godwin felt that the word "health" needed to be added to Research Question 4 and to make sure that my questions circled back to pertaining to health education. On January 13, 2021, Dr. Rose Pignataro returned the form (Appendix E) advising that Research Questions 1 and 3 also fell under the self-efficacy constructs. On June 8, 2021, Dr. Laura Wamsley returned the form (Appendix E) suggesting that for Research Question 2 I ask the parents how long and how many times per week their child was receiving services. All feedback is included in the revised version of the interview guide (Appendix E).

Member checks allow participants to correct errors and allow for participants to add information if needed (Cohen & Crabtree, 2006). Audit trails are an in-depth approach to show that findings are based on the participants' narratives (Cohen & Crabtree, 2006). A detailed table of the coding process, descriptions on how detailed codes and themes were created, and a rationale on codes that were used to form the basis of the theme were used to conduct the audit trail (Statistical Solutions, 2020). This helped thoroughly describe how data were collected and analyzed.

Interview questions were developed to better understand the perspectives of parents of autistic children who receive early intervention services. After a few screening questions to determine length of time receiving services, services received, and specific diagnoses, parents were asked to describe their experience with early intervention services. As follow-up questions, parents were also asked what had worked well in their experience and what had been challenging. Parents were also asked how the intervention services had been individualized for their child and family. Finally, parents were given the opportunity to provide any additional information related to their experience.

Recruitment, Participation, and Data Collection

I collected data through semistructured interviews over the phone or during a Zoom meeting. The way that the interview took place depended on the participant and what they felt comfortable doing during this timeframe and dealing with COVID-19. Participants were recruited from the ISD through phone or email. I personally contacted the head health educator, and she agreed to place the flyers in the classroom. She placed flyers next to the check-in sheet located on a table near the classroom door. This made the flyers accessible to parents and provided my contact information.

I transcribed the recordings by typing out the recordings into a Word document. An Excel spreadsheet was created to format the responses of each participant into a table format. Each interview took place one time and was completed within a 45-minute timeframe. All interviews were recorded with the permission of the participant.

As the researcher, I collected the data. I kept in contact with the participants and worked around their schedule to conduct the interviews during a timeframe that worked best for them. Participants who responded through teleconferencing or phone call were advised that I might have additional questions based on their answers and that this process might take longer than an hour, depending on how quickly they responded to the questions. Once the overall interviews were complete, I did not have to contact the participants for any more information.

In order to properly analyze the data if the interview is held over a Zoom meeting, the meetings were recorded through the Zoom app. Interviews that take place on the phone were also recorded but with a handheld recording device. Interview times ranged from 22 – 31 minutes. After the interviews were completed, I properly debriefed the participants after the interviews and went over their study involvement. No follow-up interviews were needed. Data collection events were done within a two-week timeframe allowing the participants to choose the day and time that works best for them. Member-checking was conducted by sharing a brief summary of the findings to the participants through email. All participants approved of the findings and thought their answers were sufficient. None of the participants added anything else after the interviews were concluded.

Data Analysis Plan

All interviews were recorded and then processed in full transcription. Data analysis included establishing themes and codes to organize the data into categories. The qualitative analysis software NVivo was used to help organize and analyze the data. All data was put into categories based off the original research questions. If any cases were considered discrepant, this was noted and the data was not used for this study.

Thematic analysis was applied by analyzing interview transcripts. A six step process was used: familiarization, coding, generating themes, reviewing themes, defining and naming themes, and write up (Caulfield, 2020). For coding, the data was separated from its original context to be reorganized and renamed. Coding is used to create patterns of words or phrases to be placed into categories (Saldana, 2016).

Issues of Trustworthiness

Appropriate strategies were taken in order to establish credibility. Credibility was ensured through member checking, which entailed detailed interpretations of the findings allowing both the research and the participant the ability to review the information (Korstjens & Moser, 2017). Data triangulation was also used, which included member checking and transcript review. The data was returned to the participant to review prior to analyzing the data. I played back the recorded interviews twice to ensure the recordings were transcribed correctly. During the recruitment phase participants were asked to answer a questionnaire in order to determine eligibility. The questions that determined eligibility were: Is the child currently or has recently been enrolled in an early intervention program? If so, for how long, did the child actively participate 1-2 times a week in the program, and has the child ever had a diagnosis of ASD?

The variation of participant selection was based solely on the answers from the questionnaire, which did not ask for any information such as: gender, race, or ethnicity. To establish transferability connections were made to cultural and social contexts as well as mentioning where the interviews occurred and the time and date the interviews took place (Colorado State University, 2020). Transferability can be ensured through thick description by describing the experiences to the point where the information is useful to any reader (Korstjens & Moser, 2017). This information allows readers to make assumptions and apply this content to the aspects of our daily lives.

An audit trail was used to establish dependability. An audit trail allows the researcher to take an in-depth approach to explaining that the findings are based on the participants answers and describes how the data was collected and analyzed (Lani, 2020). This strategy was used by describing the research step by step from the start of the project to the finished results (Korstjens & Moser, 2017). An audit trail was kept throughout the whole process of this study including: transcripts, data analysis notes and tables, final drafts, and any other form of notes collected. A reflexive journal (Appendix H) was used to make regular entries during the study. This allowed me to record methodological decisions and their reasonings.

Ethical Procedures

All ethical standards set forth by Walden University's IRB (Approval Number: 01-21-22-0985692) were followed. Areas required by the IRB include: All forms be clearly articulated and documented appropriately, ensure privacy of data collection, data is to be stored securely on a password protected computer and all paper documents are kept in a locked filing cabinet, only include contact information if necessary. All forms were emailed to the participant to review and verbally read to them. Participants were asked if they understood the documents and each participant provided their verbal acknowledgment of fully understanding the documents. All participants verbally consented to the study and all recorded and transcribed interviews are secured in a password protected file on the researcher's laptop.

This study involves minimal risks, consent forms were verbally signed, the researcher made sure the individuals volunteering for this study remained anonymous. Demographic details are shared in a way that will not make the participants identifiable (Walden University, nd). Data collection did not take place until I had IRB approval #

01-21-22-0985692. The participant’s information will not be shared or distributed; it will be kept confidential at all times. The informed consent provided sufficient information so the participant could make the decision if they want to enroll in the study. Verbal consent was also accepted as long as the patient agreed the consent can be recorded.

Summary

Early intervention is a very important factor in helping children with autism succeed and meet their developmental goals throughout life. Without the parent’s perspectives on these services they would not be tailored to the child to create the ideal learning environment. Communication is important during the duration of the services to ensure the child is receiving the proper therapies and making progress. With the prevalence continuing to rise, the need for early intervention services is increasing.

Recruitment of this study took take place through the ISD facility and social media platforms. If parents wanted to participate they completed a screening. Semistructured interviews took place over the phone, through Zoom, or by email depending on which method the participant chose. Data was then analyzed with NVivo to establish themes and codes to organize the data into categories.

Chapter 4 includes detailed information on the setting and participants, data collection, the recording process, data analysis, categories, codes, and themes, evidence of trustworthiness, and the study findings.

Chapter 4: Results

Introduction

The purpose of this basic qualitative study was to analyze parents’ perspectives on early intervention services. I investigated the perspectives of parents with a child diagnosed with autism and currently enrolled in an early intervention program. Three research questions were investigated. The first research question focused on the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention. The second research question focused on whether the parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention. The third research question focused on what parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build the parents' self-efficacy.

This chapter contains five sections. The first section contains setting and participant information. In the second section, I discuss data collection characteristics, including the number of participants, the location, and the frequency and duration of data collection. The next two parts contain the data analysis process and results of the data analysis. The final two parts of Chapter 4 include a presentation of findings and a chapter summary.

Setting and Participants

The setting for this study was an early intervention program located in Southeast Michigan. This program offers therapies one to two times a week. These therapies include speech and language therapy, physical therapy, developmental therapy, psychological services, and occupational therapy. I conducted interviews over the phone or through Zoom, depending on what each participant felt comfortable doing. All parents who participated had a child who was diagnosed with autism. No demographic information was obtained. There were eight participants in this study: five females and three males. Parents’ experience with early intervention ranged from 3 months to 3 years.

Data Collection

This section includes information on the location, frequency, and duration of the data collection process. An introduction to the study was presented over the phone to the early intervention teacher who placed the flyers in her classroom near the sign-in sheet for parents to take if they were interested. A social media post was made by the early learning center on Facebook. The flyer and social media post consisted of the same information. Participants informed the teachers at the learning center if they were interested and gave them their email. The teachers passed the email addresses to me, and I then emailed potential participants. I informed possible participants of the eligibility requirements and went over the screening questions with them prior to obtaining their consent. Out of the eight participants, four were recruited from the early education center and four were recruited from the social media post.

The interviews took place over a 6-week period from January 24, 2022, to February 28, 2022. Some participants wanted to proceed with the interview immediately after answering the screening questions; the others were contacted to set up a date and time for the interview. The interviews lasted on average 30 minutes and took place over the phone or on Zoom. I conducted all interviews, including the screening procedures (2 minutes), informed consent (5 minutes), and preliminary and interview questions (23 minutes). Out of the eight participants, three did not want to be recorded, and I typed their notes as they answered the questions. The remaining five audio recordings were uploaded to NVivo, and a copy of the transcript was sent to each participant to review. All eight participants received transcriptions or summaries of their interviews for member checking.

The Data Recording Process

The interviews took place over the phone or on Zoom, and I was in a private room for the duration of each interview. The phone interviews were recorded on an iPad app called Voice Recorder, and the Zoom interviews were recorded on Zoom. Each interview was recorded separately and transcribed using NVivo transcription software.

Data Analysis

In this basic qualitative study using semistructured interviews, I explored parents' perspectives on early intervention for children with autism. Every participant was asked the same two preliminary questions and 10 open-ended interview questions in the same order. I transcribed each recorded interview before analyzing the data and listened to the recording a second time while rereading the transcription to ensure accuracy. The transcription took place by uploading files to NVivo.

Thematic analysis was used to analyze the data. A six-step process was used: familiarization, coding, generating themes, reviewing themes, defining and naming themes, and write up (Caulfield, 2020). Each transcription was searched for common words and phrases. These common words and phrases were then categorized into codes and themes. These codes and themes were used to address the three research questions of this study.

Categories, Codes, and Themes

Two steps were used to create the categories, codes, and themes. Thematic coding was used to describe the topic and create categories. Thematic coding involves recording or identifying passages of texts that are linked by a common theme (Gibbs, 2007). Secondly, pattern coding was used to recognize similar ideas based on the participants' answers. Codes were grouped together based on similarities within the interview and research questions to create categories. Themes were created from the categories based on the characteristics of the groups.

Table 1 includes the codes and categories that were created from the participants' interviews. Column A contains the category, and Column B contains the code that was created. Column C contains the participant's study ID, and Column D contains an excerpt of their answer. The codes and categories align with the excerpts.

Table 1

Codes and Categories

Category	Code	Participant	Excerpt
Experience with early intervention	Improvement	P4	I've seen a huge improvement with my child.
	Hands on	P3	Very hands on, my daughter greatly benefited from this.
	Learns skills	P4	Learn skills early on.
Early intervention meets educational needs	Patience	P1	Everyone being patient and willing to answer questions.
	Help assists	P5	Teachers were always willing to assist.
Easier process	Availability	P1	Teachers being available, patient, and willing to answer questions.
	Transportation	P6	Traveling back and forth can be expensive.
	Incorporating at home	P4	Incorporating things at home. I find this hard to do sometimes.
Hardest thing about early intervention	Hard	P8	Making it to class 2x a week is hard.

Category	Code	Participant	Excerpt
Communication process	Easy	P7	I have felt like this whole process has been easy
	Write down questions	P2	I have found it best to have communication written down
	Health	P5	Important to be educated about your child's health
	In-person	P8	In person. I haven't had to contact them outside of the classroom sessions.
Incorporate early intervention	Parent classes	P3	Give parents more information or offer us classes
	Healthy eating	P4	Healthy eating options on a budget would be a tremendous help.
	Healthy habits	P5	Teaching your child healthy habits
Anything else about early intervention	Improvements	P4	I really have enjoyed the experience
Additional health education topics	Development screening	P2	Access to developmental screenings
	Picky eaters	P1	It's hard to find foods for picky eaters.

A table with all the codes used to create subcategories can be found in Appendix G. Table 2 includes the codes and subcategories created during data analysis.

Table 2

Codes and Subcategories

Code	Subcategories
Improvement	Health education course Courses offered outside working hours
Parent classes	Teach parents more hands-on techniques Offer classes at nights and on weekends
Hard	Difficulty traveling to and from services
Healthy habits	Teach parents how to start healthy eating habits Talk to children about healthy eating options
Health	Incorporate health education classes for parents and family members

Interview Questions 1, 3, 4, and 8 aligned with Research Question 1. The themes and categories related to Research Question 1 were obtained from parents' perspectives on their experience with early intervention, how to make the process easier, what made the process hard, and additional health topics participants would like to see offered. The categories and themes emerged from the codes. Table 3 shows the categories used to form the themes regarding parents' perspectives on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention.

Table 3

Categories and Themes

RQ1: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention?

Category	Theme
Experience with early intervention	Theme 1: Teachers are interactive and tailor programs to each individual child through communication
Easier process	Theme 2: Parents struggle with transportation and work to attend two sessions a week
Hardest thing about early intervention	
Additional health education topics	Theme 4: Parents lack outside resource information

Interview Questions 2, 5, 6, 7, and 8 aligned with Research Question 2. The themes and categories related to Research Question 2 were obtained from parents' perspectives on how early intervention meets health educational needs, the communication process, how health education is incorporated in early intervention, any additional information participants would like to add about the process, and additional health topics participants would like to see offered. The categories and themes emerged from the codes. Table 4 shows the categories used to form the themes regarding parents' perspectives on factors identified as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention.

Table 4

Categories and Themes

RQ2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention?

Category	Theme
Early intervention meets educational needs	Theme 1: Teachers are interactive and tailor programs to each individual child through communication
Communication process	Theme 3: Teachers' availability through phone and in person provided good communication.
Incorporate early intervention	Theme 4: Parents lack outside resource information
Anything else about early intervention	
Additional health education topics	

Interview Questions 3, 4, 5, 6, 7, and 8 aligned with Research Question 3. The themes and categories related to Research Question 3 were obtained from parents' perspectives on their experience with early intervention, how to make the process easier, the communication process, how health education is incorporated in early intervention, any additional information that the participants would like to add about the process, and additional health topics that the participants would like to see offered. The categories and themes emerged from the codes. Table 5 shows the categories used to form the themes regarding parents' perspectives on what health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build the parents' self-efficacy.

Table 5

Categories and Themes

RQ3: What do parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build the parents' self-efficacy?	
Category	Theme
Easier process Hardest thing about early intervention	Theme 2: Parents struggle with transportation and work to attend two sessions a week
Communication process Incorporate early intervention Anything else about early intervention Additional health education topics	Theme 3: Teachers' availability through phone and in person provided good communication Theme 4: Parents lack outside resource information

Evidence of Trustworthiness

Trustworthiness was ensured through credibility, dependability, and transferability strategies for evidence of trustworthiness. To address content validity, a face validity assessment was completed with experts in the field. The use of semistructured interviews allowed the participants to share their perspectives on early intervention for children with autism.

Credibility ensures that a study is accurately measuring what it is intended to measure. To assure credibility, I used the following data collection strategies: interview recordings, interview notes, transcriptions, reflective journal, and member checking. After the semistructured interviews were complete, participants received a summary of study findings. All the participants agreed with the findings and had nothing more to add. A reflective journal was maintained during each interview session to capture my personal thoughts and feelings.

Transferability provides readers with evidence on the study such as time, population, situations, and context (Merriam, 2009). Transferability was ensured by provided an in-depth description of the study. Details about the data collection methods used and the participants selected for the study were provided. Information about the setting was provided to allow the reader to determine if this study may be transferable to another setting involving parents' perspectives on early intervention with children with autism. I recorded and transcribed all interviews word for word to ensure the data was collected accurately. No follow-up interviews were needed. To eliminate any personal bias I also maintained a reflective journal to record my thoughts (see Appendix H). All interview questions were asked in the same order, utilizing the same original interview document for every interview. Right before starting the interview, I reminded participants of their rights to withdraw from the study at any time. The emerging code, categories, and themes were aligned to the research questions to validate the findings.

Findings

I examined parents' perspectives on early intervention for children with autism through a basic qualitative study using semistructured interviews. All participants were asked if they would like to provide any additional information and all 8 participants answered no. In this section, I described the results of the responses that I collected during the interviews with 8 participants. I used 2 preliminary and 8 open-ended interview questions to help answer the research questions (see Appendix B). Parents were able to provide in-depth and thorough responses through interviews.

Table 6 includes the results of the preliminary questions asked to the participants prior to conducting the interviews. Each participant was asked each question in the exact same order: How long has your child been receiving early intervention series, tell me about the services your child is receiving, and how long does your child receive these services per week. The length of time the child has been receiving services was recorded in years and if the child was not in the program for at least a year it was noted within the table how many months the child has been attending early intervention.

Table 6

Preliminary Questions

	Length of services	Types of services	Number of weekly visits
Participant 1	1 year	General, speech and language, occupations, physical therapy	1
Participant 2	2 years	General and speech and language	2
Participant 3	3 months	General	1
Participant 4	1.5 years	General	2
Participant 5	5 years	General and behavioral	2
Participant 6	1 year	General, speech and language, and physical therapy	2
Participant 7	2 years	General	1
Participant 8	4 months	General	1

Table 7 consists of the findings based on the research questions that guided this study. Research Question 1 was as follows: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention? Interview Questions 1, 3, 4, and 8 addressed this research question. Research Question 2 was as follows: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention? Interview Questions 2, 5, 6, 7, and 8 addressed this research question. Research Question 3 was as follows: What do parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build parents' self-efficacy? Interview Questions 3, 4, 5, 6, 7, and 8 addressed this research question.

Table 7

Research Questions and Themes

Research questions	Themes
RQ1: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention?	Theme 1: Teachers are interactive and tailor programs to each individual child through communication Theme 2: Parents struggle with transportation and work to attend two sessions a week Theme 4: Parents lack outside resource information
RQ2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention?	Theme 1: Teachers are interactive and tailor programs to each individual child through communication Theme 3: Teachers' availability through phone and in person provided good communication Theme 4: Parents lack outside resource information
RQ3: What do parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build the parents' self-efficacy?	Theme 2: Parents struggle with transportation and work to attend two sessions a week Theme 3: Teachers' availability through phone and in person provided good communication Theme 4: Parents lack outside resource information

Theme 1: Teachers Are Interactive and Tailor Programs to Each Individual Child Through Communication

Seven participants provided positive feedback on their experiences with early intervention. Participants stated tailored programs, the teachers being hands on, and the focus on individuality help the development of their child. P4 stated, “They get a chance to learn skills early on to make sure they can eventually learn at the same pace as kids without disabilities. I’ve seen a huge improvement with my child”. P5 added, “Teachers were always willing to assist”. P1 shared, “The whole process helped my child”. P2 shared, “Early intervention has been a tool in helping young children learn and develop in the most developmentally appropriate ways. The teachers focus on individuality and the context from which the child has come from, forming a learning technique specific to them. Early intervention has made a huge difference within children”. P6 added, “At first, I didn’t know if my child would have any progress but after a while we started getting compliments how she was doing so much better”. P7 stated, “They definitely tailored the services to my child’s needs. I was impressed how much they knew and were able to help him”. Whereas P8 shared, “I’ve only been attending classes once a week for the past 4 months so I can’t really tell a difference yet”.

Theme 2: Parents Struggle With Transportation and Work to Attend Two Sessions a Week

Four of the participants expressed concerns about transportation issues and missing work to attend these sessions during the week. P6 stated, “Traveling to the ISD center. It takes up half the day with driving and sitting through the sessions. It’s worth it but it is a challenge”. When asked what the hardest part of early intervention was, P1 stated, “Transportation”. P3 shared, “The whole process is overall easy, and it would be easier with better hours and offering weekends. It’s hard going during the week during working hours”. P8 added, “Making it to class 2x a week. It’s hard. I work and find it hard to find someone to help me if I am unable to attend. Thankfully, my job is flexible an allows me to take her one day a week, but we can’t attend both sessions”.

Theme 3: Teachers’ Availability Through Phone and in Person Provided Good Communication

All of the participants talked about asking questions in person or over the phone to communicate with the teachers. P4 stated, “Usually in person is the best way to communicate. I try calling sometimes but don’t always get ahold of someone. I usually write down any questions and ask the teacher at the next class. This seems to work well for me”. P5 added, “Teachers were always willing to assist”. P8 stated, “In person. I haven’t had to contact them outside of the classroom sessions”. P1 shared, “Early on I felt lost. It took me awhile to finally figure out exactly who I needed to contact. I met so many people at once I felt overwhelmed”. P3 added, “Honestly, my wife takes care of most of this. I really didn’t understand what they were telling me a lot of the time. My wife would further explain everything to me”. P7 shared, “At first, everything was in person. As I started having more questions I would call”. P6 added, “I call when I have a question. I try to call when they don’t have classes so I can talk to someone right away. They always seem to answer all my questions”. P2, “I have found it best to have communication written down in a ‘communication journal’ that is shared with each individual working with the child.”

Theme 4: Parents Lack Outside Resource Information

All participants stated they would like additional resources related to outside sources, specialized services, and health education. P1 stated, “More options on what to eat and how to make eating fun for the kids. It’s hard to find foods for picky eaters”. P4 added, “Healthy eating options for small children that are picky eaters.” P7 also added, “Incorporate healthy food to picky eaters” Whereas P8 stated, “Outside services such as specialized therapists”. P5 shared, “I think I’d like to see more communication, ASL, and community outreach programs that allow for volunteers to help”. P6 shared, “Maybe after school programs that my child could benefit from”. P3 stated, “Outside resources we may not be aware are available”. P2 added, “Early intervention should include healthy practices that support every developmental domain. Some important topics to be considered consist of childhood obesity, physical activity, healthy sleep habits and access to developmental screenings”.

Data triangulation was ensured through checklist prompts (Appendix F). The participants’ responses to the checklist questions were compared to distinguish any similarities or differences. The prompts from the checklist included the following questions: I would like to receive more information on, I would like to receive more information on, my experience with early intervention has been, and health topics I would like to learn. The themes created, aligned with the participants’ answers within the table (Appendix J).

Summary

In Chapter 4, I addressed the data analysis and the findings of my study. This study was formed from 3 research questions and explored parents' perspectives on early intervention for children with autism. A total of 8 parents from Southeast Michigan shared their perspectives for this basic qualitative study using semi structured interviews. During data analysis, Nvivo was used to transcribe the data. Thematic analysis was used to analyze the data. A 6-step process was used: familiarization, coding, generating themes, reviewing themes, defining, and naming themes, and write up (Caulfield, 2020).

Four themes emerged that reflected the perspectives of the 8 participants. From completing the data analysis 3 themes emerged, that reflected the parents' perspectives of Research Question 1: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention? Three themes emerged. Theme 1: Teachers are interactive and tailor programs to each individual child through communication, Theme 2: Parents struggle with transportation and work to attend two sessions a week, and Theme 4: Parents lack outside resource information.

From completing the data analysis 3 themes emerged, that reflected the parents' perspectives of Research Question 2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention? Theme 1: Teachers are interactive and tailor programs to each individual child through communication, Theme 3: Teachers ’availability through phone and in person provided good communication, and Theme 4: Parents lack outside resource information.

From completing the data analysis 3 themes emerged, that reflected the parents’ perspectives of Research Question 3: What do parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD and build the parents' self-efficacy? Theme 2: Parents struggle with transportation and work to attend two sessions a week, Theme 3: Teachers availability through phone and in person provided good communication, and Theme 4: Parents lack outside resource information.

Chapter 5 includes an interpretation of the results, limitations of the study, recommendations, and implications. Interpretations of the findings for each theme and limitations are discussed in detail and connected to the literature. Opportunities for social change as well as implications for the study are presented.

Chapter 5: Discussion, Conclusions, and Recommendations

I conducted a basic qualitative study with semistructured interviews to examine parents' perspectives on early intervention for children with autism. A total of 8 parents with a child with autism enrolled in an early intervention program in Southeast Michigan participated in the study. Parents shared their perspectives on their experiences with early intervention. Through the analysis of data, four themes emerged:

- Theme 1: Teachers are interactive and tailor programs to each individual child through communication.
- Theme 2: Parents struggle with transportation and work to attend two sessions a week.
- Theme 3: Teachers' availability through phone and in person provided good communication.
- Theme 4: Parents lack outside resource information.

Gathering input from parents whose children receive these services might allow for improvement to be made to existing therapies. Chapter 5 includes interpretations of the results, limitations, recommendations, implications, and a conclusion.

Interpretation of the Results

I obtained approval from the Walden University IRB before data collection began. I used the three following research questions to gather qualitative data for this study:

- Research Question 1: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention?

- Research Question 2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention?
- Research Question 3: What do parents of children with ASD believe that health professionals and health educators could have done better to improve their early intervention, increase their knowledge of ASD, and build the parents' self-efficacy?

Data triangulation was used to evaluate the consistency of findings (Appendix G). Interviews were conducted on different days and at different times depending on the availability of the participants. The data analysis results were compared to two similar studies: Puthussery et al. (2019) and Baglama and Demirok (2016). This study and the one conducted by Puthussery et al. had similarities by proving that parents need additional support such as outside parent programs. The difference was that the study conducted by Puthussery et al. included all programs involving early childhood development and was not limited to early intervention.

This study and the one conducted by Baglama and Demirok (2016) had similarities such as having tailored individual programs per the child’s needs and new training programs and techniques for teachers. The difference was that the study conducted by Baglama and Demirok (2016) analyzed teachers' perspectives on early intervention instead of parents' perspectives.

The parents were asked 8 questions about their perspectives on early intervention for children with autism and 3 screening questions. The preliminary questions were asked to ensure that the child was diagnosed with autism and currently attending early intervention. Four themes aligned with parents' perspectives on early intervention for children with autism. The findings of this study indicated that the parents think the teachers are interactive and have good communication, their children received individually tailored programs and therapies, parents struggle with transportation due to expenses and having to take off work, the teachers 'availability through phone and in person provided good communication, and parents lack outside resource information.

Theme 1

Theme 1 indicated that teachers were interactive, teachers had good communication, and parents were impressed with individually tailored programs for their children. The parents stated that they saw a significant improvement in their children once they started early intervention. Early intervention provides children with general health education (Ison, 2020). Diverse circumstances are taken into consideration when creating a health education curriculum for children with autism. P6 stated, "One-on-one resources were provided to us when they realized my daughter was going to need a little extra help." P4 shared, "They get a chance to learn skills early on in order to make sure they can eventually learn at the same pace as kids without disabilities. I've seen a huge improvement with my child."

A study conducted by Baglama and Demirok, (2016) showed that over 90% of teachers interviewed agreed that appropriate programs are prepared for children based on their interests and needs through assessing their development levels, that instructive counseling is provided to families to help provide a solid foundation for communication and parental feedback, that early intervention programs require collaboration between different groups in order for them to be successful, and that early intervention programs require regular follow-up.

While all services provided through early intervention have a direct impact on health promotion, health education specifically is provided to help a child's development during these programs (Leadbitter et al., 2017). Parent P2 shared,

> The teachers within early intervention programs are sure to focus on each developmental domain: physical, cognitive, cultural, and social. By focusing on each domain individually children are provided with the most appropriate care. Within the classroom children learn about and are provided with healthy snacks, lots of physical activity, and a positive teacher model.

SCT refers to how the social environment affects an individual's behavior (Bandura, 1986). P5 also shared,

> Along with the help of several therapists we were able to teach her motor skills and sign language. She excelled at everything. Her meltdowns were quite awful though. Her scream was crazy ridiculous. It was daily that she would have these meltdowns out of nowhere. With early intervention we were taught the warning signs and how to redirect her attention.

A common trend seen in children with autism throughout Michigan is impaired communication (Autism Alliance of Michigan, 2020). A strong parent–teacher relationship is almost equally as important as the child–teacher relationship to maintain effective communication and build trust (Patton, 2015). P1 shared, “I have learned a lot of information and the teachers are always willing to answer my questions.” P2 stated,

> The teachers have created informational papers and packets explaining the practices they use and why. Teachers have also established developmental activities for families to participate in at home. It helps to have these activities directly from the teacher that has been observing the child each day.

Parents expressed the importance of health educators being interactive with the children during therapy sessions. P3 talked about how health educators interacted with her child, stating, “Very hands on, my daughter greatly benefited from this. I liked how interactive the teachers were with her.” P1 shared, “The teachers were very good at listening to our concerns and watching our child interact with others. The teachers were able to teach me new things and show me how to do these things at home.”

The results of this study indicated that parents need solid communication with health educators and hands-on programs for their children to have a successful experience. These findings supported SCT by showing that through good communication and having individually tailored programs, a beneficial environment can be created to allow the child to learn and develop.

Theme 2

Under Theme 2, parents expressed the challenges of transportation and attending two sessions of early intervention a week. Most of the parents stated that it is hard to attend sessions due to sessions being held during working hours. Parent P8 stated,

> It's hard. I work and find it hard to find someone to help me if I am unable to attend. Thankfully, my job is flexible an allows me to take her 1 day a week, but we can't attend both sessions.

P6 expressed her concerns on what she thought the hardest thing was about early intervention by stating, "Traveling to the ISD center. It takes up half the day with driving and sitting through the sessions. It's worth it but it is a challenge." P1 also stated, "Transportation," Adequate transportation ensures that families can attend health education services (Abe et al., 2017).

By providing parent perspectives on the intervention, it is possible to improve the experience of parents in program delivery. P3 recommended, "Better hours and offering weekends. It's hard going during the week during working hours." The perspectives of parents can help improve program availability and delivery services. Early developmental opportunities, such as early intervention, can provide the child with academic success, health, and well-being (CDC, 2019d).

Therefore, the results of the study showed that improvements are needed in certain areas of early intervention. Service delivery and being able to successfully participate are vital to children with autism. The current study findings supported the research reviewed in Chapter 2 and SCT by proving concerns on how to attend early intervention and the expectations that parents have.

Theme 3

Theme 3 showed that the teacher's availability through phone and in person provided good communication. P4 stated,

> Usually in person is the best way to communicate. I try calling sometimes but don't always get ahold of someone. I usually write down any questions and ask the teacher at the next class. This seems to work well for me.

Puthussery et al.'s (2019) study showed that parents who were provided information packets and had good communication with the health educators felt more confident in their choices and were more involved.

Parents who feel that they are involved throughout the process have a more suitable understanding of exactly what services their child is receiving and the reasons for the services (Williams, 2019). P5 shared, "We have an open communication. With literature and helpful videos, early intervention has been made easier. Emails, texts, calls, and even Zoom social media chat rooms have made early intervention a complete success." P2 stated,

> Communication is always established in the beginning of early intervention. Through many trial and error attempts, the teachers, parents, and medical personnel have created several forms of communication to find which one works best. I have found it best to have communication written down in a

"communication journal" that is shared with each individual working with the child.

If communication is lacking between health educators and parents, this could lead to low parent confidence, low expectations, and no observational learning, which could result in little to no training techniques being used at home (Edwards et al., 2017). P1 stated, "Early on I felt lost. It took me awhile to finally figure out exactly who I needed to contact. I met so many people at once I felt overwhelmed."

If a parent is not confident in their ability to follow through on these interventions at home, they will not do them. A parent who has a strong self-efficacy will have the confidence and abilities to succeed in therapeutic techniques required at home (Pourmovahed et al., 2018). P3 shared, "I really didn't understand what they were telling me a lot of the time. My wife would further explain everything to me. So, I guess maybe they should use more basic language for me to understand." Effective communication between professionals and parents can prevent unnecessary confusion (Lee, 2015). Early intervention can be a difficult process if the parents do not fully understand what it all entails and how the process works (Lee, 2015). The current findings supported the research found in Chapter 2 and SCT by providing evidence that self-efficacy for parents is vital to effective interventions.

Theme 4

Theme 4 showed that all parents expressed concern about lack of outside resource information such as referrals to specialists, parent and family programs, and ways in corporate health eating for children who are picky eaters. Regarding additional health education resources that the parents would like to receive, P3 stated, “Outside resources we may not be aware are available.” Parents who are not fully aware of other intervention options may feel lost during the whole intervention process due to lack of information and resources (Crane et al., 2018). Self-efficacy emphasizes an individual’s attitudes, abilities, and cognitive skills (Pourmovahed et al., 2018). P2 stated,

> I believe holding informational nights with health educators and families would incorporate health education into early intervention better. From here, connections can be made between parents and professionals that may not have been made in any other way. Teachers may also form connections with health educators/personnel to establish practices that can be considered within the classroom beyond what is already in place.

Involving the parents is one way that parents can feel included and able to voice their opinions on any concerns that they may have (Patton, 2015). Puthussery et al.’s (2019) study proved that self-efficacy improved within mothers following parental therapies that taught parents how to conduct interventions at home. P5 shared, “I think I’d like to see more communication, ASL, and community outreach programs that allow for volunteers to help.” Therefore, the results of the study showed that parents have concerns about an inadequate number of outside resources. The current study findings supported the research reviewed in Chapter 2 and SCT by emphasizing the importance of parental self-efficacy and having a solid foundation for effective communication.

Triangulation of data was ensured within a table (Appendix J) created with prompts (Appendix F). This table showed similarities pertaining to health topics that parents would like to learn about, such as outside resources and healthy food options, and all experiences from the parents were overall good. When asked if there was still anything that the parents need to know, four parents stated, “Nothing,” while one still needed information on healthy eating, one needed information on health education, and two needed more information on outside resources.

Limitations of the Study

Potential limitations in this study included the COVID-19 pandemic, participants’ willingness to participate, and researcher bias. Limitations of basic qualitative design include the following: It is a time-consuming process, it is hard to verify the results because participants have more control over the content, it is labor intensive, it is difficult to investigate causality, and results are not statistically representative (Merriam, 2019). This study was limited to parents who had a child who had been diagnosed with autism, was currently enrolled in an early intervention program in Southeast Michigan, and was actively participating in early intervention one to two times per week.

I posted on social media and placed flyers in an early intervention center to recruit participants. I interviewed eight participants. More parents might have participated if the interviews had also been offered in person, but due to the COVID-19 pandemic, all interviews had to be held remotely. COVID-19 health and safety mandates prohibited me from conducting interviews face to face. Therefore, I interviewed participants by Zoom and telephone. Transferability would be applicable to all parents of children in early intervention, even those without autism. Researcher bias was also a limitation because I had two children with autism who went through early intervention in 2017 and 2018. To address these potential biases, I asked open-ended interview questions to allow for the participant to answer honestly.

Recommendations

The purpose of this study was to understand parents' perspectives and experiences on early intervention services to improve health and service delivery to individuals with autism. Participants in the current study identified that teachers were hands-on and created individually tailored programs for their children, teachers had good communication in person and through phone, and outside resource information for the whole family would be beneficial.

This study could lead to further research focusing on parents' perspectives on early intervention with child with autism. The study could extend to observing the child to see if the parents' input is incorporated and if it negatively or positively affects the child. Parents' perspectives on early intervention services can determine how they feel their child benefits or does not benefit from the program. The following are recommendations for future research.

The first recommendation is to replicate this study and focus on the perspectives of parents whose children with autism have recently completed early intervention. Collecting input from parents whose children have recently completed the intervention can allow for more detailed perspective. Early intervention is for children ages birth to 3 years old (Bellini et al., 2016). If a child has participated in the program for a majority of this duration, the parents will have a better understanding of the intervention from prolonged experience.

The second recommendation would be to replicate this study as a basic qualitative study and include a larger population and other geographic areas. The new study could expand the geographical location and record parents' demographics. By recording the parents' demographics, the researcher could look for a trend in different social and cultural contexts. The study should not be limited to early intervention centers but also in-home services. This could benefit health educators by allowing them to analyze the improvements and challenges of both on-site and in-home services. This study was limited to the perspectives of parents whose child with autism attends an early intervention program located in the southeast Michigan. The perspectives of parents from other regions of the United States may provide additional insight to increase rates of success and adherence to treatment, thus improving health outcomes across the lifespan.

Implications

A goal of the study was to gain insights into the parents' perspectives on early intervention. Parents in the study expressed concerns about transportation issues and missing work to attend these sessions during the week. All participants provided positive feedback on their experiences with early intervention. Participants stated tailored programs, the teachers being hands-on, and the focus on individuality help the development of their child. Parents also talked about how accessible the teachers were when questions needed to be asked. Parents were able to ask questions in person or over the phone to communicate with the teachers. All parents also expressed the need for outside resources and how it would benefit the whole family.

At the family level, this study could impact family functioning as it pertains to the health and wellness of the family unit. Feeling more confident in helping their child, parents can become more invested in supporting and implementing therapy. This study can also provide information to providers on ways to improve ways to incorporate the techniques at home and possibly providing evening hours for working parents. Providers could also provide parents with information on outside resources for health and wellness. The study findings support the gaps in research regarding parents perspectives on early intervention services and how they feel their child benefits or does not benefit from the program.

The results of the current study have implications for improving early intervention programs at the organizational level. This study may lead to early intervention programs developing new techniques. Positive social change may occur by improving early intervention programs along with starting new programs. Positive social change results in the improvement of human conditions and findings from this study could help the intervention services of children living with autism. Positive social change could occur at an individual and family level through increased communication and newly developed techniques. Involving parents by providing them sufficient information and classes could help incorporate health education strategies into their everyday life.

This study can allow health educators to create new educational learning techniques tailored to certain behaviors and areas of struggle. Health educators could develop individually tailored programs that require the child to have annual evaluations. Topics to be discussed during early intervention could include meal prepping, how to create healthy meals on a budget, cooking information and recipes for parents who struggle with cooking healthy meals, and how to maintain a healthy physical lifestyle. These evaluations could also inform parents of the resources that are available to the child and the whole family.

Other implications for social change include, understanding factors that can improve self-efficacy, expectations, and observational learning for parents of children with ASD who are receiving early intervention services, can help the field of health promotion by identifying factors that will aid in improved health service delivery.

Conclusion

The purpose of this basic qualitative study is to understand parents' perspectives and experiences on early intervention services to improve health and service delivery to individuals with autism. The results of my study filled a gap in research by regarding parents' perspectives on early intervention services and how they feel their child benefits or does not benefit from the program. Research exists on the importance of the role of parents, but there is very little data on parent perspectives of these services. The results of this study have implications for improving early intervention programs. Parents indicated they saw improvement in their children with while attending early intervention services.

The results of this study demonstrated that the parents have a good relationship with the health educators and teachers by maintaining a healthy communication process. Parents also indicated they are challenged to attend early intervention twice a week due to work and transportation issues. The results of this study provide evidence that parents need additional outside resources to better serve their children and their family members.

The findings of this study fill the gap in practice by contributing to an increased understanding of parents' perspectives of children with autism receiving early intervention services.

I hope that results from my study will allow health educators to create new educational learning techniques tailored to certain behaviors and areas of struggle. The information from my study may inform health educators on the importance of communication, individually tailored programs, and programs available outside of working hours to meet the needs of parents with children with autism attending early intervention. The study may also continue to support positive social change by improving early intervention programs along with starting new programs.

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Appendix A: Recruitment

Email to Parents for Recruitment

Dear_________,

My name is Tiffany Schmidt and I am a student at Walden University. I am writing to invite you to participate in my research study about parent’s perspectives on early intervention for children with autism. You're eligible to be in this study because your child has been diagnosed with autism and is currently enrolled in the Monroe County ISD early intervention program. I obtained your contact information from the Monroe County Intermediate School District.

If you decide to participate in this study, you will participate in an interview over the phone, through a zoom meeting, or through e-mail.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me.

Thank you very much.

Sincerely,

Tiffany Schmidt

Appendix B: Preliminary and Interview Questions

Preliminary questions:

1. How long has your child been receiving early intervention services?
2. Tell me about the services your child is receiving? How long does your child receive these services per week?

Interview Questions:

3. Tell me about your experience with early intervention for your child?
4. How has the early intervention been developed to meet the health educational for your child and family?
5. What things have made the early intervention process easier?
6. What have been the hardest things about early intervention?
7. Can you explain the communication process you have established with the therapists and health educators since your child started early intervention?
8. How could health education be incorporated into early intervention better?
9. Is there anything else you would like to tell me about your experience with early intervention for your child?
10. What health education topics they would like to receive as part of early intervention?

Appendix C: Qualifications Questionnaire

1. Is the child currently or has recently been enrolled in an early intervention program? If so, for how long?
2. Did the child actively participate 1-2 times a week in the program?
3. Has the child ever had a diagnosis of autism spectrum disorder?

Appendix D: Script Prior to Interview

Script prior to interview:

I'd like to thank you for participating in this study. As previously mentioned, the purpose of my study is to examine parents' perspectives on early intervention for children with autism. Early intervention services support babies and toddlers with developmental delays/disabilities and support their families as well. These services include: speech and language therapy, physical therapy, developmental therapy, psychological services, and occupational therapy. Developmental therapy is a service that uses fun and spontaneity of play to help a child develop skills such as language and speech, gross motor skills, and self-help skills. Occupational therapy helps individuals across their lifespan through the therapeutic use of daily activities to promote health and prevent, or to live better with, an injury, illness, or disability. Physical therapy includes activities and exercises that help build motor skills and improve strength, posture, and balance Speech and language therapy helps improve the abilities to communicate and interact with others. Verbal skills include: Correctly naming people and things, better explaining feelings and emotions, using words and sentences better, and improving the rate and rhythm of speech. Nonverbal communication includes: Using hand signals or sign language and using picture symbols.

Early intervention services have the potential to improve the quality of life of children with autism and their families. The parent's perspectives allow for proper intervention services to be dedicated to their child. We would appreciate learning more about your experience and perspectives on your early childhood intervention experience.

[Review aspects of consent form]

Over the phone you completed a consent form indicating I do/do not have your permission to record our conversation.

Are you still okay with me recording our conversation today? ____Yes _____No

If yes: *Thank you, if at any time you would like me to stop recording or would like something off the record please let me know.*

If no: *Thank you for the clarification, I will only be taking detailed notes during our conversation.*

Appendix E: Assessment Tool for Face Validity

Request for Expert Assessment of Face Validity

To whom it may concern:

I am reaching out to see if you would be willing to review the interview script and questions listed under Appendix C in my dissertation.
My study is on parents' perspectives on early intervention for children with autism. The purpose of this study is to analyze the parent's perspectives on early intervention services. Autism Spectrum Disorder is a lifelong condition and traits of this disability include: not responding to their name, trouble understanding feelings, delayed speech and language skills, obsessive interests, repeating of words or phrases, getting upset by minor changes, and avoiding eye contact.
This study will be conducted as a basic qualitative study utilizing constructivist theory and a family centered approach. To further support the connection with health education the social cognitive theory will also be used.

In this document, you will find the purpose of the study, the research questions, the script for the beginning of the interview, and two tables. Table one includes the Interview Questions and their alignment with theoretical constructs. Table two details the alignment of the interview questions with the research questions.

Please read the interview script and alignment. Feel free to use track changes and comments to make suggestions. Then please complete the three questions at the end on appropriateness and alignment of the interview protocol. Please feel free to contact me or my dissertation chair, Dr. Jill Nolan (jill.nolan@mail.waldenu.edu) with any questions. When you have completed the assessment, please return it to Dr. Nolan or me.

Thank you,

Tiffany Schmidt
tiffany.schmidt3@waldenu.edu

Questions for Professional Assessment of Face Validity
Please rate if you believe the interview protocol is appropriate based on the following likert scale:
Not Appropriate 1 2 3 4 5 6 7 Appropriate
Comments:

Please rate the alignment of the research questions with the interview protocol on the following likert scale:
Not Aligned 1 2 3 4 5 6 7 Well Aligned
Comments:

Please rate the alignment of the interview protocol with the theoretical constructs on the following likert scale:
Not Aligned 1 2 3 4 5 6 7 Well Aligned
Comments:

General Comments:

Alignment of Interview Questions with theoretical constructs.

	Constructivist Theory			Social Cognitive Theory			
Interview Questions	Understanding childhood development	Adults as mediators of children's learning	Importance of Child initiated actions	Reciprocal Determin-ism	Self-efficacy of the parent	Collective efficacy of the family unit	Reinforcements
1. How long has your child been receiving early intervention services?		X			X	X	
2. Tell me about the services your child is receiving. How long does your child receive these services per week?	X	X					
3. Tell me about your experience with early intervention for your child.	X	X	X				
4. How has the early intervention been developed to meet the special needs for your child and family?	X	X	X	X	X	X	
5. What things have made the early intervention process easier?				X	X	X	X

6. What have been the hardest things about early intervention?				X	X	X	X
7. Can you explain the communication process you have established with the therapists and teachers since your child started early intervention?				X	X	X	
8. How could health education be incorporated into early intervention better?					X		
9. Is there Anything else you would like to tell me about your experience with early intervention for your child?	X	X	X	X	X	X	X
10. What health education topics they would like to receive as part of early intervention?	X			X	X		

	Background Information	Research Question 1	Research Question 2	Research Question 3
Interview Q1	X	X		
Interview Q 2	X		X	
Interview Q 3		X		X
Interview Q 4		X		X
Interview Q 5			X	X
Interview Q 6			X	X
Interview Q 7			X	X
Interview Q 8		X	X	X

Appendix F: Checklist of All the Possible Interventions

List of interventions

Please circle all services your child is currently enrolled in:

Developmental therapy

Occupational therapy

Physical therapy

Speech and language therapy

Please provide any additional information you'd like to share below:

1. I still need to know …
2. I would like to receive more information on…
3. My experience with early interventions has been…
4. Health topics that I would like to learn...

Appendix G: Codes

Codes	
Parent Classes	Improvements
Healthy Eating	Hands on
Healthy Habits	Write down questions
Developmental Screening	Learn skills
Picky Eaters	Patience
Hard	Help assist
Easy	Availability
Transportation	Incorporating at home
Health	In-person

Appendix H: Reflective Journal Excerpt

“While conducting interviews, I listened carefully to every participant answers and made sure wait until they were completely done answering until I moved onto the next question. For two of the participants, I felt as if they were rushed or didn’t have the time to give extremely detailed answers. I did offer to do it another time, but they said that right now was the best time”.

Appendix I: Alignment of Research Questions

Research Questions	SCT Constructs	Interview Questions
Research Question 1: What are the perspectives and experiences of parents of children with autism from Southeast Michigan on factors that influence SCT constructs of self-efficacy, expectations, and observational learning in early intervention?	• Expectations • Self-efficacy of the parent • Collective efficacy of the family unit	How long has your child been receiving early intervention services? a. What were your expectations about how these services would go? b. How confident were you in your ability to use these services?
	• Expectations • Observational Learning • Reciprocal Determinism	Tell me about your experience with early intervention for your child? a. How did this experience influence your expectations?
	• Expectations • Reciprocal Determinism • Observational Learning • Self-efficacy of the parent • Collective efficacy of the family unit	How has the early intervention been developed to meet the special health needs for your child and family? a. What are the impacts of early intervention and health education methods used at home? b. Do you think more health education is needed?
	• Expectations • Reinforcements • Reciprocal Determinism • Self-efficacy of the parent	How could your early intervention experience be better? a. What changes do you recommend from a parents' perspective?
Research Question 2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention?	• Expectations • Reciprocal Determinism	Tell me about the services your child is receiving? How often and how long does your child receive these services per week? a. What are the impacts of receiving services weekly?

Research Questions	SCT Constructs	Interview Questions
Research Question 2: What do parents of children with ASD participating in early intervention in Southeast Michigan identify as facilitators and barriers to improve self-efficacy, expectations, and observational learning in early intervention?	• Expectations • Reinforcements • Self-efficacy of the parent • Collective efficacy of the family unit	What things have made the early intervention process easier? a. What were the pros and cons of the process?
	• Expectations • Reinforcements • Self-efficacy of the parent • Collective efficacy of the family unit	What have been the hardest things about early intervention? a. What were the strengths and weaknesses of the process?
	• Expectations • Self-efficacy of the parent • Collective efficacy of the family unit	Can you describe the communication process you have established with the therapists and teachers since your child started early intervention? a. How did this experience influence your expectations? b. Do early interventions have integrated health education topics? What topics?
	• Expectations • Reinforcements • Reciprocal Determinism • Self-efficacy of the parent	How could your early intervention experience be better? a. What changes do you recommend from a parents' perspective? b. Tell me about your experience with early intervention for your child? c. How did this experience influence your expectations?
Research Question 3: What do parents of children with ASD believe that health professionals could have done better to improve their early intervention, increase their knowledge of ASD and build the parents' self-efficacy?	• Expectations • Observational Learning • Reciprocal Determinism	Tell me about your experience with early intervention for your child? a. How did this experience influence your expectations?
	• Expectations • Observational Learning • Reciprocal Determinism • Self-efficacy of the parent • Collective efficacy of the family unit	How has the early intervention been developed to meet the special health needs for your child and family? c. What are the impacts of early intervention and health education methods used at home? d. Do you think more health education is needed?

Research Questions	SCT Constructs	Interview Questions
	• Expectations • Observational Learning • Reciprocal Determinism	What things have made the early intervention process easier? a. What were the pros and cons of the process?
	• Expectations • Reciprocal Determinism • Observational Learning	What have been the hardest things about early intervention? a. What were the strengths and weaknesses of the process?
	• Expectations • Self-efficacy of the parent • Collective efficacy of the family unit	Can you describe the communication process you have established with the therapists and teachers since your child started early intervention? a. What are your views on communication methods and effectiveness? b. Do early interventions have integrated health education topics? What topics?
	• Expectations • Reinforcements • Reciprocal Determinism • Self-efficacy of the parent	How could your early intervention experience be better? a. What would your expectations be for future intervention services?

Appendix J: Prompts From Checklist

Prompts from Checklist	Participants' Response
I still need to know..	P1, "Nothing" P2, "Nothing" P3, "Outside resources". P4, "Health education, I don't really remember receiving any specific documents pertaining to health education either". P5, "If there's any outside resources". P6, "Nothing" P7, "Incorporate healthy food to picky eaters". P8, "Nothing"
I would like to receive more information on	P1, "More options on what to eat and how to make eating fun for the kids" P2, I believe holding informational nights with health educators and families would incorporate health education into early intervention better". P3, "Classes for parents". P4, "Health topics in general". P5, "Outside resources and volunteer opportunities". P6, "Maybe after school programs that my child could benefit from". P7, "Incorporate healthy food to picky eaters". P8, "Outside services such as specialized therapists"
My experience with early intervention has been	P1, "Good. The whole process helped my child, but I felt unsure how some processes. I should have asked more in-depth questions, but I didn't". P2, "Early intervention has been a tool in helping young children learn and develop in the most developmentally appropriate ways. The teachers focus on individuality and the context from which the child has come from, forming a learning technique specific to them. Early intervention has made a huge difference within children". P3, "Very hands on, my daughter greatly benefited from this. I liked how interactive the teachers were with her. Shas really enjoyed going to the classes every week. I wish I could take her twice a week, but we just don't have the time to do so". P4, "Umm, I think it's good for the kids. They get a chance to learn skills early on in order to make sure they can eventually

Prompts from Checklist	Participants' Response
	learn at the same pace as kids without disabilities. I've seen a huge improvement with my child". P5, "Pretty much birth. She trembled during the first 6 months and I would swaddle her tight and lay close to her and hold her at all times. This was possibly due to her being born premature and she has inactive brainwaves that needed to mature. She would cry due to colic nonstop for the first 8 months. I of course, put everything into calming her and comforting her." P6, "Great program for children that need a little extra help. At first, I didn't know if my child would have any progress but after awhile we started getting compliments how she was doing so much better". P7, "They definitely tailored the services to my child's needs. I was impressed how much they knew and were able to help him. My son would scream constantly, and I didn't know how to stop him or help him. They showed me so many different ways to help him communicate what he wants and how I can help him". P8, "So far so good. I've only been attending classes once a week for the past 4 months so I can't really tell a difference yet. With all the cancellations due to weather too we've gone a few weeks where we didn't receive services."
Health topics that I would like to learn	P1, "Food options for picky eaters". P2, "Early intervention should include healthy practices that support every developmental domain. Some important topics to be considered consist of childhood obesity, physical activity, healthy sleep habits and access to developmental screenings". P3, "Outside resources we may not be aware are available". P4, "Healthy eating options for small children that are picky eaters". P5, "I think I'd like to see more communication, ASL, and community outreach programs that allow for volunteers to help".

Prompts from Checklist	Participants' Response
	P6, "Maybe after school programs that my child could benefit from". P7, "Parent information class". P8, "Outside services such as specialized therapists".