Parent perspectives on the clinician-client relationship in speech-language treatment for children

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Abstract

Few studies have explored clinician-client relationships in speech-language treatment for children, although evidence indicates that these relationships may be important. Parents play a unique role in clinician-client relationships and their views have yet to be considered in the speech-language pathology literature. This study explored parents' perspectives on the clinician-client relationship in speech-language treatment for children using both quantitative and qualitative information. An online survey collected responses from 159 parents with children enrolled in speech-language services. Respondents were asked to complete a rating of the clinician-client relationship, provide information on length of treatment and treatment setting, and respond to open-ended questions about what enhances the clinician-client relationship. Length of treatment was unrelated to the parent rating of the clinician-client relationship. However, ratings did vary by treatment setting; parents of children enrolled in treatment services in schools provided lower ratings than parents with children enrolled in other settings. Thematic analysis of parent views on what enhances the clinician-client relationship yielded four main themes: qualities of the speech-language pathologist (SLP), session characteristics, the child-SLP bond, and communication. The most frequent subthemes in the analysis related to characteristics of the sessions: the integration of play and fun, and a child-oriented approach to sessions. These results provide insight into the development of clinician-client relationships in children's speech-language treatment, with implications for both clinicians and researchers.

Keywords: alliance, rapport, caregiver, speech, language, therapy, intervention, thematic analysis

There is ample evidence that clinician-client relationships influence the success of behavioral treatments (Flükiger, Del Re, Wampold, Symonds, & Horvath, 2012). In other words, a productive working relationship between a clinician and a client is a key component of treatment-induced change (Bordin, 1979). Bordin (1979) conceptualized this working relationship as consisting of three parts: the emotional bond between clinician and client; their congruence on common goals; and their collaboration on tasks used to work towards those goals. Although these ideas originated in counseling psychology, a variety of other fields have endorsed the importance of the clinician-client relationship to treatment progress and outcomes (e.g., Eveleigh et al., 2012; Ferreira et al., 2013; Kim, Yates, Graham, & Brown, 2011).

When children are the recipients of treatment, clinician-client relationships become somewhat more complex: parents are considered to play a key role both in the relationship and in the ultimate success of treatment (e.g., Accurso, Hawley, & Garland, 2013; Lamers, Delsing, van Widenfelt, & Vermeiren, 2015). Parents not only form their own relationship with the treating clinician but also develop a perspective on the relationship between the child and the clinician, and both may influence treatment (Shirk, Karver, & Brown, 2011).

Several studies suggest that the importance of clinician-client relationships extends specifically to speech-language pathology (Ebert & Kohnert, 2010; Fourie, Crowley, & Olivera, 2011; Plexico, Manning, & DiLollo, 2010). However, little attention has been given to parental perspectives on these relationships within the speech-language pathology literature. The purpose of this study was to explore factors that may influence the strength of the clinician-client relationship from the viewpoint of parents. Both quantitative and qualitative data are considered.

Clinician-client Relationships in Children's Treatment

The majority of existing research on clinician-client relationships in behavioral treatment for children comes from the field of counseling psychology. Although there are far fewer studies on the impact of such relationships on treatment outcomes for children than there are for adults, the effect of the clinician-client relationship is nonetheless established: two recent meta-analyses (McCleod, 2011; Shirk, Karver, & Brown, 2011) found significant correlations between measures of the clinician-client relationship and treatment outcome measures. In other words, stronger relationships are connected to better outcomes for children. In these meta-analyses, clinician-client relationships are typically measured by scales based on Bordin's model; that is, goals, tasks, and bond are all included in the clinician-client relationship measures (Shirk et al., 2011). It is also important to note that the association between clinician-client relationship measures and treatment outcomes is nearly equal when parent's views are considered separately from children's views (McLeod, 2011). Thus, there is ample reason to believe that parent perspectives are important.

There may be specific mechanisms by which clinician-parent relationships influence treatment outcomes for children. At least two studies have suggested that measures of the clinician-parent relationship predict specific outcome measures such as attendance at treatment sessions and discontinuation of therapy without the clinician's agreement (Accurso et al., 2013; Hawley & Weisz, 2005). Such findings make sense, as parents are often responsible for arranging treatment sessions and transporting children to them; parents who do not develop a strong working relationship with the clinician appear less likely to bring their children to services. In contrast, the clinician's ability to develop a successful working relationship with the *child* may affect different outcome measures. In particular, measures related to symptom relief

are more closely linked to the clinician-child relationship. One study (Hawley & Weisz, 2005) found that older children (aged 7 to 16 years) receiving counseling services experienced greater symptom reduction when they felt a stronger working relationship with the clinician.

Parents may also play an important role in interpreting this clinician-child relationship. They may be able to provide insight into the child's behavior with and feelings about the clinician, particularly for children whose developmental stage limits their ability to recognize and express their own views on the clinician-client relationship. Children as young as 4 years have been shown to complete clinician-client rating scales reliably in counseling psychology (Accurso et al., 2013); however, this finding does not negate the value of parent insight as well (Shirk et al., 2008).

Although much of the work from counseling psychology on clinician-child and clinician-parent relationships may extend to speech-language pathology, there may be differences between the two fields as well. For example, communication disorders are likely to negatively impact children's ability to express their views on the clinician-client relationship. This may increase the importance of parent perspectives on the relationship. Alternatively, it is possible that relationships play a smaller role when the targets of treatment are speech or language disorders, rather than psychological ones. Thus, it is important to have field-specific research on clinician-client relationships in children's speech-language treatment.

In fact, the study of clinician-client relationships in speech-language pathology is in its infancy. The importance of these relationships has been acknowledged in the literature (e.g., Kovarsky, Schiemer, & Murray, 2011; Manning, 2010) but few empirical investigations exist. Moreover, most work has been qualitative and focused on clinician-client relationships in adult treatment (e.g., Plexico et al., 2010). In a recent effort to enable quantitative work in this area,

Ebert (2017) adapted a tool for measuring clinician-client relationships (including goals, tasks, and bond) to fit speech-language treatment for children. The tool was then used in a preliminary validation study with 22 school-age children enrolled in speech-language treatment, their parents, and their speech-language clinicians. Results provided preliminary evidence that parallels findings in counseling psychology: parent ratings of the clinician-client relationship significantly predicted children's later attendance at therapy, even within this small sample (Ebert, 2017).

Determinants of clinician-client relationships

If clinician-client relationships play a crucial role in children's speech-language treatment, it is in turn crucial to understand the factors that influence the development and strength of clinician-client relationships. Such research is inherently complicated, but there are again some insights from the field of counseling psychology, and fledgling work in speech-language pathology. One factor that may play a role in the strength of clinician-client relationships is the length of treatment. Kendall et al (2009) found that ratings of the clinician-client relationship in children treated for anxiety disorder increased steadily across the first 8 to 10 treatment sessions. These increases were apparent in both parent and child ratings of the relationship, and in both cases leveled off after the initial increase. Similarly, Kazdin, Whitley, and Marciano (2006) found increases in child ratings of the clinician-client relationship within the first 8 weeks of treatment for behavioral disorders. Although parent ratings in this study also increased, the difference over time was not significant.

Clinician experience may also play a role in the formation of clinician-client relationships. Although it might be expected that clinicians with more experience would be more skilled at forming strong working relationships with clients, Accurso and Garland (2015)

found the opposite pattern: parents of children enrolled in counseling therapy for disruptive behavior disorders reported stronger relationships with clinicians who had *less* experience. This same study found weaker relationship ratings initially among parents who reported Hispanic ethnicity or non-white race; however, relationships improved more over time for these groups (Accurso & Garland, 2015).

These studies provide a list of measurable and empirically tested factors that may contribute to the formation of clinician-client relationships in children's treatment. A variety of clinician personality traits and behaviors have also been associated with stronger clinician-client relationships in psychology (Ackerman & Hilsenroth, 2003), although the majority of this work has been conducted with adults. Examples include traits such as flexibility, honesty, warmth, and respectfulness, as well as behaviors such as noting past therapy successes, being supportive, and being reflective. Although all of these factors might also apply to speech-language treatment, it is again important to recognize that there may be differences across the disciplines. Thus, research on the determinants of clinician-client relationships that is specific to children's speech-language treatment is needed. Moreover, it is important to consider these determinants from different perspectives – those of children, parents, and clinicians.

One study that sought to explore children's perspectives on clinician-client relationships in speech-language pathology was conducted by Fourie and colleagues (2011). Six school-age children enrolled in speech-language treatment were interviewed regarding their experiences in treatment. Interview data were subjected to a qualitative analysis that found six themes relevant to clinician-client relationships: the clinician as a "source of play and fun," "power differentials," "trust," "routines and rituals," "role confusion," and "physical characteristics of the clinician" (Fourie et al., 2011, p. 320). Because Fourie et al (2011) is the first published study to consider

children's perspectives on speech-language treatment, these themes offer an important first step into children's perspectives.

Clinicians' perspectives were explored in another study specific to speech-language pathology. Ebert and Kohnert (2010) surveyed practicing speech-language pathologists regarding their views of the factors that make speech-language clinicians more or less effective in producing treatment gains. It is important to note that this study was neither specific to children's treatment (as the surveyed speech-language pathologists worked with both adults and children) nor focused specifically on the development of relationships. Nonetheless, results indicated that responding clinicians valued the ability to create strong clinician-client relationships over any other clinician trait or behavior. Other valued clinician behaviors included the ability to place therapy in a functional context, to engage in effective communication with the client, and to change the therapy approach as needed.

Finally, one recent exploratory study considered the possible determinants of clinician-client relationships within a small sample of children. Graham, Gillenwater, and Ebert (2016) examined clinician behaviors in videorecorded speech-language treatment sessions. One session was recorded from each of the 22 child-parent-clinician triads in Ebert (2017)., and clinicians' behaviors during the session were rated along 16 dimensions (e.g., "Validates child's feelings", "Establishes treatment goals and/or encourages child to discuss treatment goals", "Uses routines and rituals in treatment session"). The ratings of the clinicians' behaviors were correlated with the clinician-client relationship ratings made by the parents, clinicians, and children. Relationship ratings made by parents correlated significantly with judgments of the clinician's ability to connect therapy activities to the child's daily life. Specifically, parents who provided higher ratings of their relationship with the clinician had clinicians who received higher ratings

on “Places therapy activities in a functional context” and “Identifies the purpose of therapy activities”. Relationship ratings made by clinicians correlated with judgements of how well the clinicians connected emotionally with their clients. Specific items included, “Validates child’s feelings”, “Demonstrates positive regard”, and “Attempts to understand child’s point of view” (Graham et al., 2016). Finally, the children’s ratings of the clinician-client relationship did not correlate significantly with any of the clinician’s behaviors, as judged from the therapy videorecordings.

Thus, the literature to date on the determinants of clinician-client relationships in children’s treatment is both promising and limited. Studies in counseling psychology have established that measurable factors such as length of treatment, clinician experience, and client demographics may influence clinician-client relationships. Specific personality traits and behaviors have also been associated with stronger relationships. However, speech-language treatment may not pattern exactly the same way. In work specific to speech-language pathology, the perspectives of children and of clinicians have been considered (Ebert & Kohnert, 2010; Fourie et al., 2011), and one small-scale study attempted to consider all three perspectives on the clinician-client relationship (Graham et al., 2016). Further exploration of the determinants of clinician-client relationships in speech-language treatment for children would expand the literature; more information on parent perspectives is particularly needed, as few studies have considered the population of parents. Ultimately, this literature has the potential to provide guidance on how to improve clinician-client relationships, leading to enhanced outcomes.

The Current Study

The purpose of this study was to explore parent perspectives on the relationship between clinicians and clients in speech-language treatment for children using both quantitative and

qualitative information. A nationally-distributed survey was used to obtain a large and representative sample of parents. The study built off of previous work by utilizing the scale developed in Ebert (2017) to obtain quantitative information, and the survey methods of Ebert and Kohnert (2010) to obtain qualitative information.

The following specific research questions were addressed:

(1) Do parent ratings of the clinician-client relationship vary according to quantitative variables such as length of treatment or treatment setting?

(2) In the view of parents, what can enhance clinician-client relationships in children's speech-language treatment?

Method

Study procedures were approved by the Rush University Medical Center Institutional Review Board.

Survey Content

The survey contained three sections. The first section contained background questions concerning the setting, purpose, and duration of speech-language treatment. The second section contained the clinician-client relationship rating scale for parents from Ebert (2017); this scale includes items related to goals, tasks, and bond in an overall score of the clinician-client relationship. The final section contained two open-ended questions: "What does your child's speech- language pathologist do that makes it easier for your child to work with him or her? In other words, what enhances their relationship?" and "What does your child's speech- language pathologist do that makes it harder for your child to work with him or her? In other words, what stands in the way of a successful relationship?"

Survey Distribution

The survey was implemented online using Survey Monkey. It was open for responses during a five week period in the summer of 2016. The survey was advertised to parents via advocacy organizations and support groups related to developmental disabilities or speech-language treatment. These organizations included: Apraxia-Kids, National Autism Foundation, National Down Syndrome Society, National Fragile X Foundation, Stuttering Foundation of America, Speech Buddies, and United Cerebral Palsy. Organizations were contacted electronically with an explanation of the project and a request to post or distribute an invitation to participate. The invitation stated that the survey was intended for parents of children enrolled in speech-language treatment, that its purpose was to examine relationships, and that participation would require 10-15 minutes. No incentives for participation were offered.

A total of 179 responses were received during the 5-week period of data collection. Of these, 159 parents completed all items on the clinician-client relationship scale (in Section 2) and 140 completed the open-ended questions (in Section 3). Descriptive statistics were completed for only the 159 responses that included a completed clinician-client relationship scale.

Analyses

To examine relations between parent ratings of the clinician-client relationship and treatment setting and duration, a total relationship score was created from the parent ratings in Section 2 (see also Ebert, 2017, which used the same procedure to calculate a total relationship score from this scale). The relationship rating scale contains 12 items, with each item rated on a 7 point Likert scale. Ratings on negatively worded items were inverted so that higher scores indicated a higher rating of the relationship for every item. Scores across the 12 items were then summed, for a maximum score of 84. Because the relationship ratings were ordinal data,

nonparametric analyses were used. To examine the role of the treatment setting in the relationship ratings, a Kruskal-Wallis test was conducted comparing the total relationship rating scores for parents who reported treatment in schools, private clinics, home-based services, and hospital outpatient clinics. Pairwise posthoc comparisons were conducted using the nonparametric Mann-Whitney U test. To examine the association between treatment duration and the total relationship ratings, the Spearman Rho correlation between these variables was calculated.

To characterize possible influences on clinician-client relationships, the 140 parent responses to the first open-ended question (which asked what the SLP does to enhance the relationship) were subjected to an inductive thematic analysis (Braun & Clarke, 2006). Responses to the second open-ended question, which asked what the SLP does that stands in the way of the relationship, were not formally analyzed because roughly half of the respondents did not identify anything specific in response to this question; instead, example responses were “N/A”, “nothing”, or “can’t think of anything”.

A graduate student research assistant completed the thematic analysis according to Braun and Clarke’s (2006) procedure. First, all responses were read and reviewed multiple times. This familiarization phase leads to the development of initial codes, which are derived directly from the participant responses. The codes are used to represent the information in the original responses, with minimal interpretation of the respondent’s meaning. The codes were then reviewed and organized into themes and subthemes. The research assistant and first author met regularly during this process to review and discuss the codes and themes. Differences were resolved via a consensus procedure. Finally, the themes and subthemes were organized graphically into a thematic map (Braun & Clarke, 2006).

Credibility.

Consistent with qualitative paradigms, several steps were taken to ensure credibility of the work. First, because responses were submitted in writing, there was no opportunity for transcription errors. Secondly, investigator perspectives were acknowledged in the coding process (Plexico, Manning, & DiLollo, 2005). That is, the primary coder (a graduate student) had minimal prior experience with literature in this area, or even with forming clinician-client relationships. The principal investigator, in contrast, had conducted prior research on clinician-client relationships and also practiced as a clinical SLP. In order to minimize bias in the coding process, the coder primary generated the codes from the data, and reviewed them with the PI for clarity.

In order to ensure that the resulting coding scheme was reproducible, a second graduate student research assistant recoded all data. This coder was not involved in any prior aspect of the project. The second coder was given the codes and themes that had been developed in the initial thematic analysis, along with the original responses to code. A percentage agreement was then calculated as the number of codes that the two coders agreed upon for each response divided by the number of codes originally assigned by the first coder. This procedure resulted in an overall agreement of 78.8%. This figure, along with the consensus process used to create the original codes, was judged to be adequate to suggest that this preliminary qualitative analysis is reproducible.

Results

Sample Characteristics

Responding parents (N = 159) reported that their children received speech-language treatment across a variety of settings: schools (N = 38), private clinics (N = 82), home-based

service (N = 16), hospital outpatient clinics (N = 17), and other settings (N = 6). The range of reported treatment duration in months was 1 to 240 when all responses were considered. However, examination of these data indicated that there were a small number of extreme outliers on this question: five parents reported treatment durations of 132-240 months, with no other responses over 90 months. These outliers were eliminated before any further analyses. Following this, the mean duration of treatment was 22 months with a standard deviation of 18.4 months and a range from 1 to 90 months.

As a group the responding parents provided strong ratings of the clinician-client relationship. The mean relationship rating was 74.9 points (out of a possible 84 points), with a standard deviation of 10.2.

Variations in Ratings by Setting and Treatment Length

The first research question asked whether total parent ratings of the clinician-client relationship differed according to the treatment delivery setting or length of treatment. Because only six parents reported that their children receive treatment in “other” settings, this category was excluded from the analysis. The Kruskal Wallis test comparing total relationship ratings across the four treatment settings was significant, χ^2 (3) = 15.61, $p < .001$. Figure 1 depicts the median total relationship rating by setting. Post-hoc testing indicated that the total relationship rating differed significantly between those receiving treatment in a school setting compared to a private clinic (Z= -3.79, p<.001) and between a school setting and a hospital outpatient clinic (Z= -2.31, p =.021). The comparison between school settings and home-based treatment approached but did not reach significance, Z= -1.95, p=.051. There were no significant differences between any of the other treatment settings (private clinic versus home-based, Z= -1.08, p = .281; private clinic vs. hospital outpatient, Z= -0.58, p = .565; home-based vs. hospital, Z= -0.98, p = .326).

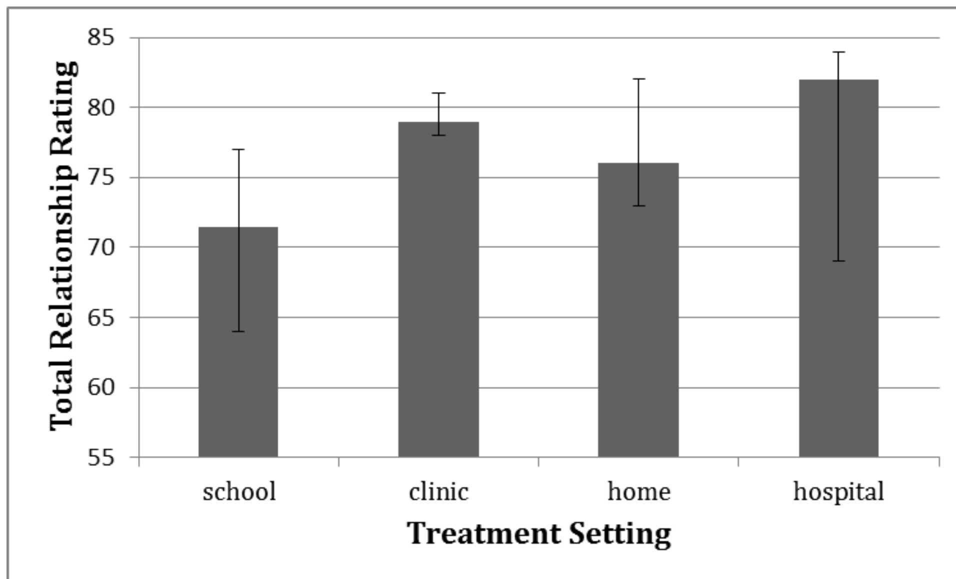

Figure 1. Median total relationship rating by treatment setting. Error bars represent 95% confidence intervals around the median. The maximum total relationship rating is 84.

The Spearman rho correlation between total relationship ratings and length of treatment in months was then calculated. This correlation was not significant, ρ *(146)* = .06, *p* = .487.

Qualitative Analysis of Open-Ended Responses

Thirty-three unique codes were created to characterize the 140 open-ended responses regarding SLP actions that enhance the clinician-client relationship with children. Because each response could be assigned more than one code, the codes were applied to the data a total of 399 times. Figure 2 contains the codes and the frequency with which they were applied to the data.

One of the codes, “negative”, was used to characterize responses that did not answer the question because they made negative rather than positive statements about the SLP and/or her actions. For example, one respondent stated, “I have absolutely no idea because she fails miserably in communicating with me”. Responses coded as “negative” were excluded from the final thematic analysis because they did not answer the question as posed on the survey. This code was used a total of 5 times.

The codes were then organized into themes. Four main themes emerged: qualities of the speech-language pathologist; characteristics of the treatment sessions; aspects of the bond between the SLP and child; and communication. Codes and responses were reviewed iteratively to map the codes into the themes and to identify links among the themes. This process resulted in a thematic map. Figure 2 depicts the thematic map. The sections following Figure 2 explain the four main themes.

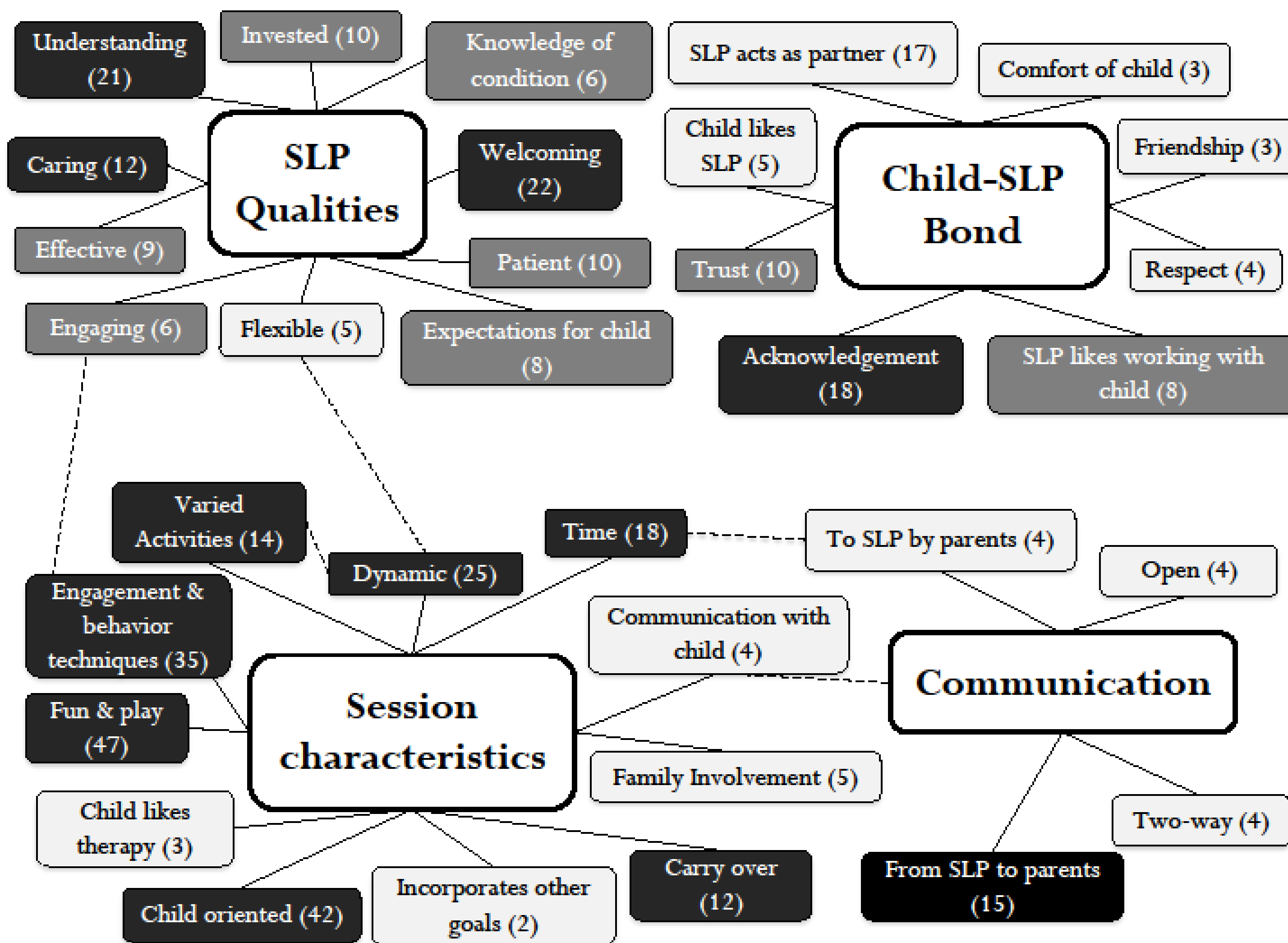
Understanding (21)
Invested (10)
Knowledge of condition (6)
SLP acts as partner (17)
Comfort of child (3)
Caring (12)
SLP Qualities
Welcoming (22)
Child likes SLP (5)
Child-SLP Bond
Friendship (3)
Effective (9)
Patient (10)
Trust (10)
Respect (4)
Engaging (6)
Flexible (5)
Expectations for child (8)
Acknowledgement (18)
SLP likes working with child (8)
Varied Activities (14)
Time (18)
To SLP by parents (4)
Dynamic (25)
Open (4)
Engagement & behavior techniques (35)
Communication with child (4)
Communication
Fun & play (47)
Session characteristics
Family Involvement (5)
Two-way (4)
Child likes therapy (3)
Carry over (12)
From SLP to parents (15)
Child oriented (42)
Incorporates other goals (2)

Figure 2. Thematic map of parent responses to, **"**What does your child's speech-language pathologist do that makes it easier for your child to work with him or her? In other words, what enhances their relationship?". Main themes are depicted in the four large white bubbles. Codes within each theme are depicted in smaller bubbles with shaded backgrounds. The frequency of the code is listed in parentheses after the name (e.g., "Fun & play (47)" indicates the fun & play code was encountered 47 times. Frequency is also captured in the darkness of the background, such that codes used 11 or more times are shown with a dark background, codes used 6-10 times are shown with a medium background, and codes used 5 or fewer times are shown with a light background. The "negative" code was excluded from the final thematic map because these responses did not answer the question as posed on the survey. Dotted lines indicate implicit connections that cross themes.

Qualities of the speech-language pathologist. The codes within this theme related to the qualities or characteristics of the SLP. These included a variety of personality traits, such as patience, flexibility, and caring. Such traits were highly valued by respondents, as shown in responses such as, “her work ethic clearly demonstrates her knowledge, but most importantly she shows great patience and compassion in all she does”. A welcoming and understanding nature were also traits that were valued by respondents.

The theme also included SLP characteristics that were more specific to a particular child or disorder, such as the SLP’s knowledge of the disorder, her investment in the child, her expectations for the child, and her ability to effectively run sessions with the child.

Session characteristics. The session characteristics theme encompassed responses that directly described an aspect of the treatment session. Several of the codes encompassed in this theme related to the child-directed nature of sessions, including the most frequently used codes, “fun & play” and “child oriented”. Example responses included “makes a game out of doing exercises”, “makes it fun, challenging, and kind of a game”, and “works on speech through doing what he loves”. In other words, providing an enjoyable experience for children was a highly valued aspect of treatment for these parent respondents. Parents also valued efforts to relate sessions to other contexts, such as by emphasizing carryover, involving the family, and incorporating other goals. Finally, a common code within the Session Characteristics theme was Time, which was applied to responses that discussed the SLP taking the time to do something the parent valued. For example, “she understands Fragile X syndrome and takes the time to get to know my child personally” and “takes time to figure out what works and what doesn’t work”.

Child-SLP bond.

The third major theme included responses about the emotional aspects of the child-SLP relationship. A simple acknowledgment of the bond between the child and SLP was a common response, such as when parents referred to a “personal connection” or “friendship bond” between the SLP and their child. Other responses in this theme were slightly more detailed, including descriptions of trust and of the SLP enjoying his or her work with the child. For example, one parent wrote, “She is kind and genuinely likes working with my child and it shows - my daughter knows that they are 'friends' and enjoy working together.”

Communication.

The final theme was communication. Parents valued open communication between the SLP and the parents. For example, one respondent stated, “Our very open communication & her willingness to listen to my concerns.” Encouraging communication from the parents to the SLP was mentioned less frequently in responses, but was also categorized in this theme. Of note, communication to the child was categorized under the “session characteristics” theme rather than the “communication” theme because responses usually described the SLP’s communication with the child within the context of the session. However, the implicit connection between this code and the “Communication” theme is acknowledged with a dotted line in Figure 2.

Discussion

This study used both quantitative and qualitative methods to explore parent perspectives on the clinician-client relationship in children’s speech-language treatment. An online survey collected responses from a nationwide survey of parents with children enrolled in speech-language treatment services.

Quantitative Analyses

Quantitative analyses considered differences in parent ratings of the clinician-client relationship according to treatment setting or length of treatment. Parent ratings of the clinician-client relationship included items related to goals, tasks, and bond. In contrast to prior studies in counseling psychology (Kendall et al., 2009; Kazdin et al., 2006), the length of treatment did not correlate with the strength of the clinician-parent relationship. One methodological difference that may influence this result is that the Kendall et al. (2009) and the Kazdin et al. (2006) studies investigated a much smaller timeframe than the one observed here (i.e., 8-10 sessions vs. an average of 22 months of treatment). Another possible explanation for this result is the relatively high relationship scores provided by the parents who responded to the survey. In general, parents who responded thought highly of their SLP (averaging nearly 75 out of 84 possible points on the total relationship score). This result may reflect some self-selection bias in the sample, reducing the ability to find significant correlations.

However, a significant relationship was found between treatment setting and clinician-parent relationship. Parents with children enrolled in speech-language treatment at school provided significantly lower relationship ratings than those with children enrolled in two other treatment settings (private clinics and hospital outpatient settings). The three non-school settings did not differ from each other. The most likely explanation for this result is that SLPs working in school-based settings have fewer opportunities to develop relationships with parents, as parents would not be present during or after sessions. In terms of the themes developed via qualitative analysis, school-based SLPs may have difficulty maintaining strong communication with parents – but communication is clearly valued by parents. These results, then, suggest that school-based SLPs may wish to pay particular attention to communication with parents, as the

school-based setting could pose particular challenges in developing strong clinician-parent relationships.

Qualitative Analyses

The qualitative analysis resulted in 33 codes and 4 major themes within the data. This analysis provides a preliminary framework for understanding the viewpoint of parents with children enrolled in speech-language treatment. These parents valued specific qualities of the SLP, a variety of aspects of the sessions themselves, the emotional bond between SLP and child, and communication. Several of the themes and codes uncovered by the analysis relate to prior literature in this area.

The most common codes included integrating fun and play into the session, using a child-oriented approach to the session, and engaging the child. These comments mirror a key theme uncovered by Fourie et al. (2011) in interviewing children enrolled in speech-language treatment: the SLP as a source of play and fun. Within the field of speech-language pathology, there is currently a major push to uncover 'active ingredients' of speech-language treatment (e.g., Turkstra, Norman, Whyte, Dijkers, & Hart, 2016). However, these results should remind clinicians that the delivery mechanism of speech-language treatment for children matters to both parents and children; that is, delivering treatment within a fun, child-oriented, and engaging context is highly valued by our clients.

Parents also valued the emotional bond between the child and the SLP. Within the classic framework of Bordin (1979), the emotional bond is just one aspect of the clinician-client relationship. Collaboration on tasks and agreement on goals form the other essential components of the clinician-client relationship (Bordin, 1979). Some aspects of the Session Characteristics theme (such as varied activities, or the emphasis on fun and play) could be interpreted as

referring to collaboration on tasks, and there were a few explicit mentions of goals (e.g., the "Incorporates other goals" code). Other codes, particularly those in the Communication theme, may relate to goals, tasks, and bond; for example, open communication between SLP and parent likely enhances agreement on goals and collaboration on tasks. However, the emotional bond was the aspect of the relationship that was most explicitly recognized by parents in this study.

It is important to note that many of the parent priorities uncovered in this analysis can potentially be cultivated by clinicians who are seeking to improve their relationships with parents and children. As noted above, clinicians can actively try to improve communication with parents and to integrate fun and play into therapy tasks. They can also strive to vary activities in sessions, to consciously address carry over of skills, and to take the time to listen to the perspectives of children and their parents. Additional studies in this area should seek to clarify and operationalize the themes uncovered here; transparent, clearly defined themes will help clinicians determine how they may improve clinician-client relationships.

Limitations and Future Directions

This study was intended as a preliminary exploration of parent perspectives, and several limitations are evident. First, the online survey format allowed for selection bias in the sample. That is, participants could freely elect to join the sample, and the relatively high ratings of the clinician-client relationship in this sample suggest that parents who felt positively about their child's speech-language pathologist were more likely to complete the survey. Moreover, parents were recruited primarily via membership in parent advocacy organizations, and thus the sample here may over-represent parents who are proactive about interacting with their children's clinicians. Of course, it is also possible that the relatively high relationship ratings obtained here do reflect the general population of parents with children enrolled in speech-language treatment.

The advantages of the online survey methodology used here were the ability to obtain a relatively large and geographically diverse sample. Nonetheless, future research in this area should attempt to recruit parents with a range of views on their child's speech-language pathologist.

In addition, a limited number of quantitative variables were considered. In particular, the demographic information collected about participants was very limited. Potentially important factors, such as clinician experience (Accurso & Garland, 2015), child or clinician age, and child diagnosis were not explored here. Accurso and Garland (2015) also provide evidence that race and ethnicity can influence caregiver perceptions of the clinician-client relationship, and we did not collect information on race and ethnicity here. Client perceptions of progress in treatment can also influence clinician-client relationship ratings (Luborsky et al., 1996), and it was not possible to measure treatment progress accurately in an online survey format. Future work can build off of the results here by expanding the range of factors considered to be potentially important in the formation of clinician-client relationships in speech-language treatment.

Finally, the qualitative methodology used to create the thematic map carries a unique profile of strengths and weaknesses. Qualitative methodology is considered ideal for richly describing a subjective experience (Johnson & Onwuegbuzie, 2004), and thus it was selected to explore parent views on the clinician-client relationship. However, qualitative methodology is often viewed as less generalizable and objective than quantitative methods (Johnson & Onwuegbuzie, 2004). Ultimately, the themes uncovered here will need to be validated through further studies, perhaps spanning a range of methodologies.

Although these results are preliminary, they may also spur speech-language clinicians who work with children to consider how they may enhance their own relationships with clients

and their families. Open communication, a strong emotional bond, a child-oriented approach to sessions, and a welcoming, caring approach to families are just a few of the ideas generated here. Given the potential importance of establishing strong clinician-client relationships (Ebert, 2017; Flükiger et al., 2012), there is ample reason for clinicians to consider efforts to improve them.

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