Taking a closer look at the therapist's role: two perspectives from the field of intervention

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In the field of early language intervention, our goal is client change—both in the parents' and child's interactive behaviours and use of language. Our approach to treatment is based on the pediatric research that shows that the intervention is the main variable affecting that change. This approach assumes that intervention is uniformly applied by therapists, so manualizing interventions ensures that outcomes are consistent across clients. But there's more to intervention than a program.

The field of mental health takes a different approach to determining the most effective elements of successful therapy. Mental health research focuses on the therapist as the factor affecting client outcomes. This research has determined that the variance in client outcomes can be attributed to the therapist, more specifically the therapist-client alliance (King, 2017). However, there is limited knowledge on ***how*** the change occurs.

My experience with the therapist-client alliance

I can think back to many of the families I've worked with over the years, but two families stand out for me. I tried to offer both families the same intervention and I made every effort to develop a good relationship with them. However, the outcomes were very different,

On paper, the children's needs were very similar. Both boys—Devon and Shane—were just under two years old and had significant expressive language delays. And both had early signs of autism. But Devon and Shane had very different outcomes when our therapy ended.

Devon

I first met Devon's family in their home when they were referred to the Birth to Three program I worked in (in the United States). Devon's extended family spent a lot of time with him and even participated in therapy. During our sessions, they would all try to apply the strategies they were learning and would ask questions to make sure they understood why they were doing what they were doing. In addition, between our sessions, they would find new activities in which to incorporate therapy strategies. The family eagerly participated in the It Takes Two to Talk® Program when it became available. Some of Devon's family worked in education, so when I recognised signs of autism, we had earnest conversations about getting a developmental assessment and his eventual diagnosis. Devon received lots of early intervention and, by first grade, he was in a general education classroom and was participating

in his community's extracurricular programs. His family had the information they needed in order to seek out support for him and help him build his independence. He is now a happy, confident boy. I will always consider this family a great success story.

Shane

In contrast, Shane's family was one I struggled with. Shane lived with his parents and grandparents. His grandmother—Gloria—was the children's primary caregiver. Gloria had some physical limitations that prevented her from sitting and playing on the floor, but we still maximized the moments she and Shane were face to face – for example, when he sat on her lap or when they were at the kitchen table. Gloria tried out strategies when I coached her but seemed skeptical and was inconsistent on follow through during the week. We brainstormed in an effort to find activities that would work for her, but I think the biggest barrier to our success was that Gloria and I had fundamentally different opinions about what Shane needed. I felt that Shane's challenges would lead to more significant learning issues as he got older, while she believed he would outgrow them over time. And his road to an autism diagnosis was much longer because Gloria and I viewed the impact of Shane's difficulties so differently. The family was very kind and loving, and clearly wanted the best for Shane. But I just never felt like I was able to connect with them and, as a result, I wasn't able to help them support Shane effectively and set him up for long-term success.

What was the difference between my relationship with Devon's family and Shane's? It was hard for me to put my finger on the actual difference, but when I read an article written by researchers in the mental health field, who looked specifically at this dynamic, it helped me identify what had happened with these two families.

The therapist-family relationship

Researchers in the field of pediatric rehabilitation have started to look at the importance of the therapist-family relationship (Dodd, 2007; Durlak & DuPre, 2008; Hanna & Rodger, 2002), but those in the mental health field have taken an even more focused look at what specifically about this relationship makes therapy successful. They have focused on the therapist's role in creating an environment for change (King, 2017).

> *"MH research has considered the therapist as a random factor affecting client outcomes, the nature of the therapist-client alliance, and the therapist's role in facilitating change. These topics have received less attention in PR but have important implications for PR outcomes."*
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> -King, 2017, p.122
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> (MH = Mental Health, PR = Pediatric Research)

The evolution of pediatric rehabilitation therapy

Before we look at the mental health research, let's review how far we've come in pediatric rehabilitation research. After all, our profession has evolved, and we are very good at providing evidence-based practice.

When research in pediatric rehabilitation therapy began, it was guided by the medical model. It focused on ways to facilitate skill development or client change. (King, Imms, Stewart, Freeman & Nguyen, 2018). The theory was: treat the disorder *and the desired outcomes should follow*. In the 1970s and '80s, our field shifted to the parent coaching model (Hanna et al, 2002). The Hanen Centre was the leader in developing this method. This time, the focus was to give the parents the information so they could facilitate treatment *and the desired outcomes should follow*. In more recent years, the benefits of parent coaching—or parent-implemented intervention—have been proven and this has led to the need for standardization. Research shifted to focusing on manualized interventions, which are now

considered the gold standard in that this should ensure treatment fidelity (Durlak et al, 2008). The theory was: provide the prescribed intervention *and the desired outcomes should follow*.

As Hanen-certified speech-language pathologists/therapists, we have committed ourselves to best practice. We use research-based, manualized, parent-implemented interventions. But why doesn't that always work the way we expect? When it came to Devon and Shane, my strategies were the same, but my outcomes were different.

Why manualization isn't enough

I'm sure many of you have worked with families like Devon's and Shane's. Though their communication profiles were similar, their family dynamics and caregiver priorities were different, as were their therapy outcomes. Mental health research has focused on the particular elements of the relationship between the therapist and the receiver of therapy— i.e. the patient in mental health and the family in pediatric rehab therapy. The mental health research looks more closely at the therapist's role in facilitating change than pediatric research, but it has an important place in our work. For that reason, we thought it would be interesting to look at early language intervention through the lens of mental health research and consider what we can learn from it.

Gillian King, a researcher from Toronto, Canada, has been looking closely at the mental health research and found that successful therapy outcomes— i.e. changes— are dependent on four distinct but interconnected constructs. In 2017, King's article "The Role of the Therapist in Therapeutic Change: How Knowledge From Mental Health Can Inform Pediatric Rehabilitation" was published. In the article, she describes these constructs so that, as pediatric therapists, we can consider these elements of our relationships with the families we serve and try to build them into our interactions.

Four therapist-related constructs

Based on King's literature review, she consolidated the mental health research into the following four sections:

1. Therapist variables alone
2. The therapist-client relationship
3. Treatment implementation variables
4. Therapy process variables (King, 2017)

1. Therapist variables alone

This piece looks specifically at what the therapist brings to the relationship. In pediatric rehabilitation research, the focus has been on level of experience. It is supposed that a novice therapist will be less competent at strategy use and will differ in how to approach intervention compared to one with more experience. The mental health research takes a different approach; it "group[s] therapists based on client outcomes, then look[s] at therapist characteristics or traits" (King, 2017, p. 124), including being supportive, providing hope to the client, and creating an environment conducive to self-change.

2. The therapist-client relationship

In pediatric rehabilitation research, this relationship is highlighted through the importance of being sensitive and responsive to parents' concerns through active and reflective listening (Dunst, Boyd, Trivette & Hamby, 2002). The mental health research adds to the relationship that is built with the parent in the therapy context. It refers to the relationship as a **therapeutic alliance**, which consists of three elements:

- **Emotional**: the parent's trust in the therapist leads to optimism about the treatment
- **Cognitive**: the parent understands why therapy is recommended and how to implement it
- **Behavioural**: the parent feels confident in the manageability of the therapy plan and in his or her own ability to carry it out

***Therapeutic alliance**: The relationship that includes emotional, cognitive and behavioural connections to support seeking opportunities for therapeutic activities in many contexts*

3. Treatment implementation variables

This refers to the differences in therapy delivery— not just between different therapy models, but also within them. While the research may say exactly what therapy we should provide (intervention), how we should provide it (fidelity), and how often we should deliver it (dosage), research also shows that we vary widely on this (Durlak, et al, 2008; King, 2017; Warren, Fey & Yoder, 2007; Yoder, Fey & Warren, 2012). We may advertise the successful outcomes of an intervention, but results will vary based on the therapist's fidelity to the program and the dosage of therapy. We may assume we are delivering a certain therapy based on the research behind it, but if we modify the intervention by offering fewer sessions or by not adhering to the prescribed implementation, we can no longer expect to obtain the results obtained in the studies that showed the intervention was effective. Treatment modifications result in families perceiving their treatment differently from those who receive the original version of the treatment. Of course, this isn't always within a therapist's control. For example, the workplace may mandate a certain number of treatment sessions or require a certain level of productivity which reduces the number of sessions families can receive. This isn't necessarily negative if the therapist is making modifications based on the family's needs and priorities (though it can no longer be considered a research-based intervention).

4. Therapy process variables

In the mental health field, change is related to the patient's behaviours and thought processes; in pediatric rehabilitation, change is related to the parents' and children's. While our work is not in mental health, we have a close connection to that discipline because of our change-based outcomes. The common factors of change in both disciplines answer the following questions:

What brings about change?
A supportive relationship that is established by setting collaborative goals, and by the therapist providing information, encouragement, assistance and motivation throughout the intervention.

Why does change occur?
The therapist provides positive expectations for the parent by providing credible treatments, fostering hope and motivating change.

How does change occur?
The therapist provides opportunities for new learning and mastery of skills in therapeutically relevant activities, leading to the desire for self-change.

Borrowing from the field of mental health….

As professionals in the field of early language intervention, we aim to empower parents. That's why we work with families and that's what Hanen Programs are all about. However, perhaps if we take a closer look at the four constructs outlined by King et al (2017), we can consider whether there are nuances that could lead to some adjustments in our work with come families.

These constructs are interconnected and work together to create the impetus for change. Focusing on **the therapeutic alliance** provides some guidance in starting to help parents determine the best ways to implement therapy strategies— i.e., which activities would have the most impact and in which contexts?

One of the best ways to answer these questions is to look at the child requiring services as **someone at the centre of a complex, nuanced and often-changing environment—including his family and community—that is unique to him**. For example, a new baby changes the schedule, daily activities, and the people in the child's life. A parent starting a new job can also precipitate these changes. It's important to discuss any and all changes in the family as they occur to see how they might affect the child, and then review the goals together, adjusting them if needed.

We also need to **rely on and facilitate the parents' and caregivers' sharing of their concerns, priorities and values**— and recognize that these may be different from our own. For example, parents might want to be able to take their child to the playground but might have stopped going because their child grabs toys from other children. In that case, we can still come up with developmentally appropriate language goals and put them in the context her parents want. For example, a goal may be to help their child learn to make requests so she can ask for the toys she wants. She might also then be able to request asking for a turn on the slide or the swing if she enjoys those activities. Working on this goal will help her learn how to interact with other children, empowering her parents to feel more confident about taking her into their community more often.

By keeping the child and his family at the centre of our focus, we're ensuring that we provide the support parents need to become empowered as their child's best teacher and the primary agent of change in their child's development. These four constructs can help us build on our work with families, especially those who seem to struggle with their role in the intervention.

Final thoughts

While we all strive to provide intervention based on best practice, we know that intervention doesn't occur in a vacuum. The research shows that there is still wide variation between therapist implementation (i.e. delivered treatment) and therapy outcomes (i.e. received therapy). Even when we do adhere to the dosage and fidelity of manualized interventions, treatment outcomes are always affected by the therapeutic alliance.

As Hanen-certified speech pathologists, we know that the child and the family benefit most when we step back from the role of the agent of change, which involves explaining to parents what they should do to help their child, and viewing ourselves as facilitators who support the parents to become the agents of change. By starting intervention with this framework, we can promote the value and importance of a collaborative, dynamic relationship.

Hanen Resources on Relationship-Building

Check out these resources on building relationships with families on the Hanen website:

E-seminars:

- Collaborative Goal-Setting with Parents: Targeting Interaction Skills First
- Taking Parent Coaching to the Next level: Helping Parents Make Behavioural Changes That Stick!
- Sharing Sensitive News with Parents
- Coaching parents in How to Play

Online Member Meetings:

- Let's Talk! Video Feedback Series

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About The Hanen Centre

Founded in 1975, The Hanen Centre is a Canadian not-for-profit charitable organization with a global reach. Its mission is to provide parents, caregivers, early childhood educators and speech-language pathologists with the knowledge and training they need to help young children develop the best possible language, social and literacy skills. This includes children who have or are at risk for language delays, those with developmental challenges such as autism, and those who are developing typically.

For more information, please visit www.hanen.org.

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