PEDIATRIC SLPS' PERCEPTIONS OF THE THERAPEUTIC ALLIANCE ACROSS COMMUNICATION DISORDERS

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PEDIATRIC SLPS' PERCEPTIONS OF THE THERAPEUTIC ALLIANCE ACROSS COMMUNICATION DISORDERS

A Thesis for the Degree

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Introduction

Historically, the concept of the therapeutic alliance (TA) began with the work of Freud (1958), but has since evolved to be recognized as an important aspect across almost all therapeutic approaches (Ackerman & Hilsenroth, 2003). Many researchers have stated that the therapeutic alliance is an important factor in therapeutic change (Bordin, 1979; Fuertes et al., 2017; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). In fact, Bordin (1979) suggested that the working alliance is not just important, but is the "key" to the change process. In support, based on a series of meta-analyses, Norcross and Wampold (2011) concluded the therapeutic alliance accounts for client improvement at least as much as the treatment approach itself and plays a significant role in treatment outcome. The same result is observed within pediatric populations (Shirk & Karvar, 2003); however, children show slightly different values within the therapeutic relationships than has been evidenced with adults (Fourie et al., 2011). The therapeutic alliance also has been discussed within the field of speech-language pathology as it relates to positive therapy outcomes (Sønsterud et al., 2019) as well as client and clinician perspectives (Lawton et al., 2018; Plexico et al., 2010). Much of the evidence from this discipline, however, is concentrated in the area of stuttering. Therefore, making it unclear how well the therapeutic alliance is understood and fostered when treating different types of communication disorders, especially with pediatric populations. The current project examines speech-language pathologists' (SLPs') perceptions of the therapeutic alliance across different communication disorders. The following review provides a definition for the therapeutic alliance, how the therapeutic alliance is a part of healthcare, the role of the therapeutic alliance in explaining treatment outcomes in adults and children, and reports examining TA when treating communication disorders.

Definition of the Therapeutic Alliance

To understand its role in different clinical contexts, the therapeutic alliance must be defined. Several different terms have been used to reference the relationship between the client and clinician. For example, Bordin (1979) and Fuertes et al. (2017) used the term "working alliance," while Bachelor and Horvath (1999) preferred "therapeutic relationship," and Manning (2010) opted for the term "therapeutic alliance." Despite the diversity of terms used, the concepts they convey share common attributes such as clinician-client agreement on therapy goals and tasks, affective bond between client and clinician, unconditional positive regard, and empathy. Fuertes et al. (2017) defined the therapeutic alliance as

> a professional relationship characterized by agreement between the health care provider and patient about the goal(s) of the treatment, the extent to which there is agreement about the tasks that each participant will engage in order for the goal(s) of treatment to be attained, and the extent to which there is trust and liking between the provider and the patient. (p.610)

For the purposes of this study, the term "therapeutic alliance" as well as the definition posed by Fuertes et al. (2017) will be used as it is most consistent with what is frequently referred to in communication sciences and disorders literature.

The Therapeutic Alliance

The therapeutic alliance was initially referenced in psychotherapy literature through the work of Freud (1958) and has since expanded into a large body of literature centered around a model for the therapeutic alliance posed by Bordin (1979). Bordin suggested a converging point for psychotherapy theories and treatment approaches in four points:

> 1) All genres of psychotherapy have embedded working alliances and can be differentiated most meaningfully in terms of the kind of work each alliance requires. 2) The effectiveness of therapy is a function in part, if not entirely, of the strength of the working alliance. 3) Different approaches to psychotherapy are marked by the difference in demands they make on the patient and therapist. 4) The strength of the working alliance is a function of the closeness of fit between the demands of a particular kind of working alliance and the personal characteristics of patient and therapist. (p. 253)

Bordin (1979) proposed that the therapeutic alliance consists of three features based on synthesis of psychoanalytic literature: agreement on goals, agreement on tasks, and the development of affective bond. All three of these components focus on aspects specific to the life of each individual and, therefore, strengthen the idea that person-centered care and compatibility of therapist and client improve treatment outcomes separate from the treatment approach being used. Since the work of Bordin (1979), the contribution of the therapeutic alliance to therapy outcomes has been extensively explored within the area of psychotherapy.

The therapeutic alliance has been tied to therapy outcomes extensively throughout psychotherapy literature. In one body of research surrounding what is referred to as the Common Factors Model, the therapeutic alliance is thought to be one “common factor” in treatment that can account for change in therapy despite the treatment approach being used. As early as 1936, Saul Rosenzweig proposed that the therapeutic method used may be of minimal importance when considering the unconscious processes contributing to therapy. Factors such as the therapist’s personality, therapy adapted to client’s problems and alignment of the client, and therapist’s personalities may lead to successful therapy outcomes across all different methods of treatment (Rosenzweig, 1936). Since Rosenzweig’s hypothesis, many studies investigated the

possibility of other factors playing a crucial role in therapy outcomes. Research confirmed that different bona fide treatment approaches yield near zero difference in treatment outcome (Ahn & Wampold, 2001; Luborsky et al., 2002; Wampold, 1997). Therefore, changing the treatment approach does not change the result of treatment, which supports Rosenzweig's idea that there must be something else accounting for variation in treatment success. Wampold (2015) suggested, in agreement with Rosenzweig (1936), that since different treatment approaches yield a near zero difference in outcome, there must be something else similar across treatments that accounts for change in therapy. In fact, empathy, expectations, therapists' effects, and the therapeutic alliance showed statistically significant relationships with therapy outcomes (Bell et al., 2013; Wampold, 2015). According to Wampold (2015), factors that demonstrated large effect sizes were consensus/collaboration, empathy, the alliance, positive regard and the therapist's personality. Interestingly, all of those areas, if not the alliance itself, are vital components contributing to a successful relationship between the client and clinician.

Relationships have been found when examining the effect of the therapeutic alliance on outcomes in psychotherapy treatment. When examining the therapeutic alliance specifically, a recent meta-analysis, including 190 independent studies, found an effect size of d=.27 ($p>.0001$) indicating a significant relationship between therapeutic alliance and therapy outcomes in different psychotherapy treatments (Horvath et al., 2011). These results are consistent with findings of previous meta-analyses supporting the relationship between the therapeutic alliance and positive treatment outcomes (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). While the role of the therapeutic alliance in treatment outcomes is important, studies show that clinicians and clients value different aspects of the alliance. Bachelor (2013) investigated relationship between clinician and therapist views. He found that clients revealed greater concern

with helpfulness and joint work in therapy while being more sensitive to negative aspects of the relationships. Clinicians, however, placed a greater emphasis on client contributions to therapy and their willingness to disclose information (Bachelor, 2013). These findings highlight the importance of collaboration within therapy goals and alliance. The therapeutic alliance, and the factors that contribute to forming it, are important for therapists to consider when cultivating an environment for therapeutic change.

The Therapeutic Alliance in Healthcare

The therapeutic alliance has been identified as an important contributor to positive treatment outcomes in many difference disciplines, including healthcare. However, within healthcare the term "compassionate care" is frequently used. Compassionate care is defined as "involving awareness or sensitivity to the pain or suffering of others that results in taking deliberate verbal and non-verbal physician action to remove, reduce or alleviate the impact of such affliction" (Crawford et al., 2014, p. 3591). Further, Von Dietze and Orb (2000), suggests that compassionate care goes beyond sensitivity to pain and suffering and "entering into a person's experience so as to share their burden in solidarity with them and hence enabling them to retain independence and dignity" (p. 169). Therefore, the goal of compassionate care is partnership with an individual which allows for holistic consideration of the person within the context of treatment. Importantly, characteristics such as kindness, empathy, partnership, and positive regard are essential to providing compassionate care. This indicates that, by definition, in order to provide compassionate care, one must enter into a working alliance or therapeutic relationship with the patient. Despite its undeniable importance, evidence reveals that compassionate care is often not being provided within healthcare settings (Lown et al., 2011).

This suggests that key elements of the therapeutic alliance are not being used during treatment and, as a result, patient outcomes may be less positive.

According to the U.S. Health Affairs (Lown et al., 2011), despite the common view that compassionate care carries importance with both patients and physicians, there was a gap when care was actually provided. In other words, the amount of people stating the valued compassionate care was not consistent with those providing it. Compassionate care is not only important for patients and physicians but can influence physiological treatment effects to improve patient outcomes across different areas of medical treatment. While compassion does not resolve a disease or impairment it has been found to lower feelings of stress and improve functioning of the parasympathetic nervous system (Kemper & Shaltout, 2011; Shaltout et al., 2012), reduce perceptions of pain (Sarinopoulos et al., 2013), increase patient compliance (Attar & Chandramani, 2012), and contribute to the treatment of depression and anxiety (Blatt et al., 1996; Burns & Nolen-Hoeksema, 1992; Kirby et al., 2017; McKay et al., 2006; Weiss et al., 2017). These findings indicate that the relationship between the clinician and patient, on a physiological level, leads to improved outcomes in healthcare. In other words, there are real physical and mental health benefits resulting from engaging in an alliance with patients which lead to more positive outcomes. Therefore, the therapeutic alliance has important implications for speech-language therapy patients with medically based disorders such as aphasia and traumatic brain injury.

The Therapeutic Alliance in Speech-Language Pathology

The therapeutic alliance has also shown importance for speech-language pathology (Ebert & Kohnert, 2010; Fourie et al., 2011; Plexico et al., 2010). Although perceptions of the alliance have not been consistently investigated across all areas of speech-language pathology,

different areas including stuttering, aphasia, and traumatic brain injury (TBI) provide important insights about clinician and client perceptions in communication sciences and disorders.

Stuttering

The therapeutic alliance has been evidenced as an important factor in therapy outcomes within the area of stuttering treatment, especially in relation to agreement on tasks and goals (Sønsterud et al., 2019). In a qualitative analysis of factors that influence a positive relationship between the client and clinician in adult participants who stutter, Plexico et al. (2010) found that perceptions of clinician competence were highly related to the clinician's ability to promote an effective alliance. Data revealed that clients perceived effective clinicians as those who are passionate and committed, who use the client's needs and goals to influence clinical decisions, who build trust with clients, who listen to clients, and who encourage and acknowledge cognitive change (Plexico et al., 2010). Clinician versus client perceptions of the therapeutic alliance have also been investigated. Croft and Watson (2019) found differing views of the alliance between the client and clinician. Interestingly, clients related the therapeutic alliance more to outcome satisfaction than treatment effectiveness or perceived progress, while clinicians perceived a stronger relationship between the therapeutic alliance and treatment effectiveness and perceived progress.

Aphasia and Traumatic Brain Injury

In the area of aphasia rehabilitation post stroke, researchers have investigated both patient and clinician perspectives of the therapeutic alliance. Lawton et al. (2018) used semi-structured in-depth interviews to explore therapist perceptions of the therapeutic alliance with questions pertaining to agreement on goals, affective bond, and agreement on activities (Bordin, 1979). Data revealed three main themes: developing a relationship with the patient (including aligning

expectations and empowerment), being responsive to the patient, and recognizing environmental factors that may influence treatment. While all three areas of the alliance were present, they were nuanced in the context of acquired language impairment. The results support the importance of all areas of the therapeutic alliance as well as emphasize the significance of differences in establishing a successful alliance with patients who have a communication impairment. In a similar study, Lawton et al. (2020) investigated the perspectives of aphasia patients post stroke. Data revealed five main viewpoints including support and acknowledgment, hearing and encouraging, being frank with and motivating, directing and challenging and understanding and laughing with. These viewpoints highlighted the importance of relational aspects of the alliance to the patients as well as flexibility of the therapist and person-centered care. Interestingly, the data also revealed a difference in important qualities of the alliance between patients with milder versus those with more severe injuries who had longer duration of care. Those attending therapy for a longer period of time expressed the importance of therapeutic empathy, enjoyment, and hope and those with shorter durations of therapy placed a high value on technical and professional competence as well as therapeutic challenge and firmness (Lawton et al., 2020). These results suggest that the nature of the injury could impact the clinician-client relationship. Schönberger et al. (2006) found that the nature of a traumatic brain injury could have an impact on the therapist's view of the alliance initially but was unrelated to the client's view of the relationship. This was due to clinical experience with patients who have certain types of TBI can be more difficult to work with. In other words, expertise with certain types of impairment impacted clinician views of new patients during initial stages of therapy. While limitations on the amount of data available, as well as the variation of procedures among different disorders, there

is evidence suggesting that the views of the therapeutic alliance differ between both the client and clinician and may change depending on the nature of impairment.

The Therapeutic Alliance and Pediatrics

Although there are limited investigations reporting the perceptions of the therapeutic alliance in the pediatric treatment areas of speech-language pathology, the therapeutic alliance has been referenced in other areas of pediatric treatment within psychotherapy literature. The impact of the therapeutic alliance on treatment outcomes in pediatric therapy mirrors that seen in adult treatment. Two metanalysis' have shown correlations between the therapeutic alliance and treatment outcome in child and adolescent psychotherapy across multiple different treatments and developmental stages (Shirk & Karvar, 2003; Shirk et al., 2011). When investigating the therapists perspective of the therapeutic alliance with the child, Campbell and Simmonds (2011) found that therapists perceived bond as the most important aspect, therefore, emphasizing the positive contribution of the bond as well as characteristics such as empathy and trust. Further, the quality of the alliance between the parent and clinician was found to have a significant contribution to the quality of the alliance between the clinician and the child (Campbell & Simmonds, 2011). These findings are consistent with previous studies discussing the importance of the relationship between the parent and clinician in child therapy outcomes and alliance (McKay et al., 2004; Shirk & Phillips, 1991).

Despite the clear importance of the therapeutic alliance in pediatric treatment, there are unique barriers limiting the construction and maintenance of the alliance that are not present in adult treatment. More specifically, children are often not self-referred. Consequently, the lack of the child's self-knowledge about problems and the desire to change significantly impacts motivation for treatment (Digiuseppe et al., 1996). Digiuseppe et al. (1996) stipulated that when

children are not self-referred, a lack of motivation makes it more difficult to come to an agreement on tasks and goals—components of the alliance necessary for the client to self-evaluate. Further, Digiuseppe et al. (1996) posed that different techniques may be required to establish an effective alliance with children and adolescents, as compared to adults, depending on their developmental stage and type of problem. Strategies suggested to help build an alliance with children and adolescents, especially as it related to agreement on goals and tasks, included motivational interviewing, a combination of emotional script training and social problem-solving skills training and strategies for overcoming resistance from strategic therapy. Therefore, the way in which clinicians form an alliance with children must be individualized based on specific client needs at the start of therapy. Marcus (1988) also suggested that understanding a child's developmental level is crucial in building an effective alliance and failing to do so can lead to frustration and anxiety in therapy and, therefore, impede progress. This is due to what the child's ego can assimilate and understand at certain points during development. Marcus suggested that the alliance is strengthened both by empathy and understanding as well as respecting the child's need for defense (Marcus, 1988). Children are still learning to navigate their own emotions. Therefore, supporting children's emotions serves to strengthen the alliance and lead to a stronger alliance and more positive experience for the child.

Although it is clear the therapeutic alliance is an important factor in pediatric psychotherapy, little is known about perceptions of the therapeutic alliance in pediatric speech-language pathology. In one study, Fourie et al. (2011) investigated the significance of the therapeutic alliance in speech therapy with children. The study identified common themes children perceive within a successful alliance, including fun activities, a safe environment, structured routines, agreement on goals, and a decrease of the power dynamic between the client

and clinician. When compared with data on adult perceptions within the area of speech-language pathology, it is evident that although there are many similarities, there are areas where children's values differ from adults' values in relation to the therapeutic alliance, such as placing more value on affective bond and enjoyment of activities (Fourie et al., 2011; Lawton et al., 2020; Plexico et al., 2010). Although this study provides valuable insights about the differences in the formation of alliances with young clients, limitations are posed by its small sample size. This reveals the need for more research investigating the therapeutic alliance with children with communication disorders.

Statement of the Problem

The therapeutic alliance is an important factor in therapeutic change as evidenced in psychotherapy (Horvath & Luborsky, 1993; Horvath & Symonds, 1991), healthcare (Kemper & Shaltout, 2011; Sarinopoulos et al., 2013) and speech-language pathology (Sønsterud et al., 2019). Although the constructs of the therapeutic alliance remains consistent, perceptions of the degree of importance of each part of the alliance has been found to be different given the severity of the impairment (Lawton et al., 2020), between the client versus the clinician (Croft & Watson, 2019) and between adults versus children (Fourie et al., 2011; Plexico et al., 2010). Although much of the evidence on client and clinician perceptions of the therapeutic alliance are concentrated on adults, evidence supports its importance in positive therapy outcome in pediatric treatment (Shirk & Karvar, 2003). Further evidence on perceptions of the therapeutic alliance with children is needed to increase understanding of the clinician-client relationship across the speech-language pathology scope of practice within pediatric populations, identify gaps, and increase the effectiveness of client-centered treatment. The purpose of this study is to investigate

clinicians' perceptions of the therapeutic alliance across different areas of speech-language pathology pediatric treatment.

Research Questions and Hypothesis

1. Do speech-language pathologists' perceptions of the value of the key components of the therapeutic alliance differ when treating children with different communication disorders?
Hypothesis: Speech-language pathologists' perceptions of the value of key components of the therapeutic alliance will differ across different communication disorders.

2. Are these perceptions different depending on the age of the child?
Hypothesis: Speech-language pathologists' perceptions of the value of key components of the therapeutic alliance will relate to the age of the child. Specifically, Bond and Task/Goals subscales will be valued differently depending on the age of the child.

3. Are clinician characteristics related to SLPs' perceptions of TA among children?
Hypothesis: Clinician characteristics related to experience with counseling and disability will be related to SLPs' perceptions of the value of key components of the therapeutic alliance.

4. What do clinicians perceive as benefits and barriers to the formation and maintenance of the therapeutic alliance with children?

Methodology

To answer the research questions, responses to an online Qualtrics survey from ASHA certified speech-language pathologists working with children were examined.

Participants

Participant eligibility was based on the following criteria:

A) is a certified Speech-Language Pathologist (CCC-SLP) whose primary professional activity is clinical practice

B) works in a pediatric setting

The group of respondents analyzed represented ages from 24 to 77 years, all of ASHA's 4 regions, and multiple genders and ethnicities (See Table 1). There were significantly more female respondents (98.7%) than male (1.3%) as well as many more white respondents (85.7%) than other ethnicities. The skew of gender and ethnicity distributions in this survey is consistent with demographics reported by ASHA which reported 95.6% of members being female and 91.3% being white with only 8.6% being from minoritized groups (ASHA, 2022). Additionally, all age groups (preschool, elementary or secondary school age) that best described the clients' respondents primarily work with were identified (See Table 1).

Recruitment

Participants were recruited via American Speech, Language and Hearing Association (ASHA) communities and special interest groups, speech-language pathology related Facebook groups and though special education directors of public-school districts. Researchers posted a detailed recruitment message (Appendix B) to ASHA communities and special interest groups as well as Facebook groups of which they were members. For groups where researchers were not

members, coordinators of these groups were contacted to post the recruitment message. A list of groups where the survey was posted can be found in Appendix C.

In addition to the group posts, special education directors from select districts within US regions defined by ASHA (2021) were contacted and asked to forward the recruitment email to the speech-language pathologists within their district. Districts were determined by using a random number generator to select one state within each of ASHA's nine regions. Once the state was selected, a random number generator was used to select 10 public school districts from each state. Email addresses for special education directors was found on the state education website or on the websites for each respective school district and compiled for survey distribution. The survey was distributed to the following states within each region:

Region / Subregion	State
Northeast	
New England	Rhode Island
Mid Atlantic	Pennsylvania
Midwest	
East North Central	Illinois
West North Central	Missouri
South	
South Atlantic	Virginia
East South Central	Tennessee
West South Central	Texas
West	
Mountain	Utah
Pacific	California

Currently practicing SLP's were recruited through ASHA communities' boards, Facebook groups and public-school districts. Individuals were asked to complete a survey (taking about 15 minutes) regarding their perceptions of the therapeutic alliance with different clinical populations. Participants were given a description of the study, informed consent

document as well as researcher contact information in addition to the link to take the survey. The survey was sent out an additional time to increase the response rate.

Consent

An informed consent document outlining the general purpose of the study, known associated benefits and risks, the confidentiality and anonymity of responses, and the freedom to discontinue participation at any time appeared on the first page of the survey. Participants indicated consent by clicking the arrow at the bottom of the page to continue to the rest of the survey.

Potential Risks and Benefits

Potential participant benefits include gaining greater clarity about therapy outcomes through reflecting back on current or past clinician-client relationships as well as the opportunity to gain knowledge and/or awareness of the therapeutic alliance.

As with any survey, participation may affect a participant's feelings, otherwise, there are no known risks associated with this study.

The study was reviewed by Texas Christian University's Institutional Review Board and was determined to be minimal risk, qualifying for an exemption from further IRB review (IRB#2021-264).

Procedures to Maintain Confidentiality

Participant anonymity will be maintained by random selection of participants as well as the survey being sent to eligible participants by those recruited by researcher. Additionally, no identifying information will be required to take survey.

The survey will be created using Qualtrics and will only be accessible by the authors of the study, therefore, maintaining confidentiality of survey data and results.

Measures

The online Qualtrics survey consisted of two sections. The first section collected personal (i.e., age, gender, and ethnicity) and professional (i.e., years of practice, caseload, specialty certification etc.) demographic information. The second section included questions to examine clinicians' perceptions of TA across different communication disorders.

TA survey questions were developed and based on validated TA measurement instruments. The *Clinician-Client Relationship Rating Scale* utilized by Ebert (2016) to measure the clinician-client relationship in speech and language treatment for school age children was developed from the *Therapeutic Alliance Scales for Children- revised* (TASC-r) (Creed & Kendall, 2005; Shirk & Saiz, 1992). The TASC-r consists of three forms: one for the child, the caregiver, and the SLP. Each form consists of the same 12 questions, rated on a 7-point Likert scale, with modified wording to fit each respondent group. Since the current study was examining SLPs' perceptions, the SLP version was used in this study. The measure examines each of the three components of the therapeutic alliance (goals, tasks and bond) following the theoretical foundation of the Bordin (1979) model. Ebert (2016) found acceptable internal consistency and reliability ($\alpha = .91$) as well as significant correlations for test-retest reliability between the first and second administration ($r = .91$), therefore, supporting the measurement reliability for this current study.

Since the *Clinician-Client Relationship Rating Scale* (Ebert, 2016) was developed from The *Therapeutic Alliance Scales for Children* (Shirk & Saiz, 1992), the subscales from the TASC were used for analysis. Shirk and Saiz (1992) created the TASC under the model proposed by Bordin (1979) and the assumption that a child's affective orientation to the therapeutic relationship could be differentiated from their participation in the process of

treatment. Under this framework, they had three subscales for their measure: bond, negativity, and task/goals. For the purposes of this study, the subscales Bond (questions 1, 3, 5, 6, 8, 10) and Tasks/Goals (questions 2, 4, 7, 9, 11, 12) were used. Questions of the TASC-r and *Clinician-Client Relationship Rating Scale* were matched, then divided into the two subscales.

In the present study, the *Clinician-Client Relationship Rating Scale* was used to investigate clinician perceptions across multiple pediatric communication disorders and age groups. The communication disorders selected for the study were determined from the most recent ASHA schools survey (2020). The criteria for inclusion on the survey was that 47% of SLPs reported that they saw the communication disorder on their caseload. Further, the client age groups were classified under the same criteria as specified on the ASHA schools survey (preschool, elementary, and secondary school age). The following communication disorders were selected for inclusion in this study:

- Autism Spectrum Disorder (ASD)
- Augmentative and Alternative Communication (AAC)
- Fluency Disorders
- Hearing Loss
- Language Disorders (including syntax, semantics, morphology, and pragmatics)
- Speech Sound Disorders (including childhood apraxia of speech)
- Cognitive Communication Impairment (including traumatic brain injury and intellectual impairment)

This criteria was used because over half of ASHA certified SLP's work in the school setting (ASHA, n.d.). Participants were asked to rate on a 7-point Likert scale the importance (1=not at all important; 7=extremely important) of each TA item when treating each of the

specific clinical populations. Respondents only rated the populations for the primary age group they reported treating. The questions from the *Clinician-Client Relationship Rating Scale* were not changed and the same questions were asked for each group on the survey.

Data Analysis

In addition to descriptive statistics used to examine respondents' characteristics, practice, and training, data were analyzed in the following ways to address each research question. Non-parametric statistics were used since the data were negatively skewed (mostly high ratings) and were not normally distributed.

1. Do speech-language pathologists' perceptions of the value of the key components of the therapeutic alliance differ when treating children with different communication disorders? Friedman tests were completed to compare respondents' total TA ratings and TA subscale ratings across the different communication disorders. Pairwise comparisons with a Bonferroni correction were completed if statistical significance ($p < .01$) was observed.

2. Are these perceptions different depending on the age of the child? Kruskal-Wallis tests were completed to compare respondents' total TA ratings and TA subscale ratings across age group served.

3. Are clinician characteristics related to SLPs' perceptions of TA among children? Kruskal-Wallis tests were completed to compare respondents' total TA ratings across their work setting. Spearman's rank order correlations were completed to examine the relationship between total TA scores and the following respondent variable ratings/reports:

- Experience with counseling
- Personal experience with disability
- Years of experience as a CCC-SLP

- Caseload size
- Respondent's age

4. What do clinicians perceive as benefits and barriers to the formation and maintenance of the therapeutic alliance with children? A thematic analysis of open-ended responses was completed to identify pediatric SLPs' perceptions of benefits and barriers to the formation and maintenance of TA.

Results

A total of 405 clinicians opened the survey and completed some portion of the survey. Not all participants completed the entire survey. Before analyses were completed, data were prepared. The dataset was checked for missing data and criteria was set and agreed upon by all researchers to determine which respondents would be included in analysis. Participants' responses were included in analysis if they gave therapeutic alliance ratings for at least one communication disorder. Additionally, to ensure accurate ratings of TA perceptions both overall and for each subscale examined, participants had to rate at least 11 out of 12 items on the scale to be included in analysis. After inclusion criteria were applied a total of 224 participants responses were included in analysis.

Findings addressing each of the research questions are presented below. As noted in Table 2, participants' ratings related to the therapeutic alliance were negatively skewed, indicating that most respondents rated these items as important. As a result, non-parametric statistics (utilizing IBM SPSS Statistics, Version 27, 2020) were used to answer research questions one through three.

Question 1: Do speech-language pathologists' perceptions of the value of the key components of the therapeutic alliance differ when treating children with different communication disorders?

To determine if SLPs' perceptions of the therapeutic alliance varied when treating children with different communication disorders, a Friedman test (SPSS, 2020) was completed examining average TA ratings across the seven disorders. Only participants who completed at least 11 TA questions for all disorders on the survey were included in analysis of the first research question. Results indicated no statistically significant differences across the communication disorders ($\chi^2[6] = 10.638$, $p = .100$).

SLPs' perceptions of the therapeutic alliance as it relates to key components of TA, affective bond between client and clinician and task/goal agreement, were also examined. In order to investigate these areas the *Clinician-Client Relationship Scale* (Ebert, 2016) was divided into two subscales, Bond (mean of questions 1, 3, 5, 6, 8, 10) and Tasks/Goals (mean of questions 2, 4, 7, 9, 11, 12), based on the *Therapeutic Alliance Scales for Children* (Shirk & Saiz, 1992). Friedman tests were executed to determine if there were differences in Bond and Task/Goals subscale ratings across communication disorders. Results indicated statistically significant differences ($p < .01$) across the communication disorders in the Bond reports ($\chi^2[6] = 20.479$, $p = .002$) but not the Task/Goals reports ($\chi^2[6] = 12.978$, $p = .043$).

To examine the differences between Bond subscale ratings across communication disorders multiple pairwise comparisons were performed with a Bonferroni correction. Statistical significance was accepted at the $p<.05$ level. Difference in Bond subscale scores between language and fluency ($p=.034$) and speech sound disorders and fluency ($p=.040$) were statistically significant. Additionally, Fluency median (*Mdn* = 5.73) scores were higher than both

language (*Mdn* = 5.67) and speech sound disorders (*Mdn* = 5.67). There were no other statistically significant differences between Bond subscale scores across the disorders.

Question 2: Are these perceptions different depending on the age of the child?

Kruskal-Wallis tests were completed to determine if average TA ratings differed across primary age groups of the children served by the clinician (i.e., preschool, elementary school, or secondary school) and to examine if the age group clinicians served influenced Bond and Task/Goal subscale ratings. No statistically significant difference in average TA ratings were observed for the primary age group of children served ($H(2)=2.861$; $p=.239$) or for Task/Goal subscale ratings across children's age groups ($H(2)1.008$; $p=.604$). However, Bond subscale scores across the different age groups approached statistical significance ($H(2)\ 5.321$; $p=.070$). These findings suggested that Bond may be different based on the age group treated. Specifically, mean ratings of the Bond subscale suggested that the affective Bond between client and clinician may be of greater importance to SLPs when treating preschool age children; however, additional investigations are needed to confirm this possibility.

Question 3: Are clinician characteristics related to SLPs' perceptions of TA among children?

To determine if clinician characteristics were related to their perceptions of the therapeutic alliance, Spearman's rank-order correlations were completed examining the relationships between total TA scores and respondents age, number of years in practice, the extent of their counseling training in undergraduate/graduate school and post-graduation, the extent of their personal experience with disability, and number of children served. As noted in Table 3, no relationship was statistically significant at the .05 alpha level. However, the clinician's age, extent of counseling education post-graduation, and the number of children they

served all approached significance ($p < .10$). The correlation coefficients for these relationships, however, were quite low.

Additionally, a Kruskal-Wallis test was completed to determine if average TA ratings differed across respondents' primary work settings (i.e., private practice/clinic, medical and educational). No statistically significant difference in total TA scores were observed ($H(2)$ 3.892; p =.143), suggesting that clinicians believed TA was important regardless of their work settings.

Question 4: What do clinicians perceive as benefits and barriers to the formation and maintenance of the therapeutic alliance with children?

A thematic analysis was used to examine participant's responses to open ended survey questions in order to gain a more in-depth understanding of SLPs' perceptions and beliefs about the benefits and barriers to the formation and maintenance of the therapeutic alliance with children. Analysis followed an inductive, semantic approach which allowed themes to emerge directly from explicit content in the data. Data was categorized then key themes were identified. This was done by first breaking up responses into subthemes that emerged. Responses were categorized based on the explicit information given by respondent. After all responses were in subthemes, the responses corresponding to each subtheme were again analyzed to identify any overlapping themes. Then, subthemes were grouped into main themes (see Table 4 and Table 5). Categorization, subthemes and themes were reviewed by all researchers and discussed until a consensus was reached.

Benefits to Forming and Maintaining the Therapeutic Alliance with Children

There were originally 100 responses to the question "What are the benefits to forming and maintaining a therapeutic alliance with children?" These responses were initially categorized as representing one of 21 subthemes describing each response's main components. Further

analysis of these 21 subthemes, yielded four main themes: (1) increases child engagement in therapy / therapy process, (2) promotes progress towards therapy goals, (3) provides child safety and support, and (4) facilitates child's self-efficacy.

Theme 1: Increases Child Engagement in Therapy / Therapy Process

There were nine subthemes that contributed to the theme "Increases Child Engagement in Therapy/ Therapy Process (see Table 4), all of which described the way in which the child interacts with therapy and the processes of therapy, such as their motivation and attention. The responses subsumed in this category described benefits as increases in the child's willingness to participate and more positive attitude towards speech itself. For example, one participant stated, "The student is eager to learn and try their best", while another participant wrote, "The client is more focused and more readily participates in the sessions. The client feels he/she are playing instead of 'working'".

Theme 2: Promotes Progress Towards Therapy Goals

There were three subthemes that contributed to the theme "Promotes Progress Towards Therapy Goals" (see Table 4), which together described benefits of the therapeutic alliance as it related to the outcomes of therapy. Many respondents described benefits of the alliance as serving as a foundation for therapy gains and facilitating productivity during a given session. For example, one participant responded, "Sets foundational skills for making consistent progress", and another stated, "(the) majority of the session time can be used to address the goal allowing for more repetitions and practice".

Theme 3: Provides Child Safety and Support

There were three subthemes that contributed to the theme "Provides Child Safety and Support" (see Table 4), which together described benefits of the alliance as providing the child

with a trusted adult and ally and a loving environment to feel encouraged. For example, one participant stated, “students have a safe person to connect with and talk to”, and another responded, “Developing a strong connection where child feels comfortable supported and loved”. Other responses described feelings of safety and support as it related to therapy engagement, such as one participant stating, “If a child trusts me and enjoys being with me, they feel safe attempting areas of weakness that we are working on”.

Theme 4: Facilitates Child’s Self-Efficacy

There were three subthemes that contributed to “Facilitates Child’s Self Efficacy” (see Table 4), all of which described benefits of the alliance as empowering the child to take ownership and feel confident within the context of treatment. Respondents described benefits of the alliance in terms of creating a space where children can voice their own thoughts and feelings and increases their understanding of their role in the therapy process. For example, one participant responded, “children are able to advocate for themselves and their needs because they are comfortable”, while another stated, “It helps the client understand the goals they are working towards and take more ownership of their progress”.

Barriers to Forming and Maintaining the Therapeutic Alliance with Children

There were 98 responses to the question “What are the barriers to forming and maintaining the therapeutic alliance with children”. These 98 responses were categorized into 26 subthemes describing each response’s main components. Upon analysis 7 main themes were identified as barriers: (1) child’s adverse behaviors, (2) lack of child engagement in therapy / therapy process, (3) parent / caregiver relationship with therapist, (4) imposed workplace demands / challenges, (5) child’s environmental factors, (6) ineffective therapy environment, and (7) child’s traits.

Theme 1: Child's Adverse Behaviors

Many respondents identified the child's behavior as a barrier to forming and maintaining the therapeutic alliance, therefore, this theme was identified as a key component that occurred throughout the responses. Most respondents simply identified "behavior problems" or "behavioral impairment" when describing behavior as a barrier. One respondent stated, "Lots of times there are extra behaviors that interfere with alliance".

Theme 2: Lack of Engagement to Therapy / Therapy Process

Four subthemes were identified as part of "Lack of Engagement in Therapy / Therapy Process" (see Table 5), which related to the child's participation, motivation, and attitude towards therapy. Some responses describe a child's complete disinterest in making changes in therapy, such as when one responded stated, "some students really don't want to change the way they speak but they're forced into therapy by the school or parents", while others described children not wanting to miss out on other activities to come to speech, for example, when a respondent stated, "A lot of them do not want to be there, feel as though they are missing out on homework time or social time with peers". Respondents also described a child's lack of interest in activities being done in therapy as a barrier, such as when one responded stated, "(lack of) willingness to participate in structured activities".

Theme 3: Parent / Caregiver Relationship with Therapist

Six subthemes were identified as part of "Parent / Caregiver Relationship with Therapist" (see Table 5), which together described barriers imposed by parent and caregiver interactions with the SLP and therapy process. Reponses described the SLP's relationship with the parent, such as one participant who said, "Barriers can form if you don't have a good working

relationship with the adults in the child's life". There were also simple statements, such as "parents who don't' buy-in" and "lack of family cooperation".

Theme 4: Imposed Workplace Demands / Challenges

Four subthemes were identified as part of "Imposed Workplace Demands / Challenges" (see Table 5), which described challenges specific to the work setting, scheduling or government that create barriers to the therapeutic alliance. Many different challenges were stated including group sizes, insurance, and time. One respondent stated, "scheduling in a school setting sometimes means the groups are larger than preferred. The required paperwork and other duties SLPs are requested/mandated to do take away from therapy planning and effective implementation of activities that are engaging and relationship building", while another said, "not enough time in the day/week to build the most beneficial relationship with my clients/students".

Theme 5: Child's Environmental Factors

Four subthemes were identified as part of "Child's Environmental Factors" (see Table 5), which all described things and experiences outside the therapy setting that influence the formation of the therapeutic alliance. Some responses globally addressed environmental factors that could be impacting a child, such as one respondent who stated, "previous negative Speech experiences, bullying, age, attitude, desire to fit in/acceptance, desire to appear smart/competent, anxiety, traumas/abuse, other mental illnesses" as barriers to TA, while others mentioned the influence of home environment, such as, "Currently, many of our children are dealing with mental health issues and living situations that are less than ideal".

Theme 6: Ineffective Therapy Environment

Four subthemes were identified as part of "Ineffective Therapy Environment" (see Table 5), which described factors with therapy related to engagement with the child and the therapy being provided itself. Participants reported difficulty with motivating the client in therapy, such as one responded who stated, "Sometimes it is hard to figure out exactly what the student's interest is". Other respondents described a disconnect between the clinician and child within the therapy environment, such as one participant who stated, "Clinician has difficulty understanding the child's interests, understanding her/his behavior, difficulty understanding her/her needs".

Theme 7: Child Characteristics

Four subthemes were identified as part of "Child Characteristics" (see Table 5), which described factors relating specifically to the child. Respondents noted differences in culture, personality, and cognition as barriers to TA. One respondent stated, for example, "Language barriers between clinician and parent and/or language barrier between clinician and client", while another said, "Sometimes it is more difficult to build an alliance with students who have significant anxiety".

Discussion

The purpose of the present study was to investigate speech-language pathologists' perceptions of the therapeutic alliance when treating children with different communication disorders. The following discussion explores the study results as they relate to clinical practice and future research.

Therapeutic Alliance Differences Across Communication Disorders

Results of the present study revealed that speech-language pathologists report that the therapeutic alliance is important when treating all children with communication disorders. The importance of the therapeutic alliance did not change when considering different disorders.

When examining the specific components of TA (Bond and Task/Goals), statistically significant differences were found in Bond scores across disorders, but not Task/Goals scores. Therefore, the hypothesis that speech-language pathologists' perceptions of the value of key components of the therapeutic alliance would differ across communication disorders was not supported when looking at overall ratings of TA and ratings of Task/Goal related items of the scale but was supported when examining Bond related items of the scale. Clinicians reported that the therapeutic alliance was more important when treating children with fluency disorders when compared to children with language disorders and speech sound disorders. They did not report any other differences in the importance of TA importance when treating other disorders.

The importance of bond was further highlighted in the SLPs' responses to the benefits of TA. Clinicians commented on the value of the trust between the child and clinician as well as the child's felt safety and support. Previous research investigating therapists views of the therapeutic alliance with children has also found particular importance of bond aspects of the alliance and highlighted empathy and trust as positive contributors (Campbell & Simmonds, 2011). However, it is not known how the responses of the present study translate to actual practice across different communication disorders. Given potential response bias related to social desirability, reports indicating that TA is important may be inflated and inconsistent with actual activities and approaches observed in clinical settings.

Therapeutic Alliance Ratings for Different Age Groups

When examining whether or not speech-language pathologists perceived TA differently when treating different age groups, clinicians reported that the therapeutic alliance is important regardless of the age group treated. Results yielded no statistical significance when comparing differences between overall TA scores and the primary age group of children the SLPs' served.

Therefore, the hypothesis that speech-language pathologists' perceptions of the value of key components of the therapeutic alliance will relate to the age of the child and that stating SLPs' value of Bond and Task/Goals subscales will be different depending on the age of the child cannot be confirmed.

These findings suggest that SLPs' viewed Task/Goals and Bond similarly when they treated children of different ages, as reflected in rating TA with a high level of importance. Further, the Bond scores approached significance suggesting that even though they saw TA as important across all ages and all disorders, it could be valuable to further investigate the roles of these two subscales as they relate to the formation and maintenance of TA with children.

Clinician Characteristics and Therapeutic Alliance Ratings

Findings demonstrated that a number of personal and professional characteristics were not related to the importance of TA in SLPs' practice with children. No statistically significant results were found when relating overall TA ratings to respondents' age, number of years in practice, the extent of their counseling training in undergraduate/graduate school and post-graduation, the extent of their personal experience with disability, and caseload size. Additionally, the relationship between overall TA ratings and work setting was not statistically significant. Therefore, the hypothesis that clinician characteristics related to experience with counseling and disability will be related to SLPs' perceptions of the value of key components of the therapeutic alliance cannot be confirmed.

These findings indicate that participants rated TA as important regardless of personal or professional characteristics, including the setting they worked in. This finding was further supported in the responses to questions about barriers to establishing TA. For example, although

clinicians' identified workplace demands and challenges, such as caseload size, as a barrier to establishing the therapeutic alliance, they still viewed the TA as important with all children.

Benefits and Barriers to TA Formation and Maintenance

Results of the analysis of benefits and barriers to the formation and maintenance of the therapeutic alliance with children revealed four main themes for benefits and seven main themes for barriers.

Interestingly, although many participants reported child motivation as both a benefit and barrier, only a few participants mentioned the child enjoying therapy as a benefit and none used "satisfaction" (for the children or parents) to describe benefits of the therapeutic alliance; however, therapy progress and a child's engagement in the therapy process was a common theme. Therapeutic alliance literature with adults shows a similar pattern. Clinicians typically define a successful alliance in terms of therapy outcomes, whereas clients tend to define it more by satisfaction (Croft & Watson, 2019). Further, the emergence of barriers related to child motivation and engagement support previous research stating that a unique barrier to child engagement and motivation stems from no being self-referred. That is, the decision for a child to attend therapy comes primarily from caregivers or teachers. (Digiuseppe et al., 1996).

Many clinicians had parallel responses for benefits/barriers. That is, if a child demonstrated a certain trait, it was a benefit (such as "motivation"), but if they lacked the same thing it was a barrier (such as "lack of motivation"), which is represented by two parallel themes regarding the child's engagement in therapy and the therapy process. Given some of these responses within these parallel themes, there appeared to be a lack of what it means to build therapeutic alliance. The therapeutic alliance is not dependent on what the client does or does not do. Rather, it is a collaborative working relationship in which both the clinician and client are

coming to agreement on the tasks/goals of therapy and have some degree of liking and trust (Bordin, 1979; Fourie et al., 2011). These results reveal a disconnect between therapists' responsibility and TA. On a similar note, almost all of the barriers presented by respondents were related to factors external from themselves (ex: parent cooperation, child behaviors, workplace demands etc.). Even responses included in the theme "Ineffective Therapy Environment" discussed factors that were unrelated to the respondent. For example, talking about other clinicians as opposed to using "I" statements such as in the response, "if a clinician isn't familiar with children with special needs", or putting the student at the center such as the response, "student feels overwhelmed by amount of work that must be produced". Therefore, clinicians' appeared to find importance in what the client contributed to the alliance, which is consistent with previous studies showing clinician's place a higher value on client contributions to the relationship (Bachelor, 2013). Other studies have shown that clients view qualities of the therapists to be a strong contributor to the quality of the alliance (Plexico et al., 2010). A similar trend was seen with barriers within the theme "Parent / Caregiver Relationship with Therapist", with respondents almost exclusively focusing on the engagement of the parent with the therapist as opposed to vice versa. For an example, subthemes such as "poor caregiver involvement" and "lack of parent buy in" frequently appeared throughout responses.

Future Research

Limitations

Since responses did not show a normal distribution, analysis was limited to non-parametric stats. Further, the survey completion rate was lower than expected. Many respondents stopped after answering the demographic questions or after answering the demographic

questions and one TA rating questions. This could be due to challenges the respondent may have has with the length of survey, level of thought involved in answering the questions, and rating disorders they do not currently or have never served. Additionally, the measure used to rate perceptions of the therapeutic alliance included questions in both negative and positive phrasing. For example, “The child likes spending time with me, the SLP” and “The child is resistant to coming to speech therapy.” Considering feedback from a couple respondents expressing confusion over how to respond to questions that were stated in a negated way, it is possible other respondents experienced the same confusion and rated certain items in a way that did not reflect their actual perceptions. There were also respondents who rated all items as either a “1” or a “7” across all disorders indicating they either thought none of the aspects of TA were important or all of them were extremely important. It is unclear the intention behind such responses, but it is important to note due to the impact of such answers on averages within the rest of the data.

Future Directions

The therapeutic alliance is of undeniable importance when it comes to treatment outcomes in speech-language pathology (Ebert & Kohnert, 2010; Fourie et al., 2011; Plexico et al., 2010), however, little is known about the formation and maintenance of the alliance across pediatric communication disorders. Despite the self-selection observed in survey research and the possible social desirability bias in responding to the survey, this study supports the need for future of TA in the treatment of pediatric communication disorders. Future research could be directed at understanding the formation and maintenance of the therapeutic alliance or therapeutic approaches that facilitate this working relationship with children. Further, factors related the therapist’s relationship with the parent was frequently referred to when respondents described benefits and barriers to forming TA. We know that the strength of the alliance between

the parent and the clinician plays a significant role in the strength of the alliance with the child (Campbell & Simmonds, 2011); however, little is known about the differences in the construction of the alliance with the child and parent as well as the impact of differing family backgrounds on these relationships. Future research could seek to understand the dynamic between parent / caregiver, client and therapist in order best serve the family unit. Prior studies have suggested that the formation of the therapeutic alliance may require different techniques than with adults due to unique barriers and child development (Digiuseppe et al., 1996; Marcus, 1988). Additionally, Clinician's reports in the present study support the idea that TA is multifaceted. Therefore, future research could be aimed at clinician training regarding forming these multifactored and dynamic therapeutic relationships with children in speech-language pathology practice.

Conclusion

Overall, the perceptions of the therapeutic alliance were rated as important among pediatric SLPs' and did not significantly differ when considering various communication disorders, ages of children being treated, or characteristics of the clinicians themselves. However, when considering Bond aspects of the alliance significant differences were noted when comparing the treatment of fluency disorders to speech sound and language disorders. The therapeutic alliance has been referred to within the area of fluency(Plexico et al., 2010; Sønsterud et al., 2019); however, these results suggest the need for increased research of the therapeutic alliance and its importance for areas such as speech sound and language disorders.

These results indicate that the client's diagnosis, age, and clinician characteristics do not make a difference in the SLPs' perception of the therapeutic alliance with children. However,

since data on perceptions was gathered using a voluntary, self-reporting survey results are subject to social desirability bias. Since the survey asked clinicians to rate their perceptions of importance of each item on the scale, it may not be considered "socially desirable" to rate any aspects of the relationship with the client as unimportant. Further, there was a disconnect between respondents' reports of benefits and barriers to forming and maintaining the therapeutic alliance and the definition of TA itself. Therefore, it is expected that responses on the survey may not translate directly with the extent to which clinicians engage in TA with their pediatric clients.

This exploratory study provided valuable insight into the perceptions of the therapeutic alliance across pediatric disorders and age groups with a representative sample of clinician's from across the country and SLP scope of practice. While there were limitations to the present study, results point to areas of future research that will aid in understanding the therapeutic alliance with pediatric clients within speech-language pathology practice in order to improve quality of care.

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Table 1. *Respondent Demographics*

Clinician Characteristics

	M	SD	R
Age	45.33	12.885	53
Years of Experience	17.82	11.782	51
Caseload Size	37.68	23.528	199

Clinician Experience

Counseling Pre	2.30	1.155	4
Counseling Post	2.79	1.214	4
Disability	3.03	1.420	4

Primary Age Group

	N	%
Preschool Age	71	31.7
Elementary School Age	115	51.3
Secondary School Age	38	17.0

Work Setting

Private Practice/ Clinic	49	21.9
Medical	36	16.1
Educational	139	62.1

Gender

Male	3	1.3
Female	221	98.7

Ethnicity

White	192	85.7
Asian	7	3.1
Latinx	6	2.7
Black	2	0.9
American Indian/ Alaskan	1	0.4
Other	14	5.4

Region

Northeast	47	21.0
Midwest	56	25.0
South	72	31.1
West	44	19.6

Employment Status

Full-Time	171	76.3
Part-Time	53	23.7

Key: M = Mean; SD = standard deviation; R = Range; Years of Experience = number of years practicing as a certified SLP; Caseload Size = number of children clinician currently serves; Counseling Pre = experience with counseling during undergraduate / graduate school (rated 1-5); Counseling Post = experience with counseling as a professional (rated 1-5); Disability = personal experience with disability (rated 1-5); 1 = no experience; 5 = extensive experience; N = number of respondents; % = percent of respondents

Table 2. *TA Descriptive Statistics*

	n	Mean	Median	SD
TA Total	224	5.32	5.41	1.01
TA Bond	224	5.45	5.58	1.56
TA Task/Goals	224	5.18	5.23	1.05

Key: n = sample size, SD = standard deviation

Table 3. *Spearman's Correlations*

			TotalTA_Mean
Spearman's rho	Age	Correlation Coefficient	.118
		Sig. (2-tailed)	.080
		N	222
	No. Years in Practice	Correlation Coefficient	.083
		Sig. (2-tailed)	.223
		N	217
	Extent Counsel Prep UG/GR	Correlation Coefficient	.045
		Sig. (2-tailed)	.507
		N	222
	Extent Counsel Trg PostGR	Correlation Coefficient	.128
		Sig. (2-tailed)	.058
		N	220
	REC PerDisEper	Correlation Coefficient	.107
		Sig. (2-tailed)	.111
		N	224
	No. Children Served	Correlation Coefficient	-.114
		Sig. (2-tailed)	.091
		N	221
	TotalTA_Mean	Correlation Coefficient	1.000
		Sig. (2-tailed)	.
		N	224

Table 4. *Benefits*

Increased Child Engagement in Therapy / Process
Increased Enjoyment
Better Communication
Improved Cooperation
Increased Engagement
Increased Individualization of Therapy
Better Attendance
Increased Child Motivation
Joint Attention
Promotes Progress Towards Therapy Goals
Facilitates Progress
Higher Productivity
Increased Skill Generalization / Carryover
Provides Child Safety and Support
Child Feels Safe
Increased Trust
Child Feels Loved / Supported
Facilitates Child's Self-Efficacy
Empowers Child
Facilitates Child Confidence
Increased Child Buy-In

Table 5. *Barriers*

Child's Adverse Behaviors
Adverse Behaviors
Lack of Child Engagement in Therapy / Therapy Process
Poor Child Buy-In
Lack of Engagement
Lack of Motivation
Poor Attention
Poor Attendance
Parent / Caregiver Relationship with Therapist
Fostered Family Dependence
Poor Caregiver Involvement
Lack of Parent Buy-In
Poor Caregiver Cooperation
Poor Caregiver Attitude
Poor Caregiver Relationship with Clinician
Imposed Workplace Demands and Challenges
Workplace Demands / Challenges
Insurance
Time
Covid Restrictions
Child's Environmental Factors
Child Past Negative Experience with Therapy
Child Past Trauma
Child's Home Environment
Stigma
Ineffective Therapy Environment
Inappropriate Therapy Activities
Therapist Lack of Understanding of Child / Disorder
Difficulty Motivating Client
Lack of SLP Training
Child Traits / Characteristics
Cognitive Deficits
Sensory Needs
Child Traits
Cultural Differences

Appendix A

Survey Questions

Demographic Questions

The demographic questions will appear in the following manner on the survey:

First: Informed consent document.

You have been selected to participate in this research study because you are a) an ASHA certified speech-language pathologist (CCC-SLP) whose primary professional activity is clinical practice, and b) work in a pediatric setting (preschool- high school).

The purpose of this study is to advance the knowledge of clinician perceptions of the clinician client relationship across the scope of pediatric communication disorders. If you agree to take part in this study, you will be asked to complete the survey/questionnaire on the next page. The survey will ask about your perceptions of the clinician-client relationship across the different areas of speech-language pathology practice, and it will take you about 15 minutes to complete. This study will provide you with the opportunity to reflect on your own experiences and your participation will advance the evidence base within pediatric treatment to improve quality of care. As with any survey, participation may affect your feelings. There are no risks associated with participation in this study.

This survey is anonymous, and your answers will remain confidential. No information identifying you as a respondent will be collected or retained and whether or not you complete the survey will not be shared with anyone. You are free to skip any question you choose as well as withdrawal at any time without penalty. Decision to participate or not will not affect your employment status now or in the future.

If you have any questions about this project or have a research-related problem, you may contact Kayla Grupe (kayla.grupe@tcu.edu) or Dr. Jennifer Watson (j.watson@tcu.edu). If you have questions about your rights or are dissatisfied with any part of this survey you may anonymously contact the Office of Research at (817)- 257- 7104.

By clicking the arrow at the bottom of the screen to move onto the next page you are indicating that you have read and understood the consent form and agree to participate in the research study.

Thank you for your time and willingness to participate.

What is your current age in years? (free response)

What gender do you identify as? (drop down)

- Male
- Female

- Non-binary
- Transgender
- Prefer not to say
- Other

What is your ethnicity? (drop down)
- White
- Asian
- Black
- Latinx
- Middle Eastern/ Arabic
- Native Hawaiian/ Other Pacific Islander
- American Indian or Alaskan Native
- Two or more ethnicities
- Prefer Not to Say
- Other

In what setting do you currently practice, primarily? (multiple choice)
- Audiology/ hearing clinic
- SLP or audiologists' office
- Speech and hearing center or clinic
- General medical hospital
- Home health agency/ client's home
- Outpatient/ rehabilitation center
- Pediatric hospital
- Rehabilitation hospital
- Private physicians' office
- Secondary school
- Elementary school
- Pre-elementary school
- Special day school
- Special day/ residential school
- Other (response box)

What age group do you primarily work with? (multiple choice)
- Pre-Elementary School (preschool)
- Elementary School
- Secondary School (middle school, junior high, senior high)

In what state do you currently practice? (drop down)

Approximately how many students do you currently serve in each of the following areas? If a student has overlapping areas of intervention, they may be counted more than once. (constant sum)
- Acquired brain injury (ABI)
- Auditory processing disorder (APD)

- Autism spectrum disorder (ASD)
- Childhood apraxia of speech (CAS)
- Cognitive communication disorders
- Fluency disorders
- Hearing loss
- Language disorders: pragmatics/social communication
- Language disorders: semantics, morphology, syntax
- Nonverbal, augmentative and alternative communication (AAC)
- Reading and writing (literacy)
- Selective mutism
- Speech sound disorders
- Voice or resonance disorders

Which of the following categories describes your employment status? (multiple choice)
- Employed Full-Time
- Employed Part-Time

If any, what Clinical Specialty Certification's do you hold? (free response)

In what year did you receive your graduate degree in speech-language pathology? (free response)

For how many years have you practiced as an ASHA certified speech-language pathologist? (free response)

What is the approximate number of children you currently serve? (free response)

Describe the extent of your pre-graduation preparation or training in counseling. 0 = none 5 = extensive (0-5 multiple choice scale)

Describe the extent of your post-graduation training in counseling. 0 = none 5 = extensive (0-5 multiple choice scale)

Describe the extent of experiences with disability that you have had personally or with a family member. 0 = none 5 = extensive (0-5 multiple choice scale)

Therapeutic Alliance Questions

If **"Pre-Elementary (preschool)"** is selected on question number 5, the participant will view and answer the following questions:

> **When considering preschool age clients with Autism Spectrum Disorder (ASD), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.**

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering preschool age clients with Augmentative and Alternative Communication (AAC), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering preschool age clients with Fluency disorders rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP

- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering preschool age clients with Hearing Loss rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering preschool age clients with Language disorders (including syntax, semantics, morphology and pragmatics), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills

- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering preschool age clients with Speech Sound disorders (including Childhood Apraxia of Speech), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering preschool age clients with Cognitive Communication Impairment (including traumatic brain injury and intellectual disability), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you

- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

What are the benefits to forming and maintaining a therapeutic alliance (i.e. a cooperative working relationship between client and clinician) with preschool age children? (open response)

What are the barriers to forming and maintaining a therapeutic alliance (i.e. a cooperative working relationship between client and clinician) with preschool age children? (open response)

If **"Elementary School"** is selected on question number 5, the participant will view and answer the following questions:

When considering elementary school age clients with Autism Spectrum Disorder (ASD), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Augmentative and Alternative Communication (AAC), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Fluency disorders rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Hearing Loss rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP

- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Language disorders (including syntax, semantics, morphology and pragmatics), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Speech Sound disorders (including Childhood Apraxia of Speech), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally

- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Cognitive Communication Impairment (including traumatic brain injury and intellectual disability), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

What are the benefits to forming and maintaining a therapeutic alliance (i.e. a cooperative working relationship between client and clinician) with elementary school age children? (open response)

What are the barriers to forming and maintaining a therapeutic alliance (i.e. a cooperative working relationship between client and clinician) with elementary school age children? (open response)

If **"Secondary School (middle school, junior high, senior high)"** is selected on question number 5, the participant will view and answer the following questions:

When considering secondary school age clients with Autism Spectrum Disorder (ASD), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering secondary school age clients who use Augmentative and Alternative Communication (AAC), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering secondary school age clients with Fluency disorders rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering secondary school age clients with Hearing Loss rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering secondary school age clients with Language disorders (including syntax, semantics, morphology and pragmatics), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Speech Sound disorders (including Childhood Apraxia of Speech), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals
- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

When considering elementary school age clients with Cognitive Communication Impairment (including traumatic brain injury and intellectual disability), rate the significance of the following statements. Even if you are not currently working with children with the given disorder, please rate as though you are or will in the future.

(scale from Ebert, 2016; 1-7 Likert Scale 1= not significant 7= extremely significant)

- The child likes spending time with you, the SLP
- The child finds it hard to work with you on speech-language goals

- The child considers you to be an ally
- The child works with you on improving speech and language skills
- The child appears eager to have sessions end
- The child looks forward to having sessions with you
- The child feels that you spend too much time working on his/her speech-language skills
- The child is resistant to coming to speech
- The child uses his/her time with you to work on speech-language goals
- The child expresses positive emotions towards you, the SLP
- The child would rather not work on speech-language goals
- The child is able to work well with you

What are the benefits to forming and maintaining a therapeutic alliance (i.e. a cooperative working relationship between client and clinician) with secondary school age children? (open response)

What are the barriers to forming and maintaining a therapeutic alliance (i.e. a cooperative working relationship between client and clinician) with secondary school age children? (open response)

Appendix B

Hi,

My name is Kayla Grupe. I am a speech-language pathology graduate student completing a master's thesis at Texas Christian University, titled *Pediatric SLPs' Perceptions of the Therapeutic Alliance Across Communication Disorders*, under the supervision of Drs. Jennifer Watson and Anthony DiLollo. We are interested in understanding clinicians' perceptions of the therapeutic alliance across communication disorders in pediatric treatment. The purpose of this study is to advance knowledge of how the clinician-client working relationship may differ in the treatment of a variety of pediatric communication disorders.

We are asking that **ASHA certified speech-language pathologists currently working with children with communication disorders in a pediatric setting** (preschool, elementary, middle and/or high school) complete a 15-minute online survey. The survey will ask about your perceptions of the clinician-client relationship when treating a variety of communication disorders. No further commitment is required for participation in this study. To access the survey, please click the link below or paste the link into your web browser.

https://tcu.co1.qualtrics.com/jfe/form/SV_cBC0EnjC2H4s9yS

This study has been approved by the Texas Christian University Institutional ReviewBoard (2021-264). Participation in this survey is completely voluntary and will not affect your current or future employment status. No information identifying you as a respondent will be collected or retained and whether you completed the survey will not be shared with anyone.

Your time and willingness to participate are greatly appreciated and ultimately will help us improve the quality of services provided to children.

Feel free to contact me with any questions you may have at kayla.grupe@tcu.edu.

Thank you for your help!

Kayla Grupe, B.S.

Graduate Student Clinician

Texas Christian University

Appendix C

ASHA Communities

- Autism
- Early Career Professionals
- SLP Healthcare
- SLP Private Practice
- SLP Schools
- Early Intervention
- Global Issues
- Research

Facebook Groups

- Clinical Research in Speech-Language Pathology
- SLP Early Intervention
- K-12 Speech Language Pathologists
- AAC- Alternative Awesome Communicators
- SLP School Jubilee
- Speech Therapy Ideas
- Teletherapy Materials

ASHA Special Interest Groups

- Language Learning and Education
- Neurogenic Communication Disorders
- Voice and Upper Airway Disorders
- Fluency and Fluency Disorders
- Craniofacial and Velopharyngeal Disorders
- Auditory Rehabilitation
- Pediatric Hearing and Hearing Disorders
- Augmentative and Alternative Communication
- Swallowing and Swallowing Disorders
- School-Based Issues
- Telepractice