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A Qualitative Exploration of Therapeutic Relationships from the Perspective of Six Children Receiving Speech–Language Therapy

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Although some studies have explored the adult therapeutic relationship in speech–language pathology, few, if any, have examined it with regard to children. This study aimed to explore the therapeutic relationship in pediatric speech and language therapy, focusing on the child's experience. Accordingly, the study was qualitative and involved the interpretive phenomenological analysis of 6 semistructured interviews with children, aged 5 to 12 years, attending for speech–language therapy. The children described their experiences of therapy, which included the following themes: "the SLP as source of play and fun," "power differentials," "trust," "routines and rituals," "role confusion," and "the physical characteristics of the speech–language pathologist." Some children did not understand the therapist's role or the purpose of speech–language therapy. The role of each stakeholder in therapy should be made explicit to the other in order to achieve a therapeutic bond through which the goals and tasks of therapy can be achieved. **Key words:** *bonds*, *children*, *phenomenology*, *play*, *therapeutic relationship*, *qualitative research*

THE therapeutic relationship is a common and crucial underlying feature of most health care professions (Fourie, 2009, 2011; Littauer, Sexton, & Wynn, 2005; Thorne, 1992), particularly those that adopt client-centered approaches. Although the components of the therapeutic relationship are difficult to define, it generally refers to the quality of the emotional bond that exists between the client and the therapist (DeVet, Kim, Charlot-Swilley, & Ireys, 2003). This bond results in a conscious and active collaboration (Ackerman & Hilsenroth, 2003). It is the compulsory context for delivery of the specific components of any therapy (Wampold, 2001).

Bordin (1979) observed that therapy involves three main components: *goals,* which generally relate to specific outcomes; *bonds,* which refer to the interpersonal relationships between therapy participants; and *tasks,* which involve activities inside and outside of therapy sessions. In the psychotherapy literature, the most consistent predictor of positive outcomes has been the quality of the *bond* between the client and the therapist (Alexander & Luborsky, 1986; Wampold, 2001). More specifically, how much the patient is able or willing to contribute to the therapeutic interaction is the best predictor of positive outcomes (Luborsky, Crits-Christoph,

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Alexander, Margolis, & Cohen, 1983; Marziali, 1984). Therefore, it appears that the bonds of therapy provide the catalytic context for the achievement of therapeutic goals. Although these findings pertain specifically to the area of psychotherapy, speech–language pathologists[1] should recognize the relevance of these concepts to the everyday practice of speech–language therapy. It is plausible that the quality of the therapeutic relationship in speech–language therapy may also be an important predictor of outcomes; this theory, however, remains largely untested.

THERAPEUTIC RELATIONSHIPS IN SPEECH–LANGUAGE THERAPY

Some speech–language pathology researchers have studied relationships in speech–language therapy. For example, Stech, Curtis, Troesch, and Binnie (1973) focused on what clinicians feel about their client's behaviors. They used factor analysis to investigate factors that speech–language pathologists believed were important for a good therapeutic relationship. These researchers found that speech–language pathologists valued "appropriate" responses, positive motivation, and compliance in clients as important factors for a positive therapeutic relationship. Conversely, speech–language pathologists identified clients' negative emotions and poor interpersonal skills as having a negative impact on the therapeutic relationship (Stech et al., 1973).

Other researchers have focused on what clients felt about their clinicians, focusing on how therapist characteristics contributed to therapeutic interactions. For example, Haynes and Oratio (1978) used factor analysis to investigate adult clients' perceptions of their speech–language pathologists. Data from this study suggested that the participants valued skillful interpersonal proficiency in their speech–language clinicians as essential. In particular, clients valued empathic genuineness, which consisted of the speech–language pathologist listening in a careful and accepting way, having a sense of humor, and not playing a false role (Haynes & Oratio, 1978). In addition to these qualities, Crane and Cooper (1983) found that adult clients reported speech–language pathologist characteristics such as assertiveness, flexibility, and confidence as being crucial elements of clinical effectiveness. Similarly, Fourie (2009) studied how adult clients with acquired communication and swallowing disorders described various qualities and actions in their clinicians that they believed were therapeutic. These included being understanding, erudite, inspiring, confident, soothing, practical, and empowering (Fourie, 2009).

Studies examining clinical interactions in speech–language therapy also have highlighted the value of relationship variables in interaction. For example, Ferguson and Armstrong (2004) pointed out that clinical relationships that emphasize the role of the speech–language pathologist as professional expert and reinforce the powerlessness of clients can result in restricted engagement in the therapeutic process. Such communicative asymmetries can be disempowering for clients with communication disorders (O'Malley, 2010), placing them in dependency roles (Pillay, 2003). Simmons-Mackie and Damico (2011) reported interactional processes between clinicians and adult clients in which clinicians control turns, evaluate performance, request known information, and control interpretation of meaning as demonstrating differential power (Simmons-Mackie & Damico, 2011).

Most studies assessing the role of the therapeutic relationship have concerned adult clients. Those examining this topic in relation to children often refer to child psychotherapy (Carroll, 2000, 2002; Reisman & Ribordy, 1993; Shirk & Saiz, 1992). However, research on this relationship may be relevant

[1]In Ireland, where this study was conducted, the term *speech and language therapist* is used instead of the term *speech-language pathologist*, and *therapy* is used where *intervention* might appear in the US.

to speech–language therapy with children as well because it is in the context of constructing intersubjective bonds that children make the effort to engage in tasks and work toward therapy goals (Bloom & Tinker, 2001; Longtin & Gerber, 2008). Moreover, the therapeutic relationship may be crucial for helping children deal with the negative consequences of a communication disorder (Green, Crenshaw & Kolos, 2010; van der Kolk, 2005).

THE THERAPEUTIC RELATIONSHIP IN THERAPY WITH CHILDREN

Bickman and colleagues (2004) pointed out that the therapeutic relationship may be even more important in child-oriented therapy than in adult-oriented therapy, as children do not voluntarily initiate treatment. Indeed, a failure to establish a caring and beneficial relationship between the therapist and the child-client may (1) hinder treatment efforts, (2) increase resistance to a clinician's intervention, and (3) lead to premature termination of therapy. Anna Freud, daughter of Sigmund Freud and a pediatric psychotherapist, noted that an affectionate relationship between the child and therapist was a necessary prerequisite for therapeutic work. She posited that the relationship would promote insight into the *purpose* (or goals) of therapy (Freud, 1965; Shirk & Saiz, 1992).

With regard to children with communication disorders, Danger and Landreth (2005) suggested that there may be a bilateral relationship between emotional wellbeing in children and their ability to communicate. More specifically, these authors cited research by Audet, Burke, Hummel, Maher, and Theadore (1990), which suggested a significant relationship between degree of speech disorder and anxiety levels in children. This anxiety may be due to the social rejection of children with communication disorders, as reported by Bishop (1994). Therefore, improvements in the affective domain could have a positive impact on communication (Danger & Landreth, 2005).

Another factor essential for children's engagement in therapy is a sense of feeling safe with the clinician (Wright, Everett, & Roisman, 1986). According to van der Kolk (2005), a sense of safety can be achieved in the context of a secure attachment bond. It is within this safe context, van der Kolk proposed, that fun provides the essential backdrop for children to regulate themselves and to focus on what is relevant in their environment. Moreover, safety in the therapeutic relationship allows for children to be empowered to deal with difficulties (Green et al. 2010). Indeed a positive feeling toward the clinician may predicate active collaboration by children in treatment (Shirk & Saiz, 1992).

Research specific to the therapeutic relationship with children is scarce. Carroll (2002) interviewed 14 children between 9- and 14-years-old about their relationship with their psychotherapy clinicians. Although children found it difficult to isolate specific qualities in their therapists, many were able to describe various activities, processes, and qualities in the therapeutic environment that they valued. For example, some children liked it when therapists offered them a drink or a snack, made them comfortable, provided folders or boxes for therapeutic activities, or provided them with toys. Toys represent play, which is the natural medium in which children develop self-regulation, social, emotional, and cognitive development (Bodrova & Leong, 2005; Vygotsky, 1978).

Some children in Carroll's (2002) study also described positive characteristics in their therapists, such as being relaxed, kind, and not easily angered. These children liked it when their therapists cajoled them in a friendly sort of way. Moreover, some children were able to articulate that they liked their therapists being helpful, understanding, and easy to talk to, and that they liked it when their therapists respected their preferences and choices. Although the children in Carroll's study were very aware of the appearances and dress of their therapists, they were ambivalent about talking, especially when being questioned by their therapists. This latter finding may be

disconcerting for speech–language pathologists who depend upon talking, communication being both the medium and the focus of therapy.

In a meta-analytic study of associations between therapeutic relationship variables and treatment outcomes in children and adolescent psychotherapy, Shirk & Karver (2003) reviewed the results of 23 investigations. They found a consistent, though moderate, association between the therapeutic relationship and treatment outcomes across widely varying methods of child psychotherapy, but they were unable to clearly identify the relevant components of the therapeutic relationship. Nevertheless, they explained that children who acted out their interpersonal difficulties in a hostile manner were less likely to form (or respond to) therapeutic alliances (Shirk & Karver, 2003). Although this may also be the case in speech–language therapy involving children, there is as yet very little research in this area.

THE CHILD'S VOICE IN HEALTH CARE

Woodgate and Kristjanson (1996) demonstrated that children as young as 4-years-old could provide relevant insights into their daily lives and health experiences. Much of the research pertaining to children relies on parental and health care practitioners' perspectives (Sandelowski, 1998), however, and the voices of children are not frequently included (Irwin & Johnson, 2005). Landreth (2002) claimed that children are an excellent source of information about themselves. This concept is not new in the profession of speech–language pathology, and there are many examples in which children's voices have been included in research (Bernardini, Vanryckeghem, Brutten, Cocco, & Zmarich, 2009; Clarke, McConachie, Price, & Wood, 2001; Ezrati-Vinacour, Platzky, & Yairi, 2001; Markham, van Laar, Gibbard, & Dean, 2009; Owen, Hayett, & Roulstone, 2004).

Some researchers have determined that young children are aware of communication difficulties, both in themselves and in others (De-Nil & Brutten, 1991; Ezrati-Vinacour et al., 2001). In addition, Markham et al. (2009) found that children with communication disorders reported difficulties making and maintaining friendships with their peers. Similarly, Owen and colleagues (2004) found that children were accepting of speech–language therapy, seeing it as an opportunity for learning.

Findings derived from the perspective of the child can potentially have important implications for clinicians choosing models of intervention, and for *how* speech–language pathologists implement evidence-based therapy. If speech–language pathologists are not aware of the child's perspective, and do not use such insight when implementing therapy, this may, in the terminology of Bordin (1979), have a negative impact on the implementation of tasks and the achievement of goals in speech–language therapy.

By understanding how clients, children included, describe their relationships with speech–language pathologists, clinicians are better able to reflect on *how* therapy is conducted rather than only focusing on *what* therapy is conducted (Fourie, 2009). To achieve the goals of therapy, the tasks of therapy may need to be conducted within the catalytic context of a therapeutic bond. To do this, information is needed on how children describe these interpersonal bonds during speech and language therapy.

For these reasons, we examined children's accounts of their experiences in speech and language therapy. We did so by conducting semistructured interviews with children in which they described their experiences with their speech–language pathologists.

METHODOLOGY

Qualitative analysis

After conducting semistructured interviews, an interpretive phenomenological analysis (IPA) (Smith, 1996; Smith, Flowers, & Osborn, 1997) was conducted to reveal the life-worlds of six children participating in speech–language therapy. Borrowing from Husserl (1970), the life-world concept refers

to those often taken-for-granted, subjective experiences that help constitute human social reality.

Participants

Participants were Irish monolingual children, aged between 5 and 12 years. They had received speech–language pathology services for at least 6 weeks prior to interview. Only children whose language and communication skills were sufficient for the purposes of interview could be included in the study. In addition, participants had no other medical or psychological conditions as reported by caregivers. On the basis of these criteria, six children, two females, and four males were selected to participate. Table 1 provides details of these participants, their pseudonyms, their speech difficulties, and their ages.

Ethics

The current researchers received permission to undertake the current study from local teaching clinical research ethics review boards. Participants were given child-friendly information pertaining to confidentiality and safety in the interviews (Ireland & Holloway, 1996). The researchers also obtained informed written consent from parents and written assent from each child participant.

Interviewing

No researcher was the clinician for any of the children interviewed. Interviews were conducted by authors 2 and 3, both of whom were final year students in speech–language pathology, under supervision of researcher 1, in a clinical program at University College Cork (UCC), in the Republic of Ireland. More specifically, researcher 1 instructed researchers 2 and 3 with regard to child-friendly phenomenological interviewing. Accordingly, the interviewers used child-friendly props, such as arts and crafts materials, children's parlor games, play putty, and colorful activity sheets to provide a context for discussions pertaining to the therapeutic relationship. No participants had prior relationships to the interviewers. Furthermore, the participants were assured that their anonymity would be protected by a pseudonym when the study was reported; and therefore, that no speech–language clinician would be able to connect any reported comments to the specific participants. In this context, semistructured interviews were conducted and recorded on high fidelity digital recording equipment and then transcribed.

In line with the recommendations of Mauthner (1997), the interviews were organized around play, drawing, and reading activities. Children were asked to share their experiences of speech–language therapy and their reasons for attending. As part of the process, the children were encouraged to make evaluative comments about their experiences with speech–language pathologists. To minimize the researcher's influence on child responses, yes/no questions and forced alternative questions were avoided when possible. And in an effort to elicit more spontaneous narratives, open-ended questions (such as "Tell me about N") were used. These open-ended questions were then followed by direct questions, such as "What did you do with N?" as recommended by Smith and Osborn (2008) and M. S. Steward and D. S. Steward (1996). The following interview protocol provided a framework for semistructured interviews:

Can you draw a picture of your speech and language therapist and tell me about it?

Tell me about [name of clinician, after establishing name with child].

How did you get on with [name of clinician]?

How did your speech and language therapist make you feel?

Tell me your best memory about working with [name of clinician].

What was your worst session like?

What was it like, working with [name of clinician]?

What would you change about your speech and language therapist?

Tell me about what you think of speech and language therapy.

Table 1. Description of recruited participants

Pseudonym[a]	Age (yrs)	Speech–language diagnosis	Place of interview
Mary	8	Phonological delay	Child's own home
Richard	7	Speech and language delay	Child's own home
Johnnie	5	Phonological delay	Clinic room
Peter	8	Phonological delay	Child's own home
Seannie	6	Speech and language delay	Child's own home
Sarah	12	Phonological delay	Child's own home

[a]All names in this study are pseudonyms.

To further minimize bias, the first author reviewed transcriptions and removed any responses from participants that appeared to be elicited on the basis of leading questions.

Data analysis

According to Beyer (2009), bracketing in qualitative research refers to a process in which the researcher actively refrains from making assumptions about the objectivity of a participant's experience. Instead, the researcher focuses directly on how the participant directs consciousness to his or her own world (Beyer, 2009). This is because phenomenological researchers aim to gain access to the personal processes and attitudes of participants that are, as far as is possible, uncontaminated by the researcher's own concepts and experience. Accordingly, researchers in the current study committed to suspending their own worlds of experience and to analyzing the data without any specific theoretical agenda.

As advised by Smith and Osborn (2008), the researcher paid particular attention to distinguishing clearly between what a participant said and the researcher's interpretation of it. Accordingly, researchers 2 and 3 transcribed and analyzed their own interviews independently, by reading and rereading transcriptions, and then writing descriptive notes about theoretically relevant content as advocated by Smith and Osborn. These notes involved summarizing responses and categorizing these responses into themes. For example, researcher 2 wrote the following notes in the left margin of the first interview: "Refers to therapist as 'teacher'; Describes the therapist as 'nice'; Child does not perceive the relationship as a friendship."

Next, researchers 2 and 3 reread their transcripts and coded the data by using succinct phrases to describe what the participants had said in the interviews. Similar codes were grouped into themes. The researchers also wrote memos, which noted their initial thoughts about the data, its codes, and its themes. Researcher 1 then cross-checked the analyses and coding of researchers 2 and 3 and searched for similarities between the themes described independently by researcher 2 and researcher 3. Next, the first author referred back to the interview transcripts to validate these themes as representing the actual words and meanings of the participants and compiled an index of the participants' phrases that supported related themes. The first author then referred the overall analysis of all interviews to researchers 2 and 3 to confirm that the higher level analysis was representative of all the data.

The results provide thematic descriptions with examples and attempts to relate these to the literature. Although the data for this study are limited, interesting findings emerged about the children's perspectives on therapeutic relationships.

RESULTS

Interviews lasted for between 30 minutes and 2 hours and were terminated when no new information was being obtained from participants. Some of the child participants found it difficult to describe their interpersonal relationships with therapists, and instead focused on the tasks of therapy. Nevertheless, most of the participants, except for Johnnie, the youngest (a boy aged 5 years), were able to share some experiences with regard to their speech–language pathologist and therapy. Themes below are discussed in no particular order, as the study was exploratory and, therefore, did not aim to quantify the relative importance of each of the themes.

Source of play and fun

Children in this study provided evidence that they valued the fun, games and rewards associated with interacting with their speech–language pathologists. Mary, a 12-year-old said:

> She [the clinician] had this cool game . . . We did all this play fun . . . I loved it . . . I liked to get the stickers and the painting. Because we had to paint like all this stuff.

Another participant, Johnnie, age 5 said of his speech–language pathologist:

> She helped me with the games . . . . She was funny! . . . I like lots of things about her . . . em . . . the stickers.

These two participants, when asked to imagine a "bad" speech-language therapist, both mentioned the idea of not playing or not having fun. To illustrate, Mary provided an example of this: "She would say . . . 'Stop laughing'." When asked what she might miss about her speech–language pathologist, Mary replied, "Games . . . and just not to have any fun."

Interestingly, Sarah, who had attended speech–language therapy for 7 years, explained how her clinician had "lured" her into participating with fun tasks when she was younger, but how this had become, as she aged, more business-like:

> Sarah: When I was younger fun was . . . it; what got me interested I think.
>
> Researcher: Um?
>
> Sarah: I think it kind of lured you in. It kind of got me interested and they did fun ways of teaching it, but as you get older they do kind a like step it up, like it's a bit more dull as you get older; it would probably be, it wouldn't be dull-dull like maths maybe,
>
> Researcher: Yeah.
>
> Sarah: But it's still a bit dull compared to maybe when you were a kid, where you thought bubbles were [laughs] the best thing.

For Peter, who attended group therapy, this goal of play seemed very important and he expressed that he would have liked to play even more than he did in therapy:

> Researcher: When you were playing games with [clinician], who won all the time?
>
> Peter: Um, I won the snakes and ladders, but we couldn't have time to play with the balls or the cards.
>
> Researcher: Would you have liked more time?
>
> Peter: Yeah.

It appeared that play was usually initiated and regulated by the clinician, rather than the child. This is relevant in terms of the power dynamic of the therapeutic interaction.

Power differentials

One way that power is evidenced in clinician interactions is to examine the opportunities to make choices about something and to act on those choices. Some children in the current study exposed the inherent regulatory role of the clinician as an adult in relation to a child. Seannie was asked to describe his clinician:

> She would let you go to the toilet whenever you wanted and you did not have to ask her.

Most participants (except Sarah; see next for a counterexample) discussed speech–language therapy as though it were mandatory. For example, it seemed that Richard's

therapist was aware of this dynamic and at times was willing to provide him with choices.

Researcher: So what made that an extra special day?

Richard: Yeah. (short pause) I got like a (long pause) I got stickers like.

Researcher: Emmm. What kind of stickers.

Richard: Emm. Emm. Emm. I got a match tap.

Researcher: Ohh.

Richard: Do you know what they are?

Researcher: Yeah. Little car things are they?

Richard: Eh. (short pause) soccer players.

Researcher: Oh soccer players.

Richard: The books.

Researcher: Ahhh . . . And did she give you that?

Richard: Yeah.

Researcher: How did she know you'd like that?

Richard: Emm. I choose.

It is clear that the researcher in this interview occupied the powerful role of topic initiator and maintainer due probably to her research agenda. Although the role occupied by the researcher was clearly different to the role of a speech–language clinician, there are similarities between these roles, for example, in the role of the controller of dialogue. It could be argued that such control, while aimed at a clinical goal, could reduce the naturalness and spontaneity required for meaningful communication.

Unlike most participants whose participation in therapy was mandatory, Sarah described quite eloquently how she was allowed to make a choice about whether or not to attend therapy.

Researcher: This might be your last year.

Sarah: Yeah. It's up to me really to choose kind of.

Researcher: And you've chosen to go back.

Sarah: Yeah.

Researcher: And work on the 'rs' for your final block.

Sarah: Yeah. I think this might be my last block session.

Researcher: Emm . . .

Sarah: But I went back simply 'cause I thought it would be better, like better fix it now than you know, older when . . .

Sarah and Mary were able to report on events in therapy that indicated how power could be exercised in a positive manner to promote camaraderie. For example, Sarah said:

They wouldn't make you feel like you had a problem. Like you know the way sometimes like, if you went to a hospital sometimes they overwhelm you with like loads of long words and sometimes you feel really out of it, but like what I found out is they never did that with me. They would use simple words like, for me, and I could understand quite easily and, like, ever since, like, I have been kind a getting better and better and better so . . .

In this interaction, Sarah explains how her speech–language pathologist did not flaunt her status by speaking down to Sarah. Similarly, Mary perceived a lessening of the power differential between herself and her speech–language pathologist:

I made friends with her [the clinician] . . . She was really nice and she was friendly . . . I used to speak about me, and then when I'm done she'd speak about her, and then me, and then her. I wanted to be on my own to talk to her and all that stuff . . . because she is really nice and I could tell her anything, but not to Mommy . . . because Mommy doesn't really keep secrets. She [the clinician] wouldn't tell anyone else . . . We used to talk about how I like things, how I don't like things, how I'm afraid of things . . .

Mary saw her clinician as a confidant who was on her level and someone she could trust. This trust was an important issue for some of the participants.

Trust

Not all participants trusted their speech–language pathologists so fully. For example, Peter described his mistrust of his speech–language pathologist:

My worst day going [to speech and language therapy], was when she promised me to have these pencils I liked, like she said she had them for me, she promised and then when I went she never had them there. She forgot an awful lot of times.

Peter recognized the lack of trust he had in the speech–language pathologist, which contributed to his negativity toward their relationship.

In contrast, Mary expressed trust in the confidentiality of speech–language therapy:

My resource teacher knows my teacher, and I always get the feeling she would talk about me, you know, in the staff room, you never know what they might say. But I know my speech therapist, well she wouldn't say it, she sees lots of people like me anyways. Why would she say it? It's private.

Seannie seemed to trust his speech–language pathologist. He described her as being nice, not mean, someone who would not be shouting at him:

Researcher: So what kind of a person was N? (the clinician)

Seannie: Em . . . She would be very nice.

Researcher: Was she?

Seannie: Yeah. She wouldn't be shouting any time.

Researcher: She wouldn't be shouting at all?

Seannie: Yeah.

Researcher: Wow. How did you know what does 'nice' mean. How did you know she was nice?

Seannie: Because, em, she wouldn't do anything mean.

This trust differential demonstrated how children experienced their relationships with various clinicians. In one case, trust was absent or minimal, while in another, trust was a crucial focus to the bond between therapist and child. However, even Mary, who expressed quite explicit trust in her clinician, said: "I made friends with her, but it was weird; I knew I was never gonna see her again." In other words, the trust between clinician and client may be complicated by the fact that this relationship has an "expiration date."

ROUTINES AND RITUALS

Most of the children in this study discussed the therapeutic process in terms of routines and rituals. For example, some children described arriving to sessions where the speech–language pathologist would welcome them to the clinic, help take their coats, show them to the "little chair," and ask them how they were. In particular, one of the children, Seannie, had high levels of anxiety participating in group therapy and commented on the speech–language pathologist's welcoming actions at his first day attending speech–language therapy and the consistent introductions that followed from week to week:

She would say hello, is it your first time here? I guess you know some of these people . . . you were all introduced, and that was the way it always was.

Seannie was able to detail the opening and closing ritual of the sessions:

Every time I went I had to hang up my coat there, [points] and then I would sit down here . . . It was always the same, and after, I got two stickers, but I didn't put them on my head, I put them in my folder.

Seannie constructed the therapeutic experience around the predictability of these opening and closing rituals. Mary indicated explicitly how her therapist made such rituals enjoyable:

If I get it [pronunciation] right she gives me a sticker, and if I get another right she gives me two stickers, and another right she gives me more stickers. I like getting stickers.

Mary also shared another ritual, which she thought was fun:

She [clinician] was really nice. She thought I was a Supergirl. We used to pretend. She went out and then she'd come back in and she'd be like "Where did you go? Supergirl disappeared with her super powers!"

When taken together, these described rituals revealed the kind of positive rapport that existed between the children and their therapists.

ROLE OF THE SPEECH–LANGUAGE PATHOLOGIST

Not all the children in the current study evidenced a clearly differentiated understanding of the specific professional roles of various people in their lives such as speech–language pathologists, teachers, doctors, and others. Some children described their speech–language pathologist as simply another adult in authority, tasked with teaching and instruction. For example, Richard said the following of his clinician:

> She could have done a few spellings and a few readings, and some maths, and I didn't even get homework . . . . I thought she was not very good for learning me things, I wanted to do spelling and reading and more things for a second class boy.

This child's transcript revealed a feeling of disappointment in the therapeutic experience, which affected his belief in the value of his relationship with the therapist. He said: "I thought she wasn't very good." In fact, he attributed none of his improved outcome to the clinician or the therapy, and commented that he had instead caught up by himself.

Another participant, Peter, was uncertain in distinguishing between his school resource teacher and the speech–language pathologist. He frequently confused the two; and repeatedly asked the researcher to clarify which individual was being referenced, asking, "Oh are you talking about [Name] now?" Similarly, Richard revealed some awareness of the fact that his speech–language pathologist helped him with his speech, but did not differentiate between her and his speech and drama teacher.

Mary was relieved to find that she was not going to have to work hard in therapy:

> And I said 'I'm nervous', and she [child's mother] said 'Don't be nervous' . . . I thought I was going to get hard work . . . and then I went in and it was so much fun . . . and I played this cool game . . .

Mary understood why she needed speech and language therapy:

> . . . when I opened my mouth I didn't know how to say *kitchen*, I said 'picthen,' and I didn't know how to say *pigeon*, I said 'wigeon.'

However, she referred to her speech and drama teacher as her "other therapist," demonstrating an unclear differentiation of each role. Although Mary was pleasantly surprised by the informality and fun of therapy; her expectations of speech–language therapy were similar to those for a teacher. Similarly, other children in the study used the language of the adult world to describe how they had to sit at the table, engage in "work," and do "exercises" and "homework." For example, Mary said, "I didn't like the homework. She gave me really hard homework."

A few children were able to express clearly why they had come for speech–language therapy. The following dialogue from Seannie clearly demonstrates this:

> Researcher: Do you know why you were going to speech and language therapy?
>
> Seannie: Yeah. Cause I couldn't talk better.
>
> Researcher: You couldn't. You had some problems with your talking.
>
> Seannie: Yes.
>
> Researcher: Oh right.
>
> Seannie: Most I couldn't say what 's'.
>
> Researcher: You had some problems with the 's' sound.
>
> Seannie: Yes.

PHYSICAL CHARACTERISTICS OF THE CLINICIAN

Some participants were interested in or remembered the physical characteristics of their speech–language pathologists. For example, Mary said:

> And I didn't like her nails, 'cause they were kinda blacky . . . 'cause her nail polish was blacky and red.

Similarly, when Mary was asked to describe an ideal speech–language pathologist she appeared to value attractive physical qualities:

[She must be] Pretty . . . wear make-up . . . She has grey shoes, grey high heels, I really like them. She has a lovely smile . . . [a] smile is very important.

Likewise, Johnnie said that he would like a speech–language pathologist who was: "Pretty and [who had] spiky hair". Similarly, when Johnnie was asked to describe an ideal therapist, he used the word "pretty."

DISCUSSION

This study elicited children's perceptions of their experiences of speech–language therapy. It, therefore, represents a successful effort to enter into the child's world, as advocated by researchers such as Docherty et al. (1999) and Landreth (2002). Although some of the children found it difficult to reflect on relationships, most were able to share something of theoretical interest to the therapeutic relationship in speech–language pathology. This is relevant, as most existing research on this topic pertains to adult client or speech–language pathologist perspectives (Crane & Copper, 1983; Fourie, 2009; Haynes & Oratio, 1978; Stech et al., 1973).

Specifically, the current study identified a number of themes relevant to therapeutic relationships including "source of play and fun," "power differentials," "trust," "routines and rituals," "role confusion," and "physical characteristics of the clinician." These themes provided a structure for describing the children's experiences of speech–language therapy.

In the life-worlds of most of these children, speech–language therapy was appreciated and positive relationships or bonds were built when activities contained play and fun. Although speech–language pathologists may think about play and fun as vehicles for achieving psycholinguistic goals, our data indicate that play and fun can also be key to building rapport. However, it is interesting to consider Stech and colleagues' (1973) findings that many speech–language clinicians preferred compliant and appropriate clients. It is not difficult to appreciate how such values could conflict with the child's world of play. Nevertheless, most clinicians would recognize the value of meeting children in their own phenomenal worlds. Play, in and of itself, represents the child's innate drive to develop self-regulation, social, emotional, and cognitive development. Clinicians appreciate that play and fun are the media for achieving this natural learning (Bloom & Tinker, 2001; Bodrova & Leong, 2005; Longtin & Gerber, 2008; Vygotsky, 1978).

The data in the current study suggested that activities were generally clinician-led, with the clinician being the initiator and driver of activities. Simmons-Mackie and Damico (2011) reported similar interactional processes between clinicians and adult clients attending for speech–language therapy. More specifically, these authors indicated that such interactions often lead to unnatural sequences of communication in which the clinician exposes the client's errors in a manner characterized as "teaching" (Simmons-Mackie & Damico, 2011, p. 39).

With regard to power differentials, speech–language pathologists inevitably inhabit the powerful role of adult in relation to their child clients. However, relationships that reinforce powerlessness can result in restricted engagement in the therapeutic process (Ferguson & Armstrong, 2004). It is, therefore, relevant to avoid such situations, and to promote the empowerment of the client (Fourie, 2009).

Indeed, this study evidenced that clinicians appeared to offer choices to children, thus providing them with a measure of empowerment over the activities of therapy. This provision of choice by the clinician is relevant to children who naturally occupy the more vulnerable position and who may be more susceptible to a sense of powerlessness because of the presence of a communication disorder (Ferguson & Armstrong, 2004). In addition, some of the potentially deleterious consequences of power differences seemed to be mitigated when children viewed their therapists as confidants and friends. These characterizations of the clinician as a friend are of interest, particularly when considering the reported difficulties of children with

communication disorders in forming and maintaining friendships (Markham et al., 2009).

Not all the children in the current study trusted their clinicians. For example, Peter lost trust in his clinician when she failed to follow up on a promise. Unfortunately, without this trust, children's willingness to cooperate could suffer, thereby undermining the bonds that create the context for achieving therapy goals. When children trust their clinician, they will take risks in therapy (Weiss, 2004). In fact, Weiss reported that risk taking increased children's level of participation in phonology therapy sessions. This, in turn, improved their production of target responses and generalization.

Children's risk-taking likely is associated with their perception of the therapist's consistently accepting responses. This is unlikely to occur in the presence of a perceived threat, or in the absence of safety (Landreth, 2002). Irrespective of the tasks or goals of therapy, this trust relates to the bond between the client and the clinician. Mary's description of her trusting friendship with her clinician demonstrated how she valued the bond as a goal in and of itself, as something desirable for its own sake. It is likely that this bond was effort- and engagement-stimulating, to use the terminology of Bloom and Tinker (2001).

Most of the children were clearly aware of the routines and rituals of therapy. With regard to the rituals of therapy, our results were consistent with prior research that showed that therapists develop routines so that children are able to accurately demarcate boundaries at the beginnings and ends of the therapy sessions, and thus feel more comfortable (Carroll, 2002). Similarly, the consistency of attitude and behavior on the part of the therapist helps children feel secure (Landreth, 2002). Our results from the children's perspectives supported the effectiveness of such procedures.

Children and parents need to agree on the purpose of treatments (Shirk & Saiz, 1992). However, in this study, some children did not understand the purpose of speech–language therapy, and consequently did not understand their own role, or that of the therapist. For example, in the data given previously, Richard indicated that he was not satisfied with his speech–language pathologist, as she did not focus on his curricular goals. In this case, the clinician focused on the client's speech development, as opposed to his curricular needs. This highlights the role conflicts clinicians might need to clarify with clients and their parents.[2] Therefore, the role of each stakeholder in therapy should be made explicit to the other to achieve a therapeutic bond through which the goals and tasks of therapy can be achieved. Indeed, Bunning (2004) indicated that helping children and parents understand the function and purpose of speech and language therapy, may be one of the most important things the clinician does. Speech–language pathologists need to communicate an understanding of what therapy is and what children and parents can expect from their service. Accordingly, McLeod and Bleibe (2004) stated that initial sessions with children should include an introduction to the goals and procedures of speech–language therapy. As part of this process, treatment goals need to be negotiated and agreed upon (Paul & Haugh, 2008).

Although only two of the six children interviewed referred to physical characteristics, these references seem to corroborate Carroll's (2002) observation that children are aware of the appearances and dress of their clinicians. Interestingly, comments about positive physical appearance were associated with characteristics of a positive therapeutic relationship, whereas negative remarks about appearance were associated with a bad clinician.

CONCLUSION

Although not all the children who participated in the current study were able to make explicit the various aspects of the goals, tasks,

[2]In school service delivery in the US, children's speech-language intervention goals must be related to the curriculum, so the role would need to be explained differently.

and bonds of therapy (Bordin, 1979), the researchers were able to elicit and analyze interview data relevant to therapeutic relationships. These interviews and their analysis provide speech–language pathologists with a rare and tentative glimpse into the life-worlds of children attending speech–language therapy. All in all, the participants indicated that they appreciated therapy occurring within the context of fun and play; a context that was egalitarian; a context that was structured through routine; that recognized the personal goals of children; and that occurred in an atmosphere and safety of trust.

Interviews with children in the current study suggested that many of their clinician were able to facilitate rapport by providing an environment of play and fun, by avoiding power differentials, by evoking a sense of trust, and by providing structure through routine.

Although the data in this study are exploratory, the investigation raises interesting questions for reflection with regard to the importance of rapport in terms of clinicians' communicative relationships with children in clinical contexts. Future research might investigate questions such as the following: How important are the apparent components of the therapeutic relationship to psycholinguistic outcomes, and is it possible to measure these? Is it plausible that a failed relationship will result in a failure to achieve the goals and tasks of speech–language therapy? Similarly, is it possible that the bonds of therapy might not sufficiently form when the child does not understand the purposes of therapy; or when the therapist does not understand the priorities of the child? It is our contention that the elements of the therapeutic relationship are essential for achieving psycholinguistic goals and tasks and that a failure to establish and maintain a positive bond with children will likely sabotage these goals and tasks.

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