Parental beliefs and experiences regarding involvement in intervention for their child with speech sound disorder

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Abstract
Parental beliefs and experiences regarding involvement in speech intervention for their child with mild to moderate speech sound disorder (SSD) were explored using multiple, sequential interviews conducted during a course of treatment. Twenty-one interviews were conducted with seven parents of six children with SSD: (1) after their child’s initial assessment, (2) during intervention and (3) at the conclusion of an intervention block. Qualitative analysis of the interviews revealed several factors that influenced the parents’ beliefs and experiences. These included: (1) their motivation to do the right thing by their child; (2) their expectations of parent/professional roles; (3) their interactions with their child in the experience; (4) their interactions with the speech language therapist (SLT); and (5) the nature of the child’s difficulties. The parents in the study wanted to be involved in their child’s intervention but were reluctant to participate in intervention sessions. This preference appeared to be influenced by prior expectations of parent/professional roles and a belief that they would ‘interfere’ in the session. Additionally, whilst they appreciated being asked for their opinion regarding intervention goals and activities, the parents had a preference for the therapist to take the lead. Parental belief in the SLT as the expert influenced this preference, but the SLTs’ beliefs and practice may also have played a role. The less pervasive nature of the child’s difficulties influenced the form of service preferred by the parents. Most particularly, the parents were more eager to work with their child at home and had a more marked preference for intervention sessions with the SLT to focus on their child rather than their family than did parents of children with pervasive disabilities investigated in other studies. The

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findings of the study have implications for how therapists may best work with families of children with less pervasive difficulties in intervention.

**Keywords**
beliefs, families, family-centred practice, intervention, practices, speech sound disorder, speech and language therapist, speech-language pathologist

## I  Introduction

In recent years there has been a significant reorientation of the way in which speech and language therapists (SLTs) and other professionals work with the families of their paediatric clients (Rosenbaum et al., 1998). Traditionally, a therapist-centred approach was employed, in which the therapist both planned and provided the intervention, with little or no involvement from the family (Crais, 1991). Current recommended practice encourages practitioners to work in partnership with parents and families in a family-centred approach to service delivery (King et al., 2004). This model promotes parent involvement in not only intervention provision (such as doing homework activities with their child or participating in the intervention sessions) but also planning (such as involvement in goal-setting) and orients intervention toward the whole family, rather than just the child. Changes to policy internationally now mandate the use of family-centred practice (FCP) in early intervention, creating an imperative for therapists to use this form of service in their practice with parents and families. For example the Individuals with Disabilities Education Act (IDEA) passed in 1990 in the USA extended the role of families in decision-making in intervention for young children and introduced the concept of the family as client rather than solely the child (Wehman, 1998). A similar trend occurred in the UK, with government policy mandating the use of FCP in intervention for children from 1991 (Franck and Callery, 2004). Although no comparable legislation has been passed in Australia (where this study was situated), family-centred policies in individual health and educational services have been developed (Hanna and Rodger, 2002).

Definitions of FCP vary but most include the following components:

1. whole family as client;
2. positive family/professional relationships;
3. empowerment and enablement of families;
4. parental decision-making.

A body of research has been conducted evaluating the acceptability of FCP to both clinicians and families (for a review, see Cunningham and Rosenbaum, 2014; King et al., 2004). However, the majority of research to date has focused on the families of children presenting with pervasive disabilities, such as cerebral palsy. In comparison, limited research has been conducted exploring parents’ perceptions of their involvement in intervention for children with less pervasive difficulties (Watts Pappas et al., 2009). Additionally, the majority of studies conducted have been limited, employing surveys or isolated, structured interviews.

## Parent perceptions of speech and language therapy

Within the field of speech and language therapy (SLT) there is a dearth of literature regarding parent preferences and views (James, 2011). While there is an acknowledgement of the importance of family involvement in intervention for children with speech, language and communication...
needs (SLCN) only a small number of studies have been conducted investigating parents’ perceptions of their involvement in SLT services. Of these, only a few studies have been conducted using more in-depth techniques, such as interviewing (Baxendale et al., 2001; Carroll, 2010; Glogowska and Campbell, 2000; Lyons, O’Malley et al., 2010; Marshall and Goldbart, 2008).

The children in two of these studies presented with pervasive disabilities such as cerebral palsy and intellectual impairment. Marshall and Goldbart (2008) investigated parent’s perceptions of having a child who requires augmentative and alternative communication (AAC). They found that parents varied in the amount of decision-making and involvement they wished to have in their child’s intervention. The extent of their child’s disabilities impacted on their capacity for involvement. Carroll (2010) used a mixed methods approach (focus groups and a survey) to investigate parents’ perceptions and expectations of SLT for their child with intellectual impairment. She found that the majority of parents saw the SLT as the primary provider of intervention in their child’s care and were ambivalent about their own level of involvement.

The studies that have focused on children with developmental delays have found parents to be more eager to be involved in their child’s intervention. However, a common theme was the importance of establishing a shared frame of reference between therapist and parent at the beginning of the therapeutic process. For example, Baxendale et al. (2003) investigated parent perceptions of a parent-training program for children with delayed language. They found that the majority of families had expected therapy would have a 1:1 ratio of child:therapist. Similar findings were reported by Glogowska and Campbell (2000) in their study of 16 parents of children with SLCN who were interviewed at the end of their SLT intervention. Whilst the parents generally viewed their involvement in SLT positively, misunderstandings regarding the type and level of their involvement in the intervention sometimes led to dissatisfaction and disengagement with therapy services. Lyons et al. (2010) interviewed families in focus groups both pre and post SLT intervention. They again found that parents and therapists shared different views and expectations of parental involvement in intervention. Contrary to the principles of FCP, in all of these studies the parents considered the therapist as the primary decision-maker.

2 Parent perceptions of involvement in intervention for speech sound disorders

As mentioned previously, the majority of research investigating parents’ views of early intervention have been located in the disability field, with children with life-long impairments. It is hypothesized that the needs and wishes of these families in relation to intervention for their child may be different to families of children with less significant difficulties. This study therefore, investigated parents’ views of the experience of intervention for their child with what could be considered a less pervasive difficulty, speech sound disorder (SSD). SSD encompasses difficulty with perception, storage and production of speech sounds and includes difficulties with articulation and/or phonology. Whilst intervention for SSD has been reported to account for up to 70% of SLTs’ caseloads (McLeod and Baker, 2014; Watts Pappas et al., 2008), no specific studies of parents’ experiences of intervention for SSD have previously been conducted.

Studies of SLTs’ reported practice in intervention for SSD indicate that the majority involve parents in some way in intervention provision (McLeod and Baker, 2014; Ruggero et al., 2012; Watts Pappas et al., 2008). Furthermore, SLTs report that they believe that family involvement is essential for the success of intervention for SSD (Watts Pappas et al., 2008). Indeed, parent participation is a fundamental component of many intervention approaches used with young children with SSD (e.g. Parents and Children Together; Bowen and Cupples, 1998). To better facilitate parent involvement, it is of value for SLTs to understand what motivates families to be involved in their child’s intervention.
Research to date investigating parents’ views of SLT has been predominantly retrospective in nature, asking parents to reflect back on their experience. Considering previous findings regarding the impact of parent expectations on their involvement and engagement in SLT intervention, this study sought to capture the changing nature of the experience of parental involvement in speech intervention over time. Therefore, parents were interviewed three times over the course of an intervention block: (1) after their child’s assessment, (2) during the intervention, and (3) after the intervention block was completed.

3 Research questions

The following research questions were posed:

1. How are parents involved in their child’s speech intervention?
2. What are parents’ beliefs about and experiences of their involvement in their child’s speech intervention?
3. What influences parents’ choices regarding the way they involve themselves in their child’s intervention?
4. How do the beliefs and experiences of parents of children with SSD receiving intervention compare with the beliefs and experiences of parents of children with more pervasive disabilities?

4 Research design

An interpretivist framework was used to guide the data collection and analysis of this study. Interpretivism is based on the belief that people continually and actively make sense of their life experiences within a cultural framework of socially constructed, negotiated, and shared meanings (Hughes, 2003). The interpretivist framework was chosen for this study as the research asked questions about how parents experienced parental involvement in speech intervention and how their interactions with their SLT, their child and societal expectations of parent/health professional interactions influenced their actions, beliefs, and interpretations of events.

As parental involvement in speech intervention was a relatively new area of inquiry and it was anticipated that exploration of this topic may lead to novel findings, existing theory was not used to guide the design of the study. Rather, an inductive approach (Ezzy, 2002) was employed to allow the researcher to be open to new insights and understandings that may arise during the course of the study.

II Method

1 Participants

Seven parents (six mothers and one father) were recruited for the study by three SLTs who had responded to an advertisement in the monthly newsletter of Speech Pathology Australia, requesting participants for the study. Each family had a child with SSD who was accessing SLT services from a community health clinic. Both father and mother participated in two of the interviews for one child. The parents’ education level varied; one had completed high school only, two parents had or were currently attending a technical college, and three parents had or were currently completing a university degree. All parents had conversational English skills.

The children in focus ranged in age from 3;0 to 5;1 years at the beginning of the study and presented with mild to moderate SSD of unknown origin. Their time on the waiting list for public
(free) services ranged from 5–21 months. Three of the six children had been to see a private SLT whilst waiting for public services. For an outline of information regarding the parents, their child and their SLT, see Table 1. The study was conducted in a state capital city in Australia. The Charles Sturt University Ethics in Human Research Committee approved the proposal. As the study was to be conducted in Queensland Health sites, approval was then sought from the relevant Queensland Research Ethics Committee.

2 Procedure

a Data collection. The parent(s) of each child were interviewed three times over the course of an intervention block for their children’s SSD. An intervention block consisted of a set number of intervention sessions offered to a child after an assessment. As per health centre policy, five of the children attended a block of intervention lasting six sessions, with the sessions conducted weekly, and one child was offered an intervention block of four sessions. To gain an understanding of the parents’ experience over the course of an intervention block for their children, interviews took place at different times. The initial interview took place following the children’s speech-language therapy assessment and before intervention began. The second interview took place during the intervention block, and the final interview took place after completion of the intervention block.

The first author interviewed all of the parents and had no involvement in their intervention. However, the parents did know that the interviewer was a SLT who worked in the same overall organization as the SLTs who provided the intervention. This may have influenced their responses to the interview questions. During the study the key researcher kept a reflective journal, considering after each interview the impact of her own preconceptions and assumptions regarding parental involvement in intervention on her interpretation of the findings and her relationship with the research participants.

The three in-depth interviews followed a list of predetermined topics; however, as Minichiello et al. (1999) suggested, the interviewer also followed the parents’ lead to explore emergent topics. This form of interviewing allowed interviewees to raise their own issues about the topic of inquiry as well as responding to the interviewer’s areas of interest. The interviews focused on the parents’ interpretations of their experience of being involved in speech-language therapy intervention for their child. The duration of the interviews ranged from 45 to 70 minutes and were conducted in the participants’ homes.

As the parents were recruited for the study over time, emergent findings from interviews conducted with the early recruits were used to inform the themes explored in interviews with later-recruited parents. This allowed deepening of insights over time. Additionally, in the second and third interviews conducted for each parent, new probe questions were added to the interview outline in response to some of the tentative themes developed from the first interview. At the final interview a participant validation process (Ezzy, 2002) was employed, in that the developing themes were presented to the parents in a written format and they were asked to clarify whether these themes resonated with their own experience of intervention. This is a common method used to ensure trustworthiness of qualitative research.

b Data analysis. Data were analysed thematically drawing on two approaches: thematic networks analysis (TNA) (Attride-Stirling, 2001) and framework analysis (FA) (Ritchie and Spencer, 1994) as well as incorporating other generally accepted principles of qualitative data analysis such as the commencement of data analysis while subsequent data was being collected. TNA is a data analysis technique that uses coding, abstraction of themes and the formation of visual representations to interpret qualitative data. The unique aspect of the approach that was utilized in this study is the formation of web-like networks to visually represent and aid interpretation of themes derived from
<table>
<thead>
<tr>
<th>Parent interviewed (pseudonyms are used)</th>
<th>Child receiving speech intervention (pseudonyms are used)</th>
<th>Therapist who provided the intervention (pseudonyms are used)</th>
<th>Attended private intervention prior to public intervention</th>
<th>Child’s attributes</th>
<th>Length of wait for service</th>
<th>Work status</th>
<th>Education level</th>
<th>Spouse’s work status</th>
<th>Outcome of intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenna</td>
<td>Kyle</td>
<td>Susan</td>
<td>No</td>
<td>5;1 years; mild speech impairment</td>
<td>21 months</td>
<td>Student</td>
<td>University</td>
<td>No spouse</td>
<td>More intervention required, offered another intervention block</td>
</tr>
<tr>
<td>Rebecca</td>
<td>Eli</td>
<td>Susan</td>
<td>Yes</td>
<td>4.5 yrs; moderate speech impairment</td>
<td>18 months</td>
<td>Home duties</td>
<td>University</td>
<td>Worked full-time as a town planner</td>
<td>No further intervention required - discharged</td>
</tr>
<tr>
<td>Sarah</td>
<td>Jacob</td>
<td>Helen</td>
<td>No</td>
<td>3.9 yrs; mild speech impairment</td>
<td>6 months</td>
<td>Home duties</td>
<td>University</td>
<td>Worked full-time as an architect</td>
<td>More intervention required, offered another intervention block</td>
</tr>
<tr>
<td>Kylie</td>
<td>Lily</td>
<td>Helen</td>
<td>Yes</td>
<td>3.0 years; moderate speech impairment</td>
<td>5 months</td>
<td>Student</td>
<td>University</td>
<td>Business owner</td>
<td>More intervention required, offered another intervention block</td>
</tr>
<tr>
<td>Belinda</td>
<td>Sean</td>
<td>Fran</td>
<td>No</td>
<td>4.7 years; mild speech impairment</td>
<td>6 months</td>
<td>Home duties</td>
<td>Technical college</td>
<td>Worked full-time as a mechanic</td>
<td>No further intervention required - discharged</td>
</tr>
<tr>
<td>Leonie</td>
<td>Brian</td>
<td>Fran</td>
<td>Yes</td>
<td>3.0 years; moderate speech impairment</td>
<td>7 months</td>
<td>Worked full-time as a nurse</td>
<td>University</td>
<td>Spouse of Doug</td>
<td>More intervention required, offered another intervention block</td>
</tr>
<tr>
<td>Doug</td>
<td>Brian</td>
<td>Fran</td>
<td>Yes</td>
<td>3.0 years; moderate speech impairment</td>
<td>7 months</td>
<td>Renovating their house full-time at the time of the study</td>
<td>High school</td>
<td>Spouse of Leonie</td>
<td>More intervention required, offered another intervention block</td>
</tr>
</tbody>
</table>

Table 1. Demographic details of the seven parent participants and their families.
the data. FA is a form of qualitative analysis that was particularly developed for use in applied social policy research. FA uses several techniques for organizing the data according to major themes (such as charting, indexing and mapping). Its focus on using the data to answer specific questions was found to be particularly useful for this study. In combination of these approaches the data analysis involved eight steps.

1. Informal data analysis concurrent with data collection: Unlike the procedure followed in FA and TNA, informal data analysis began during the process of data collection, with key ideas and recurrent themes identified after each interview. Data analysis concurrent with data collection was particularly useful for this study in that the progressive staging of the interviews allowed interpretations of the data from earlier interviews to shape and refine the topics discussed in future interviews.

2. Familiarization with the data: Similar to the approach used in FA the researcher initially became thoroughly familiar with the interviews by repeated reading of the transcripts and listening to the interview tapes. As the data collection took place over a period of 6 months this approach ensured that the researcher had a sense of the data as a whole before beginning more formal data analysis procedures.

3. Initial coding: The transcripts were then analysed for segments of text that related to the research questions. These segments ranged in size from a single sentence to a number of conversational turns. Each segment of text was given a code relating to its meaning in relation to the research questions. The first level codes were descriptive in nature and were grounded in the data as much as possible. In a similar process to the one used in FA, the segments of coded text were also copied from the original transcripts and re-arranged into coding categories in a separate document. In this way, the text being placed into each coding category could be checked to ensure that it was similar to the other segments of text in that code.

4. Reduction of first level codes into broader categories: In a second round of coding, the initial codes were collapsed wherever possible to form the smallest number of categories to represent the data. This is similar to the data reduction process used both in the FA and TNA approaches.

5. Reduction of second-level codes to over-arching themes: Finally, the second-level categories were organized into three over-arching or (as termed in TNA) global themes. As recommended by Attride-Stirling (2001), throughout the process of analysis the statements from the participants were constantly compared to the data in context in the original transcripts to ensure that their original meaning was not lost through the process of coding.

6. Exploration and description of thematic networks: As suggested in TNA, at this stage of the analysis each thematic network was explored and summarized. The three levels of codes were renamed as dimensions, elements and themes to highlight their relationship with each other and the data. While the initial coding had been conducted using a bottom-up approach – reducing a larger number of codes into a smaller number of over-arching categories – the thematic networks were now reanalysed from the top down, considering each theme in relation to its elements and dimensions.

7. Interpretation of patterns between major themes: At this stage of the analysis the three major themes that were derived from the analysis were compared with each other and considered in light of the original research questions and existing theory.

8. Development of visual representations of the findings of the analysis: Finally, similar to the approach used in both FA and TNA, visual representations of the thematic networks were developed to demonstrate their relationship with each other and how they were interpreted in light of the research questions.
III Results and discussion

The analysis of the data revealed three major themes: ‘doing the right thing by my child’, ‘factors impacting on the intervention’ and ‘reflecting on the experience of speech intervention’ (for a summary of the themes, see Table 2). These are presented below with their component elements and dimensions, and illustrated with exemplar quotes from the parents’ interviews. Pseudonyms are used for the therapists, parents and their children as indicated in Table 1.

1 Theme 1: Doing the right thing by my child

The overriding motivation for and lens through which the parents appeared to view their involvement in their child’s speech intervention was the desire to:

    do the right thing by your kid. (Kylie)

Other researchers have spoken about similar themes in parents’ experiences of early intervention (Kolehmainen et al., 2010; Piggot et al., 2003; Thompson, 1998). For example, Piggot et al. (2003) researched the experience of physiotherapy and occupational therapy intervention for the mothers of children with cerebral palsy. The authors articulated the parents’ efforts to access and be involved in intervention for their child as a ‘compelling challenge to do all they can for their child’ (p. 12). In the current study, the parents’ desire to do the right thing by their child appeared to be influenced by three factors:

- concern about timely intervention for one’s child;
- using the SLT’s expertise;
- parent involvement: doing whatever it takes.

2 Theme 2: Factors impacting on the intervention

3 Theme 3: Reflecting on the experience of speech intervention

Table 2. Overview of themes from the parent interviews.

<table>
<thead>
<tr>
<th>Theme 1: Doing the right thing by my child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element 1: Concern about timely intervention for my child</td>
</tr>
<tr>
<td>Element 2: Using the SLT’s expertise</td>
</tr>
<tr>
<td>Element 3: Parent involvement – doing whatever it takes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2: Factors impacting on the intervention</th>
</tr>
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<tbody>
<tr>
<td>Element 1: Child factors</td>
</tr>
<tr>
<td>Element 2: SLT factors</td>
</tr>
<tr>
<td>• Dimension 1: Responsiveness to child</td>
</tr>
<tr>
<td>• Dimension 2: Respect for parent knowledge and opinions</td>
</tr>
<tr>
<td>• Dimension 3: Approachability</td>
</tr>
<tr>
<td>• Dimension 4: Communicative effectiveness</td>
</tr>
<tr>
<td>• Dimension 5: Technical competence</td>
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<tr>
<td>• Dimension 6: Support for parental involvement</td>
</tr>
<tr>
<td>Element 3: Intervention service factors</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Theme 3: Reflecting on the experience of speech intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element 1: Extent and nature of involvement</td>
</tr>
<tr>
<td>Element 2: Expectations and response to involvement</td>
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</tbody>
</table>
particularly concerned about remediating their child’s difficulties before they began formal schooling. As Belinda reflected:

That was the most important thing for me, you know to have him ready for school.

This concern about the timeliness of intervention is a common theme in studies exploring parents’ feelings about early intervention (Kolehmainen et al., 2010; Ruggero et al., 2012).

b Using the SLT’s expertise. The parents felt unable to support their children’s speech on their own and wanted to utilize the expertise of a professional. Part of the parents’ wish to do the right thing by their child was to access this expert help and then to make the most of the help when they received it. They felt that the most important role of the SLT was to work with and ‘fix’ (Sarah) their child. The way the parents saw the SLT operationalizing this role was to work with their child in the intervention sessions. Jenna in particular seemed to indicate that this was the SLT’s responsibility in the therapeutic process:

When we go there … I let Susan do the work, it’s not so much that’s what she’s paid for, it’s not what I mean, but she’s the speech pathologist [SLT], so she’s to do the work.

This finding has considerable similarities with other studies of parent perception. For example, Glogowska and Campbell (2000) noted that the parents in their study appeared to have an expectation that the therapist would provide the majority of the treatment required in 1:1 sessions, and Lyons et al. (2010) reported that the parents in their study expected to have an ‘observational’ role only in the intervention sessions.

Although some parents appreciated being asked for their input, they all appeared happy to follow their SLT’s lead in the intervention. This may have been motivated by a desire to utilize the SLT’s expertise. The parents felt they lacked the skills to make the decisions themselves, and resisted a primary decision-making role. Rebecca encapsulated this belief:

Because that’s why you go to an expert, that’s why I’m there, to get help, so when she said to me ‘don’t touch “k”’, I was very happy not to touch “k” … I don’t want that responsibility.

When asked if they felt if they were in a partnership with their SLT many parents answered in the affirmative. However, they still saw the SLT as taking the lead role in the relationship.

c Parent involvement: Doing whatever it takes. Although this may not be the case for all parents of children receiving intervention for SSD, the parents in this study strongly believed that it was their responsibility to ‘do whatever it takes’ (Rebecca) to help their child with their speech difficulty. The parents saw their involvement as an important part of the intervention. Although they felt it was the SLTs’ role to work with their child in the intervention sessions, they believed it was the parents’ role and responsibility to actively observe the treatment sessions and work with the child at home. As Doug said:

You can’t expect him to do it once and then OK, I’ve learnt that.

It is acknowledged that parents who choose to participate in research may not be typical. However, the current participants’ satisfaction with the level of their involvement was different from that found in some other studies of parental involvement in intervention in which parents’ feelings of being overwhelmed with home practice formed a major theme in their experience (Case-Smith and
One of the possible reasons for this observed difference in parental perceptions of involvement may have been the nature of the children’s difficulties. The majority of studies that have reported parental concern about participation in their child’s intervention have involved children with pervasive disabilities, who may require a large amount of daily care and long-term intervention. In contrast, although in some cases SSD can be associated with long-term difficulties (Felsenfeld et al., 1994), the parents in this study appeared to see their child’s difficulty as something that was short term and ‘fixable’, and indeed two of the children in the study required no further intervention after their intervention block. For example, Leonie said:

that was clear to me too, that I wasn’t dealing with a problem that was going to be a lifelong thing.

The expected short-term nature of the intervention may have increased the parents’ motivation to work at home with their children.

2  **Theme 2: Factors impacting on the intervention**

During data analysis it became apparent that many factors impacted on the parents’ experience of speech-language therapy, both positively and negatively. These encompassed the parents’ interactions with their children and their SLT as well as aspects of the intervention service.

a  **Child factors.** Children’s individual responses to the intervention sessions and home practice impacted greatly on their parents’ experience of speech-language therapy and affected the way the parents acted in the experience. As a rule, the children mostly enjoyed attending the intervention sessions:

so in the actual sessions he loved it. (Sarah)

However, some of the children had negative responses to the intervention sessions. For example, Belinda’s child Sean initially did not want to attend speech-language therapy as:

he said he was stupid that he was doing it.

When children were uncooperative with homework activities or were non-compliant in the intervention sessions, the parents needed to increase their involvement and problem-solve to facilitate their children’s participation. Their children’s reaction to the intervention also appeared to influence the parents’ overall satisfaction with the service. When the children perceived the intervention as negative, on some occasions the parents also perceived the intervention negatively. The desire to ensure that the therapy was a positive experience was so compelling that one parent, Kylie, told a story of how she had discontinued private speech-language therapy after her child had a very negative experience with that SLT:

She [the child] hated it, she was so offended … I’ll never forget her face in her hands and just absolutely sobbing, and it was the saddest moment. Yeah it was so sad and she was going, ‘I have good words.’

This finding has also been reported in the literature (Carroll, 2010; Forsingdal et al., 2013; Kolehmainen et al., 2010; Washington et al., 2012). Facilitation of the child’s compliance with and enjoyment of speech intervention may subsequently increase parental satisfaction and attendance.
at therapy sessions. If children interpret speech intervention as positive, parents may also feel more positive about their own involvement in the intervention.

b Speech and language therapy factors. The factor mentioned most often by the parents when describing their experience of and satisfaction with their children’s speech-language therapy intervention concerned the qualities (particularly interpersonal skills) of their SLT. When asked to consider their relationship with their SLT and what they would consider to be partnership builders or blockers, the parents described a number of major relational competencies or skills that contributed to the formation of a parent/professional partnership. This element contains six dimensions and each are presented in turn below.

1. Responsiveness to child. The most important relationship builder for the parents was the ‘SLT’s attitude to your child, that’s probably the biggest thing’ (Rebecca). The parents’ wish to ensure that the speech intervention was a positive experience for their child meant that the SLTs’ ability to establish professional/child rapport was of paramount importance.

2. Respect for parents’ knowledge and opinions. Many of the parents highlighted that ‘it’s important [for the SLT] to just listen to the parents’ (Jenna). When the parents had negative experiences with SLTs, many of those experiences related to the SLTs’ lack of respect for the parents’ input. For example, Leonie spoke about her visit to a private SLT in which she felt: there was very little input from me, she just sort of took it and asked him to say words and played games but didn’t ask me much at all.

3. Approachability. When asked about what was important to them in their relationship with their SLT, many of the parents made comments about how friendly and caring their SLT was. The parents appreciated when their SLT was professional, but at the same time personable, ‘a real person, not condescending’ (Leonie), and when they made them feel comfortable to share information.

4. Communicative effectiveness. The SLTs’ ability to communicate with the parents was an important factor in the parents’ experience of the intervention. The parents appreciated their SLT taking the time to keep them informed about what they were doing in the intervention. Sarah particularly spoke about the importance of the SLT explaining things to parents in a way they can understand, stating:

when you know it and it’s language you use all the time, you probably don’t realize that you’re doing it, because that’s the way you speak, but it’s not the way parents speak.

5. Technical competence. The perceived competence of the SLT was important to the parents. They spoke about how:

you gain confidence in the therapist if you know that they are confident in what they’re doing. (Jenna)

6. Support for parental involvement. All of the parents believed that working with their child at home was an essential part of the intervention. However, doing the homework was made a lot ‘easier’ (Belinda) when the SLT gave activities and games to support the work at home. When Rebecca went to her private SLT she was given limited resources for home:

And homework was like one sheet with 10 words on it … so you’re thinking he knows the sheet in his sleep … I didn’t sort of think it was necessarily helping him.
The SLTs’ support of the parents’ endeavours to fulfil their desired role of working with their child at home was important to the parents and impacted on the way they were able to involve themselves in their child’s intervention. Parental involvement could potentially be limited therefore by a lack of support and explanation for home activities.

The importance of professionals’ interpersonal skills have been highlighted in many other studies of parents’ perceptions of early intervention (for a review, see Washington et al., 2012) and are an important consideration with regards to parent engagement and involvement in intervention.

c Intervention service factors. Aspects of the intervention service appeared to be another influential factor in the parents’ experience of speech-language therapy. For example, the parents were dissatisfied with what they perceived to be lengthy waiting times and the provision of limited intervention sessions. The parents experienced various waits for service from approximately three months for Kylie to 21 months for Jenna. All of the parents were initially offered a block of 4–6 sessions. Waiting for services was frustrating for the parents who ‘[didn’t] understand why they have to wait that long’ (Leonie). Three of the parents accessed private speech therapy for their children while waiting for public services because, as Rebecca put it:

I just don’t want to wait and wait and wait.

This study was not unique in this finding. Other studies of parent’s perceptions of SLT services in both Australia (Ruggero et al., 2012) and the UK (Bercow, 2008) have found that families are dissatisfied with aspects of service delivery such as waiting times and the amount and type of service provided. It is unclear how the experience of a long wait before accessing intervention might impact on parents’ perceptions of the service and their willingness to be involved in the intervention.

3 Theme 3: Reflecting on the experience of speech intervention

Throughout the interviews, the parents were asked about how they expected to be involved in the intervention, how they were actually involved, and their feelings about that involvement.

a Extent and nature of involvement. The parents reported a number of ways in which they were involved in both intervention planning and provision for their child. Each of the interviewed parents attended their child’s intervention and assessment sessions. However, parental involvement in these sessions was generally limited. Only Jenna and Rebecca, who both saw the same SLT, Susan, were asked to participate in the intervention sessions briefly by demonstrating the homework they had completed with their children during the week. The other parents reported that although they sometimes sat at the table with their child it was ‘mainly me just watching them’ (Kylie) rather than participating in the intervention session. The main way in which all of the parents were involved in their child’s intervention was by doing home practice activities.

The majority of the parents in the study were not involved in goal-setting for their child’s intervention or given a choice about the activities for the intervention sessions. The exception was Helen, the SLT who worked with Sarah and Kylie, who they reported involved them in the decision-making process. The parents’ reports of how they were involved in their child’s intervention indicated that the three SLTs who worked with the seven parents involved the parents in the intervention in slightly different ways. Each of the SLTs worked in a similar way with the parents of the two children they served. It is possible that the way the parents were involved in the intervention was influenced by the SLTs’ as well as the parents’ preference. It may be
worthwhile for SLTs to consider whether their own form of practice is potentially limiting parent involvement in intervention. Some parents may be willing to be more involved in their child’s intervention if they are given the opportunity and support to do so.

b Expectations of and response to involvement. Before they attended speech-language therapy, many of the parents did not expect to be overly involved in speech intervention for their child, other than to do home activities. They believed that it was the SLTs’ role to work with their child in the intervention sessions and to provide guidance about intervention goals and activities. Particularly, the parents seemed disinclined to participate in the intervention sessions. When asked about why they preferred to observe rather than participate, the parents indicated they did not want to ‘interfere’ (Jenna) with the therapy or ‘get in the way’ (Doug) of the SLT.

Similar beliefs and expectations about parent/professional roles have been reported in other studies of parents’ experiences of paediatric allied health intervention (Glogowska and Campbell, 2000; Thompson, 1998). Ruggero et al. (2012: 347) suggested that many parents hold a belief that 1:1 intervention between the therapist and child is the ‘gold standard’ of therapy provision. The foundation for these beliefs may have been previous exposure to health care services. The parents’ expectations of what role they would play in the intervention may have affected the intervention role they actually took or their satisfaction with the role they played. As noted by Simeonsson et al. (1995), parents’ satisfaction with services may be linked to their expectations of how these services compare with the actual experience. Parents may be reluctant to be involved in the intervention in ways that they do not perceive as part of their role. This may mean that if SLTs wish to involve parents and families in the intervention they may need to spend some time discussing expectations and benefits of involvement at the beginning of the intervention process.

None of the parents in this study was provided with what could be termed truly family-centred intervention, but all reported that they were satisfied with their level of involvement and the service they received. In fact, as in a number of other studies of parents’ perceptions of their involvement in their child’s intervention (Carroll, 2010; Glogowska and Campbell, 2000; Lyons et al., 2010; Piggot et al., 2003; Ruggero et al., 2012; Thompson, 1998), although the parents valued respectful and supportive care, some of the elements of FCP – such as parents as the primary decision-makers and a focus of services on the family rather than just the child – were not desired by the parents. For example, Sarah, who was involved in the intervention decision-making, still indicated that she preferred the SLT to take the lead (in this quote she is responding to some of the proposed initial themes presented to her at the final interview):

I don’t really think that I would know what suggestions to make. It comes back to this important one over here, ‘Happy for therapist to choose goals.’

Similarly, Ruggero et al. (2012) found that involvement in goal-setting did not significantly affect parental satisfaction with SLT services. These perceptions may be due to a dependence on their SLT for expert advice. Factors described previously, such as beliefs about parent/professional roles and the SLTs’ own form of practice, may also have affected the parents’ views about the model of practice they received. Another factor that may have had an impact on the parents’ views was the less-pervasive nature of the children’s difficulties in this study. One parent likened the relationship with the SLT to that with a mechanic.

Doug: To me it’s just like going to the quack [doctor] you know. You go along and you say you know ‘the kid’s got these symptoms’ and you let the quack deal with it. You go home and do these exercises, take this or do that. As for being partners, I don’t know about that.
Interviewer: and would you like it to be a partnership?
Doug: Well, I don’t see how it can be a partnership when you’re dealing with professional people. It’s their job, you can’t tell them what to do. You can’t take your car to the mechanic and be a partner with the mechanic, can you?

Overall, although the parents strongly believed in the importance of their involvement in intervention provision and valued being asked for their opinion about intervention planning, they wanted the SLT to assume the responsibility for setting goals and formulating intervention activities for their child. They did not report that their lack of involvement in the sessions and goal-setting was disempowering, rather that it was the most efficient way to utilize a finite service. As long as the parents trusted and liked their SLTs they were satisfied to allow them to go about ‘fixing’ their child.

IV Clinical implications

The findings of this study raise some interesting practice issues for SLTs. First, the fact that some parents resisted being involved in the intervention sessions may be problematic if SLTs wish to use forms of intervention that rely on family involvement in sessions for their success, such as intervention provided in the form of parent group training sessions. If family involvement in intervention is the goal, then therapists need to consider how best to engage parents.

This study has identified several factors that may influence how parents choose to involve themselves in intervention for their child. From these findings several strategies that SLTs could use to encourage parents to participate in intervention are suggested. These include establishing the parents’ trust in the SLT’s competence, providing parents with appropriate and family-specific resources and training to work with their child, facilitating the child’s positive experience of the intervention and ensuring that the SLT’s form of practice gives parents the opportunity to be involved. In particular, prior discussion of anticipated parent/professional roles in the intervention might facilitate a shared understanding regarding expected levels of involvement. It has been suggested that rather than attempt to pressure ‘compliance’ with involvement in intervention, therapists should ensure that treatment activities match the families’ goals for their child, as this is what will motivate their participation (Novak, 2011: 211). Discussing with parents the benefits to their child of parent involvement is suggested as one of the most important strategies to engage families in their child’s intervention.

Second, as highlighted in other studies of parents’ views of speech-language therapy, the parents in this study did not seek out a primary decision-making role and in some cases actively resisted the suggestion that they should be involved in goal-setting for their child. This raises the question: Should SLTs insist on family involvement in decision-making or does being family-centred mean accepting the families’ choice regarding the level of their involvement? Forsingdal et al. (2013: 587) investigated family involvement in goal-setting in a community clinic. They found that families varied in the roles they took in the goal-setting process from ‘dependent’ to ‘collaborator’, and that their level of involvement increased as they became more familiar with intervention services. Whilst all families may not want to be intimately involved in the specifics of goal-setting, this feeling may change over time. It is suggested that rather than expecting families to automatically assume a primary decision-making role, SLTs need to be aware of the potentially dynamic nature of parental interest in participation and follow the families’ lead regarding their readiness and interest in involvement in decision-making for their child.
V Conclusions

This study set out to answer four questions:

1. How are parents involved in their child’s speech intervention?
2. What are parents’ beliefs about and experiences of their involvement in their child’s speech intervention?
3. What influences parents’ choices regarding the way they involve themselves in their child’s intervention?
4. How do the beliefs and experiences of parents of children with SSD receiving intervention compare with the beliefs and experiences of parents of children with more pervasive disabilities?

It was found that the parents in this study were primarily involved in the provision of intervention rather than planning, in a predominantly therapist-centred model of practice. The parents all reported that they were satisfied with their level of involvement. Whilst they felt that their involvement in their child’s intervention was important, they were reluctant to participate in intervention sessions. Additionally, although they appreciated being asked for their opinion regarding intervention goals and activities, the parents had a preference for the SLT to take the lead. The parents’ choices regarding the extent of their involvement in their child’s intervention appeared to be influenced by several factors:

- the parents’ motivation to do the right thing by their child and do ‘whatever it takes’ to remediate the child’s difficulty;
- the parents’ beliefs and prior expectations of parent/professional roles;
- their child’s response to the intervention; and
- the SLTs’ ability to form positive parent–child relationships and to provide the opportunity and support for the family to be involved.

The nature of their child’s difficulty appeared to influence the parents’ actions in the intervention experience: the parents were more willing to be involved in home activities and had a more marked preference for intervention to focus on their child rather than their family than did parents of children with pervasive disabilities investigated in other studies. Families of children with less pervasive difficulties may be satisfied with a more child-focused, therapist-led approach than is suggested by FCP. Being family-centred may mean accepting the families’ wishes regarding the level of involvement they want to have in their child’s intervention whilst providing support and opportunity for further involvement if and when the family is ready.

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