Collaboration between Speech and language therapists and parents of children with Developmental language disorders

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Abstract

Title: Collaboration between Speech and language therapists and parents of children with Developmental language disorders

Background: Collaboration between healthcare professionals and parents of children with disorders, improves therapy outcomes for the child and the family. Healthcare professionals, including speech and language therapists (SLTs), experience challenges in this collaboration. Besides, it is unknow if speech and language therapists collaborate with parents of children with developmental language disorders.

Aim: To understand SLTs' approach and rationale when collaborating with parents of children with DLD between 2 to 6 years old

Method: Individual interviews with SLTs were conducted through video calling. Analysis was performed according to the steps of thematic analysis.

Results: Twelve interviews were conducted. SLTs approach in collaboration is to exchange information and to make decisions. Their rationale for this approach is based on their knowledge, experience, beliefs and assumptions, and parents characteristics.

Conclusion: SLTs approach when collaborating with parents, is providing parents with information on therapy goals and therapy planning. In addition, to improve collaboration, SLTs can change their attitudes towards participation of parents, and empower parents to make shared decisions in goal setting and therapy planning.

Recommendations: For SLTs to focus on asking information from parents, and empower parents to make shared decisions in goal setting and therapy planning

Keywords: collaboration, speech language therapy, primary care, developmental language disorder, preschool children

Samenvatting

Titel: Samenwerking tussen logopedisten en ouders van kinderen met taalontwikkelingsstoornissen

Achtergrond: Samenwerking tussen zorgprofessionals en ouders van kinderen met een aandoening verbetert de therapieresultaten voor het kind en het gezin. Zorgprofessionals, waaronder logopedisten, ervaren uitdagingen in deze samenwerking. Daarnaast is het niet zeker of logopedisten samenwerken met ouders van kinderen met een taalontwikkelingsstoornis.

Doel: De aanpak en motivatie van logopedisten begrijpen, wanneer ze samenwerken met ouders van kinderen met een taalontwikkelingsstoornis van 2 – 6 jaar.

Methode: Individuele interviews met logopedisten zijn afgenomen door te videobellen. Data analyse is uitgevoerd volgens de stappen van thematische analyse.

Resultaten: Er zijn twaalf interviews uitgevoerd. De aanpak van logopedisten in de samenwerking met ouders is om informatie uit te wisselen en beslissingen te nemen. Hun rationale voor deze aanpak is gebaseerd op hun kennis, ervaring, overtuigingen en aannames, en op kenmerken van ouders.

Conclusie: De aanpak van logopedisten in samenwerking met ouders, is ouders voorzien van informatie over therapiedoelen en therapieplanning. Om de samenwerking te verbeteren, kunnen logopedisten hun houding ten opzichte van de participatie van ouders veranderen en ouders in staat stellen mee te beslissen over therapiedoelen en therapieplanning.

Aanbevelingen: Logopedisten kunnen zich focussen op het verkrijgen van informatie bij ouders en het in staat stellen van ouders om deel te nemen in het maken van beslissingen, het opstellen van doelen en het plannen van de therapie.

Trefwoorden: samenwerking, logopedie, eerstelijnszorg, taalontwikkelingsstoornis, jonge kinderen

Introduction

Developmental language disorders (DLD) denotes disorders in speaking and understanding language, without apparent cause.[1] Prevalence of DLD in preschool children is about 7%.[2] DLD has negative effects on the social, emotional and cognitive functioning of children[3,4] which continues throughout their adult life.[5] DLD affects the child's family in communicating and building a relationship with the child.[3,4,5] The speech and language therapist (SLT) can be consulted in order to assess and treat children with DLD.

Family centred care (FCC) is identified as an essential approach in therapy for children.[6,7,8,9] FCC gives the family a central role in the treatment of a child, focussing on their strengths and possibilites.[8,10,11,12] Studies comparing FCC with usual care show positive effects of FCC in treatment of children in several domains, e.g. health improvements, more efficient use of healthcare services, improved family functioning, communication, and access to care.[13,14,15,16,17] One core aspect of FCC is collaboration between HCPs and the child's family,[6] which optimizes therapy outcomes.[18] Collaboration consists of meeting families' needs, sharing responsibility for choosing and implementing interventions, and empower families to make informed decisions.[19] Delivering collaborative service, creates more interaction between HCPs and parents, increases parent participation,[18] improves families' ability to control the child's care plan,[6] and optimizes therapy outcomes for the child and their family.[19]

Despite the benefits of collaboration, SLTs experience difficulties involving families in therapy. Australian SLTs indicate in a survey, to use a therapist-centred approach when planning therapy.[20] With this approach, SLTs retain control over the direction of intervention and parents have limited control about the extent to which they are involved in therapy.[20] As priority is given to care goals of healthcare professionals (HCPs), collaboration will continue to be challenging.[21] SLTs experience difficulties in dealing with different attitudes, cultures, expectations, understanding of roles, and to address families' needs and concerns.[22] Besides, parents' involvement in therapy is adversely affected when parents cope with physical barriers such as time and traveling distance, biopsychological problems as illness, and financial problems.[23,24,22]

Collaboration between SLTs and parents is needed in the treatment of children with DLD,[23] because the language development of a child is affected by the way parents interact.[25] Parent engagement can be more critical to therapy success than the child's engagement.[24] In the Netherlands, parent participation in their child's therapy is considered necessary. At the initiative of the Dutch professional association for speech and language therapy, Dutch parents must attend 50 percent of SLT sessions, to increase parent participation.[26] The methodology of Dutch SLTs sessions begins with intake and anamnesis, followed by assessment. When speech and language therapy is indicated, a care plan is

made and discussed, and therapy is given.[27] Discussing the child's care plan is an important session, as decisions made here determine therapy course. According to An et al.[19] discussing the child's care plan with parents contains several steps of collaboration, that is (1) mutually agreed-upon goals and (2) shared planning. Collaboration is essential in developing a child's care plan.[6] It is unknown if SLTs collaborate with parents in this session.

Although the need for collaboration has been demonstrated, it remains unclear if SLTs collaborate with parents when discussing the child's care plan. To establish whether SLTs collaborate, and with what approach and rationale, the state of current practice needs to be explored. If the current approach and rationale of SLTs is known, improvements can be made in order to optimize therapy outcomes for children with DLD.

Aim

The purpose of this study is to understand SLTs' approach and rationale, when collaborating with parents of children with DLD between 2 to 6 years old.

Method

Design

A qualitative design was performed, because qualitative research aims to describe and understand what is going on in the field.[28] This corresponds with the aim of this study, to describe how SLTs apply FCC and to understand SLTs' motivation. Individual interviews with SLTs were conducted, to provide insight in perspectives and experiences of participants,[28] when collaborating with parents. Initially, observations should be made before conducting face to face interviews. Due to the Corona crisis, observations lapsed and interviews were conducted by video calling. Data gathered through video calling is as valuable and useful as data gathered by face to face interviews. Video calling is a viable alternative.[29] Interviews were conducted in March and April 2020.

Participants

The study was opened to Dutch SLTs working in primary care with children from 2-6 years with DLD. SLTs were eligible if they had at least two years of work experience as an SLT. SLTs were excluded when already participating in the study COMPLETE. Invitations to participate were posted on social media, including LinkedIn and a Facebook page for Dutch SLTs. Additionally, SLTs known by the investigators were approached by email. Interested SLTs received an information letter. If needed, additional information was given by telephone or email. A sample size of twelve participants was aimed for, based on considerations regarding the narrow study aim, specific participants for this aim, support of theory, and a strong quality of interview dialogue.[30] Twenty-nine SLTs were willing to participate. Twelve were unable to participate for the following reasons: no suitable case (6), no time (4), unknown (2). Of the remaining SLTs, twelve were selected through purposive sampling, based on their years of work experience, because years of work experience could influence the way SLTs involve parents in the therapy of their child.[23]

Data collection

Participants prepared to talk about their most recent session of discussing a child's care plan with parents of a child with DLD from 2-6 years. Before the current therapy period, participants had not known parents. Talking about a particular parent in a particular session densifies specificity, and thereby increases information power.[30] All interviews were conducted by SB, through video calling using Whereby.[31] Interviews were audio recorded. The researcher built rapport with the participant before the interview started. Interviews were semi-structured, using an interview guide, based on elements of collaboration[19] (Appendix A). Questions were pilot tested with SLTs twice, which led to the interviewer taking more time to build rapport. The interviews took an average time of fifty-five minutes.

Data analysis

Data analysis was performed according to the steps of thematic analysis by Braun &

Clarke.[32] Recordings were transcribed verbatim by SB. Part of the first interviews was coded by SB and IK together. A second part of the interviews was coded separately by SB and IK, and compared. Further interviews were coded, and themes were derived from data, by SB. Analysis was reviewed by IK at each step. Disagreements were discussed until consensus was reached. An iterative process was followed, of reading transcribed data, and identifying and refining themes. Interviews were transcribed directly where possible, for the researcher to be aware of emerged data in following interviews. Inductive thematic saturation was aimed for.[33] Member checks were conducted, to verify results and add credibility to data[28], by sending participants a summary of the interview. By doing this, the researchers' first interpretation on most important information was checked with participants. Comments were taken into account, and did not affect codes and themes. Quotes were translated from Dutch. To ensure meaning, quotes were translated back, and checked by a native English speaker. To preserve participants' anonymity, pseudonyms are used instead of their names, and years of work experience is presented in ranges. Data analysis was performed using Atlas.ti version software[34]. Analysis of the last interview did not lead to new codes or themes. Inductive thematic saturation is reached.[33]

Ethical issues

This study is conducted according to the principles of the Declaration of Helsinki.[35] The study protocol was approved by the Ethics Committee Health Domain from the University of Applied Sciences in Utrecht. Participants provided audio recorded spoken informed consent. Privacy during video calling is ensured, because the program Whereby[31] is compliant with the European General Data Protection Regulation (GDPR).[36]

Results

Participants

Twelve female SLTs participated in this study. Demographic characteristics are presented in Table 1. In all sessions of discussing the child's care plan, that SLTs talked about, mothers were present. In two sessions the father was present as well.

Insert Table 1

Findings

An overview of the results is shown in Figure 1. The overall rationale to collaborate with parents, mentioned by all SLTs, is to optimize therapy outcomes for the child. Besides, SLTs rationale for their approach consists of two themes. SLTs competence will be described first. Secondly, SLTs response to the parent in front of her will be described. Based on this parent, SLTs make assumptions. The rationale leads to the approach SLTs use of exchanging information, consisting of providing information and asking for information, and making decisions. SLTs approach is described at the corresponding rationale.

Insert Figure 1

Competence. Initially, the approach SLTs use is based on their competence, consisting of knowledge, experience, beliefs and assumptions, which is described respectively.

Knowledge. Nearly all SLTs say their role in therapy is to be the expert, because they know the way language develops, and the best way to stimulate language.

Making decisions and providing information. Expert knowledge leads for all SLTs to deciding on therapy goals, and explaining to parents how to stimulate the child's language.

> I do not think the parent can do it [set goals]. I think that is where our expertise really lies. Our expertise really lies in accompanying the parent in the process that is important for the child. (Ingrid)

> We know which exercise works and they do not. (Stefanie)

Experience. SLTs do not know in advance how therapy will proceed, and how the child will develop. Their approach in providing information, and the amount and specificity of goals is based on this experience.

Providing information. Some SLTs make choices regarding which information to provide. A few SLTs share all information from the beginning, others want to see how the child develops, or want to build a relationship with parents first, before sharing observations.

> I actually share everything. Mmm, things that I do not share [thinking]… no, no, I did that once in a case in the past, not being open and transparent, and that, that did not work. Then, then at some point you are like oops, I am, I had quite a few concerns about that case, and I could not share that with parents, because I had never shared that with parents previously. So since then I said, you have to be honest and transparent, also for things that you see, that are more negative, or things that do not work. (Maaike)

> I am not going to indicate the first time that I think there is a very serious problem, I am not going to say that the first time. And that is because I just uh, parents uh, yeah, I want to have a better relationship with the parents before I discuss that.(Marleen)

Most SLTs present test results to parents in a standard way. Nearly all SLTs tell a standard therapy term, frequency and time for practicing at home. A few SLTs do not name roles, because they know from experience that this comes naturally. Other SLTs tell parents what is expected from them.

> I never show the form, I show uh, actually I always show that curve you know, that normal curve. And uh, then yeah, then I never actually say he scores this or he scores that, but I show it, look, this is average and he is about here, this box. (Ingrid)

> Yeah, I expect parents to focus for about twenty minutes every day and to do a speech therapy exercise, which is, yes, that is discussed with them. (Annemarie)

All SLTs make end goals, most SLTs make sub goals too. Which goals they discuss with parents differs. Based on their experience of not knowing how the child will develop, most SLTs decide to set a few sub goals, that are not too specific.

> I do not always set a fixed timeline for all children, that they must have reached a goal within that time. So, I am not really into the set timelines. You have to do it officially, and [laughs] of course I do have an end goal and I want to achieve that within three months, but um, I have noticed that for most children it does not usually work that way. (Francien)

> I think for a child with language problems, that it is not very useful at first, to set a lot of uh, sub goals. Because you do not know at all, because I only know what a child will learn and how quickly he will learn when I give him therapy. (Ingrid)

Beliefs. All SLTs believe parents should be involved in therapy, to optimize therapy outcomes.

Providing information. Some SLTs believe it is their job to give information, not to ask for it. They decide what information to provide to parents.

> As a speech therapist of course, partly, you are someone who provides information. Um, because it cannot be that I ask yes, what do you actually want to know about [name child]. Sorry, but that does not work. (Stefanie)

A number of SLTs believe it is parents' right to have all information about their child. These SLTs let parents read files and reports or they tell parents everything they think of about the child.

> A parent is simply entitled to inspect the file of his child, certainly a care plan, just turn the screen, let them read along and state that this is what is says. (Marleen)

Asking for information. All SLTs ask information from parents, because they believe this is important for therapy progress. All SLTs ask parents about their expectations of therapy, some SLTs also ask parents about their needs. A few SLTs believe parents are the experts of their child, and ask them about the child's character, interests, and what parents think works with their child.

> I ask her about her daughters' interests, what does she like, and based on that, I choose themes to practice sentence structure exercises. (Annemarie)

Assumptions. All SLTs make assumptions about how parents feel, what parents want, what parents are able to do, or what parents understand.

Exchanging information. Some SLTs assume parents are insecure. The approach of these SLTs is to talk with the parent and turn their worries into something positive.

> For her own feelings and also for her uncertainty, which I already noticed, am I doing things right and uh, that is why I wanted to tell her yes, you made a choice which seemed best for you at the moment, and now, we cannot go back in time to that moment to reconsider it, so we are going to do it now, uh, we are going to work from the current situation and look ahead what would be smart and logical. (Sara)

Providing information. Several SLTs give parents advice, exercises and information, based on their assumptions of what parents want, what parent understand and what parents can handle.

> But I think, parents do not need to know this, language comprehension score fifty-five, that does not mean anything to them. (Ingrid)

> And explaining how a person uh, how a child learns and that it actually is through repeating, so uh, those advices they often do not, do not know it. They do know a lot about, but sometimes, sometimes they even do not know things about raising a child, and this you can tell as well, and it is exactly the same with learning language. They do not know, because they are not a speech and language therapist. So you should give them tips. (Stefanie)

> They probably get more than enough information already, and to already indicate what I am going to do in scenario A, B and C in six months, let me put it this way, I think when I was told, I would have forgotten it by the time I come home. And so, no, I do not. (Desiree)

Parents´ characteristics. SLTs want to motivate parents to stimulate their child's language development. Besides SLTs´ competence, a different approach is given by SLTs, because they react differently to each parent.

Exchanging information. Some SLTs talked about assertive parents. These parents ask questions, and tell what they want and expect from therapy. SLTs approach to this parent is to listen, ask questions, give parents information and advice and take parents' information into account when planning therapy.

> Mother indicated immediately, or at least immediately, quickly uh, from previous experiences that it was not smart to be there for the whole session, because she said yes, I know how he is going to act, and that is uh, yeah, it is not useful for the therapy, because yeah, then uh, the therapy is less effective than if I am not there. So that is how we chose to do it this way. (Esther)

Other SLTs mentioned reluctant parents. SLTs' approach to a parent who does not ask questions, is to provide their information and then end the conversation.

> These were parents who did not had a lot of questions, so it was not a very long conversation. (Stefanie)

When reluctant parents do not collaborate, SLTs want to have a conversation about therapy roles. A couple of SLTs consider it difficult to have such a conversation.

> I usually find when I notice that parents do not practice, gosh I noticed that you do not practice, uhm why do you not practice, you know. Then you have such a feeling of yeah, I am very young, they are all parents you know, they have children and they think well, there she comes with what she wants. Yes, often I think that is a very difficult conversation. (Irene)

A few SLTs discussed a child's care plan with parents that did not, or barely master the Dutch language. This affects the amount and difficulty of information given. These SLTs give less information, explain the same information repeatedly and in easy language. Besides, fewer questions are asked.

> With parents who have more knowledge of the Dutch language uh, I really write down the whole therapy goal. And uh, with parents who cannot do that, like in this case with the mother, I just said: goals; vocabulary, language comprehension, sentence structure, and then I explained the terms briefly. (Vera)

Discussion

The purpose of this study was to understand SLTs' approach and rationale, to collaborate with parents of children with DLD. The approach used by SLTs is to exchange information, in which they primarily provide information, and most decisions in therapy are made by SLTs. The rationale for this approach is to achieve the best therapy outcomes for the child. Besides, SLTs rationale consists of their knowledge, experience, beliefs and assumptions, and of parents characteristics.

According to the steps of collaboration by An et al.,[19] emphasized by Klatte et al.[7] collaboration begins with discussing family needs. All SLTs in this study ask parents about their expectations of therapy. Just a few SLTs ask about family needs, preferences and routines. Insight in views of parents is needed to create mutual understanding.[24] Mutual understanding is a prerequisite for involving parents into therapy,[37] and motivates parents to work with their child.[7] Besides, mutual understanding is needed to plan and provide adequate and relevant therapy.[7,24] Training therapists in using collaborative strategies leads to a higher frequency of seeking information.[18] To achieve mutual understanding, SLTs can focus on asking parents about their knowledge and opinion.

Discussing family needs can lead to the next step in collaboration by An et al.[19], which is mutually agreement upon goals. In this study, all SLTs make goals based on their knowledge. SLTs decide the priorities. The approach of Dutch SLTs seems consistent with the approach of Australian SLTs, to retain control in therapy.[38] However, the fact that parents are unable to set goals, is often confused with the fact that parents do not want to set goals.[39] Besides, chances of implementing and achieving goals are greater if goals are meaningful to the family.[19] Parents bring personal expertise, which has to be valued as equally important to SLTs expertise in making decisions. When collaborating, families' abilities to maintain control should be enhanced, and healthcare professionals should be encouraged to change their role as single authority.[6] To enable parents to make shared decisions, both SLTs and parents need to change mindset.[21,39] Parents will have a sense of control and ownership of the intervention, when empowered by therapists.[22] To enable SLTs to empower parents, SLTs can attend training in collaborative strategies, [18,39] or use decision aids.[40]

The following step in collaboration is shared therapy planning.[19] In this study, therapy is planned by SLTs. They decide how to stimulate the child's language, based on their role as expert and assumptions of what parents need. Solely assertive parents speak up about their preferences in therapy, which is taken into account in therapy planning. However, most parents might not be able to speak up and ask questions. To enable parents to speak up, ask questions and make shared decisions, both SLTs and parents need to change attitudes towards participation, where parents' unique expertise is recognized.[39]

A strength of this study is variation in years of working experience, through purposive sampling. Also, rich data has been collected by talking about a specific case. Another strength is researchers' awareness of emerged data during the interviews. In addition, member checks did not change results and add credibility to the data.

This study has some limitations. Participants might have already been interested in, or aware of collaboration with parents. Selection bias can be present. Besides, SLTs' approach is based on self-reported practice, making it uncertain if this approach is being used. Part of the analysis was done by one researcher, which might limit the findings. However, each step was reviewed by a second researcher, and doubts have been discussed. More than twelve interviews are needed to make study results applicable to other contexts.

Future research can include observations to gain objective information on SLTs approach. Interviews with SLTs can be conducted on different points in time during therapy, to notice changes over time. Besides conducting interviews with SLTs, interviews with parents should be conducted to combine both views on therapy.

Implications for clinical practice of SLTs is to focus on asking parents for information on their needs, and empower parents to make shared decisions in goal setting and therapy planning. To achieve this, SLTs can attend training or use a decision aid. An example of a decision aid for Dutch SLTs is ENGAGE.[41]

In conclusion, SLTs approach when collaborating with parents, is providing parents with information on therapy goals and therapy planning. Less information is asked from parents. SLTs rationale for this approach is their knowledge, experience, beliefs and assumptions. In addition, to improve collaboration, SLTs can change their attitudes towards parent participation, and empower parents to make shared decisions in goal setting and therapy planning.

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Tables

Table 1. Demographic Characteristics

Pseudonym	working experience (years)	Present parent*	Age child (year;month)	Families' cultural background	Estimate of Families' SES**	Collaboration***
Stefanie	6-10	M + F	4;10	Dutch	Low	Good
Esther	6-10	M	5;9	Dutch	Moderate	Good
Sara	2-5	M	4;7	Moroccan	Moderate	Good
Irene	2-5	M	5;2	Dutch	Moderate	Good
Juliet	2-5	M	3;7	Nepalese	Low	Moderate
Marleen	16-20	M + F	3;1	Dutch + Portuguese	High	Good
Vera	2-5	M	5;7	Filipin	Moderate	Moderate
Desiree	11-15	M	4;3	Dutch + Turkish	Moderate	Good
Maaike	11-15	M	2;4	Dutch	Low	Moderate
Ingrid	36-40	M	4;8	Dutch + Moroccan	Moderate	Good
Annemarie	30-35	M	5;6	Dutch	Moderate	Good
Francien	16-20	M	6;5	Moroccan	Moderate	Good

**Present parent M=mother, F=father **Speech and language therapists' estimate of families' social-economic status ***Speech and language therapists' judgment of collaboration*

Figures

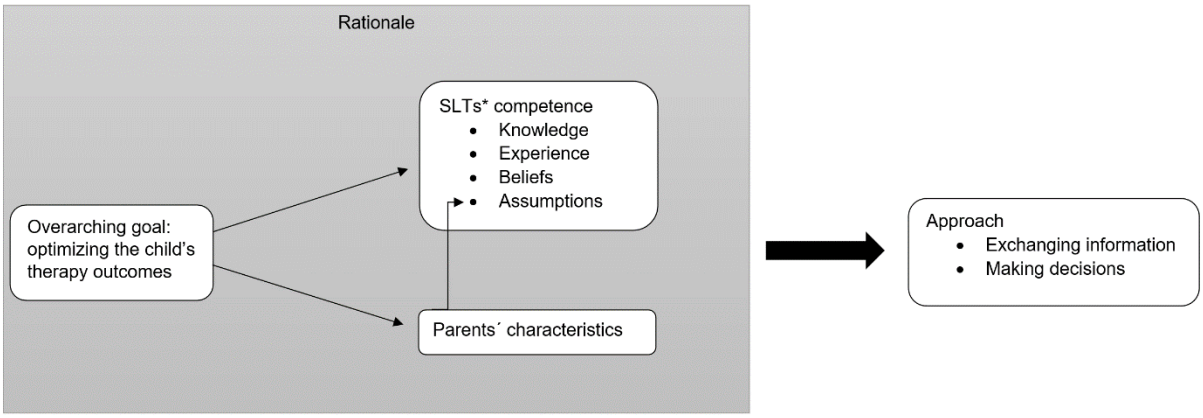

Figure 1. Speech and language therapists' rationale and approach
**SLTs: Speech and language therapists'*

Appendix A. Interview Guide

Onderwerpen	Vragen	Doorvragen
Opening	Hoe is het gesprek over het behandelplan verlopen?	Kan je daar meer over vertellen? Had dat invloed op jou tijdens het gesprek?
Begrijpen hoe logopedisten samenwerken met ouders en waarom ze dat zo doen.	Hoe betrok je de ouder bij de behandeling? Kan je uitleggen waarom je dat doet?	Kan je daarvan een voorbeeld geven? Je noemt .. als reden, zijn er nog andere redenen?
Begrijpen hoe logopedisten omgaan met: - Informatie geven over taalprobleem / behandeling - Het opstellen van doelen - Verwachtingen en behoefte van ouders - Wie doet wat (rollen)	Vragen wanneer het nog niet aan bod is gekomen. Er zijn nog een paar onderwerpen waar we het nog niet over hebben gehad. Eén daarvan is … hoe ga je daarmee om?	Wat maakt dat je dat doet? Kan je daarvan een voorbeeld geven? Kan je dat toelichten? Wat bedoel je daarmee? Je noemt .. als reden, zijn er nog andere redenen?
Afsluiting	Is er iets wat je nog wilt benoemen over deze samenwerking?	