Parents' and speech and language therapists' roles in intervention for pre-school children with speech and language needs

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Abstract

Background: Policy and practice in early years provision in education, health and social care has advanced in recent times to emphasise parents as partners in supporting children's learning. Speech and language therapists (SLT) work closely with parents of pre-school children with language learning difficulties to enable them to promote language development in the home. There is growing evidence that indicates that parents can be taught how to become effective facilitators of language skills. Nevertheless, little is known about parents' or SLTs' conceptions of their roles when working together, and how these may change during intervention.

Aims: To explore parents' and SLTs' conceptions of their respective roles in intervention for pre-school children with primary speech and language needs and to determine the extent to which parents' conceptions of roles change whilst working with SLTs .

Methods: A two phase, mixed methods study was conducted using semi structured interviews and questionnaires, with parents and SLTs in England. A smaller subset of parents participated in a longitudinal study to track any changes in their conceptions during intervention. The data were analysed using thematic network analysis for first level themes, framework analysis for comparing themes over time and statistical analysis for the questionnaire responses. Over 65 parents and 70 SLTs participated in the study during both phases, providing the perspectives of a wide range of participants.

Results: Findings suggested that before involvement with speech and language therapy, parents had a clear conception of their advocacy role, which prompted them to secure help. However, they did not have a firm conception of their role in supporting their children's language learning and did not anticipate adopting an intervener role. Parents expressed considerable variation in their conception of their intervener role. During intervention, some parents described changing this conception and adopting an

increasingly involved role as implementer and adaptor of intervention. Moreover, in some cases, they described substantial changes in their approach to parenting, suggesting wider changes in their conception of role.

SLTs had clearly formulated conceptions of their own roles as assessor, intervener and negotiator, but varied in the extent to which they involved parents as co-workers in intervention. SLTs had two conceptions of their own role as intervener: treat and plan and advise/coach. SLTs expressed intentions to help parents change their understanding of their role, but the parent education role remains largely implicit in SLT practice.

Conclusions and implications: Parents described conceptions of their roles as advocate, intervener and taking responsibility. They described important changes in their conceptions of roles, suggesting that a process of conceptual change occurred associated with greater involvement in intervention. SLTs varied in their own role conception, with intervener roles that related to lower or high level of parent involvement. Implications for the SLT practice include developing a more explicit role as parent educators, in order to enhance parental understanding as well as behaviour in supporting their children's language development.

Contents

List of Tables and Figures

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I would like to thank many people who have supported me over the last three years as I have tried to unravel the mysteries of partnership practice in speech and language therapy. I have been particularly fortunate to have a skilled and enthusiastic supervisory team. They have constantly reminded me to value evidence before opinion and clarity before opaque meanderings. Each supervisor has brought something unique to the support I have received. My thanks go to Julie Marshall for tireless support and diligent analysis of everything I did, to Juliet Goldbart for her vast wisdom and to Laura Brown for her insightful observations. Together they challenged, badgered and encouraged me to articulate clearer plans, analyse the data more carefully and interpret the findings more thoughtfully.

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Chapter One

1. Overview of the thesis

1.1 Introduction

This study investigates parents and speech and language therapists' (SLT) conception of roles during speech and language therapy intervention. Recent policy has encouraged practitioners to include parents in supporting their children's language learning. Whilst there is a growing body of evidence on the views of parents and SLTs working together, previous research has not specifically addressed differences in: (i) parents' conception of their roles; (ii) SLTs' conceptions of their roles; (iii) and changes in parents' conceptions of their role through working with SLTs. This study addresses this gap in knowledge using an approach that is informed by the conceptual change literature.

Pre-school children with primary speech and language needs[1] form an important part of speech and language therapists' (SLT) caseload. The process of assessment through to intervention often relies on parents and therapists working closely together, assuming a variety of roles over an intervention period. Currently, there is limited research exploring the nature of these roles and the conceptions that participants have in the field of speech and language therapy. This study provides an original contribution to knowledge, by exploring the role conception of parents of pre-school children with primary speech and language impairment and their SLTs, using both qualitative and quantitative research

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[1] Primary speech and language needs defined as a significant language and/or speech impairment where there is no indication of other neurological, sensory or developmental conditions that might account for the language impairment.

11

methods. Furthermore, by using a longitudinal design there was the opportunity to investigate any changes in parents' conceptions of their role over time, giving a unique perspective on the association between intervention and changes in conception. The evidence from the study is discussed with reference to theory, with a particular focus on conceptual change theory. Conceptual change has been well documented in education and psychology as an important construct in understanding children's learning (Pintrich et al., 1993; Limon and Mason, 2002; Sinatra, 2002; Vosniadou, 2013b), but has not been widely explored in the context of adult learning.

1.2   Context for the research

The principle of partnership with clients has been encouraged in speech and language therapy practice (RCSLT 2006), but a tension may exist between principle and practice, with research identifying a mismatch between the desired outcomes expressed by service users and goals set by professionals (Glogowska and Campbell, 2000; Marshall et al., 2007; Ferguson et al., 2010). This may suggest that the relationship between user and professional is not necessarily one of partnership, characterised by mutual understanding of each other's roles, with goals agreed through negotiation. At the current time, little is known about how conceptions of roles relate to the nature of the partnership or if conceptions change as intervention progresses, and the potential impact on children's speech and language outcomes.

SLTs work closely with parents of pre-school children to enable them to promote language learning in the home, with home practice and parent education programmes reported as a routine component of speech and language therapy practice for a range of speech and language needs (Watts Pappas et al., 2008; Roulstone et al., 2012). This is built on evidence that suggests many parents can learn to become effective facilitators of speech and

language development, even in the context of children with marked language delay (Law et al., 2003; Gibbard et al., 2004; Roberts and Kaiser, 2011). Speech and language therapy practice involving parents often uses either, a parent education approach (Gibbard et al., 2004; Law et al, 2003) or a parent-as-aide model (Watts Pappas and McLeod 2009).

Other notable contextual factors taking place concurrently can be seen, first in policy and legislation, such as the Children's and Families Act in England (Department for Education, 2014), and second, in organisational structures for the provision of speech and language therapy services[2] in England. The design of services for children with speech and language needs has been shaped by national initiatives promoting parental choice and involvement together with locally determined factors affecting organisation of services, such as commissioning and funding priorities (Roulstone, 2011; Davies and Davies, 2012). In addition, there seems to be a lack of understanding of the needs of children with speech and language difficulties, drawn to the attention of the public in England with the publication of a national review of provision (Bercow, 2008). One of the review's conclusions was that 'evidence illustrates that there is insufficient understanding of the centrality of speech, language and communication among policy makers and commissioners nationally and locally, professionals and service providers, and sometimes parents and families themselves' (p1). In the context of relatively poor understanding, parents and professionals may struggle to understand their own and each other's roles and responsibilities when a child shows difficulties learning language.

A literature review was conducted to evaluate the research on the theory and practice of roles in the parent-professional partnership. A systematic approach to the literature was undertaken using the principles of integrative review (Whittemore and Knafl, 2005) designed specifically to combine the findings of theoretical and empirical reports from a

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[2] http://www.england.nhs.uk/wp-content/uploads/2012/07/fs-ccg-respon.pdf

13

wide range of sources (Torraco, 2005). The findings of the literature review are reported in Chapter Two.

It is widely believed that parents and carers play a central role in supporting speech, language and communication development in young children (Kaiser and Hancock, 2003; Roberts and Kaiser, 2011). This is reflected in a number of recent policy developments in England, most notably the introduction of parenting programmes to support parenting skills, as seen in many Sure Start initiatives (Department for Education and Skills, 2008). Practitioners, such as speech and language therapists, believe that parents' roles may be particularly important for those children who are acquiring language more slowly than their peers (Marshall et al., 2007; Watts Pappas et al., 2008). Consequently, intervention for children with speech and language needs frequently uses either (i) a parent education model intended to promote change in parents' interaction style with their children (Lindsay et al., 2011), or (ii) a parent-as-aide model, with parents implementing home activities (Watts Pappas and McLeod, 2009). A typical intervention for pre-school children with primary speech and language needs uses coaching to enable parents to support speech and language development in a child's usual social context (Roulstone, et al., 2012). A number of studies evaluating intervention, based on coaching parents, have reported positive outcomes for parents learning to support language learning, and for children's language development (Girolametto et al., 2002; Westerlund, 2008; Roberts and Kaiser, 2011). A parents-as-aide model conceptualises parents as assuming an active role in supporting implementation of therapy objectives in doing activities prescribed by the SLT. In this instance, SLTs often provide home activities for parents to reinforce learning that has taken place during therapist-led intervention with the child (Bowen and Cupples, 2004; Watts Pappas et al., 2008). Little is known about parents' and therapists' conceptions of their own and each other's roles during either approach. Moreover, the part

that relationship building plays in encouraging a shared understanding of roles and responsibilities between parents and professionals, has rarely been explored in speech and language therapy (Fourie et al., 2011). The evidence from a small number of studies of parents' views suggests that parents may feel excluded from the team(s) supporting their child with speech and language needs (Band et al., 2002; Rannard et al., 2005; Bercow, 2008) suggesting that professionals do not readily acknowledge parents' roles. However, it is difficult to generalise from these studies to the wider context of speech and language therapy or evaluate the changes that may be taking place as a result of increasing awareness of partnership and co-working (Beresford et al., 2007; Davis and Meltzer, 2007)

1.3 Aims and scope of the research

Research aims: To explore parents' and SLTs' conceptions of their respective roles in intervention for pre-school children with primary speech and language needs and to determine the extent to which parents' conceptions of roles change whilst working with SLTs .

Research Questions

1. What is the range of parents' and SLTs' conceptions of their own and each other's roles during speech and language therapy intervention for children with primary speech and language needs?

2. In what ways and to what extent do parents' conceptions of roles change whilst working with SLTs and how is this associated with partnership practice?

3. What is the relationship between SLTs' and parents' conceptions of roles during intervention?

4. In what ways and to what extent do SLTs promote conceptual change for the parents they work with during speech and language therapy intervention?

The work was undertaken from September 2011 to August 2014, using data collected from parents and SLTs involved in publicly funded speech and language therapy services in England. The study formed part of a Programme Grant for the Applied Research Programme of the National Institute for Health Research (Grant Reference Number RP-PG-0109-10073). The project determined inclusion criteria such as the children's age range (2.00 - 5.11years) and nature of the speech and language difficulty (primary speech and language needs).

1.4 Motivation for researching conceptions of roles

The motivation for researching parents' and SLTs' conceptions of their roles has been triggered by the researcher's extensive experience working with children and families, and the changing roles for parents and professionals that have emerged as a result of efforts to improve parent involvement. Widespread changes have taken place in the nature of speech and language therapy intervention in the UK over recent years, potentially related to changing policy and culture in terms of partnership, and growing evidence about the nature of effective intervention. Research has challenged the practice of working with children only and encouraged a growth in parent programmes, judged as effective as traditional intervention (Law et al., 2003). Recent policy in children's services more generally has placed a strong emphasis on encouraging professionals to involve parents as partners in all aspects of children's learning and development (Department for Education and Skills, 2007; Department for Education, 2011). There is an assumption that this will improve children's outcomes and enhance parents' experience. Parents are encouraged to voice their preferences for the services they need, actively choosing provision for their children and contributing closely to all aspects of children's development as part of the policy development for integrated services and special education in England (2014).

Partnership between parents and professionals is thought to be critical to the success of such policies, with a recognition that the respective roles of each partner are likely to change and develop as parents and professionals aspire to build a reciprocal relationship with equal contributions from each participant.

Despite the emphasis on partnership working, little is known about implementation of such policies in speech and language therapy. This study is therefore important for the speech and language therapy profession: it should extend understanding of how SLTs and parents think about their respective roles during intervention and how such roles complement or counter one another, as part of a working partnership. Furthermore, it should provide evidence of whether parents' conceptions of role are open to change during intervention and consider how new and different roles can be encouraged as part of partnership practice. Finally, through the application of conceptual change theory, it should offer a means of understanding parents' role as learners during their child's speech and language therapy intervention, and a framework for articulating SLTs' role as teachers.

1.5   Structure of the thesis

The thesis reports the findings of a two phase mixed method research project exploring parents' and SLTs' conceptions of roles. Chapter Two reviews the literature on parent and SLT roles, models of partnership practice and theoretical considerations of role construction and conceptual change. The literature review has been drawn from a wide range of disciplines and research areas and has not been confined to the field of speech and language therapy, given the limited number of studies available in speech and language therapy relating to role conception. Chapter Three presents a discussion of the methodology. Chapters Four and Five describe the method and the results of phase one, including a longitudinal study using qualitative methods. Chapter Six presents the method and results of phase two, using quantitative methods. A discussion of the findings and

implications for practice are presented in Chapter Seven. The conclusion summarises the research and presents the unique contribution of the study to the field of speech and language therapy, discusses the limitation of the study and presents recommendations for future study.

Chapter Two

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2. Literature review of parents' and SLTs conceptions of roles

2.1 Introduction

This chapter provides

1. A rationale and description of the review method used (Section 2.2).

2. A review of the evidence relating to the conception of roles in partnership practice, using a framework to conceptualise models of practice based on decision-making. The theoretical rationale for each model, and the implications that the models have for levels of success and satisfaction within speech and language therapy services are then considered (Section 2.3).

3. A review of the evidence of parent and SLT role conception and associated characteristics (Section 2.4).

The review draws on a wide literature base from education, health, psychology and social care, as well as speech and language therapy, in keeping with the recommendations of a number of researchers (Malterud, 2001; Salmon, 2013). A number of theories from different disciplines are included in the review to contribute to understanding conceptions of roles in speech and language therapy, and developing a theoretical framework (Salmon, 2003; Jones, 2007). Gaps in current knowledge are highlighted, focusing on issues used to inform the design of the research project described in Chapters Four to Six.

2.2 Review method

2.2.1 Rationale for review method

The current review was seeking to synthesise evidence from emprical studies using qualitative or qauntitative methods, as well as theoretical and policy documents on partnership practice and conception of roles in speech and language therapy. Systematic reviews are routinely used to identify, evaluate and synthesise results from quantitative studies where causality is being investigated. Many of these use prescribed methods such as those recommended by the Cochrane Collaboration Reviews[3]. However, their approach has been questioned for reviewing evidence using research methods other than quantitative designs and there is considerable debate about appropriateness of a tightly prescribed review method for research relating to complex interventions (Pawson, 2006b). A number of researchers (Popay et al., 1998; Pawson et al., 2005) have questioned the application of systematic review methods to qualitative studies and use alternatives such as a 'qualitative evidence synthesis' (Noyes et al., 2008). They argue that there are unresolved weaknesses in an approach that excludes potentially valuable studies that use different methods (Pawson, 2006a; Suri and Clarke, 2009). Consequently, alternative review methods are recommended for synthesising evidence from qualitative studies or those using mixed methods (Whittemore and Knafl, 2005; Pope et al., 2006).

Moreover, the research base on roles and partnership between parents and SLTs is relatively small and therefore evaluating evidence from the wider literature was important to understanding the issues of role conception. This required a method that could accommodate studies from a range of disciplines using contrasting research methods. As a result, the review used a method that could systematically evaluate qualitative and quantitative studies and support interpretations that could be applied to alternative

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[3] http://www.cochrane.org/

professional groups. This depended on a clear and transparent synthesis of the evidence (Whittemore and Knafl, 2005; Gough et al., 2010; Marshall et al., 2011).

Realist synthesis and integrative review were considered more appropriate for the purposes of the review. Realist synthesis (Pawson et al., 2005, pS1 21) is intended to evaluate the way complex interventions work within specific contexts: 'what works, for whom, in what circumstances, in what respects and how'. It enables evidence from a range of research methods to be reviewed and explicitly acknowledges that apparently identical interventions are rarely implemented in an identical way or in an identical setting, so precluding direct comparisons between studies. Realist synthesis encourages the reviewer to be responsive to emerging ideas and new data that can then be incorporated into the review as it progresses through feedback and revision. Pawson (2004) argues that this is an integral part of any literature review but often not acknowledged in the prescriptive and linear process recommended for systematic reviews. The steps in undertaking a realist synthesis provide a transparent framework for ensuring the reviewer can represent the logic clearly, described as 'logic of discovery' (Pawson, 2006a). The literature review for the current study was not exploring a single 'intervention' for children with speech and language needs, but was concerned with roles during complex interventions used by SLTs with pre-school children. The type of intervention, the conception of roles of the participants and the context were all considered aspects that contributed to success of intervention.

Integrative review provides a similar approach to reviewing the literature as realist synthesis, but is not restricted to evaluating interventions. It was, therefore, an ideal choice for reviewing models of partnership practice. It is used in nursing research as an approach that enables review of studies using diverse methods, and aims to generate new frameworks on defined topic areas to extend understanding of specified phenomena

(Torraco, 2005; Whittemore and Knafl, 2005). An integrative review includes appraisal of publications presenting theoretical debate as well as empirical evidence from quantitative and qualitative studies.

Integrative review is consistent with the paradigm of critical realism adopted in the research study and provided a clear approach for reviewing the literature. It is able to accommodate diverse publications and specifically encourages new conceptual frameworks to extend understanding, in this case of role conception in parent-SLT partnerships. The following review used an integrative review method, outlined in (Table 2-1).

2.2.2   Purpose of review

The literature review contributes to the aims of the research study outlined in Chapter One, identifying what is known to date of parent and SLT role conception and the gaps in knowledge that will be addressed by the research study.

2.2.3   Review protocol

The process of preparing the literature review (Table 2-1) followed the steps outlined by Whittemore and Knafl (2005).

Table 2-1: Summary of the review protocol using guidance from integrative review

	Integrative review	Review protocol for models of partnership practice in speech and language therapy
Purpose	Review studies using diverse methods, and aims to generate new frameworks on defined topic areas	Review empirical, theoretical and policy papers relating to models of partnership practice between parents and professionals, with specific reference to speech and language therapy Aim to generate a framework for speech and language therapy based on decision-making. Review evidence of conception of roles of professionals and parents.
Step 1	Problem identification: a clear formulation of the review variables and purpose, creating clear boundaries of the focus of the review	1. What models of partnership practice have been developed, described and evaluated in different disciplines across health, education and social care? 2. How do differing models of partnership practice relate to parent and SLT conception of roles? 3. What are the different role conceptions of parents and SLTs and how are these determined and influenced, drawing on cross disciplinary evidence
Step 2	Literature search: searching is therefore both comprehensive and purposive. Search methods should be clearly documented and seek sources that may not be accessed through computerised databases of research, such as networking and hand searching.	Seven databases were searched between September 2012 and May 2014 for papers published between 1997 and 2014 to identify publications exploring parent/patient and professional partnership, models of partnership practice and parent and professional conception of roles. Databases were Pubmed, PsychInfo, ASSIA, Linguistics and Language Behaviour Abstracts, AMED, CINAHL and Google Scholar which included access to sources included in the Web of Science and Scopus databases. Inclusion criteria: 1. Studies on parent/patient and professional partnership, including partnership between adults and professionals, where relevant to the review questions 2. Studies of parents' roles with children 2-11 years with speech and language needs supported in community services 3. Studies from the disciplines of health, education, and psychology 4. Quantitative and qualitative research, including international studies, theoretical papers, UK policy/reports, from 1997-2014

Step 3	Data evaluation: a pragmatic approach, incorporating different quality instruments to match the kind of studies under review. The emphasis is placed on systematically analysing the data in a creative, as well as critical manner.	Prompt questions for quality appraisal of research (Dixon-Wood et al., 2004)
		
		1. Research questions clearly described
		2. The following are clearly described and appropriate to research question
		  • Sampling
		  • Data collection
		  • Analysis
		3. The evidence support the claims
		4. The data, interpretations, and conclusions are clearly integrated
		5. The paper makes a useful contribution

Step 4	Data analysis: constant comparison method, with extracted data compared item by item, enabling similarities, patterns, themes and differences to be recorded. Critique should demonstrate the key contributions and the deficiencies of the literature, and identify the inconsistencies and omissions in the literature (Torraco, 2005)	A conceptual framework was designed to compare findings from different papers. The review identified common themes and differences between models of practice and considered the relevance of partnership models for the provision of specialist support for children with speech and language needs and the profession of speech and language therapy
Step 5	Interpretation of data: a synthesis of current knowledge is created.	The review synthesis used a framework designed according to decision-making within the parent-professional partnership for the review of models of practice.

Step 1: Setting the review questions

1. What models of partnership practice have been developed, described and evaluated in different disciplines across health, education and social care?

2. How do differing models of partnership practice relate to parent and SLT conception of roles?

3. What are the different role conceptions of parents and SLTs and how are these determined and influenced, drawing on cross disciplinary evidence

Step 2: Designing the literature search (Table 2-2). The aim of the search was to obtain examples of a wide range of perspectives, selecting key papers that add to knowledge relating to the review questions before reaching saturation, where nothing could be added

by further searching (Pawson et al., 2005). A range of published sources was reviewed from the last seventeen years (1997-2014), commencing with the influential and much cited paper by Charles et al on decision-making in healthcare (Charles et al., 1997). Seven databases were searched between September 2012 and February 2014 for papers published between 1997 and 2014 to identify publications exploring partnership between service users and professionals. Using academic databases can limit the search for relevant literature, such as policy documents and evaluation reports, so searching for grey literature and searching cited references from reviewed publications, was an important part of the search strategy (Thomas and Harden, 2008). Criteria for inclusion in the review were devised according to the research questions, though this did not preclude following up references recommended by academic colleagues, or citations in papers reviewed, in keeping with integrative review.

Search terms, however comprehensive, can limit the studies that are identified. SLTs use variable terminology (Marshall et al., 2011; Bishop, 2014). Alternative terms, where they were known, were used to address this. For example SLP (speech-language pathologist) was used as well SLT to ensure that Australian and North American literature was included.

Table 2-2 provides a summary of the search strategy based on the seven steps recommended for Cochrane Review and Figure 2-1 outlines the process for the selection of articles for review.

Table 2-2: Summary of search strategy

Databases searched	Pubmed, PsychInfo, ASSIA, Linguistics and Language Behaviour Abstracts, AMED, CINAHL and Google Scholar
Date the search was performed	Between September 2011 and May 2014
Years covered by the search	1st January 1997- 1st May 2014
Search strategy	Parent AND speech language therapy AND partnership
	Models of practice AND speech language therapy AND children
	Partnership models of practice AND parents
	Parent AND speech language therapy AND decision-making
	Parent AND professional partnership
	(Family centred care OR person centred care) AND (parent OR children)
	Family centred care AND speech language therapy
	(Parent role OR speech language therapy role) AND speech language therapy intervention
	Working alliance
	Parent involvement schools
One or two sentence summary of the search strategy	Review empirical, theoretical and policy papers relating to models of partnership practice between parents and professionals, which have features in common with delivery of speech and language therapy
Language restrictions	Publications written in English

Step 3: Data evaluation. Abstracts were reviewed for relevance and full texts of selected articles were then critically appraised on the basis of relevance to the review question, quality of evidence (described in Table 2-1) and explanatory contribution to understanding models of partnership practice. Systematic reviews of quantitative studies follow a clearly prescribed format for judging the quality of a study, and comparing study

findings with the intention of foregrounding causal relationships. Appraising the evidence from a complex literature base, often including non-comparable studies, is a recognised problem for reviewers (Dixon-Woods et al., 2004; Dixon-Woods et al., 2007). Pawson (2003) has challenged the benefits of using a rigid appraisal tool to review qualitative studies, commenting that long checklists are of questionable benefit to the interpretation of the evidence, 'They involve wholesale grilling of the primary inquiries and still fetch up no more than a considered opinion on quality' (Pawson, 2006a, p.87). He argues that studies are unlikely to have been designed with reference to the theoretical propositions of the review and therefore appraisal criteria should be guided by the contribution that the study makes to the synthesis, rather than a judgement about the study in its entirety. Studies may contribute 'nuggets' of valuable information to the overall review, regardless of the intrinsic quality of the study (Pawson, 2006b). Pope et al. (2006) also commented that, while quality appraisal is helpful, it should not be the only means of judging inclusion of studies in a review. The quality appraisal of studies for this review followed Pawson's (2005) principles of relevance and rigour. Initially, the reviewer judges whether the primary study is relevant to the review question, considering each study individually. The assessment of rigour does not use a pre-determined checklist, but asks the question 'to what extent does the primary study support the emerging inferences of the review?'. Researchers acknowledge that the evaluation of evidence is subjective (Pawson, 2003; Dixon-Woods et al., 2005).

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│ Databases searched                  │
│                                     │
│ Pubmed, Psychinfo, ASSIA, Linguistics and │
│ Language Behaviour Abstracts, AMED, CINAHL, │
│ Google Scholar (1993-2014)          │
└─────────────────────────────────────┘
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                   ▼
┌─────────────────────────────────────┐        ┌──────────────┐
│ Abstracts reviewed for match with inclusion and │ ─────▶  │ 505          │
│ exclusion criteria                  │        │ abstracts    │
└─────────────────────────────────────┘        └──────────────┘
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                   ▼
┌─────────────────────────────────────┐        ┌──────────────┐
│ Articles reviewed for relevance to research │ ─────▶ │ 131 articles │
│ questions and quality               │        │              │
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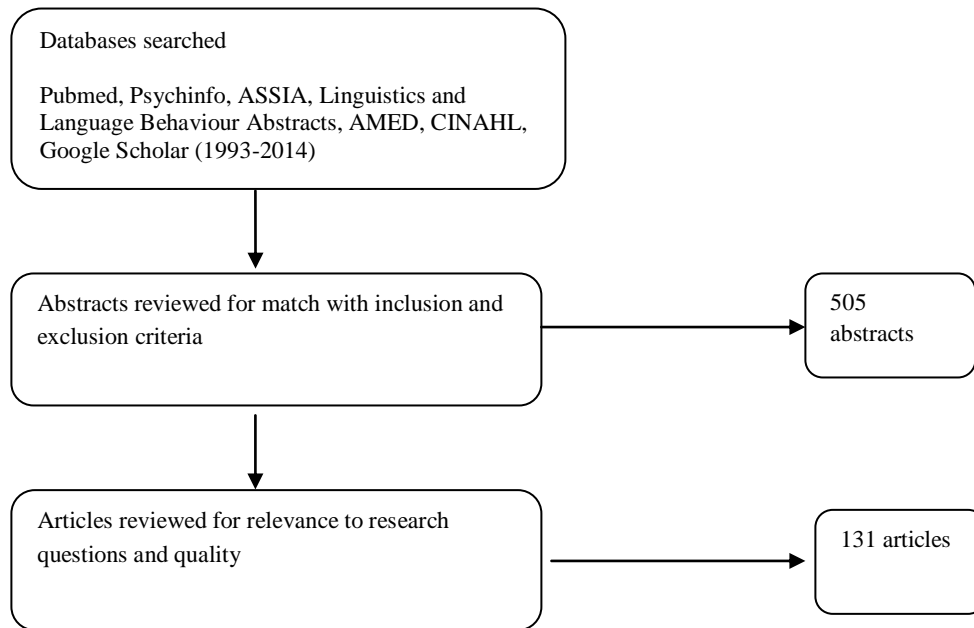
Figure 2-1: Flow chart of selection of literature for review

Step 4: Data analysis. A conceptual framework was designed to compare findings from different studies, based on decision-making in partnerships. The review identified common themes and differences between models of practice and considered the relevance of partnership models for the provision of specialist support for children with speech and language needs and the profession of speech and language therapy.

Step 5: Interpretation. A review synthesis was prepared to support interpretation of the literature. This is presented in Section 2.

2.3 Findings from the review

2.3.1 Context

Policy across health, education and social care in the UK has been shaped by the principles of partnership, user choice and personalisation (Needham, 2009; Department of Health, 2010; Kettle et al., 2011). These principles have been applied to services for children with special educational needs (Glasby et al., 2011), however there is very little robust research to support these policies. There has been a range of initiatives to improve parent participation and professional approaches (for example, the Family Partnership Model, Davis and Meltzer, 2007), each with their own distinctive focus and terminology (Newman and Vidler, 2006; Department of Health, 2010; Department for Education, 2011). In speech and language therapy, policies related to Sure Start (1998-2010) have been hugely influential in the organisation and delivery of speech and language therapy (Fuller, 2010). In this example, the policy, together with significant financial investment, encouraged closer participation of parents and expected practitioners to assume partnership models of practice (Department for Children, Schools and Families, 2007).

The tensions between competing ideology and values in devising policy that includes greater involvement of parents and professionals in determining the delivery of support is summed up in a government paper on special educational needs in England (Department for Education, 2011). This recommended that future practice should 'give parents confidence by giving them control *and* transfer power to professionals on the front line and to local communities' p4 (my italics). This inherent tension between parents' control and professionals with power may not be easily resolved through policy that advocates personalised provision. The Government paper therefore calls for a clearer understanding of roles and responsibilities within partnership practice in the context of greater

participation and choice from parents. The statutory guidance arising from this paper (Department for Education 2014) does not elaborate how parents' control will be applied in special education, though it remains a key theme in the guidance.

One model of practice thought to improve partnership is that of co-production based on encouraging reciprocity in roles adopted by both service user and professionals (Boyle and Harris, 2009; Kettle et al., 2011; Sheridan et al., 2011). In children's speech and language therapy, the professional, who acts on behalf of the organisation as well as their own profession, can be considered a co-worker with parents, necessitating negotiation and consensus with parents as partners (Davis and Meltzer, 2007; Goodall and Vorhaus, 2011; Sheridan et al., 2011). Similarly, parents, who act on behalf of their children, are conceptualised as collaborators in addressing their child's needs. Thus, while such theoretical models are becoming increasingly prominent, SLTs have very little hard evidence about how they should operate in practice, and what approaches genuinely promote co-working.

An approach thought to facilitate greater collaboration has been the introduction of personal budgets to encourage parents to select the support that they consider is right for their family (Department for Education, 2011). Currently, the extent that this will be applied to families with children with speech and language difficulties is unknown and is likely to be locally determined and susceptible to local variation and challenges (Department for Education, 2013). Theoretically, parents, who become budget holders, are placed in the role of consumer. They are likely to have a different relationship with professionals (Newman and Vidler, 2006; Owens, 2012), which will challenge the nature of the partnership. According to Hirschman's theory of exit and voice (Hirschman, 1970), consumers, if they are dissatisfied with a service from an organisation can either voice

their dissatisfactions or leave to use another provider. This appears to be the rationale for policy makers; they anticipate that budget holding will encourage service users in health and education to become decision-makers in a similar way to consumers. However, there may be implications in voicing preferences that have significant impact on provision: service users may request intervention that is not recommended by current evidence, professional opinion, or the priorities of the provider organisation. Rather than resolving tensions between parents and professionals, budget holding may contribute to misunderstanding and the need for more complex negotiation and decision-making (Roulstone, 2011). These tensions are of increasing importance for the practice of speech and language therapy, where evidence is beginning to suggest that parents themselves may need to understand and adopt different, potentially more demanding roles, as interveners (Law et al., 2003). These changes are unlikely to occur in a simple consumer-provider exchange. In turn, SLTs need to adopt different roles when working in response to a budget holder compared to those needed in a co-worker model. In addition, SLTs have the challenge of meeting management and commissioning expectations of service delivery, which may further influence their conception of their own and parents' roles (Bercow, 2008; Davies and Davies, 2012). The introduction of the 'Any Qualified Provider' policy in England[4], which intends to 'improve standards in service provision through increasing competition between, and choice of, service providers' (Centre for Workforce Intelligence Planning, 2012, p.5,) may create further difficulties for promoting partnership.

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[4]
http://www.impressresp.com/index.php?option=com_docman&task=doc_view&gid=36&Itemid=6 9

2.4 Three models of partnership practice

The following literature review uses a form of organisation which highlights key themes and issues in the literature. In line with usual practice in integrative review, the headings used to organise the review were developed through the reading of policy, practice and research literatures. The review is therefore organised using three headings to categorise papers according to decision-making in the parent-professional partnership based on the increasing focus on user involvement in decision-making in health and social care (Edwards and Elwyn, 2006; Beresford and Sloper, 2008; Jackson et al., 2008; Dy and Purnell, 2012). Three models of partnership practice were commonly described in the literature, based on the role of decision-maker within partnerships (Charles et al., 1999; Coulter, 1999; Davis and Meltzer, 2007). These were:

a) Professional as decision-maker

b) Negotiated decision-making

c) Parent as decision-maker

The rationale for using decision-making was two-fold: first, responsibility for decision-making is considered an important indicator in health which is associated with improved outcomes for service users in some studies (Charles et al., 1997; Jackson et al., 2008; Edwards and Elwyn, 2009). Second, using decision-making allows descriptive labels, such as 'parent as decision-maker', to be used for categorising types of partnership that avoids the positive or negative bias that existing labels convey. Examples of labelling in the field, such as 'non-compliant' for parents and 'paternalistic' for professionals, are heavily value laden and inevitably associated with ideological positions.

Models of practice provide a clear framework for the way professionals operate. They offer an opportunity to articulate both the underpinning principles and practical application of working practice. However, they often present practice from the professional perspective (Davis and Meltzer, 2007), illustrating a one-sided process of decision-making as evidenced by the professional standards for SLTs. The guidance states that decision-making 'results in the therapist determining the best course of action at any one time given the particular set of circumstances. A competent therapist therefore needs to have high level reasoning skills in order to work with the many relevant factors and perspectives involved when identifying the best possible option' (RCSLT 2006, p.33).

Few models of practice focus on the roles that individuals assume from both 'sides' of a partnership, or indeed consider the way conception of roles within a partnership may influence one another. The following review considers the role of decision-maker, whether it contributes to shared practice and the implications of decision-making on the roles assumed during involvement in services.

The evidence for each of the three models of practice is presented in three sections:

   (i) Description, with specific reference to policy context

   (ii) Rationale

   (iii) Implications for speech and language therapy practice

2.4.1 Professional as decision-maker

Description: A model based on the professional as decision-maker places the practitioner in the role of the informed individual with expertise and the parent in the role of an uninformed client, seeking advice. The professional takes responsibility for assessment and determining intervention using expert skills and knowledge (Crais, 2011). The

professional or parent, or any other relevant person, then implements the intervention, but always under the professional's direction. A number of researchers in health contexts have presented this as a *traditional* model of care characterised by assigning an expert role to the professional that encourages paternalism (Charles et al., 1999; Coulter, 1999). They have argued that the professional as expert discourages partnership and fails to acknowledge the expertise of the service user, resulting in an unequal relationship between service user and professional, argued to show an imbalance of power (Askham and Chisholm, 2006; Coulter and Ellis, 2006; Davis and Meltzer, 2007;). Recent policy in healthcare in the UK indicates a steady shift away from visualising the professional as the expert, with a growing emphasis on patients as experts with the ability to lead decision-making regarding their own health (Department of Health, 2009; Department of Health, 2010).

Rationale: One theory used to explain unequal partnerships in the context of information exchange is principal-agent theory (Stiglitz, 1988). The theory originated in economics, but has been used to understand the role of the patient and professional in medical settings (Vick and Scott, 1998; Waterman and Meier, 1998; Coast, 2001). In healthcare, patients are the principals and professionals, as the agents, act on behalf of principals. Principals are likely to have limited knowledge of health and are therefore reliant on agents to provide information, make recommendations and acquire resources (Coast, 2001). The partnership between patient and professional (principal and agent) may therefore be viewed as a contract that is determined by asymmetric information: the professional has specialist information that can benefit the patient. This may be seen as advantaging the professional, who could maximise his or her own interests and exploit the patient's lack of information (Vick and Scott, 1998). Whilst the professional acts as agent, the principal's needs may not determine the decisions that are made. This may not be an explicit or exploitative process

34

but, nonetheless, advantages the professional. The contrasting argument, presented by the theory of public service motivation, suggests that professionals are motivated by altruism to provide high quality services for the public, based entirely on the needs of patients (Myers, 2008; Andersen, 2009; Perry et al., 2010).

Empirical evidence on variation in health care appears to endorse the principal-agent theory (Wennberg, 2002; Wennberg, 2011), illustrating how availability of health care can influence treatment decisions by professionals. Variation in health provision between regions in the USA appears to be unrelated to the level of need in the population (Wennberg, 2011) but more closely associated with the number of medical practitioners. The increased use of services by principals in the study reflected the capacity of health providers, in terms of the number of doctors, to provide a treatment. In this context, the agent, as expert, rather than the principal with the health needs, can be seen to create the demand for specific treatments.

Implications for practice: A model based on the professional adopting the role of decision-maker does not fit well with the current emphasis on partnership, choice and personalisation. However, empirical evidence suggests that service users value expertise and that this is associated with participation and engagement in care (Jungermann and Fischer, 2005). Two characteristics are seen in the evidence reviewed below: first, expertise is regarded as reassuring when individuals are making decisions that are outside their own knowledge base, and second, individuals may have an explicit preference for the professional, as expert, to be the decision-maker. In other words, people seeking advice are unlikely to have the experience or knowledge to consider the range of available options and make an informed choice in a specialist field (Hibbard et al., 1997). They look to experts to enable speedy access to information, using experts' knowledge and highly

developed interpretive skills, to reduce the search costs for themselves (Hibbard et al., 1997; Jungermann and Fischer, 2005). People, therefore, actively seek a credible expert who can give specialist advice. The professional has skills that are cultivated through training and experience, which supports decision-making for the less experienced partner (Ericsson et al., 2007; Greenhalgh, 2011; Roulstone, 2011). Implicit in the process of consulting a professional is the expectation that they have expertise and knowledge resulting in asymmetric information. Service users have an expectation of asymmetric information and, on balance, may not consider asymmetric information problematic.

An interesting example from a non-medical context showed that students viewed advice about personal problems differently when delivered by expert rather than generic advisers (Bo Feng and MacGeorge, 2010). The expertise of the advice giver was an important factor in how advice was received, adding credibility to the recommendations made. Furthermore, the expertise of the advisor influenced participants' intention to implement advice. These findings should be applied to other contexts with caution: the participants did not represent a diverse group in terms of age or education. However, the findings coincide with evidence from a health study of pre-natal diagnostic screening (Jungermann, 1999). Advice seekers, who did not have the knowledge and skills to make independent decisions, evaluated the expert's recommendation based on trust and credibility. Patients in this study were seeking recommendations from experienced professionals who could help them understand the options.

Thus, advice from an individual in an expert role may be essential for individuals to make decisions about health interventions. Furthermore, some people may prefer the expert to be the final decision-maker (Longo et al., 2006; Beresford and Sloper, 2008). A population based survey of over 2,000 respondents seeking general medical advice in the USA

(Levinson et al., 2005) asked participants to identify their preferences for patient-led or doctor-led decision-making. Over half of the sample preferred to leave the final decision-making to the doctor. The authors indicated that demographic differences such as gender, education and well-being were associated with patient preferences, though the study did not identify the variation that occurred according to type or severity of disorder or intervention required.

In paediatric speech and language therapy, evidence indicates that goal setting is an example of decision-making that is generally led by the SLT as the individual with expertise in speech and language development. Goals are usually formulated by the professional as decision-maker following assessment (Lindsay and Dockrell, 2004). Decision-making is therefore, largely expert-led, with parents contributing relevant information, but rarely leading the decision-making (Watts Pappas et al., 2008). Parents, in some studies, were explicit in indicating that they expected goal setting and intervention to be led by the professional (Baxendale, 2001). Carroll (2010) used both quantitative and qualitative methods to ascertain parents' perception of attending speech and language therapy with school age children with learning difficulties. She found that parents expected clinicians to make the decisions and carry out intervention. Arguments from other professional fields propose that professional-led decision-making leads to dependency in the service user (Coulter, 1999). To date, this has not been explored in the literature in paediatric speech and language therapy. The role of the professional in determining parents' expectations and behaviour is also under-researched. Marshall et al. (2007) indicated that therapists' behaviour may reinforce an expectation that decision-making and intervention is led by the professional, through failing to acknowledge or build on parents' existing approaches, implying that the professional has a critical role in determining who is deemed informed enough to lead decision-making.

In summary, the evidence indicated benefits, as well as disadvantages, of the professional assuming the role of decision-maker. Accessing a professional with expert skills and knowledge who can quickly evaluate needs and recommend intervention goals appears to be regarded positively by parents, but the evidence in speech and language therapy is too limited to draw firm conclusions about parents' perception of the professional as decision-maker.

2.4.2   Negotiated decision-making between parent and professional

Description: Policy initiatives in England (Desforges and Abouchaar, 2003; Department for Education and Skills, 2007; Department for Education, 2008) have presented the parent-professional relationship as shared practice, with full parental participation, though the nature of joint working has not been clarified (Pinkus, 2003). This level of participation depends on increased involvement in decision-making, based on negotiation (Goodall et al., 2011). Negotiation is a necessary skill throughout the decision-making process, from the initial exchange of information through to the final agreement about intervention choices (Edwards and Elwyn, 2009). Negotiated decision-making has become a central tenet of family centred care recommended by policy makers in Australia, Canada and the USA (Dunst et al., 2007) and the family partnership model in England (Davis and Meltzer, 2007).

Rationale: The rationale for negotiated decision-making highlights the importance of mutual respect for the skills and expertise of each participant in a partnership. Carlhed et al. (2003, p 76.) acknowledges the different, but equally important, roles of parents and professionals in contributing their own expertise to decision-making and intervention planning using the term *cumulative expertise*. This conveys the shared nature of problem solving and the expertise of professionals and parents alike, 'professionals have expertise

in helping parents to make informed decisions by defining problems and goals......parents however have knowledge of how, when and by whom interventions should be implemented'

Implications for practice: Two features of negotiated decision-making are highlighted by the research: (i) consensus building in order to agree interventions that are most appropriate for a family (Charles et al., 1997); (ii) relationship building between parents and professionals, based on shared responsibility and trust (Messer and Wampold, 2002; O'Connor, 2008;). This is often termed working alliance or therapeutic alliance in the literature (Dunst and Dempsey, 2007; Elvins and Green, 2008)

First, building a consensus about preferred intervention does not necessarily mean parents lead the decision-making. The negotiation may result in a professional-led, shared or individual-led decision (Jackson et al., 2008). In this instance, negotiation will involve a process where practitioners ascertain an individual's preferred level of involvement as a process of consensus building. In reality, determining preferences about level of involvement appears to be a complex process and practice varies markedly (Goossensen et al., 2007). Studies from medicine indicate that clinicians do not routinely negotiate patients' preferences for their level of involvement in decision-making. The majority of people consulting general practitioners in the USA preferred being offered choices about possible care (Levinson et al., 2005). However, over half the patients preferred to leave the final decision to the health professional. An additional complication is finding that people's perception of decision-making does not always coincide with the reality of practice. An observational study of general practice in the UK, (Ford et al., 2006) found that 77% of decisions were doctor led, 12% shared and 11% patient led. However, patients' perception

was quite different, with 53% of people in the same study believing they were sharing decision-making.

Parents report considerable variation in their perception of involvement in intervention decisions (Band et al., 2002; Lindsay and Dockrell, 2004; Rannard et al., 2005). The findings of a national review in England (Bercow, 2008) indicated that they struggle to be recognised by professionals as partners in the team supporting their child's speech and language development, suggesting that parents do not perceive decision-making as negotiated.

Misperceptions are also evident in professionals' awareness of their own practice. According to a survey of SLTs in Australia (Watts-Pappas et al., 2008), therapists working with children with speech sound difficulties believed they were providing family centred care that included negotiated decision-making. However, their decisions during assessment and intervention indicated their approach was more consistent with a therapist-led model of decision-making (Watts Pappas and McLeod, 2009). Consensus building and negotiated decision-making appears to be viewed as important by parents and SLTs, but practice is not always consistent with these views.

Second, the relationship between the professional and the family has been described as the essential mechanism for achieving negotiated decision-making. This, in turn, is thought to foster an enhanced sense of control over events for parents of children with disabilities (Keen, 2007; Elvins and Green, 2008). Studies from psychology have indicated that the relationship, termed therapeutic alliance, is associated with better outcomes and is characterised by shared goals between the client and professional, as part of a trusting relationship. In speech and language therapy, Plexico et al. (2010 p 348.) explored the nature of the relationship between SLTs and adults who stammered. They identified

characteristics such as empathy, on the part of the professional, and honesty from both participants, as important factors. A strong alliance was described as 'based on the ability to convey a sense of acceptance, understanding and trust'. The alliance between parents and SLTs may well be built on the same characteristics. However, whilst alliance may be associated with variation in treatment outcomes in the literature, understanding and measuring alliance has been difficult to achieve and is potentially more complex in a three-way relationship between parent, child and professional.

2.4.3   Parent as decision-maker

Description: Policy in health and education increasingly considers parents as decision-makers in making informed choices (Hanna and Rodger, 2002). This has been associated with the application of concepts of consumerism in health care (Woolf et al., 2005). Positioning the patient as consumer has been expressed as a means of generating greater patient involvement through encouraging a sense of increased control and responsibility in decision-making (Kaufman et al., 2013). The consumer, as decision-maker, chooses the intervention and sets the terms of involvement for themselves and the professional (Hogg, 1999). This notion has been challenged by a number of researchers (Cawston and Barbour, 2003; Edwards and Elwyn, 2006; Greener, 2007; Entwistle et al., 2010) and has largely been superseded by an emphasis on choice and control as part of a personalisation agenda (Tritter, 2009). However, consumerism continues to have a powerful influence on policy makers' and practitioners' thinking (Hare et al., 2013). Less is known about how this concept is viewed by service users and whether parents, when seeking support for their children, perceive their role to be that of a consumer. Introducing personal budgets as part

of special educational needs policy in England may consolidate or counter conceptions that parents have of their role as consumers over the coming years[5].

Rationale: Using the terms of the principal-agent theory, parents as decision-makers can be expressed as achieving a balanced agency in a relationship. The professional acts as an agent for the client, providing assessment and information, whilst the client, as principal, becomes the informed service user, competent to act as decision-maker. In the context of working with families, this represents a clear shift away from the professional as decision-maker to parents leading the decision-making on behalf of their children (Dunst et al., 2007). Smith et al. (2006) argue that applying the 'principal-agent' theory to healthcare commissioning is problematic because 'there are two sets of principal agent relationships: commissioners as the agents of patients and providers as the agents of commissioners' (p.8). Owens (2012) expresses concern that the professional may be viewed as little more than the source of information in this kind of model, resulting in provision based on a business relationship, which lacks any personalised care rooted in a reciprocal relationship.

Implications for practice: Encouraging parents to be independent decision-makers is consistent with the principles of choice and autonomy, as promoted by policy in England (Department of Health, 2009). However, Valentine et al., (2008) found that people rate prompt attention, dignity and communication in health care more highly than choice. Furthermore, studies of parents of children with health needs present contradictory findings. Some researchers have argued that responsibility for intervention has been passed to parents too readily, with insufficient negotiation of roles or support (Franck and Callery, 2004; Crais et al., 2006). Conversely, other researchers suggest that professionals

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5 (https://www.gov.uk/government/news/special-educational-needs-support-families-to-be-given-personal-budgets)

are reluctant to pass responsibility for medical care to parents despite parents' readiness to take on additional roles (Corlett and Twycross, 2006). This was interpreted as reluctance on the part of professionals to relinquish responsibility, in this case, for medical care, though no reasons for this were reported.

Giving parents independence and autonomy is often associated with enhancing their knowledge and skills through training (Pelletier and Brent, 2002). Parent education programmes are a regular option for intervention in speech and language therapy (Law et al., 2003; Roberts and Kaiser, 2011; Beecham et al., 2012; Roulstone et al., 2012) and may consist of formal training programmes or consititute part of the routine intervention provided by SLTs in individual therapy sessions. This approach aims to enhance parents' skills in supporting children's language development through improving the interaction between parent and child, using practices such as group training, video-reflection and individual coaching (Girolametto et al., 1996; Baxendale, 2001). However, few of these explicitly aim to build the parent as decision-maker and studies rarely evaluate parents' role in making decisions or changes in parents' capacity to make decisions about intervention. Indeed some researchers argue that parent education is disempowering (Turnbull et al., 2000), a theme discussed in more detail in Section 3.

The role of parents, as decision-makers during speech and language therapy can only be inferred from findings reporting the difficulties parents experience in partnership practice. For example, Band et al (2002) and Lindsay and Dockrell (2004) noted that parents reported considerable frustration at the assessment process for children with speech and language needs, describing it as 'a fight'. Rannard, Lyons and Glenn (2005) found parents struggling to access appropriate specialist support for children with long-term speech and language needs, noting that parents are often aware of difficulties from a very early age,

but feel isolated in expressing their concerns. This coincides with the observation that some parents regard themselves as experts in knowing their children, whilst SLTs do not take account of what parents are doing or have tried (Marshall et al., 2007, p.551-552).

The review indicated the importance of decision-making in partnership working. However, decision-making is a complex process, with variation acknowledged in theory and practice (Kahneman and Tversky, 1984; Shafir et al., 1993). As Kahneman and Tversky (1984, p.349)) observed, the 'conception of an idealised decision-maker who is able to predict future experiences with perfect accuracy and evaluate options accordingly' is an assumption that overlooks the uncertainty inherent in ordinary decision-making.

The following section reviews studies that investigated how parents and professionals perceive their roles and how these perceptions differ. The implications of both sections of the literature reviews are discussed in the final section.

2.5   Parent and SLT conception of roles

2.5.1   Introduction

Section 2.3 described the evidence relating to models of partnership practice and their implications for parent and SLT conceptions of roles. This section considers the nature of parent and SLT role conception and how it is thought to be determined and influenced, drawing on cross-disciplinary evidence.

 Four areas of interest relating to parents' role conception are reviewed in Sections 2.4.2-2.4.5:

(a) Role conceptions and relationship with social factors

(b) Parents' role conceptions and their children's characteristics

(c) Role conceptions and parental self-efficacy

(d) Role conceptions and parent education

Section 2.4.6 critically evaluates the evidence for negative influences on parents' role conception relating to power relationship and voice. Section 2.4.7-8 reviews the evidence relating to parent and SLT conception of roles in two parts: parent expectations of their own and SLT roles, and SLT expectations of their own and parents' roles. Section 2.5 discusses the implications of the evidence and summarises the gaps in evidence that informed the design of the research presented in this thesis.

The roles that people assume throughout their lives are varied and complex (Merton, 1957). How parents perceive their roles in given contexts informs their behaviour, with behaviour thought to follow from perception, beliefs and values (Mowder and Shamah, 2011). Role conception is thought to be important in understanding parents' involvement in school, and has been associated with characteristics of parents' behaviour related to supporting learning (Hoover-Dempsey and Sadler, 1997). It is, therefore, surprising that studies extending knowledge of role conceptions in SLT partnerships have featured so rarely in the literature. Accordingly, the following section draws largely on the evidence from the research base in education, health and psychology. The areas of interest (a) – (d) will be discussed with reference to four notable theories that are particularly pertinent to the study of parent and professional roles:

i) *The theory of parental involvement* describes the influence of school organisations and individual teachers on parents' role conception (Hoover-Dempsey and Sandler, 1997; Hoover-Dempsey et al., 2005)

ii) *The parent development theory* explores the influence of children's characteristics on parents' role conception (Mowder, 2005)

iii) *The theory of self-efficacy* provides an explanation of parental confidence and self-belief in their roles (Bandura, 2001)

iv) *The conceptual change theory* describes how individuals learn new concepts through major revision of existing knowledge (Vosniadou, 2013b)

It is important to take into account at the outset that role conception is a complex phenomenon, with many associated factors, and there will always be a risk of oversimplifying complex characteristics or omitting important contributory features in order to understand the phenomenon. Reviewing the literature from a range of disciplines is intended to provide a broad review of current understanding of role conception, and ameliorate any tendency to oversimplify.

2.5.2 Role conception and social factors: theory of parental involvement

Cognitive role theory describes how roles are socially determined behaviour patterns (Biddle, 1986). Roles are believed to vary and change over time, raising questions about the way role conceptions are determined in relation to the social context. There are two key concepts from cognitive role theory that are particularly relevant for understanding the social influences on parent and SLT conception of roles:

(i) Consensus: referring to agreement of expectations by people involved in a social situation

(ii) Role taking: referring to alignment of expectations that people attribute to others with the expectations that the others hold themselves

There appears to be little recent research in the area of role taking, with no progress to refute Biddles's assertion that the empirical evidence on role taking is inconclusive and fragmented (Biddle, 1986). Moreover, the focus of interest for researchers has been largely consensus relating to social norms for subgroups of people, rather than roles that are established between individuals as part of a new relationship, such as parents and SLTs. Educational research has contributed relevant evidence in investigating parents' involvement in children's learning. A number of empirical studies have investigated parents' role as 'helper' in their children's education through undertaking home based activities such as homework, and school based activities such as volunteering in class (Tveit, 2009; Avvisati et al., 2011). Hoover-Dempsey et al. (2005) argue that role construction is a socially determined concept that includes attitudinal elements, such as beliefs and aspirations, and behavioural elements, reflecting the actions that parents intend taking. Role concepts are thought to develop and change in response to parents' experience over a lifetime. Interaction with family, friends and the wider social group influence underlying values, whilst ideas continue to grow as parents participate in different groups during their child's development.

Hoover-Dempsey et al. describe three elements that influence parents' role construction as: (a) group expectation of a parent's behaviour, expressed as 'what do others expect of me in my parent role? ; (b) individual parent's personal role conceptions, expressed as 'what do I expect of myself?'; (c) role behaviour, expressed as 'what do I do in my role or what else should I do?'.

The authors' empirical studies provide evidence of three themes relevant to the work of SLT. First, role construction was open to change and responsive to social factors, such as parents' experience and context. Second, self-efficacy played an important part in shaping

role construction. Third, direct invitations from teachers to parents to be involved in children's education served as an important motivator signaling that parents' role as helper was valued. The authors comment that this may be important for parents 'whose role construction is relatively passive and whose sense of efficacy is relatively weak' (p.110). They concluded that partnership-focused role construction was the most important predictor of parental involvement in school and that this can be influenced by the way institutions and individual teachers approach their work with parents. Different findings were found from a survey of 431 parents suggesting that role construction and self-efficacy did not have the strongest association with parental involvement behaviours (Anderson and Minke, 2007). The authors acknowledge that these findings are puzzling and suggest that the complexity of constructs of role conception and self-efficacy may require more comprehensive measures in future research to provide clearer evidence of the role of self-efficacy.

The relationship between role conception and parents' school involvement has yet to be confirmed by further research, but it seems clear that teachers' roles in encouraging parents to adopt new or different roles plays an important part in parents' participation. Two other studies from different international contexts consider the way professionals may influence parents' role conception. Lawson (2003) reported a disparity between teachers' and parents' expectation of involvement in school in an urban community in the USA: teachers anticipated that parents should support the teacher's role as clearly prescribed by the professional. However, parents indicated that they were unprepared for this and felt compromised. Parents cited family and time constraints as contributing to their reluctance to support the teacher's role. A study of teachers' views from Norway (Karlsen Bæck, 2010) suggested teachers choose to limit parents' influence on their children's education. They preferred to see parents in support roles rather than roles that

required greater involvement in children's learning. Studies of parents with children with additional needs tend to confirm this. Parents perceived themselves as excluded from genuine involvement in their children's education believing that their knowledge of their children was undervalued, whilst professional knowledge was the privileged voice in the partnership (Case, 2000; Rannard et al., 2005; Hodge and Runswick-Cole, 2008). These authors report that parents are expected to contribute to children's learning in a closely prescribed way determined by professionals. This exists despite the different emphasis on working with children and parents in policy from different countries (Vandenbroeck 2014).

School involvement is an experience common to almost all parents, and therefore contrasts with parents' involvement in speech and language therapy. Only a small proportion of parents have children with speech and language needs, which contributes to feelings of isolation for parents (Glogowska and Campbell, 2000). Many parents attending speech and language therapy are encountering an entirely new experience; they are unlikely to have had opportunities to shape their expectations or understanding of their roles fully. It is therefore, important for SLTs to reconcile the two features of parents' inexperience and parents' openness to adapt their role conceptions. Features that are associated with enabling greater parental involvement in school may be helpful in understanding parental role conception and engagement in speech and language therapy.

Research has investigated other theories of socially determined constructs, such as parenting styles, but these are beyond the scope of this review on conception of roles.

2.5.3 Role conception and children's characteristics: parent development theory

A central part of parents' social world is, of course, their child, who will influence their role conception significantly and profoundly. The role of parenting is new to each parent, at some point, and is likely to change and develop as his or her child grows. Parent development theory is a framework that has been used to explore parent perspectives of their roles in relation to developmental delay (Mowder, 2005). It proposes that the parenting role is composed of six characteristics that vary according to children's developmental stage. These characteristics are bonding, discipline, education, welfare and protection, responsivity and sensitivity (Sperling and Mowder, 2006). The researchers measured parents' beliefs and behaviour using two self-report tools, the Parent Behaviour Importance Questionnaire and the Parent Behaviour Frequency Questionnaire (Mowder and Shamah, 2011). Sperling and Mowder (2006) found that differences between parents' perceptions of their roles were associated with their children's developmental progress. 79 parents participated in the study, 50 with typically developing pre-schoolers and 29 with children with developmental delay. Parents of pre-schoolers with developmental delay emphasised welfare and sensitivity in their parenting role, contrasting with parents of typically developing children who prioritised an education role. The type and severity of the developmental need was not clearly identified in the study and therefore the findings cannot be directly applied to parents of children with speech and language needs. However, it clearly indicates variation in role conception related to children's development and implies that roles change and are shaped by one another, an important finding relevant to the parent-professional partnership.

2.5.4 Role conception and self-belief: the theory of self-efficacy

Self-efficacy refers to beliefs that individuals hold regarding their ability to undertake roles, in this case parenting. Higher self-belief is associated with more positive thinking and behaviour in a given situation that may apply to parents in their caring or education role (Bandura, 2001). Parents with high self-efficacy believe they are able to influence their child's development positively and are more responsive to their child's needs, engaging more fully in interaction with their children (Coleman & Hildebrandt-Karraker, 1997; Pelletier and Brent, 2002). Harty et al. (2007), assessed the self efficacy of parents of children with communication difficulties. The authors measured parents' self efficacy relative to roles of nurture, discipline, play, teaching and emotional availability. According to the authors, parents generally had high scores for self-efficacy, but tended to be lower in the roles of teaching and discipline (Harty et al., 2007). This contrasts with parents of typically developing children who rated education as a role they felt confident to participate in (Sperling and Mowder 2006), though the studies used different methods so may not have been measuring the same constructs. Harty et al. (2007) argue that parents of children with disability find joint working with professionals tends to undermine their self belief, although their study did not ask parents about joint working with professionals and therefore did not provide evidence to support this claim. The study has two further marked anomolies: first, they use a small sample in their study (25 parents) which places uncertainty on the statisitical analysis and, second, the sample was largely middle class, degree educated and accessing specialist support, and therefore unrepresentative.

2.5.5 Parents' role conception and learning

Parents' roles are important in enabling young children to learn language (Kaiser and Hancock, 2003). However, little is known about parents' conception of working with professionals to learn new skills themselves to support children's language learning, or the relationship between changes in parental conceptions and their behaviour. Conceptual change has been well documented in education and psychology as an important construct in promoting children's learning (Vosniadou, 2013b), but has not been widely explored in the context of adult learning, particularly in relation to understanding health concepts (Kaufman et al., 2013).

Conceptual change theory describes learning as an interaction between a learner's current conceptions and prior knowledge and their experiences, influencing their emerging beliefs in ways that encourage fundamental changes to their understanding (Pintrich et al., 1993; Kaufman et al., 2013). Vosniadou (2007, p.48.) describes this as 'restructuring prior knowledge which is based on everyday experience and culture'. There are thought to be at least three forms of prior knowledge associated with learning (Chi, 2008): no knowledge, limited knowledge or misperceived knowledge that conflicts with new knowledge. The nature of learning for each form is therefore described as adding knowledge, gap filling or conceptual change. In the latter case, an individual's experience may conflict with their existing conceptual model, such that their conceptual framework is challenged and altered, representing a significant shift in their understanding. Alternatively, the new experience may be resisted, giving rise to misperceptions that are resistant to change. Learning involves changing these misperceptions. Vosniadou (2013a) suggests four conditions that are necessary to enable conceptual change: (i) dissatisfaction with current conceptions (ii) new conceptions must make sense and be understandable for the learner (iii) new conceptions must appear to be plausible, even if the learner does not initially consider

them true (iv) new conceptions should appear a potentially valuable tool for thought. Applying this to parents and their learning as part of their involvement in speech and language therapy could provide a helpful explanatory model relevant for intervention based on parent education and coaching. However, conceptual change theory has considered learning as a purely cognitive process with little acknowledgement of social aspects of learning. Linnenbrink and Pintrich (2002) and Sinatra, (2005), have addressed this through extending conceptual change theory beyond 'cold conceptual change' to 'hot conceptual change'. This includes motivational beliefs as an important feature in the process of conceptual change, in keeping with the social nature of learning. Miyake (2013, p.469) highlighted the importance of collaborative learning in enabling children's rudimentary understanding to be transformed into abstract concepts. She describes conceptual change resulting from 'collaborative reflection' where two or more individuals approach problem solving as a joint or shared endeavour promoted by questions and criticisms between participants. Problem solvers are thought to exchange roles during learning, between 'task doer' and 'monitor', as part of an iterative cycle of understanding leading to conceptual change. In the context of student learning, an individual learns to 'externalize his/her understanding in words, providing data for reflection and evaluation, for the teacher as well as the student' (p 480). Teachers are seen as 're-voicing' pupils' utterances to promote discussion leading to conceptual change.

Conceptual change theory applies to changes in understanding conceptions, potentially relevant to conceptions of role, but makes little reference to how this is related to behaviour (Kaufman et al., 2013). In contrast, behaviour change theory, seen in health psychology (for example, the theory of planned behaviour, Perkins et al., 2007), focuses more explicitly on changing behaviour and tends to present health knowledge as facts and information (Kaufman et al., 2013). Kaufman et al., (2013, p. 241) suggest that 'conceptual

understanding of health issues gives individuals the power to derive predictions and explanations' to support problem solving and decision-making relating to behaviour.

Drawing on conceptual change theory may improve understanding the conceptions underpinning parent behaviour in relation to participation in speech and language therapy and provide a basis for helping parents develop a deeper understanding of the issues relating to language learning. The framework is new to SLT and potentially valuable for understanding change in parents' conception of their roles.

There is a consensus among educationalists that strong associations exist between parental involvement in learning at home and a child's achievements (Desforges and Abouchaar, 2003). However, little is known about the impact of different types of support, which can vary from encouraging parents to adapt interaction and use home conversations to reinforce learning to assisting with prescribed homework activities (Desforges and Abouchaar, 2003; Harris and Goodall, 2008; Goodall and Vorhaus, 2011). The importance of helping parents learn to support their children's development is evidenced by the growth of parent education programmes. These can be categorised as either behaviour based, aiming to change parents' behaviour or cognitive based, intending to change attitudes and beliefs (Moran et al., 2004). However, few programmes outline the adult learning theory that has informed their development. When reference is made to theory, it tends to be theories of attachment or the social learning theory, focusing on children's learning (for example, Herschell et al 2002) but provide no indication of learning theory in relation to parents as learners. Conceptual change theory could usefully be applied to adult learning as part of parent education programmes.

Parent education to support parents with young children may either be universal, offered to all families, or targeted in response to a specific set of needs, such as behaviour problems, maternal health or developmental delay (Mahoney et al., 1999; Olds et al., 2007;

Lindsay et al., 2011). These programmes focus on three broad areas: a) adapting the home environment to promote learning (for example, Melhuish et al., 2008); b) promoting specific skills such as communication (Kaiser and Hancock, 2003) and c) implementing pre-set home activities to address specific developmental needs (Pennington and Noble, 2009). Parent education programmes in speech and language therapy adopt the same aims of promoting specific skills, helping parents adapt home learning, and implementing language-focused activities. This review provides a brief summary of evidence relating to parenting programmes generally and aims to focus more closely on those used in speech and language therapy.

2.5.5.1 Home Activities

Providing home activities in speech and language therapy is thought to support generalisation of learning to the natural setting of day-to-day communication, promoting continuation of learning and allowing targets to be moulded to the interests of the child and family. The evidence from the perspectives of parents and professionals presents contrasting findings. Studies from other disciplines tend to confirm that parents' views of the helper role vary considerably. Leiter (2004) found that mothers perceived having home activities as a positive addition to their many existing roles whilst Brady et al. (2006) noted that some mothers regarded undertaking teaching activities as a reduction to their role as mothers. Goldbart and Marshall (2004) reported that some parents, with children with longer-term communication difficulties, felt unprepared for using communication aids at home. Hinojosa (1990) found that parents in their study adapted programmes to fit in with family life, rather than implement activities exactly as recommended.

The evidence relating to the factors that support or discourage parents' participation with home activities is equivocal. Evaluation of the US Headstart programme indicate that

professional approaches involving modelling activities together with parents and discussing relevance of activities to the home setting, were important factors in the effectiveness of the programme (Love et al., 2005; Raikes et al., 2006).

Research with SLTs indicates a strong belief in the benefit of home activities. In an Australian study, 95% of respondents in a survey of 227 SLTs working with speech sound difficulties (Watts Pappas et al., 2008) specified that they always or usually gave parents home activities. However, responses were less clear when asked about parents' involvement in intervention, with 40% indicating that they were dissatisfied with parental involvement. The authors identified three factors that SLTs believed interfered with parents doing home activities: (i) service barriers, such as school based provision, preventing involvement of parents; (ii) speech and language therapy constraints, such as time and experience; (iii) and parent barriers, including capability, time and expectations. SLTs questioned parents' ability to implement home activities, quoting inadequate knowledge of speech and language development and limited commitment to their children's development as major issues (Watts Pappas and McLeod, 2009). This seems to suggest that SLTs provide home activities without necessarily involving parents in interventions, or having faith in their ability to implement home activities.

Bowen and Cupples (2004) describe parent training using home activities for children with speech sound difficulties. In a small experimental study, comparing a parent-training programme and SLT only intervention, they identified positive outcomes for children's phonological skills following parents' involvement with the parent programme. However, as the authors commented, the level of home activities reported by parents was exceptionally high (averaging 15 times per week) and would not be considered typical of parents' usual level of implementation.

2.5.5.2   Adapting home learning

Adapting the home learning environment through parent programmes has been incorporated in policy and promoted by governments internationally for example, Sure Start[6] in the UK (1998-present) and Head Start in the US[7] (1965-present). These initiatives tended to provide generic programmes to improve children's development, including communication and language, through focusing on the home learning environment. They used the principle that parental involvement in children's learning is important for later educational achievement (Goodman and Gregg, 2010). Home learning may be associated with learning specific skills that enable children to be ready to learn in school, and are thought to be indicative of more general features of supportive parenting, such as a positive attitude to learning, that are present in some home environments (Melhuish et al., 2008).   Nevertheless, the evidence of success of parenting programmes is inconclusive with recent systematic reviews presenting equivocal results and raising questions about the evidence for a causal relationship between parent intervention and improved outcomes for children (Barlow and Parsons, 2003; Pickstone et al., 2009; Gorard et al., 2012)

Evidence from a large randomised trial used data from parental interviews, assessment of children and observation of parent-child interactions to evaluate the impact of an early intervention programme in the USA (Love et al., 2005). This indicated that parents who participated in the programme provided more learning activities at home, with children demonstrating better outcomes in language and cognitive development. However, there is considerable variability in the delivery of early intervention programmes and attempts to isolate the specific factors that contribute to supporting successful home learning has been

[6] https://www.gov.uk/find-sure-start-childrens-centre
[7] http://www.acf.hhs.gov/programs/ohs

limited (Raikes et al., 2006). Raikes et al. found that the amount of 'child focused' activity observed during home visits was related to language development, parental support and home environment, but it was unclear how the relationship between these variables influenced each other and the role of home visiting support.

In conclusion, supporting the home learning environment as part of universal parenting programmes seems to be beneficial for some families and children but the nature of the home activities, how they are introduced to a family and the responsiveness of parents are likely to be associated with success or failure of interventions. Speech and language therapy intervention does not explicitly include programmes aimed at changing the home learning environment, despite the SLT contribution to the design and delivery of such programmes (Fuller, 2010).

2.5.5.3 Parent-child interaction

Three important features of parent education programmes have been identified in the literature: (i) parent education has become a regular option to support parents with a range of needs (ii) parent education is generally well evaluated (iii) professionals question whether all parents have the ability or motivation to benefit from parent education.

There has been a marked growth in the use of parent education to enhance parents' skills as an alternative or addition to professional-led intervention in a number of disciplines over the last twenty years (Law et al., 2009; Lindsay et al., 2011; Colmar, 2013). SLTs regularly use programmes such as the Hanen Programme (Manolson 1992) and Parent-Child Interaction (Herschell et al., 2002; Allen and Marshall, 2011).

Research evaluating parent education programmes designed to improve language development through improvements in parent-child interaction generally indicate favourable results (Kaiser and Hancock, 2003; Roberts and Kaiser, 2011). Studies suggest

that parent education is as effective as standard speech and language therapy in terms of children's outcomes (Baxendale, 2001; Law et al., 2003). Moreover, parents express positive views about learning how to improve language development in their young children (Wake et al., 2011).

Parent education in speech and language therapy has targeted a variety of speech and language difficulties. For example, improving parent-child interaction (Baxendale, 2001; Pennington et al., 2004; Pennington and Thomson, 2007), expressive vocabulary (Girolametto et al., 1996; Gibbard et al., 2004; Sheridan et al., 2011) and phonology (Bowen and Cupples, 2004). A Cochrane Review of speech and language therapy interventions compared a number of studies that included parent administered intervention associated with parent education (Law et al., 2003) . The authors concluded that the few studies eligible for the systematic review did not show a significant difference between intervention delivered by SLTs or by trained parents, suggesting that parent education may be equally valuable as a principal intervention. The studies included in the review tended to be difficult to compare, using very different study designs and sample charactersitics, as well as small sample sizes, such that firm conclusions should not be drawn.

Professionals express doubts about parents' capability in adopting an intervener role at home. Minke and Scott (1995, p345) gave examples of staff who commented that parents made poor choices or lacked concern about their child, 'There was a feeling among most staff members that at least some parents cannot be relied upon to act in the best interests of their children. Such views may encourage professionals to maintain a lead role and undervalue parents' skills and contribution. Leiter (2004) observed that in using the language of compliance and employing key indicators such as 'following the professionals' recommendations', staff were often failing to make allowances for parental circumstances.

Only a few professionals in this study acknowledged that parents should decide which and how much therapeutic care they wanted. She also reported that parents' considered the professionals' input had greater value than their own contribution, but the direction of influence is a matter of speculation.

In the context of helping children learn language, it is important to acknowledge that the parent's role as teacher is complex. The effectiveness of intervention focusing on training parents to teach their children in speech and language therapy may depend as much on a child's responsiveness during interaction as on a parent's ability to change their style of communication or implement home activities, making it difficult to identify which factors are influencing a child's progress in language.

2.5.6   Role conception and power relationships between parents and professionals

2.5.6.1   *Power over or power through parents*

This section provides evidence from the field of special education that is then considered in relation to power and role conception within parent-SLT partnerships. Two issues are highlighted in the literature: (i) the presence of an unequal relationship between advisers and parents; (ii) little recognition of parents' expertise.

Many commentators from health and education research have argued that power relationships and the associated privileging of specific voices within a professional-user partnership has positioned control with professionals rather than service users (Turnbull et al., 2000; Pinkus, 2003; Hess et al., 2006; Harris and Goodall, 2008; Rix and Paige-Smith, 2008). The literature from early childhood special education argues persuasively that the balance of power in family-professional partnerships has often disempowered parents, despite the evident 'evolution along a power continuum' that has been observed over a number of years (Turnbull et al., 2000, p.630). It is difficult to discern the interplay of

factors associated with the explicit or implicit agreement of the balance of power at any given time in a parent-professional partnership and, therefore, the debate often represents strongly held opinions rather than clear empirical evidence. It is ironic that the debate about power and voice presented by the researchers above is frequently presented by the voices of a small minority in special education. Consequently, it is difficult to determine how much power relationships influence the conception of role for either partner in routine encounters between parents and professionals.

The relationship between those seeking advice and the adviser cannot represent an equal and equivalent relationship. One participant, the parent, needs information and guidance, despite being expert in knowing their child, whilst the other has knowledge of specialist conditions gained through training and experience that could be beneficial to the first participant (Coast, 2001). This is not an unusual situation for individuals and involves roles that are familiar in a range of contexts. In the situation of a consultation with a specialist relating to a specific and relatively unknown condition, the lay person gains expertise through interaction with the professional, as a transfer of knowledge, in this case, from a trained professional to an untrained parent. Parents assume the role of learner and the professional that of adviser or teacher. However, research has shown that some parents find themselves in the role of information giver, but not decision-maker about intervention suggesting that either knowledge is not transferred and remains with the professional or it is not exercised by the parent (Hutchfield, 1999; Weatherley Valle and Aponte, 2002; Tveit, 2009). This is consistent with a 'power-over' model (Turnbull et al., 2000). Turnbull et al (2000) propose that both counselling and parent education models are based on a power-over relationship between the professional and parent. This is not presented as a failure to give parents an intervention role, but represents a 'conflict in role expectations. Often parents did not want to take on a pedagogical role, but instead

wanted to be "just" parents, not teachers' (p.638). They conclude that some parents may not want a teaching role. This is partially corroborated in a study by Rix and Paige-Smith, (2008). Parents' experience of adjusting parenting roles following their child's diagnosis of learning difficulties is described as a process of powerlessness, with parents often questioning the benefit of professional involvement and advice, but becoming professionalised themselves, using professional language and perceiving their child in the same way as the as the professional. The researchers described this as an acceptance of the professional way of thinking, focusing more on their child's developmental progress than their child's enjoyment of activities or interaction. The authors propose that this leads to parents assuming a didactic and over directive approach to their children as they adopt the role of teacher. The term *ad hoc professional* is used to describe how parents adapt to the expectations and challenges of working with professionals. The process is described as one of survival rather than empowerment. Professionals may regard transfer of knowledge as a good and necessary process, but there is a question about the new roles expected of parents and whether these add to their skills as parents.

Other studies suggest that parents rarely feel empowered by involvement with professionals. A number of studies from a range of countries report that there is little recognition of parental expertise or their role in decision-making with criticism of confusing systems, incomprehensible terminology and pre-determined decisions (Weatherley Valle and Aponte, 2002; Donaldson et al., 2004; Beresford et al., 2007; Head and Abbeduto, 2007).

Few studies consider the impact of power and expertise in speech and language therapy. What should we make of Glogowska's (2000) observation that parents felt a greater sense of power when working closely with the SLT? Parents reported that they felt less powerful

at the points where they took full responsibilty for supporting their child at inital and final stages of intervention. These findings suggest an alternative perspective that conceptualises the partnership as less about the power of expertise, associated with dominance and exclusion, and more about the skill of the professional in helping parents to gain knowledge and a new understanding of their role supporting their child's learning. This is difficult to reconcile with the wider consensus from special education that professionals assume power in parent-professional partnerships (Tveit, 2009; Verkaaiki et al., 2010). The tension between needing an expert role for problem solving and the risk of reducing parents' confidence to provide support is unresolved. One solution suggested by some researchers to rebalance the power differential resides in the quality of the relationship and prioritising relationship building (Kazdin et al., 2006; Davis and Meltzer, 2007; Elvins and Green, 2008; Verkaaiki et al., 2010). This has been discussed in detail in Section 2.2.2.

2.5.6.2 *The disqualified voice of the parent*

Redressing the imbalance in power through relationship building depends on the place that the parent voice has within the partnership. Policy initiatives and legislation, such as the Children and Families Act in England (2014), encourage parents to be involved as partners in every aspect of their child's development, with professionals and institutions urged to listen to the parent's voice (Desforges and Abouchaar, 2003). Policy makers have used the theory of markets to promote parents' voices in services (Kahneman and Tversky, 1984). Parents have been encouraged to perceive themselves as consumers, exercising choice by voicing their preferences, and responding to levels of satisfaction with provision by either maintaining 'loyalty' to a provider or seeking alternative provision in the face of dissatisfaction, that is 'exit' in Hirschman's terms (Hirschman, 1970; Greener, 2008). This may appear consistent with increasing parental voice and control, but adherence to a

theoretical principle may smother the voice of parents (Hogg, 1999; Gabe et al., 2004). To date, the literature has largely focused on strongly held positions and opinion, rather than empirical evidence and it is difficult to discern the views of parents from the literature.

Weatherly Valle and Aponte (2002) described a 'disqualification of parents' voices by school professionals' and Band et al (2002) argue that parents' voice is minimised by the power of professional language and behaviour. Voice and language are closely related: issues of professional language and the potential to silence parents' voices have been debated for many years (Brown and Trimbee, 2007). Bernstein's (1973) analysis of linguistic codes and social language focused on the language of the classroom, but the argument of exclusion by virtue of language codes can been applied to wider social contexts. For example, Brown and Trimbee, (2007) argue that the power of expert discourse excludes parents, silencing their voice and undermining their capacity for decision-making and leading to increased dependence on professionals. However, empirical evidence at this stage is limited.

Nevertheless, the UK has seen a burgeoning of partnership initiatives as a means of giving parents a stronger voice: examples include parent partnership services, parent partnership networks, pre-school learning alliances and patient involvement initiatives[8]. Legislation and policy in England (Department for Education and Skills, 2007; Department for Education, 2008; Department for Education, 2014) have encouraged service users to voice their preferences as part of partnerships with professionals. However, despite the enthusiasm for these initiatives, parents' voices are often not heard and little is known about how this relates to role conceptions of parents and professionals.

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[8] (http://www.parentpartnership.org.uk/,(https://www.pre-school.org.uk/parents/support-advice/423/parental-involvement http://nhsvoices.nhsconfed.org/2013/09/11/were-finally-hearing-how-vital-it-is-to-listen-to-patients-says-dr-katherine-rake-obe-2/).

2.5.7 Parents' expectations of their own and SLT roles

Research suggests that parents' expectations of their own roles include the role of advocacy but not necessarily one as intervener. Their expectation of SLT roles indicates that they anticipate that SLTs will have assessor, adviser and intervener roles. The evidence for each is reviewed below.

Parents play an important part in recognising, and following up concerns about their child's language difficulties, as advocates for their child (Glogowska and Campbell, 2004; Lindsay and Dockrell, 2004; Law and Roy, 2008; McAllister et al., 2011). The role involves identifying concerns, judging progress and seeking advice, if considered necessary. Parents assume this role routinely, though little is known about their variation in competence and confidence in the role. Parents' role in decision-making about referral to the SLT is reported in two studies: McAllister et al. (2011) reported that half the parents they surveyed in an Australian study made decisions that services were not needed, whilst in the UK, parents described controlling when a referral to the SLT occurred (Glogowska and Campbell, 2004). These studies indicate that parents expect to have an advocacy role, often including elements of assessment in order to judge when to seek help. However, there is little discussion about the variation in the advocacy role and characteristics associated with parents' confidence in their advocacy role.

In contrast to adopting an advocacy role, it appears parents' are more uncertain about assuming an intervention role. Evidence indicates that parents do not anticipate leading intervention themselves and assume the SLT will have the intervener role. In a survey of 120 parents in Ireland, there was an expectation that their child would receive face-to-face intervention with the SLT (Carroll, 2010). The study indicated that parents expected the clinician to be the decision-maker and intervener, suggesting parents rarely expected to

have a role as the main intervener. Similar findings were reported in two other studies from speech and language therapy services (Baxendale, 2001; Ruggero et al., 2012). However, evidence from a qualitative study exploring parents' views in depth, tends to contradict this conclusion (Glogowska, 2000). Parents were keen to have activities and ideas from the SLT to enable them to have an implementer role and they became frustrated when this failed to occur. They looked to the SLT for direction and guidance, as decision-maker, but were anxious to have activities they could do with their child. Parents wanted to be doing intervention even if they were not keen to decide treatment, set goals or evaluate progress.

One implication of these findings is that many parents, given an opportunity to learn how to help or provide intervention at home, welcome parent education by SLTs. As discussed in Section 2.4.3, the literature indicates that parent education programmes are increasingly used by SLTs (Law et al., 2009) with the intention of enabling parents to take a lead role as implementer of activities to support their children with a variety of speech and language needs (Baxendale, 2001; Bowen and Cupples, 2004; Gibbard et al., 2004; Colmar, 2013). Parent education, a regular element of the SLTs' practice, is reported to be one of the principal modes of intervention for pre-school children (Roulstone et al., 2012). Parents are expected to learn to adapt their interaction, which goes beyond implementing activities set by the SLT in the parent-as-aide approach. This implies an expectation that parents will change their understanding as well as change their behaviour. However, it is unclear whether the decision to use a parent education approach is SLT led or based on parents' desire or ability to be implementers of intervention.

Sperling and Mowder (2006) suggest that parents' conception of their role varies according to the progress their child is making (see 2.4.3). The study does not show to

what extent parents of children with speech and language delays have conceptions of roles relating to welfare and care, rather than education roles. Moreover, it does not specify how important characteristics such the severity of the child's difficulties or parental SES is associated with role conception. This poses a challenge regarding understanding the variation in parents' perception of their roles.

Another source of evidence relating to parents' conceptions of their own roles is their expectation of other people's roles relative to their own. Baxendale (2001) and Ruggero et al., (2012) found that parents expected others to be the intervener, with the implication that their own role is relatively passive and uninvolved. However, Marshall et al. (2007) found that some parents perceived that they had a teaching role. Notably, the SLTs in this study did not appear to acknowledge the active support parents were already providing for their children. This raises the question of the influence of parent and SLT conception of roles on one another's conception and behaviour during intervention.

2.5.8   SLTs' expectations of their own and parents' roles

SLTs expectations of their own and parents' roles have rarely been directly investigated in the literature, although it is often implicit in the perception of their therapy role. Two important issues relating to roles arise from recent studies of SLTs' perception of their working practice: (i) conceptions of roles in direct and indirect intervention and (ii) responsibility for decision-making.

There appears to be a contradiction in the evidence about SLTs' perception of their key roles, be it as intervener providing *direct* therapy, or facilitating change, through consultation, referred to as *indirect* therapy. Pring et al., (2012) surveyed 515 UK therapists about their views of their working practice. They found that SLTs believed they were gaining a wider set of roles and spending more time training others, including

parents. This was reported as not necessarily improving practice, or parents' and children's experience, by the participants. The reduction in providing *direct* therapy with children was viewed as reducing speech and language therapy effectiveness and changing their therapy role. This suggests that SLTs believe their primary role is that of intervener, providing *direct* intervention with children, with other roles such as training others, perceived as additional or *indirect*. The study does not define 'direct' and 'indirect' therapy, or discuss whether there is a shared understanding between SLTs of these terms. Moreover, these terms are not value-free, with indirect therapy suggesting intervention that is potentially less worthwhile. The results certainly appear at odds with findings from another UK survey of 500 SLTs reviewing intervention practices (Roulstone et al., 2012). SLTs described a large array of interventions they used, which firmly placed developing parent skills as an important focus of intervention, with 48% of respondents viewing parents as the main intervener for 4-5 year olds.

At first sight, these contrasting findings suggest contradictory evidence of SLTs' expectations of their roles in relation to 'doing' the intervention or facilitating parents. However, this may be an anomaly of the study designs, where different methods, questions, client groups and interpretation could have contributed to these contrasting findings. For example, Pring et al. (2012) assert that SLTs perceive providing training as an additional responsibility, but they do not include a question in their survey that makes any mention of training. It is therefore unclear how these conclusions were formed.

Neither study strongly suggests that SLTs perceived their role as one of educating parents. However, this is implicit in the way SLTs described the interventions they used. Watts Pappas et al (2008) report that 75% of SLTs in their survey had firm expectations that parents should find the time to do homework, presumably under the tuition and guidance

of the SLT in a teaching role. Intervention such as Parent Child Interaction (Kaiser and Hancock, 2003; Roberts and Kaiser, 2011) and Hanen (Girolametto et al., 1996) are described as methods of teaching parents to interact with their children, and form a regular part of practice (Sheridan et al., 2011).

The second issue relates to the debate about who assumes the role of decision-maker during speech and therapy intervention. The question of who takes ultimate responsibility for deciding the treatment goals for a child was illustrated by responses to a survey of Australian SLTs working with children with speech sound difficulties (Watts Pappas et al 2008). This suggested that SLTs perceived they were the ultimate decision-maker and implementer of therapy; only 38% expected parents to make the final decision. These authors point out that therapists' expectation and reported behaviour did not correspond in this study, suggesting a mismatch between what SLTs believe they were doing and what happened in practice. These therapists believed that parents should have the final say in goal setting during intervention, but in practice they reported using a therapist-led approach. They also reported variation in role conception among SLTs; those with more experience led the decision-making, and made the final decision about therapy goals more frequently than less experienced colleagues. This finding appears consistent with the results of another study exploring SLT working practice (Keilmann et al., 2004): therapists with many years' experience spend less time with parents. Neither study provided an explanation for this; therefore it is not possible to draw conclusions about characteristics associated with adopting roles. It is also important to note that both studies were conducted outside the UK (Australia and Germany) with different service delivery models that may have been a factor in the way SLTs responded.

SLTs varied in how they perceived parents' roles in an Australian survey. SLTs agreed that parents should be involved in intervention, but varied in the nature of the involvement (Watts Pappas et al., 2008). A high proportion indicated that parents were *present* during sessions (84% during assessment and 80% during intervention), but a much smaller proportion (35%) indicated that parents were *involved in intervention*. The study does not stipulate how 'involvement' was interpreted by the respondents, but potentially provides an interesting point of comparison between being present and being involved. Issues of parent capability and time were raised as barriers to parent involvement. The implication from this study is that the parent's role was more likely to be that of observer, rather than intervener. Contrast this with the 75% of SLTs who expected parents to implement activities at home as directed by the SLT; there is a clear contradiction between expectation and practice which may influence the way parents' develop their conception of roles during intervention.

In summary, evidence indicates that SLTs have a strong conception of their role as decision-maker and intervener, with a less clear conception of their education role. SLTs' conception of parents' roles are not clearly identified in the literature, but are implicit in what they do and the type of intervention they provide, indicating a parent as helper role.

2.6 Discussion

This chapter reviewed research on conception of roles of parents and SLTs in the context of policies, principles and practice of partnership between parents and professionals. The following section summarises the key findings from the literature review and highlights important points informing the design of the research study presented in this thesis.

Three important issues emerge from the review of policy: (i) policy does not always align with local organisation; (ii) policy is not necessarily evidence-led; (iii) there is a policy-

practice gap. Policy initiatives have promoted parental choice and involvement (Sure Start, 1998; Davis and Meltzer, 2007; Department for Education and Skills, 2007) whilst local commissioning and funding priorities have enabled, or at times hindered, parent involvement in speech and language therapy intervention (Bercow, 2008; Roulstone, 2011; Davies and Davies, 2012). A second concern is the reliability of policy itself, with some researchers questioning whether it is determined by evidence or convincing theory (Black, 2001; Brownson et al., 2009). The tension between policy based on a consumer model and that promoting partnership was illustrated by contradictory guidance for reform of special education in England (Department for Education, 2011). Consequently, policy on partnership practice may be important in setting the direction for speech and language therapy, but how it relates to evidence and influences practice is uncertain. Finally, policy can be difficult to implement and evidence from other disciplines questions the extent that policy has been implemented by practitioners (Cawston and Barbour, 2003; Pinkus, 2003) and there are uncertainties about the implementation of policy in relation to partnership practice for children with speech and language needs (Rannard, 2005; Bercow, 2008).

The principles of partnership have been usefully described using theoretical models of practice in a wide range of professions in health and education. These were reviewed using a framework based on decision-making. Whilst negotiated decision-making is intrinsically a preferred option, epitomising equal contributions from partners, the literature pointed to a complex picture, with people using services expressing variable preferences regarding who leads decision-making.

Evidence from the literature review suggests the following tensions exist in partnership practice in speech and language therapy.

1. *Parents' and SLTs as decision-makers*: SLTs do not use a single model of partnership practice and there are few studies investigating parent and professional perspectives of decision-making within the partnership, despite the growing emphasis placed on decision-making in the wider health care context.

2. *Role conception in intervention:* There is a lack of empirical evidence exploring parent and professional perspectives of their own and the roles of each other, particularly in terms of how conceptions of roles influence one another during intervention in speech and language therapy.

3. *Changes in role conception*: Role conception is not a static, unchanging characteristic, but open to influence and change in response to the social context. This raises a question about whether speech and language therapy intervention aims to change parents' conceptions, whether explicitly or implicitly, and to what extent a process of conceptual change is taking place during intervention.

4. *Parents and SLTs as learners and teachers*: SLTs' roles routinely include 'teaching' parents as part of their intervention. This may be formal parent education programmes or supporting parents' skills as part of usual intervention. One implication of adopting a teaching role in speech and language therapy may be that therapists are intending to change parents' conceptions as well as their behaviour. However, the teacher role, in relation to

72

parents, has not been investigated extensively in speech and language therapy.
Therefore, little is known of the role of parents as learners during intervention.

2.6.1 Parents and SLTs as decision-makers

The increasing emphasis on respecting parents' preferences and encouraging parents to voice their choices drew attention to the importance of the role of decision-making within a partnership approach. The first part of the review used a framework based on the role of decision-maker, suggesting three models of practice: professional as decision-maker, negotiated decision-making by parent and professional, and parent as decision-maker. The evidence to date provides an equivocal picture of parents' preferences for decision-making and the strands of evidence tend to be contradictory. People using services consider that there are advantages to decision-making led by professionals. This suggests that they do not necessarily find this disempowering, or are prepared to concede power in exchange for expertise. Negotiated decision-making involves professionals determining parents' preferred level of involvement in decision-making, but in reality this can be a complex process and susceptible to misperception by all those involved; encouraging parents to lead decision-making complies with the direction of policy (see NHS England[9]) in encouraging informed choice, but may not reflect parents' preferences for clear support and guidance. The consensus from other disciplines in health is that patients want *some level of involvement* in the *process* of decision-making (Deber, 2007; Dy and Purnell, 2012), implying that a negotiated process accords most closely with the findings from research.

Research investigating negotiated decision-making in a range of healthcare settings suggests that this could be an important line of enquiry for speech and language therapy where little is known about parent or SLT perception of shared decision-making.

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[9] http://www.england.nhs.uk/ourwork/pe/sdm/

Roulstone et al., (2012) have described the range of interventions, though many are adapted by practitioners who use eclectic approaches (Lancaster et al., 2010), but there is little record of negotiating decisions, agreeing roles and sharing intervention with parents. The professional discourse that frequently refers to 'clinical decision-making' (Justice, 2010) may, by implication, assume the SLT leads the decision, perpetuating a professional model of practice that encourages SLTs to perceive themselves as the decision-makers, rather than parents. Justice (2010, p. 85) expresses surprise 'that most treatment studies within the field of SLP largely ignore the potential relevance of clinician level factors in treatment delivery'. An equally important question is what place do patient level factors have, and the role of individuals, in influencing treatment decisions in speech and language therapy. In the context of working with pre-school children, where intervention often requires parent involvement, the realisation of the intervention is likely to be entirely dependent on the conceptions and behaviour of parents, as well as conceptions and behaviour of clinicians.

The absence of a single model of partnership practice with parents may obscure the clarity of expectations and explanations that take place between parents and SLTs.

2.6.2 Role conception in intervention

The literature review considered evidence of different role conceptions of parents and professionals during intervention, including the influence of one participant adopting a given role on the other participant. Research in speech and language therapy suggests that parents have a conception of their role as advocates but not necessarily of intervener: they do not anticipate leading intervention themselves and assume the SLT will adopt the intervener role. How much this is influenced by the assumptions that the SLT makes, and the role they assume in partnership, is not clear (Marshall et al., 2007). There are few

studies of SLTs' conceptions of roles that provide conclusive evidence of their perception. Some suggest that despite SLTs believing they are using a family centred approach to intervention they continue to have a strongly SLT led approach, indicating a mismatch between belief and behaviour (Watts Pappas et al., 2008).

Whilst there is little evidence that decision-making is shared in speech and language therapy, research suggests that the intervener role is implicitly regarded as shared by SLTs. SLTs work closely with parents of pre-school children to (i) maximise the participation of young children; (ii) to gather important assessment information and (iii) enlist parents to implement intervention in a parent-as-aide model (Watts Pappas et al., 2008; Bray, 2012). Intervention approaches frequently use parents as helpers or train parents to support speech and language development as part of parent programmes (Gibbard et al., 2004; Law et al, 2010). There is an increasing body of evidence showing that many parents can be taught how to become effective facilitators of language skills, often associated with good outcomes for children (Law et al., 2003; Gibbard et al., 2004; Roberts and Kaiser, 2011; Colmar, 2013). This has encouraged SLTs to embrace parent education as a routine component of practice (Roulstone et al., 2012). However, there has been little investigation about the process of decision-making in recommending a parent education approach or the way such an intervention is implemented. The 'shared' nature of a helper or parent education approach is likely to be quite different from an SLT as intervener in terms of the level of parent involvement and independence of parents as interveners. Parent education might be thought to help parents change sufficiently to support their child's language independently, whilst implementing activities and homework as directed by the SLT preserves the SLTs' control of decision-making regarding intervention. Studies investigating either model do not indicate whether parents view one approach as more 'shared' and empowering. Moreover, they show little of how

75

parents' and SLTs' conception of their own and each other's roles vary in response to the different intervention approaches. This forms a key line of enquiry in this research study, captured in research question one, 'what is the range of parents' and SLTs' conceptions of their own and each other's roles in different stages of intervention?'(see Section 1.3).

2.6.3   Changes in role conception

The question of how ready and able parents are to be learners in intervention draws on research from education indicating that parents' role conception is open to change. This is associated with social factors such as the effect of parents' self-efficacy and professionals' approaches (Hoover-Dempsey and Sandler, 1997), as well as the influence of children's development (Mowder, 2005). This challenges the notion of intervention that is strongly SLT-led (Watts Pappas et al., 2008), suggesting that therapy may fail to capitalise on parents' capacity to change and become more closely involved in intervention. However, there is uncertainty about how much professionals want parents to change and indeed, how much parents vary in their readiness to change. Evidence from other disciplines, such as teaching and nursing, show that professionals may choose to restrict the roles that parents adopt, preserving a 'helping' role rather than encouraging changes in parents' role conception as intervener. There are indications that professionals doubt parents' capability, but they may also have a tendency to preserve their own specialist skills in leading intervention. A similar process may be going on in speech and language therapy as indicated in one study where SLTs did not report building on what parents were already doing with their children (Marshall et al. 2007). This may suggest that full parent involvement is discouraged.

How much SLTs are aiming to change parents' role conception as intervener depends on the extent SLTs support conceptual change. The distinction between providing knowledge

about facts and encouraging explanatory knowledge to instigate changes has rarely been debated in speech and language therapy. Applying the reasoning of conceptual change to adult learners, parents can be seen as attending intervention with undeveloped concepts of children's language development and associated difficulties, which through collaborative learning may be transformed into a fuller understanding of their child's needs. This is addressed with the research questions, 'In what ways and to what extent do parents' conceptions of roles change whilst working with SLTs and how is this associated with partnership practice?'.

2.6.4   Parents and SLTs as learners and teachers

There is considerable evidence that parents' involvement in supporting children's learning is important. However, the role of parents supporting speech and language learning in intervention remains unclear. There is little to indicate that parents expect to be *learners* when they seek help from SLTs (Glogowska and Campbell, 2000; Baxendale, 2001). However, in other social contexts, such as school involvement, they show openness to changing role conceptions (Hoover-Dempsey, 1997; Mowder, 2005), suggesting parents may welcome adopting the roles of learner and intervener. The majority of language programmes (for example Hanen, Baxendale, 2001) focus on behavioural change, such as helping parents interact differently or undertake specific activities at home, with limited reference to changing parents' understanding. This gives rise to a question about how much 'teaching' (as part of therapy) is achieving change in parents' thinking about speech and language development. Indeed, the relationship between doing activities, developing understanding and changes in role conception would be a valuable route for future research.

The increasing use of parent education indicates that SLTs assume parents will adopt a learner role, but there is little to suggest that *teaching* is considered an integral part of SLTs' roles. The speech and language profession has embraced teaching parents but there are signs of tensions and uncertainty in using parent education. SLTs appear to be equivocal about parent education or training, described as an add-on to intervention, rather than an integral part of intervention (Pring et al., 2012). Moreover, there has been little discussion within the profession about the underlying purpose of parent education and the teacher-learner roles. The researcher's clinical experience suggests that adopting a 'teacher model' may be regarded as incompatible with a therapist's sense of self as a member of a unique profession, potentially contributing to the absence of debate or research. However, the model of collaborative problem solving together with collaborative reflection, expressed in the conceptual change literature, may indeed be usefully applied to understanding the teaching role assumed in speech and language therapy.

In order to understand role conception in speech and language therapy, the researcher has to draw on implicit features of practice, akin to 'tacit knowledge' in nursing (Phelvin, 2013). Finding a means of describing teacher and learner role conceptions could support greater understanding of the relationship between parents' and SLTs' conceptions, and whether these change over time. This knowledge gap provides the motivation for the research design and research question three, 'What is the relationship between SLT and parent conceptions of roles during intervention?' (Section 1.3).

2.6.5 Summary

In conclusion, policy and principles highlighted the importance of parents' voice in decision-making on behalf of their child in intervention. Three themes were found in the literature review that are particularly relevant for the professional practice of SLTs and informs the focus of new research. First, there is uncertainty about the factors that encourage parental involvement in intervention, although shared decision-making is a consistent theme associated with patient satisfaction in other areas of health research. Second, there is a lack of empirical evidence about parent and professional perspectives of roles within partnerships, particularly in the way roles complement and influence one another. The roles of learning (parents) and teaching (SLTs) have been under-researched in the context of the increasing use of parent education programmes in intervention. Third, there is evidence that parents' conceptions of roles are open to change, raising a question of whether intervention is aiming to help parents achieve substantial changes in their understanding as well as changes in what they do, as a process of conceptual change.

2.7 Gaps in knowledge and directions for research

In conclusion, Hess et al., (2006, p.151) describes a dichotomy for parents between 'passive compliance and learning to become an advocate for one's child'. Participation in intervention is likely to involve learning new roles in preference to passive compliance, but currently relatively little is known about the roles that parent and SLTs assume and expect of one another. The evidence presents a confusing and at times contradictory picture. Several studies exploring parent-SLT partnerships indicate, at best, uncertainty about respective roles and expectations, and more importantly, there appears to be a distinct mismatch between parents' and SLTs' expectations (Glogowska, 2000; Band et al., 2002; Rannard et al., 2004; Rannard et al., 2005; Marshall et al., 2007; Bercow, 2008; Watts Pappas et al., 2008). This review suggests a significant gap in knowledge relating to

understanding conception of roles during intervention, providing the impetus for this study. The following issues were identified:

1. There are many theoretical models of partnership, together with policy initiatives, but their contribution and influence to practice has not been investigated. This is not unique to speech and language therapy and is seen in other disciplines in health and education (Davis and Meltzer, 2007; Scullion, 2010).

2. Decision-making regarding intervention is considered important in promoting patient involvement, but has been unexplored in children's speech and language therapy. The indications that parents feel excluded from the team supporting their children with speech and language needs, stimulates a particular interest in investigating this issue in speech and language therapy.

3. There is little evidence exploring conception of roles in speech and language therapy and the relationship between parents' and SLTs' conception of roles. This has given rise to uncertainty about how conceptions of respective roles influence one another. Questions relating to how roles complement one another, as paired conceptions, are important to understanding how SLTs and parents respond to one another.

4. Conceptions are open to change, but little is known about how conceptions change during speech and language intervention. Conceptual change theory has been valuable in understanding changes in conception in education and psychology but has not been applied to adult learning in speech and language therapy.

5. Conception of roles and the relationship between conception and behaviour has not been explored in speech and language therapy. The conceptions that parents

and SLTs have may potentially influence participation and engagement of parents and change during involvement.

6. The benefit of parent education to enable parents to implement intervention and support their children's learning is beginning to be evidenced. However, there is contradictory evidence about SLTs' views of their role as teacher. The argument concerning the relative merit of roles as direct intervener compared to training others with pre-school children has not been resolved by research evidence. Contributing to the research on learner-teacher roles should be a positive addition to the evidence.

The following chapter describes a research project addressing four of the gaps identified in the evidence identified in the literature review (3-6). Extending understanding of conceptions of roles is likely to have implications for models of practice and decision-making in speech and language therapy, contributing to research gaps (1) and (2). These will be considered in the discussion of the findings from the research in Chapter Seven.

Chapter Three

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3. Methodology

3.1 Introduction

This chapter provides a description of and rationale for the research methods selected for this study, exploring parents' and professionals' roles during speech and language therapy interventions. The first section discusses the research paradigm used to guide the research design and interpretation of findings. The second section describes and justifies the design of the data collection and analysis for a two phase mixed method study. The detail of the method and analysis for each phase of the study can be found in the respective chapters for phase one and two (Chapters Four, Five and Six). The third section discusses the ethical considerations and explains how these were addressed. The chapter concludes with a discussion of study quality and limitations of the research design.

3.2 Research paradigms

Guba and Lincoln (1994) define research paradigms as basic belief systems or worldviews that guide researchers. A paradigm therefore provides a framework for the design of a research study. This section starts with a brief overview of three research paradigms: positivism, interpretivism and critical realism. This research was carried out within a critical realist perspective and the section continues with a discussion of the implications of this choice for research design and the relationship between the research paradigm and the research questions.

3.2.1 Positivism

The positivist paradigm is characterised by the belief that phenomena can be tested and measured mathematically, contributing to an understanding of causal mechanisms in the world. This paradigm is chiefly exemplified through randomised controlled trials (RCTs) in health research (recommended by Cochrane Collaboration[10]) and specifically in speech and language therapy through large scale projects and experimental designs (Carding and Hillman, 2001) and systematic reviews (e.g. Law et al., 2003; Cirrin et al., 2008). RCTs test the effect of well-defined interventions by randomly allocating individuals to either an intervention or control group. RCTs assume that different researchers studying the same phenomenon will achieve similar results by the rigorous application of carefully controlled research methods. The application of RCTs in health has received some criticism (Pawson, 2003; Cartwright, 2007) and the use of RCTs in the speech and language research has been questioned on the grounds of their capacity to adequately control for heterogeneous client groups (Pring, 2004; Glogowska, 2011). However, as shown in the review chapters, there have been no large scale RCTs of different models parent-therapist partnerships. The research presented in this thesis is observational, but could potentially be used to inform future evaluations and research through RCTs.

3.2.2 Interpretivism

Whilst there are different strands within interpretivism (Schwandt, 1994), they share an assertion that the social world must be understood through the beliefs of actors in that world. In this paradigm, individual and social behaviour is viewed as a consequence of how people interpret events and circumstance (Wahyuni, 2012). The emergence of interpretivism has given rise to a range of qualitative research methods that have broadened the way in which the complex social world is studied (Guba and Lincoln, 1994).

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[10] http://www.cochrane.org/cochrane-reviews

There are five key issues relevant to the research in this thesis which have to be addressed in an interpretivist approach:

i. Since the research paradigm insists that we must understand behaviours through the beliefs of the participants, how does the researcher avoid simply seeing what they want to see when they collect and analyse data? Interpretive research aims to address this through systematic data collection and analysis, and through the researcher's reflexivity. A systematic approach to data collection and analysis is intended to limit the risk that the researcher will 'lead' interviewees or be biased in their data analysis. By exercising reflexivity, carefully documenting their own involvement, as the human instrument in the research, the researcher is expected to become aware of how their beliefs might bias their interpretation (Goldbart & Hustler 2005).

ii. Is the research aiming to capture *shared* belief and behaviour within a social group or *variation* in belief and behaviour within a group? To some extent, this issue arises from different disciplinary traditions. Interpretive research in sociology has frequently been used to identify norms of belief and behaviours within particular social groups. For example, Bobo and Hitchings (1996) studied feelings of alienation resulting from racial differences of a whole social group. Blumer's model of group refers to the benefits of studying social groups as *wholes* rather than the individual's position (Blumer, 1958; Bobo and Hitchings, 1996). In contrast, psychologists investigating conceptual change, such as Vosniadou (2013), have sought to identify categorical differences between individual's conceptions of the same phenomenon. A relationship between the two approaches is suggested by Huberman and Miles (1994) with the use of the terms 'case' and 'sub-case'. They

refer to a case as 'a phenomenon of some sort occurring in a bounded context…boundaries can be defined by social unit size (an individual, a role…)' p. 440, and they assert that 'cases may have sub-cases'. In these terms this study investigates two cases: SLTs and parents within the context of supporting children with language problems. It may be that all the SLTs within the study share the same conception of their role, reflecting a common professional orientation, as exemplified by professional discourse and professional culture (Ferguson, 2009). Alternatively, different SLTs might develop different conceptions of their role in supporting language development in a similar way to teachers who have different conceptions of their role as teacher (Beijaard et al., 2004).

iii.   Will the research gather evidence of what people say, what they do, or both? The third issue bears upon the kind of evidence which is collected. Interpretivists who adopt an ethnographic approach collect data through observation and interviews to provide an in-depth and fully rounded view of people's perceptions and behaviour linked to their social context (Jessor, 1996). Savage (2000) argues that ethnography can help researchers explain a variety of different individuals' perspectives. For example, they use it to describe the influence of social phenomena on experience and actions in complex health care practice. Adopting this approach in this thesis would have required observation of SLTs interacting with parents and observation of parents interacting with their children at home in an informal setting. This would have raised a number of challenges for data collection. First, it would have been necessary to secure the permission of parents and SLTs to consent to a relatively intrusive activity by the researcher. Second, it would have demanded considerable time from the researcher which would have restricted the number of SLTs and parents who could have been included in the

study. Third, it would have been difficult to avoid the presence of the researcher affecting the behaviour of the SLTs, parents or children in these settings. The research design in this study opted to include a larger sample of SLTs and parents than would have been feasible for an ethnographic study.

iv.   To what extent should the process of identifying patterns in the data be informed by prior theory and evidence or restricted to inference from data collected in the study? This issue concerns how data collection is informed by previous theory and evidence. The 'grounded theory' approach to this issue emphasises the generation of theory through the analysis of the data collected *in* the study. However, Strauss and Corbin (1994) suggest that existing grounded theories can be adapted and extended as new data is thoroughly compared and incorporated. This statement suggests that in the process of 'constant comparison' during data analysis, the researcher may compare 'incoming data' with a category based on previous research. Huberman and Miles (1994) adopt a firmer position towards this, using a category from previous research to make sense of data collected in the study. They assert that 'starting with them (deductively) or getting gradually to them (inductively) are both legitimate and useful paths' p.431.

v.   Does the researcher regard all knowledge as relative or do they believe that there is some external reality which can be at least partially known? With regard to the final issue, Guba and Lincoln (1994), adopting an interpretivist perspective, treat all knowledge as relative. This ontological position implies that no appeal can be made to an 'external reality' to justify an assertion that one conception or behaviour is superior to another. This implies that SLTs who seek to change parents' conceptions or behaviour in supporting their child's language

development cannot justify their professional actions by appeal to evidence. This does not reflect the researcher's ontological position and therefore an alternative stance is adopted based on the belief that there is an external reality that is at least partially knowable. This is in keeping with the critical realist paradigm described in the following section.

As the intention of this study is to explore parents' and SLTs' perceptions an inductive approach is necessary which is most closely aligned with an interpretivist paradigm.

3.2.3 Critical realism

Critical realism (Bhaskar, 1998) is relatively new to the research field and can be considered part of the interpretivist paradigm (Guba & Lincoln, 1994). Critical realists assume that whilst there is an 'external reality,' individuals' knowledge of reality is shaped by social conditioning and should be understood in the context of the social actors who are part of that knowledge (Krauss, 2005). Critical realism requires the researcher to consider underlying mechanisms and contexts that are associated with outcomes, using methods that are most appropriate to the topic of study. It encourages the researcher to embrace the complexity of studying social phenomena and actively seek out the relational elements of the situation, rather than focusing on single level investigations that require precise controls for variables (Dobson, 2002). Critical realism encompasses both qualitative and quantitative methods in order to explore underlying mechanisms that influence real life proceedings (Healy and Perry, 2000). The next section explains how the adoption of a critical realist paradigm relates to the research questions and the methods employed.

3.3 Critical realism, research questions and mixed methods

This section considers the relationship between the research questions in this study, the choice of research paradigm and research methods. Many commentators have argued that the choice of research methods should be determined by the research questions rather than prior choice of research methodology (e.g. Creswell et al. 2003; Hanson et al., 2005; Ivankova et al., 2006; Johnson et al., 2007). A basis for this recommendation is provided by the assertion that researchers should embrace a diversity of methodology, combining elements from positivism and interpretivism (Hanson et al., 2005; Creswell et al., 2006; Johnson et al., 2007). This stance has been prompted by recognition from researchers that positivist approaches may limit the depth and range of research into social phenomena, whilst purist interpretivism may limit the extent that findings can be applied to a wider population. Furthermore, as speech and language therapy is an applied field of practice, there has been a broad acceptance of the need for modifying research approaches according to the nature of phenomena being studied (Glogowska, 2011).

Adopting a critical realist approach successfully integrates both positions. It proposes that individual and social experience of an imperfectly perceived 'real world' is shaped by underlying mechanisms. These mechanisms are partially shaped by the conceptions of actors and social institutions in that world. The research design in this case was guided by the research questions, but has a clear conceptual link with critical realism, thus encouraging the researcher to build on existing knowledge using a variety of research methods to extend understanding of perceptions and beliefs.

The research questions for this study are presented in Table 3-1. They require an interpretivist approach since it invites an investigation of how SLTs and parents see things rather than a depiction of the world 'as it really is'.

Table 3-1: Research Questions

RQ1	What is the range of parents' and SLTs' conceptions of their own and each other's roles during speech and language therapy intervention for children with primary speech and language needs?
RQ2	In what ways and to what extent do parents' conceptions of roles change whilst working with SLTs and how is this associated with partnership practice?
RQ3	What is the relationship between SLT and parent conceptions of roles during intervention?
RQ4	In what ways and to what extent do SLTs promote conceptual change for the parents they work with during speech and language therapy intervention?

3.4   Mixed method two phase study

3.4.1   Rationale for using mixed methods

Currently there are few established measures of parent-professional partnerships reported in the literature (Hoffman et al., 2005). Tools such as the Measures of Processes of Care (King et al., 2004) and Parent Perception of Language Development (Romski et al., 2011) are comprehensive but are long to administer and do not focus on the respective roles that parents and SLT play during intervention. The aim of the research in this thesis was to investigate the nature of parent and SLT conceptions of roles, specifically considering the variation in conceptions and the potential for change in conception, as outlined in the research questions.

In order to consider this, the study used a sequential exploratory mixed method design (Creswell et al., 2006): phase one used qualitative data collection and analysis, using in-depth interviews with parents and SLTs, and phase two, also exploratory, used a cross

sectional study analysed by quantitative methods. A number of researchers (Creswell et al., 2003; Morse, 2003; O'Cathain et al., 2007; Glogowska, 2011) have commented that mixed methods within a single study can add insight to a complex social issue and enrich the study findings. Building robust evidence based on in-depth knowledge of the phenomena of partnership working between parents and SLTs, together with quantifiable data collected from questionnaires, has the capacity to comprehensively explore a relatively un-researched aspect of practice. In this case, the conception of role and the relationship between role conception and behaviour. This is in keeping with a critical realist approach (Bryman, 2006; Johnson et al., 2007; Curry et al., 2009; Glogowska, 2011).

Phase one used semi structured interviews to gather detailed data from participants. They serve as an excellent tool for generating in-depth data that often reflect the real experiences and concern of interviewees, who use their own words to describe their experiences (Morse, 1994). The interview followed a guide that encourages the participants to describe their experiences in a flexible and expansive way in response to a 'friendly' process that encourages participation and openness (Bowling, 2009).

Phase one also used a longitudinal design to collect data from participants over three time points in order to gather evidence of any changes of individuals' views and behaviours over time (Ruspini, 2002; Ruspini, 2008). Phase two used a cross sectional questionnaire to explore further the variation in roles identified in phase one and investigate potential associations between role conceptions of parents and SLTs. The parent participants could be at any stage in involvement with SLT for phase two.

The two phase study is summarised in Table 3-2. Table 3-3 and 3-4 present the stages of the research process for phase one and two. The details of the method for each phase are presented in Chapters Four, Five and Six.

Table 3-2: Summary of two phase research study

Phase	Method	Data collection Sample	Data analysis
1	Qualitative study Semi structured interviews with parents Interviews with SLT Interviews with parents at three points during intervention stage	17 parents 12 SLTs 9 parents	Thematic Network Analysis Framework Analysis
2	Quantitative study Cross sectional questionnaire Parent questionnaire SLT questionnaire	51 parents 62 SLTs	Descriptive and inferential statistics

Both phases of the study were exploratory, with phase two confirming or challenging findings from phase one with a larger sample of parents and SLTs. Table 3-5 shows how each phase aimed to answer the research questions.

Table 3-3: Research plan for Phase One

•August 2012
•Recruit 4 SLT services through Service Managers using purposive selection

•October 2012-March 2013
•Recruit 4 SLTs working with pre-school children with primary speech/language needs, from each site

•Researcher attends assessment sessions with each SLT
•SLT invites parents with children who fulfil criteria to discuss participation in research with researcher

• Volunteer parents meet researcher: receive research information and consent to participate if willing

•First interview with parent after initial SLT assessment (20 parents invited , 16 parents agreed to be interviewed)
•First interview with SLT after assessment session with volunteer parents (12 SLTs)

•Analysis of interview data using thematic network analysis

•January 2013-June 2013
•Second interview with subset of parents after 10 weeks (9 parents)

•Analysis of the interview data using thematic network analysis and framework analysis

•August 2013-October 2013
•Third interview with subset of parents after approximately 30 weeks (5 parents)

•Analysis of the data using thematic network analysis and framework analysis
•Results identified a number of conceptions of roles informing Phase Two

Table 3-4: Research plan for Phase Two

- **July 2013- August 2013**
- 6 sites recruited to Phase Two: original 4 sites plus 2 new ones
- Service Manager recommended SLTs to participate

- **September 2013**
- Cross sectional survey designed for parents and SLTs based on findings from Phase One

- **October 2013**
- SLTs identified intervention sessions for research (12 SLTs)

- **October 2013-January 2014**
- Researcher (i) recruited new parents to study using questionnaire as structured interview (38 parents invited and completed questionnaire) or (ii) SLT distributed questionnaire to parents after intervention session (11 questionnaires returned) or (iii) nursery staff distributed questionnaire (2 returned)

- **October 2013-January 2014**
- Parent questionnaires completed: no overlap with parents from Phase One (51 parents)

- **October 2013-January 2014**
- Online questionnaire distributed as web link via managers, professional networks and study sites (62 SLTs)
- Responses were anonymous and may have included SLTs from Phase One

- **January 2014 - June 2014**
- Analysis of questionnaires using descriptive statistics and inferential statistics

Table 3-5: Relating study design to the research questions

Research question	Phase 1 Parent & SLT interviews	Phase 2 Parent and SLT questionnaire
What is the range of parents' and SLTs' conceptions of their own and each other's roles during speech and language therapy intervention for children with primary speech and language needs?	✓	
In what ways and to what extent do parents' conceptions of roles change whilst working with SLTs and how is this associated with partnership practice?	✓	✓
What is the relationship between SLT and parent conceptions of roles during intervention?	✓	✓
In what ways and to what extent do SLTs promote conceptual change for the parents they work with during speech and language therapy intervention?	✓	✓

3.4.2   Ethics

The study involved interviewing parents of children referred for specialist assessments from SLT. The interview topics may have touched on sensitive issues arising from parents' anxiety and therefore required careful ethical consideration. Ethical issues were managed as follows.

3.4.2.1 Ethical approval

Ethical approval was received from MMU, the NHS (Integrated Research Application Process for the NHS, IRAS CSP 97808) and the Research and Development Approval System for NHS sites (Appendix 1). Two submissions were made to NHS Ethics for phases one and two respectively. The first was approved by a proportionate review (2012) and the second was approved as a substantial amendment (2013).

3.4.2.2 Approval from NHS Trust sites

Each individual NHS site approved the research. Each NHS organisation follows a locally determined process and approves research individually through their R&D Departments. The research was prepared using the standard format and guidelines required by the NHS Ethics and National Research Ethics Service and submitted to individual R&D organisations according to local procedures through the Comprehensive Local Research Networks who coordinate R&D approval in the area.

3.4.2.3 Confidentiality

Records of participants were anonymised, IT systems were pass-word protected, and participant confidentiality was maintained throughout the interview process. Whilst confidentiality was a priority in undertaking the research, the safety of children was a higher priority. Therefore the information briefs explained that local safeguarding procedures would be used in the event of any issues arising relating to child protection.

3.4.2.4 Potential harm or distress for participants

 Parents are not considered a vulnerable group; they can be vulnerable, either as a result of specialist referral or existing anxieties. Risks relating to child protection or domestic violence were managed according to procedures used in study sites. The researcher has an enhanced CRB check, training in safeguarding and up to date professional experience as a

speech and language therapist (registered Member of the Royal College of Speech and Language Therapists and HCPC registered) and am experienced in safeguarding. During the study, parents' and therapists' emotional wellbeing was monitored, drawing on expertise as a practising SLT, ensuring access to local information for signposting to patient liaison service (PALs), speech and language therapy services, parent support groups and safeguarding systems. The researcher was prepared to explain that advice or comments about provision or a child's needs could not be made.

3.4.3   Study quality: trustworthiness

The researcher has a strong responsibility to ensure that their studies can demonstrate rigour and trustworthiness and are not the result of bias and misinterpretation. The approach to demonstrating trustworthiness differs according to the paradigm adopted and the challenge of demonstrating validity in qualitative studies has been addressed by researchers such as Miles and Huberman (1994) and Guba (1981). Guba's constructs relate closely to those used for quantative methods and have been applied to the mixed method study presented in theis.

3.4.3.1   Credibility

The following measures were used to provide confidence in accuracy of the research:

(i)   Using well established research methods

The choice of research methods has been carefully justified and documented at each stage of the study. Alternatives have been described and the rationale for the final choice of methods described. The detailed application of methods is also presented for each phase of the study.

(ii)   Sampling

Restricted or closely prescribed sampling can restrict the credibility of research. The sampling for this study was purposive, with specified criteria for recruitment, but the final recruitment of participants who fulfilled the criteria was not prescribed by the researcher during the data collection. Parent participants could be any individual who was attending speech and language therapy and SLTs could be any within a service working with pre-school children. The study used four different sites to recruit participants, based on differences in demographics, to provide further assurance that the sample was sufficiently varied. Recruitment depended on individuals volunteering to participate. This may potentially influence the nature of the sample, but this was partially addressed through keeping recruitment simple, enabling participation through on site interviewing, during or immediately after existing speech and language therapy appointments. The opt-in rate was monitored and remained high throughout both phase one and two.

Elite bias (Miles and Huberman, 1994) is thought to occur when a sample lacks variation and under-represents certain categories of participants. This has been specifically addressed by purposive sampling, both in terms of the variation in site selection and monitoring SES of participants. The potential bias in this sample did not arise from limited SES status, as participants came from across the SES classes. All the services required parents to use an opt-in service where parents phoned for appointments or used 'drop-in' services. In other words, parents were already initiating a partnership with SLT and were unlikely to represent the group of parents who cannot or prefer not to become involved with services, potentially to the detriment of their children. This concern was partially addressed by working with one service that conducted all first assessments through home visits.

(iii)   Selection bias

A total of six different NHS sites were used to recruit participants for both phase one and two of the study. Selection bias resulting from the need to use volunteers, remained a strong possibility, but random sampling was impractical with the research participants. Experience from the first phase of the study indicated that the majority of parents and SLTs were happy to volunteer. The researcher made a special effort to encourage participation of a wide range of individuals by collecting data on site, targeting varied locations and types of service delivery, ranging from parent only groups to clinics providing individual intervention and children's intervention groups.

The diversity of participants cannot be assured, although the use of purposive sampling ensured that very different study sites were recruited. However, the sample was not intended to be representative of all parents with children with speech and language needs. Collecting data from volunteers and parents who are participating in therapy will influence the interpretation and conclusions that can be drawn from the study, but the research questions specifically refer to parents and children involved in speech and language therapy. The study did not provide evidence regarding those families that have chosen to opt out of support.

(iv)   Triangulation

Study findings can be corroborated by using different methods to collate information of the same phenomena. The research used a two stage sequential design which used the findings from phase one, based on qualitative methods, to inform the design of

questionnaires in phase two. The findings from each phase have been extensively cross referenced throughout the design and reporting of findings.

Triangulation is also achieved using a wide range of informants, such that individual perspectives contribute to a detailed portrait of role conception. This is further corroborated by drawing on participants who are both users and providers of speech and language therapy services.

(v)   Reliability of participants' responses

Three issues relating to reliability of responses needed to be considered: (i) social desirability bias; (ii) selective recall; (iii) the possibility that respondents could misunderstand questions. Conway and Lance (2010) suggest that research exploring self-perceptions is most appropriately conducted through self reports such as questionnaires and it is used routinely in research (Bowling 2005). Nevertheless, Van de Mortel (2008) has criticized this method, as responses cannot be independently validated, raising doubts about whether the process measures the constructs it is intended to measure. King and Bruner (2000) argue that a self-report may not reflect the respondent's true behaviour or views accurately due to the phenomenon of social desirability bias (also known as social acceptability bias). This is characterised by participants choosing to respond in a more socially acceptable manner, avoiding responses they believe will be judged as less socially acceptable. This is believed to influence the nature of research results, reducing their validity, particularly when people are expressing views about sensitive or personal issues. Van de Mortel (2008) recommended using a social desirability measure in addition to main questionnaire items, despite adding length and complexity to a questionnaire. However, Conway and Lance (2010) argue that social desirability bias does not have a consistent effect and that other methods of measuring constructs are also prone to

subjectivity. In the context of this study, the influence of social desirability bias has been moderated by asking indirect questions relating to roles and characteristics rather than direct questions that may have given rise to respondents answering according to what they considered was acceptable. For example, instead of asking SLTs if they regarded themselves as having a teaching role, they were asked about what they were trying to change when working with parents. Similarly, parents were asked to agree or disagree with a range of statements about their views on their own or the SLTs' behaviour in supporting their child, rather than asked directly if they had a supporting role.

There are also concerns about self-reporting include selective recall. Collecting data using a questionnaire involves asking participants about their past, as well as current perceptions of working together with SLTs. The questionnaire was designed to be explicit about the time being referred to in the questions.

The further issue of potential for ambiguity in the way questions were worded was partially addressed with the parents' questionnaire by using a structured interview, providing the opportunity to clarify points if parents struggled to understand any questions.

(vi)   Advisory team

The project benefited from close supervision from an advisory team with both qualitative and quantitative expertise, as well as clinical experience. The study design, analysis and interpretation of findings were discussed and scrutinised, then amended or justified accordingly. In addition, the researcher accessed the critical advice of parents' groups, parent panels and professional groups during the piloting phases of phase one and two of the study.

(vii)   Reflective commentary

The phenomenon of 'going native' refers to the researcher becoming engrossed in the perceptions of the participants. As the researcher was a practicing SLT, this was a particular concern in interpreting the SLT data. Reflexivity was essential in enabling the researcher to develop a critical awareness of these risks. There were benefits of being part of the professional community, but the research process also demanded awareness of the relationship with the topic and participants. Guidance from colleagues and critical friends contributed to the reflexivity. Many aspects of reflexivity are closely associated with the process of reflection that takes place in professional practice and was familiar to the researcher.

(viii)   Member checking

Member checking is regarded as an important means of assuring trustworthiness (Lincoln and Guba, 1985). Checking respondents' views was not undertaken formally in this study, but formed part of the longitudinal interviews with parents. Both second and third interviews gave an opportunity to check parents' views, albeit with a smaller subset of parents. Member checking also formed part of verifying the interpretation as the project proceeded with professional colleagues and the supervisory team.

3.4.3.2   *Transferability*

The findings of the qualitative study are derived from a small number of participants, which limits the extent it can be applied more widely to other contexts. However, the use of thick description of the data (Denzin and Lincoln, 1994), inclusion of different study sites, high rate of participant recruitment in the study, and the close link between the qualitative findings and the design of the quantitative study increases the value of the findings for other contexts (Shenton, 2004). Both phases recruited widely, with a total of

sixty seven parents and seventy two SLTs participating in both phases. The study was exploratory but these features add weight to the relevance of the findings to other settings.

3.4.3.3   Dependability

Researching complex social phenomena creates difficulties for replicating studies, but dependability can be addressed through careful planning and recording of research, to enhance transparency of the methods used. The research design and implementation are presented in detail in Chapters Four to Six with examples of interview guides and questionnaires in the Appendices.

3.4.3.4   Confimability

Qualitative research cannot be entirely objective. Researchers seek to reduce the risk of researcher bias through using triangulation, transparency of design and reflective commentary. Shenton, (2004) stresses the importance of an audit trail to demonstrate the steps involved in the planning and implementation of the project. The detail of the study design, analysis and interpretation are presented in the thesis to form the necessary audit trail. The researcher's own interests are disclosed in Chapter One, in describing the motivation for the study. A research journal was also used to record a reflexive account of the process (Appendix 4 provides excerpts from the research journal).

3.5   Summary

This chapter presented the rationale for the design of the study in this thesis. The following chapters describe the detail of the methods and findings for phase one and phase two of the study.

Chapter Four

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4. Exploring parents' and SLTs' conception of roles

4.1 Introduction

This chapter describes the methods and findings from a qualitative study of parent and SLT conceptions of roles. A longitudinal design was used to explore conceptions and track changes in role conception over time. Section 4.2 of this chapter describes the interview design, data collection and analysis based on the research questions and literature review. Sections 4.3 and 4.4 present results of the first level analysis of the parent interviews and SLT interviews. The longitudinal study is described in Chapter Five and full discussion is provided in Chapter Seven. Clinical implications, study limitations and recommendations for future research are also considered in the conclusion.

4.2 Method: design of parent and SLT interviews

4.2.1 Interview design

Semi-structured interviews were designed using the research questions to determine the interview questions. The research questions focused on parents' and SLTs' perception of their roles during intervention. In order to explore these perceptions the interview guide (Table 4-1) used a number of indirect, rather than direct, questions to probe interviewees' views more extensively and reduce the influence of social desirability bias (Fisher, 1993). The guide gave a clear outline for the interview, but the delivery of the interview was flexible and allowed the follow up questions with participants to vary.

Table 4-1: Interview guide for semi-structured interviews with parents

<div style="border:1px solid black">

Positive talking-positive roles

Interview guide for parents

Introduction to the study

I'd like to talk about your experience of coming to speech and language therapy with your child. Could we talk about your journey in finding out that your child had some difficulties learning language and what helped you?

1. Talk me through how your child first came to be seen by an SLT? [How did that come about?]
   a) When did you first realize he/she might need support
   b) Looking back is there anything you would change about what happened?
2. How were your child's difficulties described or labeled?
   a) Before you came to SLT
   b) After the assessment with the SLT
   c) Is there anything you would have changed about how this happened?
3. Tell me about how decisions about what your child needed were made.
   a) Could this have been done differently?
4. What kind of support is your child going to receive/receiving? How will this be provided?[specific examples of what you've been asked to do?]
   a) Is there anything you would change about this?
5. At the beginning what are you/did you hope for? What did you expect from the SLT? Were these expectations fulfilled?[in what ways?]
6. How would you sum up your role in relation to your child and the SLT?
7. In supporting your child's speech and language, has your role changed over time? How do you think it will change in the future?
8. How do you think your attendance at SLT will affect your child's progress? In what way?
9. What do you think are the most important factors helping your child's speech and language at the moment
   Your information
10. Mother/father/other (please specify)
11. Postcode:
12. Ethnicity:
13. Highest level of education: Secondary School GCSE   A Level   Degree
14. Occupation
15. Do you use the internet to find out information on services of child development?
16. Number of appointments given by the speech and language therapist
17. Number of appointments attended
18. Family:
    a) Age of your child
    b) Who looks after your child
    c) Who else is in the family

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4.2.1.1 Parent semi-structured interviews

The interviews were intended to elicit in-depth information relating to research questions one to three. The interview guide consisted of nine open-ended questions, with suggestions for further probes to explore particular interests and issues raised by parents during the interview (Table 4-1). For example, question five had a number of further probes, *'At the beginning what are you/did you hope for? What did you expect from the SLT? Were these expectations fulfilled? In what ways were the expectations fulfilled or not fulfilled?'*

4.2.1.2 SLT semi-structured interviews

Semi structured interviews were also used with SLTs to explore their perceptions of working with parents and the respective roles of individuals in the parent-SLT partnership. Interviews consisted of ten open-ended questions, as for parent interviews, with optional follow on questions to explore specific issues raised by SLTs (Appendix 3).

4.2.1.3 Piloting the interviews

A reference group of eight parents participated in piloted interviews. They were drawn from a third sector parents' group, AFASIC[11]. Changes were made to the interview guide in response to parents' comments. These related to the kind of words parents used to describe their experiences, and the concerns this raised relating to roles and responsibilities. The interview guide was amended to include questions about what they would have changed in their experience of gaining help for their child and what would have been their ideal scenario for accessing support. The pilots also emphasised the importance of managing the process of the interview, particularly allowing time for parents to recall their experiences and articulate their views.

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[11]http://www.afasic.org.uk/

The study information briefs were piloted at the same time as the interviews. Changes were made to the clarity of the commitment required in the parents' information brief. An option for follow up interviews as telephone interviews was added. The format of the information briefs was amended to a question and answer style for both groups of participants.

A professional (SLT) reference group was created through personal contacts. The interview was piloted with two SLTs. The interview guide was changed in response to their comments, specifically encouraging detail of practice through referring to specific cases rather than using generic examples. This was addressed in the interviews by prefacing questions with, 'thinking about working with X'. The criteria for parent participants were clarified following uncertainty expressed by SLTs regarding the term primary speech and language impairment.

4.2.2 Data collection

The first phase of the study used three successive semi-structured interviews with parents over a medium-term time frame of 30 weeks. The first interview targeted parent and SLT pairs, who worked together, though the interviews took place with individual participants, not parents and SLTs together.

4.2.2.1 Interviews

Parents' first interviews took place immediately after the initial assessment with the SLT in the setting where SLTs routinely provided assessment (clinics, children's centres and participants' homes). The interviews were scheduled to last 15-20 minutes, but timings could be flexible, according to parents' circumstances and length of contributions. Parents' demographic information was also collected at the first interview. Interviews were recorded using a small, unobtrusive digital recorder. Data was made anonymous and transcribed verbatim and uploaded onto NVIVO software (NVIVO, 2012) within two days of collection.

Field notes were also recorded after each interview, noting initial observations, potential themes and changes required in the interview process.

A further two interviews occurred after approximately 10 weeks (10-15 week range) and 30 weeks (28-36 week range), largely determined by availability of participants. Follow up interviews with parents were either face to face interviews or telephone interviews, depending on the preferences of the interviewees.

SLT interviews were carried out at the SLTs' place of work immediately following the initial appointment with the parents who had volunteered to participate in the study. The interviews were scheduled for 20-30 minutes, but timing remained flexible. The interviews were recorded, transcribed and uploaded onto NVIVO. Contemporaneous field notes were also made to note initial themes and any issues.

4.2.2.2   Consent

Procedures for gaining consent from participants followed NHS ethics guidelines. This included providing accessible information briefs, consent forms explaining the purpose of the research, the benefits of participating and options for withdrawing at any point. There were no risks attached for parents in participating in the study in terms of accessing usual services. Volunteers were given time to consider participating prior to the interview and then signed two consent forms, one for research records and the other for the participant (Appendix 2).

4.2.3   Participant characteristics

Identifying participants for the study used purposive sampling to ensure that parents and SLTs fulfilled the following criteria, as determined by the research questions (Table 3-1):

i) Parents with pre-school child (2.00 years – 5.11 years) with possible primary speech and language needs referred to speech and language therapy services, attending their first appointment with the SLT

ii) SLTs working with parents of pre-school children with possible primary speech and language needs

Table 4-2 and Table 4-3 show the characteristics of the participants for phase one.

The criteria were determined by the NIHR Programme Grant, Child Talk What Works. For the purposes of the study in this thesis, evidence needed to be gathered from the point that parents first became involved with the SLT. 'Involvement' was decided by the SLT on the basis of usual practice, independently of the research.

Table 4-2 Summary of parent participants in phase one

	Ethnicity	Child features-gender/reason referral	Education level of parent (QCF Levels)	Work status (International Standard Classification Occupations)	IMD[12] by postcode[13]
Parent 1	White British	Male Language	Level 5	Full time mother	32.5
Parent 2	White British	Male twins Speech	Level 2	Full time mother	58. 2
Parent 3	White British	Female Speech	No qualifications	Full time mother	20.05
Parent 4	White British	Male Language	Level 1	Full time mother	37.04
Parent 5	White British	Male Speech	No qualifications	Full time mother	58.59
Parent 6	White British	Male Language	Level 3	Service and sales	NOT AVAILABLE
Parent 7	White British	Male Language	Level 1	Service and sales	48.81
Parent 8 (mother and father)	White British	Female twins Speech	No qualifications	Full time mother	32.97
Parent 9	Asian	Male Language	No qualifications	Full time mother	51.05
Parent 10	White British	Male Language	Level 3	Full time mother	65.79
Parent 11 (mother and father)	White British	Boy Language	Level 2	Service and sales	NOT AVAILABLE
Parent 12	White British	Female Dysfluency	Level 6	Full time mother	42.49
Parent 13	White Other	Female Language delay	Level 7	Professional	13.67
Parent 14	White British	Male Speech sound	Level 1	Service and sales	10.53

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[12] Index of Multiple Deprivation
[13] Upper quartile of deprivation is 30 or above

Table 4-3 Summary of SLT participants in phase one

	Years post qualification as SLT	Role	Additional training and development	Description of service model
SLT 1	2 years	Assessment and intervention: pre-school age	Shadowing	Collaborative with integrated care pathways
SLT 2	6 years	Assessment and intervention: school age	Hanen	Flexible and collaborative
SLT 3	12 years	Assessment and intervention: all ages	Vulnerable families Becoming ELKLAN trainer	Flexible delivery Training focused
SLT 4	11 years	Assessment: pre-school age and management	Hanen Experience	Flexible and community based
SLT 5	3 years	Assessment and modelling: pre-school age	Dysfluency Hanen	Community based: universal, targeted and specific Training focused
SLT 6	3 years	Assessment, advice, group intervention: pre-school age	Dysfluency	Prescribed care pathways
SLT 7	18 years	Assessment and intervention: school age	Selective mutism Dysfluency	Advice, programme, discharge Driven by waiting time targets
SLT 8	Newly qualified	Assessment and advice: pre-school age	Joint practice	Care pathways Emphasis on discharge
SLT 9	1 year	Assessment and advice: pre-school age	Derbyshire Language Scheme, narrative therapy and social skills training	Driven by waiting time targets
SLT 10	2 years	Assessment and intervention: pre-school age	Dysfluency	Community
SLT 11	2 years	Assessment and intervention : pre-school age	Shadowing	Clinic, mainstream and specialist provision
SLT 12	7 years	Language promotion, supporting vulnerable parents: pre-school age	Supervision and reflection	Targeted and preventative for children at risk of language delay Home based

4.2.4   Site selection

The study collected data from SLTs working in services in the NHS. The sites were selected on the basis of providing services to areas with contrasting demographics, using the Index of Multiple Deprivation[14] (Department for Communities and Local Government, 2011) and information available from a recent regional review of speech, language and communication needs provision (NHS Northwest, 2010). In addition, the researcher used local knowledge to identify contrasting services in terms of models of service delivery. Five service managers were approached and invited to participate in the study. Four responded, inviting the researcher to visit the speech and language therapy teams to discuss participation and consider practical arrangements for data collection. Each site approved the study through their respective R&D governance procedures as described in Chapter Three.

4.2.5   Recruitment

Recruitment of parents took place through SLTs who volunteered to participate in the study. They invited parents attending their first assessment appointments to learn more about participating in the study, directing interested parents to talk to the researcher to consider volunteering for the study. Parents were then asked to complete the consent form before proceeding with the interview. The parent participants were from low and medium SES groups, as indicated by qualification, employment and home postcode.

A total of seventeen parents were recruited from twenty parents who were invited to participate. There were two mother and father pairs who were interviewed together and have been analysed as one set of views. In both instances, the father answered the interview questions and follow up interviews. Twelve SLTs agreed to participate. Three SLTs were interviewed about more than one parent and child. Parents and SLTs for phase

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[14] https://www.gov.uk/government/collections/english-indices-of-deprivation

one were recruited to the study incrementally over 6 months from the four NHS sites participating in the study. The sample was not intended to be representative but aimed to include variation in parent and SLT participants.

4.2.6   Qualitative data analysis

The choice of data analysis methods was consistent with the underpinning paradigm of critical realism adopted in this study. Critical realism encourages researchers to consider underlying mechanisms as influencing behaviour, in the context of complex social settings. Differences in contexts will trigger underlying mechanisms in different ways (see Chapter Three). In this case, understanding the relationship between parents and SLTs needed to be sensitive to the contexts of practice, parents' circumstances and their self-conception. The study is based on the assumption that the parent and SLT conceptions are underlying mechanisms, which vary according to complex differences in contexts.

The data from the first phase of the study was analysed in two parts (Table 4-4): a first level analysis of the initial parent and SLT interviews and a second level analysis of the longitudinal data from a subset of parents who completed second and third interviews. The analysis of all the qualitative data was a two-step process: the first level analysis interrogated the data from all the interviews and identified themes using thematic network analysis (Attride-Stirling, 2001), while the second level analysis was specifically used to compare within and between cases using Framework Analysis (Ritchie and Spencer, 2002). The following section describes the rationale for the data analysis.

Table 4-4: Summary of process of analysis for phase one

	Method of data collection	Method of analysis	Purpose
First Level Analysis	Parent first interviews SLT interviews	Thematic network analysis	Identify basic, organising and global themes to compare variation within and between cases
Second Level Analysis	Parent 1st-3rd interviewees	Framework analysis using themes from thematic network analysis	Track trajectories of change in parents' conception of role

The following section provides a brief overview of four related options for qualitative analysis: interpretive phenomenological analysis (Smith et al., 2009), thematic analysis (Braun and Clarke, 2006), thematic network analysis (Attride-Stirling, 2001) and framework analysis (Ritchie and Spencer, 2002). The rationale for choosing thematic network analysis and framework analysis is explained.

(a)   Interpretive phenomenological analysis

Smith et al. (2009) offers an ideal method for ethnographic and phenomenological studies that explore how individuals make sense of their personal world, their 'lifeworld'. Smith (2003) recommends a detailed case by case exploration of perceptions and understanding, re-reading interview transcripts, annotating significant comments, summarising, noting associations and contradictions, including how the individual may be expressing their views. Themes are identified from the single case, ordered hierarchically and then used to support analysis of further cases. Initially, this approach seemed appropriate for the current study, given the focus on exploring parents' and SLTs' conceptions of their respective roles. However, the initial interviews with parents challenged the notion that seeking advice from

the SLT was a defining 'lived' experience for parents. Parents' responses in the interviews suggested that they perceived their children's speech and language needs as a short term experience that did not define their wider experience as parents at this stage. Seeking advice for pre-school children with language delay appears to be part of a parents' lived experience, but is not a *dominant* and *defining* element. Therefore, interpretive phenomenological analysis neither coincided with the research paradigm of critical realism adopted by the researcher or fulfilled the practical requirements of the research.

(b)   Thematic analysis

Braun and Clarke (2006) describe thematic analysis as a flexible method, capable of yielding 'rich and detailed' descriptions of phenomena, whilst remaining largely independent of methodological constraints. The researcher reports patterns from the data as themes that describe and organise the evidence in detail, and enables clearly reasoned interpretation of findings. Braun and Clarke (2006) do not subscribe to the view that themes 'emerge' from data. The researcher is acknowledged as playing an interpretive role, but the process of analysis is clearly described and reported. This is illustrated by two features of thematic analysis. First, there is freedom to choose to use inductive or deductive approaches to the data; coding can be determined by the research questions as a deductive process or as an inductive process, allowing the focus of research to evolve as the analysis proceeds. Second, the level of analysis can be descriptive and explicit, based on the obvious meanings present in the data, defined as a semantic level analysis; or implicit, known as the latent level, with the researcher examining underlying assumptions and conceptions.

Braun and Clarke (2006) provide a six-step process for analysis but caution that the guidelines should not be applied in a linear manner that precludes flexibility. They also suggest that researchers are vigilant in achieving a convincing analysis warning that an overly

descriptive approach, use of unconvincing or overlapping themes, or misinterpretation should be avoided.

(c)   Thematic network analysis

Thematic network analysis (Attride-Stirling, 2001) is closely related to thematic analysis. Themes are presented as part of a visual network categorised according to basic, organising and global themes in an organisational structure that illustrates the relationship between themes. The themes are organised hierarchically with lowest order premises categorised as basic themes, organising themes are clusters of basic themes representing more abstract propositions and global themes representing overarching concepts relevant to the whole data set. This format has the potential for demonstrating both explicit meaning for the analysis and implicit significance, equivalent to Braun and Clarke's (2006) latent level of analysis.

(d)   Framework analysis

Ritchie and Spencer (2002) organise research findings as part of a framework that enables data to be analysed by case and theme. It is usual to use a priori themes in framework analysis, which in this case could be themes derived from the first level analysis of the interviews. The framework enables the researcher to map out any changes evident in later interviews and was therefore appropriate for the longitudinal study. There are five key stages of familiarisation, identifying the thematic framework, indexing, charting and interpreting. Thematic network analysis informed the development of the framework and therefore provided an excellent basis for designing a framework.

4.2.6.1 *Process of analysis*

First level analysis

Thematic network analysis (TNA) and framework analysis were used together to analyse the interview data. TNA provided a theoretically consistent process that could assure transparency and clarity of analysis, and facilitate interpretation of essential relationships between themes. It also provided the themes for the framework analysis. This first level was largely inductive, working from the data generated from semi-structured interviews with parents and SLTs. It provided sufficient flexibility to create themes that not only focused on common features of a social group, but also could capture variation within the group.

Thematic network analysis follows a six-step process:

1. Coding the data using salient features to create a coding framework. The framework is then applied to the whole transcript, highlighting portions of text that are relevant to the analysis. The codes need to be clearly defined to enable careful analysis of the entire data set.

2. Identifying basic themes from the coding. This process requires re-reading the coded text and refining themes to a manageable set of themes that are specific enough to be discrete and broad enough to include a set of ideas.

3. Constructing visual thematic networks by identifying basic, organising and global themes. The visual network allows the relationship between themes to be fore-grounded.

4. Exploring the networks. The networks provide the basis for interpreting the data, through exploring and describing the data using the themes. Sections of the text are used to support this level of analysis.

5. Summarising the networks and presenting the patterns that emerge from the analysis and interpretation.

6. Interpreting the relationships between the themes, the research questions and the theory. This stage involves integrating the findings with theoretical knowledge and relating the findings back to the original research questions.

Second level analysis

Framework analysis (Ritchie and Spencer, 2002) was used for the second level analysis. A matrix was created using the global themes from the TNA for the columns of a framework chart and cases over different time points for the rows. The second level analysis was deductive, using themes from the first level analysis, together with knowledge from existing evidence, to compare (i) change over time within cases, for a small subset of parents participating in the longitudinal study and (ii) compare cases to enable analysis of variation between participants.

4.3 Results of analysis of the parent interviews

4.3.1 Introduction

The following section presents the findings from the first level analysis derived from the first interviews with parents. It details the themes that were identified from the thematic network analysis (Attride-Stirling, 2001). The basic themes are particularly valuable in presenting sub-themes, whilst the organising and global themes express broader, more abstract categories. The advantage of the qualitative research relies on the depth and richness of the data generated from the voices of parents. As highlighted in the methodology section, it was essential to maintain a balance between providing a clear overview of the features derived from the analysis, and the variation and categorical differences between parents' conceptions of roles. The analysis, therefore, explored the variation of conceptions expressed by parents.

Four global themes were derived from the analysis:

1. Parents' conception of roles in supporting speech and language

2. Parents' expectation of support

3. Parents' emotional response to their support roles

4. Parents' priorities

Each of these is presented, together with the related organising themes and their associated basic themes, as shown in Table 4-5. Global theme one and two focus on parents' conception of their roles in supporting speech and language development and global themes three and four describe the characteristics expressed by parents that may be associated with their conception of roles.

Table 4-5: Summary of the Basic, Organising and Global Themes for the first parent interviews

Basic Themes	Organising Themes	Global Themes
Responding to other's concern Raising concerns Pursuing support/judging advice	Advocacy	Parents' perception of role in supporting speech and language
Attending appointments Doing activities/ helping Adapting activities and approach	Intervener	
Implementing recommendations Sharing support Influencing intervention	Taking responsibility	
Expecting SLT to do Expecting SLT to plan and provide activities Expecting the SLT to show how to adapt interaction	Expectation of SLT role	Parents' expectation of support
Expecting positive experiences for child Expecting reassurance Expecting information	Expectation of the process of speech and language therapy	
Readiness to support speech and language Inexperience in speech and language development	Confidence	Emotional response to their roles
Acting appropriately Feeling blamed	Guilt	
Concern about social inclusion and academic progress Concern about family and social situation	Parents' aspirations for their child	Parents' priorities
Knowing about child development Knowing about speech and language development	Parents' experience	

4.3.2   Global theme one: parents' perception of roles

There were nine basic themes relating to parents' views of their roles in supporting their child's speech and language development derived from the data. These were categorised into three organising themes of advocacy, intervener and taking responsibility, described in detail together with illustrative comments from the first parent interviews.

Table 4-6: Basic and organising themes for parents' perception of role in supporting speech and language

Basic Themes (BT)	Organising Themes (OT)
1. Responding to other's concern 2. Raising concerns 3. Pursuing and judging advice	1. Advocacy
4. Attending appointments 5. Doing activities/ helping 6. Adapting parenting	2. Intervener
7. Expecting SLT to lead 8. Implementing recommendations 9. Influencing intervention	3. Taking responsibility

Organising Theme 1: advocacy role

Parents' utterances referred to ways in which they regarded themselves as acting as advocates for their children's interests (Table 4-7). They varied in the intensity with which they expressed their advocacy role, ranging from expressing little concern about accessing help to articulating considerable urgency. The parents' words suggested that there were three aspects of the advocacy role, present to varying degrees in the parents interviewed in the basic themes:

> BT1: Responding to other's concerns: parents care about their child and their future so they respond positively to attending appointments as recommended by other professionals

BT 2: Raising concerns: parents' belief about the 'normality' (parents' words) of their child compared to others prompts them to proactively raise concerns

BT 3: Pursuing support/judging advice: parents' belief about the kind of support they could access and the difference this might make encourages them to pursue support and judge the quality of support

Table 4-7: Organising theme 1: Parent's words expressing their conception of the advocacy role

BT 1: Responding to other's concerns/ waiting for professional to initiate action	BT 2: Raising concerns	BT:3 Pursuing support /judging quality of advice
*I might have spoke to the health visitor sooner than I did, **I just kept waiting**, 'he'll do it, he'll do it'*	*I knew he needed a little bit more attention, but I didn't want him struggling*	*I think to come and get a proper opinion like this has helped me a lot, rather than listening to someone else*
I wouldn't want to come across as not caring, but it didn't matter, it just doesn't matter	*I can refer myself. I thought, why not, make sure it's nothing I should be doing more with, she hasn't slipped through the gap, so to speak*	*I think it's because you trust them, someone from a professional background and she clearly looks like she knows what she is going on about.*
We went to the health visitor and she asked how many words she says and I say 'no she doesn't' and then she said, we need to refer her	*No one said anything, always been me, been me that's made an issue*	*I wasn't hopeful to be honest, but when I went in there, they seemed completely different, the whole way they were with the children, more interested, let's see what we can do to help these kids*
	I know my children, I know every child is different, but they need help	
	I'm very passionate about my children …I refuse to move until something is done	*They're (SLT) trained in that particular area, they can identify things we can't*
	I wanted to see someone to just make sure he was OK	*I did have concerns. The health visitor didn't, but I did, so I insisted, I need, wanted something doing about it.*
		I've had to mither and mither, and asked them to do it

BT 1: Responding to other's concern

A few parents in phase one indicated a willingness to attend speech and language therapy, whilst showing little evidence of initiating action (Role 1 in Table 4-7). P7 and P14 illustrate this:

> P7: **I was referred by the nursery**. *Nursery referred him to speech therapy, and they said about this session (drop in assessment by SLT), otherwise I'd have to wait 14 weeks*

P14 is explicit in saying that she was not concerned about her child's speech and had not initiated a referral to the SLT, *'I wouldn't want to come across as not caring, but it didn't matter, it just doesn't matter'*. She had been persuaded by her child's teacher to attend speech and language therapy, but found it difficult to express her reasons for attending. She was seeking reassurance in response to the concerns the teacher, rather than responding to her own concerns. In the initial interview she seemed to be motivated by a drive to show she cared in response to the teacher's concern rather than a need to address any speech and language difficulty. Her actions in attending speech and language therapy and seeking advice were not fully consistent with the view she expressed, which clearly stated that she did not consider her child needed support.

BT2: Raising concerns

Many parents in the study reported that they had been responsible for raising concerns about their child's speech and language development. The following issues were raised: (i) concern about whether their child was developing normally; (ii) the role of other professionals in alerting or reassuring parents; (iii) parents' previous experience with children. They mentioned discussing their anxieties with nursery teachers, health visitors

and family members, as a process of raising concerns, linking this with initiating a referral to speech and language therapy. This appeared to be associated with parents' concern about whether their child was developing normally, and often included references to comparing their child with others in their social network. The following quote illustrates how one parent was prompted to make a self-referral following a conversation with a member of her family, underlining the role that her social network played in encouraging her to raise concerns:

> *P12: My cousin's in the council, children's services, she said there was a service available. I'd seen it advertised, but you never really think, oh they see you in a group, they diagnose you that way. But no-one mentioned it, **but I thought, why not, I can refer myself**. I thought, why not, make sure it's nothing I should be doing more with, she hasn't slipped through the gap, so to speak*

P7 articulated her doubt about her child's development, asking whether her child was *normal* and whether her parenting contributed to his delay:

> *P7*: *He does get so frustrated and lashes out, he hits me, hits his dad, and I question myself, **is this normal,** where did I go wrong?*

Raising concerns and taking the initiative could be seen in the kind of preliminary behaviour many parents reported, prior to referral. Some parents referred to seeking advice from other sources such as early years practitioners or the internet. Several parents reported that their concern often contrasted with professionals' tendency to assume that their children were progressing adequately and did not need additional support. Both health visitors and early years practitioners were perceived as over-reassuring by P1 and P3.

123

*P1: No-one said anything-**always been me**, been me that's made an issue*

*P3: I did have concerns. The health visitor didn't, but I did, **so I insisted, I need, wanted something doing about it** . Glad that I went on about it as a parent*

P2 expressed frustration that professionals reassured her about her child, focusing on her child's development in areas such as play or interaction, when her concerns were specific to speech and language:

*P2: I've had to mither and mither and asked them to do it, had to push. I had to mither quite a bit at school, cos it was nursery, they said , oh she plays and **I said it's not about her playing, it's her talking***

One mother (P3) thought she was considered as over-protective by professionals in raising concerns, but nevertheless felt supported by the health visitor in accessing speech and language therapy, as illustrated in the quote:

P3: I probably got looked at as if I was an overprotective mother but no-one put up any barriers, everyone was fantastic, everyone was right behind me

This mother was an experienced parent and referred to this when she talked about raising her concern. Knowledge or lack of knowledge, related to experience of children's development was cited as an important reason for raising concern by a number of parents. Several were explicit about their *inexperience*, as shown by these words:

*P7: I might have talked to him more or helped him along the way. **He's the only one and I've got no brothers or sisters, so I haven't been around babies**…I think maybe I would have done something different*

P13 described a moment of realisation, when a conversation with the health visitor prompted her to recognise that her child's progress was limited:

> *P13:We went to the health visitor and she asked how many words she says and I said 'no, she doesn't' and then she said, we need to refer her to speech therapy and **then I realised** that she was behind, that she should have to do something that she doesn't.*

This conversation with the health visitor was linked by the parent to a growing realisation and anxiety about the potential difficulties her child might be experiencing. The mother described herself as *'a little bit concerned'* and then commented later in the interview that *'I was really worried'*, when recollecting an experience of comparing her daughter with other children and identifying differences in progress.

> *P13: I got a friend. A year ago I looked after her for a day and I asked her something and she was able to say sentences and **I had a comparison***

Two parents in the study were prompted by their previous experience of other children in the family who had required speech and language therapy which seemed to help parents judge their child's development, as a form of informal assessment, as described by P10:

> *Interviewer: How did you come to be seen by the SLT?*

> *P10: Through the health visitor, over J. But J isn't the first child I've had with speech and language difficulties 'cos my eldest boy, who's 10, has speech and language. He's still having it. It was my health visitor, I had concerns that **he wasn't talking at a certain level**.*

BT 3: Pursuing and judging advice

A number of parents described themselves as showing persistence and pursuing support, illustrating a belief about the kind of support they thought they needed. They used words such as having to *press* and *push,* often seeking advice from a variety of professionals before they were referred to the SLT. Some of the interviewees perceived this as a long process, as illustrated by P2:

> *P2: When she started nursery, she was trying to do the basic letter sounds.* ***I was concerned about it before she went to nursery****, so I mentioned it at nursery cos she had a dummy so she was talking through the gap...so she went to nursery and I mentioned it and they noticed it, like she wasn't communicating as much and that the letter sounds , like the first ones they do. I went to the doctors and they went to refer me but then the teacher referred me from school*

Parents expressed variation in the first interviews in how promptly they pursued support for their children. Several parents expressed regret that they had not acted sooner in response to their emerging concerns, whilst others had raised concerns but had been reassured by family members or professionals. P3 expressed a sense of affirmation of her views about needing support as she reported that her concerns were confirmed by the SLT's opinion. The addition of the phrase, 'as a parent', emphasises this mother's sense of her parenting role, in this instance as an advocate for her children.

> *P3: The speech therapist did seem to think they need a bit of help along the way,* ***so I'm glad I went on about it, as a parent***

As parents pursued support they indicated that they evaluated the quality of the support offered. They described a strong desire for advice from an informed and experienced

126

professional. This was characterised by seeking referral, attending appointments with SLTs and participating in assessments, despite knowing very little about the SLT role and expressing their own anxiety in meeting the SLT. P4 emphasised the preference for informed advice:

> P4: I think to come and get a proper opinion like this has helped me a lot, **rather than listening to someone else**

Parents valued knowledgeable advisers, though they did not explicitly refer to how they judge whether SLTs are trained and able to provide informed advice. Several parents talked about trusting the professional and making a judgement on initial impressions, as illustrated by P12 who based her judgement on how the SLT appeared:

> Interviewer: Why did you feel confident in what she (SLT) said?

> P12: I think it's because you trust them, someone from a professional background and she clearly **looks like she knows what she is going on about,** whether she's just prepared herself and walked in, it's the way she carried herself and looked like she's done it a few times, **she has the air of 'I know what I'm doing**

Nevertheless, parents also commented on advice that accorded with their own observations and understanding of their child's needs. P4 commented that 'everything made sense' in response to a question about the advice she received, whilst P12 volunteered that she considered the SLT assessment of her child was accurate. Even in the context of advice that is unexpected and possibly challenging for one of the parents, she judged that the advice aligned with her own observations.

The words of parents in the first interviews indicated that they reflected on their advocacy role in pursuing support, considering whether they should have acted sooner, been more

persistent or taken greater responsibility for recognising their children's needs. P2 expressed this directly in the terms of letting her child down in not pursuing support soon enough, suggesting that her beliefs about the kind of support her child needed had changed:

> *P2: I feel like I've let her down in a way that I've not been able to help the way someone like a trained, proper person would and **I feel all this time I've waited I've sort of let her down.**, what I've been told, what she's behind on for her age and I've let her down.*

She also expressed regret that she did not have the skills to support her child herself. The latter theme will be explored further in global themes three and four.

As parents were being interviewed in speech and language therapy settings, often after a first assessment, this may have encouraged them to express positive views about their role in raising concerns and accessing specialist support. Furthermore, narratives of overcoming professional barriers to secure support for their child may also reflect some social desirability bias with parents conveying their role in a positive light in response to being interviewed.

Organising theme 2: intervener role

Parent conceptions of their intervener role (Table 4-8), articulated as their perception of what they do or their approach to supporting their child, indicated three potential differences in role. The relationship between parents' conception of their own role and SLTs' conception of their own roles derived from the analysis (Section 4.4) has been included in Table 4-8, (SLT conception of role presented in italics) to indicate the potential paired relationship between the way parents and SLTs conceive their roles. The

importance of the relationship between parent and SLT roles is discussed in Chapter Seven.

Three conceptions of the intervener role were identified:

> BT 4: Attender: attending appointments

> BT 5: Implementer: implementing/doing activities/teaching

> BT 6: Adaptor: adapting approach to supporting their child

The evidence suggested parents' conception of their intervention role varied considerably. Parents referred to attending appointments, doing activities to teach their child and adapting their approach as the intervener role in the first interviews, although frequently they did not elaborate about the nature of their roles. Some parents expressed 'doing' as teaching in a didactic activity, for example, '*teaching him manners'* or doing activities, as illustrated by ' *she'll put a plan together which I will be able to do at home'.* Other parents conveyed a concept of intervention and teaching that involved changing their approach, such as '*I'm quite looking forward to the parenting course, it may open my eyes to something, other ways to help him' (P7).* This involved some form of adapting (Intervener role 3 in Table 4-8). These characteristics of the intervener role were not presented as clear, discrete categories by the parents in the study, but as tendencies towards a particular conception of role.

Table 4-8: Parent conception of their intervener role related to SLT role

1. Attending appointments *SLT role: treating*	2. Doing activities/helping/teaching *SLT role: planning activities*	3. Adapting approach to supporting their child *SLT role: advice/coach*
Taking him to appointments, do things that they tell me to do and helping him and stuff.	*I'm going to have to spend a bit more time with her...I want to spend the time with her and feel that I've done something rather than in ten years time go, maybe if I've done this or I spent more time with her* *I should be doing a lot more of that, just going out and talking and things* *The most important thing for me is just that I can help him...learning how to help him the best that I can* *We just try to teach, try to educate without being overbearing* *It's better off where we're taught ourselves and we're doing it ourselves constantly at home* *I found myself doing different* *At least if I can do what I can by teaching him manners and teaching him to be polite to people, to respect other people* *I try and teach him but I'm not sure whether I'm doing it right but after I've spoken with her I think I'll get a lot better* *Just talk to him, just do what I'm doing and keep teaching him and learning him*	*I feel a lot better knowing that I'm going to help them, helping them rather than just, this is what we're going to be doing, let school get on with it* *I'm quite looking forward to the parenting course, it may open my eyes to something, other ways to help him* *Show me how to get things out of him, cos the way I'm trying at the moment is obviously not working. Hopefully show me new ways* *I feel like it's me that's doing it ...this way I can see differences* *I watched what she did with him and we'll try to mirror that at home. It's learning for me* *More about having fun, if he's having fun he more happily talks* *I think we'll be taking more of an active role rather than just looking at pictures, doing activities and talking through them so you can incorporate them into your normal life rather than going out there and buying things to do the activities*

BT4: Intervener role: attending appointments

Few parents in the first interviews expressed an intention to attend speech and language therapy without participating in intervention. Nevertheless, there were comments about expecting the SLT to provide the intervention for the child. P5 referred to the direct intervention that she anticipated the SLT would provide in school, saying, '*It's going to help him with little groups and stuff'*.

P6 expressed concern that the offer of parent groups to support her skills was not sufficient, commenting that she expected her child to have intervention with the SLT, '*the course is for me rather than for him, so in regards to his speech **I'd have liked something for him'**. Nevertheless, at a later point in the interview this parent shows signs of changing her conceptions, recognising that the SLT *'will give me the tools to be able to help him'* (P6). This suggests that even after one assessment with the SLT this parent was changing her beliefs and conceptions.

BT 5: Doing activities/helper

Many of the parents interviewed referred to expecting to adopt a helping role. They expressed an enthusiasm to learn how to help, but this was accompanied with expressing a need for accurate advice from professionals with training, expertise and experience. Thus, in order to adopt a helping role, a number of parents in the study recognised the need to be learners themselves. P4 illustrates this clearly:

> *P4: the most important thing for me is just that **I can help him**...**learning how to help him** the best that I can, you know you read all these things on the internet about what to do, you never know*

Similarly, P15 commented in response to a question about what she hoped from SLT:

*P15: Not sure, a bit more information on how to speak to him so he can learn off me....**I try and teach him** but I'm not sure whether I'm doing it right but after I've spoken with her I think I'll get alot better*

Most of the parents expressed positive views about what they were asked to do after their first appointment with the SLT. They referred to advice that was clear and easy to implement, and none of the parents felt overwhelmed or uncertain about changes they could be making to do activities at home. Parents in the study described many different forms of advice: for instance, P14 valued the visual demonstration of activities, saying, *'**I watched** what she did with him and we'll try to mirror that at home. It's learning for me'*; P8 specifically valued the spoken explanation, *'**I'd rather have it explained**, then you can talk to someone, it's better than reading a piece of paper'*; whilst P3 was looking forward to a written plan to help her focus on the goals for her children, saying '**she'll put a plan together** *for the boys which I will be able to do at home, and I'm going to share with school as well, so we can all work together'.*

Some parents referred to doing as they were asked by the SLT, as expressed by P11, *'they have given a little bit of homework, **things we can do to help** and anything they suggest we do, we're going to make sure we do the best we can'* and P14 *'**continue with the very little exercises** we've just watched'.* These words suggest a strong sense of doing as suggested in an implementer role, but little indication of adapting whole approaches at home. The longitudinal study tracked changes in these conceptions (Chapter Five).

BT6: Adapting parenting

Some parents made references to intentions to changing approaches, teaching their child and adapting circumstances even after parents had just one meeting with the SLT. P1 explicitly referred to wanting to learn new ways to facilitate speech and language development. P7 used the phrase *'open my eyes to something'* referring to attending a parents' group to learn about speech and language support. She also associated her learning and adapting her role as a means helping her child's sociability, enabling him to have a conversation, recognising the importance of mutual dialogue for her in the parenting role. When asked what she was hoping for from the SLT, she commented:

> *P7: To have a conversation with him, just talk to him, ask him how his day was at nursery*

Several other parents articulated that they needed to change their interactional styles in specific ways. This was expressed as a realisation that their interaction or approach needed to change, recognising that their current manner had not helped their child's communication. For example, P1 commented that her style was pressurising her child to communicate and lacked the enjoyment of interaction:

> *P1: Got to back off with the pressure, not so pressurising just because you want him to say it, he's not going to say it.* **More about having fun***, if he's having fun he more happily talks*

P8 specifically linked changing his approach to one with more relaxed communication as contributing to enjoyment, both for himself and for his children:

> *P8: I can relax a bit more, I'm not so in their faces, like please say this…it's more calmer and it's more fun*

133

Other examples from the parents' interviews included adapting the circumstances for interaction. P12 resolved to spend time with her child:

> *P12: I'm going to have to spend a bit more time with her...I want to spend the time with her and feel that I've done something rather than in ten years time go, maybe if I've done this or I spent more time with her*

Similarly P9 used general terms saying, *'I should be doing alot more of that, just going out and talking and things'.*

Parents often referred to concerns about their child's social integration as a motivator for adopting an adaptor role. Children's friendships, acceptance with peers, behaviour and future progress at school were cited as serious concerns. Parents linked communication difficulties with behaviour difficulties, such as tantrums, and were keen to find solutions to improve a potentially worrying feature of their child's lives. P1 said in answer to a question about what she was hoping:

> *P1: Just that he can communicate properly without screaming and tantruming...Just hoping that he starts talking some more, than shouting at me, than pulling and tugging*

P4 associated her own role as teacher with improving her child's behaviour, commenting:

> *P4: At least if I can **do what I can by teaching him** manners and teaching him to be polite to people, to respect other people*

She emphasised teaching him, but recognised there was a tension between this aspiration and using language appropriately for a young language learner. She also referred to changes in the role of family members, as well as her own role. She acknowledged that a

parenting style that used complicated sentences and had unrealistic expectations could be limiting her child's learning:

> P4: Me and D were saying 'please will you go and get the book, please', and he was like mmmm, so now we say 'get book' 'more juice'. He used to just look at us, but he does shake his juice now when it's empty, so we must be doing something right

It is interesting to note that parents in the adaptor role referred to judging the support, a feature of the advocacy role of pursuing support. P3 expressed this as monitoring her children's (twins) cooperation with the SLT, indicating that she would not continue attending if they failed to participate. Another parent placed conditions on her attendance: her child's happiness and her own sense of comfort with the process determined whether she would continue attending:

> P14: It sounds nice, what she wants to do, and he's happy. I will go as far as I'm comfortable and I'm very comfortable

The relationship between conceptions of roles as intervener and advocate was explored further in phase two (Chapter Six).

Organising theme 3: taking responsibility for supporting speech and language development

The question of responsibility for supporting a child with speech and language needs is germane to the roles that parents and professional play during intervention. Three basic themes (Table 4-9) were derived from the data: expecting SLTs to lead intervention, implementing intervention and influencing intervention.

Table 4-9: Parent conception of their role of taking responsibility for speech and language support

1. Expecting SLT to lead intervention	2. Implementing intervention	3. Influencing intervention
Obviously they're trained to do that *Well that's her expertise, it's not mine. I'm not a teacher, I'm his mum* *I don't think it's really a matter of shaping it, it's a matter of what they feel is best for him and they're educated in that manner, we're not. So they know what's best for him, you trust their judgement* *The course (Hanen) is for me rather than him, so in regards to his speech, I'd have liked something for him*	*They're going to tell me how to pronounce all the little parts, then I can teach them to M* *They (the children) have to be able to describe things a little bit more, so we'll try ourselves* *They'll get lots of support from me* *I just wanted to know if there was any way I could bring his speech on, or if maybe it was something that was definitely, he couldn't talk or was his babble leading to something* *They did say it's not really going to be helpful coming in once a week, it's better off where we're taught ourselves and we're doing it ourselves constantly at home, which I totally agree with'* *It's something I'm doing with the boys as well, I'm helping them and not just letting someone else do the work*	*I felt like if I'd made more of a point when she does it, that the therapist would have listened and said we'll do a bit more investigation, it felt like it was a two way street* *I said is there stuff that we can possibly do to make it fun rather than they're coming home from school and we're doing a lesson* *Lots of options to suit...we did try one and now we've got another to try that's new today* *The choice was open to me, if I wanted to take the sessions or just leave it* *The ST said that's something we're going to be doing together...so they're realising that mum needs to be doing this*

The three categories present parents' conception of the balance of responsibility between the parent and SLT for supporting their child's speech and language development. Influencing intervention included elements of ongoing advocacy, but focused on taking responsibility rather than acquiring help from another individual.

BT7: Responsibility: expecting the SLT to lead intervention

There was evidence of uncertainty or even tension regarding who should take the lead in intervention. Some parents expressed an expectation that the SLT would provide solutions and lead intervention, whilst others expressed a readiness to share responsibility, even when they were uncertain about the best course of action. P11, stated initially, '*it would have been nice to have **a proper one on one session with J(child)'** indicating a desire for the SLT to lead. However, he went on to *say ' they did say it's not really going to be helpful coming in once a week, **it's better off where we're taught ourselves** and **we're doing it ourselves constantly at home**, which I totally agree with'.* In this case, the uncertainty appeared to be resolving as the parent articulated changes in his conception of his role after his discussion with the SLT. Similarly, P6 indicated a changing conception, reflecting that she wanted direct intervention with her son at the beginning of the interview, but later commenting that she hoped to be given tools to support him at home (see organising theme: intervener role).

There was considerable variation in parents' expectation that the SLT would lead intervention, though none of the interviewees articulated a view that SLTs should assume full responsibility. As P6 said, '*I am the adult, I am his parent*' to indicate her acceptance of her role in supporting her child. P3 indicated that the SLT's approach helped her to assume shared responsibility as she commented positively, '*I **wasn't told** what was happening, **it was suggested to me** what would be the best thing...they'll get alot of support from me'.*

BT8: Responsibility: implementing intervention

The majority of parents in the first interviews in the study did not know what to expect from the SLT, but expressed determination to implement any recommendations. Furthermore, they expressed an expectation that they would learn how to help their

children's language development. The comments implied variation in understanding what they were being asked to do and the extent that they would incorporate changes in routine activities. Some parents referred to doing as they were asked by the SLT in general terms, as expressed by P11, *'we're going to make sure we do the best we can'.* Other parents described more specifically what they intended doing:

> *P2: They're going to tell me how to pronounce all the little parts and teach me how to say the proper letters, then I can teach them to M*

P3 described how concerned she was to be actively involved in helping her twins, contrasting this with an experience where intervention was provided in nursery and she felt excluded from sharing the intervention:

> *P3: I feel alot better knowing that I'm going to help them, helping them rather than just, this is what we're going to be doing, let school get on with it*

A small number explicitly expressed a view of themselves as implementers. P3 illustrated this by commenting that she felt positive about her participation in intervention and welcomed the responsibility:

> *P3 It's something I'm doing with the boys as well, I'm helping them and **not just letting someone else do the work***

One notable characteristic that seemed to be associated with readiness to implement intervention was parental confidence as illustrated by P13. This will be followed up in global theme 3.

*P13: I believe mums have a big role for helping their children, children are different. Sometimes I think I won't be able to give what other mums can cos of their personality....**I have to participate and I have to learn techniques***

BT 9: Responsibility: influencing intervention

The majority of parents in the study described themselves as not knowing what would help their children's speech and language development (for example, P1, P4 and P11). Nevertheless, many commented that they felt able to influence the decision-making regarding intervention. This related to practical aspects of intervention such as whether their child had further intervention and when or where this might take place, as illustrated by these quotes:

P9: The choice was open to me, if I wanted to take the sessions or if I just wanted to leave it or just take their advice, that was down to myself, there was no pressure

P12: I felt like if I'd made more of a point when she does it, that the therapist would have listened and said we'll do a bit more investigation, it felt like it was a two way street

Furthermore, some parents described influencing the nature of the intervention. P3 was anxious that she should have a clear part in supporting her children's development at home, but specified that this needed to be enjoyable and motivating for the children:

P3: I said is there stuff that we can possibly do to make it fun rather than they're coming home from school and we're doing a lesson and she said (SLT) definitely, we'll have a look at that and we'll do things in some kind of game. So I'm quite excited about that –let's get cracking

P4 described herself as having a big role in enabling her child, emphasising the extent of her influence in contrast to other people:

> *P4: I do think I play a big role, he goes to nursery one afternoon a week, but other than that it's mainly just me. I feel I have to talk to him alot, I do read alot, I try and get him toys that we can play with.....I'd be more than happy for him to have extra, whatever he needs and that's absolutely fine and if I can do anything I'd be more than happy to do anything that they wish me to do*

Several parents in the first interviews quickly recognised that implementing recommendations involved adapting the advice to suit their own situation. P8 used an example from football to explain how he intended implementing the advice:

> *P8: they (twins) have to be able to describe things a little bit more, so we'll try ourselves, like a running commentary, a game of football, describe everything and hope that helps them put a couple more words into sentences*

Another parent described incorporating advice into the daily routines, using her own interaction with her child as a way of promoting speech and language, in contrast to seeking out resources to help her implement the recommendations:

> *P9: I think we'll be taking more of an active role rather than just looking at pictures, doing activities and talking through them so you can incorporate them into your normal life rather than going out there and buying things to do the activities*

4.3.3 Global theme two: parents' expectation of support

Parents' responses in the first interviews referred to three aspects of their expectations of support, described in the following organising themes:

1. Expectation of SLT roles

2. Expectation of the process of speech and language therapy

Table 4-10: Basic themes for parents' expectation of support

Basic Themes (BT)	Organising themes (OT)
1. Expecting SLT to do 2. Expecting SLT to plan activities 3. Expecting the SLT to show how to adapt interaction	Expectation of SLT role
4. Expecting positive experiences for child 5. Expecting reassurance 6. Expecting information	Expectation of the process of speech and language therapy

Organising theme 1: Expectation of SLT roles

The first interviews with parents indicated that their expectation of the SLT role tended to be vaguely formulated (Table 4-11), but variation between parents was still discernible. The potential relationship between parents' conceptions and SLTs' conceptions of roles derived from the first level analysis is included in italics and will be followed up in the discussion. Few parents talked about how their expectation of SLT roles was formed though P10 specifically referred to the health visitor who prepared her for the way SLTs work:

> *P10: My health visitor said it may not look like much is happening but when they are playing, they're trying to get him to talk about certain cars or whatever, she said they are doing something*

Table 4-11: Parent conception of SLT role

BT1: Expecting SLT to do (eg. do the intervention) *SLT role: SLT treats child*	BT2: Expecting SLT to plan activities *SLT role: SLT plans language intervention*	BT3: Expecting SLT to show parents how to adapt interaction *SLT role: offers advice on language support and interaction*
The course (Hanen) is for me rather than him, so in regards to his speech, I'd have liked something for him *I thought maybe someone would come and teach P how to talk* *He needs to see a therapist possibly on a weekly basis* *Well that's her expertise, it's not mine. I'm not a teacher, I'm his mum.*	*It's a matter of what they feel is best for him* *I want someone else to teach me the techniques* *It's going to help him .....showing me, telling me what to do*	*I think they will just show me how to get things out of him* *Give me the tools to be able to help him* *Sometimes as a parent you don't know what strategy to follow and what's going to work and obviously they're more experienced, and sort of feel they can advise you.*

BT 1: Expecting SLT to do assessment and intervention

The first interviews indicated that parents did not have a clear conception of the SLT role in intervention, including assessment. They made little reference to assessment, though they used terms such as 'checking out' and 'proper opinion' to express their expectation of the assessment process. They alluded to an expectation of accessing assessment from experienced individuals, referring to experience or training as illustrated by the quote:

P3: Sometimes as a parent you don't know what strategy to follow and what's going to

work and obviously they're (SLT) **more experienced** *and sort of feel they can advise you*

One mother referred directly to uncertainty about her own skills in assessment: '*I'm not very good at assessment of her*' (P12), implying that she expected the SLT to assume an assessor role.

A number of parents expressed an expectation that the SLT would 'do' the intervention directly with their child, with comments such as '*he needs to see a therapist possibly on a weekly basis*' (P11) and '*I thought maybe someone would come and teach P how to talk* (P1). As illustrated above, one parent specifically queried the benefit of parent education, which she perceived as not addressing her child's difficulties, saying '*I'd have liked something for him*' (P6). Expectations were not firmly established and each of these parents indicated changes in their expectation as they talked more extensively in the interviews, suggesting that their conceptions were fluid and open to change, and potentially consolidated through articulating their views during the interview.

Parents' utterances did not explicitly indicate the rationale for expecting SLTs to do the intervention, but they referred to their perception of SLT expertise, knowledge and experience as important factors in determining their views as illustrated by P14, '*Well that's her expertise, it's not mine*'.

BT 2: Expecting SLT to plan activities

Some parents were explicit about expecting SLTs to assume a teaching role, showing them what activities would help their child, for example, P1 commented '*I want someone else to **teach me** the techniques'.* Many parents interviewed initially expressed an expectation of receiving specialist advice in the context of their own uncertainty or lack of knowledge. P8 commented that he did '*not having a clue*' about what to expect from SLT, but expressed certainty about needing support, *'I just knew I had to'.*

Parents varied in expressing their conception of the SLT as planning activities. P14 used the term 'being led', saying, '*Not knowing what would happen next, I'm being led*', whilst P2 was more explicit. She explained that the SLT would teach her to do specific activities to help her daughter, '*They're going to **tell me**'.* P3 talks about the SLTs putting a plan together.

There was evidence of a relationship between parents' uncertainty about what to do themselves and expecting to be given a plan or advice from a knowledgeable individual:

> *P9: Sometimes as a parent you don't know what strategy to follow and what's going to work and obviously they're more experienced, and sort of feel they can advise you*

BT 3: Expecting SLT to show parents how to adapt

The association between learning to adapt and regarding SLTs as teachers is loosely formulated and parents did not frequently refer to SLTs as teachers. However, some refer to it obliquely as learning to do things 'differently' as in the case of P1:

> *P1: I think they will just show me how to get things out of him, cos the way I'm trying at the moment is obviously not working-hopefully **show me new ways***

Others used words such as 'shown what to do', 'given techniques' and given 'tools' to help provide the intervention at home.

P8, who had received intervention before the first interview, described adapting following SLT advice in some detail:

> *P8: Just little bits of advice that are useful.......I've seen it helping, just little card games. First day they can do five, the next they can do eight and eventually they can say a full deck of cards, you can see it literally day by day*

144

Organising Theme 2: Expectation of the process of speech and language therapy

Parents expressed an expectation that attending speech and language therapy should be a positive experience for their children and provide parents with reassurance.

BT 4: Expectation of a positive experience for their child

Some of the parents in the study put a priority on the children's experience of participating in speech and language therapy. This encompassed the ease of working with the SLT and the nature of the activities provided for the children. Five parents specifically referred to their children's happiness in working with the SLT, mentioning the relaxed nature of the sessions (P11), the attractiveness of the resources (P8) and the importance of intervention being fun for their children (P3 and P14). In one case (P1), the parent observed that her child was noticeably more interactive when he was enjoying himself in the assessment session, signifying that this influenced her thinking about how to support him in the future. Few of the parents indicated that the child's experience was a decisive factor in ensuring continued involvement, but for P14, it was expressed as a critical factor in her decision-making:

> *P14: If he didn't enjoy it today then that would be it. But he wouldn't mind coming back again* **so I don't mind coming back**

P3 was definite about ensuring that home activities were enjoyable, expressing an intention to *'make it fun'*.

P2 cited the chance to work on speech activities as an opportunity to do something with her daughter, potentially improving her relationship with her child, commenting that activities might bring the two of them closer together.

The term, homework, referring to home activities provided by the SLT, was used by one parent (P11) only, but none of the parents indicated that they expected intervention to be formal or work-like.

BT 5: Expecting a positive experience as a parent

A number of the parents (n=8) in the study indicated that they were seeking reassurance in their initial assessment with the SLT. Several parents expressed this as a process of checking that their child was developing normally (P4, P5, P13). For example:

> *P4: I just wanted to know if there was any way I could bring his speech on, or if maybe it was something that was definitely, he couldn't talk or was his babble leading to something*

Some parents expressed surprise that they were listened to and respected by the SLT, implying that they had not expected that level of reassurance. For example P12, commented that she was anxious about the appointment with the therapist:

> *P12: The words she used and the way she said it **made me feel quite at ease**...she didn't say it in a way that made me feel stupid, belittled. She didn't make me feel , why are you bothering to look into this, it's perfectly normal*

P2 was also anxious about seeing the therapist. She expected that she would be blamed for her child's difficulties, describing herself as nervous, but then expressed surprise at how comfortable she felt:

> *P2: **I wasn't expecting them to be as nice as what they was**; no I thought they'd blame me really for not....because of how her speech is..I was nervous coming myself, but they've been nice*

146

Later in the interview she described how the assessment with the SLT had helped her to feel more relaxed about not accessing help for her child sooner.

BT 6: Expecting information

Parents in the study did not attend their first consultation with the SLT as 'blank slates' in relation to their understanding of speech and language development and had sought advice from other sources. The majority stated that they had reached a point where they were anxious to have advice that was reliable, from trained and experienced professionals. They varied in their response to previous advice, but two recurrent issues emerged. First, a number of parents described negative experiences in seeking information from the internet, finding it confusing or worrying. Second, parents perceived other professionals to be over-reassuring and not providing the advice they needed.

Finding guidance from other sources

Sources of information and guidance mentioned by parents were family (n=3) and other professionals (n=6). A number of parents referred to their wider social network. This included alerting parents to potential issues in their child's communication, as illustrated by P9. She commented that her family had made her more aware of her child's progress by comparing him with others in the family. She portrayed this as a positive feature. In contrast, P13 commented that the comparison with a cousin of a similar age had caused her considerable anxiety. The network was also a source of encouragement. P4 found advice from her mother supported her own decision-making. *' my mum is like, "well I can't remember with you, but if you feel that's best." She's been absolutely fantastic about it, so I do always ask her about things'.*

Guidance from professionals was generally presented by the parents in the study as positive in identifying areas of delay and enabling a referral to speech and language

therapy. Health visitors, teachers and nursery workers were quoted as alerting parents to concerns over speech and language or responding to parents' concerns. Two exceptions suggested that advice had been confusing. P2 believed she had to push to prompt any action, reporting that teachers discouraged a referral to the SLT. P6 described difficulty accessing health visitor advice due to her own full time work commitment and what she considered were limited availability of health visitors.

Information from the internet

Eleven parents made comments about using the internet to find information. Use of the internet, and views about the benefit varied, from parents who used the internet but not in relation to speech and language development, through to those who used it and found the information 'scary' (P2 and P 11). One (P5) commented that she loved to find information from the internet, although she made no reference to using the internet for advice about her child's speech and language difficulties. Other parents in the study used the internet to find information about childcare and developmental conditions, together with participating in parent forums discussing children's development. P11 mentioned the fear he had of finding a possible diagnosis for his child that he did not want:

> *P11: If you type in some of the things he does you get some awful things, autism and things like that*

P4 referred to the internet in a dialogue about the confusing nature of childcare advice and the importance of seeking proper advice from those who were trained and experienced:

> *P4: You read all these things on the internet about what to do and you neve*r know

P7 commented that parents' forums had led to her feeling disheartened at her child's slow progress, saying *'it puts you down'*, when others talk about what their children are achieving.

Information from the SLT

Nine parents referred to the importance of reliable advice from a trained professional. P4 valued a 'proper opinion' in the face of the confusing advice and comments she experienced in other areas of childcare. P8 mentioned a preference for having everything explained in a face-to-face conversation with a knowledgeable professional. P12 explained that she trusted the SLT advice because she looked like she knew what she was doing, her 'air of knowing' rather than whether the advice made sense.

4.3.4   Global theme three: parents' emotional response to their role

The first interviews provided evidence of issues that parents believed were important to their role in supporting their children. Their words often emphasised emotional responses to their roles. The global theme of parent's emotional responses consisted of two organising themes: feeling confident and feeling guilty. It included basic themes of

1. Inexperience in promoting speech and language

2. Readiness to support speech and language

3. Communicating appropriately and seeking help in time

4. Feeling blame

Their comments about emotional support were frequently accompanied by a strong desire for trustworthy guidance from an expert/specialist adviser (see Section 4.3.2), often linked

to statements about their own uncertainty about the best way to support speech and language skills.

Table 4-12: Basic and organising themes for parents' emotional response to supporting their child with speech and language needs

Basic themes (BT)	Organising themes (OT)
1. Inexperience in speech and language development 2. Readiness to support speech and language	1. Confidence
3. Communicating appropriately and seeking help in time 4. Feeling blamed	2. Guilt

Organising Theme 1: Confidence

BT1: Inexperience in promoting speech and language skills

The majority of the parents (n=10) referred to their own lack of knowledge and the need for trained practitioners to advise them. Parents in the study were consistent in expressing lack of confidence in supporting speech and language development. They stated that they did not know what they should be doing to help their child. For example, in the words of P9, '*you don't know .....what's going to work'.*

P11 considered that the professionals had the *knowledge* to make decisions for his child's intervention, as individuals who knew best, in contrast to his knowledge as a parent, as illustrated in the quote:

> *Interviewer: did you feel able to shape the decision?*
>
> *P11: I don't think it's really a matter of shaping it, it's a matter of what they feel is best for him and they're educated in that manner, we're not. So they know what's best for him, you trust their judgement.*

BT2: Readiness to support speech and language

Many parents expressed that they were ready to support their child, but felt they did not know what to do. This was characterised in generic terms, as with P11 and P4:

P11: Anything they suggest we do, we're going to make sure we do the best we can

P4: I just wanted to know if there was any way I could bring his speech on

Other parents were more specific, as P8 illustrates:

P8: just keep adding words on, describing things. The example he gave us was instead of saying there's a bus, say there's a man driving the bus

P3 was keen to get involved, commenting, *'let's get cracking'*. Just one parent expressed a view that she was already providing adequate support and that the advice affirmed what she was already doing, as shown by this quote:

P5: She said I'm already doing what I should be doing anyway

Organising Theme 2: Feeling guilt

Parents expressed a range of feelings that indicated degrees of self-doubt and reproach. Parents in the study occasionally talked directly about perceiving themselves as feeling guilty, but many comments suggested implicitly that they felt regret or concern about whether they acted appropriately to help their child's speech and language development.

BT3: Communicating appropriately and seeking help in time

A number of parents (n=5) questioned whether they communicated enough or in the right way with their children during their early years. P7 reflected on her approach from the earliest days with her baby:

P7: Did I communicate enough with him when he was a baby. I might have talked to him more or helped him along the way

Some parents linked these doubts to their lack of experience of parenting. *'I'm only a first time mum'* said P4. Three parents referred to their experience with older children with speech and language difficulties. Despite this experience, these parents were quick to point out differences they observed and a concern about acting appropriately. P9 commented that she should have done more and she needed prompting to contribute more fully to her current child's support:

P 9: I was aware of that, but I should be doing a lot more of that, just going out and talking and things. They emphasised that that's very important. It has been a long time since I've been here.

Experience with older children who had developed language with no difficulties was also a reference point for some parents. P1 considered her success with her older children suggested she should not or could not change her approach to supporting her child

P1: I don't think I could have changed anything. I treated him as I did the other two, encouraging him to talk same as the other two

However, later in the interview she conveyed a different perspective, commenting that she sensed she had waited too long before seeking advice and should have asked for something to be done, *'I probably would have done something sooner'*

P14 was the only parent who expressed a strong sense of feeling unconcerned about her child's speech and did not question whether she could have helped in any other way:

P14: If what she does works than great, I'm happy, but if it doesn't then it doesn't matter. It's good to come and see there could be an outcome, but if there wasn't it doesn't matter

BT 4: Feeling blamed

Some parents explicitly talked about feeling blamed for their child's potential difficulties and speculated about how they would feel in the future if they had not taken action. Both P12 and P8 referred to themselves in the future, looking back and regretting that they had not done more to help their child, in the words of *P8: 'if I didn't do something about it, then it would have been my fault'.*

Other parents' words echoed this though it was less strongly articulated. P4 and P11 described themselves as approaching language in the *wrong* way; P4 was driven by a motive to ensure her child was polite and respectful:

> *P4: **I think I've been going about it the wrong way** , I think I've been saying to him too much, I need to repeat words as opposed to saying lots of new ones. I tried to teach him manners and give him lots to think about but really I should be saying 'get your juice' (laughs). I hate children if they don't say please, don't say thank you because children now, they do sound rude*

Issues of home life and the demands of work were raised by P6 and linked to feeling guilty on three separate occasions in the interview, for example she said, '*I work quite long hours and I thought he wasn't coming along cos maybe I wasn't spending as much time with him'.* Her sense of guilt was compounded by the competing demands of paying sufficient attention to her older children:

Interviewer: Do you feel it's partly your fault

P6: Yeah yeah, obviously, I'm his parent and it's guilt. I think it has a knock on effect at home because I'm trying to spend more time with him and when I am, the other two are, well, they need attention

Several parents expressed a degree of self-reproach, implying that their child's difficulties could be their fault. A number of factors were cited, such as the way the adult talked, the time they spent with their children, and personality. P12 worried that her own style of talking and the restricted attention she was able to give her child contributed to her child's difficulties:

*P12: I do talk fast and alot of people have commented that I talk fast. **I do feel to blame** because I am a stay at home mum and there's only 6 months between the two of them. I thought maybe it was cos I hadn't spent enough time with her cos we've lived in so many houses, that's why I really want to be proactive...I want to spend the time with her and feel that I've done something rather than in ten years, go may be if I've done this or I spent more time with her or the house wasn't as clean as it is*

The strength of language she used conveys her concerns, commenting that she didn't want her child 'scarred for life' through her own inaction. Similarly P2 used emotive words that indicated self-reproach, expressed as *'I feel like I've let her down'*.

P6 referred to not responding quickly enough to her concerns:

*P6: The whole process is quite long in all honesty to get somewhere. **I suppose I should have done it a little bit earlier,** but it's knowing that the help is available and even trying to catch a health visitor...because I work such long hours , it's really hard to fit things in and obviously most services are not available on Saturday or Sunday*

154

P13 was careful in her choice of words, but they still suggested feelings of guilt as she referred to her child's progress and the influence of her own personality.

> *P13: I believe mums have a big role for helping children, children are different. Sometimes I think I won't be able to give what other mums can cos of their personality*

In summary, parents' emotional response to supporting their children varied, but views about their inexperience and guilt at the outset of involvement were frequently expressed.

4.3.5   Global theme four: parents' priorities

Parents' focus of concern suggested two firm priorities in their concern for their children: (i) parents' aspirations for children and (ii) gaining knowledge to support speech and language development.

Table 4-13: Parents' priorities

Basic themes (BT)	Organising themes (OT)
1. Concern about social inclusion 2. Concern about educational progress	1. Parents' aspirations for their child
3. Knowing about child development 4. Knowing about speech and language development	2. Gaining knowledge

Organising Theme 1: Parents' aspirations for their child

A number of parents (n=11) referred to their anxiety about their child's social acceptability and inclusion in family and school activities. Two basic themes were derived from the parents' first interviews: (1) concern about social inclusion and (2) concern about educational progress.

155

BT 1: Social inclusion

Some parents were anxious that their child's difficult behaviour or poor communication would lead to social exclusion. This included the frustration of dealing with challenges on a daily basis and the way children's difficulties were thought to reflect on parents. P3 explained that she was embarrassed when people could not understand her children; P1 described her child as naughty and clearly felt exasperated with his poor social interaction at home.

Others were concerned about their children being vulnerable and susceptible to being ignored, or worse, being bullied, due to their poor communication.

> *P3: Alot of people get frustrated with them cos they can't understand what they are saying, they give up on them, other kids will tease them and be awkward with them which will upset them*

P8 expressed a similar fear that no one would want to play with his children and the importance of addressing these difficulties before they went to school.

A related issue was an anxiety their children should not be judged by others. P2 related how the schoolteachers were positive about her daughter's interaction with other children, but she still expressed anxiety that her child had been *'branded as, I shouldn't use this word, as lazy, which upset me really and it annoyed me-she's not, she does really try'.* She was clearly concerned about the possibility that her child would be misjudged and labelled unhelpfully, potentially affecting her progress in school.

BT 2: Educational progress

Seven parents referred to anxiety about academic progress and success at school, referring to the possibility that speech and language difficulties were indicative of underlying problems that could have a negative impact on their children's progress. P2 referred to her child's imminent full time education on successive occasions in the interview as a trigger for seeking help. P3 talked at length about her children (twins) learning to read, commenting on how important it was for them, and her anxiety that their speech difficulties would interfere with their progress in school.

> *P3: My main concern is the reading and if we can help them pronounce letters a lot*
> *better then their reading is going to be a lot better*

One parent was an exception to these views. P14 explained that she knew her child had speech difficulties but did not anticipate that it would interfere with his learning; she maintained that her child's happiness was more important than addressing a speech difficulty that she perceived as insignificant.

Organising Theme 2: Gaining knowledge to support speech and language development

Many parents expressed a lack of knowledge of both child development and development of communication. They expressed improving understanding and gaining skills as a priority.

BT3: Knowing about child development

Some parents in the study referred to their lack of experience of parenting as the child attending SLT was their first child, which by implication suggested they were keen to gain knowledge. This was portrayed as contributing to their anxiety, as illustrated by P7:

> *P7: He's the only one and I've got no brothers and sisters so I haven't been round babies*

P1 and P6 found that their experience with older children caused them to question why their current children were having difficulties, contributing to ambivalence in their perception of the problem.

> *P6: I've been worried about M's difficulties for some time. He's got older sisters and I've never had any problems with them interacting*

P10 referred to 'just knowing' whether her child was lazy or genuinely had difficulties. P15 commented that seeing the SLT had helped her realise how much her child had progressed*, 'he's not as bad as I thought he was'.*

BT 4: Knowing about speech and language development

Three parents referred to their previous experience of children with speech and language needs. They expressed a level of confidence in understanding their child's difficulties, making judgments about progress and how they differed from other members of the family.

> *P5: My other little lad has learning difficulties. He's nothing like him, he's just his speech, so I was worried about that.*

Nevertheless, this experience did not enable them to feel fully confident in providing appropriate support for subsequent children.

The following exchange showed how P15 was seeking information specifically about speaking to support her in helping her child:

Interviewer: What did you hope for when you knew the SLT was coming?

P15: Not sure, a bit more information on how to speak to him so he can learn off me

4.3.6 Summary

The following section provides a summary of the findings from the first level analysis of the parents' interviews, focusing on parents' conception of their roles. A full discussion, with reference to current literature is presented in Chapter Seven. The analysis suggested six key points:

1. *Three broad conceptions of roles* were derived from parents' interviews: roles of advocacy, intervention and taking responsibility for support. The evidence did not suggest that the roles were sharply defined categories but there was evidence that within each conception, parents showed different expectations of involvement in intervention. They varied in the extent that they understood or adopted these roles and, for some, there were indications of uncertainty in their perception of their roles. The evidence suggests that parents' role conception in relation to supporting their child's language learning is tentative and open to change. Parents described themselves as new to supporting their child's speech and language development and therefore having little experience or knowledge to draw on. Nevertheless, within each broad category, parents showed tendencies towards specific types of roles, reflecting expectations about level of their involvement. For example, the

advocacy role had three sub groups, 'responding to other's concerns', 'raising concern', and 'pursuing advice/judging advice', each indicating increasing level of involvement.

2. *Paired conceptions of roles.* There are clear parallels between the roles that parents adopted and SLT roles described in their interviews (Section 4.4). The relationship between parent and SLT roles may indicate an important association between the roles that each partner adopts during intervention. This will be discussed in Chapter Seven.

3. *Parents' conceptions were open to change.* There were strong indications that parents' conceptions were open to change and evidence of changes taking place as parents reflected on their first session with SLTs. Moreover, some parents were explicitly expressing that they were seeking changes in their understanding and practice, typified by expressions like hoping that intervention would 'open my eyes' (P7) and provide 'insight' (P10). The tendency for role conception to be open to change raises an interesting question: do individuals move between roles, and if so, what influences these changes? This was followed up in the second and third parent interviews that focused on parents' description of changes associated with involvement. These are reported in Chapter Five.

4. *Parents seek expert advice.* Parents in this study sought the SLT's advice explicitly to access support from a professional with experience and knowledge. The evidence from the first level analysis indicated that parents feel inexperienced in relation to supporting a child with speech and language development. The distinction between parent and professional roles was clearly important to parents. They valued access to a professional with training and experience of

speech and language difficulties and acknowledged that they lacked experience and knowledge themselves. This raises two important features of intervention relating to parents as learners and SLTs as teachers. This will form an important element of the discussion.

5. *Parents are keen to learn*, even though they are uncertain about their role in supporting their child's language learning. Some parents' conception of the SLT role as adviser or teacher coincides with conception of themselves as a learner in the adaptor role.

6. *Balance of responsibility between parents and SLTs.* Most parents expected to assume some degree of responsibility for their child's language learning. There were no examples of parents who assumed that SLTs should take full responsibility for intervention.

4.4 Results of analysis of SLT interviews

The process for analysing the SLT interviews followed the same two stage procedure used for the parent interviews. A full description and rationale is provided in the Section 4.2.2. In brief, each transcript was analysed using thematic network analysis (Attride-Stirling, 2001) to identify basic, organising and global themes. Global themes were generated by clustering the organising themes according to similarities. The interest in this analysis lay with the therapists' conception of their own and parents' roles and their observations of changes in parents' conceptions and behaviour, and how this was related to the therapists' roles. A framework analysis (Ritchie and Spencer, 2002) supported the analysis of similarities and differences between SLTs and allowed variation in perception and practice to be noted.

Three global themes are described (Table 4-14):

1. SLT perception of their role

2. SLT perception of parents' role

3. Characteristics of parent-SLT relationship

Table 4-14: Basic, organising and global themes from interviews with SLTs

Basic theme	Organising theme	Global theme
SLT assessment without contribution of parents Assessment drawing on parents' knowledge of child Assessment drawing on parents' knowledge of speech and language norms	Assessor role	1. SLT perception of their role
Treats child Plans activities for parents Provides advice/coaching/teaching on language support and interaction	Intervener role	
Decision-maker/makes recommendations Clear explanation of roles/responsibilities Offers flexible options	Negotiator role	
Attender Helper	Parents as implementers	2. SLT perception of parents' role
Adaptor Learner-teacher	Parents as change agents	
Professional Understanding Engaging	Relationship building	3. Parent-SLT partnership
Respectful Offering choices Perceiving parents as motivated Perceiving parents as involved	Perceiving parents as collaborators	
Learning organisations Models of practice	Service characteristics informing partnership practice	

4.4.1 Global theme one: SLTs' conceptions of roles

There were nine basic themes relating to SLTs' perceptions of their roles in supporting children with speech and language needs. These were divided into three organising themes of assessing, intervening and negotiating. The following section describes these in detail using quotes from the interviews with SLTs to illustrate each theme.

Table 4-15: Basic and organising themes for global theme one

Basic Themes (BT)	Organising themes (OT)
1. SLT assessment without contribution of parents 2. Assessment drawing on parents' knowledge of child 3. Assessment drawing on parents' knowledge of speech and language norms	Assessor role
4. Treats child 5. Plans activities for parents and modelling what needs to be done 6. Provides advice/coaching/teaching on language support and interaction	Intervener role
7. Decision-maker/makes recommendations 8. Clear explanation of roles/responsibilities 9. Offers flexible options	Negotiator role

Organising Theme 1: Assessor role

All the SLTs in the study referred to their role as assessor, presenting this as a critical and unique element of their work. They clearly perceived themselves as having a specialist role in providing assessment of speech, language and communication in detail. SLT 5 stated, '*I'm the professional who can assess and advise',* and SLT 1, *'we are specialists in speech, language and communication'*. This was expressed as a unique difference between their role and those of other professionals. The majority of practitioners referred to an assessment role that included more than evaluating children's speech and language skills only.

Three basic themes of the assessment role were derived from the data: assessing children without parents' contribution, assessment drawing on parents' knowledge of their child and assessment drawing on parents' knowledge of speech and language development.

BT 1: SLT assessment without contribution from parents

The assessor role often began before the SLT met the child and family with gathering information provided by other professionals, via the referral. SLT 1 described a process of reasoning based initially on the referral information, *'I looked at the referral and obviously thinking some jargon, maybe language disorder'.*

Many SLTs described assessment as a process of identifying strengths and weaknesses in a child's language skills, but, at this stage, there was little reference to parents included in the process of identifying specific aspects of the child's language difficulties.

BT 2: Assessment drawing on parents' knowledge of their child

Some SLTs described how they used probing questions to elicit information and evaluate parental readiness to participate in intervention. Some SLTs were clearly drawing on parents' knowledge of their child as illustrated by SLT 5:

> *SLT 5: I've been doing dysfluency training that has really influenced my knowledge and skill base, **I'm asking the right questions to give you the most information** and I really understand dysfluency and what you need to ask, even asking can you pinpoint change, I wouldn't have asked in such depth or know how to probe*

The reference to acquiring this skill through postgraduate training implied that this level of parental involvement was relatively new to her. She specifically referred to applying this approach to working with parents whatever the primary diagnosis. In contrast, SLT 4

reflected how she only used in-depth interviewing with parents of children with dysfluency and did not apply this approach to children with more general speech and language needs.

Part of the assessment process for many interviewees included evaluating the readiness of the child and family to take part in intervention and which type of intervention would suit the family, drawing on parents' knowledge of their child is implicit in such a process. Therapists frequently articulated this as judging whether parents were 'on board' or 'engaged':

> *SLT 1: You want the parents to be on board-that's half the battle. You can work with the child but if the parents aren't on board. You need to get them on board before you can give them advice*

The commitment to assessment, drawing on parents' knowledge of their child was illustrated by one service that provided screening sessions with two SLTs, one working with the child and the other with the parent, gathering information about the child but also about any characteristics of home life that could affect the child's speech and language or parents participation.

SLT 7 raised an important issue about drawing on parents' knowledge relating to the reliability of parents' judgement. The concern that parents may deny that their child has difficulties was presented as a significant concern:

> *SLT 7: The most difficult thing for me is if parents deny, feel there is no problem and in fact there can be a severe problem that they haven't picked up and it's being sensitive enough to try to get them round to the idea that they may need referring on*

BT 3: Assessment drawing on parents' knowledge of speech and language development

Several therapists referred to gathering information from parents using a pre-appointment questionnaire about speech and language development which parents completed before attending speech and language therapy. This was described as a means of gathering information but also considered to help parents prepare for the assessment and begin to formulate their understanding of their child's specific speech and language needs. SLT 1 described '*setting the scene*' and helping parents understand what therapists will ask of them, linking this to building a common understanding of speech and language difficulties right from the first contact:

> *SLT 1: It's useful for parents as well, giving them an idea of what we're going to ask them. A lot of parents that we work with are reluctant to engage, a fear of the unknown really and it really helps setting the scene*

Organising Theme 2: Intervener role

SLTs' conception of their role as interveners is central to the research question relating to promoting conceptual and behavioural change in parents attending therapy. All the SLTs in the study made reference to their role as interveners. They frequently referred to therapy or direct intervention with the child, but also to a teaching role, using terms such as facilitator, coach or trainer. This was expressed as a key part of their role, both in providing formal courses for parents and other professionals, and informal teaching, as part of routine assessment and intervention, summed up by the words of SLT 5 '*We have quite a teaching-advisory role-how to help parents help their children'.* SLTs explained the rationale for including teaching as part of their intervener role based on parents spending the most time with their children. SLT 10 described how she explained it to parents, '*the*

reason we don't do the traditional, you come to the clinic room for half an hour every week, cos that won't work, is that you're with them every day'.

BT4: Treating the child

SLTs in the study rarely described treating the child only, without involving other people. The majority of SLTs interviewed referred to a range of treatment options and rarely implied that treating the child was the first or only priority. It was presented as one option that the SLT would consider, often in circumstances where they judged the family was not able to offer support at home. SLT 2 commented, *'we know the circumstances of families; we can always make allowances'*. The same SLT referred to judging whether parents were able to contribute to intervention:

> *SLT 2: We try to establish how supportive mum appears in the session and what we're best offering*

However, there were several exceptions that implied that little discussion took place between parents and SLTs. SLTs appeared to have preconceived ideas of the intervention plan, whether treating the child, giving advice or providing activities for parents to do themselves, as illustrated in this quote:

> *SLT 4: I kind of **know what I'm going to do**, but I don't really share that*

Two SLTs (SLT 3 and SLT 11) referred to the pressure they perceived from parents to treat the child:

> *SLT 11: (they) come and have the viewpoint, that it's not their job to help their child*

This raises the important issue of the way individual's conception of roles influence each other; on occasions SLTs indicated that parents' expectations of their own role can be perceived as determining the role the SLT feels is required of them.

BT 5: Planning activities for parents

Planning and modelling activities was clearly perceived by some SLTs in the study as an important part of therapy treatment and an integral part of their intervener role. As SLT 4 stated, treatment started at the assessment, '*I did try to give mum some practical things and I'm going to follow it up with more activities in the post, so that is where his treatment is starting*'.

SLTs in the study referred to providing practical activities for implementation at home by parents, either as a follow up to assessment, sending activities and ideas in the post, for example, or as homework to reinforce on-going therapy intervention (SLT 3, SLT 6, SLT 11). Few SLTs commented on whether this was successful, though one (SLT 4) did refer to frustration when parents did not complete home activities, '*There are cases where you have to give up, if parents don't want to, you can't force them to practice between sessions*'.

SLTs in the study emphasised the importance of showing parents what to do as well as providing activities. This was referred to as demonstration or modelling. Therapists did not refer to this as teaching, but used phrases such as 'show and do' or 'I model as I go'. The emphasis is placed on practical demonstration, enabling parents to learn what to *do.*

The purpose of modelling, as described by the SLTs, in this study appeared to be threefold:

  i.   To show parents what to do to support speech and language

  ii.   To give parents confidence in undertaking specific activities

iii.　　To monitor parents' ability to do activities that help their child's language learning

SLT 2's explanation of modelling suggested a process of showing parents how to do activities and then observing parents undertaking activities. This SLT linked modelling with building parental confidence as part of the learning process, '*just giving them confidence, that **they can do it**….every parent can work with their child and you can **teach them techniques** and some key strategies'*.

BT 6: Provides advice/coaching on language support and interaction

Therapists regularly referred to increasing parents' knowledge and understanding through providing advice and coaching. This ranged from providing appropriate information about conditions and types of intervention through to enabling parents to think and behave differently with their child. This basic theme focused on the SLTs' role in enabling parents to understand their child's speech and language needs, support speech and language development and understand respective roles and responsibilities. The words of the therapists did not suggest that they distinguished between informing, as in the exchange of information, and advising, as in making recommendations and building understanding. Where therapists referred to providing information, their intention was more akin to supporting learning and changing understanding. SLT 3 referred to **embedding** the information, and **redirecting** parents, suggesting that the message was associated with learning and change.

SLT 2 used words such as 'understand' and 'realise' to describe parents' learning during intervention, suggesting a deeper and more thoughtful position than simply receiving information:

*SLT 2: help mum to **understand** the difficulties she's (her child) got and possibly the reason why I think for some parents the **realisation** of it doesn't hit home until further down the line*

A number of SLTs in the study used the expression 'take on board' to refer to a process of parents internalising advice. SLT 4 commented that having the parent on board was a big factor in effective intervention, describing this as *'take advice on board, use appropriate strategies, be committed to trying things with him, working with us and **doing what we ask them to do'***

Another illustration from SLT 2 links advising with observing the parent, suggesting a process of teaching involving advice, observation and review.

*SLT 2: I think it's the key thing, because it's important for you to **observe parents** in the session and **see how they're working** with their child to **make sure they take on board exactly what advice you've given** cos sometimes it can be misinterpreted and then it's a way you can then coach them and talk to them about how to carry out the activities*

Therapists did not clearly distinguish between changing parents' understanding and changing behaviour. Statements more frequently related to changing behaviour, such as interaction, rather than changing conceptions. Two SLTs (SLT 1, SLT 5) alluded to changing parents' thinking to enable them to become participants in the intervention. SLT 1 talked about parents having time to put *'theory into practice'*, which suggests an association between conceptual change and behavioural change.

A number of the therapists referred to their 'modelling' role as a routine part of their work, and to providing parent 'training' as part of their service delivery, but few gave details of

their concept of training, beyond referring to coaching and demonstration of activities and more formal education programmes.

SLTs' confidence in modelling varied. For example, a newly qualified SLT reflected that she could have done more demonstration in the assessment, including involving mum:

> *SLT 8: I think her participation was..mmm.. as much as it could have been today. Perhaps I could have thought about a different assessment approach, perhaps got her to join in play with the child to see if he communicates differently with her. It's not something I may be considered before*

Evidence from the interviews indicated that SLTs perceived their modelling role as prompting change in parents, particularly in what they *do*. However, little reference is made to changing parents' *understanding*. It is difficult to discern from the words of the SLTs whether there is a clear frame of reference or language for explaining the role of modelling and its place in 'parent education'. Therapists presented teaching as integral to their therapeutic role, but rarely talked in detail about what this role entailed in the study.

It is worth noting that SLT 5 commented that her own initial training had not helped her build skills of modelling or coaching, *'you're not taught to model it, you're not taught how to explain it to parents'*. This raises an important question about SLT skills and how their conceptions of roles develop. Is it a natural development of skills related to experience of working with parents? What place do service cultures play in shaping these conceptions? References to learning from shadowing others as well as specific training suggested that this conception of role needed to be learnt. This is discussed further in the organising theme on service characteristics.

There was a strong sense of adapting and adjusting the approach, in a process of constant evaluation of parents' readiness to receive advice. Several referred to anxieties of overloading parents with too much information (SLT 3, SLT 5, SLT 7), indicating that therapists modify and adjust the way they transfer knowledge and support understanding in response to individual parents' knowledge and circumstances.

Many SLTs in the study indicated that they reflected on how they provided information and encouraged understanding. SLT 12, who had a specialist role supporting parents with significant social needs, implied that she aimed to change parents' behaviour by incorporating advice into general support for families.

> *SLT 12: We're trying to change the home learning environment, trying to intervene early and very focused on getting, delivering intervention before the baby is born. It might not be using specific therapy techniques, specific programs like Target Words. It's taking elements and its success is about the way it is delivered, general early language strategies moulded into family specific targets*

SLT 8, working in a more traditional service, expressed the same intention of helping parents learn specific strategies that are integrated into learning activities at home:

> *SLT 8: For her to go away and think about the strategies I've talked about, think about what I've identified as the strengths and weaknesses, and to put them into place in the home learning environment*

Two therapists (SLT 4 and SLT 8) described situations where they judged that they could not add to parents' knowledge and skills because parents had worked with SLTs before, with previous children.

SLT 4: I don't think she felt I'd left her with anything practical. She was using some nice strategies so I tried to reinforce these

SLT 8: I got the impression I was telling her what she already knew …you can't always give more cos parents know their child best

There was just one case where the SLT indicated that she expected parents to accept her professional advice without question or necessarily understanding it.

SLT 4: You assume that parents will see that you are the professional and what you're saying is right, they don't

Organising Theme 3: Negotiating

The majority of the SLTs referred to some form of negotiation during their first appointment with parents. The organising theme of negotiation consisted of three basic themes: decision-making, clear explanation of roles and responsibilities and offering flexible options.

BT7: Decision-making

Evidence from the interviews revealed the delicate balance between leading decision-making through recommending best approaches to parents and handing responsibility to parents to opt for the intervention that suited their child and circumstances. The SLTs in the study described themselves as the decision-maker in terms of identifying the difficulties through assessment and making recommendations for intervention. The process reflected an SLT led approach, offering a range of best options for support available in the service, in the words of SLT 1 making '*sure she knew what was appropriate'*. Recommendations for intervention were rarely described as a shared decision. SLT 1 was

an exception, stating, *'we decided together'* suggesting a joint process. She also referred to an incremental process of passing responsibility across to parents:

> *SLT 1: We do assessment, provide the intervention and facilitate the intervention with an assistant, but then **the parents take ownership of that then**. That's what we are striving for, that they then take ownership of the advice, that they can detach away from SLT*

This is portrayed as a process of leading clearly, providing choices and encouraging parents to take responsibility in a form of 'supported decision-making'. SLT 12 reiterated the importance of enabling parents to make decisions following the advice and information provided by the therapists, saying, '*I put it back to parents, what do you think, what do you want to happen, how long do you want to try these strategies...**I put it to her..and then it was probably a joint decision'**.*

SLT 10 believed that parents came to a professional for recommendations. It was therefore the role of the SLT to provide choice over where and when the parent wanted intervention, but to make the decision about what was needed: *'I'd want the professional to tell their professional opinion, it's a very difficult choice and we do try to give them that power about where and when they want it'.*

Two therapists linked decision-making with shared responsibility. SLT 11 described an expectation of shared responsibility between therapist and parent, referring to the importance of parent participation as part of the decision about intervention:

> *SLT 11: I always say to parents I haven't got a magic wand, it is a process between us all where we all put as much effort in*

SLT 2 went further by suggesting parents took the ultimate decision. She discussed the child's needs, provided advice but the parent decided to follow the advice or not, and make changes:

> *SLT 2: All we can do is discuss that and discuss the risk with mum and what our advice is, but then it comes to mum making those decisions and changes. We can try and support her as best we can*

Evidence from other SLTs in the study did not indicate that the process of decision-making was so carefully balanced. The choice of words made by SLTs conveyed an important difference. Compare '**we** *decided'* (SLT 1) with '*I've decided'* (SLT 8) or '***I've made a decision***, *what's best for him'* (SLT 10). Furthermore, some SLTs implied that decisions were made without reference to parents' situation or preferences:

> *SLT 4: It is frustrating,* **parents not seeing the value of what you're doing** *and you've not got a lot of time to explain the whys and evidence base*

In conclusion, SLTs showed variation in the way they described the degree of joint decision-making and who took responsibility for the final decision, but predominantly described the therapist as leading recommendations based on assessment. Few SLTs referred to parents as ultimate decision-makers.

BT 8: Clear explanation of roles and responsibilities

SLTs referred frequently to setting out clear expectations as part of an open dialogue with parents.

> *SLT 6: We're always* **setting the expectation***, being clear about what you've seen and what you anticipate is going to happen and* **why you've made that decision**

176

A number of therapists pointed out the importance of being direct (n=7). For example, SLT 2 stated '*I think you need to be quite **direct** with them to **help them understand***'. SLT 1 described herself as 'open' in using an approach that was '*quite level with parents, saying this is what we can offer, this is how we do it, and just being really open and honest with parents*'. SLT 12 used the term, '*I put it to her*' conveying a direct approach. SLT 3 expressed the need for direct discussion in the context of perceiving SLTs as being '*too forgiving*', often rearranging appointments when parents failed to attend rather than challenging parents. She described her approach as '*being very upfront, you know **setting your stall out** at the very beginning, then saying there's no magic wand*' and even goes as far as saying '*I'm much better at saying you're wasting your time coming*' when parents have failed to implement home activities.

Several therapists touched on the importance of influencing or forming a clear understanding of roles and responsibilities with parents from the outset of involvement. This was not presented as optional for parents, even where therapists talked about responsive and flexible services. SLT 3 described herself as learning to be plain spoken and explaining to parents you have '*a massive role cos this is not going to change*'. She commented on how she perceived SLTs had promoted an unhelpful impression of responsibilities:

> *SLT 3: In the past we've not helped ourselves by this air of mystique or that these children are going to come and then we're going to fix them. Yes we've always given them homework, but as I say, we're much better at setting out our stall out right at the beginning and saying this is what we do, how we work*

SLT 1 described the service as an '*in and out service*' that worked on an approach of handing responsibility back to parents, '*there you go, there's your advice, come back if there*

are any problems'. SLT 11 was also specific in attempting to adjust parents' understanding of their own role and SLT roles. She described how she questioned parents' expectations, outlined her own and directly explained what parents needed to do, '*please be aware I'm going to be giving you homework activities and I'm going to be asking you how you got on and if it's suitable to bring them in so you can demonstrate, show me'.*

There was considerable variation between SLTs' ease in negotiating roles and responsibilities. SLT 4 ascribed her reluctance to be direct to the tendency for parents to be over demanding. She implied she avoided exploring parents' concerns too carefully due to a belief that they would always expect more than she could offer, commenting '*not committing yourself to anything you can't provide'.*

BT 9: Offering flexible options for support

Flexibility in terms of intervention options and parental choice were frequently raised by SLTs in the study. Therapists believed parents had choice from the outset in deciding when, or possibly, where their first assessment took place, using opt-in systems and telephone booking. They did not describe parental choice as a process of parents having whatever option appealed to them, and therapists then acquiescing, but referred to several points where choices were clearly available.

The first point of choice usually involved arrangements for parents to attend the initial assessment. One SLT described the use of telephone opt in as promoting better commitment from parents, whilst another described it as empowering parents by giving them control from the beginning of their involvement in SLT. The second point for offering choices related to intervention options, often referred to a prescribed list of options that a service had designed around care pathways. SLT 1 outlined the range of options she believed she could offer parents, including home visits, nursery intervention,

demonstration sessions or written advice. She included discharge as an option that parents could take without judgment from the SLT or prejudicing future intervention. The majority of SLTs did not indicate such an extensive range of interventions and some described very few options due to service arrangements.

The most distinctive difference between the options offered by SLTs was related to the type of intervention, whether planned options, determined by service care pathways, such as parent groups, or evolving options, determined on a week-by-week basis by the individual SLT. Many SLTs (n=7) in the study referred to giving parents options of attending pre-scheduled intervention groups such as parent workshops. The planned options appeared to provide a level of standard practice valued by SLTs, as illustrated by SLT 3 '*we provide fairly standard language advice, obviously tailored slightly'.* In addition to providing standard practices for parents, SLT 10 observed that following a pathway improved her confidence in decision-making in less frequently occurring conditions. SLT 9 described a process of determining the type of intervention based on severity scales that guided decision-making. However, she clearly used the system flexibly allowing professional judgement to be the principal determinant of intervention, *'you can't stick to it, so you have to make a judgement. It's like a tool to take you in the right direction'.* One SLT referred to the limitations of planned options, related to service restrictions, '*it's led by what we've got available and what we offer'* (SLT 6).

Overall, SLTs in the study seemed to suggest that they used planned options, designed for the whole service in a locality, but adjusted, if deemed appropriate by practitioners. Only one SLT referred to intervention as evolving as it proceeded. SLT 12 described a step-by-step process '*just following the outcome of that visit'* and then described providing '*individualised packages of care, dependent on the needs of the family, focused on the family*

need, that holistic picture'. This may have been determined by the client group, which were described as vulnerable families.

In some cases, the range of options was determined by the perception that the SLT had of parents' capacity and capability. SLT 2 adjusted the offer of intervention according to her evaluation of the level of support available from parents. She was explicit in referring to providing flexibility in spite of busy caseloads, waiting lists and service policies, '*we work flexibly with what parents and children need'.* She referred to exercising professional autonomy, so enabling a more flexible provision. This example clearly suggested that the SLT conception of role of 'treating' or 'modelling' was adapted according to the roles that families were considered able to adopt.

Some SLTs indicated a tension between intervention options based on clinical reasoning or pre-determined by service capacity and design. Several therapists alluded to service restrictions altering their decision-making. Nevertheless, nothing was said that suggested that this altered the process of negotiation of roles between therapists and parents.

Offering flexible options and being direct were closely linked by SLTs and possibly represented the basis of negotiation with parents. SLT 3 argued that the profession needed to be more direct and less flexible, *'I'm working with some quite difficult families and I do think we need to toughen up'.* Nevertheless, this same therapist went on to say how she believed *'we've got much better at putting parents really centrally',* revealing a tension which was not acknowledged, but may accurately have reflected the challenge of responding to parents' situations, offering flexible solutions, and perceiving some parents as avoiding taking sufficient responsibility for supporting their child's language development.

In conclusion, therapists in the study showed variation in the way they described the degree of joint decision-making, but tended to portray themselves as leading decision-making in terms of making recommendations, with parents making the ultimate decision by accepting responsibility. Some therapists in this study specifically expressed respect for parental decisions, even where this involved opting out of intervention, whilst others expressed frustration with parents for failing to adhere their advice.

4.4.2 Global theme two: SLT perception of parents' role

Four basic themes were derived from the data relating to the global themes of SLT perception of parents' roles: attender, helper, adaptor and learner-teacher. These can be seen as a range of involvement, from the relatively generic role of attender through to the enabled role of adaptor and teacher. There was considerable variation in SLTs' confidence in parents' ability to learn how to support their child's language learning.

Table 4-16: Basic and organising themes for SLT perception of parents

Basic themes (BT)	Organising themes (OT)
1. Attender 2. Helper	i) Parents as implementers
3. Adaptor 4. Learner-teacher	ii) Parents as change agents

Organising theme one: Parents as implementers

BT 1: Attenders

The implication of parents as decision-makers and making choices (see the negotiator role) is that parents are also free to choose whether to attend SLT. Whilst expressing a belief that parents should be able to choose, a number of SLTs expressed frustration that some parents chose not to attend, at a cost to their child and sometimes to the speech and

language therapy service. Nevertheless, SLTs in the study were *not* enthusiastic about parents assuming the role of attender without greater involvement. A number of SLTs described attenders as expecting a fix, with little interest in working with the SLT to support their child, as illustrated by SLT 4:

> *SLT 4: You know alot of parents come into an appointment or have a referral to the SLT cos they want their child to be fixed by a speech thera[ist and they think you're going to 'therap' the child*

BT 2: Helpers

The majority of SLTs in the study expressed an expectation that parents would take some role in helping their child's speech and language development as illustrated by SLT 9, *'you're going to be the ones doing the therapy'*. The construct of parents as 'helper' seemed to be implicit in the majority of the SLTs' approaches to working with parents, as evidenced by SLT 6:

> *SLT 6: You need to carry on the stuff at home, you're the agent of change, you come to us once a week but you're not going to progress*

The strength of expectation of parents by the SLTs varied. SLT 7 and SLT 9 expressed a more tentative expectation: parents were perceived as the key to ensuring children made progress, but they were careful to recognise parental limitations linked to the demands of life:

> *SLT 7: I do think they've got a key role but I also feel that if they have a big family, they're very busy and to put pressure on them to do hours and hours of work with their child…**I would try to gauge the type of intervention I would expect them to use***

Organising Theme 2: Parents as change agents

BT 3: Adaptors

Many SLTs in the study referred to helping parents change their interaction with their child as a principal objective of intervention. This suggested that SLTs expected parents to make changes that permeated throughout their communication with their child, adapting their approach to facilitate interaction.

Several SLTs raised the issue of varying parental capability and capacity to be an adaptor, questioning whether all parents were able to change their behaviour. SLT 4 commented, *'I always try to give advice but I guess the word is try. Whether it was taken on board as, um, anything would be done with it really...'.*

BT 4: Learners and becoming teachers

SLT conception of parents as learners was largely implied in the data. SLTs' referred to parent training and coaching, rather than overtly referring to parent learning. This raises a question about whether SLTs perceived parents as 'learners', developing their understanding and changing practice, or as 'implementers' of advice and strategies, as indicated by these quotes:

> *SLT 1: Longer term we may be looking at bringing mum in to have some sessions, see if she's happy to commit to some sessions in clinic, so that we can **give her specific activities** that she can take away and **practice***

> *SLT 4: I did try to give mum some **practical things** and I'm going to follow it up with more activities in the post, so that is where his treatment is starting*

The data did not produce explicit evidence to show that SLTs had a strongly developed sense of parents as learners. Expressions such as *'follow the advice'* (SLT 5), *'carry on stuff at home'* (SLT 6) and *'homework'* (SLT 3) all suggested that SLTs perceived the parent role as doing as directed, rather than as a learner. Nevertheless, there was an implicit assumption that SLTs regarded parents as learners given in their description of practical activities such as demonstration, visual guidance, and simplified targets to help parents learn to intervene themselves as illustrated by this quote:

> *SLT 2: It's important for you to observe parents in the session and see how they're working with their child to make sure they take on board exactly what advice you've given cos sometimes it's misinterpreted and then it's a way you can then* **coach them** *and* **talk to them about how to carry out activities**

SLT 1 was an exception amongst the interviewees in talking explicitly about helping parents learn. At one point she declared, *'my job is about re-educating them'* indicating a firm conception of the parent role as learner*.* She referred to her aim as *'trying to alter their thinking a bit'* and her practice as *'you only learn through doing it'.* She clarified this later with *'it's not about changing, trying to influence, it's about* **educating them round***'*, overtly referring to a process of learning. She described how she explained this to parents:

> *SLT 1: I'm not here to cure the child, I'm here to show you what to do and it's all about you and you'll feel you've really achieved something if you can make that change to your child's speech*

The SLT's words signal that she expected parents to become teachers, echoed in the words of other SLTs who referred to parents as *'facilitators in the home'*.

4.4.3   Global theme three: Parent - SLT partnership

SLTs in the study often referred to the relationship with parents as an important, possibly even essential, feature of working with families. The words they chose to portray the nature of the relationship varied, but the themes reflect considerable consistency between the interviewees. Three organising themes were derived from the evidence with eight basic themes (Table 4-17).

Table 4-17: Basic and organising themes for parent-SLT partnership

Basic theme (BT)	Organising them (OT)
1. Empathy 2. Engaging 3. Professional	1. Relationship building
4. Respectful 5. Giving parents control 6. Perceiving parents as motivated and involved	2. Perceiving parents as collaborators
7. Learning organisations 8. Models of practice	3. Service characteristics informing partnership practice

Organising Theme 1: relationship building

SLTs varied in how frequently they made reference to relationship building, but all of them referred to aspects of the partnership as influencing the success of intervention. Three basic themes of empathy, engaging parents and professional approaches were derived from the data.

BT1: Empathy

Five therapists (SLT 1, SLT 3, SLT 7, SLT10 and SLT 12) specifically alluded to considering the parents' perspective in terms of family situations or personal challenges that might

influence parents' approach to involvement. SLT 3 also referred directly to thinking about participating in speech and language therapy from the parents' perspective:

SLT 3: I think it's really really hard, again from a personal point of view, you become much more aware of how hard it is to do these things, even for us when we know what we should be doing. I imagine it's really hard for a parent who it's all new to, to take that away and digest it

One practitioner explicitly referred to providing reassurance as part of her intervener role. This related to reassuring parents that they were right to raise concerns, that difficulties with speech and language were not unusual and that these difficulties could be addressed.

SLT 12: I really see a big role in reassuring them that it's a common problem and there are strategies that can be put in place

The words of another SLT expressed how she believed her approach had changed profoundly, as she learnt that speech and language therapy was more than being professional:

*SLT 10: Before I started doing the job, I would have described it (my role) as a professional therapist and someone that advises and tells you what to do and that's it. But having done it, it's so much more, you're a supporter, **you have to build a relationship**, especially with the more hard to reach families, you a have to go in as a friend almost, and **make the relationship with the mum** and then try and get some advice in*

BT2: Engaging parents

A number of SLTs in the study commented that relationship building was instinctive, a natural skill that was integral to the therapy role. Nonetheless, SLTs observed a number of difficulties, including the lack of time to build a relationship and parents who were less forthcoming and ready to build a relationship. Indeed, SLT 5 used the term 'harder to reach' for a parent she perceived as unresponsive. Another described the process of relationship building as *'a personal challenge'* with some parents who could be defensive (SLT 3).

SLTs described engaging with parents in terms of winning them over, making them feel comfortable, sharing information and encouraging them to overcome fears. The process of engagement was associated with openness as illustrated by this comment *'I'm really keen on stressing to parents that it's an open door'* (SLT 1).

BT3: Professional approaches

SLTs had a clear conception of their role in the parent-SLT relationship. Empathy and engagement were not enough. Relationship building was perceived as being professional (in terms of skill and experience) as well as friendly and empathic, summarised by SLT 2 as 'friendly but professional'. SLT 5 talked about building a good relationship quickly, interested in parents' situations, but specifically referred to maintaining the professional role as the one who assesses and advises on speech and language.

During the interview, SLT 4 reflected on her views of working with a less engaged parent. She commented that the situation with the unresponsive parent was likely to be more complex than she first thought and that relationship building required more time:

*SLT 4: **I can make assumptions**, but **I don't really know,** she could have been nervous, shy, not bothered, had difficulties herself. **If I'd had more time,** you can then begin to put yourself in their shoes and adjust your treatment to fit their, but you don't get to do that in a one off*

Organising Theme 2: Parents as collaborators

The SLTs in the study expressed respect for parents' views and situations, showing considerable tolerance of parents' variable involvement. However, very few directly reported that they considered parents as collaborators or co-workers, although their approach signified that they valued parents' involvement and aimed to promote a joint approach. SLT 5 was unusual in explicitly declaring that she regarded parents as collaborators.

BT4: Respect

SLT 1 indicated that she aimed to understand why parents' were not participating in intervention saying, *'I always think there's a reason, what can we do to make it more accessible'* indicating respect for parents' circumstances. SLT 12 commented explicitly about respect and the benefits of nurturing respect in enabling parents to support speech and language development.

Later she reported that she handed responsibility back to parents, indicative of working together, but not necessarily collaborative. The absence of comments about collaborating from the majority of SLTs did not necessarily mean that parents were not included as collaborators. It does, nevertheless, imply that SLTs do not prioritise this in describing their practice.

BT 5: Giving control to parents

Several therapists commented that the relationship with parents was better when parents had greater control over the timing of appointments and a degree of choice. Providing options was assumed to signal a more collaborative relationship from the outset.

> *SLT 1: you're finding the commitment is better cos now they're making a appointment that fits in with them, with child care and working, so they tend to come to the appt whereas before it was , yeah I want to come, send me an appt, but I just haven't got the time*

BT 6: Perceiving parents as motivated to achieve change and involved

Therapists regularly referred to judging parents' motivation to participate in intervention, often associated with parents' level of concern. SLT 3 was typical in commenting, *'I felt quite confident that those parents would…were quite motivated to go away and try things we're suggesting'.* She continued to explain how she evaluated motivation through assessing parents' concern and initiative in seeking support linked to parents' advocacy role. She commented that when parents had *'pushed for the assessment'* she felt confident that they would *'have a go at things'.*

Generally, SLTs conveyed a range of confidence in parents' motivation. P12 expressed a belief that almost all parents wanted the best for their children, even if their circumstances limited their ability to support their child, asserting that the SLT had a responsibility to build on parents' natural inclination:

> *SLT 12: I'd say all families want to help their children, they've usually got aspirations for their children. They may not realise that they've got responsibilities in proactively helping them to develop, but they want their child to do well at school*

An alternative view was presented by SLT 7 who expressed concern that some parents were critical of their children, where the motivation appeared to be one of negative fault finding in the context of a child's adequate development. Such a position was portrayed as counter to co-working and successful support:

> *SLT 7: sometimes I find I'm supporting a child against a parent who is terribly critical and I find that upsetting, there's not a lot wrong with them*

The construct of engagement is often presented as an independent characteristic that parents either possess or lack. The SLTs in this study conveyed a much more complex feature of the relationship between parents and professionals. SLT 12 indicated a sensitive balance between engagement, motivation and mutual respect associated with a co-working relationship.

> *SLT 12: If you've got **mutual respect** they're much more likely to want, they're **more motivated to change things**, to try things, because they like you and **they want to engage** and they don't feel they are being criticised for their parenting'*

Organising Theme 3: service characteristics informing partnership practice

The research question did not specifically ask about the influence of service characteristics on the perception of roles, but the interviewees in the study regularly raised it. Learning, service design and service issues were often cited as determining the characteristics of intervention and presenting obstacles to preferred practices and therefore to the roles adopted by SLTs.

BT 7: Learning organisations

SLTs were enthusiastic to describe how their practice had changed because of learning. Several SLTs referred to learning, both individually and collectively with colleagues in their teams, as a characteristic of their service. SLTs used words such as 'before' and 'after', to express the significance of what they had learnt and how differently they practiced following the learning. They referred to learning associated with formal training, delivering training themselves, experience working with others, learning from parents and learning from private practice.

With respect to formal training, learning to deliver Hanen programmes (Girolametto et al., 1996) was most frequently cited by SLTs as changing the way they practiced as illustrated by SLT 4, *'I worked in a very different way pre-Hanen'* and *'I didn't have a clue'*. SLT 2 commented that the service she worked for did not use the Hanen programme because of limited capacity but applied the principles, learnt from Hanen workshops, to their intervention. Furthermore, she talked about applying those principles to other intervention, such as phonology therapy. This is consistent with other studies that describe SLTs as eclectic in their use of programmes (Law et al., 2003; Lancaster et al., 2010), readily adapting according to context.

Two therapists (SLT 3 and SLT 4) referred to the benefits of delivering training for their own learning. In the following quote, SLT 3 described learning to deliver training for other professionals using the ELKLAN approach[15].

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[15] http://www.elklan.co.uk/

SLT 4: Then delivering it, it clicked into place just how much detail you need to go into with some parents. And certainly in this area you could spend a couple of weeks on one thing, the need to model and demonstrate

Three SLTs (SLT 4, SLT 5, SLT 12) referred to specialist training for children with dysfluency as significantly influencing their practice. SLT 5 observed that this enabled her to probe more deeply in order to understand the issues contributing to the fluency difficulties (see global theme 1). She commented that this had influenced her skill base that in turn had assisted her in working with other conditions. In contrast, SLT 4 reflected that she did not use the same techniques learnt for working with families with dysfluent children with parents who had other language needs, commenting, *'I suppose it would be useful to explore expectations at the start'.*

Informal learning and experience was also referred to by the SLTs interviewed. They mentioned practices such as shadowing, joint practice, joint supervision and ad hoc case discussions as examples of informal learning. SLT 12 illustrated this succinctly in the following comment:

SLT 12: I find CPD happening all the time, general supervision, makes you reflect. A massive thing is researching on the internet, using resources, moulding them, often new ideas you haven't thought about, wording things differently

Many therapists in the study (n=7) mentioned learning from experience, not only referring to working with colleagues but also *learning from parents and children*. SLT 4 indicated that learning to provide intervention was entirely the result of experience rather than formal training. Some therapists recalled critical points of learning involving the parents they were working with. SLT 12 remarked that she used things parents said to shape her practice and influence the way she talked with other parents. SLT 10 described an early,

formative experience, described as unsettling her, involving two parents who were clearly distressed during their child's assessment. She described a profound change *'that turned my perception around about how I need to go about this'.* She reported that her approach changed from a process of questioning parents to elicit information to '*actually caring about the answers and finding out what else is going on'.* The SLTs' narratives expressed their experience of learning from parents as highly influential to their long-term approach to working with parents. Their descriptions were detailed, which together with their use of animated and assured language, suggested it was highly prized by these SLTs. It tended to distinguish them from other interviewees who made little mention of experience or learning from parents as part of their own professional development (n=4).

Two SLTs referred to learning from the experience of providing private practice. They referred to learning to agree roles with parents, as illustrated by SLT 3, '*I'm much more direct with parents and you know, saying you have a massive role cos this is not going to change'.*

BT 8: Models of practice

SLTs tended to describe the **principles** underpinning their models of practice slightly differently, even when they were working in the same service. There tended to be no standard descriptions of models of service that SLTs used. Moreover, many SLTs struggled to explain the kind of model that their service used and did not readily have the technical language to describe how the service worked. There were examples of terms that ranged from purely descriptive, such as *team assessment* or *triage*, through to more theoretical terms conveying a position or policy stance such as *child focused* or *universal, targeted and specialist*. SLTs in the study most frequently cited using *care pathways* devised by

consensus and evidence locally within their services, as the determining feature for decision-making.

The **practical descriptions** of models of practice included *'opt-in' systems* which were common across all the sites visited. Referrals were received by services and then parents were invited to opt in and arrange an assessment. Several services operated an *assessment-discharge model*, describing this as preparing parents from the outset that intervention was time limited. SLT 7 who described a model that provided a single episode of care, followed by discharge, illustrated this:

> *SLT 7: We do a discrete episode of care of one particular aspect of their communication. We give them, the school would have, we give advice and a programme for them to work on and we give them some advice about ongoing strategies they could use, we demonstrate those activities in school and then we discharge and then they can re-refer when they've achieved those targets if there's a new issue they've identified*

Although SLTs did not refer to models of practice in terms of who delivers intervention and roles, it was clear from a number of responses that services used distinctly different means of providing intervention. Examples included SLT assistants delivering programmes set by SLTs. Others used specialist SLTs assigned for specific conditions such as dysfluency or specific language impairment. SLT 8 commented that access to specialist support was beneficial, but that the experience for parents could be confusing, *'It's good there are specialist teams, but I think sometimes they are bouncing from one to another and it takes an awful long time before they are seen by the right person'*. Finally, several SLTs described training co-workers in schools, nurseries and children's centres, although there were no comments implications for parental involvement.

194

Each service had designed their own processes and accompanying record forms and information briefs. SLTs reported a range of resources used to collect information and prepare parents for their participation in their child's assessment and intervention. Referral forms were frequently mentioned as the principal tool for collecting information initially and the majority of SLTs found the information informative and accurate. Parent questionnaires were also cited as an important process for both gathering information and helping parents to outline their expectations and rate their level of their concern.

The SLTs in the study commented on the **regular changes** that took place in service design. These changes were reported to be initiated by SLTs aiming to improve the quality of provision or driven by management requirements. SLT 1 stated '*it's moving all the time, I don't think it fits particularly well into any model, only in that we're quite dynamic and we'll go wherever we need to go'*. However, others, from different services, reported that changes were more problematic. The SLTs from one service believed the redesign was driven by the demands of reducing waiting lists and waiting times from managers, whilst SLTs in another area cited the reduction in staff arising from reduced local authority contracts as the reason for modifying provision. SLT 7 conveyed a sense of fatalism in describing their service changes, '*it keeps changing. It's driven by waiting times and we've recently, about a year ago, changed our systems. We..it changes so often'.* SLT 3 reported that her service encouraged the SLT to be autonomous, but still observed that there was a constant struggle to deliver a service that fulfilled the organisation's expectations:

> *SLT3: It's a constant battle between quality and quantity. Despite that fact that we can work autonomously, there's always that pressure about bums on seats. You know, we could see twice as many people if they all came here, versus being much more*

patient centred, well, where's the best place to see them. We kind of lurch between the

two

SLT 9 also referred to this tension where on the one hand, SLTs were driven by waiting time targets, and yet on the other, believed in building relationships with families in order to work as effectively as possible.

Notwithstanding the extensive reporting of pressures, tensions and compromise, many SLTs conveyed a positive view of the **culture** of their services. Words and phrases such as 'dynamic' (SLT 1), 'working well together' (SLT 2), 'going above and beyond to meet the child's needs' (SLT 4) indicated confidence in their professional practice. A number of SLTs in the study expressed an assured sense of the value of the work they were doing. SLT 4 declared that her service worked well in comparison to othes. She then went on to describe her concern that their carefully designed provision would be undermined by service cuts:

> *SLT4: I have a fear of losing what I feel is a good way of working, I know it is. Working privately outside the borough, I know families experiences with services that work in a very different way. I think, gosh, we don't do it like that. We are quite good in some ways-I'm not saying we're fantastic-but it's a shame we're being cut and we're being shaved down'*

In summary, the data suggested that SLTs believed they were naturally skilled at building relationships. However, subtle distinctions were derived from the evidence that could be described as differences in outlook or approach to parents. Some SLTs expressed frustration with non-engagement, whilst others endeavoured to understand the parents' position and the barriers preventing participation.

4.4.4 Summary from qualitative analysis of SLT interviews

SLTs appeared to have a strong conception of roles and articulated their views with clarity and consistency. They reported a clear conception of their own roles as assessors, interveners and negotiators, and of parents' roles as attenders, helpers, adaptors and learner-teachers. They talked about helping parents change and recognized that this can be empowering for them. However, they talk less frequently of changing parents' understanding or conceptions, and more frequently referred to changing behaviour, often referring to motivation to participate and continue activities in the home context.

Eight key points are highlighted from the analysis of SLT interviews.

(i)   *Clear conceptions of roles*

The evidence from the interviews indicated that SLTs have firm conceptions of their roles as assessor, intervener and negotiator. These three broad roles could be divided into more specific conceptions of role, which tended to reflect the degree to which SLTs involved parents. For example the intervener role was expressed at one end of the spectrum as 'treats the child', with no parent contribution, whilst at the other, the role can be described as 'coaches parents how to support speech and language development', with full involvement of parents. The SLTs' conception of parents' roles also reflected the degree of involvement of parents from the relatively uninvolved role of 'attender' through to full participation in perceiving parents in the 'learner' role. Alongside these conceptions of roles, a number of characteristics of practice were identified, which appear to function as facilitators in the parent-SLT partnership. These can be summarised as the SLT approach, possibly related to how parents are perceived by SLTs, and the context of service delivery.

(ii)   Considerable differences in role conceptions

There was evidence of considerable variation in role conceptions for each SLT. This suggests that individuals may have had a *tendency* towards a specific conception rather than adopting one to the exclusion of all other roles. They also appeared to have a degree of flexibility in the role they adopted in particular contexts. It is unclear how these role conceptions vary in response to the roles that parents are adopting; some SLTs reported that they evaluated parents' circumstances to determine the kind of intervention they offer, indicating that parent factors may be associated with the roles they assume.

(iii)   Symmetry between SLT and parents roles

It appears that SLTs' conception of roles vary in response to their perception of parents' roles. There is likely to be some symmetry between the roles that SLTs perceive parents assume and their own roles, such that the possibility that SLT and parent roles are 'paired' conceptions is worthy of further consideration. For example does 'treats the child' in the intervener role match the parent who is perceived as an 'attender'. SLTs referred to adapting their expectations of parents' roles according to their perception of parents' engagement and circumstances. This raises an interesting question about whether SLTs are responding to parents' conception of roles or aiming to change parents' conception of their own and the SLTs' role, in order to enable parents to adopt more involved roles such as adaptors and learners. There are indications that SLTs are actively intending to change parents' conceptions, in helping them adopt helper and adaptor roles, and understand that the SLT 'intervener' role includes planning activities, advising and coaching, as well as treating the child. Nevertheless, some SLTs expressed more rigid views about parents having a 'viewpoint that it's not their job to help their child'. This did not correspond with the views expressed by parents in the study. There could be a number of explanations for

this, such as a lack of a representative sample, but it may be indicative of a mismatch in expectations of role conceptions between parents and SLTs.

(iv)   SLTs as teachers

SLTs in this study were unequivocal in aiming to enable parents to support their children's language development, in either implementing specific activities or adapting parenting, and therefore assumed a teaching role with parents. However, they are equivocal about referring to their teaching role. Very few SLTs explicitly referred to 'changing' parents' thinking, but their practice of advising and coaching seems to indicate an underlying intention to facilitate change in parental understanding as well as behaviour. They use words such as coaching and modelling, implicitly referring to a teaching role, but SLTs lack a frame of reference or means of formulating what they do in practice. Helping parents to learn about speech and language support is therefore integral to a number of the role conceptions that SLTs assume, but is rarely explicitly discussed beyond the context of formal parent training programmes. The debate about privileging tacit knowledge in special education and nursing (Nind and Thomas, 2005; Phelvin, 2013) emphasises the value of intuitive and unarticulated skills, but is not applicable to a context where SLTs are aiming to change parents to be implementers, interveners and adaptors, which clearly requires a teaching role. A wider debate about the teacher role as part of therapy intervention could contribute to a clearer understanding of intervention.

(v)   A broad notion of intervention

Evidence from SLT interviews, indicated that SLTs do not conceptualise their role in intervention as predominantly 'treating' the child. Intervention routinely included home activities and teaching parents as part of their planning, advising and modelling roles. Evidence form literature suggests that SLTs value 'direct' therapy over 'indirect'

intervention, suggesting that treating the child is the preferred role for SLTs (Pring et al., 2012). These data question this assumption, potentially challenging the dichotomy of direct-indirect intervention applied to practice with parents and pre-school children.

(vi)   *Decision-making speech and language therapy*

SLTs rarely referred to themselves as either leading or devolving decision-making about intervention for children attending speech and language therapy. Some SLTs indicated the importance of giving options to parents and respecting their choices, whilst others emphasised their role as recommending appropriate action. Many SLTs conveyed a delicate balance between leading decision-making in terms of recommending best approaches for the speech and language needs identified, whilst attempting to offer options for parents. SLTs recognised the benefits of parents taking control of the decision-making and choosing options. There was some evidence of 'supported decision-making' with an explicit aim of helping parents take ownership. However, it is difficult to discern from the SLTs' words how this is achieved. SLTs refer to respect, empathy and building relationships, but not directly to collaboration with parents and their use of expressions such as 'handing over' conveys a direction of influence from the SLT to the parents rather than a co-working relationship.

(vii)   *Learning to work in partnership*

SLTs recognised that they had to learn to work with parents, that this was an addition to their skills as they gained experience. They gave many examples of how they learnt to work in partnership, including learning directly from parents themselves.

(viii)   Service constraints

Service design and constraints tended to determine the options that the SLT could offer, which was perceived by a number of SLTs as associated with how flexible they could be. Currently, too little is known about the way services are commissioned, designed and monitored to understand the impact on parental involvement (Davies and Davies, 2012).

The interaction between SLTs and parents is described by SLTs as complex. Consequently, understanding the underlying mechanisms of role conception in relation to complex and variable contexts is challenging. Nevertheless, formulating the conceptions of roles that SLTs have developed may contribute to building a framework for understanding the relationships between conceptions and context. The value of these categorisations of role conceptions will be reviewed further in phase two of the study.

The following chapter presents the method and findings from the longitudinal study of phase one.

Chapter Five

5. A longitudinal study: changes in parents' conception of role during intervention

5.1 Introduction

The following section presents the findings from the analysis of interviews over time of nine parents, tracking perceptions of roles and reported behaviour during intervention. Research question two determined the design of this phase of the study: how do parents' and SLTs' conceptions change during speech and language therapy intervention and what is the relationship between SLT and parent conceptions?

This provided an opportunity to review the similarities and differences in the way these parents reported their conceptions, beliefs and behaviour in supporting their children with speech and language needs. During the period of the longitudinal study, parents could have remained involved in intervention of any nature reflecting the usual practice of the service including the possibility of being discharged from services. The majority of parents reported specific changes in their conceptions and behaviour, but the extent, quality and the impact of those changes varied. The analysis explored both the explicit descriptions that parents provided and the implicit views expressed in their own words. This depended on interpretation by the researcher and is consistent with an interpretivist approach, as discussed in Chapter Two.

5.2   Method

The longitudinal design of the research study generated data from parents involved in speech and language therapy at three points over a 30-week period after their initial assessment with the SLT.

5.2.1   Interview design

The semi-structured interviews in the longitudinal study were based on the guide prepared for interview one. Additional questions were included to investigate parents' experience of intervention, decision-making and changes in parents' perception of their role over the intervention period based on the early analysis of themes in interview one. The questions asked about parents' actual experience and what they would have changed about this in ideal circumstances. There were nine open ended questions for interview two and thirteen questions in the final interview (see Appendices)

5.2.2   Data collection

Parents agreed to participate in follow up interviews at the consent stage of interview one. They were contacted six to ten week after their first interview by telephone and arrangements made for the follow up interview. All the parents were offered a choice of face to face interview in a local clinic or their own home, or a telephone interview. The description for recording and transcribing can be found Section 4.2 of Chapter Four.

5.2.3   Participant characteristics

The follow up interviews involved a smaller subset of the original sample (Table 5-1). This used convenience sampling based on the participants who were contactable after interview one and two; nine parents were contactable for a second interview and five were contactable for interview three. Four were not contactable and two opted out of follow up interviews when they were contacted. The sample were therefore not necessarily typical

of parents attending SLT as those who opted out of further interviews may have displayed different characteristics to those who were happy to continue involvement.

Table 5-1: Summary of participation in second and third interviews

Interview stage	Parent participants
Second interview 6-10 weeks post initial assessment with SLT	P1, P3, P4, P5, P7, P10, P11, P12, P14
Third interview 25-30 weeks post initial assessment with SLT	P1, P3, P4, P5, P11

5.2.4   Analysis

The first level analysis (Section 4.3 in Chapter Four) used thematic network analysis (Attride-Stirling, 2001) for mapping the findings from the first interviews. The global themes provided the basis of a framework for the second level analysis, which charted the findings from parents over their two or three interviews using framework analysis (Ritchie and Spencer, 2002) to map the changes in conception of roles. The themes from the first level analysis were used across the horizontal axis of the framework with the two or three interviews for each case plotted down the vertical axis. The transcripts from interviews two and three were coded using basic, organising and global themes from interview one, with descriptive statements and illustrative quotes transferred to the framework to allow comparison of the interviews for each case. Section 5.3 describes three tentative trajectories of change identified from the evidence, together with associated characteristics. Section 5.4 presents a summary of the findings with a full discussion presented in Chapter Seven.

5.3 Results: three possible trajectories of change

Evidence from the participants suggested that parents become involved in speech and language therapy in order to promote change in their child's communication, although they had few ideas about how this would be achieved when they first sought advice from SLT. Many parents agreed to see the SLT without knowing what this would entail and, for some, without feeling particularly optimistic. Indeed several parents in the study expressed scepticism about the value of attending SLT, but described a situation where they believed they had no other option than to 'give it a go'.

> *P3: I wasn't hopeful, to be honest. I didn't have faith in anyone. But when I went in there they seemed completely different, the whole way they were with the children…they seemed interested in what was going on, let's see what we can do with these kids…and I thought let's give it a go, let's see (Interview 2)*

The data suggested that some parents had a vaguely formulated conception of their own and SLT roles initially and approached SLT with uncertainty. However, even within the nine parents involved in the longitudinal study, there was evidence of change in their understanding of their roles over time (Table 5-2). It may be that each individual parent presents a unique pattern of change, but amongst the nine parents in this study, there was a clustering of individuals suggesting at least three possible trajectories of change. The parents represented a subset of the original sample and therefore, other trajectories may have been present that were not evident in this subset. The analysis has therefore focused on the predominant presentation of parents' conceptions during the three interviews over 30 weeks of involvement in speech and language therapy. These may change further over time and be in a state of flux that cannot be fully captured by the data collected in the study.

The three tentative trajectories described below are summarised in Table 5-2 and are described in detail in Sections 5.3.1-5.3.3:

i. There was a trajectory of change typified by little evidence of change in reported behaviour, in spite of expressing a change in knowledge of their child's speech and language needs.

ii. The second trajectory is characterised by parents as helpers, adjusting what they do, but not displaying a significant shift in their understanding of their child's speech and language.

iii. The third trajectory involved a fundamental modification in understanding and reported behaviour, where parents described changes in understanding their role and approach supporting their child's speech and language.

Table 5-2: Trajectories of change seen in longitudinal interviews of nine parents

	Possible trajectories of change in conception of roles using global themes	Role description derived from level one analysis	Longitudinal sample
i.	Informed and inactive Attending Expecting professional to intervene	Advocacy: responding to other's concern Intervener: attending Taking responsibility: SLT expected to lead decision-making	P12, P10
ii.	Active doer: helping Changes in behaviour / doing Understanding role as doer-changes in behaviour	Advocacy: raising concern Intervener: implementer/doer Taking responsibility: Implementing recommendations	P11, P5
iii.	Adapted intervener Internalised changes in approach to supporting language learning Understanding child's difficulties and learning to support speech and language development Understanding role as intervener	Advocacy: pursuing support/judging advice Intervener: adapting parenting Taking responsibility: influencing intervention	P1, P3, P4, P7, P14

5.3.1 Trajectory 1: Informed and inactive

Evidence from the parents in this study suggested that information can be exchanged as part of the intervention process whilst conceptions of roles remain unchanged. Two parents, P12 and P10, illustrate this. Each case is presented separately as there are notable differences between the two. The characteristics of this trajectory of change were:

a. Perceiving own role uncertainly

b. Intending to support, but difficulty prioritising supporting language learning

c. Expecting the SLT to intervene

P12, who received one assessment and advice session with the SLT, illustrates this trajectory. She was not offered intervention and had no further involvement in SLT during the study, but had access to telephone advice if needed. Her words indicated that she valued the information and advice she received (interview one) but reported few changes in her behaviour (interview two) and remained predominantly 'inactive' expressing difficulty finding time or confidence in helping her daughter.

Indeed, there was an indication that the trajectory of change in this case was characterised by an increasing perception of needing to rely on professionals over time. Her expectations changed from a desire to make time to do activities with her child to an explicit statement of wanting someone else to teach her child, monitor progress and motivate her, as parent, to keep focused on her child.

a) Perceiving own role unclearly

P12 described her role in interview one as one of spending time with her child and providing an example, without describing what this involved. However, she focused on

her role as providing opportunities, such as attending formal classes, rather than elaborating the way she provided support herself. In the following quote she expressed uncertainty about taking responsibility for teaching her child herself:

I: What is your role in supporting P?

*P12: I'm going to have to spend a bit more time with her, but I think she's learnt alot through listening to us. We do actually go to French classes too to help them learn another language. Sometimes I feel like I expect other people to do it, taking her to French classes, I sit back and **let her do it with the teacher rather than me** do it, so I think maybe **that's me being lazy**   (Interview 1)*

These words suggested that this parent was reflecting on her role and expressed a critical judgment on herself as being lazy in expecting other's to take responsibility. There are further undertones of guilt and anxiety that she expressed as she described the difficulty she had balancing the demands on her time, ' *It's difficult to split your time between "I really do need to do the dishes" and sit down and do a jigsaw with them' (Interview1)*

In interview 2, P12 expressed a clearer perception of her role as a model for her child, saying her role was to *'lead by example'*. Nevertheless, this was associated in her dialogue with her belief that she modelled poorly, talking too fast, expressing doubt about her capability as a model. Her uncertainty about her capability is evident in her desire for the SLT to set targets and provide clear direction for her:

*P12: **I want someone else to teach me the techniques** and her at the same time so I can carry on with what they've done and do the bit at home and then **they set the next set of levels**, so I don't have to say, right, she's hit this target, let's move on. **I want someone else to assess her'** (interview 2)*

b) Intending to support

The willingness to support her child was reiterated with comments about being pro-active and resolving to spend more time with her child in interview one. Her tone changed in interview two, giving the impression that she found making time burdensome. However, she expressed frustration with herself for failing to achieve what she had hoped to do, saying at one point *'I faff so much, do other things'*. She was asked about what made it so difficult:

> *P12: Yes, it's easier saying than doing*

> *I: Why do you think that is?*
>
> *P12: I think cos **you're in a routine** already and as bad as it might be, the dishes piling up or the washing, that's what you're used to and the stress levels start and you say **here we are again'** (Interview 2)*

Later in interview two she returned to saying that she wanted to teach her child but explained that she struggled to find the time. This implied that she was a willing learner but grappled with prioritising supporting her child and assuming an active teaching role at home, *'I still want to teach her, she's got reading books and things, but it's finding the time to do it' (Interview 2).*

c) Expecting the SLT to intervene

P12 presented a contradictory picture of her self-perception and attitude to taking responsibility to support her daughter. Whilst she expressed motivation to take an active role in supporting her child, she also recognised her tendency to rely on others, such as the French teacher in the quote above. In the first interview, she expressed satisfaction with the SLT guidance and accepted responsibility for supporting her child's speech and

210

language, commenting that it would be relatively easy to set aside time every day, as she was a 'stay at home mum'. By the second interview she expressed frustration with taking responsibility:

> P12: It's difficult cos I've got two, to spend time with her. It's easy for someone to come round and say you need to set time aside for her. But I need to set time aside to clean my house too and other things (Interview 2).

The question of reliance becomes most apparent when she is asked what she believed would help her daughter. In the first interview, she talked about the SLT checking up on progress periodically, described as a *'back up, just to make sure',* but by the second interview she commented that she would have liked more support, with the implication that the role of the professional should be frequent and involved with her child directly:

> P12: Having a teacher and getting to know that person, who she can trust and follow the techniques and not feeling it's just her. This is your special time, mummy and P time, and then I could do it at home (Interview 2)

It is difficult to discern from the evidence the reasons for such a marked difference between this parent and others in the study. What was responsible for the trajectory of change that P12 displayed? P12's words did not provide an obvious or clear explanation but illustrated the complex interplay between perception of own and the SLT role, and her specific context. Whilst the evidence did not enable analysis of differences relating to level of SLT support or children's level of difficulties, it is interesting to note that this parent had no follow up intervention from the SLT.

P10 was included in this trajectory of change. She also showed no change in her conception of role between interview one and two. She received assessment and advice,

but no further intervention by her own choice due to significant social difficulties. She was receiving considerable support from other services and referred to changes in her personal circumstances. Her trajectory of change is difficult to discern from the evidence of two interviews and it is likely that her case is too complex to see obvious patterns of change. She described her perception of her role as providing a settled and safe environment for her child and made little reference to speech and language development. She described what she did with her child as 'about the same' in interview two, but believed she had sufficient understanding of language development because of her previous experience with her older child. P10 did not indicate uncertainty about her conception of role, but made little reference to it, explicitly because 'she had a lot on her plate'. She expressed her intention to participate in learning to help her child's communication, but later it emerged she had not opted in for further intervention.

5.3.2   Trajectory 2: Active doer-helper-changing behaviour

Evidence from the subset of parents completing the longitudinal interviews showed that parents vary in the way home activities provided by SLTs are perceived and their impact on parental understanding and practice. Two parents were prepared to change what they did at home despite expressing little change in their understanding of their child's speech and language needs. These parents were willing to implement activities under the direction of the SLT, and adjust their behaviour as suggested, assuming a helper role. The features of this trajectory of change were:

a.   Perceiving role as 'doing' activities with their child with little reference to changes in approach, such as interaction with their child

b.   Expecting the SLT to lead

The words of these parents showed some contradictions in their ideas over the course of the interviews suggesting that their role conceptions were less clearly formulated, or possibly in a state of flux.

a) Perceiving self as doing activities/doer/helper

P11 anticipated that he would be doing activities to help his child in interview one, and indicated that he had introduced small changes following SLT advice in interviews two and three. He received assessment and advice followed by a three week parent group and individual intervention sessions with his child during the study. In interview one, his focus was on ensuring his child was happy and cared for, indicating that he perceived his role as predominantly one of caring. However, in response to a direct question about his role in supporting language development, he described a role implementing homework suggested by the therapist, indicating that he was motivated and determined to do home activities:

> *P11: They have given a little bit of homework, things we can do to help and anything they suggest we do, we're going to make sure we do the best we can (Interview 1)*

By interview two, he mentioned specific changes he believed he had made in his behaviour, but described these as 'little things' and did not associate them with any progress in his child's development. He perceived the advice he received largely as 'common sense' and did not indicate that his learning had changed his role or deepened his understanding of his child's speech and language difficulties or changed his conception of his role in supporting his child. However, when he is asked directly if his role had changed he implied that changes in his approach had occurred, albeit with some uncertainty:

> *P11: I don't think it's changed, but I think **the way I do things might have changed**, I try to let him be a bit more independent (Interview 2)*

In interview three, the father talked about a role where he looked to the SLT to help him teach his child, also suggesting a tentative move towards a role beyond 'doing' activities but the reference to a teacher role is brief and undeveloped.

> P11: It's hard to say, **we just try to teach**, to educate, it's a multi-role, try to do as much as possible without being overbearing (Interview 3)

Involvement in intervention appeared to have prompted him to consider his role as teacher, but he returns to the caring element of his role at the end of the interview three, suggesting that any changes in his conception of roles were either relatively changeable or in transition.

P5 received one assessment and advice session from the SLT, with written advice, and no further intervention. She expressed a view that it was not necessary for her to change anything in terms of supporting her child in interview two. She was seeking advice from the SLT as reassurance, but she perceived that she was doing the right things already. In interview one there was a vague notion of needing help for both herself and her child, but she did not believe the SLT could help her improve what she did, but by interview two was indicating that she thought her role had changed:

> P5: It's going to help me help him.....telling me what to do
>
> I: How is that going to be different to what you're doing now?
>
> P5: it's not, cos what she's told me to do, I'm doing already
>
> I: so you're not looking for anything extra?
>
> P5: um... no not really (Interview 1)

She was asked directly at the second interview if her role had changed, responding that she perceived that she had changed, although she was unable to elaborate further:

P5: *Yes, I just expected him to listen; I explain more, repeat more (Interview 2)*

As with P11, this indicated a more extensive change in her parenting approach than her earlier comments conveyed. However, the overall emphasis in her comments was on the 'doing' role. The helping role in these cases appears to be associated with less clearly formulated ideas about how to support speech and language development as illustrated by P5 and P11. The parents who reported focusing on doing what the SLT suggested responded less clearly to questions about their intensions or their roles. The initial inconsistencies in their responses suggested that their conception of role was either less well developed or emerging.

b) Expecting the SLT to lead

Evidence from the longitudinal interviews indicated that the helping role was associated with parents showing a strong reliance on the SLT, expecting them to lead the intervention. This was expressed through both explicit comments and implicit assumptions, such as P11 assuming that his child needed to see the SLT weekly. In interview one, he referred to the SLT knowing best and having the training and education to make the right decisions on behalf of the child and family. In interview two, he commented that the advice and guidance he received from the SLT was 'common sense', implying that it did not change his understanding. However, he later commented that the parent group was 'enlightening', suggesting a very different perception of the advice he received. The tendency to inconsistency is illustrated in the quote:

*P11: I would have liked a bit more, I'm not too sure, but what would have been **nice would have been a proper one to one session** with M. But they did say that it's not really going to be helpful coming in one a week. **It's better off where we're taught ourselves** and we're doing it ourselves constantly at home, which **I totally agree with**. It's a much better way (Interview 2)*

This tendency was also reflected in the decision he later made regarding attending further SLT appointments. In spite of the focus on the professional as the expert and expecting the SLT to lead intervention, he opts to send his child to nursery rather than continue with individual intervention. Whilst such a decision is inconsistent with expecting the SLT to lead intervention, it is entirely consistent with an expectation that professionals should lead support, *'even though the one on ones were helping, the constant environment of being in the nursery will help him a bit more (Interview 3).* It is difficult to infer how he viewed respective roles, but his words expressed uncertainty about his role, whilst conveying enthusiasm for others to lead intervention:

I: the one on one lessons, what did you feel you were gaining from them (referring to SLT)

P11: I'm not too sure really, they seemed to be more the person trying to figure out where he is in his development. There were things she was teaching him. She had to figure out where he was to make the plans to help him. Cos we'd waited a long time for the nursery and it was quite expensive, we jumped on the idea (Interview 3)

P11 swings from suggesting his understanding is growing to still viewing his child's difficulties as undiagnosed and difficult to understand. In interview three he referred to his child's communication as 'gibberish' and trying to understand him as 'guesswork' with little reference to any progress the child had made. He appeared to link his own limited

understanding to looking to professionals to find the solutions through diagnosis and one to one intervention, but then opted to focus on accessing help form the nursery. Having attended parents' groups and one to one therapy, he remained uncertain about his role and the purpose of intervention, but had gained some knowledge of things to do with his son that could have helped communication. Evidence of adapting his approach is less clear.

P5 also expressed an expectation that the SLT would tell her what to do, expressed in the first and second interview. In interview one, she commented:

> *Interviewer: Now you've seen the SLT what will happen?*
>
> *P5: Just **things to do** at home; she's given me a leaflet. She said **I'm doing** what I should be doing anyway and she's going to see his nursery to give them **things to do** with him as well (Interview 1)*

The conception that the professional taking the lead, whilst the parent is the 'doer' is seen in interview two, indicated P5's strong sense of her conception of role as 'doer' with professionals leading intervention, *'take him to appointments, **do things** that they tell me to do'*.

5.3.3   Trajectory 3: Adapted intervener- understanding and supporting

Data from five parents illustrated notable changes in understanding of speech and language support as part of an intervener role. Two of the parents in the current study were explicitly and strongly motivated to be involved in intervention from the outset (P3 and P4), but their conceptions of the role was unclear. Others talked about this in later interviews, suggesting that they grew into the role of leading intervention as part of the process of attending SLT (P1, P7, P14). All of the parents received assessment and advice, plus a variety of SLT intervention: two reviews and advice (P4), a set of three parent group

217

sessions (P7), a set of three coaching sessions to promote parent-child interaction (P1), SLT planned programme reviewed bi-monthly (P3) and one to one intervention for a six week block (P14). The analysis of these parents' longitudinal interviews indicated a trajectory of change that was characterised by *learning* to adapt. Three specific features associated with the adaptor role (see Chapter 4) emerged from the analysis of these parents' responses:

a. Perceiving self as learner

b. Gaining knowledge, understanding and confidence

c. Influencing intervention

a) Perceiving self as learner

A number of parents from the full study described themselves as keen to learn at the outset of therapy, but did not describe an expectation that their role would be central to their child's improvement. This was illustrated by the comments they made about their own knowledge and skills, often contrasting their own capability with the professional who was perceived as experienced and trained to know how to support children with speech and language needs. Parents expressed intentions to learn, but the SLTs were expected to lead decision-making, recommend intervention and provide one to one intervention. This suggested a contradictory or loosely formed perception of roles and responsibilities, possibly reflecting parents' uncertainty about the nature of speech and language therapy. The first interviews for the five parents in this subset showed they were unclear about what they expected from therapy, but were keen to be guided and involved. P3 illustrated this particularly well, when she commented in the first interview:

> *P3: I just came with the intention of finding out, if they need any help and if so what*
>
> *we gonna do   (Interview 1)*

By interview three, she showed a change in understanding her role, as well as understanding how to help her children. She talked passionately about working with her children and related this to the joint approach she had experienced with the SLT. The critical feature of speech and language therapy for his parent was the level of explanation. In the following quote, she recommended it as a model for all parents:

> *P3: They (SLT)* **explain everything** *and that's* **very very important** *to whoever the carer is, cos they need to be involved. It works so well. I don't know whether they do it with other parents, but if not then maybe it's something they could do with other parents. If they carry on with other people the way they were with me then it's brilliant (Interview 3)*

On the basis of what this parent said, it is reasonable to assume that by interview three, she perceived herself as a learner and adaptor, initially coming to find out, responding positively to the explanations she received, implementing activities at home but also adapting her approach, *'I feel like it's me that's doing it .....this way I can see the differences'*. She described herself as 'doing different' but also approaching how she taught her children as *more positive*. She described an experience that goes beyond learning to do new activities and suggests a deeper understanding of how to help her children. In the following quote, she alluded to a process of change, using the words 'before' and 'so now', which is then directly related to an important change in her parenting, described as 'more positive'. Moreover, she illustrated a sense of being in control of the intervention that helped her children:

*P3: I've got a bit more work to do. I **found myself doing different**…before I would have said , 'you do this', now I'm doing it in a bit **more positive**, how the therapist asked me to do it, so now I feel a bit more- I can't think of the word-more in control of things, I'm helping more, controlling it more (Interview 3)*

b) Gaining knowledge, understanding and confidence

Many of the parents interviewed in the study in the initial stages of involvement in interview one, commented on *not* knowing how to help their children and wanting to know what to *do* to help their child. However, parents varied in expressing a need to *understand* the difficulties that their children were experiencing. Parents did not obviously distinguish between learning what to do and gaining knowledge, though the analysis indicated that both were distinct elements of parents' readiness to be involved in intervention. Parents' description of gaining knowledge suggested an increasing understanding of their child's needs and how to help, indicating changes in their conceptions and a deeper engagement with learning how to help. P3, in the previous quote emphasized that explanation from the SLT was 'very, very important'.

This was expressed powerfully by the words of P1 at the end of the study, commenting that she believed the development of her own understanding was the critical factor in helping her child progress:

Interviewer: What has helped his progress?

*P1:I think going to speech therapy and me not being so 'you will talk'….I think **probably me understanding**, I definitely think that it's **more to do with me than him** (Interview 3)*

She described learning to interact differently as a change in her thinking. Initially she did not recognise how her interaction with her child was potentially limiting his language development, but then described how her understanding changed. She attended a 'demonstration session', observing the practitioner working with her child. Initially, she described herself as uncomfortable and unsure of her role during intervention commenting that she could not see a difference between her approach and the demonstration. Later she realised that the practitioner interacted differently to herself:

> *P1: I was watching what they were doing, you think you're doing these things, talking to him and I was talking to him but they're not like constantly repeating things for ten minutes......**it's me watching her, how she played and didn't expect him to say it** (Interview 2)*

A contrasting example is provided by P14. In interview one she did not anticipate a need to gain knowledge or change what she did with her child, stating that she was not concerned about her child's speech. Her attendance at speech and language therapy was in response to a concern raised by the teacher, but was not presented as a priority for her:

> *P14: I'll go for it. It's not a problem (the speech difficulty), but if it could be resolved that would be great (Interview 1)*

Her comments in later interviews suggested that her understanding changed, albeit gradually. By interview two she talked about learning to notice the kind of speech sounds difficulties her child had:

> *P14: It sounds awful, but I didn't pick up on the fact that he couldn't say these letters...it's now listening out for these things (Interview 2)*

This illustrates an incremental nature of gaining knowledge, conceptualised as 'knowledge in pieces' in conceptual change theory (Vosniadou, 2008). In contrast to P1, this parent did not refer to a significant moment of insight. Even so, she acknowledged that both she and her child were learning together, specifically in relation to speech, but she also referred to wider learning, suggesting that her new knowledge had influenced her understanding and approach to enabling her child to learn:

> *P14: I hope me bringing him back will show him that you don't just give up and it doesn't really matter. **It's been a learning curve for both of us**.*
>
> *I: Do you think you might apply this to other things?*
>
> *P14: Yes lots of things, even daft things like putting on his own shoes and socks. I might try and push him a little more, give him a little more time to do things, rather than say 'I can't do it'. First child, I say 'oh come here and I'll do it'. **I'll change** (Interview 2)*

This mother's description of gaining knowledge was associated with changing her behaviour in other areas of parenting.

Both P1 and P14 referred to observing the SLT working with their children, demonstrating activities, which were reported to contribute to the incremental growth of skills and confidence by P14, *'I watched what she did with him and I'll try to mirror that at home' (Interview 1).* P1's words also illustrate this clearly:

> *P1: The first session, I thought this is pointless. She just played with him and I've sat and watched. Then the next time I sat and watched and I was picking up and I thought I do these things with him and then I watched again and I thought I don't do it as intensively as she is. Really it's **more of me learning rather than him learning**.*

222

> *It's weird, **he came for help and it's been me that's been helped not him,** and I'm*
>
> *helping him (Interview 2)*

Parents referred to quite different aspects of intervention that prompted change. There were examples of parents learning and gaining knowledge through watching (P1), listening to advice (P4), explaining to others (P1), doing intervention activities with their children (P3) and learning from other parents (P7). There are no obvious patterns that indicate one approach is preferable over another and three parents expressed uncertainty about the value of the intervention they were being offered at the beginning of SLT intervention. P7 described attending a parent workshop, saying, *'I wasn't too sure at the beginning'* but then says 'it's *going really well. I'm learning techniques and having a few shocks and stuff, what's helping him and what's not really helping him' (Interview 2*). She described how she learnt from other parents talking about their experiences as well as from the SLT teaching. She expressed a fundamental change in her relationship with her child, describing how she interacted differently, linked directly by P7 to a more responsive child who helped reinforce the changes:

> *P7: it's made a **big difference to me as a parent** and **how I approach him** and how*
>
> *much **I've learnt about parent roles and techniques,** it's just **completely changed***
>
> ***the way I interact** with him (Interview 2)*

Changing conceptions of roles, gaining understanding and changing behaviour, was linked by these parents to seeing their children's progress. The importance of being able to see progress in reinforcing parents' changed conceptions of roles is illustrated by P4. In interview one, she was eager to learn, '*I just wanted to know if there was any way I could bring him on'.* In interview two, her words imply that her changed knowledge had not prompted a change in her child:

*P4 They give you lots of leaflets and they told me different things. I was saying probably too many things to him, trying to teach him manners before he could even talk. As much as that was helpful then, it's now..it's kind of , now, **he's not really talking at all, I don't know what to do, I'm still doing those things but it's not working** Interview 2)*

Nevertheless, by interview three her child had made progress, and she commented on how much she had learnt, *'She gave us so much advice and she was telling us that everything we were doing was right...Loads of advice, it was a good experience and **we learnt a lot'***

Recognising progress can be difficult for parents as illustrated by P1, *'the thing is, I don't always see how he's progressed. For me, it's slowly and you don't always see change, but the therapist may see how he's progressed'* (Interview 2). This raises a question about the importance of helping parents learn how to recognise progress, through developing skills in assessment themselves. This will be considered further in the discussion (Chapter Seven).

c) Influencing intervention

The evidence from parents in this subset did not indicate that they explicitly saw their role as one of leading intervention, but they expressed considerable confidence in working with their children following the teaching, coaching and advice of the SLT. Each of the illustrations below exemplifies how parents gained knowledge that changed their understanding *and* confidence to influence the application of advice.

P1: I was more like a master, not whipping him literally, but I was constantly battling with him, shouting at him, trying to confine him, but now I'm more like a parent..I'm more of his loving parent (Interview 2)

P1 referred to a changed approach to parenting, from a parenting style that resembled an authoritarian style to a more positive style that encouraged her child and gave space to her child to gain independence. The trajectory of change continued enabling this parent to influence intervention at home:

> *P1: Before I was more pressurizing, demanding and expecting and I suppose I became more encouraging (Interview 3)*

Another parent also commented on how she perceived a transformation from being overprotective to promoting independence. She described how she no longer had to speak for her children or protect them from the frustration and embarrassment of people not understanding them:

> *P3: Now I don't have to interfere, rarely have to say 'tell mummy'. I'm not as overprotective with them anymore and I don't get as upset (Interview 2)*

Other parents in this subset associated these changes with calmer parenting and improved well-being for themselves and their children. As P4 commented in her third interview, after her child had progressed,

> *P4: It's like a big weight has been lifted off my shoulders…and his temperament has completely changed. He's just so relaxed now. He has tantrums but something has to happen, whereas before he was so short tempered (interview 3)*

Finally, one parent talked about the barriers to gaining knowledge that she experienced when her children had nursery based SLT. This was an experience that excluded her from being able to help or influence intervention, and therefore gaining knowledge:

P3: I always had to hear everything from nursery…I could have been there when the assessment was being done and more work being given out…I didn't get anything to do at home (Interview 1)

The same parent linked her lack of knowledge about what to do with experiencing personal stress in interview one, saying, '*That frustrates and upset me cos I can't do anything about it cos I don't know what I'm supposed to be doing*'

In conclusion, five parents from the longitudinal study described how their role changed, as they gained knowledge, understanding and confidence in supporting their children. They described themselves as adjusting their behaviour and influencing the intervention, not simply 'doing' activities suggested by SLTs. This included approaching parenting differently indicating that a process of conceptual change relating to conception of their roles took place during their involvement. They focused on different aspects of the intervention that prompted change, with some reporting gradual changes and others reporting a point of realisation that changed their approach to supporting their child.

5.4 Summary

The evidence from the longitudinal study of a small subset of parents showed how role conception developed over time. The way parents described the extent of the changes implied significant learning that was associated by the parents with developing a more positive approach to parenting. The analysis did not include investigation of contextual factors associated with conception of roles. There were five important findings:

i.   *Three trajectories of change*

Parents participating in the longitudinal interviews described changes in their perceptions and behaviour that could be described as 'informed and inactive', 'active doer', and

'adapting intervener'. The data provided tentative indications of differences between parents in changes in conception. It is helpful to visualize such changes that occur during speech and language therapy intervention as trajectories of change. The categories should not be regarded as a illustrating a 'type' of parent that belongs to a specific group but providing an illustration of changes in conception of roles may take place. Evidence from conceptual change theory suggests that peoples' understanding my grow progressively and change progressively or show signs of a sudden change in conceptualisation (Vosniadou, 2013). This is reflected in the analysis of the data in the longitudinal study.

ii.   *Changes in understanding role as intervener*

A number of parents expressed significant changes in their conception of role in Trajectory 3 (Section 5.3.3). In most cases, parents did not have a clear conception about their intervener role when they first sought SLT advice, though they expressed enthusiasm to learn. Nevertheless, they described marked changes in their conceptions, as either a realisation or a growing awareness of the need to approach supporting their child differently. The evidence did not indicate whether these changes were explicitly intended by SLTs as part of the intervention process or whether it is serendipitous, a lucky side effect that contributed to the benefit of involvement. Parents in trajectory 3, 'adapted intervener', were as likely to describe changes in their understanding and approach to supporting their children as talk about activities they had been doing. They conveyed a sense of thinking differently, rather than the simply doing homework. In P7's words, she learnt techniques to do, but '*completely changed*' her interaction with her child. Several parents specifically associated the changes with working with the SLT, referring to changing their approach to their child in adopting more positive parenting. One parent commented that this was in response to '**how** *the therapist asked me to do it'.*

iii.   *Unexpected changes in role conception*

P12, in trajectory 1, was informed, but struggled to adopt a role conception of intervener or adapt her behaviour to support her child independently. This raises the question of whether providing information without additional support can promote change in conceptions or behaviour.

P12 was the only parent who had not received any further intervention from the SLT or other professionals between the two interviews. This trajectory could be described as proceeding in a different direction to the other two trajectories identified in the analysis, with changes in role conception that might suggest more dependence and less confidence in supporting speech and language. She was also the only parent who did not describe any change in behaviour, though appeared to have changed in the information she had relating to her child's speech and language. This parent showed a tension between her intentions and confidence in her ability to support her child, suggesting that parental competence and confidence with supporting speech and language needs warrants further study.

iv.   *Learning to reflect*

Parents in trajectory 3 also implicitly referred to reflecting on their own communication behaviour with their child, a feature not referred to in the first interviews. Parents reported that different features of intervention prompted reflection. P7 found she learnt from other parents as part of the parent group, P1 and P14 referred to observing SLTs working with their children, P3 described learning as she did activities with her children. SLTs in their first interviews referred to demonstrating activities, but rarely referred to promoting reflection, which was clearly reported by some parents in the study and may be an important feature of the way intervention is delivered.

v.   *Parents observing their children's progress*

Parents explained that seeing their children respond and progress was important in prompting changes in their conception of roles and subsequent approach. The importance of enabling parents to judge progress as assessors is followed up in phase two of the study reported in Chapter Six.

The findings from this part of the study are indicative, rather than conclusive. They raise important questions about changes in parental conception of role, related to involvement in intervention. The extent and the nature of changes in conception are likely to be important features of the parent-SLT partnership, and potentially important for supporting children's speech and language development. Further exploration of differences in changes in parents' role conceptions and the value of visualising these as trajectories of change should be the basis of further exploration.

The following chapter reports the findings of a phase two study that investigated conceptions of roles using parent and SLT questionnaires. The study used a cross sectional design and focused on confirming or challenging the conceptions of roles identified in phase one. The cross sectional design was not appropriate for a more detailed investigation of changes in role conception.

Chapter Six

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6. A quantitative study of parents' and SLTs' role conception

6.1 Introduction

The first section of this chapter describes the method and explains how the design and analysis of parent and SLT questionnaires was informed by the results from the qualitative study in phase one. Sections 6.3 and 6.4 present the results of the cross sectional study using descriptive statistics and analysis of correlations between items on questionnaires. Section 6.5 presents a summary of the findings.

Phase one explored potential categorical distinctions between conceptions of roles using parents' and SLTs' self-reporting. The second phase used questionnaires to collect self-report data from parents and SLTs about their *understanding* (conceptions) of what they do in supporting children but not information about what they actually do. The quantitative phase provided (i) the opportunity to verify the categorical distinctions suggested by the qualitative data and (ii) investigate associations between conceptions of roles.

The second phase was exploratory at this point in the research and used an experimental measure of parent and SLT perceptions based on the findings from the qualitative phase. The purpose was to confirm or extend the early findings, using a larger sample of parents and SLTs. This was a form of triangulation, frequently used in social science research, where using two methods provides cross verification by obtaining results from different sources and perspectives (Morse, 1994). Given the time scale for undertaking the research project, it was necessary to design the questionnaires concurrently with the analysis of the

qualitative phase. Consequently, the questionnaires were based on early findings from the qualitative analysis, imposing some limitations on the range of roles that were investigated in the second phase.

The sample size for the survey was limited by the practicalities of securing participation of SLTs and parents. Although the number of parents who participated in the survey was large compared to some previous studies in this field (Roulstone et al., 2012), it is still relatively small, and this means that the results should be treated as exploratory.

The qualitative data, presented in Chapters Four suggested a number of 'role conceptions' held by parents and SLTs. The study aimed to investigate parents' and SLTs' understanding, not their behaviour. The findings also suggested characteristics of context that may have been associated with these roles. These included the nature of the parent-SLT relationship, parents' and SLTs' experience, the type of intervention offered and service characteristics. These findings were followed up in the second phase using evidence from the questionnaires in order to map out important differences between conception of role and associated characteristics.

There were three propositions concerning parents' conception of role arising from the qualitative evidence that were explored further in the parents' questionnaire:

Proposition 1: Parents differ in how they pursue support for their child with speech and language needs in their role of advocacy.

Proposition 2: Parents see their role in intervention as attender, implementer or adaptor.

Proposition 3: Parents with a 'high involvement' conception of advocacy also have a high involvement conception of their role in intervention.

There were four propositions arising from the analysis of SLT data:

> Proposition 1: SLTs vary in the extent to which they consider that the assessor role includes parents.

> Proposition 2: The intervener role included treating the child, planning activities for parents and advising on language support according to their judgments of the roles parents are likely to adopt.

> Proposition 3: SLTs who involve parents in intervention using an advisory/coaching role are likely to offer flexible options and provide clear explanations of roles and responsibilities in their negotiator role.

> Proposition 4: SLTs with high involvement of parents in assessment and negotiation will also have a high level of involvement of parents in intervention.

6.2 Method

Phase two was a cross sectional study providing the opportunity to investigate a population at one point in time. Cross sectional studies can be descriptive or analytical in seeking to show associations between variables. In this context, questionnaires were used to collect information from two groups of individuals: parents who could be at any stage during intervention and SLTs who provided intervention for pre-school children with primary speech and language needs. This section describes the site selection, participants and recruitment, questionnaire design, process of data collection and design of the analysis.

6.2.1 Site selection

The study collected data from parents attending speech and language therapy in six NHS sites in Northwest England. The sites were selected based on contrasting demographics, relating to SES, based on the Index of Multiple Deprivation (Department for Communities and Local

232

Government, 2011) and NHS Northwest Review (2010). Each site approved the study through their respective R&D governance procedures (see Chapter 2).

Table 6-1: Summary of phase two study methods

Target population	Method of data collection	Where the data was collected	Numbers
SLTs working with pre-school children	Online questionnaire	Online link circulated through email to professional networks and study sites	62
Parents with pre-school children with primary speech and language need	Structured interview or self-administered paper based questionnaire	6 NHS services 1 nursery	51

6.2.2 Participants

The criteria for participation of parents and SLTs in phase two matched those established for phase one. Recruitment for phase two, therefore, sought participants who met the following criteria:

a.   Parents of pre-school children with primary speech and language needs, age 2-5.11 years involved in SLT support

b.   SLTs working with a proportion of their caseload which were both pre-school and had primary speech and language needs

A process of purposive sampling was used to ensure recruitment of participants who met the criteria (see Section 4.2.4).

6.2.3 Recruitment

In order to recruit parents, an email was sent to speech and language therapy managers asking them to suggest SLTs who could be approached to access parents of pre-school children receiving intervention. SLTs from the targeted sites were invited to participate in

the study by the researcher. Managers or SLTs contacted the researcher and suggested appropriate settings for recruiting parents. In part, this depended on the kind of intervention the SLT provided. For example, 'parent and children' groups were informal settings where parents worked with the SLT for part of the session and participated in a questionnaire during the session, or those attending one-to-one sessions with the SLT completed the questionnaire after seeing the SLT. Different settings were used for data collection: SLT-parent workshops, parent and child intervention sessions, individual intervention and nursery sessions.

Recruitment for the SLT questionnaire used an online link to the questionnaire circulated through the six research sites by the SLT managers. SLTs were invited to respond by completing the questionnaire using a link to the Qualtrics survey tool[16]. The link was also circulated via professional networks and personal contacts.

6.2.4 Design of questionnaires and design of analysis of questionnaires

The broad method for designing the questionnaires is presented below with the details of parent and SLT questionnaires described in Section 6.2.5.1 and 6.2.5.2. The questionnaires could not be used as validated scales due to the time constraints for developing the questionnaires. Nevertheless, they could contribute to the exploratory stage of the research.

The design of the questions for phase was based on the following features:

i) Question development

Questions were developed using the themes relating to role conception that were derived from the qualitative study. The words of interviewees were used to enhance the relevance of the questions and reduce the likelihood of misinterpretation by respondents. For

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[16] www.qualtrics.com

example, parents in the interviews referred to wanting 'tips and ideas' to help their child and these words were directly used in one of the questions for phase two ('what was your reason for coming to see the SLT: to get some tips and ideas about how to help his/her talking'). The development of the questionnaires was an iterative process, with advice from the supervisory team, parent volunteers and professional colleagues to improve the content, wording and process of data collection. Five parents and four SLTs completed pilot questionnaires. This revealed some ambiguities in wording and omissions in the text. For example, one parent commented that the questions did not include sufficient reference to children's language understanding and items were revised to refer specifically to *talking and understanding*.

ii) Questionnaire content

Questions were designed using the findings of role conceptions from phase one, but they did not ask parents and SLTs about their perception of roles directly. The questions aimed to elicit responses relating to roles through questions about beliefs and behaviour. For example, SLTs were asked about what they were aiming to change when working with parents to probe their views of their role as intervener. The rationale for avoiding direct questions about perceptions of roles was to reduce the effect of social desirability bias (Bowling, 2005).

iii) Questionnaire format

The questions used a combination of answer options: tick boxes, Likert scales and open text options (Bowling, 2009). Likert scales are useful for asking participants to rate their views or behaviour using a range of statements on a five point scale. This scaling method is used extensively in research and benefits from being quick to complete and generates valuable measurements of people's opinions. There are standard rules for ordering

questions which are intended to maximise responses and reduce bias, although there is little research from a health context exploring the effect of question ordering on responses (Bowling, 2009). Common sense guidance, such as placing easy to answer questions initially and questions about more sensitive socio-economic information at the end, was applied to the questionnaire design. The main questions within each section were assigned without following an obvious order, in order to encourage respondents to think about each question rather than follow a pattern of responses. Questions were kept simple and without obvious loading.

6.2.5   Design of the analysis

This section explains the way in which the questionnaire data were analysed. The questionnaires provided an opportunity to review the inferences from the qualitative analysis using correlations to explore associations between questionnaire responses. For example, the qualitative analysis suggested a distinction between three parental conceptions of role in intervention: (i) 'attending' (parents' role was simply bringing their child for treatment by SLT); (ii) 'doing activities' or 'implementing' (their role was to work with their child at home on tasks given by the SLT); (iii) and 'adapting' (their role was to adjust the tasks according to their experience with their child and to adjust general interaction with their child in the light of advice from the SLT). The questionnaire data provided the opportunity to review the nature of these categories. For instance, the qualitative data suggested that parents who perceived their role to be 'attenders' were keen for their child to be seen frequently and felt ill-equipped to support their child's language development. This implied that a conception of 'attender' might be rooted in parents' lack of self-efficacy in relation to language development, rather than an unwillingness to devote time to supporting their child. This interpretation implied that there would be a negative correlation between parents' expectation of their child seeing

236

the SLT every week and their belief in their own capacity to encourage their child to do activities that help talking. This could be reviewed using a correlation analysis.

Spearman's rho was the recommended test for non parametric data (Boslaugh and Watters, 2008) using Likert scales with intervals between the variables of unequal value. The current analysis reviews the relationships using bivariate correlations to measure the relationship between two variables, as a measure of strength ranging from 1 to 0, with stronger relationships represented by values closer to 1. Correlations may indicate positive or negative relationships, and vary in the strength of the relationship, highlighting association, but cannot be used to show causal relationships. The correlation analysis was computed using the 'analyse' feature of SPSS (version 19).

Steps in analysis

The quantitative analysis proceeded through the following steps:

1. Items in the questionnaire that were possible indicators of the conception of roles were identified (Table 6-2 and Table 6-3). This step of the analysis entailed determining the lead questions that appeared to most closely investigate specific conceptions of roles identified in phase one.

2. Subsidiary questions for each role conception were identified based on investigating similar or associated constructs based on the qualitative findings. Assigning lead and subsidiary questions used evidence from phase one, drawing on the quotes from parents, together with researcher judgment, to identify the questions that most closely matched the conceptions of roles emerging from phase one. The conception of roles, assigned lead questions for parents, together with the rationale is summarised in Table

237

6-2. The conception of roles and assigned lead indicators for SLTs, together with the rationale is summarised in Table 6-3.

3. Analysis of correlations between lead and subsidiary questions were computed. This investigated whether the questions were related and potentially measuring the same construct, that is, role conceptions in Column 2 (Table 6-2 and Table 6-3).

4. The relationships between subcategories in each broad role were reviewed, both within the role and between the roles. This provided an opportunity to explore whether the categories were clearly distinctive and if there was an obvious relationship between the subcategories within a role. For example, the qualitative findings suggested that pursuing support/judging advice in the advocacy role may be related to 'adaptor' in the intervener role. In order to review these using correlations, the roles that had a number of indicators for one construct required combining into one variable. Thus, three new variables for the intervener role were created. Where a negative correlation existed, as in 'attender' (Table 6-6) a reverse variable was created.

Correcting for the risk of false positives in correlation analysis

In a k matrix correlation there is a risk of falsely identifying significant relationships. One technique for adjusting for this risk is known as the Bonferroni Correction (Field 2009). This involves dividing the normal significance threshold (p=0.05) by k, that is the number of rows or columns in the matrix. Thus, for a 10 X 10 matrix the threshold for statistical significance would be .005, for a 20 X 20 matrix it would be .0025 and for a 30 X 30 matrix it would be .00167. In the parents' questionnaire a total of 34 items were available for the calculation of correlations suggesting a threshold with Bonferroni Correction of 0.00147. In the SLT questionnaire a total of 32 items were available for inclusion in the calculation of correlation coefficients suggesting a threshold with Bonferroni Correction of .00156.

Correlation coefficients were also used to examine relationships between groups of items which appeared to indicate particular roles. The reduced thresholds in these instances were: 4 groups (0.0125) and 3 groups (0.0167). However, a Bonferroni Correction is known to be a very conservative adjustment (Curtin & Schulz 1998) which increases the risk of a failing to identify a true relationship (Type 2 error). Moreover, the selection of correlations to test was identified based on the qualitative data and the number of items in the relevant matrices would therefore be very much smaller. So whilst the reporting emphasises correlations with statistical significance below the Bonferroni Correction adjusted thresholds, other correlations which fall beneath the simple 0.05 threshold are also noted.

6.2.5.1   Parent questionnaire

Format

The parent questionnaire (Appendix 3) consisted of four sections, each informed by the evidence derived from phase one:

1. Information about the child with speech and language needs. There were nine questions in this section that included information about the child's age, level and nature of parents' concern, type and amount of intervention from the SLT and reason for seeing the SLT. The qualitative findings indicated that parents differed in each of these parameters and early indications suggested that associations may have existed between these and parents' self-perception and confidence.

2. Twenty two questions were asked about parents' self-perception, probing parents' perceptions of what they did to help their child and how they perceived they worked with the SLT. Questions such as, 'I know how to help my child improve their understanding and talking' were directly informed by parents' responses in

phase one which indicated that some parents were actively seeking information and the opportunity to learn how to help their child, whilst others expressed confidence in knowing what to do. Parents' self-perception could be used to infer their role conception.

3. Sixteen questions were asked about parents' confidence working with their child, based on self-efficacy statements. These were specific to parents' roles in supporting children with speech and language needs following Bandura's guidelines (Bandura, 2001). Generic, all-purpose self efficacy scales are thought to have limited value and Bandura recommends designing scales that are relevant to specific skills and contexts (Bandura, 2006). The qualitative findings indicated that parents varied in the confidence they expressed in supporting their child and changes in confidence were highlighted from the longitudinal study.

4. Background details of parents, such as gender, ethnicity, education, occupation, postcode and other children in the family (seven questions).

Analysis

The following section describes the design of the analysis used to explore the three roles and parents' conception of SLT roles (Table 6-2 and Table 6-3). The questions also explored features that parents had raised in phase one. The evidence from parent interviews indicated three dimensions of parent roles in relation to their child's speech and language needs:

1. Advocacy (responding to others concern, raising concern, pursuing support/judging advice)

2. Intervener (attending appointments, doing activities, adapting parenting)

3. Responsibility for supporting language learning (expecting SLT to lead, expecting to implement, influencing intervention)

Table 6-2: Parent conception of advocacy and intervener roles and questionnaire items used to review associations

1 Broad role	2 Conception of role	3 Lead question from questionnaire	4 Rationale for choosing lead question	5 Subsidiary questions from questionnaire
Advocacy	Responding to others' concern	Reason for attending speech and language therapy (Q11.4)		
	Raising concerns	A2 I am worried about my child's speech and language	Indicates parents' perception of their level of concern which is likely to prompt action to find help.	A5 I am worried about my child's behaviour
	Pursuing support/judging advice	B11 I can tell whether the SLT is doing a good job	Indicates whether parents feel able to discern the benefits of SLT support.	B8 I can talk to the SLT about my child's talking
Intervener	Attending	A16 An SLT should work with my child every week	Indicates parents' expectation to attend intervention sessions with their child, emphasising the importance of the SLT in providing intervention	A 12 I am able to encourage my child to do activities that help his/her talking
	Implementer role / doing activities/helping (dependent)	A15 I expect the therapist to give me specific things to do with my child	Indicates parents' expectation to be given activities for home use.	A18 A SLT should know the best way to help my child's talking and understanding
	Implementer role/doing activities/helping (collaborating)	B5 I can use the techniques the SLT showed me	Indicates learning approaches demonstrated by the SLT. This reflects a more independent use of activities than simply doing as prescribed by the SLT	A1 I know how to help my child improve his/ her speech and language A3 The speech and language therapist makes me feel confident to help my child

241

| | | | | A4 -I work well with the speech and language therapist

A7 The speech and language therapist makes me feel at ease when I see him/her

A8 I know how to adjust activities at home to help my child's talking and understanding |
|---|---|---|---|---|
| | Adapting | B6 I can respond to my child differently following advice from the SLT | Indicates changes in parents' approach to supporting their child beyond implementing specific activities | B8 statements-I can use fun activities to help my child's talking

B9 I can talk to the therapist about my child's talking

B10 -I can change the targets that I work on with my child

B11 I can see my child is making progress with his/her talking |
Taking responsibility	Expecting SLT to lead	A6 An SLT should decide what to do about my child's talking	Indicates parents' expectation that the SLT takes full responsibility for decision-making about child's speech and language support	A10 An SLT should show me how to help my child's talking
	Intention to implement intervention	B9 I can change the targets I work on with my child	Indicates parents' readiness to take responsibility to adapt intervention goals independently	Q11 I spend time helping my child with speech and language
	Influencing intervention	A17 I expect to have choices about what will happen with my child's speech and language therapy	Indicates parents' sense of responsibility in judging best options for their child	B12 I can make the decision about whether it is worthwhile seeing the SLT

Advocacy

Parents' conception of the *advocacy role* in the interviews indicated three potential differences in role conception:

a. Responding to other's concern

b. Raising concern

c. Pursuing support and judging advice

The three characteristics of the advocacy role were explored through responses relating to reasons for attending intervention (Q9), including asking parents to prioritise the most important reason. The parent perception measure also included two items probing parents' advocacy role related to their level of concern and confidence in deciding to see the SLT, 'I am worried about my child's communication' (A.2) and 'I can make the decision about whether it is worth seeing the SLT' (B.11).

There were indications from the interviews that parents' role as advocate might alter over time, changing from responding to other's concerns to pursuing support. Parents in the study expressed different levels of concern which appeared associated with the kind of role they adopted. Contrast the parent who said, '*I wouldn't want to come across as not caring, but it didn't matter, it just doesn't matter*' with the one who said, '*I know my children, I know every child is different, but they need help'.* The strength of this parent's sense of advocacy was reinforced with the words, '*I refuse to move until something is done'.* Both parents were attending speech and language therapy, but only one was pursuing support and strongly advocating for something to be done. This was probed in phase two by asking parents to rate the severity of their child's difficulties in their opinion (Q5) and their level of concern (A2).

There also appeared to be a distinction between '*wanting something doing'* and aiming '*to get a proper opinion*' suggesting that some parents judged the reliability of advice and advocated for their children by seeking advice that they trusted. This was explored by questions A.10 and A.18 in the questionnaire, 'A SLT should show me how to help my child' and 'The SLT should know what will help my child'.

Intervener role

Parents' conception of their intervener role, derived from the qualitative phase, was evident in what they said they did or their approach to supporting their child, indicating three potential conceptions in role:

a. Attending appointments

b. Implementer/doing activities/teaching their child

c. Adapting parenting

There was evidence of parents' conception of their intervener role varying considerably. Some parents expressed teaching, but as a didactic activity, for example, '*teaching him manners',* others described doing activities, as illustrated by 'she'll *put a plan together which I will be able to do at home'.* Some parents conveyed a concept of intervention and teaching that involved changing their approach, such as '*I think the way I do things might have changed; I try to let him be more independent'*. This involved some form of adapting. These characteristics of the intervener role were not presented as clear, discrete categories by the parents in the study, but appeared to reflect parents' priorities at the time. The distinction between these conceptions was explored in phase two with questions about how parents perceived their roles had changed (Q11, A8). Confidence in

helping/teaching their child and adapting parenting was explored using items from the self-perception and self-efficacy measures (A.19, A.20 and B4-B6, B9-B10, B14).

Taking responsibility role

Parents' conception of the role of *taking responsibility* was described by parents in the interviews as:

a. Expecting SLT to lead intervention

b. Expecting to implement intervention

c. Influencing intervention

The three categories describe the balance of responsibilities between parents and SLTs that parents expected for supporting their child's speech and language development. Items asking them about allocating time and judging whether the child made progress (B8, B12 and Q10) explored parental views of taking responsibility.

Parents in phase one expressed uncertainty about what responsibilities would be expected of them during intervention and their confidence in being able to take responsibility. Parental confidence was investigated using questions about anxieties about meeting the SLT (A.14), gaining confidence during intervention (A3) and the self-efficacy measures (B1-B16).

Parents' conception of SLT role

At least three different conceptions of the SLT role roles were derived from phase one. Parents often described the SLT role with reference to their own role. For examples, parents referred to the SLT as trained and knowledgeable whilst describing themselves as *'just a mum'* (P14) or *'not trained'* (P11). The questionnaire data provided the opportunity

to explore the relationship between parents' conception of their own role and their conception of the SLT role.

Parents viewed SLT roles as:

a. Expecting the SLT to do intervention

b. Expecting the SLT to provide activities

c. Expecting the SLT to show how to adapt

These distinctions were explored in phase two using statements about the SLT knowing what to do and making decisions about treatment (A6, A10, A15). The SLT as intervener was probed through 'I expect the SLT to work with my child every week' (A16). The SLT as model was explored using 'I expect SLT to give me specific things to do' and 'I can respond differently following the advice of the SLT' (A15 and B6).

Associated features raised by parents in phase one

Other important features in the qualitative interviews that were worthy of further exploration in relation to role conception were the severity of the child's difficulties, the time they allocated to supporting their child and the length of time parents had been involved in intervention. Questions probing these features formed part of the background information in the questionnaire (Q.1-13).

6.2.5.2   SLT questionnaire

Format

The SLT questionnaire (Appendix 3) aimed to elicit SLTs' perceptions of how they worked with parents. Questions were designed on the basis of the findings of role conceptions from phase one, but did not ask SLTs about their views of roles explicitly. They aimed to

elicit perceptions of their roles through their views of what they were aiming to change when working with parents and barriers in their work with parents. The questionnaire consisted of three sections:

i. Changes that SLTs were aiming to achieve when working with parents. There were thirteen questions phrased as, 'how much are you trying to change X' with answers using a Likert scale. The qualitative findings indicated that SLTs differed in how they expressed intending to change parents' understanding, confidence and competence to help their child. Questions such as 'how much are you trying to change parents' understanding of their child's speech and language difficulties' and 'how much are you trying to change parents' capacity to work with their child on speech and language at home?' were intended to capture the variation between SLTs.

ii. Perceived barriers to working with parents. Nineteen questions probed the barriers that SLTs perceived interfered with working with parents. The qualitative findings indicated that SLTs thought a range of barriers existed associated with the roles they felt able to adopt such as service limitations, training needs for the SLT, complexity of child and family needs and parental disinterest. Questions such as 'how much of a barrier is parents' unwillingness to adapt their approach to helping their child?' or 'how much of a barrier is achieving outcomes through parents not seen as a priority?' were intended to investigate this.

iii. Background information about the therapist. Twelve questions were used to draw out SLTs' characteristics, such as experience and context, such as service characteristics, models of intervention, and client groups served.

Analysis

The interviews indicated differences between how SLTs perceived their own roles and parents' roles. The interviews also suggested that individual SLTs adopted different roles and changed their expectation of parents' roles in different cases. One inference that emerged from the analysis in phase one was the consistency between SLT conceptions of their own roles and their conception of the role of parents. That is, when SLTs referred to adopting a specific role this was generally accompanied by expressing a particular role for parents (Table 6-3):

1. Assessor (assessment by SLT only, assessment drawing on parents' knowledge of their child, assessment drawing on parents' knowledge of speech and language development)

2. Intervener (treats child, plans activities, advises/coaches)

3. Negotiator (decision-maker, explains roles and responsibilities, offers flexible options)

The following section describes the rationale for the questions exploring these role conceptions.

Table 6-3: SLT conception of roles and questionnaire items used to review associations

1 Broad role	2 Conception of role	3 Lead question from questionnaire	4 Rationale for choosing lead question	5 Subsidiary questions from questionnaire
Assessor role	Assessment by SLT only (no contribution from parents)	No lead question		
	SLT assessment draws on parents' knowledge of their *child*	No lead question		
	SLT assessment draws on parents' knowledge of *speech and language development*	1.1 How much are you trying to change parents' understanding of their child's speech and language difficulties	Indicates SLTs' intention to change parents' understanding specifically of speech and language	1.9 How much are you trying to change parents' ability to assess their child's speech and language
Intervener role	SLT treats child (Intervener 1)	2.4 How much of a barrier is the frequency with which I can see the child	Indicates the emphasis on the SLT instigating change directly with the child as the lead intervener	2.11 Parents' limited knowledge of speech and language 2.13 Parents' difficulty learning new ways to help their child 2.3 How much of a barrier is parents' willingness to allocate time to their chid 2.9 Achieving outcomes through parents is not seen as a priority
	SLT plans activities for parents to implement (Intervener 2)	1.2 How much are you trying to change parents' capacity to work with their child on speech and language at home	Indicates that the SLT intends intervention to be implemented by parents	1.8 How much are you trying to change parents' confidence in helping their child with speech and language 1.6 How much are

				you trying to change parents' motivation to help their child
	SLT provides advice on language support and parent-child interaction (Intervener 3)	1.3 How much are you trying to change parents' interaction with their child	Indicates SLTs' specific intention to support changes in parents' interaction with their child	1.6 How much are you trying to change the way parents' support their child's learning more generally 1.5 How parents work with you
	SLT models how to support speech and language intervention for the parent (Intervener 4).	2.12 How much of a barrier to working with parents is parents' unwillingness to adapt their approach to helping their child	Indicates SLTs' attitude to whether parents can respond to SLT modelling/teaching	2.13 How much of a barrier to working with parents' is parents' difficulty in learning new ways of helping their child
Negotiator role	Decision-maker	2.10 How much of a barrier is parents' low level of interest in their child		
	SLT provides clear explanation of roles /responsibilities	1.11 How much are you trying to change parents' understanding of responsibilities for supporting speech and language	Indicates SLTs' intention to enable parents to understand their own responsibilities	1.12 How much are you trying to change parents' motivation to help their child's speech and language
	Offers flexible options	No lead question		

Assessor role

The SLT conception of their *assessor role* indicated three possible conceptions:

a. SLT assessment only (without any contribution from parents),

b. SLT assessment drawing on parents' knowledge of their *child*

c. SLT assessment drawing on parents' knowledge of speech and language *development*

One difference between 'assessment only by SLT' and 'SLT draws on parents' knowledge of their child' lay in SLT beliefs about parents' interest in their children. SLTs referred to this as an indicator of the likely depth of parents' knowledge of their children's language needs. This was probed using the question, 'how much are you trying to change parents' capacity to assess their child's speech and language?' (1.9).

Some SLTs in the interviews expressed a difference between parents' general knowledge of their child and the home context, and parents' knowledge of typical speech and language development. The distinction between assessment roles was probed in the survey by a question asking SLTs to indicate the extent to which they regarded parents' knowledge of speech and language development as a barrier in their work (2.11).

The SLT conception of the assessment role, drawing on parents' knowledge of their child, included gathering information from parents about their child, but excluded an expectation that parents would be familiar with norms in language development. The evidence from the qualitative study suggested that the different conceptions of the assessment role placed increased expectations on parents. There were indications that some SLTs aimed to enable parents to play a strong role in assessment, explicitly aiming to

change parents' capacity. Questions 1.1 and 1.9 (Table 6-3) of the questionnaire probed SLTs' opinion of the degree that their practice intended changing parents' understanding of speech and language difficulties and their ability to assess their child's speech and language skills.

Intervener role

The SLT conception of their intervener role, described in the qualitative interviews by SLTs, indicated three potential differences in conception of roles:

a. SLT treats child

b. SLT plans activities for parent to implement

c. SLT provides advice/coaching on language support and interaction

Evidence from the interviews with SLTs suggested that the SLTs viewed the roles in a range from (a) to (c). SLTs varied in the intervention role they viewed as their ideal, but they encouraged parents to adopt roles that would make it possible for them to adopt their preferred role. This was explored in the questionnaire by asking about barriers that prevented the SLT from adopting their preferred role, as well as efforts made by the SLT to change what parents were ready and able to do.

The intervention role of 'treat child' places the burden of intervention fully on the SLT. Intervention relies on the frequency with which the SLT can see the child as the work of the SLT is directly seeking to change the child's speech and language. This role was probed through questions 2.4, 2.3 and 2.9.

The intervention role of 'plans activities' presumed that parents adopt the role of helper or implementer. This was explored in the questionnaire using questions 2.3 ('How much of a

barrier is parents difficulty learning new ways to support their child') and 1.8, about changing parents' confidence in helping their child's speech and language and 2.11 ('How much of a barrier is parents' limited knowledge of speech and language').

The intervention role of 'adviser/coach' depends on SLTs achieving change in parents' understanding and behaviour to enable adaption of interaction, or teaching their child specific skills. As one SLT said of parents in the interview, *'they're who I need to change the child, so I don't feel like my direct intervention is with the child'*. 1.3 was the lead question plus four subsidiary questions about changing parents' understanding and behaviour (1.2, 1.5, 1.6, 1.7 and 2.12).

Negotiator role

SLTs in phase one described the negotiator role as important for setting boundaries and agreeing roles. This was explored further in phase two asking SLTs to comment on whether being able to set boundaries about responsibilities between parents and SLTs was a barrier in working with parents (1.11) and how much are you trying to change parents' motivation (1.12). However, the negotiator role was not explored sufficiently by the questionnaire to enable a full follow up analysis of all three roles derived from the qualitative study.

SLT conception of parent roles

SLT conception of parents' roles was expressed both explicitly and implicitly in the qualitative interviews. Four conceptions of roles of parents were described:

1. Parent as attender

2. Parent as helper

3. Parent as adaptor

4. Parent as learner-teacher

Given the observation from the qualitative evidence that some SLTs expressed a range of parental involvement, the question of how SLTs enable change in parents' conceptions, progressing from a relatively general role of attender, to an enabled role of adaptor and teacher is of particular interest. SLTs described facilitators to enable change in conception of role, such as relationship building, but also barriers that hindered involvement of families in intervention.

Important features raised by SLTs in phase one

The evidence from the interviews also highlighted other important characteristic that some SLTs perceived as contributing to their conception of their own and parents' roles. It was not clear if these characteristics related to specific intervention roles. First, a number of interviewees raised relationship building with parents. For example, SLT 10 commented, '*you have to build a relationship, especially with the more hard to reach families, you have to go in as a friend almost, and make the relationship with the mum and then try and get some advice in'.* Therefore three questions about building relationships with parents were also included in phase two (1.5, 1.10 and 2.14).

6.2.6 Process of data collection

The parent questionnaires were completed over a three-month period (November 2013-January 2014).The responses from parents were collected by one of three approaches:

i.   The researcher attended speech and language therapy sessions to administer parent questionnaires as a structured interview with parents attending intervention (n=38). SLTs explained the study to the parents and asked if they were willing to participate. The researcher talked to volunteer parents, provided an information brief and gained verbal consent before completing the questionnaire.

ii. The SLTs in two participating sites distributed questionnaires to parents at the end of intervention sessions for parents to complete and return anonymously (n=11). These were collected from the SLT office where a team leader had collated them.

iii. Nursery staff distributed questionnaires to parents in one setting in one study site (n=2). Parents returned the questionnaire to a member of the nursery staff who forwarded the response to the SLT. These were then sent to the researcher.

The results from each questionnaire were then entered into the Qualtrics survey tool by the researcher within a day of completion or receiving from SLTs. The SLTs recorded their own responses to the questionnaire directly online over a two month period (September to October 2013).

6.3 Results of parent questionnaires

The results for parents' and SLTs' questionnaires are presented separately. As the tables are self-explanatory, the accompanying text highlights notable features that may be relevant for further discussion or exploration. The findings from the descriptive statistics are presented first, followed by the results of the analysis of correlations between lead and subsidiary questions.

6.3.1 Sample characteristics: descriptive data

There were 51 parent questionnaires that were completed and analysed. Table 6-4 and Table 6-5 present the details of the parent respondents in terms of demographics, parents' concerns relating to their children and their experience of speech and language therapy.

Demographics

The responses to the question on occupation and educational level suggest there was a range of socio-economic status (Table 6-4). Parents were reasonably spread across the range of employment, though it is notable that 44% of parents described themselves as full time carers, making no record of their occupation, despite the question on employment, asking for current or previous occupation. Parents' educational level was relatively evenly distributed with 33% educated to degree level and 29% to GCSE level. There were 16% who stated that they were educated to secondary level only.

The ethnicity of the sample also indicates a range corresponding broadly to national figures, (presented in brackets as a point of comparison). The greatest proportion of the parent sample were White British (70% compared to 79.1 in the United Kingdom 2011 Census[17]), with smaller proportions of Asian (12% compared to 7.8%), Black African/Caribbean (8% compared to 3.5%) and White other (6% compared to 4.6 %). The white other group and mixed ethnic groups both had 2%.

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[17] http://www.ons.gov.uk/ons/guide-method/census/2011/index.html?utm_source=twitterfeed&utm_medium=twitter

Table 6-4: Demographic detail of parents

Parents' background information		Number	Percentage
Parental status	Mother	48	9
	Father	2	4
	Foster carer	2	4
Ethnicity	White British	37	70
	White other	3	6
	Mixed ethnic group	1	2
	Asian/Asian British	6	12
	Black/African/Caribbean/Black British	4	8
	Chinese	0	0
	Middle Eastern	0	0
	Other ethnic group (please describe)	1	2
Highest level of education	Secondary school	8	16
	GCSE	15	29
	A level or equivalent	11	22
	Degree	17	33
Employment	At home caring for children	22	44
	Managerial	1	2
	Professional	9	18
	Technical	0	0
	Administrative	6	12
	Skilled	4	8
	Caring/leisure	4	8
	Sales	1	2
	Process, plant, machine	1	2
	Elementary	1	2
	Unemployed	1	2

Children's characteristics

Table 6-5 shows the characteristics of the children in terms of age, parents' description of speech and language difficulty and reason for seeking speech and language therapy referral. The most notable feature of the responses is the type of the children's language difficulties, which were described as largely expressive in nature, affecting spoken language, rather than receptive language. Parents reported their children's difficulties as predominantly (i) saying words clearly (65%) (ii) constructing sentences (53%) (iii) learning vocabulary (39%) and (iv) fluency (32%). Given the way the data were collected from parents independently from SLTs in this part of the study, parents' perceptions of their child's difficulties could not be compared with the views of SLTs.

The second notable feature of the sample was the proportion of parents who regarded their child's difficulties as serious or very serious (44%) compared to those that described the difficulties as quite serious or not serious (28%). It would be reasonable to assume that parents are motivated to attend speech and language therapy if they consider that their child's difficulties are serious. However, a relatively high proportion of parents (28%) were undecided about the severity of their children's difficulties suggesting that many parents had difficulty judging the severity of the difficulty, but were still motivated to attend speech and language therapy. This appears consistent with the qualitative evidence from phase one, which suggested that reassurance was an important motivator for seeking advice from SLTs.

Table 6-5: Children's characteristics and parents' concerns about speech and language development

		Number	**Percentage**
Children's age	1.10-3.00 years	32	64
	3.01-5.00 years	15	30
	5.01-12.00 years	3	6
Age of first SLT assessment	0.09 to 1.08	6	13
	1.09 to 3.00	35	76
	3.01-5.00	2	4.5
	5.01 +	3	6.5
Description of difficulty (any number of options could be chosen)	Saying words clearly	35	65
	Putting words together in sentences	28	53
	Learning to say new words	20	39
	Talking fluently	17	32
	Understanding what you say to him/her	9	18
	Other	3	6
Parents' description of the degree of seriousness of their child's needs	Not serious	5	9
	Quite serious	10	19
	Neither serious or not serious	15	28
	Serious	19	36
	Very serious	4	8
Reason for seeking SLT advice (any number of options could be chosen)	Help child progress at school or nursery	23	44
	Help child make friends	12	23
	Seek reassurance	17	33
	Do what someone else recommended	9	17
	Improve the way child talks	46	88
	Learn how to help child	34	65

	Change interaction with child	21	40
	Improve child's behaviour	13	25
	Seek tips and ideas to help child's talking	39	75
Three most important reasons for seeking the SLT advice	To improve the way my child talks	17	32
	To learn how to help my child	5	9
	To get tips and ideas to help child talking	5	9

Parents' self-reports about supporting their child

The items asked parents about the ways in which they had supported their child's language development. These self-reports provide evidence of parents' beliefs about what they do. This study uses these belief statements as evidence of parents' conceptions about their roles.

The majority of parents (n=42, 82%) indicated that they helped their child with talking every day. A small proportion (n=8, 16%) reported that they helped two to four times a week and one parent reported helping once a month.

A large number of parents expressed the reason for coming to speech and language therapy was either to learn how to help their child (75% wanted tips and 65% wanted to learn how to help their child) or change their interaction with their child (40%). This indicates that parents are actively seeking to change their behaviour to help support their child. Parents were also asked how much they had changed the way they tried to support their child since seeing the SLT. The greatest proportion of parents indicated making changes 'a lot' (n=20, 39%) or 'some' (n=21, 41%), whilst a smaller proportion reported a 'little change' (n=7 14%) or 'none' (n=3, 6%) indicating that many parents perceived that involvement in SLT had changed the way they helped their child's talking and understanding of language.

Parents' expectation of SLTs leading the decision-making is confirmed by the questionnaire responses. In answer to the question, 'A speech and language therapist should decide what to do about my child's talking and understanding, twenty six parents strongly agreed or agreed (51%), compared to seven (13%), who disagreed or strongly disagreed. The responses are not overwhelmingly in favour of SLTs leading decision-making, given the proportion of parents (n=16, 31%) who answered 'neither agree or disagree'. This may suggest some uncertainty among these participants about who should lead the decision-making. Parents' responses were much more definite about their expectation that SLTs should show them how to help (strongly agree or agree: n=34, 67%; disagree or strongly disagree, n=6, 12%) and give them specific things to do (strongly agree or agree, n=37, 72%; disagree n=4, 8%). Both responses suggest that parents expect the SLT to support them to do activities to help their child in an implementer role.

6.3.2   Parents' conception of roles

The analysis of the questionnaire data was framed by the results from the qualitative research reported in Chapter 4. This generated three propositions concerning parents' conception of role that were explored further in phase 2:

i.   Parents differ in how they pursue support for their child with speech and language needs in their role of advocacy

ii. Parents see their role in intervention as either attender, implementer or adaptor

iii. Parents with a 'high involvement' conception of advocacy also have a high involvement conception of their role in intervention.

In order to explore these propositions, the quantitative analysis investigated correlations between responses to questionnaire items. Phase one results suggested that parents conceived what they were doing in terms of a small number of broad roles. Each conception expressed a division of

responsibility between the parent and SLT. The framework from the qualitative research presented in Section 6.2.6 of this chapter (Table 6-2) has been used to analyse correlations between lead and subsidiary questions (Table 6-6) from the parent questionnaire.

Table 6-6: Parents' conception of roles and questionnaire items used to review correlations

1 Broad role	2 Conception of role	3 Lead question from questionnaire used to explore the construct in (2)	4 Subsidiary questions from questionnaire	5 Correlations between lead and subsidiary questions
Advocacy	Responding to the concern of others			No measures
	Raising concerns	A2 I am worried about my child's speech and language	A5 I am worried about my child's behaviour	.40 p=.003
	Pursuing support/judging advice	B11 I can tell whether the SLT is doing a good job	B8 I can talk to the SLT about my child's talking	.51 p<.001
Intervener	Attending	A16 An SLT should work with my child every week	A 12 I am able to encourage my child to do activities that help his/her talking	-53 p<.001
	Implementer role / doing activities/helping (dependent)	A15 I expect the therapist to give me specific things to do with my child	A18 A SLT should know the best way to help my child's talking and understanding	.43 p=.003
	Implementer role/doing activities/helping (collaborating)	B5 I can use the techniques the SLT showed me	A1 I know how to help my child improve his/ her speech and language	.50, p<.001
			A3 The speech and language therapist makes me feel confident to help my child	.52, P<.001
			A4 I work well with the speech and language therapist	.64, p<.001
			A7 The speech and language therapist makes me feel at ease when I see him/her	.51, P<.001
			A8 I know how to adjust activities at home to help my child's talking and understanding	.53, p<.001
	Adapting	B6 I can respond to my child differently following	B8 statements-I can use fun activities to help my	.58, p<.001

		advice from the SLT	child's talking	
			B9 I can talk to the therapist about my child's talking	.46, p<.001
			B10 I can change the targets that I work on with my child	56 p<.001
			B11 I can see my child is making progress with talk	.56 p<.001

Proposition 1: Parents differ in how they pursue support for their child with speech and language needs in their role of advocacy

The qualitative evidence suggested three categories in the advocacy role: responding to other's concerns, raising concerns and pursuing support/judging advice. The proposition was explored by analysing reasons for attending and analysis of correlations between lead questions and subsidiary questions (Table 6-6).

Responding to the concern of others

The questionnaire item that most closely indicated that the parent had responded to the concern of others was item Q11.4. This item asked parents to tick a box if they had come to see the SLT on the recommendation of the health visitor or another professional. Only 9 parents selected this option. By selecting other options, but not this one, most parents asserted that they had taken the initiative in advocating for their child's interests by seeking help. This raises the question of whether the parents who had not taken the initiative had not done so because they were less concerned about their child's language or for some other reason such as reticence about approaching professionals.

Raising concerns

The qualitative evidence suggested that parents' anxiety about their child's language skills prompted them to seek advice and alert others to their concerns. A number of parents in phase one expressed their concern about the relationship between children's communication and behaviour (see 4.3.5 in Chapter Four). Two questions specifically asked about parents' concerns (A2 and A5 Table 6-6), showing a weak correlation (.40, p=.003) between concern about speech and language and behaviour. The weak association is in line with the qualitative results, suggesting that some parents are concerned about their child experiencing communication and behaviour difficulties together and may be a reason for parents raising concern. It is also important to note that the correlation is not higher suggesting that concern about behaviour is not automatically associated with speech and language delay by parents.

Pursuing support/judging advice

The qualitative data indicated that some parents were persistent in seeking help and made judgments about the quality of advice they received (see 4.3.2 in Chapter Four). Two questions were used to explore parents' advocacy role in pursuing support (B11 and B8). These focus on parents' judgment ('I can tell whether the SLT is doing a good job') and confidence in approaching the SLT ('I can talk to the SLT about my child's talking'). There is a strong correlation (.51 p<.001) between these items suggesting that parents who have confidence in their ability to judge SLTs' advice also tend to be confident in talking with the SLT. These statements do not directly address parents' readiness to pursue support when it is not forthcoming, but they do indicate parental willingness to engage on the basis of their own judgement. There is a lack of correlation between the lead questions and subsidiary questions for the categories 'raising support' and 'pursuing support/judging advice' suggesting that the two categories are distinct and represent separate constructs. The lack of a correlation between both lead and subsidiary questions in each category

add weight to the conclusion ('I am worried about my child's speech and language' and 'I can tell whether the SLT is doing a good job' (-.08) and subsidiary questions 'I am worried about my child's behaviour' and 'I can talk to the SLT about my child's talking'(.13)). This provides tentative support for the advocacy role consisting of at least two sub categories of raising concern and pursuing support, though there were insufficient questionnaire items to explore the first subcategory of responding to other's concerns.

Proposition 2: Parents see their role in intervention as attender, implementer or adaptor.

The qualitative analysis indicated three categories in the intervener role: attender, doer/implementer and adapter. The lead question that matched the parents' view of the attender role was 'An SLT should work with my child every week'. The correlation with the subsidiary question 'I am able to encourage my child to do activities that help his/her talking' showed a strong negative association (-53, p<.001) suggesting that increases in one variable are related to decreases in the other. The correlation suggests that both items provide a useful indicator for the conception of attending and that there is an association between expecting the SLT to see a child frequently and parents not feeling able to help their child.

Two questions, A15 and B5, seemed equally matched to the way in which parents expressed an implementer role in the interviews (Table 6-6). A further six questions were identified as having a subsidiary match to this role conception (A1, A3, A4, A7, A8, A18) using the qualitative findings. Since there were no a priori grounds for preferring either A15 or B5 as a lead question, correlations between the six subsidiary questions and each of the lead questions were examined. These showed that whilst A15 was correlated with A18, it was not correlated with the other subsidiary questions. Conversely, B5 correlated with each of A1, A3, A4, A7 and A8. Moreover, each of the subsidiary questions in this group correlated with each other. This suggests that the 'implementer' role might

266

be viewed as two separate categories. One category implied an expectation that the SLT would provide activities and lead the intervention, suggesting less independence in implementing SLT intervention and therefore termed *dependent.* This can be seen in the response to the lead question 'I expect the therapist to give me specific things to do with my child'; the other indicated greater parental involvement and influence, as indicated by response to the question, 'I can use the techniques that the SLT gave me' and related questions. This indicated a greater level of involvement, reflecting a sense of empowerment, termed *collaborating*.

In order to review whether parents' answers showed clear distinctions between the role categories an analysis of correlation between the combined variables for each category was conducted (Table 6-7). A single variable was created by combining the items for each category that showed a correlation. For example, a new variable was created for the intervener role of 'collaborative implementer' by combining B5 and A1, A3, A4, A7 and A8. The category of 'attending' involved a negative correlation and therefore a reverse variable was used when combining A16 and A12. SPSS (version 19) was used to create new variables using the 'transform' feature to compute the correlations.

Table 6-7: Correlations between different parent intervener roles

	Intervener-attender	Intervener-implementer/doer (dependent)	Intervener-implementer/doer (collaborative)	Intervener adaptor
Intervener-attender	1.00	.059		
Intervener-implementer/doer (dependent)	.059	1.00		
Intervener-implementer/doer (collaborative)	-.47 p=.001	.31 p=.044	1.00	.74 p<.001
Intervener adaptor	-.46 p=.001	.33 p=.028	.74 p=<.001	1.00

Within the conceptions of role in intervention, the attender role was not correlated with 'dependent implementer' and was negatively correlated with the roles of 'implementer/collaborator' (-.47, p=.001) and 'adaptor' (-.46, p=.001). This suggests that there is a distinct intervention category of attender, implying that some parents perceive their role as attending without an expectation of greater involvement.

There was a strong correlation (.74, p<.001) between the roles of 'collaborative implementer' and 'adaptor', suggesting that it may be more appropriate to see these as a single category. It is notable that there is no correlation between the dependent implementer role and the attender role suggesting a more advanced level of involvement than attending only. There was a small correlation between dependent implementer and collaborative implementer (.31p=.044). As this is a weak

correlation, these findings require cautious interpretation, but suggest that some parents may be going through a process of change, starting to perceive their role as assuming more responsibility. This is consistent with the notion of 'hybrid' categories defined in conceptual change theory (Vosniadou, 2007). This will be considered further in Chapter Seven.

Proposition 3: Parents' with a 'high involvement' conception of advocacy also have a high involvement conception of their role in intervention.

The qualitative evidence suggested that parents with a firm conception of their role as advocate, (pursuing support and judging the support they received) were also positive about adopting a implementer or adaptor role. In order to explore this further using the quantitative data, a new variable was created for advocate 'pursing support/judging advice' using the two items B11, 'I can tell whether the SLT is doing a good job and B8, 'I can talk to the SLT about my child's talking'. An analysis of correlation was undertaken using this variable and the new variables created for the intervener roles of 'attender', 'dependent implementer', 'collaborating implementer' and 'adaptor' (Table 6-7).

Table 6-8: Correlations between advocate role (pursuing support/ judging advice) and intervener roles

	Intervener-attender	Intervener-implementer/doer (dependent)	Intervener-implementer/doer (collaborative)	Intervener adaptor
Advocate-pursuing support/judging advice	-.23	.29	.67 p<.001	.82 p<.001

There is a strong correlation (.82, p<.001) between the most involved advocate role of 'pursuing support/judging advice' and the intervener 'adaptor' role suggesting a strong association between those the two roles (Table 6-8). There is also a strong correlation between the advocate role of pursuing support and the collaborative intervener (.67, p<.001). These indicative findings suggest

that parents who pursue support are likely to be those who assume an involved intervener role as adaptor or collaborative doer. The negative association between the advocate role of pursuing support and the intervener-attender role (-.23) is not significant, but also adds weight to the proposition, suggesting that the relatively uninvolved role of attender is not related to the pursuing advocate role. These findings provide tentative confirmation of the proposition that parents' with a 'high involvement' conception of advocacy also have a high involvement conception of their role in intervention. The findings are therefore preliminary, given the relatively small sample size, but encourage further exploration in future research.

6.4 Results of the SLT questionnaires

6.4.1 Sample characteristics: descriptive data

Sixty-one questionnaires were completed by SLTs based in the UK, with an additional one from an international respondent. The results are displayed in Table 6-9, with the text highlighting any notable features.

Experience and expertise

The respondents (Table 6-9) were predominantly practitioners with over five years' experience (70%), just under a fifth had between three and five years' experience (19%) and a small proportion had one to two years' experience (11%). The level of experience was evident in the proportion who reported that they were specialist SLTs (66%), with specific language impairment representing the most frequently occurring specialist area (16% of total respondents), ASD and complex needs represented the second and third most frequently reported specialist area (12% ASD and 8% complex needs of the total respondents).

Table 6-9: Characteristics of SLT respondents

Characteristics		Numbers	Percentage
Years qualified as SLT	1-2 years	17	11
	3-5 years	12	19
	6-10 years	19	31
	Over 11 years	24	39
Current employer	NHS	56	90
	Independent	6	10
Locality of employment	North England	47	74
	South England	6	6
	Midlands England	5	5
	N Ireland	5	5
	London England	2	3
	Scotland	1	2
	Wales	1	2
	International	1	2
Percentage with specialist responsibilities	Yes		66
	No		34
Client group that SLT works with	Parents	0	0
	Parents and children	34	55
	Teachers and children	16	26
	Children	0	0
	Parents, children, teachers and other professionals	12	19
Place of provision	Children's own home	8	13
	Community clinic	21	34
	Children's Centre	3	5
	Nursery	2	3
	Primary School	15	24
	Secondary School	1	1
	Other (special school or even split between settings)	12	19
Main SLCN (any number of options can chosen)	Speech and language delay	37	
	Primary speech and language need	38	60
			61
	Complex needs	32	52
	Other (ASD & dysfluency)	6	10
	Stage/age		
	Pre-school	31	50
	Primary	30	48
	Secondary	1	2
Waiting time	**Assessment**		
	0-6 weeks	13	22
	7-18 weeks	40	67
	19-36 weeks	6	10
	Over 37 weeks	1	2
	Intervention		
	0-6 weeks	36	59
	7-18 weeks	19	31
	19-36 weeks	4	7
	Over 37 weeks	2	2

Working practice

It is notable that no SLT reported that they worked only with children or only with parents, indicating that they perceived their practice as involving several participants together. The number of SLTs who cited working with parents and children (55%), teachers and children (26%) and parents, children, teachers and other professionals (19%), confirmed this.

SLT responses to the questions about how much they are trying to change parents' behaviour and knowledge indicated a strong conception of their role as adviser/coach or teacher (Table 6-10). There was considerable consistency in the responses to items relating to changing parents' understanding, capacity and confidence. For example, in answer to 'how much are you trying to change parents' understanding of speech and language difficulties', responses were often (n= 26, 42%) and all the time (n=35, 56%) indicating that SLTs had a strong conception of their role as teaching parents. This contrasts with SLT responses to changing parents' ability to assess their child's speech and language skills that showed greater variation between SLTs and reduced focus on enabling parents to learn to assess their child's speech and language.

Table 6-10: SLT responses to questionnaire items about changing parents' behaviour and knowledge

How much are you trying to change:	Never	Rarely	Sometimes	Often	All the time
Parents' understanding of speech and language difficulties	0	0	1	26	35
Parents' capacity to work with their child on speech and language skills at home	0	0	3	22	37
Parent's confidence in helping their child with speech and language	0	0	5	25	31
Parents' ability to assess child's speech and language skills	3	17	20	12	10

SLTs raised a number of issues in the free text responses on the SLT questionnaire. SLTs were asked if they wanted to add any comments about working with parents and also to describe the service model used in their locality. These were analysed using content analysis (Bowling 2009; Hsieh and Shannon, 2005). The process involved coding the responses, identifying categories or themes, derived from the comments recorded by SLTs in a 'coding up' process. The text responses on the questionnaire were short comments rather than detailed explanations and provided a brief snapshot of SLTs' views of working with parents and their models of practice. They therefore generated a limited range of themes and can only be used to consolidate findings from elsewhere in the study. There were fifteen text comments about working with parents (30%) and over half of the respondents provided a description of their model of practice (n=37). The largest group of comments in showed the variation that SLTs perceived in relation to parents' roles in intervention and coincides with issues raised in the qualitative study. Three contrasting views were derived from the data:

   i.   Only some SLTs expressed prioritising working with parents
  ii.   Others indicated that parents are less involved in school based services
 iii.   Some SLTs find it difficult to help parents take responsibility for supporting their child's speech and language development.

SLTs in phase one rarely referred to school services excluding parents, but these results may reflect a broader sample of SLTs, and express more sharply the tension between the different ways of working that school and community services encourage. It is perhaps surprising that more SLTs did not specifically comment on prioritising working with parents. The number of difficulties working with parents raised by respondents suggested that parent-SLT partnership remains a source of tension for SLTs. This is also consistent with the findings of the qualitative study.

The results indicate considerable variation in how SLTs described their models of practice. A number of respondents (n=10, 16%) refer to a 'consultative model'. The term 'consultative' appeared to refer to working with teaching staff, with one response specifically excluding parent training. Six respondents refer to parent education, but it is difficult to discern what part it plays in other models of practice described by respondents. The term 'direct' appears to signify treatment with the child, reported as 'direct treatment' by some respondents, whilst 'indirect' is difficult to interpret from the limited comments. This raises the issue of a potential lack of consistency in the use of terms such as direct, indirect and consultative amongst SLT respondents. It may point towards a weakness in professional consensus or a lack of clarity in the use of terminology.

6.4.2   SLT conception of role

Four propositions about SLT conception of role were formulated from the qualitative results which were explored further using the questionnaire data:

  i.   SLTs vary in the extent to which they consider that the assessor role includes parents

 ii.   SLTs adapt the intervener role to include treating the child, planning activities for parents and advising on language support according to their judgments of the roles parents are likely to adopt

iii.   SLTs who involve parents in intervention using an advisory/coaching role are likely to provide clear explanations of roles and responsibilities and offer flexible options in their negotiator role

 iv.   SLTs with high involvement of parents in assessment and negotiation will also have a high level of involvement of parents in intervention

Correlation analyses (Table 6-11) were used to explore these propositions.

Table 6-11: SLT conception of roles and questionnaire items used to review associations

1 Broad role	2 Conception of role	3 Lead question from questionnaire	4 Subsidiary questions from questionnaire	5 Correlations between lead and subsidiary questions
Assessor role	Assessment by SLT only			
	SLT assessment draws on parents' knowledge of their *child*			
	SLT assessment draws on parents' knowledge of *speech and language development*	1.9 How much are you trying to change parents' ability to assess their child's speech and language	1.1 How much are you trying to change parents' understanding of their child's speech and language difficulties	.23 p=.07
Intervener role	SLT treats child (Intervener 1)	2.4 How much of a barrier is the frequency with which I can see the child	2.3 How much of a barrier is parents' willingness to allocate time to their chid 2.9 Achieving outcomes through parents is not seen as a priority	.34 p=.007 .37 p=.004
	SLT plans activities for parents to implement and models (Intervener 2)	2.13 How much of a barrier to working with parents' is parents' difficulty in learning new ways of helping their child	1.8 How much are you trying to change parents' confidence in helping their child with speech and language 2.11 Parents' limited knowledge of speech and language	No correlation -.23 .46 p<.001
	SLT provides advice/teaching on language support and parent-child interaction (Intervener 3)	1.3 How much are you trying to change parents' interaction with their child	1.2 How much are you trying to change parents' capacity to work with their child on speech and language at home 1.6 How much are you trying to change the way parents' support their child's learning more generally 1.7 How much are you trying to change the way	.303 p=.017 .41 p=.001 .32

			parents support their child's participation social activities	p=.013
			1.5 How much are you trying to change the way parents work with you	.48
				p<.001
			2.12 How much of a barrier to working with parents is parents' unwillingness to adapt their approach to helping their child	-.06
Negotiator role	Decision-maker	No measures		
	Explains roles and responsibilities	1.11 How much are you trying to change parents' understanding of responsibilities for supporting speech and language	1.12 How much are you trying to change parents' motivation to help their child's speech and language	.78 p<.001
	Offers flexible options	No measures		

Proposition 1: SLTs vary in the extent to which they consider that the assessor role includes parents

The evidence from the qualitative data identified that SLTs had a strong conception of their assessor role. However, variation in the involvement of parents in assessment prompted further investigation using questionnaire items, 'How much are you trying to change parents' ability to assess their child's language'. A relatively small proportion of SLTs (n=22, 36%) responded to this item with 'often' or 'all the time' suggesting that most SLTs do not explicitly see their assessor role as enabling parents to assess speech and language themselves. However, all the SLTs (n=61) responded that they were aiming to change parents' understanding of speech and language difficulties 'often' or 'all the time'. Assessment, as evaluation of children's level of development and progress, is essential to understanding a child's speech and language difficulty and subsequent

improvement in skills, yet is not regarded as a role SLTs assign to parents. There was no evidence of an association between changing parents assessment ability and changing their understanding (.23, p=.07). This suggests that SLTs see assessment as predominantly an SLT role, and do not necessarily anticipate that changing parents' understanding includes enabling them to evaluate speech and language skills.

The qualitative evidence also suggested that SLTs vary in the extent they based their assessment on parents' knowledge of their child or of speech and language development. However, there were no items that probed this distinction in phase two.

Proposition 2: SLTs' conception of the intervener role includes treating the child, planning activities for parents and advising on language support and interaction according to their judgments of the roles parents are likely to adopt

Conception of role as 'treating' was investigated in the questionnaire with the lead question, 'How much of a barrier is the frequency with which I see the child and parents'. There was a weak correlation (.34, p=.007) with 'how much of a barrier is parents' willingness to allocate time to their child'. This may support the proposition that SLTs adopt a role treating the child in circumstances where they judge parents are less involved, though further investigation is required.

The intervener role, which included planning activities for parents to do at home, was investigated with the question, 'How much are you trying to change parents' capacity to work with their child on speech and language at home'. The majority of SLTs (n=59) responded to this question with 'often' or 'all the time'. The lead question for the analysis of correlations was 'How much of a barrier to working with parents is their difficulty learning new ways of helping their child'. There was a strong correlation (.46, p<.001) with one subsidiary question, 'How much of a barrier is parents' limited knowledge of speech and language development'. The correlation with the second subsidiary question, 'How much are you trying to change parents' confidence in helping their child'

was not significant, but showed a negative correlation. This may be indicative of a relationship worthy of further exploration.

SLTs were asked directly about how much they were seeking to change parents' interaction with their child. This item was weakly correlated (.4, p=.002) with the subsidiary item, 'How much are you trying to change the way parents' support their child's learning more generally' suggesting that SLTs may be trying to enable parents to adapt the way they support their child's learning as well as instigate change specifically in interaction between parents and child.

Proposition 3: SLTs who involve parents in intervention using advisory/coaching roles are likely to provide clear explanations of roles and responsibilities in the negotiator role

There were no distinctive measures in the questionnaire for the decision-making or offering flexible options identified in phase one. The lead question for providing clear explanations of responsibilities was 'How much are you trying to change parents' understanding of responsibilities for supporting speech and language'. There was a strong correlation (.78, p<.001) with the subsidiary question, 'How much are you trying to change parents' motivation to help their child's speech and language', suggesting that negotiating responsibilities is closely associated with encouraging parents' motivation to help their child.

Proposition 4: SLTs with high involvement of parents in assessment and negotiation will also have a high level of involvement of parents in intervention

Lead and subsidiary questions that showed significant correlations in the intervener role were combined to create new variables using the 'transform variables' function in SPSS. The correlations between composite variables and the lead question in the assessment role, 'How much are you

trying to change parents' ability to assess their child's speech and language' were analysed (Table 6-12).

Table 6-12: Correlations between variables for intervener assessor and negotiator role

	Intervener role: treats child	Intervener role: plans and models	Intervener role : advises and coaches	Assessment role: draws on parents knowledge of speech and language	Negotiation role: Provides clear explanation of roles and responsibilities
Intervener role: treats child	1.000	.491 p<.001			
Intervener role: plans and models	.491 p<.001	1.00			
Intervener role : advises and coaches	-.14	-.25	1.00	.47 p=<.001	.47 p=<.001
Assessment role: draws on parents knowledge of speech and language	-.14	-.32 p=.011	.47 p<.001	1.00	.45 p<.001
Negotiation role: explains roles and responsibilities	.07	.14	.47 p<.001	.45 p<.001	1.00

The analysis of correlations indicated that SLTs have two conceptions of roles. Table 6-12 shows that SLTs' answers to items on the 'treats child' and 'plans activities' roles were strongly correlated (.49, p<.001). Also SLTs' answers to 'assesses drawing on parents' knowledge of speech and language', 'advises/coach' and 'explains roles/responsibilities' are strongly correlated (.47 p=<.001 and .45, p=<.001). This suggests that there are two conceptions of roles, rather than the three identified in the qualitative study. That is, role one that consist of 'treats' and 'plans activities' and

role two, 'assesses drawing on parents' knowledge of speech and language', 'advises/coaches' and explains role/responsibilities'. This confirms proposition 4, that SLTs with high involvement of parents in assessment and negotiation will also have a high level of involvement of parents in intervention.

6.5 Summary

Phase two continued the exploratory investigation of parents and SLT conceptions of roles, generating findings that can be treated as indicative. Seven key points have been identified from the analysis, building on the findings from the qualitative phase and providing a new perspective on the roles that parents and SLTs adopt during intervention.

(i)   Parents have three possible conceptions of the intervener role

Four possible conceptions of the intervener role were identified from the analysis of the quantative data: attender, dependent implementer, collaborative implementer and adaptor. There was a strong association between the collaborative implementer and adaptor conception of role suggesting that these two roles may represent one conception of collaborative implementer and adaptor.

(ii)   Readiness to change

Parents are ready and keen to adopt a 'helping' role and the majority reported that they were helping their children with speech and language routinely, that is, every day. Their reasons for attending speech and language therapy included wanting to make changes in how they supported their child, expressed as seeking tips and ideas, changing interaction or a general desire to learn how to help. The evidence of change reported resulting from attending speech and language therapy implies that parents' conception of role is open to change. There were indications that parents' conceptions of roles were in flux with evidence for a 'hybrid' conception (in conceptual

change terms). The changes in conception were in the direction of the collaborative implementer, which is one of greater involvement. This has implications for the way SLTs work with parents in supporting changes in conception of role, suggesting that parents can be encouraged to participate more fully.

(iii)   Parents' level of involvement

There were indications that parents who showed high involvement in one role, such as advocacy, also showed high involvement in the intervener and taking responsibility role. Enabling parents to adopt conceptions of roles that include higher levels of involvement could have important implications for co-working and partnership. This will be considered in the discussion (Chapter Seven).

(iv)   Parents' capacity to assess their child's speech and language

A notable proportion of parents reported that they were unsure how serious their child's difficulties were. This suggested that parents found it difficult to judge their children's speech and language development and implied that they were seeking advice to support a process of evaluating these difficulties. This is important finding should be considered alongside the results that suggest that only some SLTs aim to change parents' ability to assess their child. This indicates a contradiction between aiming to change parents' understanding of speech and language difficulties and not helping parents assess their child. A proportion of SLTs did not see their role as helping parents learn to assess, as well as understand, speech and language difficulties.

(v)   SLTs' conception of role as treat and plan activities and advise/coach

The qualitative data suggested SLTs had three conceptions of the intervener roles, but the analysis of correlations in phase two indicated that two conceptions of roles are more probable: 'treat and

plan activities' and 'advise and coach'. The latter role implies a teaching role, although SLTs in phase one rarely referred to teaching as part of their role.

(vi)   SLT involvement of parents

The association between the broad roles of assessor, intervener and negotiator suggested that SLTs who were 'high involvers' of parents in one role would have the same approach in their other roles. This suggests a distinction between SLTs with a conception of role that involves parents more fully, in an approach that 'shares knowledge' and those that perceive themselves providing treatment and activities for parents to implement whilst retaining the specialist knowledge.

(vii)   Language to explain models of practice

The free text responses on the questionnaire raised the issue confusing terminology and definitions of models of practice and approaches in SLT. This indicates that SLTs may not have a clear frame of reference to articulate practice with pre-school children and their parents. The use of terms such as consultative and direct therapy seems to be used to convey different types of provision (Law et al., 2002). A better understanding of roles and expectations could begin to enable a clearer formulation of practice.

Chapter Seven

7. Discussion of parents' and SLTs' conceptions of roles

7.1 Introduction

This discussion considers the findings from phase one and two of the study, with reference to current evidence, policy and theory. Findings from phase one (qualitative study) and phase two (quantitative study), involving different participants, have been synthesized and are considered together. Sections 7.2 and 7.3 consider parents' and SLTs' conceptions of roles during speech and language therapy intervention and Section 7.4 relates the findings to models of partnership practice. The conclusion in Chapter Eight presents a summary of the research, implications for practice, limitations of the research, options for future research and personal reflections on the research findings and process.

This study explored parent and SLT conceptions of their own and each other's roles during speech and language therapy intervention by addressing four research questions:

1. What is the range of parents' and SLTs' conceptions of their own and each other's roles during speech and language therapy intervention for children with primary speech and language needs?

2. In what ways and to what extent do parents' conceptions of roles change whilst working with SLTs and how is this associated with partnership practice?

3. What is the relationship between SLT and parent conceptions of roles during intervention?

4. In what ways and to what extent do SLTs promote conceptual change for the parents they work with during speech and language therapy intervention?

The qualitative study, in phase one of the research explored parents' and SLTs' conceptions using participants' own words. The quantitative study, in phase two, built on the qualitative evidence by surveying parents and SLTs at one point in time in order to examine the findings from phase one with a larger sample.

The research has made a distinction between roles (see Section 2.4) and conception of roles. In considering the findings it is useful to be reminded that this research did not observe and report parents' or SLTs' *behaviour* (their roles) during speech and language therapy intervention, but gathered evidence of their *conceptions* of their roles. Understanding the nature of these conceptions is important in order to interpret the behaviour of individuals and encourage behaviour that is consistent with greater involvement of parents and SLTs in partnership practice.

7.2 Parents' conception of roles

This section presents six key findings from this mixed methods study of parents' conceptions of their roles in relation to previous research and recent policy. Five findings relate to the range of conceptions of roles (RQ1, RQ3 and RQ4):

(i)   Parents expressed different conceptions of their role as advocates on behalf of their children

(ii)   Parents expressed three different conceptions of their role as interveners for supporting their child's speech and language development

(iii)   Parents have a conception of their role as learners in the adaptor role

(iv)   Parents want advice from someone they regard as an expert

(v)   Parents make judgments about the seriousness of their child's language learning difficulties

Finally, one finding reports on changes in conception of role (RQ2 and RQ4):

(vi)   Over half the parents changed their conception of their roles during intervention.

These key findings are discussed in detail below.

7.2.1   Parents expressed different conceptions of their role as advocates

All the parents interviewed in this study talked clearly about their conception of their advocacy role, seeking advice and support for their child. They expressed their advocacy as a consequence of making a judgment that their child's language development was not progressing as well as they expected. However, they were not a homogeneous group and expressed variation in the persistence with which they sought help for their child. Their views fitted into three subgroups: responding to the concern of others, raising concerns themselves and actively pursuing and judging the value of advice. These distinctions were supported by the findings of the questionnaire in phase two. Only a small number of parents (nine out of fifty) indicated that they were responding to the concern of others, suggesting that the majority perceived their role as raising concern or pursuing and judging advice (see Section 6.3).

Those studies that have examined parents' advocacy (e.g. Glogowska and Campbell, 2000; Lindsay & Dockrell 2004) have reported contrasting findings of parents' advocacy, but present evidence suggesting that all parents think the same way about their advocacy role. Lindsay & Dockrell (2004) reported that parents believed they (i) were the first to identify that their children needed support with their language; (ii) sought professional help; (iii) pursued professional help when they thought this was slow in arriving and (iv) petitioned for the child to receive special education. This description aligns closely with the conception of pursuing advice in the study reported in this thesis. Glogowska and Campbell (2000, p.398) reported that parents adopted a very different role, described as a passive role at referral, without 'actively involving themselves in decisions about what would happen'. One reason for the differences between the portrayal of parents' beliefs may

be that these studies sampled different groups of parents: the children in Lindsay and Dockrell's study were older with established language needs, whilst those in Glogowska and Campbell's study were pre-school and therefore at an earlier stage in intervention. The study reported in this thesis reports the findings from parents in the early stages of speech and language therapy.

At least some of the differences between the previous studies seem to arise in the way in which the evidence is reported in these studies suggesting that all parents think and behave in a similar way, which was not the case in this study reported here. For example, Lindsay & Dockrell (2004, p. 230) state 'parents reported that they played a key role in identification and that this had often been a frustrating process. Almost half (47%) reported that they had been the first to identify a problem'. This statement begins by commenting on parents' behaviour as a homogeneous group and then tells us that half of the parents did not report this behaviour.

Glowgoska and Campbell (2004) referred to parents monitoring their children's language development, an action that is also part of an advocacy role and formed part of both conceptions of raising concern and pursuing and judging advice in this study. However, the authors' interpretation that parents are undertaking the role of the health worker carries the implication that parents do not have a role in monitoring their child's progress. They state (p.271) that parents, 'act as informal agents of surveillance of their children's development before professional advice is sought. They also illustrate how parents, in monitoring development and alerting healthcare services to difficulties, undertake the *role of health worker'.* Their evidence does not indicate that parents themselves perceived that they were adopting a role of informal 'health worker', an interpretation that potentially diminishes the parents' role in monitoring.

Does it matter whether parents have different conception of their advocacy role? The findings of this study suggested that parents who see their advocacy role as pursuing and judging advice were more likely to be actively involved in intervention as collaborative interveners or adaptors. In order

to implement policy that encourages parents participation (for example, Davis and Meltzer, 2007; Afasic, 2010; Department for Education 2014) early years practitioners may need to encourage parents to adopt advocacy roles of pursing and judging support.

7.2.2 Parents expressed different conceptions of their role as interveners

Three different conceptions of the intervener role were expressed by parents in phase one, as described in Section 4.3: (i) *attender*, characterised by attending appointments; (ii) *implementer*, characterised by doing activities/helping and (iii) *adaptor,* characterised by adapting approaches to supporting their child. There was marked variation in the conceptions that parents articulated and the evidence from this phase suggested that these conceptions were open to change. This was evident from the longitudinal data, where some parents expressed that their conception of their role in supporting their child had changed, from conceiving their role as attender to becoming one of implementer. Findings from phase two initially indicated there were, in fact, four conceptions of roles, with the implementer role consisting of two categories reflecting the level of involvement and independence in supporting their child: *dependent implementer* and *collaborative implementer*. However, the strong association between the collaborative implementer and adaptor role suggested that this was likely to be a single category of collaborative implementer/adaptor (see Section 6.3.2).

The responses of parents in both phases clearly indicated differences in their conception of the intervener role that were characterised by different degrees of involvement, although initially this did not seem firmly formulated. The *attender* conception of the intervener role suggested that some parents expected the SLT to 'do' the intervention. The *dependent implementer* was characterized by parents assuming they would be directed, undertaking activities as suggested by the SLT, but with little contribution to the design of activities or adaption for their own context. The *collaborative*

implementer and adaptor was expressed as an expectation of learning how to help and being shown new ways to support their child.

The current findings contrast with previous studies (Baxendale, 2001; Band et al., 2002; Carroll, 2010; Ruggero et al., 2012) which suggest that parents may have one or two conceptions of the intervener role. Baxendale (2001) and Carroll (2010) reported that parents did not anticipate 'doing' the intervention and believed that therapy involved the SLT providing one-to-one intervention. This could be viewed as a conception of role as attender only. Ruggero et al. (2012) confirm this proposition, reporting that only 4% of parents indicated that they had a preference for parent training or a home programme. Glogowska and Campbell (2000) and Band et al. (2002) showed that some parents expected to have a role in intervention, continuing tasks at home or following advice, in keeping with a role conception of dependent implementer identified in this study. Importantly, Glogowska and Campbell (2000, p.402) note that 'even where they (parents) became involved in their child's therapy, this did not lessen, in their eyes, the need for the therapists to be involved', suggesting that the intervener role required ongoing support from the SLT.

Current policy may give a mixed message to parents concerning their role as intervener. Many initiatives encourage parents to participate in their child's learning (for example Allen, 2011) whilst developments in special education (Department for Education, 2014) encourages parents to be decision-makers, including taking responsibility for personal budgets, but make little reference to parents as co-workers. If SLTs are to provide intervention that influences children's language learning beyond designated intervention sessions, then encouraging parents to assume a role of collaborative implementer/ adaptor could be an important step in the parent-SLT partnership.

7.2.3　Parents have a conception of their role as learners

The distinction between different implementer roles may be useful in enabling SLTs to foster greater parental involvement.　An approach that focuses on parents as attenders or expecting parents to 'do' as suggested, following advice that is 'dispensed', may be less productive than assigning time to encouraging parents to understand as well as implement activities (see Section 4.3.3 and 4.4.2).

Those parents in phase one who had adopted the adaptor role referred to a range of features that were associated with greater involvement. They mentioned changes in their own understanding of language development, reflecting on their approach to parenting before and after advice, recognising their child's progress and gaining confidence in providing support. This suggested there were positive outcomes for those parents showing greater involvement. This raises an important question of how SLTs can help parents develop their conception of roles, prompting deeper understanding and greater confidence in implementing recommendations creatively in day-to-day activities. In order to answer this question, the evidence is discussed in relation to parent learning.

Parents in phase one expressed several conceptions that indicated a desire to learn: (i) a desire to have activities to *do* (ii) an expectation that they would be *learning how to help* and (iii) an expectation of instigating changes in interaction and communication with their child. Reviewing this alongside their comments about their lack of experience and training highlights the importance that parents placed on *learning* as part of their involvement in intervention. This readiness to learn was a characteristic of the implementer and adaptor role identified in phase one and was confirmed in the data from phase two: 65% expressed that they were attending speech and language therapy to *learn how to help* their child and 75% were seeking tips and ideas *to help* their child. Recognising parents as learners may be an important element in involving parents in intervention.

Previous studies (Baxendale, 2001; Kaiser and Hancock, 2003; Bowen and Cupples, 2004; Gibbard et al., 2004) refer to the importance of professionals teaching parents new skills in supporting language learning (see Section 2.4.5). Kaiser and Hancock (2003, p.12) asserted that 'all parents can learn new and effective strategies for supporting their child's development'. This is then qualified, although they do not quote any empirical evidence, with 'not every parent is ready or willing to learn new strategies at a particular point in time'. Their guidance for teaching parents focuses on supporting behavioural change, suggesting that parents' conceptions of their roles are not important in encouraging participation in the programmes.

The findings from this study provided a different perspective from previous literature. Many parents attending speech and language therapy expressed a conception of their role as a learner and were open to change, suggesting that part of intervention should involve helping parents to formulate their uncertain conception of a learner more clearly. The findings illustrated how marked changes took place in some parents' conception of role. Possible trajectories of change were proposed, based on the changes described by parents. One trajectory was characterised by substantial changes in understanding and behaviour. These parents articulated doing different things with their child, but also doing things differently, which they referred to as a changed approach to their parenting. This was accompanied by comments about reflecting on what they did and how they did it, as a 'reflective parent' (sees Section 5.3.3).

Previous studies (Harris and Goodall, 2008; Melhuish et al., 2008; Goodall et al., 2011; Goodall, 2013) have found that parents' attitudes to their children's learning is a critical factor in school involvement (see Section 2.3). Parents' engagement with their children's learning was associated with parenting practices that were interactive and responsive, whilst also setting boundaries and balancing expectations with warmth. Nevertheless, Goodall (2013, p.135) contests that the concept of parental engagement may need clarifying, differentiating between 'engagement with learning

and engagement with the school'. He argues that there has been a tendency to confuse the two in educational research. Could a similar observation be made in speech and language therapy, where engagement in attending (parents' adopt an attender conception of the intervener role) is confused with engagement in children's learning (parents adopt an adaptor conception of the intervener role)? Given that parent education and changing parents' skills is a routine intervention in speech and language therapy in England (Roulstone et al., 2012) in pre-school practice, it is surprising that so few studies evaluating parent programmes consider the learner role, despite being implicit in any education model. This is exemplified in Kaiser and Hancock's (2003) study that outlines the skills that parent educators need whilst making little reference to the characteristics of parents as learners.

The findings of this study add to knowledge relating to parents as learners and provide a unique insight into parents' conception of their roles as learners during intervention. Some parents spoke of learning as transformative, articulated as thinking differently and approaching parenting more positively. Considering these changes through the theoretical framework of conceptual change provides a platform for understanding, and importantly articulating, the process of learning that takes place during intervention. Conceptual change aims to encourage a deep and lasting understanding for the learner (Vosniadou, 2007) based on restructuring learners' existing concepts or misperceptions. Some parents in this study, attending speech and language therapy, had vague notions of their intervener role at the outset, which could be construed as equivalent to a misperception of roles, in the terms of conceptual change theory (Vosniadou, 2013). The expectation that only the SLT will provide the intervention is an example of a misperception. In this instance, applying the theory to speech and language therapy practice would suggest that the role of the SLT is to facilitate the reconstruction of these expectations and conceptions through 'systematic instruction' encouraging parents as learners to build knowledge for themselves. Miyake (2013) uses the term 'collaborative conceptual change' which involves collaborative reflection

between the learner and the teacher, with roles between the 'doer' and 'monitor' swapped during learning activities, similar to the process of demonstration and observation described by some SLTs in this study. It is reasonable to propose that some parents experienced conceptual change as learners during speech and language intervention in this study (see Section 5.3.3).

7.2.4   Parents want advice from someone they regard as an expert

The words of parents in phase one of this study firmly suggest that, in the role of advocates, some parents are seeking specialist advice from professionals that they felt able to trust as experts with specific knowledge and experience of speech and language development. The parents who expressed a desire for expert advice and readiness to help their child, also referred to judging the quality of advice, aiming to learn new skills and expressing recognition of their responsibilities to provide support. Parents' desire for expert advice, on the one hand, and readiness to help their child, on the other, was also evident in the parents' responses in phase two. This suggests that seeking expert advice was not necessarily associated with dependence on the professional, a position argued by a number of previous studies (Coulter, 1999; Charles et al., 1999). The majority of parents (67%) expected SLTs to *show them how to help* their child suggesting that dependency on the expert was not a characteristic of parents in this sample. A proportion of parents in this study were therefore seeking expert advice *and* anticipating that they would have a role of responsibility, albeit expressing uncertainty about the nature of the role.

Earlier studies on parent and professional expertise (see Section 2.3.3) suggest that (i) people who conceive of professionals as the expert are likely to operate in a dependency relationship with the professional; (ii) parents' own expertise is not acknowledged by professionals who operate in an unequal partnership and (iii) asymmetric information advantages the professional. Parents in this study made few references to their own expertise as parents, contrasting noticeably with many references to their lack of expertise and knowledge about child development and language learning.

292

The words of parents in this study expressed greater variation than reported in previous literature. Some of them described actively seeking expert advice without reducing their expectations of taking responsibility for supporting their own child. Indeed, in line with Marshall et al (2007), the process of seeking expert advice is seen as a means of gaining knowledge and understanding, in order to help them begin a process of problem solving. They were seeking expertise, but this did not necessarily diminish their sense of responsibility or expectation of working jointly with the SLT. This challenges the assumption by Turnbull et al. (2003) that the role of the professional as expert and parent as learner may be disempowering for parents or perceived by parents as detracting from their role of responsibility for supporting their child. Asymmetric information during a consultation has been thought to advantage the professional as agent in principal-agent theory (Stiglitz, 1988; Vick and Scott, 1998). This issue of asymmetric information, where SLTs had the knowledge that parents needed, was not expressed as a disadvantage by parents in this study. The results of this study challenge the notion that asymmetric information is problematic for parents accessing speech and language therapy during pre-school intervention. Nevertheless, the results do raise a question about the way SLTs respond to parents in providing expert advice that promotes learning and enhances parents' confidence in supporting their child.

Previous researchers have argued that the 'professional as expert' approach fails to acknowledge the expertise of the service user (Charles et al., 1999; Coulter, 1999; Case, 2000; Turnbull et al., 2000; Davis and Meltzer, 2007). Turnbull et al. (2000) go as far as to argue that parents are engaged in a battle, using phrases such as 'battle lines' and 'power relations' that convey the professional as defending their expertise: 'Criticism of their professional role challenged the traditional power relations between the 'expert' professional and the 'amateur' parent.' (Turnbull et al., 2000, p.557). Their conclusions were drawn from a small group of parents of children with long-term disabilities and therefore may not apply to parents seeking help for children at the early stages of language learning difficulties. Davis and Meltzer (2007) describe parents as looking for experts to solve their

problems *for them,* though the authors do not present any evidence to justify these conclusions. Evidence from two studies in speech and language therapy (Baxendale, 2001; Carroll, 2010;) suggested that parents regarded the SLT as the expert and expected clinicians to lead intervention, although neither explored parents' sense of dependency on the professional. Marshall et al (2007, p.459) described parents of children with language delay as perceiving the role of the SLT as 'passing on the skills in which they are perceived to be experts'. This suggests that parents, who are described by the authors as regarding themselves as 'experts on their children' (p. 551), are also actively seeking expert advice in order to gain skills themselves.

7.2.5   Parents vary in the confidence of their own judgments about the seriousness of their child's language learning difficulties

A parent acting in an advocacy role presupposes that they make judgments about their child's language development and the need for advice, even if they are undecided about the seriousness of their child's difficulties. All parents in phase one reported that they monitored their child's language, but they responded in different ways to their uncertainty about their judgements.

The following characteristics were evident in the data from phase one:

(i)   many parents reported judging their child's language, based on comparison with other children in their family or wider social network

(ii)   some parents questioned whether their child's language development was indicative of problems in other areas of development, questioning whether their child was 'normal' (parents' words)

(iii)   other parents articulated that they were seeking support to judge the seriousness of the problem

294

(iv) some parents reported that they judged the quality of advice regarding their child's speech and language development, distinguishing between advice from a trusted source and other sources, such as the internet or other professionals, such as teachers or health visitors

Many parents expressed several of these characteristics in their advocacy role. A number of parents in phase one referred specifically to their concern about the relationship between their child's language difficulties and their child's behaviour. However, there was a relatively small association between parents' concern about speech and language development and behaviour in phase two, suggesting that anxiety about behaviour was not a major trigger for parents in seeking help in the pre-school years. This is an interesting discrepancy that may relate to parents' perception of behaviour difficulties, but this is outside a discussion on conception of roles.

The evidence from phase two showed that more than two thirds of parents made a judgment about the seriousness of their child's difficulties, with the greater proportion regarding it as serious or very serious. However, a proportion of parents (28%) were uncertain about the seriousness of their child's difficulties, but they did not assume a passive waiting role. These parents had sought advice, suggesting a conception of their role as advocates in monitoring their child's language learning and seeking advice, they judged to be reliable. One interpretation of the findings is that parents pursue advice they believe is trustworthy to help them make more accurate judgments of the seriousness of their child's difficulties. A previous study (Glogowska and Campbell, 2004) suggested that parents experience a period of uncertainty before seeking help, implying that parents were actively evaluating the seriousness of their child's language development.

Very few studies have considered parents' roles in judging the seriousness of their child's language difficulties and little is known about the benchmarks that parents use. This study did not provide any evidence about the accuracy of parents' judgements. Previous studies cast doubt on whether

all parents have the ability to monitor their child's language development accurately (Feldman et al., 2005; Law and Roy 2008; Sachse, 2008), with variation related to SES and ethnicity. Previous findings are inconsistent regarding the nature of this inaccuracy, with examples of under and over-reporting from different populations, but there is little evidence of clear patterns distinguishing different groups of parents. The results of this study indicate that parents themselves may be uncertain about judging their child's speech and language development. In this situation, it appears that parents adopting a conception of role as advocate are seeking confirmation of their judgements.

Very few studies have investigated whether SLTs utilise parents' judgment as part of the assessment process. Crais (2011) refers to parent-completed observations contributing to initial assessment but she found that few parents were offered this option. Even where intervention encourages parents to be evaluators through self-rating scales and video feedback (Bowen and Cupples, 2004; Allen and Marshall, 2011), little reference is made to encouraging parents to evaluate their child's skills, rather than their own. The results from the SLT participants in this study indicate that parents are involved in the assessment process by many SLTs though parents did not refer to this as part of their conception of their advocacy role.

7.2.6 Over half the parents changed their conception of their roles during intervention

All the parents participating in phase one and two had accepted a referral to, or chosen to seek advice from, an SLT. Their 'involvement' in intervention signalled a degree of motivation to address their concerns. This suggests that these parents were actively seeking change of some sort, whether responding to the concern of another or a vaguely framed anxiety or reacting to a clearly formulated expectation. Most of the parents expressed that they were seeking:

(i)   changes in their child's speech and language, which may or may not involve changes in parents' role conception

296

(ii)   changes in their own approach to supporting their child, which is likely to involve changes in role conception

(iii)   changes in their confidence in supporting their child, which may also involve changes in role conception

The results of the longitudinal study indicated that parents varied in the extent to which they changed during intervention. One way of interpreting the findings is to consider different trajectories of change (See Chapter Five). Analysing the words of these parents at different points in time provided a picture of some parents experiencing substantial changes in their conception of role before and after intervention. However, it was not possible to say anything about the nature of the changes taking place in terms of whether they were continuous, as in a continuum, or categorical, as in a step change. Parents in the adapted intervener trajectory (trajectory 3 in Section 5.3.3) articulated changes in their understanding of their child, and their approach to supporting their child at home, with few references to doing activities only. These parents described this as an important transformation that signalled changes in both understanding their child's difficulties and in understanding their own approach to supporting their child.

There was evidence that parents' conception of role was open to change and in transition. Changes in conception were progressing towards a role with greater involvement, that of collaborative implementer, suggesting that a 'hybrid' conception, in conceptual change terms, may have existed. Previous research (Roulstone et al., 2012) reported that parents aspire to enable their child's communication to improve, but few studies have investigated any changes parents might be seeking for themselves. The findings from this study suggested that parents are ready to learn and express some degree of readiness to change. A proportion of parents participated in speech and language therapy in order to learn 'tips and techniques' to help their child, whilst others expressed a willingness to change their interaction, signifying a readiness for a more profound change in their

approach. This can be interpreted through the framework of conceptual change theory suggesting that parents have experienced learning that has involved substantial revisions of previous knowledge and may have generated a 'deep, more difficult to accomplish learning' (diSessa, 1998, p.1156).

It is interesting to note that many parents in phase one articulated low confidence in their own role of supporting their child's speech and language development. This was expressed as a sense of inexperience and lack of confidence in supporting language learning, whilst also indicating a readiness to change at the same time. However, this was not necessarily associated with expectations that the professional should assume responsibility for support. The majority of parents in phase two reported that SLTs made them feel confident in helping their child's language learning (92%) which suggests that there may be an association between self-efficacy, capability and working with SLTs. This is consistent with a number of previous studies (Hoover-Dempsey, 1997; Hess et al., 2004; DesJardin et al., 2006; Anderson and Minke, 2007) although the literature shows considerable variation in the relationship between parents' self-efficacy and capability. There are few studies that have specifically investigated self-efficacy in parents of children with language difficulties, but findings from this study relating to parents' desire for information, knowledge and confidence accord with Bandura's (2006) assertion that specific knowledge *and* confidence work together in building self-efficacy (see Section 2.4.4). Accordingly, it can be hypothesized that parents of children with language learning needs require knowledge about language development and how to encourage speech and language skills, as well as feeling confident as an intervener. This reiterates the importance of promoting parents' understanding of their child's difficulties as well as providing information and offering emotional support to build confidence.

7.3   SLTs' conception of roles

SLTs described their roles in relation to both working with children with language needs and with their parents. This section discusses three key findings of SLTs' conception of role in relation to previous research and recent policy: (i) SLTs expressed three different conceptions of roles as interveners; (ii) SLTs adopt a negotiator role in co-working partnerships; (iii) SLTs have an implicit conception of their role as teachers.

7.3.1   SLTs expressed three different conceptions of roles as interveners

Evidence in this study initially indicated that SLTs had three conceptions of the intervener role:

(i)   treating the child, which was SLT led with little participation from the parent

(ii)   planning activities for parents to do

(iii)   advising and coaching parents to support their child's language learning

They frequently referred to roles (ii) and (iii) when describing their own approach to intervention, with few references to the 'treat' role. They referred to planning activities in terms of written plans, advice sheets and resources for parents, and to coaching, in terms of explanation, discussion and demonstration, with the assumption that parents would become interveners. The presence of these two conceptions of roles was confirmed in phase two, which showed that almost all SLTs reported that they anticipated providing activities or advising parents, in enabling them to work with their child on speech and language *at home*. Previous research, referring to the use of home activities by SLTs (Bowen and Cupples, 2004; Watts Pappas et al., 2008) also indicates that this is an important element of intervention. In the case of practitioners in Australia, the majority of SLTs provided homework for children with speech impairment and expressed beliefs that parental involvement was essential for effective intervention (Watts Pappas et al., 2008). The effectiveness of planning

activities and providing home activities has yet to be demonstrated fully (Bowen and Cupples, 2004).

The analysis of correlations in phase two indicated that there were, in fact, two conceptions of the intervener role (see Section 6.4.2). First, treating the child and planning activities for parents to do as one conception of role, and second, advising and coaching as a second conception. The correlation analysis showed a clear distinction between the planning role and the advisor/coach role.

Many SLTs referred to the advisor/coach role as a valuable approach to intervention. They expressed the importance of bringing parents 'on board' and 'giving them the tools' to support their children independently and helping them 'change their thinking.' SLTs' perception of whether advice and coaching was considered as direct or indirect intervention was not explored in this study, but Pring et al. (2009, p.696) conclude that 'A typical clinician spends less than one-quarter of their time giving direct therapy and more than one-quarter *training parents* and other professionals'. It is difficult to identify how these authors reached this conclusion, given that 'consultation' appears to be the term used in the questionnaire, without reference to training (see Section 2.4.8). Evidence from the parents' perspective (Band et al., 2002) suggests that they may appreciate working with practitioners in an advisor/coach role, given the enhanced level of support for parents to become intervenrers. This typifies the debate in the profession relating to training parents that may be regarded as part of the advisor/coach conception of role.

SLTs' conception of their role as advisor/coach in this study is consistent with the behaviour and beliefs of SLTs reported in a recent survey (Roulstone et al., 2012). Nearly half the SLTs questioned in the survey believed that parents were the main intervener for 4-5 year olds and that developing parent skill was a principal activity in intervention, indicating that advice and coaching were regarded as a regular and important component of therapy.

7.3.2 SLTs adopt a negotiator role in co-working with parents

In phase one, the majority of SLTs referred to a conception of role as negotiator with parents, although there was variation in how they described this and the extent to which parents were involved in decision-making. The findings from this study indicated that many SLTs considered that a professional approach to partnership included:

(i)   clear explanations of the assessment, goal setting and intervention, involving negotiation

(ii)   SLT making recommendations about most appropriate intervention

This was described by some SLTs as a delicate balance between making recommendations and handing responsibility to parents in a process of 'supported decision-making.' However, their words conveyed a firm direction of influence, from the SLT to the parents, with the use of phrases such as 'handing over' and getting parents 'on board'. The extent to which this approach to working with parents was based on knowledge shared between SLTs and parents was difficult to ascertain from the SLTs' words. An association between the SLTs' conception of their roles as assessor, intervener and negotiator suggested a distinction between those who had a conception of role that involved parents more fully across all aspects of intervention, and those who perceived themselves as retaining specialist knowledge and providing treatment and activities for parents to implement (see Section 6.4.2).

Some SLTs in phase one emphasised the importance of explaining their own responsibilities and expectations of parents, setting boundaries and offering clear options for intervention. The responses in phase two showed an association between the conception of role of advising and coaching, and the conception of negotiating responsibilities, suggesting that negotiation was closely related to involving parents more closely in intervention. Similarly, there was an association between building parents' capacity to assess their child's language and approaches that encouraged

greater involvement of parents. One interpretation is that some SLTs adopt a conception of role that consistently includes parents in supporting their child throughout their involvement in SLT.

Previous literature (Glogowska and Campbell, 2000; Watts Pappas et al., 2008; Carroll, 2010) provides a picture of SLTs leading decision-making and not necessarily negotiating clearly with parents. However, very few studies directly investigate negotiation between parents and SLTs, although several conclude that shared decision-making and explanation is limited (Glogowska and Campbell, 2000; Carroll, 2010). Carroll (2010, p.358) commented that 'collaborative decision-making did not occur' with 'service providers' failing to take into account parents' feelings, in this case, about participating in group therapy. Watts Pappas et al. (2008) noted that SLTs varied in the extent that parents were involved in goal setting and intervention. The authors concluded that relatively few SLTs, in an Australian context, provided options regarding the format of service delivery; the findings from phase one signalled that the situation in England may also show a wide variation in the extent that SLTs involve parents in negotiation and provide flexible options for intervention.

7.3.3   SLTs have implicit conceptions of their role as teachers

Three notable features were identified from the evidence:

(i)   SLTs did not appear to have an explicit conception of their role as teacher

(ii)   little reference was made to parents as learners suggesting that SLTs did not have an explicit conception of parents' roles as learners

(iii)   only some SLTs included teaching parents to assess their child's language skills as part of the advisor/coach role

What do these findings tell us about the role of advising and coaching in speech and language therapy?

In phase one, SLTs used a range of terms (verbs and phrases) to convey their sense of role in relation to supporting parents (for example, facilitating, demonstrating, modelling, 'giving them tools'). Many of these terms expressed a role of showing parents what to do, but relatively few mentioned changing parents' understanding. Changing understanding tended to be referred to obliquely with words and phrases such as helping parents 'take on board' advice or 'embedding information'. In the phase two, all the SLTs reported that they were aiming to change parents' understanding of their children's speech and language difficulties. Is this an example of differences between the findings from different samples or is there another explanation for the contrasting findings?

Four possible explanations are proposed, relating to differences in the method of data collection or norms of professional practice:

(ii)   SLTs may not have fully revealed the way they were thinking in the interviews

(iii)   SLTs have norms for the way they talk about working with parents which do not encourage them to talk of teaching or changing the way parents think

(iv)   SLTs may have responded according to social desirability bias in the questionnaire, assuming that they should answer positively to the question about changing parents' understanding

(v)   The format of the question in the questionnaire did not allow any distinction between the way SLTs aim to change parents' understanding.

How much of typical intervention involves changing parents' understanding and is this the purpose of parent education programmes in speech and language therapy? SLTs' description of intervention in phase one frequently used words such as coaching and demonstrating, as well as assigning activities for homework, but they tended to focus on behavioural outcomes such as completing

prescribed activities, rather than referring to building parents' understanding of speech and language needs. This is consistent with the literature on SLT intervention (Bowen and Cupples, 2004; Fourie et al., 2011). SLTs in phase one of this study described a coaching role that aimed to help parents learn to adapt their own intervention in response to showing and/or explanation from the SLT. There is likely to be an important distinction between parent education that encourages parents' understanding *and* promotes changes in their behaviour, and intervention that simply provides example behaviours for parents to use.

SLTs' limited reference to teaching in phase one may indicate that SLTs have yet to frame their education role clearly, with unambiguous conceptions of learner and teacher roles. Alternatively, this could be interpreted as another example of a mismatch between perception and practice, as found in Watts Pappas et al.'s study (2008) of SLTs' practice and beliefs about family centred care. The 'teaching role' remains largely implicit in many previous studies (Girolametto et al., 2002; Moore et al., 2014) although the description of the activities that SLT use (such as, instruction about strategies, discussion, modelling, reflection and performance based feedback) could be construed as techniques that encourage learners to create meaning, as in constructivist learning theory (Biggs, 1996).

Very few studies have explored how SLTs teach parents, in contrast to the teaching of education staff as part of a consultative model of practice (Law et al., 2002; Law et al., 2003; Boyle et al., 2009). These findings raise questions about why SLTs do not explicitly refer to changing parents' understanding through teaching. A more explicit discussion of changing parents' conceptions of roles during intervention could foster a deeper engagement with parents as learners in all therapy contexts. If parent training is regarded as important by SLTs (Carroll, 2010), then understanding conceptions of the intervener role, as well as focusing on what parents do (the tasks) in intervention could contribute to a more meaningful partnership between parents and SLTs. The

profession may need to develop a professional discourse to encourage a more open discussion of teaching within the intervener role.

7.4   Models of practice

This section reviews the findings of parent and SLT conception of roles in relation to the literature of models of partnership practice. Three key findings are presented: (i) there is symmetry between SLT and parent role conception; (ii) SLTs do not have a model of shared decision-making but have conceptions of role as negotiator; (iii) SLTs promote high involvement of parents in partnership practice.

7.4.1   There is symmetry between SLT and parent role conceptions

SLT and parent role conceptions appeared to be related in two ways. First, each conception that an SLT or a parent expressed about their own role was associated with a role played by the other (parent or SLT) (Table 7-1). For example when an SLT spoke about their role in intervention as X they also spoke about the parent acting as Y. For example, many SLTs referred to setting expectations with parents and negotiating the roles that each would be adopting, whilst several specifically referred to adapting their role in response to parents' circumstances, acknowledging that some parents could not assume an intervention role. This symmetry is summarised in Table 7-1.

Table 7-1: Possible alignment between parent and SLT conceptions of role

Parents' conception of roles
1A Parent attends appointments
1B SLT does intervention
2A Parent helps/does activities
2B SLT plans activities
3A Parents adapt parenting approach and activities/learning
3B SLT shows how to adapt/teaches

SLTs' conception of roles
1A SLT treats child
1B Parents are attenders
2A SLT plans goals and activities
2B Parents is helper
3A SLT advises/coaches
3B Parent adapts/learns

Second, each pair of conceptions (e.g. 1A and 1B in a parental conception of roles) was similar to a pair of SLT conceptions (1A and 1B) signalling how conceptions of one's own role are linked to conception of the other in the parent-SLT relationship. However, the research design in this study did not allow an investigation of whether there was symmetry between the conceptions of a particular parent and a particular SLT who were working together. Bowen (2004, p.257) has suggested that when SLTs encourage parents to change their view of their role when implementing SLT-designed activities in the home, 'engaging in homework activities away from the therapist's supervision gives space for (and empowers) parents and significant others to engage in independent experimentation with, and development of, the tasks presented'. However, other research (Marshall et al., 2007; Watts Pappas et al., 2008,) has suggested that there is no automatic alignment between the roles adopted by a parent and an SLT who are working together.

Previous literature has suggested that SLTs rather than parents have reduced the strength of their partnership in supporting children's language. Marshall et al (2007, p. 552) reported that SLTs did not build on parents' existing skills and beliefs, 'Parents describe views and behaviours which have implications for successful intervention but which are not explicitly acknowledged by the SLTs.

These include strategies used by parents in advance of seeing a SLT and their varied expectations of SLT assessment and roles'.

The relationship between the evidence from this study and previous research may be interpreted in different ways. One possibility is that whilst SLTs believe they are encouraging parents to take on a more active role in their partnership, their practice works in the opposite direction. Another possibility is that there is substantial variation between therapists. Some may encourage parents to take more responsibility in the partnership whilst others do not. The difference between the results of this study and the results reported by Marshall et al. (2007) may arise from the preponderance of SLTs with different views in the two studies, both with relatively small samples.

If parents are to be encouraged to adopt roles that are more fully involved in supporting their child, SLTs should consider assuming roles themselves that will encourage parents to assume a complementary role that entails greater involvement and participation.

Questions relating to how SLTs' conceptions of roles (their own and parents) may determine the conception of the role adopted by parents may have significant implications for the way SLTs approach their work with parents. How important is it for SLTs to have a conception of parents' roles and attempt to align their own and parents conceptions? Is it necessary for SLTs to support parents to formulate their conceptions more clearly in order to challenge misperceptions, in the terms of conceptual change theory?

7.4.2 SLTs use supportive decision-making with parents

Parents' roles in supporting their children with speech and language needs have been identified in this study as those of advocacy, intervener and taking responsibility. The majority perceived themselves as active advocates for their children, frequently negotiating a pathway that they described as confusing, daunting or discouraging in order to find specialist advice. The parents in the study took decisions to be involved in intervention through attending SLT and co-operating

with the process, often describing a readiness to learn how to help, and do activities with their children. Many referred to their own need for information, knowledge and understanding and the importance of accessing professional advice that included specialist knowledge and experience. Those parents, acting in an advocacy role, had already made the decision to seek advice, but rarely referred to themselves as decision-makers during involvement in speech and language therapy. In contrast, SLTs often used words such as 'I've decided' or 'we've decided'. Could this be part of the complementary roles that SLTs adopt, in supporting parents as decision-makers or does it indicate an SLT-led approach to decision-making that fails to take account of parents' capacity to make decisions? The majority of SLTs described decision-making as part of a responsive relationship with parents, as an interaction between providing clear explanations and advice, based on specialist knowledge and responding to parents concern. Some SLTs were explicit in describing a process of offering options and handing the responsibility back to parents (see Section 4.4.1). In this case, the negotiation was SLT-led, but the decision was considered to be jointly agreed. Relationship building, as well as negotiation, was frequently cited by SLTs as an essential element of intervention. Nevertheless, there was little reference to the relationship between the working alliance and sharing decision-making.

Few studies have considered the process of shared decision-making in speech and language therapy (Legare et al., 2010). This is by no means unique to the profession, such that there is a growing urgency to understand the features that promote greater participation of parents and practitioners in joint decision-making. Previous literature (Marshall et al., 2007; Watts Pappas et al., 2008) suggests that SLTs assume a therapist-led approach to decision-making, despite perceiving their practice as family focused in some instances. Existing studies from other disciplines (Charles et al. 1997; Edwards and Elwyn, 2006; Beresford and Sloper 2008; Corlett and Twycross, 2006) indicate that decision-making is a complex social interaction, requiring consensus through negotiation and a trusting relationship. Understanding the relationship between conceptions of

roles and approaches to decision-making could contribute to supporting parents to adopt proactive roles as interveners during intervention.

7.4.3   SLTs promote high involvement of parents in partnership practice

There are two separate findings from this study regarding levels of parental involvement: (i) some SLTs have a conception of role that includes 'high involvement' of parents in assessment, negotiation and intervention; (ii) some parents' conception of involvement changes over time during their participation in speech and language therapy. Whilst this study did not aim to investigate the relationship between changes in parents' and SLTs' conception of role, the two findings stimulate questions about the influence that each participant has within a partnership model.

The variation in SLTs' conception of their roles as assessor, intervener and negotiator conveyed different levels of expectation regarding parental involvement in their child's intervention. For example, the SLT intervener role consisted of three conceptions of role: a 'treat' role (the SLT provided the intervention with little parent involvement), 'plans activities' role (the SLT plans activities for parents to do) and the 'advice and coaching' role (the SLT enables parents to adapt and become interveners). The findings from phase two indicated that those SLTs who have a conception of a high level of involvement of parents in assessment and negotiation also had a high level of parental involvement in intervention. The association between these roles in phase two suggested a distinction between SLTs who had a conception of role that involved parents more fully across all aspects of intervention, and those that perceived themselves as retaining specialist knowledge and providing treatment and activities for parents to implement.

Existing studies (Hoover-Dempsey et al., 2005; Coyne and Cowley, 2007; Marshall et al., 2007; Lees et al., 2009; Goodall and Vorhaus, 2011; Hornby and Lafaele, 2011) have explored the relationship between parents and different professionals, considering the barriers and facilitators for parental

involvement. There is evidence that a positive approach by teachers that 'invites' parental involvement, is important in encouraging high involvement of parents (Hoover-Dempsey et al., 2005). The variation in professionals' readiness to involve parents seems to be associated with their preconceived ideas about parents' roles and assumptions that parents are not interested in being involved in their children's learning (Lees et al, 2009; Hornby and Lafaele, 2011). SLTs in this study did not explicitly express doubt about involving parents, and very few assumed a 'treat' role only, but the evidence indicates that only some SLTs are 'high involvers', which included intentions to change parents' ability to assess their child's speech and language, a feature that varied considerably.

Many parents in the study reported changes in their conceptions and behaviour. The majority of parents in phase two reported that they had changed the way they tried to help their child since working with the SLT. The results from the longitudinal study indicated that parents' conceptions changed during their involvement in SLT, following different patterns of change. The parents who expressed a trajectory of change characterised by greater involvement, 'adapted intervener', described substantial changes in their understanding of their role in supporting their child's language development. These parents' accounts did not suggest that they were anticipating being highly involved in intervention when they first sought advice, but described how they reflected on their own parenting approach and reached points where they realised they could lead the intervention and be responsible for supporting their child's language learning. This study extends the use of the model of conceptual change (diSessa, 1998; Limon and Mason, 2002; Sinatra, 2002; Vosniadou, 2007; Vosniadou, 2013) to the field of parents' conceptions and proposes that some parents undergo conceptual change during participation in speech and language therapy. The conceptual change model was originally developed through studies of the development of children and young people and has been used to investigate the development of teachers' thinking (for

example Patrick and Pintrich 2008). As far as I am aware, has not been used to analyse changes in parents' understanding of their roles.

The majority of SLTs in phase two reported that they were aiming to change parents' capacity to work with their child on speech and language skills. The relationship between SLTs' approach and parents' level of involvement was not investigated in this study, but these findings prompt questions about how SLTs encourage parents to change their conceptions of roles and adopt higher involvement whilst others are less enabling.

7.5   Summary

This chapter has reviewed the key results from the study in the light of previous evidence. They have been grouped in three sections: 7.2 parents' conceptions of roles, 7.3 SLT conceptions of roles and 7.4 models of practice. This study adds to knowledge by providing evidence relating to parent and SLT conceptions of roles, which has been collected using a mixed method longitudinal design. It has also employed a conceptual change framework to investigate parent and SLT conceptions of role that has not been used previously in speech and language therapy.

Chapter Eight

8. Conclusion

The conclusion is presented in five sections: (i) key findings from the research in relation to the four research questions; (ii) implications for speech and language therapy policy and practice; (iii) limitations of the research; (iv) a personal reflection of the how the research has influenced my own perspective and practice; (v) suggestions for future research.

Partnership practice with parents has become an imperative in children's services, supported by policy and research that acknowledges the essential role of parents in supporting children's learning. Parents of pre-school children with primary speech and language needs are frequently actively involved in speech and language therapy, but the nature of the involvement and the roles that parents adopt during intervention have been reported to vary from relatively passive participation through to full responsibility for delivering intervention. To date, few studies have considered parents' conception of roles and any variation in roles that parents adopt, or the relationship between their roles and those assumed by SLTs. Moreover, little is known about whether these roles change during intervention. The nature of both parents' and SLTs' roles may potentially change the quality of the partnership between parents and practitioners and therefore have implications for the success of intervention for children with primary speech and language needs.

This research investigated the conceptions of roles of parents and SLTs during speech and language therapy intervention using a mixed method research design. Sixty-seven parents and seventy-three SLTs participated in the study during two phases, providing the perspectives of a wide range of participants. The two-phase study focused on parents' and SLTs' conceptions of their roles,

expressed in their own words initially using qualitative methods, followed by questionnaires, using quantitative methods, to extend the early findings of parent and SLT conceptions. A subset of the parent participants in phase one took part in a longitudinal study, to track any changes in parents' conceptions during their involvement in intervention. At times, combining different research methods complicated the data collection, analysis and reporting, but added to understanding the phenomenon by extending and triangulating the findings.

There were several distinctive aspects to this study. First, the application of a framework from conceptual change theory added a unique perspective to the planning of the study and interpretation of the findings. To date, this theoretical perspective does not appear to have been applied to studies in speech and language therapy. Second, few studies have focused on both parents' and SLT conceptions of (i) their own role and (ii) the roles of their co-workers in the parent/SLT relationship. This study aimed to reveal what parents and SLTs *thought* about their roles, rather than their behaviour; (iii) there are no studies that have used a longitudinal design to track changes in the way parents' think of their roles during SLT intervention; (iv) the questionnaire represented a first attempt at evaluating parents' and SLTs' conceptions of roles using a self-rating measure of conception of role and, in the case of parents, self-efficacy.

8.1 Adding to knowledge: key findings

8.1.1 Research question 1

What is the range of parents' and SLTs' conceptions of their own and each other's roles during speech and language therapy intervention for children with primary speech and language needs?

An investigation of the conception of roles revealed three broad conceptions for both parents and SLTs, but within each conception there was considerable variation which reflected different

degrees of parent involvement, indicated by the arrows in Table 8-1. There were two key findings: (i) there was a range of parents' and SLTs' conception of roles that corresponded with different levels of parental involvement; (ii) there were indications of an alignment between parent and SLT conceptions of the roles of each other. Parents' conception of the advocacy role was clearly formulated, whilst their conception of the roles of intervener and taking responsibility were less clearly expressed; SLTs' articulated their roles with clarity, verbalising conceptions of assessor, intervener and negotiator.

Table 8-1: Summary of the range of parents' and SLTs' conceptions of roles from phase one and two (the arrows indicate increasing parental involvement)

Parents' conceptions of roles		SLT conceptions of roles
Taking responsibility • Expecting SLT to lead intervention • Implementing at home • Influencing intervention		Negotiator • Decision-making • Clear explanations of roles and responsibilities • Offers flexible options
Intervener • Attender • Dependent implementer • Collaborative implementer and adaptor		Therapy/ Intervener • Treat and plan • Advise and coach
Advocacy • Responding to the concern of others • Raising concern • Pursuing and judging advice		Assessor • Assessment by SLT only • Draws on parents' knowledge of their child • Draws on parents' knowledge of speech and language development

> **(i)** **There is a range of parents' and SLTs' conception of roles that correspond with different levels of parental involvement**

Parents and SLTs have conceptions of one another's roles that are also characterised by different levels of involvement Increasing level of involvements are indicated by the arrows in Table 8-1. Many parents in this study began their partnership with SLTs with a vague notion of their own

roles. They expressed a strong conception of their advocacy role in following up or raising concerns, but conveyed uncertainty about their own roles as interveners or taking responsibility. Moreover, they articulated uncertainty about their expectations of the SLT's role. One possible explanation for this may relate to many parents' references to their lack of knowledge of language development and experience of supporting their child with delayed language skills.

Parents articulated different degrees of involvement. The research findings indicated that a parent with a conception of high involvement in one role, such as advocacy, tended to have conceptions of high involvement in other areas, such as taking responsibility. Enabling parents to adopt conceptions of roles that include higher levels of involvement should have important implications for co-working and partnership.

SLTs had two clear conceptions of their role as intervener as 'treat and plan' and 'advise and coach'. This too was associated with low and high involvement of parents. The SLTs with conceptions consistent with high involvement share knowledge with parents and anticipate that parents will learn to intervene and adapt. Those SLTs with a conception consistent with low involvement of parents provide treatment and activities for parents to do. The advise and coach role encompasses an implicit assumption that parental learning is an essential element of therapy. Those SLTs who adopt a treat and plan role conception retain their specialist knowledge and express less intention to enable parents to learn how to support their child.

(ii)   There were indications of an alignment between parents' and SLTs' conceptions of the roles of each other

Identifying the range of roles has given a unique insight into the way both parents and SLTs think about their roles during intervention. Individuals within a partnership have conceptions of the roles they need to assume, whether clearly formulated or vaguely shaped (see Section 2.4.2). The evidence from this study showed that they also have expectations of the roles of the other during

speech and language therapy intervention (Table 8-2). As noted above, SLTs expressed clear conceptions of their own and parents' roles consistent with the professional identify they have developed through training and experience. Parents, on the other hand are in a very different position, with experience of roles within their own social context, but not in partnership with an SLT.

Table 8-2: Expectations of the role of other in parent-SLT partnership

Parents' conceptions of SLTs' role	SLTs' conceptions of parents' roles
Expecting SLTs to do the intervention	Expecting parents to attend
Expecting SLTs to plan activities	Expecting parents to help implement activities
Expecting SLT to teach-show how to adapt interaction and implement activities	Expecting parents to learn and adapt

Many SLTs take the initiative in helping parents understand the roles of each person in the partnership, allocating time in the initial appointment to discuss roles and responsibilities, and aiming to build parents' confidence as involved interveners. However, not all SLTs indicated that they had a conception of parents' roles that included that of adaptor and learner.

8.1.2 Research question 2

In what ways and to what extent do parents' conceptions of roles change whilst working

with SLTs and how is this associated with partnership practice?

A number of parents expressed significant changes in their conception of their role in becoming adapted interveners, a trajectory that was described by parents as changing their understanding

and approach to supporting their child. A further two trajectories of change were also identified from parents' description and they were characterised by less marked changes in conception of roles (Section 5.3.3).

(i) Changes in parents' understanding of the intervener role

In most cases, parents did not have a clear conception about their intervener role when they first sought advice from the SLT, though many expressed an intention to learn how to help their child. A number of parents described changes in their conceptions during involvement in intervention, either as a relatively sudden realisation of how to support their child differently, or as a gradual increase in awareness of the need to adapt their approach. The evidence did not indicate whether these changes were an explicit aim of the SLTs working with the parents or whether they were serendipitous, a fortunate side effect of intervention that promoted parents' understanding. Parents in trajectory three, 'adapted intervener', were as likely to describe changes in their understanding and approach to supporting their children, as talk about activities they had been given to do. They conveyed a sense of thinking differently, that then influenced the way they did activities with their children, rather than simply referring to 'doing homework'. A number of parents specifically ascribed the changes in their conception to working with the SLT in partnership. The implication of policy (for example, the Children and Families Bill, 2014) that encourages parents to make choices regarding additional support on the basis of information, rather than through interaction with a professional, may fail to acknowledge the importance of learning within a partnership (see Section 7.2.2).

8.1.3   Research question 3

What is the relationship between SLT and parent conceptions of roles during intervention?

(i)   Conception of roles are aligned during intervention

The role conception of parents and SLTs differed in the clarity with which they were formulated in relation to intervention. This is an unsurprising finding that reflects the difference between professional identity, underpinned by years of training and experience, and parental identify which does not routinely involve providing support for children with difficulties in language development. An initial assumption might be that parents and SLTs roles will inevitably be mismatched. However, there appeared to be marked symmetry between parents' advocacy role and readiness to support and therapists' advisory and educational role. This could be considered as parents' and SLTs' roles offering complementary functions, activated by explicit discussion and negotiation, as part of a decision-making about intervention (a matter for further research, see Section 8.4). A key role for SLTs within a partnership is enabling parents to assume new roles themselves as primary agents of change in supporting their child's speech and language development.

SLT and parent roles seemed to be related: the role that SLTs expressed for themselves was related to a role they expected of the parent, such that roles could be seen as paired in an ideal partnership. For example, the SLT with a strong conception of role as treating and planning activities also has a conception of role of parents as helping/doing activities (see Section 7.4.1). However, the research design did not investigate *how* parents and SLTs influenced one another and whether either partner changed their conception of their role in response to the expectations of the other.

8.1.4   Research question 4

In what ways and to what extent do SLTs promote conceptual change for the parents they work with during speech and language therapy intervention?

(i)   SLTs do not have a language to express a teaching role

The evidence suggested that some parents experience conceptual change during involvement in SLT. However, SLTs do not express a clear conception of their role as teacher. Some refer to showing, demonstrating and coaching as part of intervention, but there were few references to parents as learners or SLTs as teachers, indicating that SLTs do not have an explicit conception of their role as teacher, either in enabling parents to understand their roles or support speech and language development. This study used conceptual change theory (diSessa, 1998; Limon and Mason, 2002; Sinatra, 2002; Vosniadou, 2007; Vosniadou, 2013) to explore the changes reported by parents during speech and language therapy intervention. The theory proposes that some kinds of learning encourage a deep understanding that takes place as a result a restructuring of existing concepts. The findings indicate that for some parents there was a substantial change in their conceptions of roles, but to what extent were the SLTs in this study explicitly aiming to change parents' understanding of their role, as well as behaviour and to what extent was this in line with conceptual change? The evidence that all SLTs believed that they were aiming to change parents' understanding would indicate SLTs do intend changing parents' conceptions, but this was not evident in how SLTs described their practice in their own words in phase one. This research did not collect data on SLTs' actual practice and therefore presents no data on what SLTs actually did during intervention, but their accounts seemed to lack a language to articulate their role in helping parents change their conceptions. In using terms such as 'advising', 'coaching' and 'demonstrating', is there sufficient emphasis on teaching that changes conceptions? The study did not gather evidence of what SLTs believed encouraged changes in parents' thinking, but the results do raise a

question about whether the SLT conception of role as advisor/coach includes a sense of teaching to achieve deep and enduring changes in parents' understanding. Does the use of language, such as coaching, indicate a general intention to teach, with parents learning more by osmosis, rather than a direct intention to promote understanding that might be seen in a teaching role?

(ii)   SLTs do not use a single model of practice to explain their work

SLTs in the study did not express their practice in terms of a single model of professional practice. The variation in conception of roles was accompanied by considerable variation in how SLTs described their approach to practice. The free text in the questionnaire responses suggested that SLTs have a range of descriptions to express how they work with parents, but terminology does not appear to be used consistently. This indicates that SLTs may not have a clear frame of reference to articulate their practice with pre-school children and their parents. The use of terms such as consultative services, direct and indirect therapy and parent engagement requires more detailed explanation and understanding within the speech and language therapy profession. A better understanding of roles and expectations of each individual in the parent-SLT partnership could form the basis of a clearer formulation of practice.

8.2   Implications for policy and practice

8.2.1   Implications for SLT practice

This study has a number of implications for the practice of SLTs, including for how professionals could approach co-working with parents.

(i)   A successful partnership depends on understanding one another's roles. An approach that explicitly supports a better understanding of roles during intervention could contribute to a closer partnership between parents and SLTs. This study has uniquely mapped the range of conceptions of roles that both parents and SLTs have when pre-school children receive

speech and language therapy. Understanding these conceptions may provide SLTs working with parents, an opportunity to help parents adopt a fully involved role as a collaborative implementer and adaptor.

(ii)   There are important implications for SLTs in considering their conception of their role to advise and coach. This role is associated with aiming to gain greater involvement of parents and is likely to be crucial for promoting parents' participation. Nevertheless, the tendency to refer to teaching implicitly may reduce SLTs' emphasis on parents' learning in the adaptor role. SLTs with a firmer conception of role as advisor and coach, including teaching, would support parents' understanding as well as encourage changes in their behaviour, relating to 'doing' activities. This may entail a shift in some SLTs' thinking about their own roles as interveners that automatically and explicitly included teaching parents. This would then enable parents to develop a 'deep' understanding of how to support their own child as 'collaborative implementers and adaptors' (see Section 7.2).

Conceptual change theory provides a framework to describe this process of learning. The following steps for SLTs working with parents, suggested by the application of conceptual change theory, may be a valuable framework for developing the advise/coach role in SLT. The theory suggests a process that considers the following steps: (a) understanding the conceptions that the learner has already, which in this case is the conception of role that parents have as they begin their involvement; (b) identifying a clear notion of the conception they are encouraging, such as a helper or adaptor role; (c) assuming or devising a strategy for challenging an existing framework that parents may have, using techniques such as modelling, video feedback or learning from other parents.

(iii)   Parents in this study were explicitly seeking advice from a knowledgeable professional. The debate about expertise that has arisen from policy and practice related to personalisation needs

wider discussion in paediatric speech and language therapy. There is an important place for SLTs explicitly to share their expertise in order to enable parents to become interveners. This, it is hoped, should enhance parents' skills and confidence. Recognising roles that are potentially complementary and can be aligned should encourage a more even balance of power between parents and SLTs, and may need to become part of SLT professional development.

(iv) In order to discuss complex roles and support changes in conception, SLTs need to be skilled in negotiation. Negotiation was regarded as an important role by SLTs in the study in encouraging parents' motivation and involvement in intervention, but as yet, research in SLT has not focused on negotiating as part of decision-making and parent choice in the early stages of intervention with pre-school children. The importance of learning to negotiate with parents has implications for the training of SLTs.

(v) SLTs in this study referred to intervention options that were either pre-planned options, determined by service pathways, or evolving options, decided as the intervention proceeded. The pre-planned options did not encourage SLTs to offer alternative options as part of their negotiation with parents, and were regarded as militating against considering parents' values and circumstances. There is an important implication for developing a better understanding of the relationship between service design and parental involvement and participation.

8.2.2 Implications for policy

The findings of this research have implications for a number of policy areas in speech and language therapy such as shared decision-making, patient involvement and SLT education. The most immediate implication relates to the new SEND Code of Practice (Department for Education 2014). The implications of the introduction of personal budgets for children with speech and language needs are not known and are unlikely to apply to pre-school children with primary speech and

language needs. Nevertheless, policy that encourages parents to consider themselves as consumers, procuring the services they believe their child needs, requires SLTs to consider more carefully how they present options based on evidence and then negotiate roles that encourages greater parental involvement. Parents may need additional support to understand their roles as interveners, together with SLTs in a partnership model, rather than seeing roles in a polarised model of consumer and provider.

The second implication for policy relates to future SLT education. SLT practice requires an understanding of, and ability to work in, partnership with parents and this research suggested more is needed about roles etc etc . The SLTs in this study expressed considerable variation in their approach to working with parents and there was a lack of consistency in how they expressed their own roles and their expectations of parents. Two particular issues are relevant for SLT pre-qualification education:

 (i) Developing an understanding of parent and professional conceptions of roles could prepare SLTs to approach partnership with clear expectations and the ability to encourage parents as collaborative implementers and adaptors. A number of SLTs in this study referred to initially lacking the knowledge and skills to work with parents (see 4.4.3). They clearly recalled episodes where they learned to think differently, either related to their experience with specific families or participation in more formal training. Notably, several SLTs referred to learning from parents. Gaining an understanding of parents' conceptions of their own roles, together with learning about professional roles that nurture greater parental involvement could provide an important basis for SLTs developing their practice.

(ii) Professional education could lead changes in SLTs' conception of their role to advice and coach and extend the development of skills as parent educators. This study identified critical differences between those SLTs who adopted an advise and coach role in terms of parental involvement. Enabling SLTs to adopt this role and explicitly to extend this to include teaching could contribute to

323

substantial changes in the SLT profession. Currently, speech and language therapy does not have a set of professional standards relating to the teaching element of therapy, and lacks a clear framework that includes these roles. Developing understanding and skills in the advisor/coach role during training could contribute to a new generation of professionals who are better equipped to work with parents as learners.

8.3 Limitations of the research

There are a number of limitations of this study relating to methods, practical constraints and the scope of the study.

8.3.1 Limitations arising from the choice of methods

The research design was exploratory and therefore aimed to investigate the nature of parents' and SLTs' conceptions. It was not designed to definitively prove the existence of different roles or demonstrate the presence of any causal relationships between conceptions of roles and behaviour. Exploratory research is particularly suited to examining issues that have not been extensively researched. It was the most appropriate method for enquiring about conceptions of roles in speech and language therapy, where little is known about either parents' or SLTs' conceptions. Nevertheless, there are limitations that are outlined below.

(i)   *Self-reporting.* The data collection relied on self-reporting, known to be susceptible to issues such as selective recall, attribution (attributing positive events to one's own activity and negative events to external factors) and accuracy (see section 3.4.3). In this study, the impact of self-reporting could potentially bias the results. Nevertheless, it is only through using self-reporting that evidence can be collected relating to the way people think or experience events and therefore proved to be the best method to answer the research questions for this study.

(ii) *Researcher bias.* Collection and analysis of qualitative data are necessarily a subjective processes and may be prone to researcher bias. It is not feasible to suspend a researcher's knowledge and my own experience as a practising SLT is likely to have influenced the data collection, analysis and interpretation of the results. There needs to be a careful balance between exploiting the benefits of experience which can add insight and understanding to the process of analysis, and the impact of researcher bias. This was managed through careful discussion with the supervisory team, reference to parents and professional networks, being explicit about my experience and background and transparent about the processes of data collection, analysis and interpretation (see Section 3.4.3).

(iii) *Associations.* Analysis of correlations indicates association between variables, but cannot be used to indicate causal relationships. This limits the interpretation of the findings and requires caution in claiming any ability to generalise findings to other situations. It does, however, provide a valuable platform for planning further research to confirm or challenge the relevance of the findings in other populations.

8.3.2 Limitations from practical constraints in implementing methods

(i) *Questionnaire design.* There were three issues relating to the design of the questionnaires. First, phase two questionnaires were designed using the early findings from phase one. The analysis of extensive in-depth data in phase one was an iterative process with themes that were refined and adapted as the analysis proceeded. Due to the time constraints for this study, the questionnaires could not be designed using the full findings of the qualitative analysis. Therefore, there were some significant themes, such as how decision-making took place between parents and SLTs were not fully investigated in phase two. Second, the questionnaires were intended to be a means of evaluating parents' self-perception and self-efficacy, but this could not be fully tested

325

and refined to create a validated measure in the time available. It therefore represented a first attempt to collect data on conceptions of parent and SLT roles and was consistent with an exploratory study. Third, questionnaires, by nature, limit the answers that individuals can provide and may influence the kind of responses made by the wording, lack of neutrality and individuals' response to social acceptability bias.

(ii)   *Social desirability bias* (also known as social acceptability bias) can influence the responses that participants make during data collection in questionnaires and interviews (see section 3.4.3). This is characterised by participants choosing to respond in a more socially acceptable manner, avoiding responses they believe will be judged as less socially acceptable. Social desirability bias may well have influenced the responses of parents and SLTs, explaining some of the discrepancies between the findings in phase one and two. For example, a number of parents expressed concern about their child's behaviour in phase one, but this was less frequently reported in phase two.

(iii)   *Participant bias.* Parents involved in the study were already involved in SLT, by their own choice, and therefore may have been more likely to express positive views in order to confirm the decisions they had made. Collecting the views of people will always be influenced by a complex interaction between social and psychological features, but in this case, the views of parents who were not involved in intervention were not included.

(iv)   *Follow up interviews.* It was difficult to maintain contact with all the parent participants in the longitudinal study. Parents were contacted by phone, but were unavailable or opted not to respond to the researcher's phone calls. Consequently, the follow up interviews for the longitudinal study were completed with a small subgroup of nine parents, which may have given rise to selection bias reflecting a group who were keen

to share their views. It is impossible to determine if these parents were typical and caution needs to be applied in generalising any findings.

(v)   *Limited sample.* The service areas where the data collection took place limited the sample characteristics. The sample was not intended to be representative, but the use of purposive sampling was employed to ensure that a range of socio-economic Status were included. Nevertheless, the recruitment to the study may have been affected by the following features: (a) all the services used an opt-in system that expected parents to arrange initial appointments with the SLT. Consequently, parents were already 'engaged' enough to seek an initial assessment. This study does not provide evidence concerning parents who did not opt into speech and language therapy services; (b) Recruitment depended on individuals volunteering to participate in the study and thus may have attracted parents and SLTs who felt more interested or confident in expressing their views. This could have influenced the results in two quite different directions: parents and SLTs may have wanted to participate in the study because of fundamental frustrations with their experience of speech and language therapy or because they felt positively about the subject of partnership. Nevertheless, the opt-in rate to participate was relatively high in both phases and few parents refused to participate when they were approached in research sites.

8.3.3   Limitations arising from the scope of the study

The scope of any study will be limited by the characteristics of the sample. In the case of SLTs, this was limited by the services that volunteered to be involved. My own previous clinical experience indicated that that services that had difficulties working with parents and families, or had problems with delivering services, would not have volunteered to participate in the study in the first instance. There are therefore implications for the generalisability of the findings from this study. Moreover,

SLTs' conceptions of roles may be different when they work in services that are delivering different models of practice, are under-resourced or undergoing organisational change. In the case of parents, the range of backgrounds may have been limited by the demography of the sites. The sample could not be representative, given the sample size and the methods of data collection, which relied on parents as volunteers.

8.4 Implications for future research

There are three important areas for further research suggested by this exploratory study:

(i) Confirmation of parent and SLTs' conceptions of roles. This study identified a number of conceptions of roles that parents and SLTs assume during intervention. These findings, however, were based on a relatively small sample, that was undifferentiated by parents' socio-economic status, children's type and severity of speech and language needs and SLTs' service characteristics. In order to confirm the generalisabilty of the findings, further research needs to confirm and extend understanding of conception of roles using a larger sample of parents and SLTs, who represented distinctive groups or specific contexts.

(ii) Investigating changes in parents' conceptions of roles. The study provided early indications that parents' conceptions of roles may change during intervention. The possibility that parents tend to follow a specific trajectory of change (Chapter Five) needs to be explored further with a larger sample. Answering questions about the nature of parental changes in role conception and how such changes are promoted is important for enabling parents to be involved in the parent-SLT partnership. This should inform the way SLTs support change in parents' conceptions and add to understanding of how to create the right circumstances or context to enable parents to adopt a collaborative implementer and adaptor role. Initial findings seemed to suggest

328

that parents' competence and confidence were important in helping them adopt more involved roles (see Section 5.3). The relationship between self–efficacy and adopting a collaborative implementer and adaptor role could be a valuable area for further research.

(iii)   Exploring if and how SLTs develop parents' roles. This study suggested that SLTs were intuitively trying to develop parents' roles, but did not investigate how parent-SLT dyads culminated in changes in parents' conceptions. The study design should be extended to include a close investigation of how matched pairs work together and measure if there is any association between practice, characteristics such as the family context and changes in role conception. Any causal association with children's progress and eventual outcomes during SLT intervention are also important considerations for future research.

(iv)   Investigating the advisor/coach role and the relationship to teaching in speech and language therapy. Whilst this study indicated that SLTs were aiming to change parents' conception of roles, more needs to be known about the SLT teaching role. It is essential that SLTs gain a better understanding of their teaching role, and consolidate the approaches and techniques that are used. This study seemed to indicate that the profession may lack clarity about its teaching role in relation to parents, using loosely defined approaches to parent education, resulting in considerable variability in how parents' learning is supported. Further research is urgently needed to develop an understanding of parent education, in the context of routine intervention for pre-school children with primary speech and language needs.

(v)   Decision-making as part of the roles of taking responsibility (parents) and negotiation (SLTs). This study did not investigate the relationship between role conceptions and parents' preferences for the form of intervention, or the interaction between SLT role

conceptions and their approach to supporting decision-making. Further research should consider if and how the negotiation process is related to changes in parents' conception of their intervener role and their satisfaction with the process of decision-making. The issues of whether service constraints influences the SLT's approach to negotiating options should also be included in future research.

8.5 Implications for my own perspective and practice

The study has been a complex undertaking, demanding practical resourcefulness to recruit parents and academic thoroughness to apply appropriate methods of data collection and analysis. At this point, it is important to ask how the research journey has changed my professional perspective as a SLT. The research process and findings from the study have revealed a number of important issues for my own practice, outlined below.

(i)   Parents' descriptions of their expectations relating to seeking help for their child have challenged my preconceived ideas that parents expect speech and language therapists to provide face-to-face intervention. In common with many colleagues, I tended to assume that parents expected me to be the problem solver and intervener, with little recognition of parents' ongoing commitment to helping their own child, whether they expressed this explicitly or tended to remain concealed or unformulated. I rarely considered that parents were unlikely to know what roles they would need to adopt as during speech and language therapy, and that part of my role was to support the development of their conceptions as intervener. The importance of supporting parents' understanding of their role, before improving their understanding of what they needed to do to help their child, has provided a new perspective on my professional practice.

(ii)   I have used a framework to explain my practice that focused on the roles of assessor and intervener, but rarely explicitly acknowledged the role of negotiator, which tended to be

taken for granted as part of the background to clinical decision-making. I did not use the language of shared decision-making with parents and rarely considered the nature of my own role as intervener, particularly relating to supporting parents' learning. This raises an important question about professional norms of practice and our own discourse to describe intervention that involves parents, or indeed any service users, more fully. The issue of negotiation and decision-making before intervention is underway, and the place of parent education in routine intervention has prompted me to question how SLTs define therapy. Very few SLTs in this research included teaching as part of their professional discourse in the conversations I had with them, reflecting my own reticence to consider teaching, beyond formal training, as part of the therapist's role. My own use of descriptive terms such as 'direct' or 'indirect' intervention has tended to simplify the range of SLT practice and devalue the education role that was implicit in my intervention with parents.

(iii)   The policy that underpins current healthcare and education, whether espousing parents as budget holders or as partners, requires critical consideration. I am deeply embedded in an NHS culture that encourages, or requires, professionals to accept new initiatives without necessarily considering the implications for their own client groups. I have learned to question policy, to seek to understand the ideological position as well as evaluate the evidence underpinning policy, and also to recognise the contradictions and my own responses to the implementation of policy. The inherent contradiction between policies that encourage service users to consider themselves as consumers and partners, helps to consolidate my own views about the roles that I consider I should be encouraging in my own practice. More importantly, this study has given me the opportunity to see how parents understand their roles, which did not align with either a consumer or partner role. Understanding parents' different priorities and supporting

their development as interveners should be an important part of my intervention. Encouraging roles that are more closely linked to supporting language learning, such as collaborative intervener, could be a much more productive approach for my practice.

(iv) I have learned how important it is to support parents' understanding of their role as intervener *as well* as giving them things they do with their children. If parents can undergo substantial changes in their understanding of their roles, often associated with differences in their approach to their child, then my practice needs to more routinely focus on enabling such changes.

(v) Finally, the ideology of patient choice, and a growing emphasis on patients as experts, has prompted me to consider my professional expertise and experience as something that contributes to an unhelpful power imbalance between parents and SLTs. This was counteracted by listening to parents in this study who were explicitly seeking advice they could trust. They expressed the importance of expert guidance to help them understand how to improve their child's speech and language. This study provided an opportunity to consider the differences between parent and SLT roles and consider the complementary nature of roles that collectively provide greater support children with difficulties learning language.

The rhetoric of partnership with parents has been present in my professional practice for a number of years and it has an intrinsic appeal. Yet my practice has been challenged by parallel, seemingly incompatible demands of evidence based intervention and efficient, cost effective provision. It has therefore been difficult to discern what my own practice looks like and how parents have experienced the partnership. This study has given me the opportunity to listen to parents, to learn about their perceptions of their roles and, in some cases, hear their stories of transformation. It has also given me the opportunity to see how professional colleagues balance competing demands and despite challenges continue to enable parents to learn, not through

applying rigid practices, but by using approaches that are characterised by negotiation and advising/coaching.

8.6 Concluding remarks

This research has explored the conceptions of parents' and SLTs' roles during speech and language intervention. It has added to knowledge by considering the way parents and SLTs think about their own roles and the roles of each other in supporting pre-school children with primary speech and language needs. Investigating conceptions of roles and revealing the variation within roles, serves as a reminder of the complexity of partnership practice. Many parents in this study described important changes in their behaviours and their conceptions of roles, suggesting that a process of conceptual change. Two types of changes were seen: first, in conception of their role in relation to working with their child and the speech and language therapist; and second, wider conceptual change relating to being a parent.

The range of conceptions that SLTs expressed were in line with the professional expectations of their practice. Nevertheless, most practitioners now adopt roles that are beyond the typical responsibilities of assessor and intervener, to encompass a teaching role, often referred to implicitly and described using terms such as coaching and demonstration. This role has developed over recent years, and there are indications that many SLTs embrace this approach to working with parents, but the profession has yet to define teaching in explicit terms and agree the place that it has as part of the therapeutic process. The application of conceptual change theory to the field of parent learning, offers the opportunity to explain the complementary roles of the parent as adaptor and the SLT as advisor/coach, providing a framework for parent education as part of intervention. The possibility that parent and SLT roles can be aligned during intervention, as complementary pairs of roles, should surely be the ambition of every SLT working in partnership with parents.

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10. Appendices

Appendix 1: Letters of ethical approval from the Health Research Authority and NHS R&D

Approval letter for phase one (dated 5.4.12)

Approval letter for phase two (dated 27.8.13)

Approval from NHS R&D (dated 25.6.12)

NRES Committee North East - Newcastle & North Tyneside 1

TEDCO Business Centre
Room 002
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0191 428 3564
Facsimile: 0191 428 3432

05 April 2012

Mrs Karen Davies
8 Orme Crescent
Macclesfield
SK10 2HS

Dear Mrs Davies

Study title:	**Parents' and speech and language therapists' roles in intervention for pre-school children with speech and language needs.**
REC reference:	12/NE/0148

The Proportionate Review Sub-committee of the NRES Committee North East - Newcastle & North Tyneside 1 reviewed the above application on 03 April 2012.

Ethical opinion

The Sub-Committee confirmed that they would only be able to provide an opinion of Phase 1 of this application.

You confirmed that you would be applying for further ethical approval for Phase 2 of the study

Members of the Sub-Committee advised the researcher to consider a section in both the Parent and Therapist Participant Information Sheet to cover withdrawal from the study. The Participant Information Sheet might stress that if potential participants wish not to take part that is OK and that the therapist intervention will continue as planned

You replied that the option to withdraw from the study and reassurance that this will not affect usual intervention is highlighted in Paragraph 6 of the Participant Information Sheet for Parents and Paragraph 9 of the Participant Information Sheet for Speech and Language Therapists

You provided an amended copy of the following documents:

- *Speech and Language Therapist Consent Form (Version 2, 31/03/2012)*
- *Parent Consent Form (Version 2, 31/03/2012)*

The Sub-Committee requested your views on the lack of non-negligent insurance cover in comparison with Human Volunteer Phase 1 Clinical Trials. It was also recommended that the University should consider this in principle.

You replied that insurance issues relating to non-negligent cover have been raised with Manchester Metropolitan University through their Academic Supervisor, Sponsor and Chair of the University Ethics Committee.

It was noted that the Consent Forms still needed to include an amended version of the standard statement regarding access to study records by regulatory authorities, etc.

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Additional Conditions specified by the REC:

      1.   Changes to the Consent Form(s):

           a)   Amendment of the standard statement regarding access to study records by regulatory authorities, etc. to be correct

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Evidence of insurance or indemnity	J Cunningham (MMU)	15 March 2012
Interview Schedules/Topic Guides	Parents - Version 1	13 February 2012
Interview Schedules/Topic Guides	SLT - Version 1	13 February 2012
Investigator CV	Julie Marshall	22 March 2012
Investigator CV	Karen Davies	05 March 2012
Letter from Sponsor	Professor David Raper (MMU)	15 March 2012
Letter of invitation to participant	Parents/Guardians - Version 1	13 February 2012
Letter of invitation to participant	SLT - Version 1	13 February 2012
Other: Funder's Agreement	Secretary of State for Health and North Bristol NHS Trust	21 March 2012
Participant Consent Form: Parent	Version 1	13 February 2012
Participant Consent Form: SLT	Version 1	13 February 2012
Participant Information Sheet: Parent Info Brief Full	Version 1	13 February 2012
Participant Information Sheet: Parent Info Brief Accessible	Version 1	13 February 2012
Participant Information Sheet: SLT	Version 1	13 February 2012
Protocol	(Short) Version 5	06 December 2012
Protocol	Version 2	24 January 2012
REC application	IRAS Version 3.4 97808/307210/1/472	26 March 2012
Summary/Synopsis	Version 1	13 February 2012

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National

Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/NE/0148	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

L. Kirkbride (pp)

Mr Chris Turnock
Chair

Email: laura.kirkbride@sotw.nhs.uk

Enclosures:	*List of names and professions of members who took part in the review*
	"After ethical review – guidance for researchers"
Copy to:	*Professor DW Raper*
	Ms Nicola Coe, North Bristol NHS Trust

NRES Committee North East - Newcastle & North Tyneside 1

27 August 2013

Mrs Karen Davies
8 Orme Crescent
Macclesfield
SK10 2HS

Dear Mrs Davies

Study title:	**Parents' and speech and language therapists' roles in intervention for pre-school children with speech and language needs.**
REC reference:	**12/NE/0148**
Amendment number:	**Substantial Amendment 1**
Amendment date:	**18 June 2013**
IRAS project ID:	**97808**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The Committee requested that the researchers re-submit a copy of the protocol with tracked changes. Submit a copy of the Patient Information Sheet and Consent Form with tracked changes to reflect the changes in the protocol, with new version numbers and date on them.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMPs)	Substantial Amendment 1	18 June 2013
Covering Letter	Email from Karen Davies	25 July 2013
Questionnaire: Parent Questionnaire	Version 1	11 June 2013
Protocol	Version 4	11 June 2013
Research Briefing	Version 1	11 June 2013
Questionnaire: Speech and Language Therapist Questionnaire	Version 1	11 June 2013

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

12/NE/0148:	Please quote this number on all correspondence

Yours sincerely

pp

Mr Chris Turnock
Chair

E-mail: nrescommittee.northeast-newcastleandnorthtyneside1@nhs.net

Enclosures:	*List of names and professions of members who took part in the review*
Copy to:	*Ms Nicola Coe, North Bristol NHS Trust* *Prof DW Raper*

NHS SalfoR+D Director:	Professor Bill Ollier
R&D Associate Director:	Rachel Georgiou
Enquiries:	Email: Salford-Regroup-RD@manchester.ac.uk
	Tele: 0161 206 8343
	Fax: 0161 206 4205
SalfoR+D web address:	http://www.nhssalfordrd.org.uk/
ReGrouP web address:	http://www.gmregroup.nhs.uk/index.html

25th June 2012

Mrs Karen Davies
Doctorate student
Elizabeth Gaskell Campus
Hathersage Road
Manchester
M13 0JA

Dear Karen,

Study Title: Parents' and speech and language therapists' roles in intervention for preschool children with speech and language needs.
REC Reference: 12/NE/0148
CSP Reference: 97808/GM
R&D Reference: 2012/082

Thank you for forwarding all the required documentation for your study as above. I am pleased to inform you that your study has been registered with NHS SalfoR+D and has gained NHS R&D approval from the following NHS Trusts:

- Bridgewater Community Healthcare NHS Trust (Ashton, Leigh & Wigan Division)

All clinical research must comply with the Health and Safety at Work Act, www.hse.gov.uk and the Data Protection Act. http://www.hmso.gov.uk/acts

It is a legal requirement for Principal Investigators involved in Clinical Trials to have completed accredited ICH GCP training within the last 2 years. Please ensure that you provide the R&D Department with evidence of this (certificate for completing the course). A list of GCP training courses can be obtained from the R&D Office.

All researchers who do not hold a substantive contract with the Trust must hold an honorary research contract before commencing any study activities related to this approval. The 'Research Passport Application Form'. This can be obtained from web addresses:
http://www.gmregroup.nhs.uk/researchers/passports.html and http://www.hope-academic.org.uk/academic/salfordrd/Research%20Passports.html This form should be completed and returned, with a summary C.V and recent (within 6 months) CRB to the address shown above.

It is a condition of both NRES and NHS R&D approval that participant recruitment data should be forwarded on a regular basis. Therefore, progress reports must be submitted annually to the main REC and copied to the R&D office until the end of the study.
http://www.nres.npsa.nhs.uk/applicants/review/after/progress.htm#annual.

Where clinical trials of investigational medicinal products are sponsored by Salford Royal NHS Foundation Trust or Salford Primary Care Trust, it is a condition of Trust approval that Chief Investigators submit quarterly progress reports (to include Annual Safety Reports at the appropriate time) to R&D. For clinical trials of investigational medicinal products hosted within Salford Royal NHS Foundation Trust and Salford Primary Care Trust, the local PI will be expected to submit bi-annual progress reports to R&D. It is also a condition of approval that delegated duties (as agreed within clinical trial agreements and trial delegation logs) are fulfilled by only those delegated to undertake a specific duty. This will be monitored by the Sponsor's Representative during routine monitoring of the trial. Persistent non-compliance with these requirements may result in removal of Sponsorship or Trust R&D Approval.

Any amendments to the study must gain full approval by the Ethics Committee and if appropriate, by the MHRA.

Please note, because the study has been adopted onto the NIHR Portfolio, and has been processed through CSP, all amendments must be submitted through the Lead CLRN. Please do not send any amendments to R&D directly, the Lead CLRN will inform us of any amendments to the study and will send any relevant information to us for our approval.

On completion of the study you are required to submit a 'Declaration of End of Study' form to the main REC, which should also be copied and forwarded to the R&D office at the address shown above.

Any serious adverse events or governance issues related to the research must be notified to the R&D office.

Yours sincerely,

**Sue Gowland
R&D Manager**

CC GMCLRN

Appendix 2: Parent and SLT consent forms and information briefs

Parents and SLT forms

Manchester
Metropolitan
University

Parent consent form **(version 2; 31.3.12)**   **Identification Number_____**

Research project: Working together in speech and language therapy

Investigator: Karen Davies, Speech and Language Therapist and Researcher

I (full name) ………………………………………………………....

	Signature
Have read the information brief [Version 1;13.2.12]	
I was able to ask questions and these have been answered satisfactorily.	
I have received enough information about the study.	
I understand that my participation is voluntary.	
I understand that I can withdraw at any point.	
I understand that audio recordings will be made during the interview	
I understand that the recordings will be used by the researcher from Manchester Metropolitan University	
I understand that in the analysis of these recordings my right to privacy will be respected and that the recordings will be kept anonymously (any names, addresses, phone numbers removed).	
I understand that all information collected about me during the course of the research will be kept strictly confidential, and any information about me which leaves the NHS Trust will have my name and addressed removed so that\ I cannot be recognized.	
I give my consent to participate in the study and give my consent for access and use of my data as explained in the information brief.	

Signature of parent   Signature of researcher

Name   Name

Date   Date

Copy for parent   Copy for researcher

Speech and Language Therapist consent form (version 2; 31.3.12)   **Identification**

Number_____

Research : Parents' and speech and language therapists' roles in intervention for pre-school children with speech and language needs

Investigator: Karen Davies, Speech and Language Therapist and Researcher

I (full name) …………………………………………………………….

	Signature
Have read the information brief [Version 1;13.2.12]	
I was able to ask questions and these have been answered satisfactorily.	
I have received enough information about the study.	
I understand that my participation is voluntary.	
I understand that I can withdraw at any point.	
I understand that audio recordings will be made during the interview	
I understand that the recordings will be used by the researcher from Manchester Metropolitan University	
I understand that in the analysis of these recordings my right to privacy will be respected and that the recordings will be kept anonymously (any names, addresses, phone numbers removed).	
I understand that all information collected about me during the course of the research will be kept strictly confidential, and any information about me which leaves the NHS Trust will have my name and addressed removed so that\ I cannot be recognized.	
I give my consent to participate in the study and give my consent for access and use of my data as explained in the information brief.	

Signature of the speech and language therapist   Signature of researcher

Name   Name

Date   Date

Copy for speech and language therapist

Copy for researcher

Research Information Brief for Parents[18]

Parents' and speech and language therapists' roles in working together (version2; 30.7.12)

Why have I been asked?

You have been invited to take part in the study because you have a pre-school child who has been referred to speech and language therapy due to needs in speech and language.

What is the study about?

The study is looking at the roles that parents and speech and language therapists take during speech and language therapy. I will be collecting information from parents and the speech and language therapist they are working with.

The results will be used to improve professionals' understanding of working with parents of children with speech and language needs and for educational purposes, as part of my Doctoral degree. This research is part of a national study funded by the NHS (www.speech-therapy.org.uk.) The findings may be published.

What will I have to do?

I would like to talk with you on three occasions during your involvement with speech and language therapy. I will be asking questions about your experience of attending speech and language therapy. The first interview will follow the initial visit to speech and language therapy; the second one, after 6-8 weeks; and the third one, after 24-32 weeks of involvement in speech and language therapy. These interviews can take place at home or any other place you would prefer, or as a telephone interview. If you do not wish to answer any questions, you may say so and move onto the next question. They are likely to take about 30 minutes to complete and will be tape recorded for a written copy. You will have a chance to read a copy of the interview and request any changes if you think the copy is incorrect.

Please be assured that any records will be anonymous and will not have your name or your child's name on. I will also be interviewing your speech and language therapist separately.

Do I have to take part?

Your participation in the study is voluntary and you do not have to take part. If you do decide to take part, you can also change your mind and stop taking part at any point. Your decision about whether or not to take part will not affect the current or future support that your speech and language therapist will give you.

---

[18] PARENT INFO BRIEF FULL

What will happen if I take part?

There are no risks associated with your involvement in the research and your participation will not affect the speech and language support your child receives. However, should you feel uncomfortable with any of part of the interview, you can decide to withdraw from the study.

There will be no direct benefits to you, but your participation will help improve our understanding of what helps or hinders speech and language therapists working with families with young children with speech and language needs. The interviews will give you a chance to reflect on your own role, the therapist's role and your expectations of therapy.

What will happen if I don't take part?

If you choose not to take part in the study, your child's speech and language therapy will continue as usual.

Will my information be confidential?

Everything you say in the interviews will remain confidential and will not be discussed with your therapist or anyone outside the research team. It will not affect the care your child receives from your speech and language therapist. Any information collected will be made anonymous and stored in a locked cupboard.

Your child's safety will always be a priority and I shall be following the same procedures as your speech and language therapist. If anything you say indicates that your child is at risk I am required to notify the necessary authorities through the local safeguarding procedures.

Who has reviewed this study?

This study has been reviewed by the North East Research Ethics Proportionate Review Sub-Committee on 3.4.12

Do you have any questions?

Please contact me or any member of the research team Karen Davies Tel: 07982213669 karen.e.davies@stu.mmu.ac

Researcher

Karen Davies, Speech and Language Therapist and Doctoral degree student

Research Institute for Health and Social Change, Manchester Metropolitan University

Research Team

Julie Marshall, Senior Research Fellow Tel: 0161 2472581; j.e.marshall@mmu.ac.uk

Juliet Goldbart, Professor of Developmental Disabilities Tel. 0161 2472578; j.goldbart@mmu.ac.uk

Laura Brown, Senior Lecturer 0161 247 2533; laura.brown@mmu.ac.uk

Independent contact point Dr. Bill Campbell, Head of Social Work and Social Change Department, Manchester Metropolitan University 0161 247 2097

Research Study: Parents' and speech and language therapists' roles in intervention for pre-school children with speech and language needs

Information about the research (Version 1; 13.2.12)

Why have I been asked?

You have been invited to take part in the study because you provide speech and language therapy to pre-school children with primary speech and language needs.

What is the study about?

The study is looking at the roles that parents and speech and language therapists take during speech and language therapy. I will be collecting information from parents and the speech and language therapist they are working with.

The results will be used to improve professionals' understanding of working with parents of children with speech and language needs and for educational purposes, as part of my Doctoral degree. This research is part of the national programme funded by the NHS 'The development of an evidence based typology of Speech and Language Therapist led Interventions, incorporating the perspectives of families and children'. The findings may be published.

What will happen if I take part?

You will be asked to identify six referrals from your waiting list where the referral indicates that the child may have a primary speech and language need and invite their parents to participate in this study. I am only intending to interview two parents, but anticipate that some parents will not be able to participate. Once the parents have consented, I will interview the parents and yourself separately at three points during the child's involvement in speech and language therapy. I will be asking questions about your experience of working with families attending speech and language therapy. The first interview will follow the initial visit to speech and language therapy; the second one, after 6-8 weeks; and the third one, after 24-32 weeks of involvement in speech and language therapy. The parent interviews can take place at a parent's home or any other place they would prefer. Interviews with you can take place in your work location. They are likely to take about 30 minutes to complete and will be tape recorded for transcription. If you do not wish to answer any questions, you may say so and move onto the next question. You will have a chance to read the transcription and request any changes if you think the transcription is incorrect.

Please be assured that any records will be anonymous and will not have your name or the child's name on.

What will I have to do?

1. Identify 6 children and their parents from the waiting list using the following criteria
    a. child age 2.6-5.11 years

    b.   referral indicates speech and language needs not related to other neurodevelopmental difficulty or social needs

2.   Invite parents to participate, sending the information brief and consent form to the family

3.   Agree a date for your interview with the researcher after the initial assessment of the child

Do I have to take part?

Your participation in the study is voluntary and you do not have to take part. If you do decide to take part, you can also change your mind and stop taking part at any point. Your decision about whether or not to take part will not affect any other aspect of your work.

What are the benefits of taking part?

There will be no direct benefits to you, but your participation will help improve our understanding of what helps or hinders speech and language therapists working with families with young children with speech and language needs. The interviews will give you a chance to reflect on your own role and expectations of parents when they attend therapy.

What will happen if I don't take part?

There are no consequences if you choose not to take part in the study.

Confidentiality

Everything you say in the interviews will remain confidential and will not be discussed anyone outside the research team. Similarly, I will not be able to share any information with you that arises from the parent interviews. Any information collected will be made anonymous and stored in a locked cupboard.

However, in the interests of the safety of vulnerable people, any concerns relating to safeguarding that may arise will be raised through the local safeguarding procedure.

Who has reviewed this study?

This study has been reviewed by the North East Research Ethics Proportionate Review Sub-Committee on 3.4.12

Any questions?

Please contact me or any member of the research team

Karen Davies, Speech and Language Therapist and Doctoral degree student, Tel: 07982213669 or karen.e.davies@stu.mmu.ac.uk Research Institute for Health and Social Change, Manchester Metropolitan University

Research Team: Julie Marshall, Senior Research Fellow Tel: 0161 2472581; j.e.marshall@mmu.ac.uk

Juliet Goldbart, Professor of Developmental Disabilities Tel. 0161 2472578; j.goldbart@mmu.ac.uk

Laura Brown, Senior Lecturer 0161 247 2533; laura.brown@mmu.ac.uk

An independent contact point

Dr. Bill Campbell, Head of Social Work and Social Change Department, Manchester Metropolitan University 0161 247 2097

Appendix 3: Parent and SLT interview guides and questionnaires

Positive talking-positive roles

Interview guide for parents (Interview 1)

Introduction to the study

I'd like to talk about your experience of coming to speech and language therapy with your child. Could we talk about your journey in finding out that your child had some difficulties learning language and what helped you?

1. Talk me through how your child first came to be seen by an SLT? [How did that come about?]
    a. When did you first realize he/she might need support
    b. Looking back is there anything you would change about what happened?
2. How were your child's difficulties described or labeled?
    a. Before you came to SLT
    b. After the assessment with the SLT
    c. Is there anything you would have changed about how this happened?
3. Tell me about how decisions about what your child needed were made.
    a. Could this have been done differently?
4. What kind of support is your child going to receive/receiving? How will this be provided?[specific examples of what you've been asked to do?]
    a. Is there anything you would change about this?
5. At the beginning what are you/did you hope for? What did you expect from the SLT? Were these expectations fulfilled?[in what ways?]
6. How would you sum up your role in relation to your child and the SLT?
7. In supporting your child's speech and language, has your role changed over time? How do you think it will change in the future?
8. How do you think your attendance at SLT will affect your child's progress? In what way?

9. What do you think are the most important factors helping your child's speech and language at the moment?

   Your information

10. Mother/father/other (please specify)
11. Postcode:
12. Ethnicity:
13. Highest level of education: Secondary School   GCSE   A Level   Degree
14. Occupation   ………………………
15. Do you use the internet to find out information on services of child development?
16. Number of appointments given by the speech and language therapist
17. Number of appointments attended
18. Family:
    a. Age of your child
    b. Who looks after your child
    c. Who else is in the family

Positive roles - Positive talking

Interview guide for parents (Interview 2)

Introduction to the study

Could we talk about your experience of coming to SLT since we last met in August

1. What kind of support is your child receiving? How is this being provided?[specific examples of what you've been asked to do?]

    (a)   Is there anything you would change about this?

    (b)   How could you have been prepared for coming to SLT?

    (c)   How are you working with the therapist and your child?

2. Tell me about how decisions about what your child need are made. Could this have been done differently?

3. How would you sum up your role in relation to your child and the SLT?

4. In supporting your child's speech and language, has your role changed over time? How do you think it will change in the future? How have you adjusted the way you are with your child?

5. You weren't sure what would help in August-what factors have helped his progress? How did you discover that?

6. How do you think your attendance at SLT has affected your child's progress? In what way?

7. What do you think are the most important factors helping your child's speech and language at the moment?

8. How do you feel about your child's development now?

9. What are you hoping for from SLT now? What did you expect from the SLT? Were these expectations fulfilled?[in what ways?]

Positive roles - Positive talking-

Interview guide for parents (Interview 3)

Could we talk about your experience of coming to SLT since we last met

1. What kind of support is your child receiving now? How is this being provided?[specific examples of what you've been asked to do?]
    a. Is there anything you would change about this?
    b. How could you have been prepared for coming to SLT?
2. How would you describe working with the SLT
3. How have you feelings about your child's SLC changed over this time?
4. How would you describe your confidence in supporting your child? Example of how this has changed your what you do
5. Tell me about how decisions about what your child need are made. Could this have been done differently?
6. How would you sum up your role in relation to your child and the SLT?
7. In supporting your child's speech and language, has your role changed over time? Has this changed the way you approach other things with your child? How do you think it will change in the future? How have you adjusted the way you are with your child?
8. You weren't sure what would help when you first visited the SLT-what factors have helped his progress? How did you discover that?
9. How do you think your attendance at SLT has affected your child's progress? In what way?
10. What do you think are the most important factors helping your child's speech and language at the moment?
11. What did you expect from the SLT? Were these expectations fulfilled?[in what ways?]
12. What are you hoping for from SLT now?
13. What are you hoping for in terms of your child's development now?

Manchester
Metropolitan
University

Positive talking-positive roles

Interview guide for Speech and Language Therapists

Introduction to the study

I'd like to talk about your experience of working with parents of children with primary S&L needs. Could we talk about the different stages of involvement with SLT from the point of referral through to intervention. I'd like our discussion to focus on the specific family you've been working with today[19]

1. Talk me through how this child first came to be seen by you? [How did that come about?]
   - Looking back is there anything you would change about what happened?
2. How were the child's difficulties described or labeled?
   - Before assessment[by whom]
   - At your assessment
   - Is there anything about the process that you would have liked to be done differently?
3. Tell me about how decisions were made about what should be done about the child's speech and language?
   - Could this have been done differently?
4. What kind of support is the child going to receive/receiving at the moment? How will this be undertaken?[specific examples of what is going to be done, by whom?]
   - Is there any way that this could be/could have been improved?
5. How would you sum up what you expected of the mum/dad? Were these expectations fulfilled?[in what ways?]
6. How would you sum up your role in relation to the child and the parents during the different phases of diagnosis/goal setting/intervention phase of working with parents?
7. Has your role changed over time whilst working with this family? [Int 2/3]

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[19] Parents have given consent to participate in the study

8. How do you think the family's attendance at SLT will affect the child's progress?

9. What do you think are the most important factors helping the child's speech and language at the moment?

10. What kinds of frustrations do you experience in working with families?

11.

Basic information

12. How many years have you been qualified?

13. How has your additional training influenced your practice? [mention any critical professional development, such as 'parent-child interaction training'?]

14. How would you describe the service model used here

    - in your own work
    - in the service
    - please illustrate how the service model works
    - Who are your are you main collaborators?

15. How would you describe the pressures you experience delivering SLT at the moment and how does this affect the way you work [Waiting lists/caseloads]

16. Number of appointments given to this child

17. Number of appointments attended by the family

Parent Questionnaire
Your views about helping your child's speech and language

Help us understand how parents and speech and language therapists work together. Your answers will be kept strictly confidential and you will not be identified by name. The questionnaire should take approximately 5 minutes to complete.

The results will be used for educational purposes, as part of my Doctoral degree. The findings may be published. This research is part of a national study funded by the National Institute for Health Research (NIHR) under its Programme Grant for Applied Research Programme. For further details see http://www.speech-therapy.org.uk/child-talk-what-works

Information about your child

1. My child's age is ☐

2. How old was your child when you first saw the speech and language therapist ☐

3. How long did you wait to see the speech and language therapist

4. My child has difficulty with

Saying words clearly ☐   Learning new words ☐   Putting words together ☐

Understanding what I say ☐   Talking fluently ☐   Other (please specify) ☐

5. When I first saw the speech and language therapist, my child's difficulties were (please tick)

1. very serious	2.serious	3. not sure	4. a little serious	5. not serious

6. My child has other learning or health needs (please specify)

☐

7. I have seen the SLT
   once
   2-4 times
   5-10
   11 or more times

8. What type of speech and language therapy support have you had? (please tick)

Assessment of child's talking	Advice from speech and language therapist	Parent group run by the therapist	Children and parents group	Therapy for my child	Therapy in school or nursery	Other (specify)

9. What was your reason for coming to see the speech and language therapist in the beginning
   Please tick any that apply to you
   a. To help my child progress at nursery or school ☐
   b. To help my child have friendships ☐
   c. To get reassurance ☐
   d. To do what was recommended by someone else ☐
   e. To improve the way my child talks ☐
   f. To help my child's understanding of language ☐
   g. To learn how to help my child ☐
   h. To change the way I interact with my child ☐
   i. To improve my child's behaviour ☐
   j. To get some tips and ideas to help his/her talking ☐

372

Which is the most important? Please insert a letter ☐

You and the speech and language therapist. . How much do you agree with these statements? Please tick

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
I know what to do to help my child improve their understanding and talking					
I am worried about my child's communication					
The therapist makes me feel confident to help my child					
I work well with the speech and language therapist					
I am worried about my child's behaviour					
A speech and language therapist should decide what to do about my child's talking					
The speech and language therapist has made me feel comfortable					
I know how to adjust activities at home to help my child's talking					
I believe it is my fault that my child has trouble understanding language and talking					
A speech and language therapist should show me how to help my child's talking					
I am keen to help my child improve their understanding and talking					
I am able to do activities that help his/her understanding and talking					
I find it easy to take a positive approach with my child when I am helping his/her talking					
I was worried about meeting the speech and language therapist before I came see him/her					
I expect the therapist to give me specific things to do with my child					
I expect the therapist to give me choices about what should be done with my child					
A speech and language therapist should work with my child every week					

373

I like to learn how to help my child					
The speech and language therapist should know what will help my child					
I am keen to learn new techniques to help my child's speech and language					

I spend time helping my child with their understanding and talking

1. once a month	2. Once a week	3. 2-4 times a week	4. Everyday	5. Don't know

Since working with the speech and language therapist I have changed the way I try to help my child

1.Not at all	2. A little	3. some changes	4. A lot	5. I haven't seen the SLT

You and your child. How much do you agree with these statements? Please tick

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
I can help my child with his/her talking					
I can understand my child's talking					
I can enjoy interacting with my child					
I can use the techniques that the speech and language therapist showed me					
I can show my child how to say sounds and words					
I can respond to my child differently following advice from the SLT					
I can use fun activities to help my child's understanding of language and talking					
I can find the time to help my child with his/her understanding and talking					
I can get more advice about my child's understanding and talking					
I can talk to the therapist about my worries about my child's understanding and talking					
I can change the targets that I work on with my child					
I can see that my child is making progress with understanding and talking					

I can tell whether the speech and language therapist is doing a good job					
I can make the decision about whether it is worth seeing the speech and language therapist					
I am able to talk to my child's teachers about helping my child's understanding and talking					
I can motivate my child to work on activities to help his/her understanding and talking					

Background information

Which describes you? Mother   Father   Other (please specify)
Which describes you?   White British   White Other Mixed/ Multiple ethnic groups   Asian/ Asian British Black/ African/ Caribbean/ Black British Chinese Middle Eastern Other ethnic group (please describe)
What is your highest level of education Secondary school   GCSE   A Level or equivalent   Degree
Have any other children in your family had speech and language therapy? Yes   No

Please give the ages of your children	Ist child 2nd child 3rd child 4th child Others:

Occupation (current or previous)
Postcode

Thank you very much for taking the time to complete this.

Please put this in the envelope provided, seal it up and leave it with your speech and language therapist.

Karen Davies (Karen.e.davies@stu.mmu.ac.uk)

SLT Questionnaire

Questionnaire about your working practice with pre-school children with primary speech and language needs

This questionnaire is designed to help us understand how you work with pre-school children with primary speech and language needs and their families. Your answers will be kept strictly confidential and you will not be identified by name. The questionnaire should take approximately 10 minutes to complete.

The results will be used for educational purposes, as part of my Doctoral degree. The findings may be published. This research is part of a national study funded by the National Institute for Health Research (NIHR) under its Programme Grant for Applied Research Programme. For further details see http://www.speech-therapy.org.uk/child-talk-what-works

Section 1 Working with parents and children

Please tick the boxes that most closely reflects the way you work generally in your current job

When you work with parents of preschool children with speech and language needs, how much are trying to change the following?

	Not at all	Slightly	Some	A lot	Very much
1. Parents' *understanding* of their child's S&L difficulties					
2. Parents' *capacity* to work with their child on S&L skills at home					
3. Parents' *interaction* with their child					
4. Child's *S&L skills*					
5. How parents *work with you*					
6. The way parents *support their child's learning* more generally					
7. The way parents *support their child's participation* in social activities					
8. *Parent's confidence* in helping their child with S&L					
9. Parents' *ability to assess* child's S&L skills					
10. *Parents' relationship* with you					

11. Parents' *understanding of their responsibilities* for supporting S&L skills					
12. Parents' *motivation* to help their child's development/progress of S&L skills					
13. Other (please specify)					

Section 2: Barriers to working with parents

Which of the following do you find are barriers to supporting parents?

	Never	Not often	Often	Quite often	Very often
14. A *gap in my training* and development with this client group					
15. *Parents' willingness* to allocate time to their child					
16. The *frequency* with which I can see the parents and child					
17. *High level of complexity* of the child's needs					
18. *High level of parental anxiety*					
19. Parents with significant *health or learning needs* themselves					
20. *Insufficient clinical support* in my job from senior clinicians					
21. Parents' *low level of interest* in their child					
22. Parents' *limited knowledge* of speech and language development					
23. Parents' *unwillingness to adapt* their approach to helping their child					
24. Parents' *difficulty in learning new ways* of helping their child					
25. Not being able to build a *relationship* with parents					
26. *Nursery/school staff reluctant to implement* SLT objectives					
27. Not being able to set *clear boundaries* about responsibilities between parents and SLT					
28. Parents thinking I am *too young to advise* them					
29. *My lack of parenting* experience					

30. My personal background, in terms of *class,* is a barrier to working with some parents					
31. My personal background , in terms of *ethnicity*, is a barrier to working with some parents					

Section 3: About you

Please tick the statement that describes you best

32.	Which region do you work in?	London North South Midlands Wales Scotland Northern Ireland Other
33.	How many years have you been qualified?	1-2 years 3-5 years 6-10 years Over 10 years
34.	What is your main client group (tick any which apply)	pre-school school age speech and language delay primary speech and language needs complex needs
35.	I work mainly with	Children Children and parents Children and teaching staff
36.	Where do you mainly deliver your service?	Children's homes Community clinic Children's centres Nursery Primary school Secondary school Other
37.	How long is your waiting time for first assessments (approximately)?	0-6 weeks 7-18 weeks 19-36 weeks Over 37 weeks
38.	How long is your waiting time for intervention after assessment (approximately)?	0-6 weeks 7-18 weeks 19-36 weeks Over 37 weeks

39.	Do you have a specialist area of expertise?	Yes No If yes, then please specify
40.	How would you describe your model of service delivery	
41.	Who is your employer?	Independent /private SLT NHS Local Authority State School Academy school Independent school Charitable sector Other (please specify)

Appendix 4: Example of reflexive account from research journal

Journal 25th January 2012

My practice has been dominated by a belief that I need to help parents change what they do with their children, whether this means doing activities that I've suggested to help their child's talking or doing 'interaction' differently. I have never given much thought to the focus on behaviour change, which is very much in keeping with models of health promotion, such as the theory of planned behaviour. It's becoming clear that enabling change requires changes in understanding as well as behaviour. There are at least two schools of thought that are relevant to working with parents. First, there are parental empowerment programmes focusing on behaviour change, whilst in contrast, there is the theory of conceptual change, originating from work with children that aimed to help children think differently, whereby their misconceptions were challenged and their conceptual framework adapted. The literature seems to be missing a theoretical model of how these two (conceptual change and behaviour change) are linked. Delving a little deeper into the behaviour change programme described by Olin, it becomes clear that this isn't strictly a behaviour change programme-there are references to building parents' ability to problem solve and reflect, which relates much more closely to helping parents think differently.

Learning to distinguish between promoting parents' underlying understanding and helping them practice activities, has intrinsic appeal to the therapist in me, relating closely to the priority I give to promoting children's understanding. It seems ironic then, that I have rarely thought about what parents have understood about their child's speech and language difficulties and the purpose of intervention and thought intensely about what I can give them to take away to do.

My study must aim to bridge the gap between understanding what parents do (or don't do) and what they think and understand. Could it be that some parents would participate more fully in helping their child if they had a better understanding? This leads to the question of whether SLTs need to focus more on passing across their knowledge to parents-this would have a considerable impact on the way I see my own and parents' roles. My current conception of the professional role is that I assess, I analyse, I problem solve, I suggest and I give parents some excellent ideas, strategies or activities. So what does that say about my conception of the parents' role?

Journal 3rd November 2012

There is so much to learn by talking with parents. Today's second interviews were very powerful examples of parents talking about understanding how to help their child, changing their behaviour and delighting in a different relationship with their children. Both parents interviewed refered to changes in their interaction with their children. This was automatically linked to comments about feeling more in control, happier, calmer and relaxed. One of the parents explained that she did not understanding how the SLT demonstration was different to her own way of playing and conversing with her child. She became aware of differences when she started explaining to her older child how to talk to his brother. She then watched how he interacted with the child with language difficulties and how their conversation and interaction improved. It seemed a vivid example of a transformative experience that depended on her reformulating or re-articulating the kind of role

that had been advised to adopt. She talked of suddenly becoming aware of how demanding she was and how her child avoided interaction with her, seeing it as a cycle of unhelpful behaviour they both then got involved in.