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Collaborative Relationships Between Families and Speech-Language Pathologists Within Family-Centered Early Intervention

Kelly Koch,[a] **Holly Damico,**[b] **Jack Damico,**[c] **and Ryan Nelson**[b]

[a] Speech-Language Pathology Program, University of Louisiana at Monroe [b] Department of Communicative Disorders, University of Louisiana at Lafayette [c] Department of Speech, Language, and Hearing Sciences, University of Colorado Boulder

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ABSTRACT

Purpose: The purpose of this study was to generate a theory, grounded in data, explaining the collaborative relationships between speech-language pathologists and families in family-centered early intervention.
Method: Using constructivist grounded theory methodology, three pairs of clinicians and families allowed participatory observations, video recording of sessions, parent interviews, clinician interviews, and documentation collection. Seven additional pairs of clinicians and families were interviewed, culminating in 20 total interviews. Data were analyzed using the constant comparative method, and a substantive theory emerged.
Results: From this data set, the substantive theory is that family–professional collaborative relationships are established and maintained by participants in family-centered early intervention via a constant process of feedback loops. These loops are cyclical social interactions, incorporating each of the participants' backgrounds and building shared knowledge with informational interactions, in which the participants establish and meet expectations and give and accept agency from each of the participants.
Conclusions: The individual relationships varied, as shown in the variation of the themes in individual experiences. The collaborative clinical relationship at the heart of family-centered early intervention, however, requires the continual process of feedback between social interactions, background, informational interactions, expectations, and agency to be considered by professionals.
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The Individuals with Disabilities Education Act (IDEA) Part C funds early intervention (EI) programs across the United States to meet the needs of families and support the development of children under the age of 3 years. These state programs provide focused services to enhance a family's capacity to help their child develop to meet their goals (IDEA, 2004). Section 303.13 provides the guidelines of these programs, specifically defining EI to be a collaboration with parents centered on their priorities, resources, and concerns. Intervention must be designed to meet the needs of the family to enhance their abilities to assist in their child's development.

The American Speech-Language-Hearing Association's (ASHA's) Practice Portal provides five guiding principles of EI, which include services being family centered, culturally and linguistically responsive, developmentally supportive to promote the child's participation in their natural environment, comprehensive, and based on the highest quality internal and external evidence available (ASHA, n.d.). Meeting the needs of the child to better engage in day-to-day life ensures that they have ample opportunities to continue learning (Roberts, 2019). In the following sections, current literature about family-centered EI and clinical relationships will be reviewed.

Family-Centered EI

Traditional intervention services focus solely on the individual with a disorder and limit family involvement to

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Correspondence to Kelly Koch: koch@ulm.edu. ***Disclosure:*** *The authors have declared that no competing financial or nonfinancial interests existed at the time of publication.*

passive roles (Crais, 1991; Epley et al., 2010). Throughout the 1980s and 1990s, EI services in the United States moved away from this focus on the individual toward a family-centered approach, which focuses on developing both client and family strengths (Crais, 1991). To develop a clear definition of family-centered EI, Epley et al. (2010) systematically reviewed the literature across social work, education, and health care fields and found five key elements. These keys are "family as the unit of attention, family choice, family strengths, family–professional relationship, and individualized family services" (p. 273). The researchers concluded that over the course of the decade of research reviewed, a shift of focus from the family as a unit of service to family choice and family–professional relationships had occurred. This indicates that while all key elements remain valued in the conceptualization of family-centered EI, how families are treated by professionals has become the focus (p. 278). The research presented here focuses on exploring the clinical relationships between parents and professionals interacting during therapy.

The efficacy of family-centered EI has been demonstrated by multiple studies. Parent-implemented interventions following training have been shown to promote social communication for young children with autism spectrum disorder (Hampton et al., 2022; Wetherby & Woods, 2006) and the prelinguistic skills for 6- to 24-month-old children with hearing loss (Roberts, 2019). Therapies based on training parents to modify interactions with their preschool children have been found to achieve therapeutic effect internationally and across cultural groups (Buschmann et al., 2009; Suttora et al., 2021; Vahidi et al., 2017).

In IDEA Part C services, the family is the recipient of the services rather than just the child. Family resources and goals are assessed during the evaluation process and integrated into the therapeutic activities with a focus on aiding families in facilitating their children's development. The family must be involved in the process of developing the individualized family service plan (IFSP), which documents the family's desired outcomes and sets objectives to achieve their goals. This requires clinicians to gain an understanding of the family's perspectives, values, and priorities. For example, family language and/or the family's values and expectations for the child may not be the same as the clinician's (Paul & Roth, 2011; Peredo, 2016), and therefore, discovery of the family's perspective is vital. Paul and Roth, in their 2011 Clinical Forum, provide readers insight into the inherently cultural nature of all clinical activities, writing specifically for family-centered EI, "SLPs need to recognize their own as well as the family's cultural perspective and how these factors might influence their perceptions of and interactions with others. However, people within any culture represent a range of perspectives" (p. 322). IDEA Part C services are required to be within the natural environment of the child to avoid services being in clinics. This means families may be seeing their clinician in the family home, yard, neighborhood park, and local library or at the child's day care setting. This research focuses on understanding how these participants, both professionals and families, work together to build their collaborative clinical relationships.

Clinical Relationships

The clinical relevance of therapeutic relationships has been demonstrated across multiple allied health fields (Bordin, 1979; Gagne-Trudel et al., 2024; Haynes et al., 2022). In speech-language pathology, significance was seen in adult clients' experiences of treatment for stuttering (Plexico et al., 2010) and clients' experiences of aphasia rehabilitation (Bright et al., 2021). Hansen et al. (2024) completed a scoping review of the empirical studies on therapeutic relationships in speech-language pathology. These researchers concluded that there is a need for "theoretically and empirically based specifications of the concept of [therapeutic relationships]" and that research in this regard would "benefit from an expansion of the qualitative and quantitative range of methods used in psychotherapy research" (p. 176). Hansen et al. (2024) found "a small number of studies that investigated the construction of relationships in therapeutic situations" (p. 174), which this research specifically addresses. The research presented here is a necessary expansion to better understand the complexity that exists in the relationships between families and speech-language pathologists (SLPs).

In 1979, Bordin proposed a working alliance between psychotherapist and client as key to the change process. Bordin's (1979) model of the working alliance included three features: the agreement on goals, assignment of tasks, and development of bonds. Agreement on goals ensures that both client and therapist are collaboratively working toward change in the client's life (Bordin, 1979). In Bordin's framework, assignment of tasks in which both client and therapist agree on concrete exchanges ensures collaborative effort. Finally, development of bonds, specifically the trust and attachments shared, in the working relationship between client and therapist is essential. Ebert (2017) used this model as the theoretical basis for the development of the Therapeutic Alliance Scales for Children, which provides a reliable and valid measurement of the clinical relationship between school-based SLPs and their clients.

Sylvestre and Gobeil (2020) continued developing Bordin's framework of working partnerships in the speech-language pathology field by expanding the theoretical foundation for the concept of therapeutic alliance. These authors organized therapeutic alliance around two components: "(1) A therapeutic relationship of trust (affective bond) which favors (2) shared decision making aimed at helping the clinician and client/family develop a common view of (a) goals of the intervention and (b) the explicit tasks and intervention intensity required to meet these goals" (p. 129). While acknowledging the complexity of these components, Sylvestre and Gbeil argued that establishing a good therapeutic alliance with the client and the client's family is a paramount responsibility of the clinician. Sylvestre and Gbeil's framework has not been systematical substantiated with clinical data but developed through a review of literature.

Aspects of family-centered EI relationships have been studied (Brotherson et al., 2010; Lee, 2015). Lee (2015) used a phenomenological ethnographic study to follow a family through a 6-month period in EI to describe the parent–professional partnership from the mother's perspective. This mother reported overall satisfaction from the services, which included physical therapy and special instruction, but expressed frustration with the number of professionals and the burden carried by the family to participate in family-centered EI (Lee, 2015, p. 6). She also noted the lack of emotional and psychological support (Lee, 2015, p. 7) available to support the family's journey. Brotherson et al. (2010) analyzed the partnership between professionals, including seven allied health professionals (occupational therapists [OTs], physical therapists [PTs], and speech pathologists were not differentiated), and families who participate in home visits in EI and considered the emotional needs of all stakeholders. These researchers found that the optimal partnership includes both the professional's and parent's emotional needs being met, specifically when there was a match between the emotional needs and skills needed by both the family and the professionals (p. 42). These researchers focused on the emotional needs of the participants, which does not address the shared goals and tasks aspects of Bordin's (1979) and Sylvestre and Gobeil's (2020) theoretical frameworks of clinical relationships. Brotherson et al. (2010) focus on describing relationships in which emotional needs are met or not met, but these researchers fall short of documenting the clinical process of establishing and maintaining clinical relationships. The research presented here addresses this gap by focusing on providing a detailed description of the interactional mechanisms that create and develop therapeutic relationships.

In light of these findings, the purpose of this research is to document how the clinical relationship is established within family-centered EI settings between SLPs and the families they serve. By focusing this research on participants who work together in family-centered EI and by collecting both professional and familial perspectives, this study addresses gaps in the literature related to the complex dynamics of existing clinical relationships in partnerships between individuals engaged in family-centered services. Therefore, the primary research question driving this investigation became: How do participants in family-centered EI, based in natural environments, establish and maintain their collaborative relationship? The aims include exploring these relationships and developing a theory of the processes involved in the creation and maintenance of the clinical relationship that is grounded in the experiences of the participants.

Method

Constructivist Grounded Theory

Constructivist grounded theory (CGT) methodology is a systematic and empirical data collection and analysis process directed toward development of a theory, or explanation, of a data set (Charmaz, 2014). CGT (Keane & Thornberg, 2025) research includes the constant comparative method of data collection and analysis, in which the researchers moved back and forth between data sets collected and the coding process during analysis to develop an understanding of the social theories at work (Charmaz, 2014). The socially complex nature of family-centered EI makes CGT well suited to answer the research question of how collaborative relationships between SLPs and families are established and maintained.

Positionality

CGT enables the research to better account for their positionality in the research process and reflects the relationship between researchers and participants (Charmaz & Thornberg, 2021). Consistent with positionality and disclosure associated with CGT, data collection and analysis reflexivity was guided through consistent memo construction. Data from this study were collected as part of a larger study taken from the first author's doctoral dissertation (Koch, 2020). The first author was the primary memo constructor as she was the singular point of contact with the research participants. The data collection and analysis were informed by and guided by the first author's experiences as a licensed and certified SLP with clinical experience as an SLP in Louisiana. The first author is a White woman and member of predominant Cajun ethnicity of the area, which provided cultural connections to many of the participants. She is not a parent. The researcher's clinical experience as a school-based SLP shaped the research recruitment process in Phase 2, specifically the theoretical sampling (Charmaz, 2014) of participants who experienced therapy enmeshed in day-to-day life, which was different from the researcher's clinical experiences. The other authors guided analysis and are all licensed and certified SLPs with extensive qualitative research experience; however, their role in the study occurred exclusively after data collection.

Data collection. Consistent with best practices in human subjects research, both the institutional review board (IRB) at the University of Louisiana at Lafayette and the IRB for the Louisiana Department of Health approved this study (Protocol number: SP18–122 CMCN). The specific recruitment, data collection, and analysis process for each phase are discussed in the following sections. The complete data collection and analysis process took place over the course of 1 year and 6 months. A detailed flowchart of the research data collection and analysis timeline is provided in Supplemental Material S1.

Recruitment

The researchers recruited participants in two phases from the state Part C program's online postings for SLPs. The recruitment process in Phase 1 was primarily based on convenience and, consistent with CGT, moved to being primarily based on the theoretical sampling approach in Phase 2 (Charmaz, 2014; Keane & Thornberg, 2025). In both phases, participants were contacted via the clinician's contact information posted on the state Part C website, and each clinician recruited a volunteer family. The convenience sampling of Phase 1 focused on finding clinicians and families who voluntarily participated.

Phase 1

In Phase 1, three family/client/caregiver triads allowed the researchers to collect in chronological order: (a) a participatory observation of therapy sessions, during which the researcher met the family and received informed consent from participants; (b) two video recordings of therapy sessions without the researcher present; and (c) intensive interviews of guardians and clinicians (Charmaz, 2014), with artifact and document collection throughout. Data were transcribed by the first author orthographically and verbatim using transcription methods outlined in Damico and Simmons-Mackie's (2003) work.

Details about the general characteristics of Phase 1 participants are organized in Table 1, including their assigned pseudonyms, races, reasons for children's treatment, children's ages across the data collection, and places of therapy. Documents shared with the research team included notes Katherine and Nichelle took recording their contacts with their partners, the de-identified IFSP from Beverly, and Rebecca's and Caryn's Service Provider Contact Note for the recorded sessions. The researcher entered sessions only during the participatory observation after getting informed consent. The researcher met each clinician before scheduled sessions to provide a handheld camcorder with instructions to remind the family about the video recording and then to begin recording. This reduced the researcher's presence in the sessions but ensured all participants were aware and informed of recordings. The intensive interview guide with illustrative questions used during both phases is included in Appendix A.

Beginning with the first data collected in Phase 1, constant comparative analysis began, leading toward a second phase of collection (Charmaz, 2014). This approach informed the decision making that guided theoretical sampling in Phase 2.

Phase 2

The initial Phase 1 analysis helped refine recruitment for the verification group in Phase 2, which was accomplished via theoretical sampling (Charmaz, 2014). To explore the relationships built in family-centered EI, the researchers focused on recruiting families with adult caregivers who participated in intervention enmeshed in daily life. By focusing recruitment on families identified by their clinicians, the data collection process added families who consistently participated with the clinician in therapy based on daily life routines. The Phase 2 participants included seven family/caregiver pairs who volunteered in intensive interviews. Details of each of the participants in the verification group are provided in Table 2.

Data analysis. Analysis of the data followed the inductive reasoning and explanatory focus framework set out by Glaser and Strauss (1967) and informed by self-conscious reflexivity as encouraged in CGT (Charmaz, 2021).

Table 1. General characteristics of Phase 1 participants.

Clinician (race)	Parents (race)	Child (race/gender)	Age of child	Reason for treatment	Place of therapy
Katherine (White)	Beverly & Jack (White)	Wesley (White/Boy)	2;10–3	Hearing impairment; speech and language delay	Daycare or mother's apartment
Rebecca (White)	Natalie & James (White)	Carrie (White/Girl)	2–2;3	Cerebral palsy; paralyzed vocal fold	Family's suburban, single-family home
Caryn (African American)	Nichelle & Benjamin (African American)	Sonequa (African American/Girl)	2;9–2;10	Motor speech disorder	Family's rural apartment

Note. Race is indicated in parentheses. Multiple reasons for treatment are separated by semicolons. Ages are given in years;months format.

Table 2. Descriptions of verification group participants.

Participant (race)	Assigned gender of child	Reason for treatment	Place of therapy
Clinician 1 (White), Family 1 (White)	Girl 1	Language/speech delay	Home
Clinician 2 (White), Family 2 (White)	Girl 2	Hearing impairment; language and speech delay	Mother consistently attended sessions at the daycare during her lunch break
Clinician 3 (White), Family 3 (White)	Boy 3	Autism	Home
Clinician 4 (White), Family 4 (African American)	Girl 4	Autism	Home/park
Clinician 5 (White), Family 5 (White)	Boy 5	Down syndrome; hearing impairment; beginning oral feeding	Home
Clinician 6 (White), Family 6 (White)	Girl 6	Language/speech delay	Home
Clinician 7 (White), Family 7 (White)	Boy 7	Language/speech delay; voice disorder	Once a week at home and once a week in daycare

Note. Race is indicated in parentheses. Multiple reasons for treatment are separated by semicolons.

The analysis process began as data were collected, employing best practices in reflexivity. Following CGT process (Charmaz, 2014; Keane & Thornberg, 2025), memo writing served as an essential step in which the researcher enhanced reflexivity and articulated conjectures during the analysis process. The researcher sustained memo writing consistently during data collection and analysis. These memos can be made available upon request; however, an illustrative example is provided in Appendix B. Line-by-line coding in grounded theory practices begins with the generation of gerunds that stay close to the data and, whenever possible, use the actual words and actions of the participants (Charmaz, 2014). These initial codes were reanalyzed cyclically to refine emerging patterns. Focused coding followed to further synthesize and analyze the data. During this step, the initial codes were compared with each other and the data to distinguish those with greater analytical power and continue the development toward the grounded theory (Chametzky, 2022; Charmaz, 2014).

During Phase 2, the researchers continued the constant comparative method of analyzing the data as they were collected. This continued until theoretical saturation was obtained when no new themes emerged from the unique experiences of the participants (Charmaz, 2014).

In summary, the first three participating family/clinician/client groups were sampled based on convenience. As their data were being analyzed, the verification group was recruited based on theoretical sampling of families and clinicians whose therapy sessions are enmeshed in daily life. All children involved in this study qualified for speech-language pathology services under IDEA Part C, and some children received other services (physical therapy, occupational therapy, etc.). All families were monolingual English speakers, and Family 2 learned and used basic American Sign Language (ASL) in tandem with oral English.

Verification and Credibility

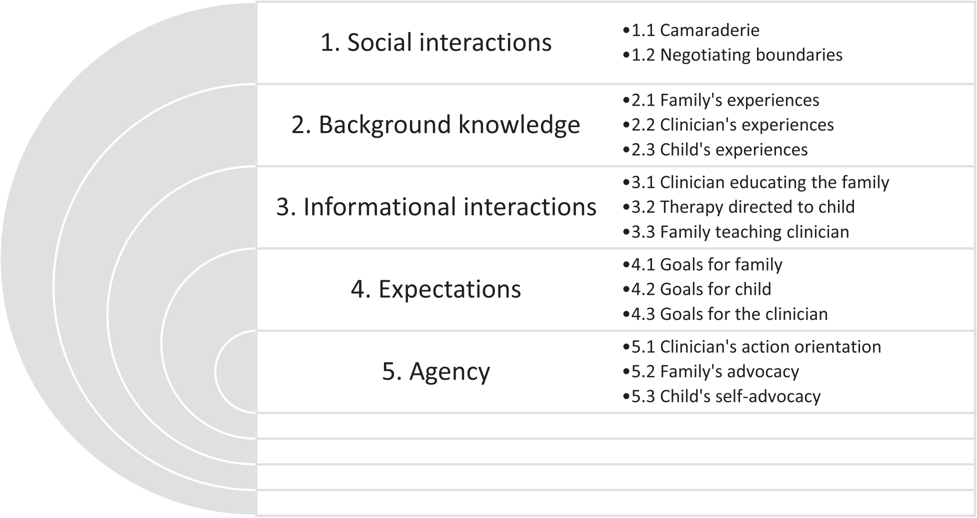
Researchers employed the process of triangulation (Damico & Simmons-Mackie, 2003) and the iterative analysis process associated with theoretical sampling, to ensure credibility and verification of the findings. This allowed for a variety of experiences to be represented and compared across the data analysis process.

Results

Researchers developed the substantive theory from the themes that arose from this data set (see Figure 1). The theory grounded in the data is that the therapeutic relationship established and maintained by participants in family-centered EI is a continual process of feedback loops between social interactions, incorporating participants' background knowledge, building shared knowledge with information interaction exchanges, establishing and meeting participants' expectations, and giving and accepting agency from each of the participants. The following sections will further explain each theme and subtheme of the process and provide examples from the data set.

It is important to note that the themes are part of the process of the relationships. The social interaction aspect is the beginning on which a relationship is built and then continues to be developed. There is no ending to social interaction; instead, it deepens as families and professionals learn from each other through the other processes while enmeshed in the social relationship. Figure 1 depicts social interactions as the largest circle that other themes are nested within because it is the foundation of the relationship. From there, each of the individual themes continues to loop back to each other for the maintenance of the clinical relationship.

Figure 1. Feedback loops of social interactions, background knowledge, informational interactions, background knowledge, expectations, and agency.



Theme 1: Social Interactions

The relationships built during EI are built on a foundation of social interaction between the participants. These interactions are based on sharing with another, which creates a trusting relationship to allow further sharing, creating a feedback loop of increasing intimacy of the relationship. Social interactions are those in which participants have the chance for free exchange and each participant's flaws are valued as part of shared humanity. For example, in Rebecca's interview, she stated:

Example 1. Rebecca's interview	
Rebecca:	I was coming in like that hey how'd how'd'j'y'all guys end up in Early Steps? That's like the first question, like hey, nice to meet'cha, get to know that I've got a bunch of kids and there's no mistake that you might make that I haven't made multiple times. So I feel like that I'm comin' in to like basically we get to know each other like human beings.

Starting her clinical relationships with clients with her experiences of parenting mistakes conveys her earned wisdom and allows parents to know her as a human being. These interactions are the basis for the intimate discussions of familial life, which is necessary for these therapeutic relationships.

Subtheme 1.1: Camaraderie. Social interactions build a trusting, nonjudgmental relationship that sets the tone and the reciprocity for the clinical and interactional enterprises. Camaraderie is gained through the social interactions the participants share, building trust as the clinical relationship continues. The clinical relationship at the heart of family-centered EI requires a trusting, comforting camaraderie for themes of informational exchange and meeting expectations to begin.

The clinical relationship built between Nichelle, Benjamin, and Caryn has developed a sense of trust important for Nichelle. During the parent interview, Nichelle shared that she can trust the Early Steps professionals to have Sonequa's best interests in mind for therapy and recommendations (Example 2).

Example 2. Nichelle's interview	
Nichelle:	So it's trust you know. I trust you that your gonna facilitate the right stuff for my kids because they've been with you guys for such a long time.

Nichelle says this trust is based on the long relationship her family has had with their Early Steps providers. Clinical relationships that include genuine camaraderie allow parents and clinicians to be able to trust each other in doing what is best for the child.

The nature of family-centered EI increases the intimacy of the clinical relationship that is hallmarked by the participants' camaraderie. In Example 3, Natalie, Carrie's mother, is updating Rebecca, Carrie's clinician, on a familial situation with Natalie's stepson, Harrison, and shares a conversation with her husband, Carrie's and Harrison's father, Jason.

Example 3. Video-recorded session between Rebecca, Carrie, and Natalie	
Natalie:	All I could think about was Harrison on Wednesday and I was like nope. [Nope.
Rebecca:	[Yeah,] save yourself. I I I mean you gotta you gotta pull yourself into the life raft.
Natalie:	I don't. I told Jason yesterday I was crying I said Harrison makes me feel like Lexapro's not gonna be enough.

This interaction is an intimate moment of sharing in which Natalie confides in Rebecca. Rebecca made the real-time clinical decision to respond with supporting affirmation along with a reminder of the benefits of self-caring boundaries. Natalie continues confiding, going as far as to explain that her relationship with her stepson is straining her mental health. Whether this discussion belongs in the scope of practice of a family-centered SLP is not in question because this family–clinician relationship required this level of intimacy to meet Natalie's and Carrie's needs in the moment. Rebecca clinically needed to provide support to Natalie's emotional needs to be able to help Carrie.

Clinicians act as trusted resources to families in EI, providing families guidance and support during their child's toddler years. This camaraderie allows the families to be as vulnerable as they need and allows families to be able trust in the advice and clinical recommendations the clinicians make.

Subtheme 1.2: Negotiating Boundaries. The level of camaraderie in family-centered EI requires clinicians and families also to be able to negotiate boundaries on what aspects of family life the clinician has access. The professional–family collaborative relationship requires an ongoing process of ensuring that each participant is comfortable with the level of sharing.

This negotiation of boundaries depends on each participant's preferences. In Example 4 below, Clinician 3 states her firm boundaries that help navigate the intimate details she is privy to by nature of her clinical relationship with the clients.

Example 4. Clinician 3 interview	
Clinician 3:	And they'll tell me amazingly intimate things. I always try to just remember that if they're bringing it up, it's important to them and we need to address it. You have to keep the lines. I'm not their friend. I don't go to birthday parties for the kids. I keep that line.

Clinician 3's boundaries are an example of her preference in working with families. Other clinicians and families have similar "lines" that they prefer to keep from crossing while navigating the waters of the relationship.

Theme 2: Background Knowledge

Clinical relationships in family-centered EI are focused on the continual facilitation of growth for the child and family. Each of the participants brings a deep fund of knowledge (Moll, 2019), such as the parents' experiences with their children, the children's expertise with their interests, and the clinicians' expertise in their scope of practice. As the relationship continues, each participant continually learns and incorporates new information into their background knowledge to approach future interactions, creating another feedback loop of shared information.

Subtheme 2.1: Family Experiences. Family-centered EI focuses on incorporating the available caregivers into the therapy sessions. This allows caregivers to continually learn new information, but it also gives these caregivers the chance to be the experts on their child and share that knowledge with the clinician. The family brings to the clinical relationship background knowledge of their child that the clinician needs to gain to be able to provide services, such as case history information, preferences, and challenges.

In her interview, Rebecca discussed her clinical positions that affect her clinical decision-making process, including her valuing the family's experiences as a part of learning about the child.

Example 5. Rebecca's interview	
Rebecca:	She, she's the expert. Of her kid, you know. Always have to honor that. You know. Big time ((laughs)).

This inclusion of the family experiences in the clinical decision-making process sets the stage for the clinical relationship to be a collaborative sharing of knowledge and experiences.

Subtheme 2.2: Clinician's Experiences. Clinicians come to family-centered EI interactions with their professional background and training in childhood communicative development and disorders. With gained clinical expertise, clinicians also bring experiences with previous clients and families. These subsequently guide their decision-making processes, including their appreciation and understanding of engaging families in EI activities. During her interview, Katherine discussed her increased understanding of language development theory from her clinical experiences in EI.

Example 6. Katherine's interview	
Katherine:	It was like oh, all the stuff all the theory you learn, it just clicks. I mean it did for me. It was like bubbles or you do puzzles, you engage and play, and you teach parents how to do it too.

From her clinical experiences in the EI age range, she gained an understanding of how engaging in play develops the language of the child and how to teach parents to facilitate their child's language development with play. These theories gained meaning in the clinical experiences she had as a family-centered EI provider.

With experience in the family-centered EI system, clinicians also gained knowledge of access and community supports for families. Clinicians who often worked with augmentative and alternative communication (AAC) access discussed their contacts in lending programs. Clinicians who often worked with deaf/hard of hearing had knowledge about sign language learning opportunities in the community and Deaf cultural events in the area. The professional knowledge and experiences these clinicians brought to their collaborative relationships were vital for the success of the family-centered EI.

Subtheme 2.3: Child's Experiences. As important as the backgrounds the adults bring to the family-centered EI relationships, the child's experiences are equally influential. The child is actively constructing knowledge of the world around them (Tomasello, 2009), and the adults they are interacting with are facilitating their experiences and negotiating their language. In the clinical interaction, it is these negotiations that are the subject of the discussion. Example 7 below provides a segment of interaction during which the child's use of background knowledge, specifically vocabulary previously learned, keeps the interaction moving forward.

Example 7. Katherine, Beverly, and Wesley's video-recorded session

Beverly:	((blows bubbles in direction Wesley is pointing))
Katherine:	Sometimes he'll say [here.=
Wesley:	[Dow' low!]
Katherine:	=and like okay but specifically?
Beverly:	Mhm
Wesley:	((bends down and chases bubbles))
Katherine:	On my? ((points to her own belly))
Wesley:	[Nahahaha!] ((jumps up and down))
Katherine:	[They were down low.] ((laughs, claps and then points downward)) ((looks toward Wesley)) Where now?
Wesley:	Up high! Again! ((jumps up while pointing up))
Katherine:	Up high again but what about on your body? ((ASL sign for on)) what about on your (2.1) ((holds out hands)) han:ds?
Wesley:	On my belly!

Importantly, Example 7 demonstrates the interplay between the subthemes in which Katherine uses her understanding of Wesley's background knowledge to increase Beverly's ability to facilitate Wesley's language growth. These themes and subthemes are, again, feedback loops in the process of the relationship's life. Each participant's background knowledge is an important source for Theme 3, informational interactions, to provide feedback and change across the relationship.

Theme 3: Informational Interactions

Each of the collaborative relationships used informational interactions to accomplish clinical work. Informational interactions are focused on the exchange of information from one participant to other participants. Parents learn from therapists who are teaching and vice versa. It is in these interactions that clinicians explain professional jargon, such as reverse mainstream as an option in some future school or, as shown in Example 8 below, forced choices to address shared control needs. This is also where clinicians act as information providers in therapy to children (e.g., direct children, ask children questions, and correct the children's answers). Parents take an active role as experts on their children by sharing updated information with the clinician. The exchange of information allows each participant to use their knowledge and be valued for their knowledge in the therapeutic interaction.

Subtheme 3.1: Clinician Educating the Family. Analysis of video-recorded sessions and interviews show clinicians in family-centered EI prioritize educating the family. This is in line with the requirements of IDEA Part C, which states that the statewide system must provide "supports and services necessary to enhance the family's capacity to meet the developmental needs of the infant or toddler" (IDEA Subchapter III, 1436). The clinicians in this data set made various attempts to ensure the family left the therapy relationship with more understanding of their child and more tools to help their child. Example 8 below demonstrates an informational interaction in which Katherine is supporting the parents, specifically Beverly, with incorporating strategies into daily interactions with Beverly's child, Wesley.

This interaction took place in Beverly's living room and overlaps with Wesley playing next to Beverly and Katherine. Katherine shares her knowledge of Wesley's successfully sharing control with other children and the forced choice technique to facilitate the children's interaction. This segment of Katherine, Beverly, and Wesley's clinical relationship—especially focused on the informational exchange in which "what works for this child"—becomes shared knowledge between his caregivers.

Example 8. Video-recorded session between Katherine, Beverly, and Wesley	
Katherine:	And at school in class it worked out.
Beverly:	Okay.
Katherine:	Rea:lly well and I even told the teachers try to use those things. Which
Wesley:	((drops boat))[Man:]
Katherine:	[can] he have and she have? Instead of said [share at]=
Beverly:	[Right]
Katherine:	=the preschool. [Nah]=
Beverly:	[No]
Katherine:	=I don't want to.
Beverly:	Right.
Katherine:	But if ya say which one he's [like oh I have a choice.]
Wesley:	((playing with boat, sail breaks)) [(uh da sail broke)]
Katherine:	It's a forced choice but.

Subtheme 3.2: Therapy Directed to the Child. At the heart of the clinical relationships in family-centered EI are the therapeutic interactions directed at helping the child communicate more appropriately. This subtheme of the clinical relationship focuses on interactions in which the SLP specifically reacts in moment to the needs of the child. These informational interactions include the clinician providing the child facilitation in their exploration of the world. In the sample of the expanded field notes from an observed clinical session, Caryn demonstrates making clinical choices to direct information toward the child as Sonequa explores picture books.

Example 9. Caryn, Sonequa, and Zoe's session participatory observation
Zoe tells Caryn that Sonequa always labels the parts of the book: the cover, the spine, and the back of the book. Caryn reads the title, *Noisy* Farm . . . On each page, Caryn asks Sonequa, "What is this animal?" and "What sounds does it make?"

In the above sample of the expanded field notes from the participatory observation, Caryn engages Sonequa in the exploration of an early book with a labeling activity. Over the course of the shared book experience, Caryn asks Sonequa *wh*-questions about the content of the book. At the beginning of the book activity, Zoe, Sonequa's adult sister, shares with Caryn that Sonequa has carried over this repeated activity to their daily reading time together.

Therapeutic activities in family-centered EI are focused on both the child achieving therapeutic change and the family learning from the modeled behavior of the clinician. During the family interviews, parents discussed activities they witnessed during typical clinical sessions, including the segment from Family 5's interview in Example 10 below.

Example 10. Family 5 interview	
Mom 5:	The last session, she brought out a book, a picture book—it was a sticker book. We were looking on the color, red. So there was a red apple, red tractor, four red things, whatever. So we put the sticker on the thing and gave her a color and let her try to color. Then we did bubbles that day. We did two books. An hour goes by fast because me and Clinician 5 are like talking and with stuff.

In this example, the mother of Boy 5 recounts the previous session of therapy. In this recount, it is important to note that the mother lists herself as an actor, using "we" when discussing what is done during therapy. Finally, the mother notes that part of the time of a therapy session is used for her and the clinician to talk. This collaboration builds the family's knowledge of helping their child and the agency of the family.

Subtheme 3.3: Family Teaching the Clinician. The family-centered EI relationship differs from traditional child-focused therapeutic relationships because of access and respect to familial expertise. The family is actively engaged in learning from the clinician and the child, but the clinician is also actively engaged in learning from the family about their values, concerns, and preferred activities. While services received from IDEA Part C funding are required to assess the family's priorities and concerns, family-centered services go further by including the family in the therapeutic process. In Example 11, Rebecca's attitude of humility when entering the familial space can be viewed in the interactions between Rebecca and Natalie during the participatory observation session.

Example 11. Rebecca, Natalie, and Carrie's participatory observation session
Rebecca asks Natalie about Carrie's work with the OT/PT, specifically how Carrie is sitting up. Natalie reports that Carrie's been sitting up for meals but has missed her last few physical therapy/occupational therapy sessions because she's still recovering from a bout of pneumonia.

Rebecca relies on Natalie to report important information regarding Carrie's medical state, especially feeding and positioning. Natalie must consistently update Rebecca and Carrie's other clinicians to ensure that they can adjust their services as necessary. This open flow of information from parent to clinician allows the clinician access to both the child's changing status and the family's knowledge of the child.

Theme 4: Having Expectations

As the participants learn about family-centered EI, the speech-language pathology field, and each other, they develop expectations for themselves and the other participants. Expectations are in continual negotiation as social and informational interactions change the participants' background knowledge, creating another feedback loop between the themes. The interactions that drive these clinical relationships provide opportunities for all participants to learn and change expectations.

Subtheme 4.1: Goals for the Family. Participants in this research were part of IDEA Part C services, either receiving services or providing them. As such, these clinical relationships include official goals in the form of IFSPs and unofficial goals focused on changing the family's abilities to support their child. During her interview, Clinician 7 discussed the services she provided for a child with a voice disorder, specifically changing the familial vocal behaviors.

Example 12. Clinician 7 interview	
Clinician 7:	I watched for thirty minutes and here's what's happening. You're yelling from the kitchen for them to get something. Nope. You gotta walk in there. You gotta model what you want 'em to do.

In this segment of interview, this clinician's goals were for behavioral change for the mother to model more vocally safe behaviors to the child. The goals referred to in this theme may not be written specifically in the IFSP or even agreed upon by the clinician and client. Facilitating adult understanding of the child's needs and modeling for the adult how to have interactions that facilitate the child's growth are done to meet the goal of the parent better being able to meet their child's needs.

Subtheme 4.2: Goals for the Child. The adult participants come to clinical interactions with goals that are discussed and formally recorded in the IFSP. These formal goals are just a subsection of all the possible goals at play in the therapeutic relationships in family-centered EI. Many goals for the child are, like goals for the parent, unwritten but focused on interactions.

During the theoretical sampling interviews, Mother 2 discussed how she learned to change her expectations for her child by observing Clinician 2's interactions. Mother 2 observed almost every session with her child and learned her child was capable of more than Mother 2 had expected. From her interactions with her child's SLP, she learned how to hold her child to expectations of growth and how to help her child learn.

Example 13. Family 2 interview	
Mother 2:	Every week they would bring a more challenging toy or more challenging activity. And I'm like, she's too young for that. The first time they brought a puzzle, I flipped out. She can't do puzzles. I know she can't do puzzles. But I had never tried because she was so young at the time. Why are you bringing it? But she did it. She proved me wrong. If you keep challenging them. That's one thing I never would have done. I always bought toys based on the age on the box, you know. Now I'm realizing you can push them. They may not be able to master it right away but you can encourage it and they'll learn.

While this clinical interaction has formal goals in the IFSP, doing puzzles and playing with toys labeled for older children was what the mother learned in the interaction to be her goal. She reports a change in her understanding of challenging the child to help the child meet her goals.

Subtheme 4.3: Goals for the Clinician. In family-centered EI, clinicians are part of a reciprocal working relationship, with expectations of professionalism and clinical competency as defining features. Professionalism, however, may look different in a client's home with the family than it would in a more controlled clinical environment. By IDEA guidelines, therapy must happen in the child's natural environment, which, for many clinicians, means they are stepping into their clients' familial lives. This breach into more private settings results in expectations that the clinician will be flexible and accepting of the family's situation. In the example below, the mother mentions in her interview that the value of family-centered EI includes therapeutic changes in her child's swallow behaviors but also the "girlfriend"-like relationship she has developed with her clinician.

Example 14. Family 6 interview	
Mom 6:	It's kinda like just having a girlfriend over who's like helping my kid out. Which is great, I mean, I love their relationship that we've built with all of 'em. I've learned a lot as far as like the feeding, the different techniques like she uses with the spoon, the side spooning and those techniques are good for whenever he's moving his tongue all over the place. I have noticed that when he is eating, his tongue isn't pushing it out as much.

This example demonstrates the unwritten expectations for the clinician, including the goal of therapeutic effectiveness as well as meeting the social needs of the family. In the collaborative relationship built in family-centered EI, each participant develops expectations for the others. The family learns what to expect from their therapist and child, and the therapist makes a clinical plan based on what can be expected from the family and child.

Children learn what's expected of them and what to expect from their communicative partners. Each of these participants learns and takes agency of their own learning through the relationships.

Theme 5: Agency

Agency is the capacity to influence your life and your environment. The clinicians are using their agency to continue their careers as health care providers as well as aiding the families in the process of learning how to help their children. By engaging in the process to begin and maintain EI services, these families have already demonstrated their agency over their lives and their children's lives. The family members involved in family-centered EI are also learning with the clinician about how to best advocate for their child's particular needs to ensure future agency. The children are in the process of developing a sense of agency within their own lives and using communication to achieve change in their environment (Tomasello, 2009). The individual's expression of agency is required for the clinical relationship to continue through the process of family-centered EI.

Subtheme 5.1: Clinician's Action Orientation. Clinicians in family-centered EI are responsible for both supporting therapeutic change in the child and supporting the familial unit's knowledge. The professionals in this data set were consistently focused on problem solving with the families to ensure parents learned their options and how to navigate the educational and health care systems by the time EI ended. These dual professional responsibilities ensure that clinicians are acting as agents of change in the lives of their clients. In the example below, Clinician 1 connects her philosophy for practice with giving clients the tools they need to communicate functionally.

Example 15. Clinician 1 interview	
Clinician 1:	That's what we do, essentially, y'know, give them the tools necessary to help, the play scripts, in a very functional manner. Y'know, so that's, y'know, that's my philosophy as to the way I practice . . . And what I have newly launched I don't if you saw this at (specific location). I have launched this program to help educate parents on how to communicate with their toddlers.

Clinician 1 offered extra programs to provide more opportunities for parents to learn. In the statement above, this clinician brings together her goals for her clients and how she acts to help her clients achieve those goals.

Clinicians in family-centered EI clinical relationships are employed to act as agents of change in their clients' lives. These clinicians incorporate collaborative problem solving in interactions with families to both ensure immediate solutions and support the parents' continued advocacy for the child.

Subtheme 5.2: Family's Advocacy. Parents seek and begin the EI process. Each participant in EI is there because the parents advocated for their child to receive services. While clinicians were recruited based on willingness and availability, parents and clients were chosen by the clinicians because they matched the theoretical sampling needs for parents who were involved in the clinical relationship that is the focus of this research. As such, this may have influenced the results to include abnormally advocacy-focused parents. In the following Discussion section, this will be further explored with clinical implications for supporting a family's comfort in advocating.

During Nichelle's interview, she discussed how her increased knowledge of Sonequa's needs, gained from her time in family-centered EI, prepares her for future school situations, completing a feedback loop across the themes of informational interactions and agency. In Example 16 below, she also compares how parents who did not have family-centered EI therapy may feel at school meetings.

Example 16. Nichelle's interview	
Nichelle:	I know that I need to provide that to you because it's been told to me by the the Early Steps people. You know, I know the assistive devices she needs. I know her weakest and her strongest. Um but a parent that didn't have the Early Steps process and their kid is in need now you know now that you're at school and being evaluated you'd be there sitting twiddling their thumbs being we- well, I I I want.

As Nichelle explains above, what is learned in the informational interactions of family-centered EI becomes the background knowledge for the family to arm themselves with in the future. In Mother 2's interview, she describes her experiences of both family-centered EI and other therapies centered on Child 2. Below, she shares that after her family moved and began therapy with another therapist, Mother 2 turned back to Clinician 2 to seek help and advice.

When a new clinician wanted Mother 2 to sit out of the sessions, Mother 2 "immediately" called Clinician 2. With the support of Clinician 2 and Mother 2's sister, Mother 2 contacted her Family Service Coordinator (FSC in line 335) to request a change of clinician. Mother 2 continues discussing her perspective that she is investing time into learning how to "extend the benefit" of therapy and that therapists are helping both the child and the parent.

Example 17. Family 2 interview	
Res 1:	You mentioned um the clinician that didn't want y'all in the room. How'd that go?
Mom 2:	I called Clinician 2 immediately and said this doesn't seem right, like why is, cause if she just let, I was so upset. I was already upset I had to leave Clinician 2 and then now I get somebody who won't let me interact. If I (.) I don't know. I just. And so I called my sister, too. And I asked her to weigh in and she's like, "No, Mom 2, it's way better if you're in the room." So she was like, "Mom 2, if you don't feel comfortable with that, then you can request a different person." I didn't know I had a choice. And so I called FSC with Early Steps and I said, "Is there any way I can get either, Clinician 2 back or get somebody else, cause I really just, I don't feel comfortable with this" and she's like yeah that's fine. And the lady's super nice like I have no doubt she was a great therapist, but it's just I wanted to be involved.
Res 1:	Oh yeah, for you and your family.
Mom 2:	Yeah, for me to learn, first of all, because I'm paying them to help her, but also to help me. So that I can help, y'know, teach and like extend the benefit, but also because I'm taking an hour off of, more like two hours off of work cause I have to travel and hmm. So like I'm taking, investing a lot of my time, too.

Parental advocacy in relation to family-centered EI is demonstrated in both Examples 16 and 17. Parents of children who are receiving EI have already taken proactive steps to ensure their children are supported. Parents who are active participants in the family-centered EI relationships, as was required in the theoretical sampling procedures, are learning how to advocate for their own and their children's needs.

Subtheme 5.3: Child's Self-Advocacy. The children involved in family-centered EI are active participants in their worlds and therapy. They are learning self-advocacy skills as they are learning to affect change in the world around them with functional communicative development. The children in this data set are receiving EI services to continue this development with the aid of their clinicians and their families. Throughout the data, children demonstrated their advocacy, and adults recognized and responded meaningfully to communicative attempts. Example 18 is a segment of a therapy session between Rebecca, Natalie, and Carrie, in which Rebecca incorporated the family's two new books into the therapy session.

Example 18. Rebecca, Natalie, and Carrie's video-recorded session	
Rebecca:	I bet. Here maybe cat or dog? ((holding up two books in front of Carrie)) Wha'd'ya think?
Natalie:	[Which one Carrie?
Rebecca:	[Biscuit or Splat?
Carrie:	((reaches over and points to Biscuit))
Natalie:	[Biscuit!
Rebecca:	[Haa!] Biscuit it is. Yeah, I think she will do nicely with uh ((pointing))

Here, Rebecca has set up a situation in which Carrie is expected to decide and communicate that decision. Carrie, who is learning AAC modalities while living with partial paralysis, reached across her weaker side to point at her selected book. Natalie and Rebecca both respond meaningfully to Carrie's communicative behaviors and follow Carrie's lead. Rebecca additionally talks through her thought process on how this interaction indicates Carrie will continue with her AAC modality learning. By using this in-the-moment behavior to talk through the larger AAC process, Rebecca is including Natalie in learning about AAC and Carrie's abilities in future AAC learning. In Example 19, Mother 4 discusses how encouraging her child's agency by accepting communicative attempts is a concept that Clinician 4 helped her learn.

Example 19. Family 4 interview	
Mom 4:	[Clinician 4] said, "You should take that." It's not communicated through the mouth, but she's telling you "No." That's what [Clinician 4] said. You'd better just compensate and take that because some parents don't want to take that, but you have to take baby steps and take that.

Mother 4's knowledge of language development and the value of responding to communicative attempts was affected by Clinician 4's direct teaching. Clinician 4 helped this parent learn to recognize and value her child's agency when communicating "no" when not using "through the mouth" speech.

While the adults in family-centered EI are expressing agency consistently, they also are learning how to interpret and accept the developing agency of the children. These children may not have access to conventional means of expression, by nature of their EI needs, but they are communicators using multiple modalities to express their agency to their social partners.

Discussion

The theory that emerged from the data describes the maintenance of the relationship between clinicians and families in family-centered EI as an ongoing process of feedback loops between (a) social interactions, (b) background knowledge, (c) informational interactions, (d) establishing and meeting participants' expectations, and (e) giving and accepting agency from each of the participants. These findings describe the clinical relationships that are possible with continual effort from the participants to achieve collaboration within family-centered practices. The following discussion seeks to highlight the reciprocity within each theme and the feedback loops that connect the themes.

The theme of social interaction provides insight into the value of a level playing field for the participants to get to know and care about each other. The participants share aspects of their lives together because many in family-centered EI are building a relationship across multiple years. Life experiences shared during family-centered EI, therefore, are often more intimate in nature. For example, consider the sharing of parenting wins and mistakes and familial struggles described above. These free exchanges arise from and allow trust to be built between the participants, which supports the clinical relationships at the heart of family-centered EI (Holland & Nelson, 2020). Bordin's (1979) theoretical framework of the clinical relationship included bonds as a major aspect. The social interactions documented by this research demonstrate how bonds of comradery tie together the clinical participants and allow for negotiation of healthy connections and boundaries (Hansen et al., 2024).

Consistent with other learning contexts, EI partnerships must embrace the resources of experience and preferences that those involved bring to the relationship (Moll, 2019). When these resources are valued, they offer funds upon which to draw as collaborative relationships unfold. This study demonstrates how each participant in family-centered EI brings to the interaction these funds, in the forms of relevant background knowledge. The collaborative relationship provides opportunities for each participant to share knowledge for the success of the therapy. The negotiation of boundaries taking place in the social interactions helps define who is expected to bring relevant information to the interaction. Families brought knowledge of their experiences with their children, clinicians brought clinical knowledge and experience, and the children brought experiences and interests in the world around them. The framework of clinical alliance defined by Sylvestre and Gobeil operationalizes the importance of background knowledge in their highlighting the need for informed shared decision making (p. 128).

As a theme, information interactions ensure background knowledge can be shared and the expertise of each participant is valued throughout the relationship. As experts of communication development, SLPs provide therapy to children and education to parents (Hansen et al., 2024). As experts in their children, parents provide case histories and updates on changes. As experts in their communicative intentions, children engage in the interactions around them. With the trust and comradery that is built by social interactions, more frank conversations can take place, allowing for more background knowledge and experiences to be disclosed across the participants during these informational exchanges.

As each participant learns about and with the others, their expectations for each other evolve. The focus of Part C family-centered EI services is on meeting the needs of the family and helping them meet their own goals (IDEA Part C, 2004). The family and clinician have goals for a child's development, which are, possibly, written formally for documentation needs. Informally, the family has goals for the clinician, and the clinician has goals for themselves. In Sylvestre and Gobeil's (2020) therapeutic alliance framework, "goal setting implies a mutual understanding of the problem about which the client is consulting and of the client's strengths and needs" (p.128). This principle is demonstrated clearly in our discussion of the feedback loops between informational interactions and expectations. Each participant in the collaborative relationship is working together to make changes and meet these goals (Freckmann et al., 2017).

The adult participants in family-centered EI have and express their agency in the process of beginning and sustaining their clinical relationships. Agency is listed here as the final theme of interest, but it is an important reminder that these are not operationalized as isolated aspects but instead continual aspects of the relationship that is being built by the participants. Participants require agency to begin the therapeutic relationship, and that agency is continually built as they gain knowledge from informational interactions and develop confidence and comfort needed to build upon social relationships. Sylvestre and Gobeil's framework centers shared decision making as "the heart of therapeutic alliance" (p. 129) and a key aspect to client autonomy (2020). Clinicians adopting an action orientation ensure that continued change in the lives of the families and children is guided by background knowledge in childhood development and their gained knowledge of the families' needs (Brotherson et al., 2010; Hoepner, 2024). Families advocate for their children to begin services, during which they learn new information that can be used to continue advocating after their EI relationships end. As demonstrated in the data above, the children's self-advocacy continually changes as they construct more effective communication methods and the families learn to respond.

The individual themes discovered within these data sets are never separate. Each overlaps continuously with the others to build and maintain a productive clinical relationship. The feedback between sharing information and valuing the background information the participants bring to the therapeutic interaction allows the development of personal agency within the relationships. The individuals are more capable and comfortable in learning from each other and using their gained knowledge to make changes as their individual roles and expertise are recognized and utilized within therapy. Each participant uses individual agency to make changes in their lives and interactions, thereby implementing what is learned from the informational exchanges and assimilating new information that becomes background knowledge for future interactions.

Clinical Implications

This research explores the clinical relationship-building process that family-centered EI nurtures. The themes that are most within the control and manipulation of the clinician are the social and informational interactions. Being consistently supportive and consistently informative allows the clinician to have the social and informational interactions, which can build the family's background knowledge and ensure that the family's expectations for therapy are being met. While direct control and manipulation over the family and the child's agency is not clinically possible, by building a consistent relationship that the family can trust and rely on, the family can build background knowledge, expanding their expertise and practice being a source of valuable information and influence over their child's care.

SLPs and early interventionists interested in incorporating family-based services can encourage parental advocacy by valuing the efforts already present in clinical relationships. Every family enters therapeutic services with some level of agency. Minimally, by nature of having gone through the process of getting services, families have developed strategies and capacities that can be drawn upon moving forward. Looking for and celebrating the steps the families have already taken for their children begins the trust-building process with families. This stance acknowledges the difficult and emotionally laden work families are already doing. It positions the clinician to open relationship pathways for learning from the family. Clinicians should begin by seeking family knowledge and immediately incorporating this information into therapy plans. For example, motivating routines for the family and child, such as going grocery shopping or to the park, can be the context for family-centered therapy but requires the clinician to first learn about each family's motivations and goals (Clark et al., 2024).

Clinical interactional styles of traditional speech-language pathology services are associated with more impairment-focused therapy and characterized by the therapist correcting the person with a disability (King et al., 2013; Simmons-Mackie & Damico, 2011). In the family-centered EI clinical relationships studied here, the interactional styles are characterized by ongoing reciprocal social and informational interactions, with parents, clinicians, and children sharing and receiving to build a shared bank of background knowledge together. The clinicians' candid discussions about their professional and personal experiences demonstrated their knowledge and actively built trusting relationships with their clients. Simmons-Mackie and Damico discussed "relationship-centered therapy," writing that "it is the task of the clinician to achieve a 'relatively' egalitarian relationship in which interactional power shifts between client and clinician in a way that effects change and bolsters self-esteem" (2011, p. 50). The clinicians share and listen to allow clients the chance to discuss their knowledge, experiences, and needs, which in turn allows the clinician to learn how to respond in the clinical interaction. As demonstrated above, parents leave these family-centered EI relationships with increased knowledge of how to advocate for their children and their family needs as well as increased awareness of their children's communicative styles.

Many of the themes here are consistent with the findings of Plexico et al. (2010) with adults who stutter, discussing the characteristics of effective and ineffective SLPs. By turning the focus from the individual adult client and toward family-centered EI, this research demonstrates that the clinical relationship needs of speech-language pathology clients are shared across these populations and experiences. This highlights the need for increasing the empirical research within speech-language pathology on clinical therapeutic alliances. This also highlights the need for increased instruction on clinical therapeutic alliances in preprofessional training.

Limitations and Future Directions

It is important to be mindful that each therapeutic relationship is necessarily different to meet the needs of the individuals involved. The themes explored here were found throughout the data set. The recruitment process for this study and the theoretical sampling used resulted in the population represented. With only two African American families and one African American clinician, the lack of cultural, racial, and ethnic diversity in the sample is a weakness of the research. Future research could address the limited documented diversity of the participants by overtly seeking such variables in the sampling process. Readers should be cautious about generalizing these findings to all Part C programs or all family-centered programs because all participants in this research were under the same state-level agency. Different results likely would be found in different Part C programs and different family-centered programs.

The recruitment process during theoretical sampling introduces a limitation into this research. The researcher contacted Part C providers from publicly available information, and the clinicians selected the family to recruit. This was done to ensure the family and clinician had a relationship, according to the clinician, to be relevant to the research questions and to collect rich data from informed participants but may have biased the recruitment. The recruitment continued until the themes reached theoretical saturation (Charmaz, 2014; Charmaz & Thornberg, 2021), and no new properties emerged in the constant comparative method.

Understanding the clinical relationships in speech-language pathology and understanding how clinical relationships are established and maintained requires more research. How family-centered relationships differ or do not differ from other clinical relationships should be addressed in future research. Empirical research on how the participants in the clinical relationship act and build meaning will provide the field a framework of clients' experiences and perspectives during the therapeutic interaction.

Data Availability Statement

To protect participants' identities, the raw documents and audio and video recordings are not available. The first author can provide de-identified data upon request.

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Appendix A

Sample Interview Questions

Descriptive Questions

- Grand tour examples:
  Tell me about a typical therapy session.

  Tell me about your experiences with early-intervention.
- Mini tour examples:
  Tell me about your most recent therapy session.

  Could you tell me about getting started in early-intervention?

  Where do you see your/this family in a few years?
- Experience examples:
  Tell me about working with "the therapist/the family."

  What's your opinion on family-centered early-intervention?
- Native language examples:
  What do you do if you don't understand what "therapist/family" meant?

  What do you do if you and "therapist/family" disagree?

Structural Questions

- Inclusion examples:
  What kinds of activities happen during early-intervention?

  What kinds of tasks make up family-centered intervention?
- Location examples:
  What places do family-centered interventions take place?

  What places do environment-based intervention take place?
- Means-ends examples:
  Tell me about what you do to make intervention family-centered happen?

  Tell me about what you do to collaborate with the family/your clinician?

Appendix B

Memo Example

Sept. 10 Reciprocity

There is a reciprocity to the relationship between mothers and clinicians. The mother learns when the clinician teaches, yes, but there is also a clinician learning when the mother teaches. There is openness in the relationship that allows for both adult participants to share freely. When the mother expresses an emotional need, the clinician provides support AND empathizes. I noted this in my earlier memo about the sharing/matching of stories, in which I looked at Katherine and Beverly. Beverly would share a story from her life and Katherine would match with a similar story. As I'm writing this, it stands out to me that after Natalie shares how she's stressed about her older stepson's actions and virus, Rebecca shares how she talked to her children about safe sex practices. In these moments, they're not just clinician advising mother, but instead two mothers sharing fears and experiences. In Natalie's interview, she calls her Early Steps therapists like, "older sisters, aunts, whatever you want to consider them that I um don't have." Part of this family metaphor is an intimacy shared. She talks about and does bring more than Carrie's language and speech needs to Rebecca, and, in turn, Rebecca advises her on more than Carrie's language and speech needs. Clinician's role and mother's role are consistently reciprocal in nature with neither being expected to give without getting in return (information necessary for the clinical work or social/emotional needs).

Themes must consider and highlight how these interactions are reciprocal. The parent shares a bit of herself and the clinician responds with a bit of herself. These women come together under difficult circumstances (child with diagnosis, not developing normally, something wrong) and the clinician is entering their home no matter what is going on before or after (families fight/forget to fold laundry/mothers don't always get to grab a shower). Clinician 3 is the only clinician that specifically talked about boundaries and "not being her friend," but she was talking about not listening to mother's boyfriend issues more than anything. She even readily talked about giving finance and marriage advice to the parent and, when she did, she couched it in "my husbands' job let's me do Early Steps therapy and I'm thankful for it, so you should be thankful for what your husband's job let's you do." She had to share her life experience in a personal manner to make the advice matter. A comparison of her own life experiences to illuminate someone else's.