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Consensus on the Components of Therapeutic Alliance in Stuttering Intervention: An e-Delphi study with Speech and Language Therapists

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Abstract.
BACKGROUND: Therapeutic alliance is the term used to describe the interactional and relational processes that occur during therapy. The strength of a therapeutic alliance is associated with treatment adherence, treatment outcomes and clients' satisfaction with treatment. Therapeutic alliance has been identified by key stakeholders as an essential component of stuttering intervention, however, this construct and its components remain relatively underexplored in the literature.
OBJECTIVE: This study aims to build consensus amongst speech and language therapists working with adults who stutter on the core components of therapeutic alliance, and the factors that influence its development. It also aims to develop a guiding framework for the establishment and maintenance of therapeutic alliance with this client group.
METHODS: Speech and language therapists participated in a three-rounded e-Delphi survey focused on: (1) identifying the core components of the therapeutic alliance; and (2) gaining group consensus on the core components of therapeutic alliance. Statements representing the core components that obtained consensus were categorised using a framework of therapeutic alliance.
RESULTS: A total of 24 speech and language therapists agreed to participate. 24/24 (100%) completed Round 1, 24/24 (100%) completed Round 2, and 23/24 (95.83%) participated in Round 3. Following inductive content analysis of Round 1, 62 statements were generated, and consensus was achieved on 60 statements which were agreed by participants to represent the core components of therapeutic alliance. These statements were then categorised, resulting in a guiding framework of therapeutic alliance to support speech and language therapists working with clients who stutter.
CONCLUSIONS: Consensus on the core components of the therapeutic alliance for stuttering intervention was reached through engagement with speech and language therapists. The framework presented demonstrates the vital role speech and language therapists play in the formation and maintenance of therapeutic alliance during the delivery of stuttering interventions with adults.

Keywords: Therapeutic alliance, stuttering intervention, e-Delphi study, speech and language therapists

1. Introduction

Stuttering is a communication condition that is characterised by motor speech difficulties, irregular rate and patterning of speech, and emotional and cognitive consequences which can influence the quality of living and life-participation of an individual (Craig et al., 2002, Craig et al., 2009; Lavid, 2003; Tichenor & Yaruss, 2019). For adults who stutter (AWS), disruptions can occur in their speech, most frequently at the beginning of words and sentences (Guitar,

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2013; Jackson et al., 2015). These disruptions can encompass involuntary blocks, repetitions, or prolongations, and the degree of disruption can vary extensively depending on the situation (Staróbole Juste & Furquim de Andrade, 2011; Tichenor & Yaruss, 2021; Van Riper, 1973). AWS may present with accompanying motor behaviours that coincide with the overt speech disruptions such as eye blinking, lip and tongue tremors and disordered breathing (Lavid, 2003; Tichenor & Yaruss, 2021). These difficulties can frequently be intensified by societal and fluent speakers' misconceptions about stuttering as well as the unfavourable judgements and attitudes that people can have (Constantino et al., 2022; Ginsberg & Wexler, 2000). Some research has established an association between stuttering and psychological health, which is understandable given the effect that stuttering can have on communication and socialisation (Brignell et al., 2020; Iverach et al., 2009; Smith et al., 2014). Stuttering can lead to negative communication experiences and AWS can often demonstrate avoidance behaviours, anxiety and reduced participation in daily living activities because of their stuttering (Davis et al., 2007; Iverach et al., 2009; Iverach & Rapee, 2014; Tichenor & Yaruss, 2019).

Traditional intervention strategies have often been confined to 'fixing' or 'curing' stuttering, however this practice is no longer considered the gold-standard (Connery et al., 2022b). By virtue of the multifaceted nature of stuttering, there is acknowledgement throughout the literature on the importance of a comprehensive approach to stuttering intervention that targets the overt speech difficulties (if this is a client's personal goal), as well as the individual's affective, behavioural and cognitive reactions to their stuttering (Craig et al., 2002; Tichenor & Yaruss, 2019). In more recent times, conceptualisations of disability such as the social model and the neurodiversity paradigm are increasing in dominance in the stuttering literature and are translating into clinical practice and advocacy work with those who stutter (Bailey, 2019; Constantino, 2019; St Pierre, 2019). These advocate for speech and language therapists (SLTs) to facilitate an individual's reflection and acceptance that their stuttering is a legitimate and valuable way of speaking (Constantino, 2018). (Note: SLT can be taken to mean either the speech and language therapist, or speech and language therapy, depending on the context). Recent qualitative research exploring the perspectives of adults who stutter on therapeutic alliance in stuttering intervention found that an individual's acceptance of their stuttering as a different, but equally valuable way of speaking, as well as an SLT's acceptance of them as an individual who stutters, were fundamental to the establishment of a positive therapeutic alliance (Byrne & Connery, 2023). Participants in this study also acknowledged the importance of the SLT presenting a range of therapeutic approaches to their clients, rather than relying on one sole approach, as this would negatively impact the therapeutic alliance. Therapy is therefore a complex and collaborative process, and in order for it to be successful, the SLT's skill set must lie beyond the specific intervention technique itself and include interactional and relational qualities.

Therapeutic alliance is defined as; "*the interactional and relational processes operating during therapeutic interventions*" (Lawton et al., 2018, p.1). This concept has stemmed from psychodynamic theory and from origins which can be drawn from the ideas of Sigmund Freud and Carl Rogers (Bernecker et al., 2014; Freud, 1958; Rogers, 1951). More recently, Bordin (1979) proposed that the therapeutic alliance encompasses three branches; reaching a shared agreement on goals, unity on the tasks to be completed throughout therapy, and the formation of a satisfactory emotional bond between the client and clinician. Most of the literature on therapeutic alliance stems from the discipline of psychotherapy, which has concluded that it represents a substantial determinant of treatment efficacy (Bernecker et al., 2014; Castonguay et al., 2006; Constantino et al., 2002; Elvins & Green, 2008; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). The broader healthcare literature has more recently identified a range of client, clinician and contextual variables which can influence both the construction and the maintenance of therapeutic alliance. These include the client and clinician being present, receptive, genuine and committed, the client being motivated and ready to participate in therapy, the client's past experiences of therapy and the organisational influencers such as time and resource constraints (Bernecker et al., 2014; Cheng & Lo, 2018; Connery et al., 2022a; Horvath et al., 2011; Lawton et al., 2018; Miciak et al., 2018; Sønsterud et al., 2019a). In addition, some emerging evidence from healthcare disciplines including physiotherapy, occupational therapy and SLT, suggest that the therapeutic alliance may indeed impact treatment outcomes, client engagement and client treatment satisfaction (Babatunde et al., 2017; Crom et al., 2020; Lawton et al., 2018).

Relatively little attention has been paid to the therapeutic alliance within the field of SLT and there is therefore a gap in our knowledge in terms of its role as a component of intervention. Sylvestre and Gobeil (2020), however, presented theoretical foundations of the therapeutic alliance as it relates to the discipline of SLT. Their framework highlights therapeutic alliance's core concept of shared decision-making, and also the variables that influence it. These include clinician-related factors (e.g., flexibility in applying a therapeutic approach), and client-related factors (e.g., motivation to change). Further, a recent study in the area of aphasia post-stroke rehabilitation explored SLTs' perspectives of the construction and maintenance of the therapeutic alliance (Lawton et al., 2018). This study found that acknowledging the client as a person, sharing therapeutic expectations, and encouraging goal ownership are all vital elements of the therapeutic alliance (Lawton et al., 2018). SLTs in this study conveyed that prioritising getting to know the client during the first few sessions of intervention is vital as this facilitates comprehension of their unique preferences for therapy while also developing a sense of bond between the SLT and their client (Lawton et al., 2018). A prevailing lack of clarity exists, however, surrounding the specific components that constitute an effective therapeutic alliance in relation to working with AWS.

There is some evidence within the stuttering literature that highlights the important role of therapeutic alliance in stuttering intervention for adults. For example, Sønsterud and colleagues (2019a) concluded that Bordin's elements of *task* and *goal setting* are particularly pertinent for stuttering intervention. The authors postulated that the mutual understanding of goals and the accordance on therapy tasks, both of which an SLT can facilitate, may be among the most optimal characteristics for fruitful therapeutic alliances and therapy outcomes for AWS (Sønsterud et al., 2019a). In addition, studies engaging with key stakeholders (AWS and academic and clinical stuttering experts) have identified therapeutic alliance as an essential component of effective stuttering intervention (Connery et al., 2021; Connery et al., 2022b). However, what therapeutic alliance specifically constitutes according to key-stakeholders (e.g., SLTs or AWS) has not been fully explored in-depth and there appears to be a lack of consensus regarding perceptions of the therapeutic alliance between SLTs and AWS (Croft & Watson, 2019). As practice-based evidence is essential for advancing the discipline of SLT, (McCurtin et al., 2019; Sackett et al., 1996), retrieving and integrating the clinical experiences of SLTs working with adults who stutter will develop our understanding of the components of therapeutic alliance and will identify ways to improve its quality. As Horvath and colleagues (2011) suggest, therapeutic alliance is a skill which clinicians can be trained to develop, just as they can become competent with various other aspects of their scope of practice. For this reason, the involvement of SLTs is vital for investigating what needs to be completed during therapeutic interventions to cultivate productive therapeutic alliances with AWS, and to support SLTs development of the specific skill set associated with it.

This study aims to build consensus on the core components of therapeutic alliance in stuttering intervention, and the factors that influence its development, using a panel of SLTs with experience working with this client group. It employs an e-Delphi technique to achieve this aim (Keeney et al., 2011). The Delphi technique is based on the belief that group consensus is more accurate than individual judgement (Keeney et al., 2011; Trevelyan & Robinson, 2015). It takes the format of a multi-staged questionnaire interspersed with feedback, and it aims to achieve reliable consensus on important issues where no unison on the topic has previously existed (Dalkey & Helmer, 1963, p. 458; Keeney et al., 2011; McKenna, 1994). The e-Delphi technique is a fitting methodology for this study's aim as there is a lack of agreement on the individual components needed to foster effective therapeutic alliances in stuttering interventions for adults (Connery et al., 2022b; Powell, 2003).

2. Methods

This e-Delphi study consisted of a series of three structured rounds. Round 1 introduced the topic of therapeutic alliance. It aimed to identify this construct's core components as it applies to stuttering intervention, as well as the factors that influence its development, through engagement with a panel of SLTs. Rounds 2 and 3 aimed to achieve group consensus amongst the SLTs on the core components of therapeutic alliance as it applies to stuttering intervention (and the factors that influence its development). The Conducting and REporting DElphi Studies (CREDES; Jünger et al., 2017) was used to ensure validity, reliability and replicability in the results captured. Ethical approval was obtained for

this study from the Research Ethics Committee, School of Linguistic, Speech and Communication Sciences, Trinity College Dublin (TT52).

2.1. Participants

The Delphi technique utilises non-probability sampling in order to recruit a panel of *experts* (Trevelyan & Robinson, 2015). The term *expert* in this study refers to qualified SLTs who have experience working with AWS. This criteria allowed the authors to determine SLT's as *experts* in the sense that it ensured all panel members had prior experience developing therapeutic alliances with AWS and thus, they could suitably make accurate judgements on this topic. SLTs working with AWS in a national (Irish) or international public or private healthcare setting were invited to participate in this research. SLTs who were not currently working with, or who did not have previous experience working with AWS, were excluded. Participants were recruited through multiple professional bodies, national and international stuttering associations, social media, snowball sampling and personal contacts of the authors (Supplementary Table 1). Each participant who expressed interest in participating in this research was sent a Participant Information Leaflet (PIL) via email. Participants also signed a consent form prior to their receival of the first round of the survey. There is little agreement within the literature in relation to the size of the expert panel required to constitute a representative sample in Delphi studies, however, 8–12 participants have been recommended for a homogenous sample recruited using specific criteria (Keeney et al., 2011; Sumsion, 1998; Williams & Webb, 1994a, 1994b). A total of twenty-four participants were recruited and constituted the panel for this study with panel members residing in Ireland, UK, Australia, New Zealand, USA and India (Table 1 summarises the demographics of the participants).

2.2. Questionnaire development

A review of the literature specific to the composition of therapeutic alliance in stuttering intervention with adults was completed by the first author of this study. A variety of items perceived within the literature to be a component of therapeutic alliance for adults who stutter were identified and collated. Explicit components of therapeutic alliance which had been identified and singled out from the literature were then used to generate 22 individual statements for the Round 1 questionnaire using the following studies: (Connery et al., 2021, 2022b; Croft & Watson, 2019; Plexico et al., 2010; Sønsterud et al., 2019a; and Sylvestre & Gobeil, 2020.) The participants were asked to read this list of 22 statements, and they were instructed to express their agreement or disagreement with these statements by ticking either 'Agree' or 'Disagree' (Supplementary Table 2). After this was complete, the participants were given the opportunity to add any additional statements which they felt should also be included in the list. Hence, this Round 1 questionnaire was exploratory in nature. It served as a foundation for the participants to reflect on their opinions of therapeutic alliance in stuttering interventions for adults and to essentially capture any additional components of therapeutic alliance which had been omitted by the authors of this study due to inadequate knowledge or lack of representation of the component within the literature. Therefore, Round 1 served as an opportunity for participants to list core components of therapeutic alliance which had not been identified by the authors themselves. This Round 1 questionnaire was piloted with one SLT with experience working with AWS, and feedback from this exercise resulted in the wording of one statement being modified to simplify the meaning of the statement.

2.3. Data collection and analysis

This e-Delphi study was conducted using three rounds of questionnaires which were designed and distributed online using Qualtrics (Qualtrics, 2022). Each questionnaire round consisted of a unique link which was emailed to the participants over a period of 3 months, from October to December 2022. All questionnaires were available to complete for a period of two weeks and a reminder via email was sent 3–4 days after the initial email, encouraging participants to complete the questionnaire. Only the participants who had completed Round 1 were emailed the link to Round 2 and similarly, only those who had completed Rounds 1 and 2 were sent the final link for completion of Round 3. Participants were asked to provide demographics in the Round 1 questionnaire including their name, gender, country of living/work and how many years they had provided SLT to AWS (See Table 1). The demographic data collected were managed using IBM SPSS version 27 (IBM Corp, 2020).

Table 1
Demographic data of the participants from Round 1

Demographic variable	SLTs ($n = 24$, no. of recruited participants)	
Gender:	*n*	*%*
Female	20	83.33
Male	3	12.50
Non-binary / third gender	1	4.17
Country of living or work:	*n*	*%*
Ireland	8	33.33
United Kingdom	11	45.83
Australia	1	4.17
New Zealand	2	8.33
USA	1	4.17
India	1	4.17
Number of years providing SLT to adults who stutter:	*n*	*%*
1–5 yrs	7	29.17
6–10 yrs	3	12.50
11–15 yrs	3	12.50
16–20 yrs	2	8.33
21–25 yrs	4	16.67
26–30 yrs	4	16.67
31–35 yrs	0	0.00
36–40 yrs	1	4.17
Distribution of workplace:	*n*	*%*
Private clinic	8	33.33
Public sector	7	29.17
Hospital	4	16.67
Research academic	4	16.67
Retired	1	4.17

2.4. *Round 1: Exploring core components of therapeutic alliance in relation to stuttering intervention for adults*

Participants were presented with the list of 22 statements which the primary author accumulated from the literature representing core components of therapeutic alliance (Supplementary Table 2). After the participants expressed their agreement or disagreement with these statements, they were then given the opportunity to list any other components which had not been included by the authors, with the open-ended question; "Please list any other components of therapeutic alliance which have not been included in the list" in Round 1. Inductive content analysis was used to analyse the qualitative data gathered from this open-ended question which had allowed SLTs to add any additional components of therapeutic alliance to the list. Content analysis is a systematic and objective method for analysing, identifying and quantifying phenomena (Elo & Kyngäs, 2008). This analysis grants researchers an opportunity to test theoretical topics while enhancing better understanding of the data (Cavanagh, 1997; Elo & Kyngäs, 2008). Inductive content analysis was appropriate for this study as it aimed to provide knowledge and new insights for the study's aims (Cavanagh, 1997; Elo & Kyngäs, 2008; Krippendorff, 2019). The process involved reducing all of the qualitative data, merging similar ideas together and classifying the remaining core components into smaller and more precise statements (Keeney et al., 2011). This was completed by the first author and reviewed by the second author. During this process the authors discussed the similarities and differences between the additional components which had been provided by the participants. Following in-depth discussion, reflection and agreement, an additional 42 statements were integrated alongside the original 22 statements, which would later be introduced to the panel in

Table 2
Statements that reached group consensus on importance, listed by mean value (highest to lowest level of importance)

Statements that reached group consensus on their importance as core components of the therapeutic alliance in stuttering intervention for adults	Mean
The speech and language therapist provides the adult who stutters with an opportunity to express themselves.	4.96
The speech and language therapist acknowledges the adult who stutters' feelings and emotions.	4.92
The speech and language therapist displays effective listening skills and makes links to previous things that the adult who stutters has said.	4.88
The speech and language therapist is mindful and acknowledges the impact that stuttering has on the adult who stutters' psychological wellbeing and their mental health.	4.88
The speech and language therapist is responsive to the adult who stutters (i.e., by paying attention to the adult who stutters' body language and their verbal and non-verbal communication, and adapting to the needs of the adult who stutters in a flexible and positive manner).	4.88
The speech and language therapist is approachable.	4.83
The speech and language therapist is compassionate towards the adult who stutters.	4.79
The speech and language therapist helps the adult who stutters to see themselves as valuable and worthy.	4.79
The speech and language therapist helps the adult who stutters to develop a positive self-identity.	4.79
The speech and language therapist works collaboratively with the adult who stutters (i.e., not just in goal setting but throughout agenda setting for sessions, when discussing homework activities, by asking questions to facilitate personal reflection from the adult who stutters, and by reflecting and summarising key points talked about during sessions).	4.79
The speech and language therapist promotes the adult who stutters' acceptance of being an individual who stutters.	4.79
The speech and language therapist keeps the adult who stutters informed throughout the therapeutic process.	4.78
The speech and language therapist is empathetic (e.g., the speech and language therapist has the ability to put themselves in the adult who stutters' shoes, to relate to and understand where they are coming from, even if they have never stuttered or experienced problems with dysfluency).	4.75
The speech and language therapist supports the adult who stutters to set meaningful, realistic and achievable goals for intervention which are specific to the adult who stutters' real-life situation.	4.75
The speech and language therapist has acceptance for the adult who stutters when they do not want help for their stuttering or when they would like to terminate intervention.	4.75
The speech and language therapist spends time getting to know the adult who stutters.	4.71
The speech and language therapist encourages self-compassion.	4.71
The speech and language therapist is encouraging and assists active participation from the adult who stutters during therapy sessions.	4.71
The speech and language therapist acknowledges and honours the adult who stutters' expertise and knowledge of stuttering.	4.71
The speech and language therapist recommends any additional services to the adult who stutters (e.g., support from a psychologist, should the speech and language therapist believe that the adult who stutters would benefit from this).	4.71
The speech and language therapist helps the adult who stutters to overcome ingrained negative attitudes towards stuttering (i.e., this is about supporting the adult who stutters to let go of deep-rooted pessimistic beliefs about stuttering).	4.67
The speech and language therapist is self-aware (e.g., the speech and language therapist is aware of the limits to their professional skills and their scope of practice and recognises when supervision or onward referral would be more appropriate for the adult who stutters).	4.67
The speech and language therapist addresses social anxiety and communication-related anxiety which the adult who stutters may be dealing with internally.	4.63
The speech and language therapist preserves hope (e.g., by listening to and not dismissing the adult who stutters' hopes for progression).	4.63
The speech and language therapist is open and truthful about the model of therapy being used during sessions (i.e., the 'model' of therapy essentially determines the therapeutic tasks or activities which will take place during sessions. There are various different types of models for stuttering therapy such as block modification, avoidance reduction therapy or cognitive behavioural therapy, and the speech and language therapist is able to disclose details about these models to the adult who stutters, in an open and truthful manner).	4.63
The speech and language therapist encourages goal ownership (e.g., openly discussing goals in an affirmative and collaborative manner).	4.58
The speech and language therapist has knowledge of relevant counselling skills and principles.	4.58
The speech and language therapist demonstrates allyship (e.g., this is about the speech and language therapist unapologetically supporting the adult who stutters).	4.54

(*Continued*)

Table 2
(*Continued*)

Statements that reached group consensus on their importance as core components of the therapeutic alliance in stuttering intervention for adults	Mean
The speech and language therapist has a positive attitude about change and the expectations of change occurring throughout intervention.	4.50
The speech and language therapist is attuned (i.e., the speech and language therapist is aware of the adult who stutters' abilities).	4.50
The speech and language therapist empowers the adult who stutters to work on the therapeutic goals which were discussed throughout sessions and which were recognised to align with the adult who stutters' own individual and personal values.	4.50
The speech and language therapist provides education to the adult who stutters about stuttering itself (i.e., information about neurology and genetics, for example).	4.50
The speech and language therapist has respect for the adult who stutters' experience as a person who stutters and for the route that they would like to take regarding intervention (e.g., the speech and language therapist demonstrates a non-judgemental attitude when the adult who stutters' values or choices about what they want from therapy differ from the speech and language therapist's own values, opinions or preferred domain of therapeutic practice).	4.46
The speech and language therapist applies principles of trauma-informed care (i.e., the speech and language therapist ensures that the adult who stutters feels physically, emotionally and psychologically safe while in their care).	4.46
The speech and language therapist has an unconditional positive regard for the adult who stutters.	4.46
The speech and language therapist is warm.	4.46
The speech and language therapist provides sufficient time with the adult who stutters during sessions.	4.42
The speech and language therapist advocates for the adult who stutters (e.g. the speech and language therapist discusses discrimination and promotes equality for the adult who stutters within the healthcare context and within their workplace, for example).	4.42
The speech and language therapist initiates discussion with the adult who stutters in relation to their history of past stuttering interventions which were not beneficial, early on in the intervention process.	4.42
The speech and language therapist combines therapies targeting speech change and therapies targeting the psychological impact of stuttering.	4.38
The speech and language therapist discusses with the adult who stutters the rationale for exploring and choosing various different intervention approaches, ultimately to check goodness of fit.	4.38
The speech and language therapist is confident (i.e., the speech and language therapist is self-assured of their clinical expertise and their ability to provide stuttering intervention to adults of this population).	4.33
The speech and language therapist uses effective ways of challenging the adult who stutters, and the speech and language therapist challenges and supports the adult who stutters in the right balance.	4.33
The speech and language therapist is trusting (i.e., the speech and language therapist is able to assure the adult who stutters that they have the knowledge and skills needed to support them to achieve their desired goals).	4.29
The speech and language therapist is comfortable with emotions and they are able to carry the adult who stutters' emotions and uncertainty.	4.29
The speech and language therapist uses humour with the adult who stutters on occasion.	4.29
The speech and language therapist explains to the adult who stutters that there is no quick fix or cure for stuttering and that 'curing' stuttering should not be a goal for intervention.	4.29
The speech and language therapist and the adult who stutters share expectations of intervention.	4.29
The speech and language therapist uses the adult who stutters' own language or way of describing their communication difficulties, especially during the early stages of therapy (e.g., the speech and language therapist says; you 'get stuck' in response to the adult who stutters, instead of rephrasing 'get stuck' to the technical or medical term of 'having a block').	4.29
The speech and language therapist providing the intervention to the adult who stutters has stuttering-specific training.	4.25
The speech and language therapist resolves conflict (e.g., by accommodating the adult who stutters' particular needs and by collaborating).	4.21
There is continuity of care (e.g., the adult who stutters is seen by the same speech and language therapist throughout therapy).	4.04
The speech and language therapist activates ownership during sessions by delineating roles (e.g., the speech and language therapist explaining and setting out clearly what they need from the adult who stutters in order to continue therapy. This could be the speech and language therapist's need for the adult who stutters to engage during sessions. The speech and language therapist may then ask the adult who stutters which therapeutic actions they will require from their therapist in order to achieve effective therapy which can be of benefit to the adult who stutters).	3.96
The speech and language therapist inspires the adult who stutters to request support from their family (e.g., the speech and language therapist encourages involvement of a partner or family member of the adult who stutters during intervention sessions).	3.91

(*Continued*)

Table 2
(*Continued*)

Statements that reached group consensus on their importance as core components of the therapeutic alliance in stuttering intervention for adults	Mean
The speech and language therapists brings their own fallibility to intervention (i.e., making mistakes or being wrong on occasion, in attempt to strengthen the adult who stutters' ownership and the overall therapeutic relationship. This is about the speech and language therapist showing that they are not the 'expert').	3.87
The speech and language therapist arranges for intervention to take place outside of the clinic room where possible (i.e., completing goals in the home or community of the adult who stutters).	3.79
A warm and friendly clinic room for the adult who stutters positively influences therapeutic alliance.	3.78
The speech and language therapist is reassuring (e.g., the speech and language therapist knows exactly what to say to the adult who stutters in order to help them move forward and feel a sense of ease and comfort).	3.71
The speech and language therapist uses self-disclosure (e.g., telling the adult who stutters a little bit about themselves and their own personal life).	3.70
The speech and language therapist offers different intervention formats to the adult who stutters such as individual, group, and intensive therapy blocks, so that the adult who stutters can choose the format that suits them best.	3.57

the following round (Round 2) (See Supplementary Table 3).

2.5. Round 2: Building consensus

The Round 2 questionnaire was developed from the initial list of 22 statements in the first round and the additional 42 statements following analysis of the Round 1 questionnaire (Supplementary Table 3). Each panel member was requested to rate their level of disagreement or agreement with each of the 64 statements representing core components of therapeutic alliance, using a five-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree). Likert scaling assumes the distances between each choice are equal and thus, the range of this Likert scale captured the intensity of the participants' opinion for each item (Preston & Colman, 2000). The presentation of statements was randomised, and the panel members were advised in advance that the list of statements were outlined in no particular order. The resulting data obtained was inputted into IBM SPSS version 27.0, which generated descriptive statistics (IBM Corp, 2020). Median and interquartile ranges (IQRs) were calculated for each statement to determine which statements reached consensus on importance, consensus on lack of importance, and which statements had not reached group consensus. The authors used IQR and median as they are frequently used measures with Delphi studies and represent an objective and rigorous means of determining consensus (Keeney et al., 2011; Von der Gracht, 2021). Consensus on importance was defined by $\geq 70\%$ of the expert panel acknowledging the importance of a statement (Keeney et al., 2011). This was determined based on a statement having a median score greater than or equal to 4 (median ≥ 4) which is deemed as a high level of agreement, along with a small IQR of less than or equal to 1 (≤ 1). Von Der Gracht (2012) recommended that an IQR of ≤ 1 is a suitable consensus indicator when using five-unit scales such as the Likert scale, as it ensures that $\geq 50\%$ of the entire panel's opinions fall within 1 point on the scale. The statements that did not reach consensus were used to develop the Round 3 questionnaire and were presented to the panel again, with a further attempt at reaching group consensus.

2.6. Round 3: Providing individual feedback to each participant and extending the consensus-building

The third round was emailed to each participant who completed Rounds 1 and 2, along with a Microsoft Word document detailing their responses in the previous round and the overall group's responses to each of the 64 statements. The document also listed the statements that reached consensus on importance and those that reached consensus on lack of importance from Round 2, in no particular order. Participants completed the round 3 questionnaire, in which they were asked to re-examine each of their own responses in the context of the group response, to the nine statements that had not reached consensus. It was made very clear at the beginning of the questionnaire that participants were not required to change their response in regard to the overall group opinion should they still stand by their original response made in Round 2. Participants were requested to rate the 9 statements again using the same five-point Likert scale that was provided in the Round 2 questionnaire.

The data that followed was inputted into IBM SPSS version 27.0 (IBM Corp, 2020). Once final consensus on importance and lack of importance had been reached for all statements from Rounds 2 and 3, they were ranked in order of importance using the mean value of each statement, which was produced from the SPSS version 27.0, database (IBM Corp, 2020). This activity allowed the authors to understand the data in a more diligent and comprehensive manner, it facilitated the presentation of statements according to their level of importance, and it facilitated formation of the guiding framework. This analysis is frequently recommended in guidelines for the completion of Delphi studies (e.g., Keeney et al., 2011; Von der Gracht, 2021).

2.7. Categorisation of statements

The statements that reached consensus on their importance as components of therapeutic alliance were categorised using Sylvestre and Gobeil's (2020) 6-domain framework which is informed by Bordin's (1979) renowned tripartite model of the therapeutic alliance. This framework was deemed appropriate as it applies to therapeutic alliance specific to the discipline of SLT. The framework allowed for the authors' reflection of each of the statements that reached consensus on importance, in line with Bordin's (1979) views, as the framework compromises Bordin's (1979) three elements which include; (1) the client and therapist's agreement on the therapeutic goals of intervention, (2) the mutual mediation and collaboration on the tasks required to be sought out in order to meet the desired goals, and (3) the interpersonal bond between the client and their therapist. The framework also encompasses influencing stakeholder variables such as client and clinician factors as well as external variables which can influence the formation and development of therapeutic alliance. The first author performed the categorisation task which involved assigning each of the 60 statements which achieved consensus on importance into one of the following domains; 'Therapeutic relationship', 'Goals of intervention', 'Tasks and intervention intensity to meet the goals', 'Factors relating to clinicians', 'Factors relating to clients', and 'External factors', and this was reviewed and critically discussed with the second author. Due to some statements representing more than one of these categories a decision was made to select the category which was perceived to be primarily associated with the statements. For instance, the statement; "*The speech and language therapist helps the adult who stutters to develop a positive self-identity*", could have been assigned to either the 'Tasks and intervention intensity to meet the goals' domain or the 'Therapeutic relationship' domain, following the authors' reflection. However, this statement was assigned to the 'Tasks and intervention intensity to meet the goals' domain as it was believed to be predominantly a task that SLTs can carry out during therapeutic interventions rather than an outcome of the therapeutic relationship itself, and thus, it was believed to be chiefly correspondent with this domain (Supplementary Table 6).

3. Results

Figure 1 summarises the overall e-Delphi process and the results of each round. A total of 24 SLTs with experience working with AWS formed the expert panel. The response rates for each round were > 70% which, as discussed by Sumsion (1998) and Keeney et al., (2001), is required for each round in order to maintain the rigour of the Delphi technique. Of the initial group of 24 recruited SLTs, all participants (100%) completed the Round 1 questionnaire, 24/24 participants (100%) completed the Round 2 questionnaire and 23/24 participants (95.83%) completed Round 3.

Content analysis of the panel's responses to the single qualitative question in the Round 1 questionnaire resulted in 42 separate statements which were presented to the group in Round 2, alongside the original 22 statements provided in Round 1. Based on the author's aforementioned protocol for gaining consensus, in Round 2, 53 of the 64 statements reached agreement on their importance as components of therapeutic alliance (i.e., a median ≥ 4 and IQR ≤ 1) and were omitted from the Round 3 questionnaire. These 53 statements were later presented to the panel as having already reached consensus and were therefore set aside from the statements that would be included in Round 3. Two statements reached consensus on their lack of importance as core components of therapeutic alliance (i.e., a median ≤ 3 and IQR ≤ 1) and were omitted from the framework categorisation. The remaining 9 statements that did not reach group consensus were used to design the Round 3 questionnaire. Supplementary Tables 4 and 5 display the median scores and IQRs for all of the statements mentioned. Of the 9 statements that did not reach group consensus in Round 2, 7 later reached consensus in Round 3 on their importance as core components of therapeutic alliance. The remaining 2 statements of

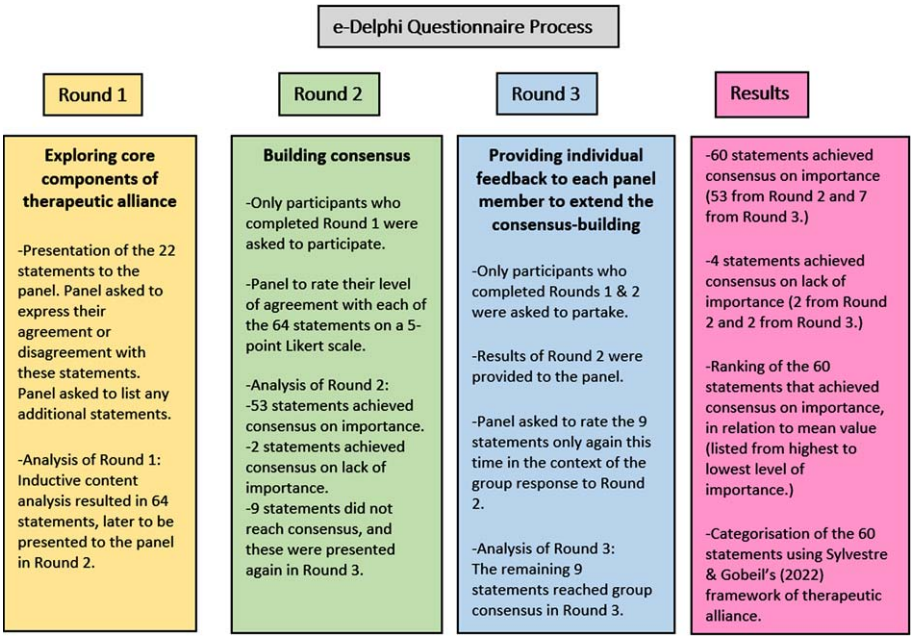

Fig. 1. Summary of the e-Delphi process.

the 9 that did not reach consensus in Round 2 reached group consensus on their lack of importance as core components of therapeutic alliance in Round 3. The level of importance of each of the total of 60 statements that attained consensus on their importance, which was calculated using their mean values, is also presented in Table 2, from highest to lowest level of importance.

3.1. Categorisation of statements

The statements that reached consensus on their importance as components of therapeutic alliance were categorised using Sylvestre and Gobeil's (2020) framework comprising of 6 key domains. Twenty-one (35%) of the 60 statements were categorised under the 'therapeutic relationship (affective bond)' domain. Without an initial therapeutic relationship, a therapeutic alliance cannot be consolidated, and this domain relates to all of the feelings and attitudes that both the client and therapist share for each other (Fourie et al., 2011; Norcorss, 2022; Sylvestre & Gobeil, 2020). Sixteen (26.66%) of the statements fell under the 'factors relating to clinicians' domain. This element relates to the role the therapist plays in the development of therapeutic alliance and in creating an environment in which the AWS feels both emotionally and physically protected and safe (Bordin, 1979; Gelso et al., 2014; Hatcher & Barends, 1996; Safran & Wallner, 1991; Scaturo, 2010). Fifteen (25%) statements were assigned to the 'tasks and intervention intensity to meet the goals' category. This category outlines the impact that routine tasks and goals agreed upon by the AWS and their therapist together, can have on the AWS' overall progression (Bordin, 1979; Safran & Wallner, 1991; Scaturo, 2010). Also related to this construct is the timing or pacing of the tasks being administered and carried out (Johnson & Wright, 2002). Five statements (8.33%) were categorized under the theme 'external factors' which consists of the intervention context, the client's environment and the people they surround themselves with, that may also influence the establishment of a therapeutic alliance. Examples of external factors include the role of family members, and organisational constraints such as limited resources (Ross et al., 2008; Sylvestre & Gobeil, 2020). Three (5%) of the statements fell under the 'goals of intervention' domain. This category demonstrates the role of collaboration whereby the AWS and the SLT work alongside each other when deciding which approach to take to therapy and when allocating goals. No statements were characterised under the 'factors relating to clients' domain which relates to a client's willingness to actively partake in intervention and the decision-making process, as well as their readiness to

participate in therapeutic interventions. Supplementary Table 6 outlines this categorisation task and the resulting guiding framework.

4. Discussion

Using e-Delphi methodology, this study explored the perspectives of SLTs on the components of therapeutic alliance for stuttering intervention for adults, and the factors that influence its development. Following three rounds of questionnaires, consensus was reached on the importance of 60 statements representing the key components of therapeutic alliance, and these statements were categorised using Sylvestre and Gobeil's (2020) framework of therapeutic alliance. The therapeutic *relationship* (or affective bond) develops from the initial point of contact between the client and their therapist and the results of this study depict the relationship as the foundational block in the process of building therapeutic alliances with AWS, as well as for achieving desirable therapeutic outcomes with this cohort (Fourie et al., 2011; Norcross, 2002; Sylvestre & Gobeil, 2020). Participants in this study identified the ways in which an SLT can foster the development of this initial therapeutic relationship through for example, being empathetic, compassionate, non-judgemental and affording the AWS time in getting to know them as an individual. Such qualities are also identified in the stuttering literature as being essential for the management of the psychosocial needs of AWS, thus elucidating the parallels between the development of an effective therapeutic alliance and the holistic management of stuttering (Connery et al., 2022b; Quesal, 2010). The importance of a clinician demonstrating a genuine interest in the personal experiences of their client in order to establish a therapeutic relationship and to demonstrate allyship has been discussed in the literature, and it was also identified by SLTs in this study (Dumez, 2012; Joosten et al., 2008; Kelley et al., 2014). In addition, SLTs in this study agreed that an effective therapeutic relationship or emotional bond is characterised by the SLT acknowledging that the AWS is an expert on their own stuttering and the impact it has had on their life, and this is also supported in the literature (Leahy, 2004). The importance of this initial therapeutic relationship was clearly evident within the context of the current study, with this domain containing the largest number of statements.

Participants also identified therapeutic tasks and intervention intensity to meet the client's goals as an important component of therapeutic alliance. One example of this was the panel's agreement on the important role of SLTs to work collaboratively with AWS and to implement and schedule tasks and goals which are agreed upon collectively as meaningful to their intervention. Research has identified the wide-ranging goals an AWS may arrive to therapy with, relating to both the physical and psychosocial elements of stuttering, and participants in the current study articulated the need for therapy tasks to clearly align with these goals in order to foster the therapeutic alliance (Bothe & Richardson, 2011, Sønsterud et al., 2019b). In addition, it was agreed by this study's participants that the SLT's ability to offer various intervention formats to the AWS and provide sufficient time with the AWS during the therapy sessions influences the quality of the therapeutic alliance. The importance of an SLT offering a range of formats, including group and individual, and their role in setting the right intervention intensity to meet the client's targets has been discussed in the literature (Connery et al., 2022b).

Research has outlined two types of competence that a therapist must master in order to become an effective clinician including *clinical* and *relational* competence (Connery et al., 2022a; Sylvestre & Gobeil, 2020; Wampold, 2001). Clinical competence is the mastery of knowledge linked to a specific area of expertise (e.g., an SLT's ability to administer an assessment, or to implement a specific intervention). Relational competence, in contrast, encompasses the SLT's attitudes and skills that are required to establish and maintain a therapeutic alliance with a client. This current study clearly highlighted the influencing role of the SLT in developing and maintaining a therapeutic alliance with AWS using both of these competencies. Clinical competence (e.g. the SLT having expertise in the delivery of stuttering interventions) and relational competence (e.g. the SLT bringing their own fallibility to intervention sessions, the SLT being reassuring, the SLT's use of humour and their ability to listen to the AWS) were both identified by participants as influencing the quality of the therapeutic alliance, (i.e., the development of relational competence is typically neglected in the educational training of student SLTs, however this study highlights the importance of equal weight being placed on the development of both competences for optimal delivery of stuttering intervention (Connery et al., 2021).

A further finding of the current study was the establishment of consensus on a range of external or contextual factors that influence the therapeutic alliance. Participants agreed on the importance of a continuity of care, where the AWS is seen by the same SLT throughout therapy, as well as the SLT's recommendation of additional services (e.g., a referral to a psychologist) should the SLT believe that the AWS would benefit from this. External and contextual factors have been previously identified in the research as influencing therapeutic outcomes for both AWS and clients with other communication conditions such as aphasia (Connery et al., 2021; Lawton et al., 2018).

4.1. Clinical implications

This study has presented a guiding framework, with a range of recommendations for SLTs to integrate into their clinical work with AWS to enhance therapeutic alliances with this client group. SLTs are advised to reflect on the items in each of the six categories of the framework and consider whether or not they are currently implementing these in clinical practice. It is imperative that student and graduate SLTs receive training on how they can establish therapeutic alliances given the nature of stuttering intervention and the need for interventions to integrate psychological approaches. Allocating sufficient time for the development of therapeutic alliance is something that needs to be considered at an organisational level and may need to feature more in policies to ensure adequate time and resources are allocated for its establishment and maintenance. SLTs may, for example, play a role in educating policymakers, such as clinical managers, about the benefits of the therapeutic alliance and the time required for its establishment.

4.2. Recommendations for future research

Findings of this study highlight the need for further exploration of the role of therapeutic alliance in stuttering intervention for adults. Qualitative research, for example, exploring the perspectives of SLTs on the construct of therapeutic alliance is warranted to expand on our understanding of the components and the role of this complex intervention component. Importantly, there is the need for the collection of perspectives of other key stakeholders such as AWS on therapeutic alliance and its role in intervention delivery and therapeutic outcomes. The inclusion of such patient-based evidence will provide essential guidance to SLTs working to establish and maintain effective therapeutic alliances with those who stutter. SLTs in the current study identified no factors relating to clients that influence the therapeutic alliance. This is in contrast to the literature demonstrating the role of client-related factors (e.g., motivation to engage in the decision-making process) that influence the quality of the therapeutic alliance (Lawton et al., 2020; Sylvestre & Gobeil, 2020). The collection of the perspectives of AWS on the therapeutic alliance is therefore a priority.

4.3. Strengths and limitations

One key strength was the study's international recruitment of SLTs representing 4 different continents, thus increasing the generalisability of the results. The e-Delphi methodology was paramount to this as it assisted with participants' easy access to each questionnaire round. In addition, the professional experiences of approximately 11 SLTs (with over 15 years' experience working with AWS) and 13 SLTs (with less than or equal to 15 years' experience) suggest that our recruited expert panel were knowledgeable and capable of making judgements on the components of therapeutic alliance in stuttering intervention. Furthermore, the extremely low attrition rate, which is unusual for Delphi studies, ensured the robustness of the findings. This study encountered some limitations which are worth noting. The SLTs who participated contacted the first author to express their interest, thus representing a potential for sample bias. The panel that was recruited were most likely SLTs who hold strong views in relation to the therapeutic alliance. In addition, the e-Delphi process requires a high level of commitment by virtue of its multi-staged questionnaire rounds, and SLTs whose workloads did not allow for them to participate, may not have had the opportunity to contribute to the current study. Despite a level of cultural diversity achieved with the study participants, the authors acknowledge that the study's results may not be universally representative of SLTs' perspectives of therapeutic alliance due to their countries of work being predominantly of Western culture. Therapeutic alliances may be constructed differently in different cultural contexts and certain components identified may assume greater prominence within some cultures. Categorisation of some of the statements using Sylvestre and Gobeil's (2020) framework was challenging due to overlap between the framework domains. For example, some of the statements categorised as '*Factors related to*

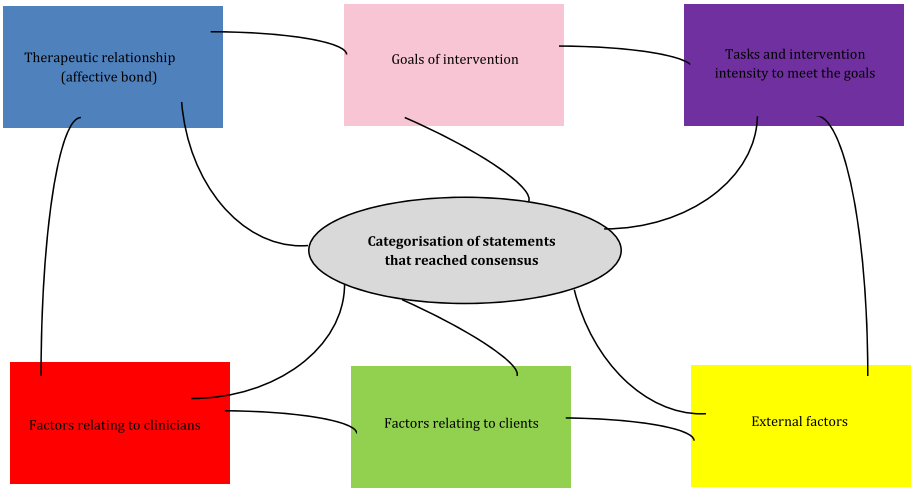

Fig. 2. Categorisation map for statements that reached consensus (Sylvestre & Gobeil, 2020).

clinicians' *(e.g., The speech and language therapist is trusting)* could also be categorised as 'Therapeutic relationship (affective bond)'. Another example can be seen with the following two statements: "The speech and language therapist explains to the adult who stutters that there is no quick fix or cure for stuttering and that 'curing' stuttering should not be a goal for intervention" and "The speech and language therapist and the adult who stutters share expectations of intervention". Such statements, however, reflect the wide-ranging opinions of the panel and the flexibility in their understanding of the therapeutic alliance. Finally, despite the authors following guidelines for conducting and reporting Delphi studies (Jünger et al., 2017; Keeney et al., 2011), the decision to exclude statements that had reached consensus in Round 2 from being re-rated in Round 3 meant that stability of consensus was unable to be established.

5. Conclusion

This study obtained consensus amongst a group of SLTs on the core components of therapeutic alliance for stuttering intervention, and the factors that influence its development, using e-Delphi methodology. The results demonstrate the vital role that SLTs play in the formation and maintenance of therapeutic alliance in stuttering interventions with adults. This research has provided new insights into an under-explored construct, from the point of view of the SLT, who represents one key stakeholder. Future research is however recommended to further explore the construct of therapeutic alliance, in particular from the viewpoint of AWS.

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Conflict of interest

The authors have no conflict of interest to report.

Supplementary material

The supplementary material is available in the electronic version of this article: https://dx.doi.org/10.3233/ACS-240004.

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