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"It's About Walking Alongside a Family": Practitioner Perspectives on Caregiver Coaching With Families of Children Who Are Deaf or Hard of Hearing

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Abstract

Practitioners use caregiver coaching in early intervention services, but coaching principles and practices are not well understood in the context of listening and spoken language (LSL) services with families of children who are deaf or hard of hearing. The purpose of this study was to examine practitioners' experiences with coaching, including definitions, training, and practices they use in their work with families. Using semi-structured, qualitative interviews and video observation discussions, this study examined the perspectives of 14 practitioners providing LSL services to families at three intervention sites in the United States and Canada. Results indicate that practitioners' underlying beliefs about their coaching proficiency and caregivers' capacity impact their coaching practices and how they engage with caregivers. Results highlight practices such as mentoring and accountability that supported practitioners' coaching skills. This study contributes to the understanding of caregiver coaching in LSL practice and has implications for practitioners working to improve their coaching skills, which may improve LSL services and optimize child outcomes.

Keywords: deaf or hard of hearing, early intervention, listening and spoken language, caregiver coaching

Acronyms: CoP = community of practice; DEC = Division for Early Childhood; EI = early intervention; DHH = deaf or hard of hearing; FCEI = family-centered early intervention; LSL = listening and spoken language

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The Division for Early Childhood has established evidence-based recommended practices to guide practitioners in implementing family-centered early intervention (FCEI) with families of children with disabilities, including caregiver coaching to build on families' strengths and impact child outcomes (Division for Early Childhood [DEC], 2014). Coaching empowers caregivers by building their capacity, confidence, and competence to support their child's development and maximize learning opportunities throughout their daily routines (Dunst & Trivette, 2009a; Rush & Shelden, 2019; Woods et al., 2011). Caregiver coaching increases both the quality and quantity of intervention that children receive, and as a result, improves child outcomes (Heidlage et al., 2020; Roberts, 2019; Roberts & Kaiser, 2011; Sone et al., 2021).

The Joint Committee on Infant Hearing (2019) recommends FCEI services provided by professionals with expertise in hearing loss as the most appropriate way to meet the needs of children who are deaf or hard of hearing (DHH) and their families (Moeller et al., 2013). For families who choose listening and spoken language (LSL), practitioners abide by principles that prioritize caregiver involvement in all aspects of intervention, and caregiver coaching is used to achieve this goal (AG Bell Academy for Listening and Spoken Language [AG Bell Academy], 2017; Kendrick & Smith, 2017; Moeller et al., 2013). Caregiver coaching necessitates that practitioners engage caregivers as the primary learners in intervention sessions, facilitating and enhancing caregiver-child interaction rather than teaching the child directly. Through coaching, practitioners teach caregivers specialized LSL skills, provide opportunities for them to practice, and offer feedback in the context of an intervention session. Coaching enables caregivers to learn strategies to embed intervention within their daily routines, providing the intensity of services needed for their child to develop language.

Coaching positions caregivers as the primary learners in the intervention process, therefore, practitioners must use practices geared toward adult learners. Adult learning refers to a collection of theories about processes and conditions that optimize learning for adults (Dunst & Trivette, 2012; Trivette et al., 2009; Yang, 2003). Adult

learners must be ready to learn, actively participate in the learning process, be self-directed, and the learning must be solution-centered and contextual (Cox, 2015; Dunst & Trivette, 2009b, 2012). Active learner participation, opportunities to practice new knowledge and skills, and reflection are important components for effective adult learning (Dunst & Trivette, 2009b; Trivette et al., 2009). However, practitioners providing intervention services to families of children with disabilities often report a lack of training in adult learning principles (Douglas et al., 2020; Meadan et al., 2018). Even when practitioners claim to implement caregiver coaching, research suggests that a significant amount of time is spent engaging the child directly during intervention sessions (Campbell & Sawyer, 2007; Salisbury & Cushing, 2013), suggesting a need for training and accountability in coaching.

There is lack of consensus on the principles and practices of caregiver coaching in the FCEI literature (Friedman et al., 2012; Ward et al., 2020). However, most coaching models contain elements of the following evidence-based practices, as outlined by Rush and Shelden (2005, 2019): (a) joint planning, (b) observation, (c) action, (d) reflection, and (e) feedback.

The lack of consensus about best practices in coaching for families raising children with disabilities also applies to the specialized intervention services provided by LSL practitioners (Noll et al., 2021). Practitioners can pursue a Listening and Spoken Language Specialist (LSLS) certification through the AG Bell Academy, which requires 3 to 5 years of mentorship and extensive professional development, and results in a professional designation of LSLS Auditory-Verbal Educator (AVEd®) or Auditory-Verbal Therapist (AVT®; AG Bell Academy, 2017). Practitioners abide by principles for the provision of high-quality services to children who are DHH, including guiding and coaching caregivers (AG Bell Academy, 2017). However, these principles lack specificity and guidance on specific practices for coaching as suggested by Rush and Sheldon (2005, 2019) and it is unclear whether LSLS practitioners incorporate well-established FCEI practices (Noll et al., 2021).

Recent research has begun to explore caregivers' experiences participating in FCEI services, including coaching. Families of children who are DHH have reported positive experiences with coaching in LSL services, indicating that participation increased their skills and confidence in supporting their child's speech and language development (Josvassen et al., 2019; Noll et al., 2022; Stewart et al., 2020). In addition, caregivers have reported that a supportive, collaborative coaching relationship that involved shared decision-making and working together with their practitioner in the context of their daily routines was key to building their knowledge and skills (Salisbury et al., 2018). In interviews with caregivers participating in LSL intervention, three factors were indicated that contributed to a positive caregiver coaching relationship: (a) practitioner attributes, (b) how expectations are set for caregiver participation, and (c) the evolution of the coaching relationship over time in response to changing caregiver needs (Noll et al., 2022).

Fewer studies have examined the perspective of practitioners who use caregiver coaching. In previous research examining the perspectives of general FCEI practitioners, participants reported challenges with implementing coaching due to incongruent expectations and family characteristics. The incorporation of pre-coaching strategies, such as trust-building, facilitated caregiver engagement and helped to overcome these barriers (Douglas et al., 2020; Meadan et al., 2018). Practitioners reported that meeting families' needs required flexible, individualized practices, and that engagement in intervention through positive caregiver/practitioner relationships promotes caregiver competence and empowerment (Meadan et al., 2018). Similarly, practitioners implementing a highly structured model of coaching reported that although they felt it to be worthwhile, it was challenging to implement despite participating in professional development activities to support their skills (Salisbury et al., 2018). In a study specific to LSL practitioners, King and colleagues (2021) reported providers' perceptions that services for families of children who are DHH differ from other FCEI services due to the specialized nature of developing LSL skills through audition, and there is a need for intensive and continual professional development to develop and maintain the requisite skills.

Although the use of caregiver coaching is supported in the literature and LSL practice guidelines, a recent scoping review found that the current literature lacks a clear description of caregiver coaching with families of children who are DHH (Noll et al., 2021). Furthermore, very little research has examined caregiver coaching from the perspective of LSL practitioners. Gaining greater insight into LSL practitioners' knowledge, coaching practices, and professional preparation can identify changes in practice and professional development that could ultimately result in higher quality services for children and families. Therefore, the purpose of this qualitative study was to understand practitioners' experiences with coaching in LSL early intervention (EI) services, including how they define coaching, how they learned to coach, how they engage caregivers in coaching, and practices they use in their work with families. The specific research questions addressed were:

1. How do LSL practitioners conceptualize coaching?
2. How do LSL practitioners describe how they coach caregivers?
3. How do LSL practitioners incorporate and encourage active caregiver participation and reflection in their coaching practices?

Method

This qualitative research study included semi-structured interviews and video observation discussions with practitioners providing LSL services at one of three sites. The design and methods were informed by the principles of interpretive description (Teodoro et al., 2018; Thorne, 2016; Thorne et al., 1997, 2004). The foundation of this applied qualitative research approach is to investigate a

clinically relevant phenomenon and generate an inductive interpretation to advance clinical understanding (Burdine et al., 2020; Thorne et al., 2004). Research ethics approval for this study was obtained from the University of Ottawa and the CHEO Research Institute in Ottawa, Ontario (19/106X).

Participants

Participants were selected from one LSL program in Canada and two programs in the United States. These sites were purposively selected to represent diversity in service delivery models and chosen for their reputation for providing exemplary LSL services. The sites were accessed through personal networks of two authors, and some of the practitioners were familiar with the first author, who completed the interviews. Service delivery differs between sites: on-site (Site 1), in the home (Site 2), and an approach that includes both in-home and school-based service delivery (Site 3). All practitioners at each site met the following eligibility criteria and were therefore invited to participate: (a) providing LSL services to families of children who are DHH from birth to 3 years of age, and (b) implementing family-centered services using a caregiver coaching model, per each organization's intervention model. Practitioners were invited to participate in an interview and guided discussion based on a short, self-selected segment of a video-recorded coaching exchange between the practitioner and a caregiver. Permission was obtained from site administrators to contact practitioners directly via email. Information about the study was sent by email, followed by a group meeting to allow practitioners to ask questions and make an informed decision about participation. The goal was to interview all practitioners to gain an understanding of the coaching principles and practices at each site, and all agreed to participate. Informed consent was obtained from practitioners prior to each interview and from caregivers prior to viewing each video.

The intent of this study was to capture the diversity of approaches among practitioners with regard to coaching, while also gaining a broader understanding through identifying similarities between practitioners implementing LSL services in different contexts (Braun & Clarke, 2021; Burdine et al., 2020; Thorne et al., 2016). The principles of interpretive description informed efforts to generate a deeper understanding of practitioners' perspectives and experiences, while recognizing the variability inherent in applied practice (Abdul-Razzak et al., 2014; Burdine et al., 2020; Thorne, 2016).

Data Collection and Analysis

Individual, semi-structured interviews were conducted in person at the two intervention sites in the United States from February to March 2020. Interviews with the Canadian practitioners were completed from July to August 2020 using Zoom video conferencing software due to COVID-19 pandemic restrictions put into place during data collection. Practitioners were asked to describe how they learned to coach and to share their overall experiences with caregiver coaching (see Appendix A for interview guide). Although examining how each practitioner defined coaching was part of the purpose of these interviews, the interviewer provided a cursory definition of coaching to facilitate deeper discussion as the point at which they "coach or teach caregivers to implement intervention strategies themselves, throughout their daily routines, in-between intervention sessions."

To supplement the interviews, practitioners self-selected a portion of a video-recorded session and participated in a guided discussion with the interviewer about the interaction they selected (see Appendix B for video observation guide). Practitioners chose a 10-minute segment that contained a coaching exchange between the practitioner and the caregiver. Since there is no agreed-upon definition of coaching components or procedures (Noll et al., 2021), the practitioners' selection provided insight into what they consider coaching and allowed for rich discussion of their beliefs and practices in the context of the practitioner/caregiver interaction. This component was not evaluative, but rather was used to augment the interviews, giving the practitioners an opportunity to explain their decisions and coaching behaviors during an interaction with a caregiver. This type of video-elicitation has been shown to facilitate reflection and enable a deeper understanding of participants' thought processes (Hamel & Viau-Guay, 2019; Paskins et al., 2017).

Interviews and guided video discussions were audio recorded, transcribed verbatim, and verified before being uploaded into NVivo 12 (QSR International Pty Ltd., 2020), a qualitative data analysis software used to organize and facilitate analysis. The interview transcripts were combined with the video-based guided discussion transcripts for interpretation and analysis. Participant and site names were removed and assigned pseudonyms to preserve confidentiality in the final report. Videos were viewed on the practitioners' devices and not collected by the researcher.

To ensure rigor and trustworthiness and account for potential bias (Holmes, 2020), credibility processes were incorporated throughout this study (Cypress, 2017). The primary researcher conducted all interviews to maintain consistency, critically reflected on her positionality, participated in reflexive memo writing throughout data collection and analysis, maintained a careful audit trail and detailed field notes, and participated in frequent debriefing sessions with members of the research team to challenge assumptions, reflect, discuss, and refine codes and themes. Practitioners were de-identified and quoted directly to ensure adequate representation and thick description of their perspectives. This study followed the Standards for Reporting Qualitative Research (O'Brien et al., 2014).

The primary researcher who completed the interviews and data analysis is the parent of a child who is DHH and an experienced LSL EI practitioner. This dual perspective, along with experience in caregiver coaching, provides a unique lens through which to identify and examine matters of clinical significance, and informed the design of this research.

Results: Underlying Beliefs Drive Process and Promote Participation

All practitioners recruited at each intervention site agreed to participate, as did the program directors at two sites, both of whom are still providing services to families, for a total of 14 interviews (see Table 1 for demographics). The site distribution was as follows: Site 1, *n* = 4; Site 2, *n* = 6; Site 3, *n* = 4. Eight practitioners supplied video clips to supplement their interviews. Video recordings were prohibited once pandemic restrictions were implemented, limiting the number submitted.

The video discussions provided rich and informative insight into practitioners' conceptualization of coaching and illustrated differences in their approaches that were not evident in the interviews. The majority of practitioners reported that they chose clips that demonstrated a *typical* rather than *ideal* coaching exchange with caregivers. The videos allowed the practitioners to elaborate on and explain their coaching practices and decisions in real time.

All practitioners ascribed to caregiver coaching and reported efforts to actively engage caregivers in intervention. However, variations existed between sites and among practitioners as to the definition and specific practices they incorporate in their LSL intervention with families. As understanding of the practitioners' perspectives increased, an overarching concept became clear: the underlying beliefs practitioners held about the role and capacity of caregivers impacted both the process of coaching and the ways in which they engaged caregivers. As such, we identified themes in three categories: (a) underlying beliefs: caregiver capacity, conceptualizing coaching, and perspective shifting; (b) process: equipping and shared understanding of concepts and procedures; and (c) participation: built on relationship, engagement leads to empowerment, matching goals to caregiver priorities, and recognizing challenges. See Figure 1 for a graphic representation of themes and subthemes.

Table 1
Demographics

Variable	Number	Percentage
Time in Early Intervention		
1–4 years	3	21.43%
5–10 years	3	21.43%
11–15 years	1	7.14%
16–19 years	1	7.14%
20+ years	6	42.86%
Professional Designation		
ToD	10	71.43%
SLP	3	21.43%
AVT only	1	7.14%
Certification Status		
LSLS Cert. AVEd®	4	28.57%
LSLS Cert. AVT®	1	7.14%
Not certified	9	64.29%
Highest Degree		
Masters	13	92.86%
Bachelors	1	7.14%
Country Where Degree Conferred		
USA	10	71.43%
Canada	2	14.29%
Australia	1	7.14%
Egypt	1	7.14%

Note: ToD = Teacher of the Deaf; SLP = Speech-Language Pathologist; AVT = Auditory-Verbal Therapist (practicing, but without official certification; undergraduate degree in special education); LSLS Cert. AVEd®/ AVT® = Listening and Spoken Language Specialist Certified Auditory-Verbal Educator/Therapist

Underlying Beliefs

Practitioners revealed how they conceptualize coaching and their underlying beliefs related to caregiver capacity, and many of the practitioners discussed how experience and new learning shifted their beliefs over time. These underlying beliefs impacted how they talked about the process of coaching and expectations for caregiver participation in intervention sessions.

Caregiver Capacity

Practitioners discussed their views about caregiver capacity and desire to engage in coaching as certain and expected of all caregivers or based on extenuating circumstances, and therefore variable. The majority of practitioners expressed belief in caregiver capacity; however, five practitioners from one site expressed that although they believe caregiver coaching is ideal, it is not always feasible.

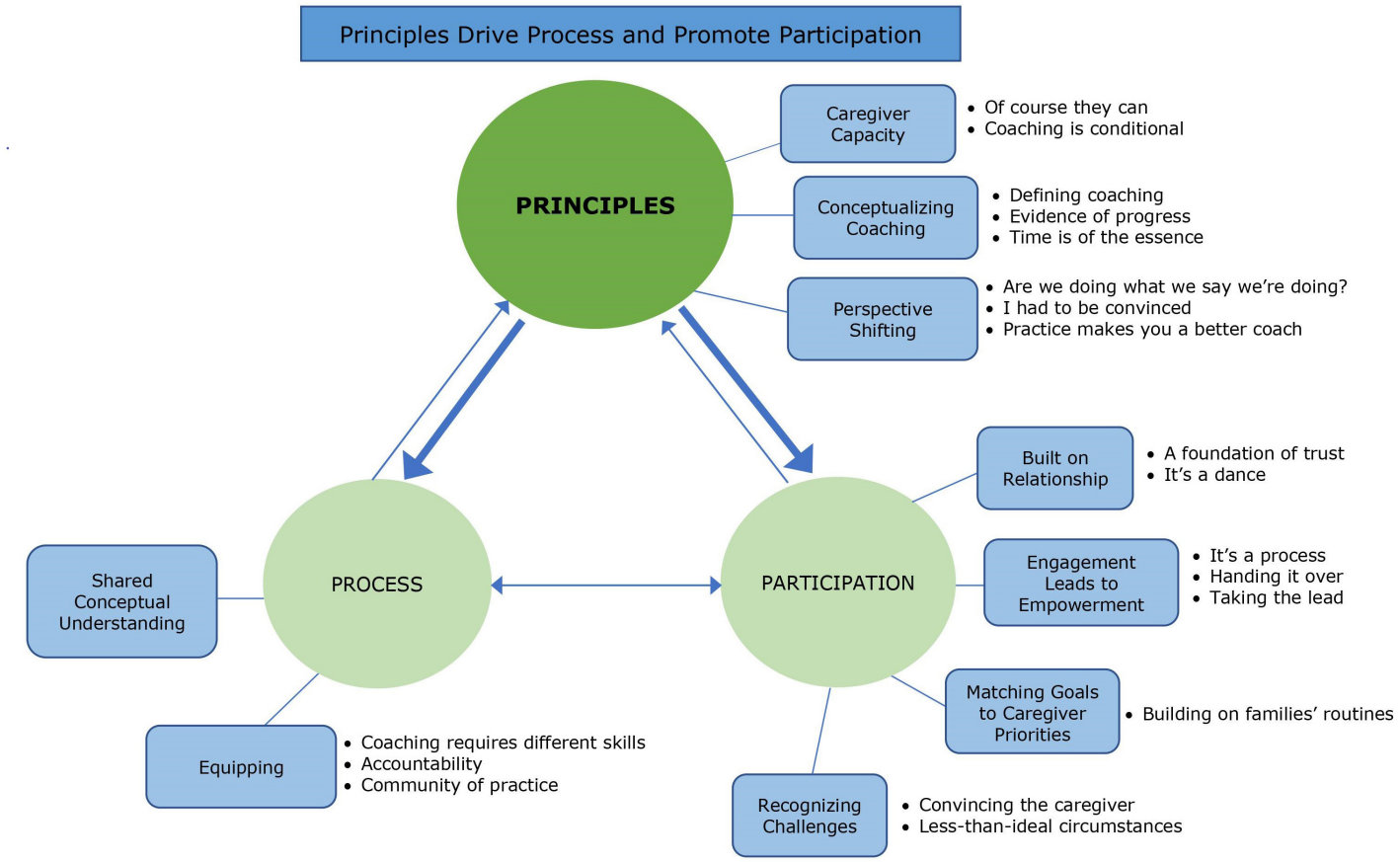
Of Course They Can. All practitioners from two sites and one from the third site expressed the belief that caregivers can and will engage meaningfully in caregiver coaching. Several participants recounted instances in which caregivers chose not to participate in coaching, but indicated that it was rare and they were "not okay" with it, but ultimately, they indicated that choice belonged to the caregiver. In some cases, the practitioner provided direct service to the child rather than coaching and in others, the caregivers sought services elsewhere. Alexis shared her frustration with other practitioners in this way: "Therapists… make assumptions on what the parents are feeling. 'Oh, they're not ready…they've already been through too much.' And it's like, 'No, let's ask them, because it might be the one thing they think they *can* do.'"

The assumption that the majority of caregivers will engage in coaching was particularly evident in the self-selected video clips. Several practitioners chose families who were facing significant challenges that might have impacted their ability to fully engage in coaching. However, the practitioners shared the obstacles the caregivers had overcome and how proud they were of the progress they had made, indicating that they believed in their capacity to engage and benefit from coaching despite the challenges they faced.

Coaching is Conditional. In contrast, five practitioners talked about coaching as the ideal, but not always

Figure 1

Practitioners' Experiences with Caregiver Coaching in Listening and Spoken Language Practice



Note: This is a visual representation of the themes (circles), subthemes (rectangles), and codes within the subthemes (bullet points) from the data. The arrows indicate directional relationships between the themes.

possible, citing reasons such as caregiver personality and family situational factors. These practitioners used words such as "awkward" and "uncomfortable" to describe coaching interactions and described some caregivers as "pretty fragile," and, as such, they did not want to push them too hard to engage in coaching. Ann reported, "Sometimes it just, it does not matter how well you explain it, it's not going to happen."

These practitioners identified strategies they might use to encourage engagement, such as using siblings as an example and "indirectly modeling" in an effort to encourage the caregiver to take a turn. These practitioners, all from one site, discussed coaching as if it were the exception, rather than the norm. These same practitioners reported lower levels of self-efficacy with regard to their coaching practices and were less likely to report supervisor and/or colleague accountability as a regular part of their practice.

Conceptualizing Coaching

Defining Coaching. The definition and practices of coaching varied widely. According to Kelly:

> Everybody gets this big global idea, but then when it comes down to how you implement it and which parts are really the most important, you probably get many varied answers…the biggest definition I would have is…it's about walking alongside a family.

In general, practitioners within each site shared similar viewpoints of what caregiver coaching is and the practices that comprise it, although differences between sites were considerable. These differences included which parts of an intervention session are considered coaching, specific practices that should or should not be included during coaching, and the terminology used to describe specific coaching practices. Site 1 practitioners conceptualized coaching as the teaching portion of a session, when practitioners provide information or explain strategies, rather than the activity part of the session, when strategies are applied and practiced. Site 2 practitioners considered coaching to encompass most of an intervention session, including providing information, explaining and/or demonstrating a strategy, practicing in the context of an activity, and reflecting with the caregiver. Site 3 practitioners conceptualized coaching as a specific part of the intervention session, when the caregiver engages in an activity with their child, incorporating LSL strategies while the coach sits back to observe and provide feedback, and reflection with the caregiver after the completion of the activity.

These differences were especially apparent as the practitioners discussed their video clips and shared what

they considered to be a typical example of a coaching exchange. One site has developed specific criteria and protocols for coaching practices, and accountability is built into their organizational professional practices through regular reflective supervisory and collaborative team meetings. Practitioners at this site, in particular, clearly articulated their coaching practices using shared language as a staff. Practitioners from the other sites shared the same general criteria for coaching as their coworkers, although more variability existed in how they talked about their coaching practices.

Evidence of Progress. Practitioners discussed methods for determining whether caregiver coaching was effective in terms of caregiver learning and the child's LSL outcomes. All practitioners reported using a variety of formal and informal assessments to document child progress, and several talked about attributing child progress to their caregivers learning LSL skills and implementing them at home. No practitioners reported the use of a formal measure for documenting caregiver learning through coaching. A few mentioned informal measures for assessing caregiver learning, such as observing their interactions with their children during intervention sessions. Sara indicated that observing how a caregiver talks with her child provides insight into how well she has learned intervention strategies, saying, "She will talk to him, she will tell him, she will comment about what's going on, parallel talk, self-talk. She will be a talkative parent."

Time is of the Essence. Another conceptualization of coaching was evident in how practitioners viewed their time with families. Several of them talked about the value of the length of time they are able to work with families—typically approximately three years—which afforded them the opportunity to establish trust and develop a meaningful coaching relationship. Several practitioners viewed caregiver coaching as a way to make the most of a 45–60-minute intervention session, and indicated that they value the time caregivers commit to intervention and do not want to waste a moment of it. The value of time was also evident in the emphasis practitioners placed on teaching caregivers concrete skills to carry over into naturalistic environments, to optimize their child's learning during the critical period for language development. Sara shared that it upsets her when she sees other practitioners "waste the critical age" for a child's language development. She went on to explain that intensive intervention during this critical period is crucial, stating, "I'm very keen for all my kids not to waste a day."

Perspective Shifting

All practitioners indicated that perspectives about caregiver coaching can change over time, through experience and professional development. Eight of the practitioners have worked in EI for more than 10 years, and many discussed how their understanding and expectations for caregiver coaching in LSL practice have evolved over the course of their career. However, even the less-experienced practitioners mentioned that their perspective about caregiver coaching has evolved since they began working with families.

Are We Doing What We Say We're Doing? Five of the practitioners described the shift to caregiver coaching as an internally-motivated decision to more explicitly engage caregivers in intervention sessions. Practitioners questioned whether their intervention practices reflected their conceptualization of caregiver coaching, as they claimed, or if they needed to implement changes to best serve families. Olivia described a desire for improvement, stating, "I knew what we were doing was good work, but I also knew that what we were doing could of course be better, because it can always be better." She recalled a conversation with her coworkers during which they agreed that the caregivers should be making the decisions and engaging with their child during sessions, and, as a result, they decided to change their coaching practices. However, they were not without doubts. Olivia recalled that they initially "did not trust that the parents would be able to rise to the occasion," indicating a skepticism that had to be overcome to change their practice, despite their conviction that it was a worthwhile change.

I Had to Be Convinced. Nine practitioners shared that their reasons for changing their coaching practices were more externally-motivated. They described a shift in thinking after learning about changing recommendations in the field; however, several reported that the decision to change their practices ultimately resulted from being held accountable to implement coaching by a supervisor and their colleagues. Several of these practitioners reported doubt that relinquishing control of the intervention would be effective, but were convinced after caregivers were willing and able to actively participate in coaching. Susan described this initial hesitation and how she was eventually convinced of the feasibility of coaching:

> I didn't believe it at first…I thought parents needed me to be telling them everything…I just didn't really realize the power of empowering them…When we really started doing it…we saw the parents be more responsible and kind of doing things on their own…I think it empowered us, as well, to believe this was a good thing.

Four practitioners reported learning about coaching and believing that it should be implemented, but are still working to change their practice. This was reflected in their reported perception that coaching is conditional, impacted by external circumstances.

Practice Makes You a Better Coach. Although a few practitioners reported feeling confident in their ability to coach from the beginning, most said that they gained confidence with experience, which changed their perspective on coaching. Kelly described making the adjustment from teaching in an LSL classroom to coaching caregivers, indicating that there was a significant learning curve. Over time, she reported gaining confidence, stating, "More practice with coaching just makes you a better coach." However, four practitioners indicated that although they feel more confident now than they did when they began coaching, they still feel uncertain about their coaching abilities. Interestingly, this included two

practitioners with more than ten years of experience who reported that they are still working to gain confidence in their skills as a coach.

Process

Coaching practices varied among practitioners and sites, including coaching components and how they are implemented. Practitioners described how they learned to coach and discussed factors that facilitate their coaching practice, including ongoing professional development, systems of accountability, and support from colleagues sharing similar experiences.

Equipping

Practitioners indicated that caregiver coaching requires specialized training and ongoing support that they did not necessarily gain in their professional preparation programs. Practitioners highlighted several components that went into equipping them with the knowledge, skills, and confidence necessary to effectively coach caregivers.

Coaching Requires Different Skills. All practitioners acknowledged that coaching caregivers requires a different skillset than teaching children, which is primarily what they learned in their professional preparation programs. Jessica shared, "I was…very nervous because…the whole responsibility of…teaching a family… versus working with a child…I knew that required a whole other set of skills." Four practitioners reported learning about coaching in their graduate programs, although only two of them reported this as a primary focus of their training. Other ways practitioners reported learning coaching skills included professional development activities, on-the-job learning, and mentoring from more experienced practitioners. Nine practitioners reported that providing tele-intervention services sharpened their coaching skills, and six reported refining their skills through teaching other professionals.

Many practitioners reported a desire for more opportunities to develop their skills, including Hannah, who put it this way: "I want to…coach the parents to teach their child. I feel like a link that's missing is—who's coaching me to do that?"

Accountability. Several practitioners mentioned accountability as a facilitator for coaching. They described accountability as answering to and brainstorming with a supervisor and colleagues about their coaching practices and challenges, as well as the responsibility inherent in training others to coach. The practitioners at Site 3 in particular shared how much they value having a supervisor who has high expectations and holds them accountable, to which they attributed gaining confidence in their ability to coach caregivers.

Practitioners from Site 3 also shared that part of their accountability practice included video recording sessions and reviewing them with a supervisor as well as using them regularly for self-reflection. When discussing her self-selected video clip, Ann shared an example of supervisory reflection when she stated, "This is a moment where (director) helped me through a part that could be coaching or strategy." Olivia felt strongly about using video for self-reflection, declaring, "The most enlightening thing is to videotape yourself."

Community of Practice. Another facilitator for coaching was regular interaction with colleagues with whom practitioners can share ideas, problem-solve, and pursue professional learning and development. Several practitioners mentioned the value of learning and growing together and stated that they appreciated having someone with whom to problem-solve difficult situations. Paula articulated the importance she places on sharing with her colleagues by saying, "It's nice to have peers with experience in the same boat as you, that you can talk to…I'm not an individual provider out there by myself. Because we do give each other a lot of feedback."

Shared Understanding of Concepts and Procedures

According to the practitioners, a shared and clear understanding of coaching principles, components, and procedures was a facilitator for gaining confidence and implementing coaching with fidelity. Susan reported that "there's certain components of every session that we know need to happen in order for it to be well done." Alternatively, a lack of clarity impeded coaching practices, resulting in a lack of confidence in coaching skills for some practitioners.

Several specific coaching practices were identified during the interviews including: checking in, setting goals, explaining the strategy, demonstration, observation, an opportunity to practice, providing feedback, reflection, planning for carryover, and wrapping up. Of these, reflection was reported as most difficult by many practitioners. They described it as "difficult," "challenging," and "uncomfortable," and several considered it "an area of growth," and, as a result, they did not always include it as a component of their coaching. Two practitioners reported that it was difficult when they first incorporated reflection into their coaching practice, but, as Kelly stated, "Now it feels pretty natural."

Practitioners also shared practices that supported the coaching exchange, including establishing the expectation for caregiver engagement and providing information to caregivers. Practitioners felt that these practices were particularly important at the onset of EI services and during transitions, such as preparing to exit EI services. As coaching practices varied between sites, not all of these components were included by all practitioners in every coaching session.

Participation

Practitioners' expectations and experiences regarding caregiver participation derived from their underlying beliefs about the capacity of caregivers to engage in coaching. Their expectations for participation ranged from full, active participation in all aspects of the session, including choosing goals, to expecting caregivers to take a turn after the practitioner modeled a strategy with the child. All practitioners agreed that caregiver engagement is a crucial criterion for coaching.

Built on Relationship

A Foundation of Trust. All practitioners reported that a foundation must be built with a family before establishing a meaningful and effective coaching relationship, and eight practitioners specifically mentioned trust as an important component of that foundation. For example, when asked, "What makes coaching work?" Kelly replied, "I think trust is the most important thing."

It's a Dance. Twelve of the practitioners mentioned that every family is different and adapting coaching to meet individual needs is an important skill for a practitioner to develop. Stephanie described adjustments made to coaching practices to meet families "where they are" in this way: "So, it's sort of a dance…it's so different for different parents and different children."

Engagement Leads to Empowerment

All practitioners agreed that the goal of caregiver coaching is to empower and equip caregivers to facilitate language growth in their children and the most effective way to do that is to actively engage caregivers in sessions. According to Susan, "It's all about empowering the parents and helping them believe that they have the skills in order to do this." However, they all reported that this is challenging at times. Practitioners reported expectations for engagement on a continuum, ranging from observing to taking the lead in all aspects of the session.

It's a Process. Practitioners reported that some caregivers are hesitant to engage during sessions, preferring to observe rather than participate, and described efforts to increase engagement as a process that can take time. Patrice described using demonstration to help caregivers understand the expectation: "Even the families who aren't there yet, you're mostly demonstrating…they're the ones who won't take a turn, even in spite of your best efforts…still it's engaging them and pulling them into seeing their role."

Handing it Over. One level of engagement that practitioners reported was that of taking a turn following demonstration of a strategy. In this scenario, practitioners lead the session and expect the caregivers to actively participate. Most practitioners described this as an acceptable level of engagement, as it gives caregivers an opportunity to practice skills during the session, during which the practitioners can offer feedback and encouragement. Carrie described her approach in this way: "I will say, 'Ok, so I will start. So, the cow says moo, and then I wait.' And then I'll just take the bag and give it to the parent, 'your turn.'"

Taking the Lead. Some practitioners expect an even greater level of engagement from caregivers, in which they take the lead and participate in all aspects of the session, including establishing goals for the session and deciding which activity they would like to use to target them. For these practitioners, the primary focus of the session is the caregiver/child interaction, and they see their role as facilitators who observe and provide feedback. One site's approach to coaching hinges on this premise; their practitioners generally do not engage with the child directly and use demonstration minimally. When describing this level of engagement, Paula said, "The parents would do the activity with the baby. My goal is to sit there and coach…offering suggestions, making comments about what's good and what needs work."

Matching Goals to Caregiver Priorities

Practitioners talked about the value of partnering with caregivers to choose goals that are meaningful to them. Kelly described a time when she struggled to get a caregiver to engage, and once she realized that her goals for sessions did not necessarily match what the caregiver wanted for his child, she elicited his ideas, and his engagement completely changed. She said this helped her realize the importance of listening to caregivers when choosing goals because, "It's just something that sticks and it has more value to them because they were engaged in making the decision."

Building on Families' Routines. Twelve practitioners talked about the importance of teaching LSL strategies in the context of a family's daily routines to optimize language learning. They achieved this by using routines for their session activities, such as snack time and outdoor play, or teaching strategies using specific toys or activities, making sure to discuss ways caregivers could use the same strategies in the natural context of their everyday lives. Dawn reported that she teaches families that specialized toys or structured activities are not required for implementing LSL strategies, telling them, "If you don't do anything else, narrate life…talk to them all the time and make them aware of things they hear and see."

Recognizing Challenges

In addition to the challenges practitioners reported with implementing coaching related to their principles and process, they shared perceived challenges related to caregivers' active participation in coaching.

Convincing the Caregiver. Twelve practitioners mentioned the perception that a caregiver's lack of buy-in is a barrier that must be overcome to establish a good coaching relationship. Some practitioners attributed lack of buy-in to the fact that some families expect direct therapy for their child and do not understand or subscribe to the coaching model. They talked about strategies they use to convince the caregiver of the effectiveness of coaching, including clearly explaining the expectations and setting them up for success so they experience the benefits first-hand. Susan reported that most of her caregivers eventually "come around." She said, "It's not very natural for some parents…it takes a little while…once they see that the suggestions I'm giving them…helping the speech get better or helping the language get better…then they start believing that my suggestions are good."

Less-than-ideal Circumstances. Other perceived barriers that practitioners reported were difficult family situations, including low socio-economic status, single parenthood, and having a child with complex needs in addition to

hearing loss. They shared that they were empathetic to families' struggles and understood that not all of them would be able to fully engage in coaching. Brenda shared, "There are families who…never bought in…maybe it's too much work and they are already overwhelmed with other things...their kids are maybe more complex…are not as successful."

Discussion

The results of this study contribute to the literature by explicating the perspective of LSL practitioners using caregiver coaching in their work with families of children who are DHH. It is clear that LSL practitioners value caregiver coaching and believe it is an effective means for impacting child outcomes, and they work to actively engage caregivers during intervention sessions. The findings indicate that the underlying beliefs practitioners hold about caregivers' capability and their own coaching competency impact their coaching practices and how they partner with caregivers in LSL intervention. This study highlights practical actions practitioners can take to facilitate caregiver coaching.

Although the conceptualization and practices of coaching varied between sites, the common thread was active caregiver participation during intervention sessions. This supports previous research that reported EI practitioners' perspectives that active engagement in coaching promotes caregiver competence and leads to empowerment as caregivers realize their crucial role in supporting their child's development (Meadan et al., 2018). In this study, how practitioners engaged caregivers was linked to the practitioners' underlying beliefs in the caregivers' willingness and ability to engage in their child's intervention. This aligns with principles of adult learning, particularly the need for caregivers to practice skills in a meaningful context and receive feedback on their performance (Dunst & Trivette, 2009b). All practitioners maintained that caregivers can and should be involved in the coaching process, although their expectations for the extent of involvement varied. Expectations of caregiver participation ranged from leading the sessions to actively taking a turn following practitioner demonstration. However, some of the practitioners discussed the challenges of engaging caregivers and shared what they felt were valid reasons for lack of participation, indicating an implicit belief that active engagement in caregiver coaching is the exception and some caregivers may be unwilling or unable to participate. This aligns with recent research in which practitioners reported difficulty getting caregivers to engage and step out of their comfort zone in sessions (Douglas et al., 2020). Practitioners in the present study who successfully engaged caregivers reported that they did so by establishing clear expectations and matching goals to caregiver priorities.

The results from this study indicate that practitioners must believe in a caregiver's willingness and ability to engage meaningfully in coaching, as well as have confidence in their own coaching abilities, to establish a consistent and successful coaching relationship. These two fundamental beliefs are inexplicably linked; as practitioners become convinced of caregivers' capacity, their feelings of self-efficacy increase because they experience coaching as successful. Likewise, as their self-efficacy increases, they are better able to engage with caregivers in ways that facilitate their active engagement in sessions. Research relating to self-efficacy suggests that it is a malleable concept that can be influenced by intensive and specialized professional development and training (Bruder et al., 2013). Our results support this finding, as practitioners reported that underlying beliefs can change, either through successful coaching experiences or professional development specifically targeted at improving caregiver coaching skills.

However, our results suggest that knowledge of coaching alone is not enough to change practitioner behavior. It is evident from the results that pairing knowledge with accountability and a community of practice (CoP) facilitates the implementation of caregiver coaching. A CoP is a group of individuals with shared expertise and a desire to learn together (Li et al., 2009; Wenger, 2010; Wenger & Snyder, 2000) and has been recommended as a means to bridge the research-to-practice gap in a variety of health contexts, including audiology and speech-language pathology (Li et al., 2009; McCurtin & O'Connor, 2020; Moodie et al., 2011). CoPs can be informal or formal in structure, and have been used to provide mentorship, learn and share new knowledge, and foster a sense of belonging between members (Li et al., 2009). This aligns with early childhood intervention professional development research that found several key components of successfully implementing newly learned practices: (a) opportunities to discuss and reflect on practice experiences; (b) coaching, mentoring, and performance feedback during training; and (c) ongoing follow-up by supervisors, mentors, and peers to reinforce learning (Dunst, 2015). All of these can be accomplished through establishing a reflective community of like-minded practitioners who are working to implement coaching practices in their work with families and the accountability that stems from actively learning and growing together.

Several of the practitioners shifted their understanding of coaching, but not enough to change their belief in caregiver capacity. The way that they described their coaching practices and level of confidence did not align with a change in their underlying beliefs. Whether practitioners adopted caregiver coaching due to extrinsic or intrinsic factors or started this work convinced that caregiver coaching works or had to be convinced, their underlying beliefs guided their coaching practices. Our results suggest that although practitioners can decide to change their behavior, fully embracing the fundamental beliefs of caregiver capacity and their own self-efficacy may be what facilitates a lasting change in coaching practices. Therefore, intentionally adding accountability and a reflective CoP into a program may scaffold the shift in underlying beliefs that facilitate caregiver coaching.

Although not designed as a comparative study, a few important differences in how practitioners talked about

caregiver coaching between the three sites were noted. The literature has long reported a lack of operationalized definitions and practices in caregiver coaching (Friedman et al., 2012), and more recent research indicates that this lack of standardization persists in both the EI and LSL literature (Noll et al., 2021; Ward et al., 2020). Similarly, the practitioners in this study differed in their conceptualization of coaching. Practitioners from one site defined coaching narrowly and the practitioners operated from a very specific set of procedures. These practitioners expressed confidence in their approach because they knew exactly what they were expected to do and were held accountable for doing so. Another site defined coaching more broadly and the practitioners described their practices more variably. Both of these sites loosely based their practices on the Rush and Shelden (2005, 2019) framework for caregiver coaching. The final site, however, did not use the same language when talking about their coaching practices, and reported that they coached according to the conventions of AVT, even though they did not all hold LSLS AVT® certification. It is likely that differences in training and background tradition at the three sites accounted for some of these differences. Interestingly, the specific conceptualization of coaching seemed to have a lesser impact on practitioner confidence in the implementation of coaching than having a clear understanding of the distinct practices they considered to comprise coaching. This suggests that caregiver coaching may be facilitated by well-defined and clearly articulated coaching practices.

The practitioners at one of the sites were more likely to talk about coaching as conditional and seemed to have less confidence in their ability to engage the caregivers in coaching consistently. Previous research suggests that practitioners sometimes find coaching challenging due to conflicting expectations or family circumstances, such as a perceived lack of motivation, stress, or socioeconomic factors, which they consider barriers that may preclude families from actively engaging in coaching (Douglas et al., 2020; Meadan et al., 2018). In this study, some practitioners talked about coaching with more variability and less certainty than others. Practitioners who used words like “awkward” and “indirect modeling” when talking about their interactions with families indicated ambiguity in what coaching should entail, which likely impacted their ability to implement it with confidence and consistency. The practitioners who talked about coaching this way also detailed a lack of confidence in their ability to coach. The practitioners who articulated clear expectations for coaching practices reported greater confidence in their coaching ability, which aligned with previous research indicating that clearly-defined procedures facilitated practitioners’ confidence in implementing coaching practices (Salisbury et al., 2018). This indicates a need for the development of clear standards of practice and high-quality professional development to address caregiver coaching in LSL practice.

Implications for Practice

It was clear from our results that caregiver coaching was facilitated at sites that had established well-defined coaching practices. As suggested by previous researchers (King et al., 2021), a need exists for the establishment of a standard of practice for caregiver coaching among programs offering LSL services to families. This presents an opportunity for professional preparation programs to evaluate whether they are developing proficiency specific to caregiver coaching in future LSL practitioners, as well as for the establishment of targeted professional development and mentoring programs to support practitioners working with families. There have been recent efforts by seven national professional organizations, including the American Speech-Language-Hearing Association, to establish cross-disciplinary competencies for EI practitioners, including family-centered practices, although not specific to caregiver coaching (Bruder et al., 2019). Certification bodies specific to LSL practice such as AG Bell Academy may wish to consider establishing standards and embedding targeted training for coaching caregivers in the certification process, as well. According to the practitioners in this study, coaching caregivers requires different skills than teaching children who are DHH**.** There is a need to define practitioner competencies for effectively teaching adult learners and to develop robust and highly specialized pre-service and in-service professional development programs.

The results of this study suggest that underlying perceptions can impact coaching practice, so the inclusion of intentional reflective practices may facilitate a change in practice. Additionally, establishing a CoP, which facilitates peer-to-peer reflection, problem-solving, and learning, as well as accountability practices that promote caregiver coaching may improve practitioners’ confidence in coaching caregivers. Programs that provide LSL services to families of children who are DHH can incorporate these elements into their practice to foster the development of coaching skills, as well as develop consistency and fidelity of implementation.

Limitations

This study was not without limitations. The Canadian practitioners were interviewed after their sessions shifted to online service delivery due to COVID-19 restrictions. Although most practitioners indicated that tele-intervention was a facilitator for their coaching, it was not without its challenges, and may have impacted their perceptions about the coaching experience. COVID-19 restrictions also limited the number of videos we obtained due to privacy concerns arising from recording intervention sessions conducted on Zoom. The videos we did receive were fairly well distributed across all three sites, added depth to our interviews, and strengthened our analysis of coaching practices. Using video for reflective discussions on a broader scale would be an interesting direction for future research.

Personal connections were used to access the intervention sites and the first author was familiar to some of the practitioners due to shared professional experiences. Although this may have impacted how freely practitioners shared their experiences, intentional procedures were followed to reduce bias and ensure that practitioners

understood the non-evaluative intentions of the inquiry. While shared disciplinary understanding of clinically-relevant issues is a hallmark of Interpretive Description and the researcher's pre-understandings are critical for generating meaningful and practical findings (Thorne, 2016), we took steps to ensure rigor, including careful reflexivity, frequent debriefing, transparency, and maintaining strict confidentiality (McDermid et al., 2014; Shenton, 2004). As a result, we believe the author's disciplinary experience provided deep insight and resulted in practical, applicable findings that provide new understanding of caregiver coaching in LSL practice.

Additionally, although it was valuable to elicit the perspectives of practitioners from three different sites, a larger study would provide more information about coaching practices of LSL practitioners, and comparative case studies would be beneficial to understand the differences among intervention sites. It would also be interesting to examine the perspectives of practitioners following the wide-spread implementation of tele-intervention due to COVID-19 restrictions. Future research could include an examination of differences in training (speech-language pathology versus deaf education), service delivery models, LSLS certified versus non-certified, and characteristics of the demographic of caregivers served. Additionally, there is a significant need for studies that measure caregiver and child outcomes as a result of caregiver coaching.

This study provides a unique contribution to the LSL literature by examining caregiver coaching from the perspective of the practitioners who implement it. The results indicate an interplay between practitioners' underlying beliefs and their practices, including how they engage caregivers in intervention. Our results suggest that a practitioner's beliefs, especially about caregiver capacity and self-efficacy, are the key to implementing caregiver coaching with confidence and consistency. If practitioners have a clear understanding of coaching components, build skills through professional development and a supportive CoP, and are held accountable for implementing coaching practices, they are more likely to report positive experiences with coaching caregivers. Ultimately, increasing practitioners' self-efficacy may lead to more fully engaging caregivers in intervention, which is likely to improve LSL services and optimize child outcomes.

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Appendix A

Practitioner Interview Guide

Study ID _____ Date_____

Purpose: The purpose of this interview is to learn more about your experiences implementing AV/LSL services for families of children with hearing loss. Specifically, I am interested in learning about how you 'coach' or teach caregivers to implement intervention strategies themselves, throughout their daily routines, in between intervention sessions. I am also interested in learning about how you learned to coach caregivers.

Procedure: Before we begin, I'll ask you to fill out a short information sheet about your work. Next, I will ask you some questions to guide our conversation, but please feel free to talk openly about your experiences and add anything that you think is important. Please don't hesitate to ask questions.

Interview information:

Location of interview: ☐ Clinic ☐ School ☐ Other: _____

Informant's professional background: SLP ☐ TOD ☐ Other: _____

LSLS certified: ☐ Yes ☐ No ☐ Working toward certification

Interview questions:

1. How long have you been in this field? How long have you been working with the birth–3 population specifically?
2. I know that all sessions are different, but can you describe a somewhat *typical* session?
   Prompt: Who participates in sessions, generally?
   Prompt: Where do you normally have sessions?
   Prompt: What kinds of activities do you do during sessions?
   Prompt: Can you tell me a little about the structure and sequence of your sessions?
3. Can you describe an *ideal* session?
   Prompt: Where would it be located? Who would participate?
4. What do you like about working with this age group? What do you find challenging?
5. I'm specifically interested in learning more about coaching in AV/LSL services. How would you define *coaching*?
   Prompt: What does this look like in a typical session?
   Prompt: In your opinion, what are key characteristics of coaching in an intervention session?
6. How did you learn about caregiver coaching?
   Prompt: Did you learn about coaching during your graduate training? Through professional development trainings at your workplace or conferences?
   Prompt: Please tell me more about how you learned to coach.
7. Do you use a particular model of coaching in your work?
   Prompt: Did you learn about coaching models in your training? If so, which ones?
8. How do you incorporate reflection in your practice?
   Prompt: What role did reflection play in your training?
   Prompt: Did someone teach you how to reflect? What did that look like?
   Prompt: Do you incorporate reflection in your sessions with parents? What does that look like?
9. When you began working with the birth–3 population, how confident were you in working with caregivers?
   Prompt: How has your confidence changed with experience?
   Prompt: What did you do to increase your confidence?
   Prompt: How confident are you now?

10. Has your practice changed over time? If so, in what ways?

    Prompt: Has your philosophy changed at all since you started practicing? If so, in what ways?

11. What do you think the caregivers' role should be in the early intervention or therapy process? How would you describe your role?

    Prompt: How are targets for sessions determined?

    Prompt: How are the overarching long-term goals determined, such as IFSP goals?

    Prompt: What kinds of strategies do you use to establish roles or encourage caregivers to take on the role you feel is important in the intervention process?

12. How do you encourage caregivers to be actively involved in sessions? In the early intervention or therapy process in general?

    Prompt: How do you elicit participation during an activity?

    Prompt: What do you do if a caregiver is not actively involved?

13. What is your opinion about coaching caregivers as an intervention strategy?

    Prompt: What do you think are the benefits of coaching? What are the challenges?

14. What would you say is the most important thing for a good coaching relationship? What is most important for effective services overall?

15. Is there anything you'd like to discuss about coaching caregivers that we haven't covered?

Appendix B

Practitioner Video Observation Guide

Study ID _____ Date_____

Purpose: The purpose of this observation is to provide you with an opportunity to explain your thoughts and decision-making process within a coaching interaction. My purpose is not to evaluate your coaching, but to better understand your thought process during a coaching exchange with a caregiver. In addition to the information you provided during our interview, this will add to my understanding of your coaching practices in intervention sessions with caregivers. I am also interested in how you reflect on your practices as we watch the video together.

Procedure: We are going to watch a 10-minute clip of an intervention session that you provided to me. I will stop the video at certain points to ask questions, and please feel free to ask me to stop it when you'd like to comment or explain something. I am specifically interested in talking about how you are coaching or teaching the caregiver in the interaction. Again, I will ask you some questions to guide our conversation, but please feel free to add anything that you think is important and don't hesitate to ask questions.

Session information:

Location: ☐ Home ☐ Clinic ☐ Other: _____

Caregiver(s): ☐ Mother ☐ Father ☐ Both ☐ Other: _____

Age of child: _____ Length of time working with the family: _____

Video observation questions:

Before

1. Have you ever watched your sessions on video before? If so, for what purpose (performance evaluation with your supervisor, personal reflection, peer reflection, certification purposes, etc.)?

   Prompt: Have you found this useful in your work?

2. Is there anything you would like to tell me about this family or interaction before we begin?

During

Throughout the observation, the following prompts may be used, where appropriate:

- Can you explain to me what was happening there?
- I noticed that you paused there. What were you thinking?
- What prompted you to make that decision?
- What just happened there?
- How did that compare with what you were aiming for?

After

1. What are your general thoughts about this coaching interaction?

   Prompt: What do you think went well? What do you think could have been better or different?

   Prompt: How effective do you think this interaction was in achieving the goals for the session?

2. Do you think this is a good example of a coaching interaction? Why or why not?

3. How is this coaching exchange similar or different from your typical sessions with this family? What about with other families?

   Prompt: Do you use similar or different coaching strategies with each family?

   Prompt: How do you decide which strategies to use with each family?

4. Is there anything else you would like to share about this coaching interaction? Or about the video observation process in general?