PERSPECTIVES SIG 16

Clinical Focus

Motivation, Rapport, and Resilience: Three Pillars of Adolescent Therapy to Shift the Focus to Adulthood

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Purpose: The purpose of this clinical focus article is to encourage speech-language pathologists (SLPs) to shift their operational framework as students grow from childhood to adulthood by focusing on three pillars of interaction: motivation, rapport, and resilience. We need to foster greater independence and interpersonal skills in older students, but researchers have not explained how to help SLPs successfully transition their intervention strategies. Here, we identify three pillars of adolescent therapy—motivation, rapport, and resilience—to help clinicians shift their perspective from childhood to adulthood. We rely on social constructivism to guide practice and argue that client-centered models of therapy are more appropriate than therapist-centered models for adolescent students. For each pillar, we discuss clinician behaviors, student results, and clinical implications.
Conclusions: By strengthening these three pillars of interaction, clinicians can shift their focus toward client-centered therapy models and facilitate skills students need in adulthood. Strengthening skills related to motivation, rapport, and resilience will help support more symmetrical and flexible clinical partnerships in adolescent students with communication disorders.

Speech-language pathologists (SLPs) who work in schools have a unique opportunity: we have the potential to accompany students across the threshold of school on their first day of kindergarten, watch them cross the stage at their high school graduation, and help them navigate every milestone along the way. According to current data, 53.9% of SLPs work in educational settings, but only 3.8% list secondary schools as their primary placement (American Speech-Language-Hearing Association [ASHA], 2020a). Despite working with students at every grade level, only a small percentage of SLPs work with adolescent students (ASHA, 2020a; Salley, 2012). However, SLPs have the right and responsibility to be an integral team member in secondary schools, working to identify at risk students, supporting teachers, and advocating for best practices (ASHA, 2001).

Students being educated under the Individuals with Disabilities Education Act (IDEA) can remain in school until age 21. Since students receiving school-based services are the focus of this clinical focus article, we define *adolescence* as individuals who are 11–21 years, consistent with IDEA (2004). Adolescent students pose unique challenges to clinicians: SLPs report pressure to dismiss students after elementary school, lack of administrative support, lack of adolescent participation, and difficulty with curriculum (Ehren, 2002; Salley, 2012). These challenges result in fewer adolescents receiving speech-language services despite researchers advocating for ongoing intervention (Burns, 2020; Larson & McKinley, 2003; Salley, 2012).

Considerably more research has been devoted to young children than adolescent populations, despite the "heightened neuroplasticity" that occurs in the teenage years (Burns, 2020, p.1767). Given the tremendous growth during adolescence, this is the time for SLPs to shift their operational framework. We need to foster greater intrapersonal and interpersonal skills in our students, but researchers have not explained how to help SLPs successfully transition their intervention approaches and strategies.

To address this need, we considered the components of evidenced-based practice: clinical expertise, client perspectives, and evidence. Evidence is two-fold. Internal evidence includes subjective and objective observations about clients; external evidence requires reviewing scientific,

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peer-reviewed literature (ASHA, n.d.). In this clinical focus article, the authors reflected on our combined clinical experiences with adolescent students and reviewed research related to aspects of well-being and independence. Longitudinal studies demonstrate that adolescents with language impairment become adults with language impairment (ASHA, 2002; Burns, 2020; Conti-Ramsden & Durkin, 2012; Joffe & Nippold, 2012; Lindsay & Dockrell, 2012), resulting in economic and social repercussions (National Joint Committee on Learning Disabilities, 2008). It is within our scope of practice to continue addressing the language, literacy, and metacognitive needs of older students with language impairment (ASHA, 2001, 2002; National Joint Committee on Learning Disabilities, 2008). Yet, SLPs need to approach adolescent students differently than young students. Thus, our purpose is to present three pillars of adolescent therapy—motivation, rapport, and resilience—that support the therapeutic transition from childhood to adulthood as students grow.

Using social constructivism as a theoretical framework, these principles ground clinical decision making. To shift the focus from childhood to adulthood, we first describe differences between therapist-centered versus client-centered therapy models and we connect these concepts to the theoretical perspective of social constructivism. We then define each pillar, highlighting examples and implications.

Therapist-Centered Versus Client-Centered Therapy Models

Service delivery models common with young children—called *therapist-centered models*—differ from *client-centered models* more common with adults (Simmons-Mackie & Damico, 1999; Simmons-Mackie et al., 2007). Therapist-centered models have also been called "adult-centered" in interactional research (Kovarsky & Duchan, 1997, p. 297). This is similar to Fey (1986) continuum from child-centered to clinician-directed intervention, although that model focuses on naturalness of activities, rather than therapeutic collaboration between the client and clinician. In this section, we identify two characteristics of therapist-centered versus client-centered models: (a) expanded outreach into the community and (b) greater control symmetry (defined below) in therapy. See Table 1 for clarification and examples of these service delivery models.

Expanded outreach into the community is one characteristic of client-centered models more common in adult therapy. Expanded outreach means SLPs move beyond the classroom to include community partners; they work directly with employers, legal authorities, and social workers who interact with young adults (Clegg et al., 2012; Joffe & Nippold, 2012; Snow et al., 2012). This is consistent with recommendations to use nonschool settings to support academic and social needs for adolescents (ASHA, 2002). For example, SLPs can accompany high school students who are attending job fairs. This creates authentic opportunities to review aspects of job fairs that have not been explicitly taught before, such as permission to take free trinket items from tables. We have also attended community outings with groups to visit colleges, ordered from restaurants using augmentative and alternative devices, and invited law enforcement to talk to students about encountering police officers. All these examples, depending on the cognitive and communicative abilities of the students, increase their exposure to the broader community.

Another characteristic of client-centered therapy more common with adults is greater *control symmetry*. Control symmetry occurs when the clinician acts as an equal member of the group rather than an authority figure in therapy (Simmons-Mackie et al., 2007). With therapist-centered models common with younger students, there is imbalance—less symmetry—in therapeutic interactions. Even if clinicians follow a child's lead and incorporate naturalistic activities, they maintain a dominant interpretive framework due to age differences and power structures in elementary schools, resulting in greater control of the therapeutic process (Damico & Damico, 1997; Ulichny & Watson-Gegeo, 1989). In client-centered therapy, control symmetry is a key component of successful group interactions (Lee & Azios, 2020; Simmons-Mackie & Damico, 2009; Simmons-Mackie et al., 2007). Incorporating the three pillars into adolescent therapy orients clinicians to move toward more client-centered models, helping them set up flexible opportunities with greater symmetry.

Using Social Constructivism to Guide Clinical Practice

Theory is an intrinsic navigation system for our clinical decisions; the three pillars framework presented here is consistent with principles of social constructivism. Social constructivism emerged from the field of developmental psychology. This theoretical perspective is the understanding that all learners are active, not passive, participants. Social constructivists emphasize that humans are uniquely wired for interaction; linguistic and cognitive development occurs as humans make sense out of interaction with other people (e.g., Bruner, 1983, 1996; Piaget, 1954). Our cultural perspective also greatly shapes development and the lens through which we view the world (Vygotsky, 1986).

When two people interact, the more competent social partner in that context scaffolds or mediates the interaction. Vygotsky (1986) described the zone of proximal development (ZPD) as an area between what a learner can solve independently and the upper limit of what they can problem solve with mediation from more capable social partners. When clinicians target the ZPD of an adolescent student, they make aspects of language and culture accessible to the student. Importantly, the dynamic between the clinician and the adolescent student is a social interaction that facilitates the cognitive and linguistic development of both participants.

Three Pillars: Motivation, Rapport, and Resilience

Neuroplasticity makes adolescence an ideal time for responsiveness to therapy that targets communication, language, social, or cognitive skills (Burns, 2020). Throughout the rest of this clinical focus article, we discuss in greater depth the three pillars of therapy with adolescent students.

Table 1. Characteristics of therapist-centered and client-centered therapy.

Operational framework	Characteristics	Examples
Therapist-centered model (Simmons-Mackie & Damico, 1999) also called "adult-centered" model (Kovarsky & Duchan, 1997)	1. Explicit focus on specific deficits	Decontextualized picture naming
	2. Evaluate performance of accuracy	Quiz structure: "How many pictures show sadness?" Accuracy response: "That's right."
	3. Control asymmetry	"Today we are going to work on naming pictures and play BINGO."
	4. Rigid structure	Request—Response—Evaluation discourse (see Simmons-Mackie et al., 2007)
Client-centered therapy (Simmons-Mackie et al., 2007)	1. Focus on natural communication	Authentic conversation is the activity
	2. Social orientation	Embrace complexity in group interaction
	3. Control symmetry	SLP is resource not authority figure: "What should we work on this week as a group?"
	4. Flexible structure	Projects depend on co-construction of meaning by all participants

Within each domain, we (a) define the concept, (b) discuss clinician behaviors, (c) describe student results, and (d) explore clinical implications for each concept. When clinicians incorporate these three pillars into adolescent therapy, they can smoothly shift the focus to more client-centered models of therapy (see Figures 1, 2, and 3).

Pillar I: Motivation

How do we motivate our adolescent students to participate in therapy, or do *we* really do the motivating? Consider the following: Football fans find it easy to read the sports pages, Minecraft gamers study building designs, and teenagers who love the *Twilight* series (Hardwicke, 2005) easily reach that last sentence of a 300-page book. Intrinsic motivation occurs when a student has engagement due to personal interest, enjoyment, and inherent satisfaction in an activity (Schunk et al., 2013).

Definition

Intentionally fostering motivation in our students requires a conceptual understanding of the term. *Motivation* is a dynamic continuum of choice, action, and persistence toward reaching goals (Clark, 2011). This continuum can be understood as ranging from total amotivation to totally motivated learning (Deci & Ryan, 1985; Gagné & Deci, 2005). Different states of internal and external motivation exist along this continuum. Motivation is dynamic and social; it evolves and can be strengthened. In the following sections, we consider clinical behaviors, student results, and clinical implications related to motivation.

Clinician Behaviors

SLPs have a strong impact in co-constructing a student's motivation or desire to learn, consistent with social constructivism. Clinicians can maximize motivation by fostering self-determination through feedback that empowers students (Ruppar, 2014). As clinicians, we have more control over the context than the internal state of our students, so consider how to approach therapy in a way that supports a desire to learn. Think about therapy from your student's

Figure 1. Motivation.

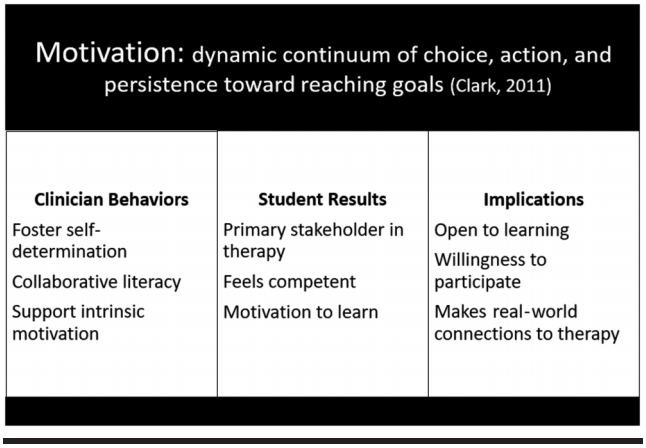


Figure 2. Rapport.

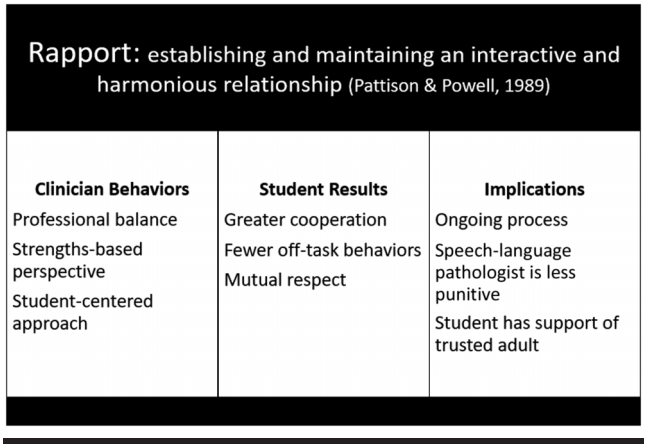
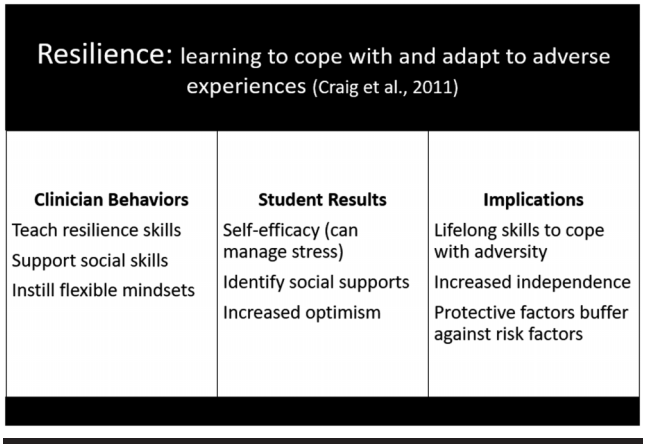


Figure 3. Resilience.



perspective; what do they feel or understand about working with an SLP?

Fostering self-determination is one way we can create positive motivation for learning and is an important learning outcome (Ruppar, 2014). Self-determination strongly impacts motivation; one's actions are determined by the ability to choose and have personal choices (Deci & Ryan, 1985). When SLPs allow students to collaborate, make choices, and set their own goals, students become active learners who are intrinsically motivated to participate.

A passive learner is not personally invested in the co-construction of meaning. They are not a primary stakeholder in speech-language therapy. For example, students are part of the Individualized Education Plan (IEP) team and adolescent students should be part of the team meeting. Prior to the meeting, however, devote at least one speech-language session to prepare for the meeting, helping the student identify what goals they want to target and practice what they want to say to the group. One student felt that it was unfair when a teacher made him stand up when he got distracted. By practicing beforehand in a speech-language therapy session, the student tactfully addressed this in front of the IEP team and played an active role in selecting more appropriate accommodations.

Empowering feedback is another important clinician behavior to support intrinsic motivation. Rather than using extrinsic rewards—such as stickers and toys—that are common with younger students, older students need genuine feedback that acknowledges their effort, achievement, and competence. Feelings of competence have long been recognized as positively impacting motivation pursuant to learning (Feuerstein et al., 1988). Rather than saying "good job," SLPs can use phrases like, "You really worked hard to get that done," "It took a lot of courage to write about that," or "You put your heart into that story, it is so personal." By fostering self-determination and providing empowering feedback that praises effort and competence, SLPs can create a social dynamic that supports motivation.

Student Results

How do we know when a student is developing intrinsic motivation? Motivation is directly tied to perception of self (deCharms, 1972; Deci & Ryan, 1985). We fear failure when we do not view ourselves as competent, and we struggle to find the focus and energy needed to engage in activities at hand. When students are active stakeholders in therapy and feel increasingly competent, they demonstrate self-determination; the result is greater intrinsic motivation.

Of course, not every academic topic will be intrinsically motivating to every student. In addition to increased intrinsic motivation, we also look for student *motivation to learn.* Clark (2011) contrasts the affective response of enjoyment (pure intrinsic motivation) with cognitive skills related to motivation to learn. This exists when students try to make sense of a topic, use their background knowledge to participate, and demonstrate mastery of a concept, regardless of their pure enjoyment of the task (Clark, 2011). A student who is transitioning to greater independence should have more freedom to explore motivating topics *and* exhibit motivation to learn in academic tasks.

During a unit on job interviews, an adolescent student asked about quitting his job at a fast-food restaurant, "Can I just quit, or should I call and let them know?" As a group, we talked about the pros and cons of giving an employer notice before leaving a job. After active discussion, the student decided to give a 2-week notice in case he needed a reference in the future. The student connected quitting his job with the speech-language unit (job applications) and his future goals (getting another job), to actively participate in the session. With enhanced self-perception and real-world connections, he showed intrinsic motivation to develop professionalism that would boost his job prospects in the future.

At a different high school, a student felt embarrassed about attending speech-language sessions and resisted activities. Through discussion with the SLP, he identified his low standardized test scores as a barrier to his desired career in sports medicine. After connecting intensive literacy remediation with improving his placement test, he ultimately saw an increase in his test scores at the end of the year. Even though he did not enjoy the task, he fostered motivation to fully engage (Clark, 2011). This example demonstrates how SLPs can foster motivation—one of the three pillars—while targeting language and literacy goals consistent with ASHA (2001).

Clinical Implications

Adolescent students with communication disorders face obstacles in secondary school; hidden curricula, low expectations, and low self-perception can all lead to decreased motivation (Dudley-Marling, 2004). Learning disabilities not only arise from the actual limitations of the individual but also are socially constructed throughout life as educational experiences unfold. Students may have little motivation before they try because social interaction reinforces the concept of disability (Dudley-Marling, 2004).

Clinicians can boost intrinsic motivation by fostering self-determination—letting students participate as active stakeholders in therapy planning and goals—and offering feedback that assumes competence while rewarding effort. When students are intrinsically motivated, they enter classrooms with openness to learning, willingness to participate, and actively making real-world connections that benefit them in adulthood.

Pillar II: Rapport

Rapport is essential to successful clinical interactions with adolescent students. The power of rapport leading to trust and positive relationships benefits the entire therapeutic process. Rapport goes beyond a student *liking* a clinician or supervisor; it describes an ongoing relationship that requires effort from both parties.

Definition

Pattison and Powell (1989) describe rapport as:

> the establishment and maintenance of an interactive, harmonious, communicative relationship between the examiner and the examinee. Rapport has been obtained when the participants share mutual feelings of trust and respect; however, rapport is transient in nature and the sensitive clinician will take steps to ensure its continuation (p. 77).

Pattison & Powell (1989) described clinicians assessing young children, but their recommendations also apply to older students. They explain how familiarity, encouragement, and invitations rather than demands to participate positively impact rapport. Additionally, nonverbal behaviors such as smiling, leaning forward, and head nodding can help establish rapport (Akamoglu et al., 2018; Tickle-Degnen & Rosenthal, 1990).

Clinician Behaviors

Clinicians can support rapport with adolescent students by maintaining balance, viewing off-task behaviors through a lens of compensatory adaptations, and using client-centered therapy. Balance is an important concept related to rapport. Clinicians who build rapport with their students recognize the "balancing act" required for responding to negative or avoidance behaviors (Pattison & Powell, 1989, p. 79). Research supports getting to know students and making personal connections by showing interest in what they enjoy as ways to encourage rapport (Akamoglu et al., 2018). One student was thrilled when the SLP acknowledged their interest in *The Fellowship of the Ring* (Tolkien, 1991) and began writing them a welcome note before every session in Tolkien Elvish alphabet characters. Another group of students got a good laugh at the SLP memorizing a song by a little known but local musician the students followed. In every session, clinicians make spontaneous decisions to balance the needs of the student with other group members and therapeutic goals. SLPs must also balance professional rapport and personal familiarity, particularly as it pertains to self-disclosure (Herd & Cohn, 2009).

Balancing personal familiarity and professional boundaries can be hard given social media and instant communication. Based on our experience, rapport is the result of trust and respect, not personal friendship. For example, we would not give students our personal phone number or message them on social media, but they could list us as a professional reference for a job application using the school phone number as means of contact. When used intentionally, achieving professional balance builds trust and rapport in the therapeutic dyad.

Imbalance occurs when SLPs encounter off-task behaviors from teenage students and fail to understand compensatory adaptations. From a strengths-based perspective, *compensatory adaptations* include off-task behaviors that are attempts, often subconscious, to respond to difficult interactions by relying on alternative systems of communicative competence (Perkins, 2007). These behaviors occur across ages and manifest in different ways such as describing a picture instead of reading text, disruptive comments, joking, asking on-topic questions that avoid the task, direct refusal of the task, excessive talking, and some echolalia (Damico & Nelson, 2005; Damico et al., 2008, 2011; Perkins, 2007).

While compensatory adaptations can be challenging on the surface, these behaviors are not personal attacks. Compensatory adaptations reflect the desire to preserve a social interaction or turn at talk despite the student lacking confidence they can complete the task. Compensatory adaptations can also be attempts to save face in a group interaction. At times, responding to compensatory adaptations with additional scaffolds and mediation rather than a punitive response can foster stronger relationships (Whited & Damico, in press).

In addition to maintaining balance and viewing compensatory adaptations from a strengths-based perspective, clinicians develop rapport through client-centered approaches with a comprehensive model, including careful program planning, functional goals, and counseling (Larson & McKinley, 2003). SLPs can achieve this by giving adolescent students greater decision making in therapy, such as collaborating to construct projects rather than having preplanned activities. For example, in one middle school, an authentic writing project developed when the school district mandated students read a bullying prevention guide. The students felt that this material was disconnected from their lived experiences. In response, they created a shared writing project titled a *Handbook of Bullying for Teachers* complete with real-life examples and illustrations (Hays et al., 2014). Clinicians develop rapport by maintaining professional balance, developing a strengths-based perspective of compensatory adaptations, and offering students greater decision-making ability.

Student Results

As a result of positive rapport, students show greater cooperation in therapy and increased progress (Akamoglu

et al., 2018). Increased cooperation and fewer off-task behaviors occur when students feel trusted and respected. Another student behavior that corresponds with strong rapport is increased risk taking in the form of responding to questions and participating in difficult speech-language tasks. When students trust that the SLP offers a safe space to participate without fear of losing face, participation increases dramatically.

Akamoglu et al. (2018) noted that even in telepractice formats, SLPs describe rapport as critical to successful outcomes. That study indicated that rapport increased progress toward goals as reported by SLPs. When activities are collaborative and clinicians use a client-centered model of therapy, students feel greater freedom to participate. Similarly, having the freedom to opt out of an activity can be a powerful motivator with teenagers who want greater control symmetry in the therapeutic dyad.

One 16-year-old student presented with a developmental language disorder. The student disliked all reading activities and often refused to participate, citing boredom with the tasks. To encourage participation and to develop stronger rapport, the SLP helped the student in planning a trip of their choice. They planned a trip to a convention for fans of Polly Pockets. The task integrated the student's unique interests, which naturally highlighted their strengths (i.e., their background knowledge of Polly Pockets). This project improved the student's cooperation and increased therapeutic rapport because the student directed the activity.

Clinical Implications

Researchers across disorder type have reported the importance of using conversation and open-ended questions to *establish* rapport (e.g., Beilby et al., 2012; Nippold et al., 2008, 2015; Russell & Abrams, 2019). However, for SLPs working with adolescent students, rapport is an ongoing process (Akamoglu et al., 2018; Murphy & Rodriguez Manzanares, 2008). Once established, rapport can be fragile and must be maintained as one would a garden. For example, a student approached one of the authors at their high school, saying "You're not gonna like me anymore. I stole something from your desk yesterday." Rather than focusing on the theft, the SLP responded, "I like you because telling me you stole something took honesty and courage. I wasn't that brave at your age." In that pivotal moment, the SLP chose rapport rather than a punitive response and succeeded in maintaining a strong, cooperative relationship with this student the rest of the year. The message here is *not* to let everything slide. Certainly, as the authors are both mandated reporters, we have reported instances of suspected abuse, student reports of self-harm, and suicidal ideation immediately. Yet for small infractions, acknowledging the student's vulnerability and focusing on mutual respect can improve the therapeutic relationship so that the student can make progress toward goals.

As a result of strong rapport, students feel respected and trust the SLPs as a source of support during the school day. Additional examples from personal experience help contextualize rapport: seniors who ask the SLP to sit with their family at their graduation, teenagers who cry when they "graduate" from speech, students confiding that speech-language therapy is the best part of their week because they can be themselves, students who send the SLP a postcard about what book they are reading over summer vacation, and teachers who ask the SLP how to gain a particular student's trust. These examples underscore how building rapport in the therapeutic context can have a positive trickledown effect for students who need academic support.

Pillar III: Resilience

Resilience is critical to well-being in both children and adults; it has been discussed in research across communication disorders (Caughter & Crofts, 2018; Craig et al., 2011; Lyons & Roulstone, 2018). We face adversity throughout life and resilience relates to how we cope with that stress (i.e., resilience is a learned skill that can be taught). SLPs also have a responsibility to increase our own cultural competence to support students who have communication disorders and face institutional or cultural barriers that increase adversity. These groups include students who are lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+), students who speak English as a second language, and students who are non-White or Black, Indigenous, and People of Color (e.g., ASHA, 2020b; Hancock & Haskin, 2015; Taylor et al., 2018).

For example, up to 70% of students who are LGBTQ+ experience bullying and may lack family support (Taylor et al., 2018). In these cases, students experience additional stressors that require emotionally responsive teaching practices (Kramer, 2020). First, all school personnel must actively work to eliminate bullying or existing barriers at the institutional level. Next, SLPs can help adolescent students develop resilience and self-efficacy as they encounter broader realities of adulthood. Although this paper discusses resilience in students, we acknowledge the responsibility that people in positions of power have to address these risk factors for students.

Definition

Resilience is a dynamic concept through which individuals learn to cope with and adapt to adverse experiences (Craig et al., 2011). Researchers juxtapose adversity in terms of risk factors and protective factors. For adolescent students, risk factors—having a communication disorder, facing discrimination, bullying, or academic concerns—can be absorbed or decreased by protective factors—hope, agency, and positive social relationships (Lyons & Roulstone, 2018).

Clinician Behaviors

Therapy should include education about resilience (Craig et al., 2011). Although Caughter & Crofts (2018) wrote about students who stutter, they described approaches to teach resiliency that could benefit all children, regardless of age or diagnostic category. We have used some of these approaches clinically with a broader range of adolescents

with communication disorders. These programs include "Growth Mindset" (Dweck, 2017), "Promoting Alternative Thinking Strategies" (Hart & Heaver, 2015), and the "Penn Resiliency Program" (Positive Psychology Center, 2018). Although the "Reaching In Reaching Out" (RIRO; Pearson & Hall, 2006) resiliency program is for children 8 years old or younger, aspects could apply to older students if they have developmental delays or language impairment. These programs teach students vocabulary and strategies to move from a fixed way of thinking to a more flexible, adaptive mindset: mistakes are learning opportunities, success follows effort, and we can develop self-control.

Clinicians can also foster social support; positive social relationships are one of the most common protective factors listed in resiliency research (Caughter & Crofts, 2018). For SLPs, this can mean working on pragmatics to improve an adolescent's social skills or working with teachers, counselors, and community partners to identify ways to increase a student's social involvement. Students themselves associate good relationships with parents, friends, and even pets as impacting their well-being (Lyons & Roulstone, 2018; Sixsmith et al., 2007).

There are specific clinical activities that SLPs can use with adolescent students to practice resiliency skills. Caughter & Crofts (2018) present activities that support emotional regulation, impulse control, causal analysis, empathy, and realistic optimism. For example, to improve optimism, students can keep a "Good News" journal where they document one positive thing that happened to them per day. To improve impulse control, students and the clinician can participate in group problem solving using real examples from their personal life. Growth mindset activities can include learning about famous failures—such as Michael Jordan failing to make the high school basketball team—and journals with prompts for guided discussion. Clinically, we have also used podcasts and TED talks to generate discussion with adolescent students about overcoming failure and developing resilient mindsets.

Student Results

Resilient people consistently show common characteristics: self-efficacy, positive social support, and optimism. These are the byproducts of developing the ability to cope with stress and overcome adversity. Self-efficacy—belief in one's ability to manage stress—is a common denominator in protective factors for resilience. A student with strong self-efficacy skills shows increasing abilities to cope with stress and belief in their own self-control strategies as a buffer to environmental stress (Craig et al., 2011).

One student co-created a goal with the SLP to improve self-regulation, as measured by fewer office referrals, due to angry outbursts in class. Using growth mindset activities, writing prompts, and a dialogue journal in speech-language sessions, she reported greater awareness of controlling her responses. She implemented a prevention plan with the IEP team that included permission to work on elaborate coloring sheets at her desk when she felt dysregulated. By incorporating resiliency work into speech-language therapy, along with other supports, the student did have fewer office referrals and became motivated to attend speech-language sessions.

Resilient students also demonstrate hope and optimism in the face of stress (Caughter & Crofts, 2018; Lyons & Roulstone, 2018). This "realistic optimism" does not deny reality—adversity will occur—but reflects a positive outlook and feelings of self-control over reactions to stress (Caughter & Crofts, 2018; Reivich & Shatte, 2002). We have witnessed increased optimism from adolescent students related to reading attitudes, employment opportunities, academics, and personal identity. One student who was failing English worked hard to develop optimism about effort—identifying that they could control what assignments they turned in but not what grade the teacher marked—and received a "most improved English Language Arts (ELA) student" award at the end of the year.

Clinical Implications

Despite the measurable cognitive and linguistic growth that adolescents experience, communication disorders impact education and life beyond high school. Resilience can be taught, and clinicians can facilitate student mindsets that promote self-efficacy while working to promote a more equitable environment. Since resilience is dynamic, we are all on a lifelong journey to learn coping techniques as new adversity occurs.

Resiliency frameworks list protective factors as buffers against risk factors. While we cannot control external risk factors, we can learn to develop protective factors. We can also help connect students to resources and other professionals, such as mental health counselors. These concepts benefit all students as they move toward adulthood. In this sense we—the clinician and students—are all learning together and can benefit from resiliency work. Even though stress is universal, our students can absorb some adversity, develop resilience, and ultimately exhibit independence.

Conclusions

The three pillars of adolescent therapy support SLPs wanting to shift their operational framework when working with adolescent students. SLPs often work with both young and older children, but do they approach therapy differently with these age groups? Adolescent students continue to grow and develop cognitively and linguistically; SLPs can facilitate student independence by targeting motivation, rapport, and resilience in therapy. As students age, SLPs may feel pressure to drop them from therapy altogether, but communication disorders have a lifelong impact requiring ongoing support in secondary school. Instead, SLPs can shift toward a client-centered model by using motivation, rapport, and resilience as pillars to foster independence. The three pillars apply to students with a range of communicative disorders who will continue needing services into adulthood. We encourage SLPs to reconsider their role in service delivery and to view teenage students as increasingly independent

and competent young adults. By incorporating the three pillars described here—motivation, resilience, and rapport—SLPs can shift their operational framework and help adolescents as they cross the threshold to adulthood.

Author Contributions

Kathleen J. Abendroth: Conceptualization (Lead), Writing - Original Draft (Lead), Writing - Review & Editing (Equal). **Jennifer E. Whited:** Conceptualization (Supporting), Writing - Review & Editing (Equal).

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