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Marriage and Family Therapists' Perspectives of Working with Couples Impacted by Aphasia: General Perceptions and Response to Relationship-Centered Communication Partner Training

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A thesis submitted to the faculty of
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Master of Science

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ABSTRACT

Marriage and Family Therapists' Perspectives of Working with Couples Impacted by Aphasia: General Perceptions and Response to Relationship-Centered Communication Partner Training

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Master of Science

The psychosocial needs of couples impacted by aphasia are often unmet. Sixty-one marriage and family therapists' (MFTs) experiences, perceived knowledge, confidence, comfort, and barriers in working with couples impacted by aphasia, and their interactions with speech-language pathologists (SLPs) were investigated using survey methodology. All MFTs were licensed, practicing in the US, and had at least 3 years of experience. Participants completed the following in order: (a) a pre-intervention survey, (b) one of two intervention conditions, and (c) a post-intervention survey. Twenty-eight respondents were randomly assigned to an education-alone intervention and 33 respondents were assigned to an education plus Relationship-Centered Communication Partner Training program (RC-CPT). The results of the present study suggest that MFTs who participated in this survey consider providing therapy to couples impacted by aphasia to fall within their scope of practice and already feel comfortable with various skills needed to provide therapy to this population. Aphasia education alone and education plus RC-CPT can both improve MFTs' knowledge, confidence, and comfort in working with couples impacted by aphasia but being shown a model of RC-CPT likely helped MFTs better visualize therapy, which bolstered changes in respondents' perceptions. Future development of RC-CPT should prioritize MFT involvement as collaborators and consultants. Continuing education courses and interprofessional collaboration are needed to better address the psychosocial needs of people with aphasia (PWA) from an interdisciplinary perspective.

Keywords: marriage and family therapy, interprofessional collaboration, aphasia, education, psychosocial adjustment

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To my husband Caden, thank you for believing in me. You have been a persistent cheerleader and helped me to remain motivated even when I wasn't sure I could do this. You have been a strength to me and have helped me to celebrate each step of the way.

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DESCRIPTION OF THESIS STRUCTURE AND CONTENT

This thesis, *Marriage and Family Therapists' Perspectives of Working with Couples Impacted by Aphasia: General Perceptions and Response to Relationship-Centered Communication Partner Training*, is written in a format that combines requirements of a traditional thesis and the format of a journal article. The preliminary pages of this thesis reflect requirements for submission to the university. The subsequent pages of this thesis are structured like a journal article and conform to the style requirements for submitting research reports to relevant journals. The annotated bibliography is included in Appendix A. Appendix B contains the IRB Letter of Approval to Conduct Research. The survey that was sent out to participants is included in Appendix C. There are two reference lists included in this thesis format. The first reference list includes citations used in the journey-ready article and the second contains citations used in the annotated bibliography.

Introduction

Aphasia is an acquired neurogenic language impairment that affects receptive and expressive language across modalities. One-third of stroke survivors have aphasia, and recent studies estimate that aphasia affects over two million people in the United States alone (Simmons-Mackie & Cherney, 2018). Aphasia, which most often results from stroke or traumatic brain injury, has a considerable impact on life participation for both people with aphasia (PWA) and their families (Buck, 1968; Christensen & Anderson, 1989). For example, because of impaired communication, relationships may undergo stress and cause decreased mental health as well as increased communication difficulties (Ford et al., 2018; Le Dorze & Brassard, 1995). Because of how aphasia affects family relationships, speech-language pathologists (SLPs) and marriage and family therapists (MFTs) could both play important roles in the rehabilitative care that PWA and their families receive. However, current research indicates that there is a lack of training for both MFTs and SLPs in this area. This represents a two-pronged problem. First, many SLPs don't feel confident in their ability to counsel couples impacted by aphasia (Simmons-Mackie & Damico, 2011) and may not know when or how to refer these couples to MFTs (Northcott et al., 2017). Second, MFTs, like other mental health providers, likely may not know how to facilitate communication for couples impacted by aphasia (Morrow-Odom & Barnes, 2019). In order to provide the necessary psychosocial support to these couples, interprofessional collaboration is essential. For example, SLPs would benefit from increased understanding of the scope of practice of MFTs and how their services could benefit couples impacted by aphasia. On the other hand, MFTs would likely benefit from increased knowledge and understanding of aphasia and how to facilitate conversations in regard to relational topics. However, no previous research that we know of has investigated what MFTs know and understand about aphasia. The present study focused on the latter part of this two-pronged problem. Specifically, we investigated what MFTs know about aphasia and what experiences they have had working with PWA and SLPs, identified perceived barriers to providing psychosocial support for couples impacted by aphasia, and sought feedback on a relationship-centered communication partner training program (RC-CPT) that is currently being developed. The long-term goal of this project is to increase collaboration between SLPs and MFTs and provide better psychosocial support for couples impacted by aphasia through interventions designed to improve communication while simultaneously strengthening family relationships.

Impact of Aphasia on Couples

Negative changes in family relationships are a common result of aphasia and may include role reversals, difficulty with conflict resolution, and loss of independence (Stead & White, 2019). Aphasia can add stress to the relationship, even when dealing with simple daily tasks, which, in turn, can result in role reversals, altered relationship dynamics, and even disharmony and resentment (Croteau et al., 2020; Le Dorze & Brassard, 1995; Nätterlund, 2010). The impaired communication that characterizes aphasia can make resolving these feelings and conflicts especially challenging (Stead & White, 2019). In this way, aphasia may contribute to a vicious cycle in which aphasia negatively impacts a couples' relationship and then prevents them from working to resolve their conflicts. This is evidenced by previous studies that have shown that as compared to before the onset of aphasia, couples impacted by aphasia experience lower levels of marital satisfaction, decreased quality of life, negative lifestyle changes, and challenges related to sexual intimacy due to decreased emotional closeness and difficulty with verbal initiation (Grawburg et al., 2013; Lapkiewicz et al., 2008; Lemieux et al., 2001; Michallet et al., 2003). According to our knowledge, there is no statistic for how many PWA get divorced, but research has shown that the lack of communication as well as role reversals puts couples at risk for divorce and relationship breakdowns (Hinckley, 2006; Nyström, 2011).

Spouses of PWA have described a myriad of challenges including communicating with their wife or husband with aphasia, talking with health care professionals, and taking on new tasks related to caregiving such as becoming adept in health literacy, financial planning, running errands, transportation, being the sole provider, and other home and family duties (Bakas et al., 2006; Le Dorze & Signori, 2010; Stead & White, 2019). As a result of these added responsibilities, spouses of PWA often experience loneliness in their caregiving role and feel that they do not receive enough emotional and practical support. Additionally, they have less time for themselves, may develop anxiety about the situation of their spouse with aphasia, and are more prone to develop mental health difficulties such as depression (Denman, 1998; Nätterlund, 2010).

For the PWA, a loss of independence or fear of a loss of independence can be a driving factor for both relationship breakdowns and activity restrictions (Stead & White, 2019). PWA need greater support post-injury in completing activities of daily living, which can lead to further caregiver dependence and alter previously established routines and activities (Nätterlund, 2010). As a result, PWA may feel like a burden to their spouse (Johansson et al., 2012; Le Dorze & Signori, 2010). In addition, their spouse may also be overprotective and speak for them, which can lead them to participate less in conversations (Croteau & Le Dorze, 2006).

Due in part to these difficulties and life changes, PWA are at high risk for depression and other psychosocial and emotional consequences (Code & Herrmann, 2003). For example, PWA commonly experience psychological consequences including stress, emotional changes, depression, anxiety, and reduced engagement (Code & Herrmann, 2003; Tanner, 2003). Overall, approximately 20–65% of the general stroke population experiences post-stroke depression and adults with aphasia have been found to be about seven times more likely to have post-stroke depression symptoms than adults without aphasia (Zanella et al., 2023). Psychological support is important for PWA because the reduced engagement and depression experienced by PWA can interfere with their lives, including their relationships; for example, it was found that there was a reciprocal relationship between depression in people who have had a stroke and the mood state of their caregivers (Carnwath & Johnson, 1987). Given the psychological difficulties that couples impacted by aphasia experience, professional support could greatly benefit this population. Unfortunately, many barriers prevent them from receiving this support.

Barriers

PWA and their spouses confront several barriers when it comes to receiving psychological support. One of those barriers is a lack of training for both mental health providers and speech language pathologists. Overall, PWA have not received much attention from mental health providers despite their great need for psychosocial support (Santo Pietro et al., 2019). Morrow-Odom and Barnes (2019) found that while the majority of mental health professionals had heard of aphasia, almost none had experiences with PWA. Furthermore, the professionals they interviewed reported little to no confidence in treating PWA. Some SLPs reported that when mental health providers are given the opportunity to treat PWA, they decline or discharge them due to an inability to facilitate conversation (Northcott et al., 2017). This study argued that PWA, especially those with severe aphasia, have a great need to receive mental health services, and should not be turned away or denied for not being able to fully express themselves. Psychoeducation, informative support, and emotional support are equally important for both the

PWA and their spouse throughout all phases of the rehabilitation process (Kneebone, 2016; Nätterlund, 2010). Psychoeducation involves educating the patient and their caregiver on the difficulties and implications of aphasia, informative support involves giving advice, personal feedback, and guidance, and emotional support means providing care, respect, love, and sympathy (Kneebone, 2016; Nätterlund, 2010). Like other mental health providers, it is likely that MFTs also lack comfort and confidence in treating couples impacted by aphasia, but, to our knowledge no studies have specifically surveyed MFTs about their perceptions of working with this population.

In addition to PWA being underserved by mental health providers who do not feel confident in facilitating communication, SLPs who are trained to facilitate communication often lack confidence and training in counseling skills. This creates a gap whereby PWA often do not have the emotional support they need to cope with the consequences of aphasia. Many SLPs avoid discussing emotional issues and use avoidance strategies such as humor and shifting treatment tasks to circumvent counseling. One of the more common ways that SLPs avoid talking about emotional issues is by maintaining therapeutic control and avoiding the subject altogether (Northcott et al., 2017, 2018; Simmons-Mackie & Damico, 2011). While SLPs do recognize counseling as an important aspect of their scope of practice, many feel that they have received inadequate training when it comes to dealing with feelings of frustration, hopelessness and depression, and facilitating adjustment and acceptance (Sekhon et al., 2019). Unfortunately, if neither SLPs nor mental health providers are addressing these needs, then the mental health of PWA, and couples impacted by aphasia, may be continuously neglected (Strong & Randolph, 2021). Beyond a lack of training, SLPs have mentioned time constraints as a cause for concern as well as general unease deviating from communication therapy tasks (Baker et al., 2021).

However, communication and psychological needs are intertwined. Without addressing the psychological needs of PWA, the communication needs of couples impacted by aphasia may not be met. With MFTs not feeling comfortable working with PWA, and SLPs needing to provide psychosocial support but not providing it for a variety of reasons, a gap has become evident in which the psychosocial needs of couples impacted by aphasia are not being met.

Solutions/Multidisciplinary Collaboration

One way that SLPs could address these problems is through communication partner training. Communication partner training (CPT) programs have effectively led PWA and their spouses to improve their communication and increase their participation (Simmons-Mackie et al., 2010). A holistic intervention where both communication and emotions of PWA, which are so heavily tied together, can be treated conjointly is desperately needed (Croteau et al., 2020). Boles and Lewis (2003) integrated techniques from solution-focused therapy with communication partner training in their study. These techniques, in the case of intimacy, might include exploring when intimacy has been satisfying and identifying the antecedents and circumstances that made those experiences positive. Rather than decreasing the severity of aphasia, such approaches focus on increasing and improving communication in order to facilitate success for PWA and their spouses. This case study (Boles & Lewis, 2003) is one of only a few small-scale studies (see Rasmus & Orłowska, 2020 for an exception) which has integrated counseling techniques and approaches with CPT and indicates that couples can make measurable gains in communication as a result of CPT. Both individuals in the couple independently reported increased self-rating measures of communication (i.e., ease and efficiency of communication, emotional expression, and overall communication independence). Additionally, facilitative gestures were used more by both individuals following treatment.

Like the previously mentioned approach, a recent pilot study integrated counseling with communication partner training but took a slightly different approach (Pertab, 2023). In this study, three couples impacted by aphasia completed an RC-CPT program. During the training, each couple participated in a brief intervention that included two sessions designed to help them learn and practice conversing together in the context of marital roles and responsibilities. In the first session, couples completed a communication partner training module that incorporated strategies such as adjusting their language, using gestures and writing to supplement verbal communication, and verifying understanding. As part of the second session, the PWA and his/her spouse individually completed a questionnaire regarding roles and responsibilities across six different categories. A conversation was then facilitated wherein they selected one role and responsibility category for which to set goals and make plans for improvement. The clinician supported the communication as needed during this discussion and explained that if certain emotions or problems came up that would be better addressed by an MFT or mental health professional, they would refer the couple for other resources (Pertab, 2023). When the role of communication partner is emphasized and the spouse of a PWA is taught how to support their communication partner, the couple experiences more communicative success. Additionally, when the spouse understands and is trained on what aphasia is and the comprehension difficulties a PWA experiences, communication is more easily facilitated (Nykänen et al., 2013; Simmons-Mackie et al., 2010).

Ultimately, this is a problem that will need to be addressed collaboratively between SLPs and MFTs. Northcott and colleagues (2017) suggested several ways in which the gap between mental health providers and SLPs could be closed including increasing awareness of each other’s roles, joint training at universities, closer working pathways, managers viewing collaboration as a priority, improved access to mental health services, more training on aphasia for mental health providers, provision at all stages including long-term, SLP education on appropriate referrals, promotion of addressing psychosocial needs within SLP profession, and more evidence-based resources. Other ideas for helping stroke health professionals to increase their understanding of and comfort in treating PWA include watching videos of counseling techniques and learning specific counseling terms, techniques, experiential learning, and reflective exercises (Northcott et al., 2018; Ross et al., 2009).

Communication partner training is one way in which SLPs may address the communication needs of couples, but ultimately, many SLPs do not feel comfortable addressing problems within marriage, or topics related to counseling. However, SLPs have a responsibility to counsel couples in relation to their communication disorder (American Speech-Language-Hearing Association, 2016). On the other hand, we do not know if many MFTs (who are equipped to provide professional assistance for depression, marital problems, anxiety, individual psychological problems, and child–parent problems) are comfortable facilitating communication and doing talk-based therapy with people who have impaired communication pathways (American Association for Marriage and Family Therapy, 2002). MFTs, as a part of their scope, should understand principles of recovery-oriented care, psychopathology, and human and family development and their implications for treatment. Furthermore, MFTs should work in collaboration with family members and professionals to assist clients in navigating complex care systems and to empower them in the process (Northey & Gehart, 2020). Both SLPs and MFTs seek to provide holistic care by centering therapy on the overall and long-term well-being of their clients. In order to provide the most effective service for couples impacted by aphasia, both professions need to address these intertwined issues collaboratively.

Both MFTs and SLPs provide different strengths that can benefit couples impacted by aphasia. To better address the psychosocial needs of couples impacted by aphasia, we must first understand the experiences and perceptions of MFTs related to working with couples impacted by aphasia and whether education and training have the potential to improve treatment and interprofessional collaboration. The aims of this study were to determine (1) what MFTs know and understand about aphasia and (2) how aphasia education alone compared with education plus RC-CPT (a) impacts the perceptions of MFTs working with couples impacted by aphasia (i.e., barriers, scope of practice) and (b) impacts their perceived knowledge, comfort, and confidence in working with couples impacted by aphasia. By learning more about perceived knowledge, comfort, training, and scope of practice of MFTs in regard to treating couples impacted by aphasia, we hope to better understand how to meet the psychosocial needs of PWA and their families. It is hypothesized that MFT respondents will have limited knowledge and confidence in the definition of aphasia and limited experience providing services to PWA or couples impacted by aphasia. After receiving education and being introduced to RC-CPT, it is hypothesized that MFTs will perceive fewer barriers to delivering therapy to couples impacted by aphasia and making referrals to SLPs. It is also expected that MFTs will consider delivering therapy to couples impacted by aphasia to fall within their scope of practice. We also expect that following the education portion of the survey, MFTs will have increased (a) perceived knowledge in the definition of aphasia, (b) perceived comfort in talking to and coaching couples impacted by aphasia, and (c) perceived confidence in working with people or couples impacted by aphasia. Finally, we expect that a combination of aphasia education in conjunction with exposure to RC-CPT will change perceptions more than aphasia education alone.

Methods

This thesis is part of a larger research project exploring interprofessional collaboration between SLPs and MFTs and an RC-CPT program for couples impacted by aphasia. The pilot program was conducted previously with three couples impacted by aphasia (Pertab, 2023). Data for the present study were taken from surveys given to marriage and family therapists and will be derived from the survey results.

Participants

Sixty-one responses from marriage and family therapists throughout the United States were analyzed in the present study. To qualify for participation, participants were required to speak English as their primary language, be currently practicing in the United States, have at least 3 years' experience, and hold current professional licensure in marriage and family therapy. Participants were recruited via emails, flyers, social media, list-serves, and word of mouth. The study procedures were approved by Brigham Young University's Institutional Review Board.

Procedures

All participants completed an anonymous survey which was created using Qualtrics. The survey was estimated to take approximately 30 minutes for each participant to complete and could be completed in more than one sitting. No identifying information was collected from the participants during the survey. Following the approval of the survey by the Institutional Review Board, the survey was sent via email to marriage-family therapists. The invitation to participate included instructions to access the link, an explanation of the survey objectives, and contact information of the faculty advisor and primary investigator. The participants who completed the survey and provided their email address in a separate form received compensation of $50 for filling out the survey.

Survey

Prior to launching the survey, questions and video clips used in the survey were approved by the developers of the original RC-CPT pilot program, an aphasiologist and speech-language pathologist, and a marriage-family therapist. These individuals were asked to provide feedback on the flow of the survey, length, appropriateness, clarity of questions and answer choices provided, and which video clips to include. Changes to the survey were made as needed following their feedback. The video-clips used in the survey were taken from the pilot program previously mentioned and were made anonymous by blurring faces. Different response formats were used throughout the survey including multiple-choice, multiple-select, free-response, and some questions allowed the participants to select "other" and write a free-response answer. All questions for the survey were presented in the same order for all participants. At the same point in the survey, half of the participants received written information educating them about aphasia, and the remaining participants received a video in addition to aphasia education that demonstrated RC-CPT and drew upon de-identified video footage from the three pilot couples seen previously (see Pertab, 2023). The questions were not mandatory to answer with the exception of the consent question and screening questions designed to certify that respondents met inclusionary criteria. The survey also included conditional questions where respondents were asked additional information if they answered in a certain way.

The questions used for this survey were adapted from previous surveys given to speech-language pathologists and mental health professionals (Morrow-Odom & Barnes, 2019; Northcott et al., 2017). An implied consent form was included at the beginning of the survey and participants were asked to check a box to "agree" prior to initiation of the survey. The participants were not able to advance within the survey without consent. After reviewing and indicating consent, the participants proceeded to fill out the survey and were asked a series of screening questions verifying that they were a marriage and family therapist practicing and licensed in the United States with at least three years of experience and English as their primary language. Six participants indicated "no" to one of the three screening questions and did not qualify for the survey. The remaining 61 respondents were then asked questions regarding demographic information, state of clinical practice, level of degree, years of clinical practice, primary population of clinical focus, and their focus of clinical practice. Following this, the participants answered questions related to their perceived knowledge, perceived confidence, and experience working with couples impacted by aphasia and interactions with speech-language pathologists. Subsequently, the participants were asked questions regarding different barriers for treatment of couples impacted by aphasia, making referrals to SLPs, perceived comfort level in using different RC-CPT strategies, scope of practice, and free-response questions where they could describe their experiences and make other commentaries regarding treatment for couples impacted by aphasia. Following this, a definition and description of aphasia was given.

Respondents were randomly placed into one of two intervention groups categorized as education alone (i.e., participants who were not exposed to RC-CPT video footage) and education plus RC-CPT (i.e., participants who were educated about aphasia and exposed to RC-CPT video footage). The education alone group continued the survey and were asked repeated questions regarding their perceived knowledge of aphasia, perceived confidence and comfort in working with couples impacted by aphasia, barriers, and scope of practice. They were again given the opportunity to include written feedback regarding their experiences working with couples impacted by aphasia. Following the initial survey questions and the definition and description of aphasia being presented, the education plus RC-CPT group proceeded to watch a

15-minute video showing clips of three couples who participated in the pilot RC-CPT program. The videos included explanations for how the program works and context for what the couples were working on. At the conclusion of the video, the participants answered repeat questions regarding their perceived knowledge of aphasia, perceived confidence and comfort in working with couples impacted by aphasia, barriers, and scope of practice. They were again given the opportunity to include written feedback regarding their experiences working with couples impacted by aphasia and how the program could be improved.

Data Analysis

Descriptive statistics were used to analyze responses regarding demographic questions and perceived aphasia knowledge. Questions related to barriers, scope of practice, and feedback were analyzed using descriptive statistics.

In addition to descriptive analyses, the impact of aphasia and RC-CPT education were analyzed statistically. Answer choices for questions regarding scope of practice allowed respondents to select “yes,” “no,” or “unsure.” In order to complete a dichotomous answer choice for analysis, the “unsure” answer choices were changed to “no.” For the definition of aphasia question, responses were categorized as correct and incorrect then analyzed for differences in groups or changes as the result of intervention. For these items, group differences were analyzed using Pearson’s Chi-squared test and effects of intervention were analyzed using McNemar’s Chi-squared test. Likert items were analyzed using two-way mixed effects analyses of variance (ANOVAs) with the group factor accounting for education alone versus education plus RC-CPT and the time factor accounting for pre- versus post-intervention. Significant interaction effects were followed with post-hoc testing using Tukey’s honestly significant difference (HSD). Prior to statistical analysis, data were checked for normality and homogeneity of variance. A family-wise error rate of .05 was used for all statistical tests with adjustments made for multiple comparisons. Effect sizes were measured for chi-squared tests using Cramer's V or Cohen's g and for ANOVA tests using eta squared. Effect sizes for eta squared indicate that .01 is a small effect, .06 is a medium effect, and .14 is a large effect. For Cramer's V, effect sizes of less than or equal to 0.2 indicate a weak effect, 0.2–0.6 indicates a moderate effect, and greater than 0.6 indicates a strong effect. For Cohen's g, effect sizes of less than or equal to 0.2 indicate a weak effect, 0.2–0.8 indicates a moderate effect, and greater than 0.6 indicates a strong effect.

Results

There were a total of 110 respondents to the survey; however, 43 of these responses were marked as spam by the primary researchers because their answers were markedly dissimilar from legitimate respondents. Of the 67 legitimate respondents to the survey, six did not qualify based on previously established criteria. Responses from the 61 qualifying legitimate respondents were analyzed using the methods described above. Sixty-one responses were used in the current study due to the removal of illegitimate or disqualified respondents. The survey was closed after sorting through the illegitimate responses, and it was determined by the primary researchers that the survey should not be reopened due to the difficulty in filtering through illegitimate responses. In order to reopen the survey to gain more responses, it would have been necessary to reformat the survey, which meant removing the anonymity feature. Additionally, the 61 responses analyzed were obtained during the planned time window for data collection and were adequate for the planned statistical analyses. Open-ended questions from the survey were not analyzed for the current study but will be analyzed later using qualitative methods. Twenty-eight respondents were included in the education alone group and 33 in the education plus RC-CPT group.

Demographic Data

Descriptive statistics for the 61 respondents are included in Table 1. Of the 61 respondents, the majority were aged 30–49 years (50.8%), possessed a master's degree (86.9%), and identified as female (70.5%). Most respondents also reported being non-Hispanic (90.2%) and White (78.7%). There were respondents from 19 different states, with the most common response locations being Utah (34.4%), Washington (9.9%), and Texas (8.2%). Respondents predominantly reported having 3–5 years of experience as an MFT (41%), with very few respondents having over 20 years of experience (3.3%). Finally, the majority of respondents reported their main population of clinical focus being individuals (77%) and married adults (74.8%) and their main clinical focus area being mental health (88.5%) and marriage and family therapy (85.2%).

Familiarity with Aphasia and Speech-Language Pathology: Pre-Intervention

Results reporting on interactions with couples impacted by aphasia and SLPs are reported in Tables 2 and 3. Although most respondents indicated that they had heard of aphasia, nearly a quarter said they had not (23%). When asked if, to their knowledge, they had provided services to a caregiver, spouse, or family member of PWA, most selected "no" (60.7%) or "I don't know" (14.8%). Overall, respondents generally indicated that they were very doubtful that they could provide services to PWA in an ethical manner given their present knowledge of the disorder (41%) and strongly disagreed that they were experienced in working with people or couples impacted by aphasia (67.2%). The two most common responses to how they first learned about aphasia were academic coursework (29.5%) or that they had not learned about aphasia (29.5%). The least common response was learning about aphasia in continuing education (1.6%).

The vast majority of respondents reported that they know what an SLP is (93.4%) but had not worked professionally with an SLP before (65.6%). Most respondents selected “not applicable” (52.5%) in response to which best described their previous professional interactions with an SLP, likely due to previously selecting “no” to having worked professionally with an SLP before; however, the next most common response was that they had referred a client to an SLP at least once (34.4%), and a few reported having received a consultation from an SLP (9.8%). Of those who selected having previously referred a client to an SLP, most indicated they had rarely done so (66.7%). If they had indicated working collaboratively with an SLP before, most MFTs indicated that they did so occasionally (61.5%) and consulted either rarely (36.4%) or occasionally (36.4%). They also indicated having received consultation from an SLP rarely (50%) or occasionally (33.3%).

Barriers to Therapy for Couples Impacted by Aphasia

Respondents were asked what the main barriers would be in delivering therapy to couples impacted by aphasia and in making a referral to an SLP, and what would help them improve their delivery of therapy to couples impacted by aphasia. These results are reported in Figures 1, 2, and 3. When asked, respondents most commonly selected feeling “under-skilled/having a lack of training” as being the greatest barrier in delivering therapy to couples impacted by aphasia (83.6%). While this barrier decreased numerically across both groups after intervention, it still remained the greatest perceived barrier (61%). No respondent selected “I don’t consider it a part of my role” as a barrier before or after intervention in either group (0%).

The two most commonly selected barriers in making a referral to an SLP included a lack of access to SLPs (32.8%) and being “unsure of when to make a referral/guidelines unclear” (42.6%). The other most commonly selected answer was that there are no barriers to referring someone to an SLP (31.2%). Across both intervention groups, fewer respondents selected being unsure of when to make a referral (31.2%) and no barriers (27.9%) after intervention. More respondents reporting a lack of access to SLPs after intervention (36.1%).

When asked what would help them improve their delivery of therapy to couples impacted by aphasia, respondents most commonly selected provision of more training (83.6%), being able to access on-going supervision/support from a practitioner skilled in delivering speech-language therapy (55.7%), and regular connection or collaboration with an SLP (52.5%). Overall, more respondents indicated after intervention that regular connection or collaboration with an SLP (55.7%) and being able to access on-going supervision or support from an SLP (65.6%) would improve their delivery of therapy. There was an overall decrease in selecting provision of more training as what would help improve their delivery of therapy to couples after intervention (78.7%).

Perceived Knowledge, Comfort, and Confidence in Working with Aphasia

When asked about the definition of aphasia, 49.2% of respondents correctly answered, from a field of seven choices, that it was a language disorder. The most common incorrect answer selected for the definition of aphasia before (44%) and after (28%) intervention was "a speech disorder." Following aphasia education, 72.1% of respondents correctly selected a language disorder as the definition of aphasia. Chi-squared tests showed no statistically significant difference between groups before and after intervention. After being asked about the definition of aphasia, participants were asked to identify their confidence level in their answer selection to the previous question. An ANOVA revealed a main effect of training on perceived confidence, $F(1, 59) = 40.09$, $p < .001$, $\eta p^2 = .40$, indicating that across all participants, perceived confidence in their selection of the correct definition of aphasia improved.

Respondents were asked to report on their perceived knowledge of working with people or couples impacted by aphasia. An ANOVA revealed a significant interaction effect, $F(1, 59) = 8.54$, $p = .005$, $\eta p^2 = .13$ (Figure 4). A follow-up Tukey's HSD test showed that education plus RC-CPT led to significantly greater perceived knowledge, $t(59) = 7.12$, $p < .001$, but not education alone, $t(59) = 2.57$, $p = .060$. Relatedly, after intervention the education plus RC-CPT group showed significantly greater perceived knowledge than the education alone group, $t(59) = 2.87$, $p = .029$.

Analysis of participants' perceptions regarding their perceived confidence about working with people or couples impacted by aphasia showed a significant difference in perceived confidence after intervention when accounting for both intervention groups, $F(1, 59) = 68.18$, $p < .001$, $\eta p^2 = .54$. Overall, the education plus RC-CPT group showed significantly greater perceived confidence than the education alone group, $F(1, 59) = 5.16$, $p < .027$, $\eta p^2 = .08$. There was no interaction effect.

An ANOVA analyzing respondents' perceptions regarding their perceived comfort talking to and coaching couples impacted by aphasia on communication strategies such as using eye contact, gestures, and verifying understanding during therapy showed that comfort increased across all participants after intervention, $F(1, 57) = 5.00$, $p < .029$, $\eta p^2 = .08$. Overall, the education plus RC-CPT group showed significantly greater perceived comfort than the education alone group, $F(1, 59) = 5.59$, $p < .021$, $\eta p^2 = .09$. In general, the majority of respondents felt that discussing communication strategies falls within their scope of practice, but this increased significantly following intervention, $\chi^2 = 30.95$, $p < .001$, $g = .38$.

An ANOVA analyzing participants' perceptions regarding their comfort in addressing changing roles and responsibilities post-stroke with couples impacted by aphasia showed that there was a significant effect of education plus RC-CPT, *F*(1, 57) = 9.29, *p* < .004, $\eta p^2 = 0.14$ (Figure 4). A follow-up Tukey's HSD showed that education plus RC-CPT led to significantly greater perceived comfort, *t*(57) = 2.71, *p* < .043, but not education alone, *t*(57) = 1.56, *p* = .410. Respondents were asked whether addressing changing roles and responsibilities post-stroke with couples impacted by aphasia falls within their scope of practice. Overall, the majority of respondents felt that addressing changing roles and responsibilities falls within their scope of practice, but this increased significantly as a result of intervention, $\chi^2 = 19.32$, *p* < .001, *g* = .31. No significant differences were found between groups for this question.

An ANOVA analyzing participants' perceptions regarding their comfort in helping couples impacted by aphasia set goals and make plans related to relationship roles and responsibilities showed that there were no significant main or interaction effects. Overall, most respondents felt somewhat comfortable (34.4%) to very comfortable (47.5%) with setting goals and making plans with PWA in regard to relationship roles and responsibilities. Respondents were asked if helping couples impacted by aphasia set goals and make plans related to relationship roles and responsibilities falls within their scope of practice. Overall, the majority of respondents felt that this did fall within their scope of practice, but this increased significantly as the result of intervention, $\chi^2 = 27.16$, p < .001, g = .36. No significant main effect of group or interaction effect were found for this question.

Post-RC-CPT Videos

Results specific to respondents in the education plus RC-CPT group are shown in Table 4. Overall, respondents somewhat agreed that implementing the type of RC-CPT program shown would fall within their scope of practice. The majority of respondents indicated that they would collaborate with or consult with an SLP on an RC-CPT program or similar initiative in the future.

Discussion

The purposes of this survey study were to determine (a) what MFTs know and understand about aphasia and (b) how aphasia education alone or aphasia education plus RC-CPT impacted MFTs' perceptions of working with couples impacted by aphasia. Overall, results suggest that both interventions resulted in more favorable perceptions across several areas; However, exposure to RC-CPT through video observation had benefits above and beyond education alone. Specifically, education plus RC-CPT significantly improved respondents' (a) perceived confidence and knowledge of aphasia and (b) perceived comfort in addressing changing roles and responsibilities. Additionally, some perceived barriers may have been reduced following both interventions.

Increasing MFTs' Perceived Knowledge and Confidence

This study helped to illustrate that overall MFT participants did not feel knowledgeable or comfortable in their ability to work with couples impacted by aphasia and had limited experience working with PWA. Many MFTs, prior to intervention, indicated that they were very doubtful that they could provide services to PWA in an ethical manner given their present knowledge of the disorder (41%). Intervention results, however, provided direction for how MFTs' perceived knowledge and confidence might be increased. While the majority of respondents indicated that they had heard of aphasia, only approximately half (49.2%) were able to correctly identify the definition of aphasia prior to intervention and their overall perceived confidence in this definition was relatively low. This corroborates previous work that similarly found relatively low knowledge (65% accuracy) across mental health professionals regarding the definition of aphasia (Morrow-Odom & Barnes, 2019). The present study found that 29.5% of respondents selected that they had learned about aphasia through academic coursework as compared with 49.8% in the aforementioned study. When they answered incorrectly, respondents in both studies often selected that aphasia was a "speech disorder." Selecting "speech disorder" instead of "language disorder" as the correct definition may have been due to a lack of understanding of the differences between speech and language. Both studies also found that continuing education was the least selected response for how individuals first learned about aphasia.

The slight differences in percentages between studies may be due to the total number of respondents or the populations surveyed. It is important to consider that the Morrow-Odom and Barnes (2019) study was given to mental health professionals generally. It is possible that some mental health professionals may be more likely to be educated about or exposed to aphasia in their academic coursework or professions than others. However, the overall similarities suggest that MFTs and mental health professionals have not had experiences working with PWA and that many may not feel comfortable providing services to PWA given their present knowledge.

Despite generally low perceived knowledge about aphasia among MFTs, findings from the present study suggest that aphasia education can improve MFTs' perceived confidence in their understanding of aphasia. This implies that one potential way MFTs could improve their perceived knowledge, perceived confidence, and experience in working with PWA is to provide them with general aphasia education. Because education alone led to many similar benefits as education plus RC-CPT, it is possible that brief written information could be sufficient for improving practitioners' ability to define aphasia accurately and their perceived confidence in treating aphasia. Such written materials could be easily developed for a continuing education course. Given that only 1.6% of respondents in the present study indicated that they had first learned about aphasia in continuing education, future research could consider how to design courses that are of interest to MFTs.

Exploring aphasia-specific continuing education options for MFTs could be one important aspect of increasing communication and connection for couples impacted by aphasia, but another consideration could be the integration of RC-CPT or other video examples with such courses. These continuing education courses could count for continuing education units (CEUs) and be set up online. Making such continuing education opportunities accessible through an online platform or free could encourage more MFTs to seek out this education. There were three important findings related specifically to MFTs' perceived knowledge about working with PWA after being exposed to RC-CPT video footage: (a) including RC-CPT footage of couples impacted by aphasia made a positive difference in aphasia education, (b) overall perceived knowledge in working with aphasia was still quite low even after education plus RC-CPT videos, and (c) the RC-CPT videos were brief, but still made a statistically significant difference in increasing respondents' perceived knowledge and confidence in working with couples impacted by aphasia. One potential implication due to the increased perceived knowledge and confidence in the education plus RC-CPT group may have been due to seeing a model of what therapy with couples impacted by aphasia could look like. The video footage also may have helped respondents better understand what aphasia is and how it can impact a couple.

Changes in responses before and after intervention suggest that education plus RC-CPT could be expanded to help MFTs feel even more knowledgeable and confident in working with PWA. Utilizing education plus RC-CPT could also combat commonly reported barriers such as feeling under-skilled or having a lack of training. Because perceived confidence also improved for both groups after intervention, it can be assumed that as MFTs receive more education, their perceived confidence in working with couples impacted by aphasia will also increase. Increasing perceived knowledge and confidence could be a logical early step towards increasing accessibility of services from mental health providers for PWA generally, as PWA have not received much attention from mental health providers (Santo Pietro et al., 2019). It is important to recognize, on the other hand, that SLPs have reported inadequate training in counseling skills, highlighting the additional need for counseling education for SLPs to aid in closing this gap (Sekhon et al., 2019). As both professions need to improve their skills, interprofessional education and collaboration is one solution that should be further explored.

Increasing MFTs' Perceived Comfort

MFTs were asked questions regarding their perceived comfort in three areas: (a) coaching couples on communication strategies, (b) helping couples set goals and make plans related to relationship roles and responsibilities and (c) addressing changing roles and responsibilities. Before intervention, the majority of MFTs reported being somewhat to very comfortable in all three areas. This is likely because MFTs are already accustomed to setting goals and making plans, addressing roles and responsibilities, and coaching couples on micro skills, such as active listening or verifying understanding (Beck, 2011; Beck & Kulzer, 2018). However, these skills can be applied and adjusted more specifically for couples impacted by aphasia as was shown in a previous pilot study that explored the feasibility and acceptability of RC-CPT (Pertab, 2023). For example, changes in responsibilities since the onset of aphasia might be discussed between partners, with a scale acting as visual support to help provide clarification during the discussion. Different communication strategies, such as the use of gestures, writing down key words, or giving multiple choice options can be used and practiced during conversations surrounding roles and responsibilities and in setting goals. More MFTs felt that setting goals and making plans related to relationship roles and responsibilities fell within their scope of practice after intervention, indicating the importance of aphasia education in helping them to apply these techniques in their work with PWA. For the area of coaching couples on communication strategies, aphasia education alone could be sufficient for increasing perceived comfort. Due to a ceiling effect in the area of addressing changing roles and responsibilities in marriage, the ability to truly measure the impact of RC-CPT in addition to education was limited. However, it is likely that RC-CPT made a significant difference in perceived comfort in this area. Video footage should be considered in future education to increase MFTs' perceived comfort addressing changing roles and responsibilities with couples impacted by aphasia. As previously stated, one potential implication from the present study is that being shown a model of RC-CPT may have helped MFTs better visualize therapy, which could have bolstered changes in their perceptions.

Though MFT respondents felt generally comfortable across all three areas discussed, perceived comfort in working with couples impacted by aphasia increased after intervention. As continuing education or other aphasia education opportunities are considered for MFTs, there could be benefit to including both written and video segments in that education. Alternative forms of education might also include receiving communication partner training (CPT) or co-treating with SLPs. One article focused on training in-patient nursing staff on communication partner training, which led to the nursing staff rating their understanding of aphasia higher and frustration during conversations lower. This training also led to increases in strategies, confidence, understanding, and willingness to initiate complex conversations. Although there is a paucity of information about how to apply these broadly used techniques with mental health providers specifically, a need for different approaches to traditional talk therapy for PWA is needed (Strong & Randolph, 2021).

Scope of Practice

Working with couples impacted by aphasia requires understanding of recovery-oriented care and being able to navigate complex care systems, which are important aspects of an MFTs' role (Northey & Gehart, 2020). Learning RC-CPT approaches like ones discussed in the present survey could provide MFTs with more tools to navigate these care systems and provide more individualized services for couples impacted by aphasia. These approaches included discussing communication strategies, addressing changing roles and responsibilities with couples impacted by aphasia, and setting goals and making plans related to relationship roles and responsibilities. Although respondents typically indicated that these approaches fell within their scope of practice, this perception was even more dominant following intervention. This suggests that most MFTs could be open to using RC-CPT approaches while working with couples impacted by aphasia and feel that doing so is a part of their role. If SLPs and MFTs work collaboratively, they could improve the overall standard of care for PWA as the mental health and relationship needs of PWA would be addressed more comprehensively (Strong & Randolph, 2021).

Most individuals in the education plus RC-CPT group strongly agreed (36.4%) or somewhat agreed (48.5%) that implementing the type of RC-CPT program described would fall within their scope of practice. The majority of respondents indicated an overall willingness to collaborate (78.8%) or consult (90.2%) with an SLP on RC-CPT programs. Their willingness to collaborate and consult as indicated in the present study is consistent with their role to work in collaboration with professionals to assist and empower their clients (Northey & Gehart, 2020). These results are encouraging as future collaboration and consultation will be needed from MFTs to continue improving RC-CPT and the services provided to couples impacted by aphasia. Their input will also be valuable as aphasia-specific continuing education courses and interprofessional collaboration opportunities are explored in future research.

Need for Interprofessional Collaboration

Results from this study combined with previous research highlight the need for increased interprofessional collaboration. For example, MFTs (as shown in the current study) and SLPs (as shown previously) have both indicated they were unsure of when to consult or refer with the other profession (Northcott et al., 2017). Since both SLPs and MFTs seek to provide holistic care by centering therapy on the overall and long-term well-being of their clients, the best-case scenario would be for both professions to address the impact of aphasia on couples collaboratively.

There are a number of methods that could be explored in order to increase interprofessional collaboration between MFTs and SLPs. First, opportunities could be created for students to interact during their education. This could include student clinicians from both programs collaborating on case studies, joint projects, or even working together with a couple impacted by aphasia. A second method to increase interprofessional collaboration is an increase in educational opportunities for SLPs to learn counseling techniques and MFTs to learn about aphasia and facilitative communication skills. Continuing education courses could be developed for this very purpose, and more clinics, hospitals, and practices could encourage their employees to pursue these education pathways. A third way to increase interprofessional collaboration is through increasing access to the other profession. Again, universities, clinics, and hospitals can lead the way in this area by increasing referrals and consultations between SLPs and MFTs. Referrals to both MFTs and SLPs could be offered at every level of care, after transitions from one level of care to another, and in all settings including acute, inpatient, outpatient, and home health. Perhaps most importantly, SLPs and MFTs themselves can advocate at their place of work for more connection with the other profession and create a list of referrals to give to the couples they work with who have been impacted by aphasia. As few MFTs reported having referred, collaborated, consulted with, or received consultation from an SLP before, it is important that SLPs and MFTs both advocate for their unique role in serving couples impacted by aphasia. As these initiatives are implemented, research should be done to measure if they are having the hypothesized effect of increasing comfort in collaborating with each other, creating greater awareness of the other profession, seeking out opportunities to collaborate in the future, and increasing psychosocial support for couples impacted by aphasia.

Some MFTs indicated that there are no barriers to referring a PWA to an SLP; however, it is important to consider that common barriers included a lack of access and being unsure when to refer. Only some MFTs reported referring to an SLP, and of those who did, most reported it was rare. While the cause of lack of access is unknown, MFTs and SLPs often do not work at the same site, so respondents may have been unaware of how to access or refer to an SLP due to a lack of proximity (Northcott et al., 2017). Improving these barriers will likely require effort from both MFTs and SLPs who would need to proactively seek collaboration and consultation from each other and provide interprofessional education opportunities for one another. To our knowledge, no research studies have looked into interprofessional collaboration between SLPs and MFTs. However, previous research has shown interprofessional experiences between SLPs and nurses, occupational therapists, teachers, physical therapists, special education teachers, social workers, school psychologists, physicians, paraprofessionals, applied behavioral analysts, and audiologists (Wallace et al., 2022). SLPs have reported that interprofessional collaboration was the result of their direct roles and responsibilities, their educational experiences, or they had a lack of or no preparation in regard to interprofessional collaboration (Wallace et al., 2022). In addition to not working at the same sites, MFTs and SLPs may not have had experiences collaborating during their educational programs. However, it is crucial that interprofessional collaboration be explored. It is probable that as MFTs develop a better understanding of aphasia and treat couples impacted by aphasia, they will seek out more collaboration or consultation from SLPs. It is also likely that as SLPs do their part to refer couples impacted by aphasia to MFTs, that MFTs will have increased opportunities to gain experience in working with couples impacted by aphasia.

Findings from the present study show that aphasia education may help MFTs better understand when to refer to an SLP. While there was an increase in perception of some barriers and decrease in perception of others, responses to several barriers did change after intervention. We suspected an overall decrease in barriers due to intervention, but it is understandable that there were some overall increases in perceived barriers as MFT respondents became more aware of the complexities surrounding aphasia and its impact on couples.

Limitations

Intervention increased respondents' desire to have regular connection, collaboration, or supervision from an SLP likely because they were able to better understand aphasia and the role of an SLP. Decrease in desire to receive more training is understandable given that they have just received intervention. However, it is important to consider that some individuals may not have found the type of aphasia education provided to be helpful, and it could be better adjusted or changed in a future study. Another limitation that should be considered is the small and potentially biased sample. Because we obtained data from only 61 respondents who self-selected to participate in the study, it is likely that this sample was not fully representative of the MFT population. Sampling bias, for example, may have resulted from MFTs with some awareness of aphasia or connection to speech-pathology being more willing to respond to a survey about aphasia. It is also important to consider that some respondents likely did not watch the full RC-CPT video footage and skipped portions of the video in order to continue the survey, which could have impacted responses. Future studies should also take into consideration that the aphasia education and introduction to RC-CPT video footage provided in the present study was brief. Future research should investigate the impacts of intervention length and other instructional design elements.

Conclusion

Findings from the present study are promising and provide useful insight for continued development of an intervention targeting communication and psychosocial adjustment for couples impacted by aphasia. These findings also set the stage for future research. While the targeted population was MFTs, similar recommendations could be made as those described following a previous survey study targeting SLPs including increasing awareness of roles, SLP education on appropriate referrals, promotion of addressing psychosocial needs within the SLP profession, more training for mental health providers and SLPs, and working to improve the evidence base (Northcott et al., 2017). Further recommendations from the present study include using both written and video aphasia education for MFTs, increasing collaboration and consultation between professions, MFT education on appropriate referrals, addressing the impact of aphasia on relationships within the MFT profession, establishing aphasia-specific continuing education courses, and involving MFTs as programs like RC-CPT are developed. Implementing these suggestions will be key in helping to better meet the psychosocial needs of PWA and their families, improve their communication, and strengthen their family relationships.

References

American Association for Marriage and Family Therapy. (2002). About marriage and family therapists. https://www.aamft.org/About_AAMFT/About_Marriage_and_Family_Therapists.aspx

American Speech-Language-Hearing Association. (2016). Scope of practice in speech-language pathology [Scope of Practice]. https://www.asha.org/policy/.

Bakas, T., Kroenke, K., Plue, L. D., Perkins, S. M., & Williams, L. S. (2006). Outcomes among family caregivers of aphasic versus nonaphasic stroke survivors. *Rehabilitation Nursing: the Official Journal of the Association of Rehabilitation Nurses*, *31*(1), 33–42. https://doi.org/10.1002/j.2048-7940.2006.tb00008.x

Baker, C., Rose, M. L., Ryan, B., & Worrall, L. (2021). Barriers and facilitators to implementing stepped psychological care for people with aphasia: Perspectives of stroke health professionals. *Topics in Stroke Rehabilitation*, *28*(8), 581–593. https://doi.org/10.1080/10749357.2020.1849952

Beck, J. S. (2011). *Cognitive behavior therapy: basics and beyond 2nd edition*. Guilford Publications.

Beck, K., & Kulzer, J. (2018). Teaching counseling microskills to audiology students: Recommendations from professional counseling educators. *Seminars in Hearing*, *39*(01), 091–106. https://doi.org/10.1055/s-0037-1613709

Boles, L., & Lewis, M. (2003). Working with couples: Solution focused aphasia therapy. *Asia Pacific Journal of Speech, Language and Hearing, 8*(3), 153–159. https://doi.org/10.1179/136132803805576110

Buck, M. (1968). *Dysphasia: Professional guidance for family and patient.* Prentice-Hall.

Carnwath, T. C., & Johnson, D. A. (1987). Psychiatric morbidity among spouses of patients with stroke. *British Medical Journal (Clinical research ed.)*, *294*(6569), 409–411. https://doi.org/10.1136/bmj.294.6569.409

Christensen, J. M., & Anderson, J. D. (1989). Spouse adjustment to stroke: Aphasic versus nonaphasic partners. *Journal of Communication Disorders, 22*(4), 225–231. https://doi.org/10.1016/0021-9924(89)90018-X

Code, C., & Herrmann, M. (2003). The relevance of emotional and psychosocial factors in aphasia to rehabilitation. *Neuropsychological Rehabilitation*, *13*(1–2), 109–132. https://doi.org/10.1080/09602010244000291

Croteau, C., & Le Dorze, G. (2006). Overprotection, "speaking for", and conversational participation: A study of couples with aphasia. *Aphasiology*, *20*(02–04), 327–336. https://doi.org/10.1080/02687030500475051

Croteau, C., McMahon-Morin, P., Le Dorze, G., & Baril, G. (2020). Impact of aphasia on communication in couples. *International Journal of Language & Communication Disorders*, *55*(4), 547–557. https://doi.org/10.1111/1460-6984.12537

Denman, A. (1998). Determining the needs of spouses caring for aphasic partners. *Disability and Rehabilitation*, *20*(11), 411–423. https://doi.org/10.3109/09638289809166103

Ford, A., Douglas, J., & O'Halloran, R. (2018). The experience of close personal relationships from the perspective of people with aphasia: Thematic analysis of the literature. *Aphasiology*, *32*(4), 367–393. https://doi.org/10.1080/02687038.2017.1413486

Grawburg, M., Howe, T., Worrall, L., & Scarinci, N. (2013). A qualitative investigation into third-party functioning and third-party disability in aphasia: Positive and negative experiences of family members of people with aphasia. *Aphasiology*, *27*(7), 828–848. https://doi.org/10.1080/02687038.2013.768330

Hinckley, J. J. (2006). Finding messages in bottles: Living successfully with stroke and aphasia. *Topics in Stroke Rehabilitation*, *13*(1), 25–36. https://doi.org/10.1310/FLJ3-04DQ-MG8W-89EU

Johansson, M. B., Carlsson, M., & Sonnander, K. (2012). Communication difficulties and the use of communication strategies: From the perspective of individuals with aphasia. *International Journal of Language & Communication Disorders*, *47*(2), 144–155. https://doi.org/10.1111/j.1460-6984.2011.00089.x

Kneebone, I. I. (2016). A framework to support cognitive behavior therapy for emotional disorder after stroke. *Cognitive and Behavioral Practice*, *23*(1), 99–109. https://doi.org/10.1016/j.cbpra.2015.02.001

Lapkiewicz, E., Grochmal-Bach, B., Pufal, A., & Tlokinski, W. (2008). Aphasia and changes in the quality of marital relations. *Acta Neuropsychologica*, *6*(3), 237–246. https://actaneuropsychologica.com/api/files/view/9617.pdf

Le Dorze, G., & Brassard, C. (1995). A description of the consequences of aphasia on aphasic persons and their relatives and friends, based on the WHO model of chronic diseases. *Aphasiology*, *9*(3), 239–255. https://doi.org/10.1080/02687039508248198

Le Dorze, G., & Signori, F. H. (2010). Needs, barriers and facilitators experienced by spouses of people with aphasia. *Disability and Rehabilitation*, *32*(13), 1073–1087. https://doi.org/10.3109/09638280903374121

Lemieux, L., Cohen-Schneider, R., & Holzapfel, S. (2001). Aphasia and sexuality. *Sexuality and Disability*, *19*(4), 253–266. https://doi.org/10.1023/A:1017953308761

Michallet, B., Tetreault, S., & Le Dorze, G. (2003). The consequences of severe aphasia on the spouses of aphasic people: A description of the adaptation process. *Aphasiology*, *17*(9), 835–859. https://doi.org/10.1080/02687030344000238

Morrow-Odom, K. L., & Barnes, C. K. (2019). Mental health professionals' experiences with aphasia. *Journal of Rehabilitation*, *85*(1), 15–21. https://lib.byu.edu/remoteauth/?url=https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip&db=asn&AN=135314651&site=ehost-live&scope=site

Nätterlund, B. (2010). Being a close relative of a person with aphasia. *Scandinavian Journal of Occupational Therapy*, *17*(1), 18–28. https://doi.org/10.3109/11038120902833218

Northcott, S., Simpson, A., Moss, B., Ahmed, N., & Hilari, K. (2017). How do speech-and-language therapists address the psychosocial well-being of people with aphasia? Results of a UK online survey. *International Journal of Language & Communication Disorders*, *52*(3), 356–373. https://doi.org/10.1111/1460-6984.12278

Northcott, S., Simpson, A., Moss, B., Ahmed, N., & Hilari, K. (2018). Supporting people with aphasia to 'settle into a new way to be': Speech and language therapists' views on providing psychosocial support. *International Journal of Language & Communication Disorders*, *53*(1), 16–29. https://doi.org/10.1111/1460-6984.12323

Northey, W. F., Jr, & Gehart, D. R. (2020). The condensed MFT core competencies: A streamlined approach for measuring student and supervisee learning using the MFT core competencies. *Journal of Marital and Family Therapy*, *46*(1), 42–61. https://doi.org/10.1111/jmft.12386

Nykänen, A., Nyrkkö, H., Nykänen, M., Brunou, R., & Rautakoski, P. (2013). Communication therapy for people with aphasia and their partners (APPUTE). *Aphasiology*, *27*(10), 1159–1179. https://doi.org/10.1080/02687038.2013.802284

Nyström, M. (2011). A bridge between a lonely soul and the surrounding world: A study on existential consequences of being closely related to a person with aphasia. *International Journal of Qualitative Studies on Health and Well-Being*, *6*(4), 7911. https://doi.org/10.3402/qhw.v6i4.7911

Pertab, K. (2023). *The acceptability of relationship-centered communication partner training for couples impacted by aphasia: A mixed methods pilot investigation* (10076). [Master's thesis, Brigham Young University]. BYUScholarsArchive. https://scholarsarchive.byu.edu/etd/10076

Rasmus, A., & Orłowska, E. (2020). Marriage and post-stroke aphasia: The long-time effects of group therapy of fluent and non-fluent aphasic patients and their spouses. *Frontiers in Psychology*, *11*, 1574. https://doi.org/10.3389/fpsyg.2020.01574

Ross, S., Barton, J., & Read, J. (2009). Staff in-service training on post-stroke psychological and communication issues. *International Journal of Therapy and Rehabilitation*, *16*(6), 342–348. https://doi.org/10.12968/ijtr.2009.16.6.42437

Santo Pietro, M. J., Marks, D. R., & Mullen, A. (2019). When words fail: Providing effective psychological treatment for depression in persons with aphasia. *Journal of Clinical Psychology in Medical Settings*, *26*(4), 483–494. https://doi.org/10.1007/s10880-019-09608-4

Sekhon, J., Oates, J., Kneebone, I., & Rose, M. (2019). Counselling training for speech-language therapists working with people affected by post-stroke aphasia: A systematic review. *International Journal of Language & Communication Disorders*, *54*(3), 321–346. https://doi.org/10.1111/1460-6984.12455

Simmons-Mackie, N., & Cherney, L. R. (2018). Aphasia in North America: Highlights of a white paper. *Archives of Physical Medicine and Rehabilitation, 99*(10), e117. https://doi.org/10.1016/j.apmr.2018.07.417

Simmons-Mackie, N., & Damico, J. (2011). Counseling and aphasia treatment: Missed opportunities. *Topics in Language Disorders*, *31*(4), 336–351. https://doi.org/10.1097/TLD.0b013e318234ea9f

Simmons-Mackie, N., Raymer, A., Armstrong, E., Holland, A., & Cherney, L. R. (2010). Communication partner training in aphasia: A systematic review. *Archives of Physical Medicine and Rehabilitation*, *91*(12), 1814–1837. https://doi.org/10.1016/j.apmr.2010.08.026

Stead, A., & White, J. (2019). Loss of intimacy: A cost of caregiving in aphasia. *Topics in Language Disorders, 39*(1), 55–70. https://doi.org/10.1097/TLD.0000000000000175

Strong, K. A., & Randolph, J. (2021). How do you do talk therapy with someone who can't talk? Perspectives from mental health providers on delivering services to individuals with aphasia. *American Journal of Speech-Language Pathology*, *30*(6), 2681–2692. https://doi.org/10.1044/2021_AJSLP-21-00040

Tanner, D. C. (2003). Eclectic perspectives on the psychology of aphasia. *Journal of Allied Health*, *32*(4), 256–260. https://pubmed.ncbi.nlm.nih.gov/14714599/

Wallace, S. E., Farquharson, K., Berdik, M., Foote, L. T., Manspeaker, S. A., & Hankemeier, D. A. (2022). Speech-language pathologists' perspectives of interprofessional collaboration.

Journal of Interprofessional Care, *36*(6), 801–809. https://doi.org/10.1080/13561820.2022.2039106

Zanella, C., Laures-Gore, J., Dotson, V. M., & Belagaje, S. R. (2023). Incidence of post-stroke depression symptoms and potential risk factors in adults with aphasia in a comprehensive stroke center. *Topics in Stroke Rehabilitation*, *30*(5), 448–458. https://doi.org/10.1080/10749357.2022.2070363

Tables

Table 1

Demographic Information and Respondent Characteristics

Age (*n* = 61)	Gender (*n* = 61)	Ethnicity (*n* = 61)	Race (*n* = 61) [a]	Degree (*n* = 61)	Years of experience (*n* = 61)	Population of clinical focus (*n* = 61)[a]	Clinical practice (*n* = 61)[a]	Location (*n* = 61)
30-39 (50.8%) 40-49 (25.6%) 20-29 (19.7%) 50-59 (3.3%) 60+ (1.6%)	Female (70.5%) Male (26.2%) Not provided (3.3%)	Non-Hispanic (90.2%) Hispanic (6.6%) Not provided (3.3%)	White (78.7%) Asian (4.9%) Black or African American (4.9%) Other (4.9%) American Indian or Alaskan Native (1.6%) American Indian or Alaskan Native, White (1.6%) Black or African American, White (1.6%) Asian, White (1.6%)	Master's (86.9%) Doctoral (13.1%)	3 to 5 (41%) 6 to 10 (29.5%) 11 to 20 (26.2%) 21 to 30 (3.3%)	Individual adults (77%) Marital (74.8%) Adolescents (32.8%) Parent-child (27.9%) Other (8.2%)	Mental health (88.5%) Marriage and family (85.2%) Trauma (44.3%) Substance abuse (9.8%) Domestic violence (4.9%) Other (3.3%)	UT (34.4%) WA (9.9%) TX (8.2%) KY (6.6%) CO (4.9%) MD (4.9%) OH (4.9%) AZ (3.3%) CA (3.3%) FL (3.3%) OR (3.3%) AL (1.6%) GA (1.6%) IA (1.6%) LA (1.6%) ME (1.6%) MA (1.6%) MO (1.6%) NJ (1.6%)

Note. All percentages were rounded to the nearest tenth. [a]Multiple response options allowed. The written responses for the "other" category for population of focus included "neurodivergent," "LGBTQIA+ relationships," "family therapy," and "all answers applied." The written responses for the "other" category for clinical practice included "medical" and "LGBTQIA+."

Table 2

Responses Regarding Familiarity with Aphasia Prior to Intervention

Survey Questions	Responses
I have heard of aphasia	Yes (77%) No (23%)
To your knowledge, have you provided services to a caregiver, spouse, or family member of a PWA? (*n* = 61)	No (60.7%) Yes (24.6%) I don't know (14.8%)
How confident are you that you could provide services to a PWA in an ethical manner given your present knowledge of the disorder? (*n* = 61)	Very doubtful (41%) Somewhat doubtful (24.6%) Neither confident nor doubtful (16.4%) Somewhat confident (11.5%) Very confident (6.6%)
I am experienced in working with people or couples impacted by aphasia. (*n* = 61)	Strongly disagree (67.2%) Somewhat disagree (19.7%) Neither agree nor disagree (8.2%) Somewhat agree (3.3%) Strongly agree (1.6%)
How did you first learn about aphasia? (*n* = 61)[a]	Academic coursework (29.5%) I have not learned about aphasia (29.5%) Media source (18%) Personal experience (9.8%) Clinical practice (6.6%) Other (4.9%) Continuing education (1.6%)

Note. All percentages were rounded to the nearest tenth. [a]Multiple response options allowed. The written responses for learning about aphasia in the "other" category included "my daughter is an SLP," "Google," and "being exposed at a previous community mental health employment."

Table 3

Responses Regarding Interactions with SLPs Prior to Intervention

Survey Questions	Responses
I know what a speech-language pathologist (SLP) is. (*n* = 61)	Yes (93.4%) No (6.6%)
I have worked professionally with an SLP before. (*n* = 61)	No (65.6%) Yes (32.8%) No response (1.6%)
Which of the following best describes your previous professional interaction with speech-language pathology? (*n* = 61)[a]	Not applicable (52.5%) I have referred a client to an SLP (34.4%) I have worked collaboratively with an SLP (21.3%) I have consulted with an SLP (18%) I have received consultation from an SLP (9.8%)
I have referred a client to a speech-language pathologist (SLP) before. (*n* = 21)	Rarely (66.7%) Occasionally (28.6%) Very frequently (4.8%)
I have worked collaboratively with a speech-language pathologist (SLP) before. (*n* = 13)	Occasionally (61.5%) Rarely (23.1%) Frequently (15.4%)
I have consulted with a speech-language pathologist (SLP) before. (*n* = 11)	Rarely (36.4%) Occasionally (36.4%) Frequently (18.2%) Very frequently (9.1%)
I have received consultation from a speech-language pathologist (SLP) before. (*n* = 6)	Rarely (50%) Occasionally (33.3%) Frequently (16.7%)

Note. All percentages were rounded to the nearest tenth. [a]Multiple response options allowed.

Table 4

Respondent Feedback About RC-CPT

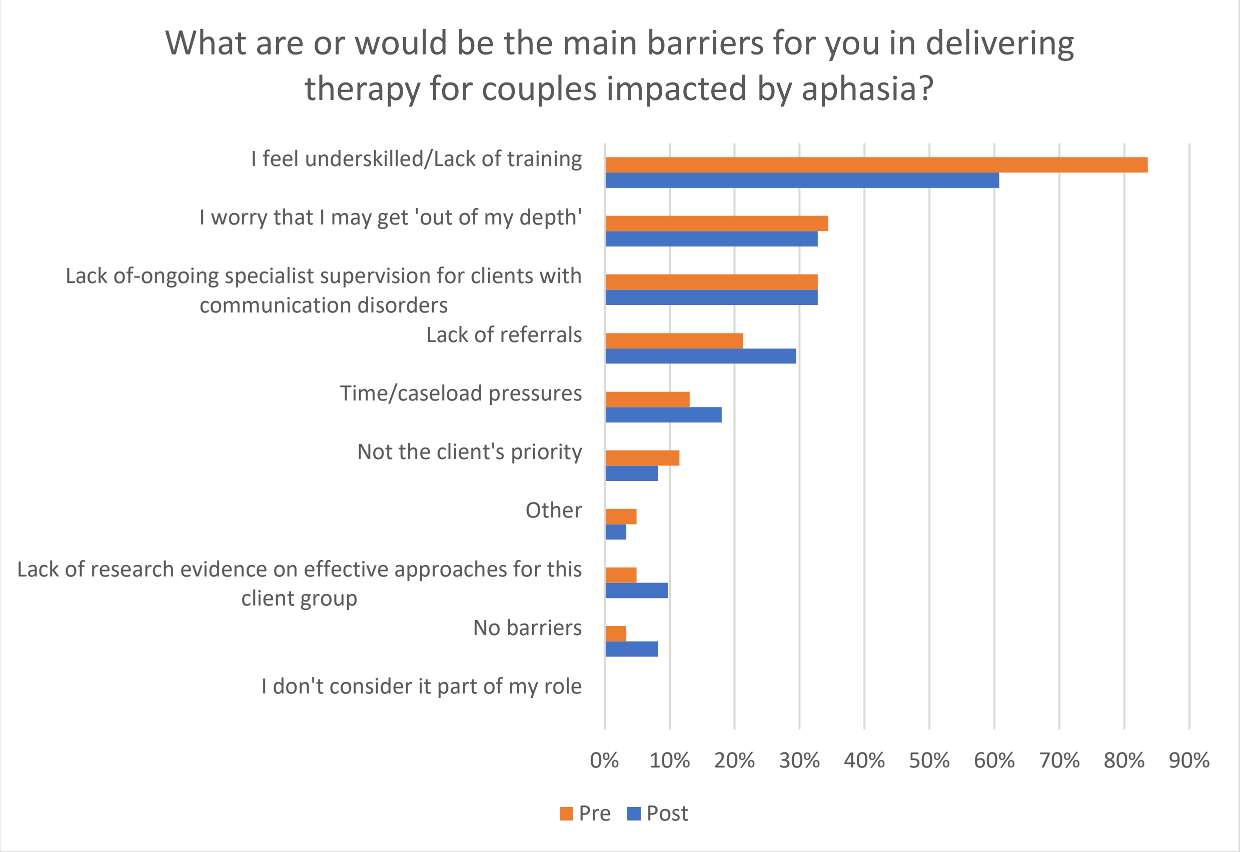
Likert statements provided after education plus RC-CPT intervention	Responses
Implementing the type of program just presented would fall within my scope of practice. (*n* = 33)	Strongly agree (36.4%) Somewhat agree (48.5%) Neither agree nor disagree (6.1%) Somewhat disagree (6.1%) Strongly disagree (3.0%)
I would collaborate with a speech language pathologist to do a therapy program like the one just described. (*n* = 33)	Yes (78.8%) No (9.1%) Unsure (12.1%)
I would consult with a speech language pathologist for a therapy program like the one just described. (*n* = 33)	Yes (90.2%) No (0%) Unsure (9.1%)

Note. All percentages were rounded to the nearest tenth.

Figures

Figure 1

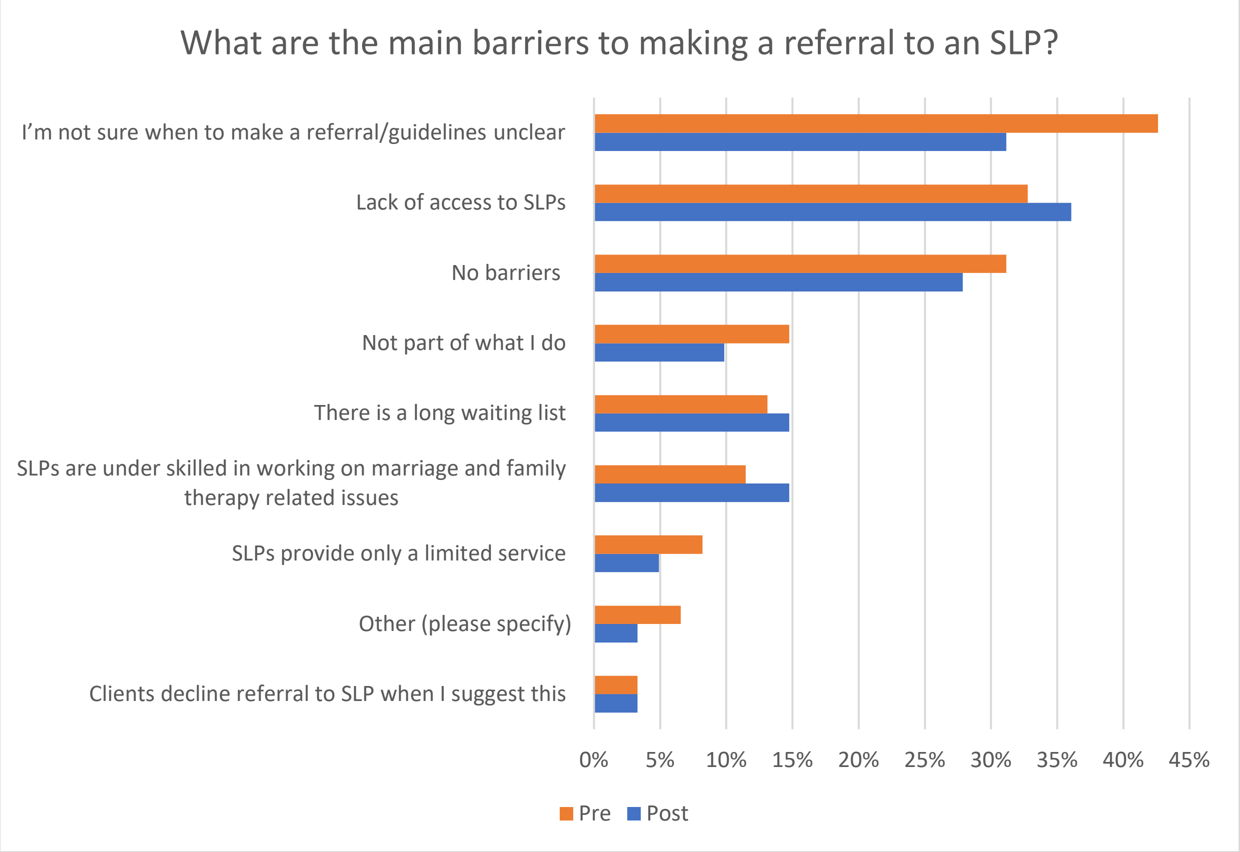
Barriers to Delivering Therapy (n = 61)



Note. Percentage of respondents who identified listed barriers to delivering therapy for couples impacted by aphasia are shown for pre- and post-intervention responses. These responses are collapsed across intervention conditions.

Figure 2

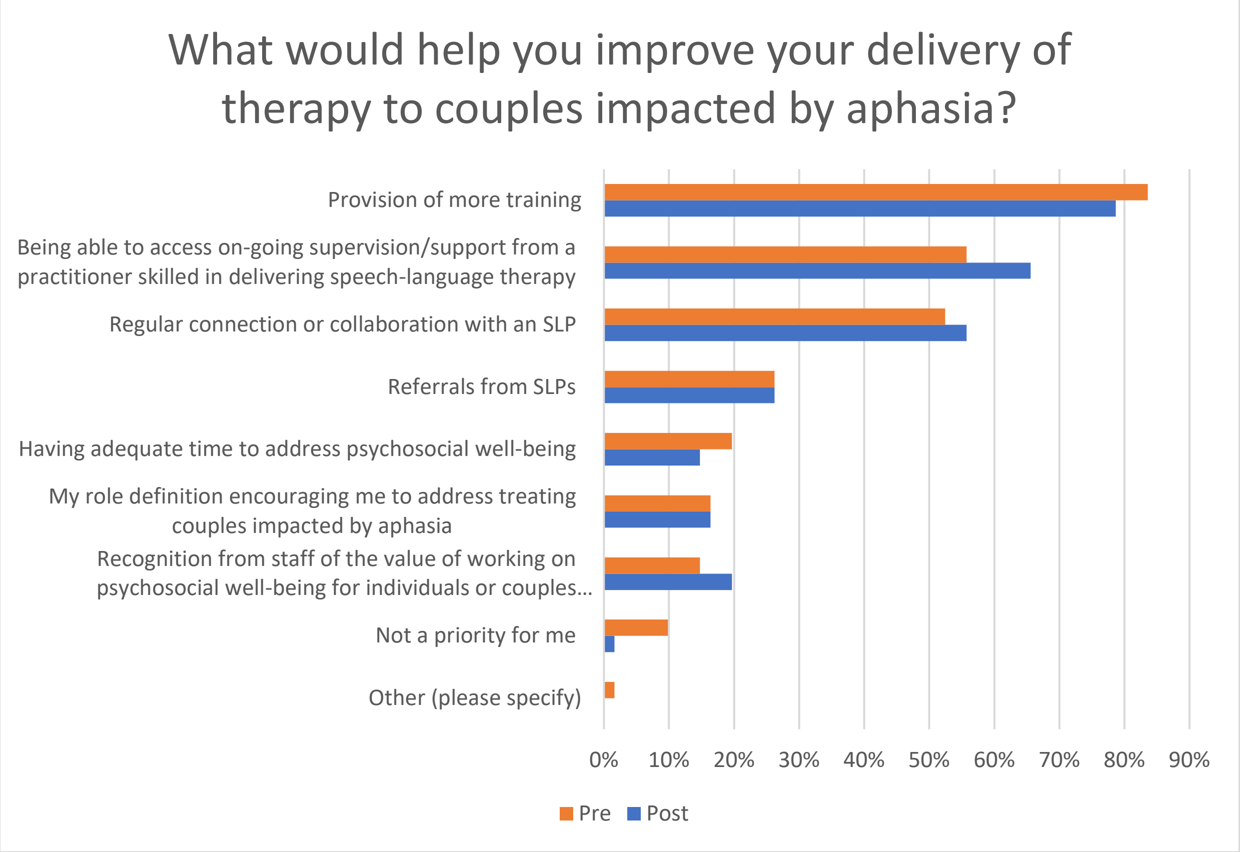
Barriers to Making Referrals (n = 61)



Note. Percentage of respondents who identified listed barriers to making a referral to an SLP are shown for pre- and post-intervention responses. These responses are collapsed across intervention conditions.

Figure 3

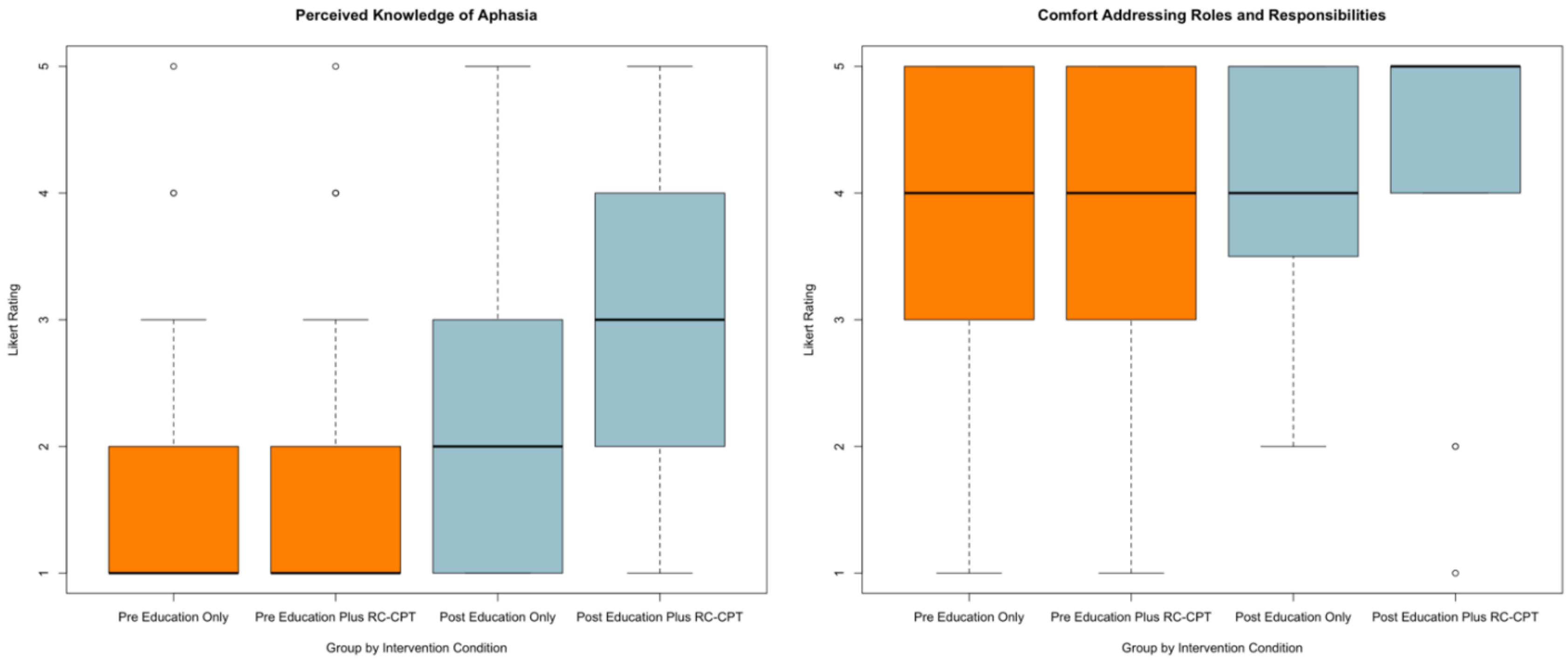
Improving Therapy for Couples Impacted by Aphasia (n = 61)



Note. Percentage of respondents who identified listed ways to improve delivery of therapy to couples impacted by aphasia are shown for pre- and post-intervention responses. These responses are collapsed across intervention conditions.

Figure 4

Perceived Knowledge and Comfort Addressing Roles and Responsibilities


Perceived Knowledge of Aphasia

Comfort Addressing Roles and Responsibilities

Note. Perceived knowledge of aphasia and comfort addressing roles and responsibilities with couples impacted by aphasia before and after two intervention conditions.

APPENDIX A

Annotated Bibliography

Baker, C., Rose, M. L., Ryan, B., & Worrall, L. (2021a). Barriers and facilitators to implementing stepped psychological care for people with aphasia: Perspectives of stroke health professionals. *Topics in Stroke Rehabilitation*, *28*(8), 581–593. https://doi.org/10.1080/10749357.2020.1849952

Objective: This study's objective was to help identify barriers and facilitators for implementing stepped psychological care to help with depression from the perspective of stroke health professionals.

Methods: Stroke health professionals participated in 5 semi-structured face-to face focus groups. Thirty-nine stroke health professionals from different professional disciplines participated. They varied in location and healthcare settings from two different Australian states (Victoria and South Australia).

Results: Three core themes: knowledge, skills, and attitudes, were found from the focus groups as having the most impact on implementation of stepped psychological care. Some barriers were no experience with stepped psychological care, limited understanding of aphasia, and lack of adequate resources. Some facilitators were specialized training, staff, leadership, and communication tools.

Conclusion: Specifically addressing the barriers and facilitators will help with implementation of stepped psychological care. Specialized training, mood assessments and treatments, resources, and modified spaces will also assist in the implementation of this evidence-based practice.

Relevance to current work: One of the aims of interviewing MFTs is to work on a tailored multidisciplinary intervention, which is something this article points out as a gap in the field. Increasing confidence in treatment of people with aphasia while targeting psychological care is an important part of my thesis.

Baker, C., Worrall, L., Rose, M., & Ryan, B. (2021b). Stroke health professionals' management of depression after post-stroke aphasia: A qualitative study. *Disability and Rehabilitation, 43*(2), 217–228. https://doi.org/10.1080/09638288.2019.1621394

Objective: This purpose of this article was to investigate the perspectives of stroke health professionals on managing depression after post-stroke aphasia.

Methods: There were 39 stroke health professionals from two Australian states (Victoria and South Australia) who participated in the study. The participants were eligible if they were currently working with stroke on their caseload and had managed at least one person with aphasia in the past year. The participants were involved in semi-structured focus groups and current practices were explored.

Results: Several core themes emerged from the focus groups including concomitant aphasia and depression after stroke being a challenging area of rehabilitation, depression not being a high rehabilitation priority, approaches are ad hoc, and trying to bridge psychological care needs and limited services.

Conclusion: Mood difficulties and depression are not always a priority during stroke rehabilitation. Multidisciplinary approaches happen as needed, but there are gaps in care. Stroke health professionals would benefit from building their knowledge, confidence, and skills in working with people with aphasia.

Relevance to current work: A core theme that was found is that aphasia is a specialty with a lack of clarity for multidisciplinary roles managing depression, and that skills for how to support communication are lacking in stroke health professionals. This is an important gap I will need to ask about when interviewing MFTs to see if they feel that their skills and knowledge are lacking.

Boles, L., & Lewis, M. (2003). Working with couples: Solution focused aphasia therapy. *Asia Pacific Journal of Speech, Language and Hearing, 8*(3), 153–159. https://doi.org/10.1179/136132803805576110

Objective: The aim of this paper was to describe solution focused aphasia therapy. The article uses as case study of an individual who benefitted from this kind of therapy post stroke.

Methods: One couple, a husband and wife, were involved in four weeks of twice-weekly conversation-based therapy. Conversations were counselling oriented to focus on 'deeper issues.' Self-assessments were used throughout the process.

Results: The couple made measurable gains in their communication with each other as shown by increased self-ratings of communication, more facilitative gestures by the spouse without aphasia, and more communication independence in the spouse with aphasia.

Conclusion: Solution-focused aphasia therapy helps people with aphasia to focus on ability to interact with their partners than on impairment-level improvement. This method addresses communication rather than aphasia.

Relevance to current work: The relationship communication partner training being evaluated by the MFTs I will be interviewing is similar to the solution-focused aphasia therapy done in this study.

Brumfitt, S., & Barton, J. (2006). Evaluating wellbeing in people with aphasia using speech therapy and clinical psychology. *International Journal of Therapy & Rehabilitation*, *13*(7), 305–309. https://doi.org/10.12968/ijtr.2006.13.7.21406

Objective: The purpose of this article was to use both clinical psychology and speech language pathology to assess emotional wellbeing in people with aphasia from a multidisciplinary perspective.

Conclusion: Both speech and language therapists and clinical psychologists would benefit from further training in aphasia and counseling.

Relevance to current work: This article emphasizes the necessity of working on multidisciplinary teams to best help people with aphasia which is important in considering how MFTs and SLPs can work together. This study provides aspects of working on an interdisciplinary team that I will want to ask about in my survey.

Christensen, J. M., & Anderson, J. D. (1989). Spouse adjustment to stroke: Aphasic versus nonaphasic partners. *Journal of Communication Disorders, 22*(4), 225–231. https://doi.org/10.1016/0021-9924(89)90018-x

Objective: The purpose of this study was to survey spouses of stroke patients with and without aphasia on adjustments including role changes, emotional problems, social adjustments, and perceived communication abilities.

Methods: Eleven spouses of non-aphasic patients and 11 spouses of aphasic patients participated in the study and were mailed a 75-item questionnaire. Participants lived in the northeast Oklahoma area. Responses were tabulated and analyzed using cross-break tables and chi square procedures.

Results: While both spouse groups were affected by communication problems due to stroke, spouses of aphasic partners were affected more. The spouses of PWA were very aware of receptive and expressive language difficulties of their partner.

Conclusion: The presence of aphasia in a relationship has a significant impact on interpersonal relationships between spouses. Both spouses of non-aphasic and aphasic partners experience role changes and other marital adjustments post-stroke.

Relevance to current work: This study supports the need for communication partner training and demonstrates why couples including a partner with aphasia could benefit from joint therapy. It will be important to know how MFTs can improve upon or work with SLPs to overcome communication problems in my study.

Croteau, C., & Le Dorze, G. (2006). Overprotection, "speaking for", and conversational participation: A study of couples with aphasia. *Aphasiology*, *20*(02–04), 327–336. https://doi.org/10.1080/02687030500475051

Objective: This aim of this study was to look at overprotection behaviors and participation in conversation for people with aphasia.

Methods: Eighteen couples participated in this study, each couple including one person with aphasia. Participants perceptions were measured, and interviews were videotaped in which couples answered questions turn-by-turn. Participants were seen in their own homes across 2 sessions for 2 hours each.

Results: Reported overprotection, speaking for behaviors, and minor participation in conversation were all positively related. The severity of aphasia and motor disability were also associated to minor participation in conversation.

Conclusion: More research on overprotection is needed to gain further understanding of communication and psychosocial aspects of aphasia. Overprotection could limit the impacts of rehabilitation efforts to improve communication.

Relevance to current work: This article is relevant because it shows the importance of addressing "speaking for" people with aphasia and the potential negative impacts it can have on their communication, which is something that both SLPs and MFTs could see and potentially address in therapy. My study will aim to help MFTs see ways to combat this as they think about feasibility of relationship communication partner training.

Croteau, C., & Le Dorze, G. (2001). Spouses' perceptions of persons with aphasia. *Aphasiology*, *15*(9), 811–825. https://doi.org/10.1080/02687040143000221

Objective: This article aimed to compare perception of spouses of people with aphasia versus without, wives' perception of men with aphasia and vice versa, and to describe spouses' perceptions of persons with aphasia.

Methods: Twenty-one spouses of persons with aphasia and 25 control spouses were the participants in this study. They were all French speaking and persons with aphasia were at least 1 year post onset. Functional Status Index and The Adjective Check List were both given.

Results: Some results included spouses of partners with aphasia having lower likeability scores and wives judged their husbands with aphasia lower on the achievement scale than husbands judging their wives with aphasia.

Conclusion: Overall, perception of persons without aphasia by spouses versus with aphasia are different. Husbands and wives differed in both endurance and achievement. Family members and people with aphasia may need help with adjusting to these new perceptions.

Relevance to current work: Partners perceptions of each other will change in the relationship as a result of aphasia and it will be important to know how MFTs feel about targeting related topics in therapy. This article describes some of the impacts of aphasia that I will want to address with MFTs.

Croteau, C., McMahon-Morin, P., Le Dorze, G., & Baril, G. (2020). Impact of aphasia on communication in couples. *International Journal of Language & Communication Disorders*, *55*(4), 547–557. https://doi.org/10.1111/1460-6984.12537

Objective: This article's aim was to explore how couples perceive the impact of aphasia on their communication.

Methods: Participants included nine French-speaking couples with one member of each couple having aphasia secondary to stroke. The 18 individuals selected for the study participated in semi-structured interviews which were later recorded, transcribed, and analyzed with qualitative thematic analysis.

Results: Themes found from this article were experiencing limitations in conversation, assuming changed speaking and listening roles, and experiencing new emotions, feelings and reactions in communication.

Conclusion: Consequences in communication as a result of aphasia were found and could be used by clinicians to gain a greater understanding of aphasia's impact on communication. This can help with communication partner training that is better fitting for couples living with aphasia.

Relevance to current work: This article is relevant because it dives into communication partner training, which is what I will be interviewing MFTs about and how comfortable they would feel in implementing it. This study also provides information about how to collect and present qualitative data.

Ford, A., Douglas, J., & O'Halloran, R. (2018). The experience of close personal relationships from the perspective of people with aphasia: Thematic analysis of the literature. *Aphasiology*, *32*(4), 367–393. https://doi.org/10.1080/02687038.2017.1413486

Objective: This article was a systematic analysis of the literature on perspectives of people with aphasia on close personal relationships and their findings.

Methods: Scoping review methodology was used including four databases which were searched resulting in 376 articles of which 21 studies were used in the article.

Results: Interview methods and cross-sectional designs were used by most studies, only seven directly examined the relationship experiences of people with aphasia. Thematic analysis revealed four themes including living with change, mediating factors within interaction, connectedness, and positive relationship outcomes for people with aphasia.

Conclusion: Relationships are central to life and challenging to maintain from the perspective of people with aphasia.

Relevance to current work: This article is relevant because people with aphasia experience changed relationships and this article highlights the importance of interpersonal relationships, including marriage. MFTs and SLPs need to understand how they can support and counsel people with aphasia in their relationships and how that can best be practiced within scope of practice.

Jokel, R., Meltzer, J., D. R., J., D. M., L., J. C., J., A. N., E., & D. T., C. (2017). Group intervention for individuals with primary progressive aphasia and their spouses: Who comes first? *Journal of Communication Disorders*, *66*, 51–64. https://doi.org/10.1016/j.jcomdis.2017.04.002

Objective: The purpose of this article was to look at group intervention for people with aphasia and their spouses.

Methods: This article was a comparison-group study that compared treatment group and control group outcomes after receiving 10 weeks of intervention or no intervention. Participants were all seen in Toronto and had received diagnoses of primary progressive aphasia. The treatment group consisted of 5 individuals and their spouses, and the control group was also 5 families.

Results: Positive outcomes such as increased knowledge of aphasia, confidence, ability to deal with progression, and nonverbal strategies were noted by participants.

Conclusion: Both people with aphasia and their spouses need to be addressed and for successful intervention, people with aphasia should work on more than just language activities and education. This article recommends that opportunities for discussing important and difficult issues as well as successes and failures should be a part of intervention.

Relevance to current work: This article is relevant because it provides further evidence for why both MFTs and SLPs need to become more comfortable in counseling people with aphasia. This article is also relevant because it talks about the importance of working with the spouse/marriage partner.

Kneebone, I. I. (2016). A framework to support cognitive behavior therapy for emotional disorder after stroke. *Cognitive and Behavioral Practice*, *23*(1), 99–109. https://doi.org/10.1016/j.cbpra.2015.02.001

Objective: The purpose of this article was to discuss and give a framework for cognitive behavior therapy to help combat things like depression and anxiety after stroke. 6 case study examples were given in this study.

Relevance to current work: The CBT therapist can help patients to question thought processes and dispute them with alternative responses and help them recognize their all-or-nothing thinking processes as well. Depending on severity of cognitive changes, the therapist might need to be more direct with patients. This article is relevant because it provides techniques MFTs might be able to use with clients and gives further insight to types of marriage relationships in the cases provided (supportive, uninterested, overprotective, collaborative, negotiator, antagonistic).

Kneebone, I. I., & Jeffries, F. W. (2013). Treating anxiety after stroke using cognitive-behaviour therapy: Two cases. *Neuropsychological Rehabilitation*, *23*(6), 798–810. https://doi.org/10.1080/09602011.2013.820135

Objective: The purpose of this article is to discuss two cases in which modified cognitive behavior therapy was used for anxiety in individuals who had a stroke.

Methods: One participant was seen for 7 sessions 45–60 minutes in length over 3–4 months by a clinical psychologist listed on the Specialist Register of Clinical Neuropsychologists of the British Psychological Society. The other participant was seen for a 4-month period for 50–60 minutes for a total of 8 sessions by the same clinical psychologist.

Results: Participants improved following intervention and results were maintained when individuals were followed up with 3 months later. Focusing on things one participant was already doing to minimize risk and helping them to understand costs and benefits of worrying helped with anxiety.

Conclusion: Cognitive-behavioral psychotherapy was proved to be effective for both cases for helping with anxiety after stroke.

Relevance to current work: This study indicates the importance and impact of stroke patients receiving psychosocial therapy as a part of treatment. My study aims to see if MFTs consider a combination of psychosocial and communication therapy in treatment as a part of their scope of practice.

Le Dorze, G., & Brassard, C. (1995). A description of the consequences of aphasia on aphasic persons and their relatives and friends, based on the WHO model of chronic diseases. *Aphasiology*, *9*(3), 239–255. https://doi.org/10.1080/02687039508248198

Objective: The purpose of this study was to describe, based on the WHO model of chronic diseases, the consequences of aphasia on aphasic persons and their relatives and friends.

Methods: Eighteen subjects participated in semi-structured interviews and the interviews were analyzed using qualitative methods. The interviews focused on certain themes to understand experiences of interviewees and get a better description of their experiences and situations. Participants were French speaking.

Results: Disabilities, handicaps, and coping behavior were descriptors of consequences of aphasia. Disabilities were related to language. Changes in situations of communication, changes in interpersonal relationships, loss of autonomy (aphasic), heightened responsibilities (relatives/friends) restriction of activities and evidence of stigmatization were handicaps.

Conclusion: A more systematic understanding is needed for greater insight to handicaps associated with aphasia and the impact on individuals and families.

Relevance to current work: Consequences of aphasia and the impact it has on marriage is relevant to my current work as I seek to understand how MFTs feel about counseling couples who have a partner with aphasia. My study will also collect qualitative data and this article shows how to do that.

Le Dorze, G., & Signori, F. H. (2010). Needs, barriers and facilitators experienced by spouses of people with aphasia. *Disability and Rehabilitation*, *32*(13), 1073–1087. https://doi.org/10.3109/09638280903374121

Objective: This paper discusses the barriers and facilitators of the spouses of people with aphasia and seeks to understand what their needs are and whether their needs are being fulfilled.

Methods: This study was a convenience-based sampling procedure. Eleven spouses were interviewed in small groups and discussions between 2–4 participants and were later transcribed and coded in order to be grouped into categories. Interviews lasted 90–120 minutes.

Results: This study showed that spouses of people with aphasia need support to help overcome barriers. Participants perceived their partner’s needs for help with communication and well-being.

Conclusion: This study confirmed that spouses need assistance in adjusting to aphasia and would benefit from support; however, support can often be unavailable or nonexistent. Access to support throughout rehabilitation is a necessity for spouses of people with aphasia.

Relevance to current work: This article is relevant because it provides examples of barriers and facilitators for spouses of people with aphasia and gives insight to how relationship partner training can help combat some of those barriers. This study describes some of the aspects of aphasia that I will want to address when interviewing MFTs.

Morrow-Odom, K. L., & Barnes, C. K. (2019). Mental health professionals' experiences with aphasia. *Journal of Rehabilitation*, *85*(1), 15–21. https://lib.byu.edu/remoteauth/?url=https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip&db=asn&AN=135314651&site=ehost-live&scope=site

Objective: The purpose of this study was to survey mental health professionals' awareness of and experiences with aphasia. This article sought to better understand what kind of aphasia training mental health professionals may have had and what their level of confidence was in working with those individuals.

Methods: The study included 1,758 mental health professionals including counselors, therapists, social workers, psychologists, and psychiatrists with active licensure in the state of North Carolina. In the survey, questions were centered on knowledge of aphasia, professional experiences, and any training received on aphasia.

Results: The results indicated that while the majority of respondents were able to identify aphasia as a language disorder, most had no professional experiences with persons with aphasia. Mental health providers indicated a decreased level of confidence if the opportunity to treat the aphasia population presented itself.

Conclusion: The findings of this study suggest that continuing education for mental health providers on the topic of aphasia would improve confidence in treatment. It was suggested in the article that speech-language pathologists would be a good resource for providing continuing education. People with aphasia may not be receiving mental health intervention because they do not have the language abilities or functional communication skills to be considered candidates for mental health services. They also may no longer be receiving care by the time signs of a mental disorder occur.

Relevance to current work: This article is relevant to my study in that I will be interviewing marriage and family therapists and analyzing those interviews in a hope to better understand what kinds of training or support they would need to increase their confidence in treating people with aphasia and their relationship partners.

Moss, B., Northcott, S., Behn, N., Monnelly, K., Marshall, J., Thomas, S., Simpson, A., Goldsmith, K., McVicker, S., Flood, C., & Hilari, K. (2021). ‘Emotion is of the essence. … number one priority’: A nested qualitative study exploring psychosocial adjustment to stroke and aphasia. *International Journal of Language & Communication Disorders*, *56*(3), 594–608. https://doi.org/10.1111/1460-6984.12616

Objective: This article’s purpose was to explore the post-acute phase of recovery for people with aphasia as well as significant others and their adjustment to life after stroke.

Methods: Twenty people with aphasia and 10 significant others were given semi-structured interviews which took place in the participants’ homes. The participants selected were sampled from a larger group of 56 people with aphasia and 48 significant others in the North London area. Framework analysis was used to analyze the interviews.

Results: Several factors were found to influence adjustment to aphasia after stroke including but not limited to mood and emotions, identity/sense of self, attitude and outlook, faith and spirituality and moving forward. For significant others, a factor was the impact of becoming a caregiver. External sources of support including communication from doctors, nurses, and hospital, therapists, psychological support, and community were some other factors mentioned.

Conclusion: The article concluded that some important considerations in caring for people with aphasia are to prioritize humanizing aspects of care offered by medical providers. Two recommendations offered were that clinicians should also help with adjustment support by focusing on relationship-centered care and monitoring mental health.

Relevance to current work: I will be working with marriage and family therapists to look at how mental health and relationship-centered care can be focused on alongside aphasia treatment.

Nätterlund, B. (2010). Being a close relative of a person with aphasia. *Scandinavian Journal of Occupational Therapy*, *17*(1), 18–28. https://doi.org/10.3109/11038120902833218

Objective: The purpose of this article was to investigate close relatives' experiences with people with aphasia and perceptions they had about everyday activities and support in daily life.

Methods: Fourteen people were interviewed for this study and the interviews were later analyzed using qualitative analysis and sorted into three themes including the influence of aphasia in the family, everyday life, and the meaning of support. The study was approved in Sweden.

Results: Some commonly reported ideas were the pressures faced as a result of illness on the close relatives, role changes, loss of friends, increased communication problems especially in the beginning, lack of previously seen activity, and emotional loneliness.

Conclusion: Close relatives of people with aphasia need support during the rehabilitation process from therapists and staff to help them cope and adjust to new life and ways of communication.

Relevance to current work: This article is relevant to my thesis as it discusses how both people with aphasia and their caregivers and close relatives need to be supported throughout the rehabilitation process and afterwards. MFTs could play an important role in the rehabilitation process and in helping couples face role changes and other relationship challenges better. This study also explains collection and presentation of qualitative data.

Northcott, S., Burns, K., Simpson, A., & Hilari, K. (2015). 'Living with aphasia the best way I can': A feasibility study exploring solution-focused brief therapy for people with aphasia. *Folia Phoniatrica et Logopaedica : Official Organ of the International Association of Logopedics and Phoniatrics (IALP)*, *67*(3), 156–167. https://doi.org/10.1159/000439217

Objective: This article's purpose was to explore the feasibility of solution-focused brief therapy. The authors wanted to investigate if solution-focused brief therapy is an accessible intervention and understand its impact on psychosocial wellbeing.

Methods: The study was a small-scale repeated-measures study that had participants receive 3–5 therapy sessions. There were 5 participants recruited through a university register in London. Psychosocial outcomes were measured pre- and post-therapy and qualitative interviews were conducted post-therapy.

Results: Participants found the therapy to be acceptable and general trends showed improved moods and communication participation. The therapy was also found to be an adaptable approach. Areas of social network and connectedness remained consistent.

Conclusion: Solution-focused brief therapy demonstrated promise due to positive changes in both mood and communicative participation in people with aphasia. This study adds evidence that SFBT can be used to help combat chronic issues.

Relevance to current work: This study is relevant to my current work because it is important to find a way in which MFTs can feel more confident in the language and communication aspects of aphasia so that patients can find greater value in therapy. I will be interviewing MFTs about a similar program to solution-focused brief therapy.

Northcott, S., Simpson, A., Moss, B., Ahmed, N., & Hilari, K. (2017). How do speech-and-language therapists address the psychosocial well-being of people with aphasia? Results of a UK online survey. *International Journal of Language & Communication Disorders*, *52*(3), 356–373. https://doi.org/10.1111/1460-6984.12278

Objective: This study explored how SLTs address psychological and social needs of PWA and their experiences with mental health professionals.

Methods: SLTs in the UK were given an online survey. Afterwards, analysis of the results was completed using descriptive statistics and qualitative content analysis.

Results: Social participation and psychological well-being were acknowledged by SLTs as a part of their scope of practice and implemented these in treatment through strategies including supportive listening and writing holistic goals. Barriers to supporting psychological well-being included time constraints, lack of support, and feeling underqualified. Mental health providers lacking skills working with aphasia and large caseloads of MHPs were also mentioned.

Conclusion: Improving confidence and skills of SLTs through training and an increase in accessibility of mental health professionals for PWA are greatly needed.

Relevance to current work: This study provides further evidence for an increase in counseling training for SLTs as well as collaboration and interprofessional education with MHPs. My study intends to further explore what that collaboration can look like.

Northcott, S., Simpson, A., Moss, B., Ahmed, N., & Hilari, K. (2018). Supporting people with aphasia to 'settle into a new way to be': Speech and language therapists' views on providing psychosocial support. *International Journal of Language & Communication Disorders*, *53*(1), 16–29. https://doi.org/10.1111/1460-6984.12323

Objective: The aim of this article was to explore how speech language therapists view their scope of practice as well as barriers and facilitators they face in addressing mental health and psychosocial needs.

Methods: Twenty-three speech language therapists participated in six focus groups, each coming from different psychosocial backgrounds. Qualitative results were analyzed using framework analysis.

Results: Barriers including emotionally challenging work, lack of support, caseload and time pressures, attitudes, documenting psychosocial work, and complexity of patients were all reported. Facilitators included support, experience, management support, and personal belief.

Conclusion: Psychological care needs to be seen as a necessity for people with aphasia and viewed in a valuable and plausible way with interprofessional collaboration between both SLPs and mental health providers.

Relevance to current work: This study provides further evidence for the necessity of interprofessional collaboration between SLPs and mental health providers. My study will hopefully help MFTs and SLPs find ways to work together in a more collaborative manner.

Nykänen, A., Nyrkkö, H., Nykänen, M., Brunou, R., & Rautakoski, P. (2013). Communication therapy for people with aphasia and their partners (APPUTE). *Aphasiology*, *27*(10), 1159–1179. http://dx.doi.org/10.1080/02687038.2013.802284

Objective: This study's purpose was to describe APPUTE, a new intervention, where partners receive therapy equally and practice functional communication strategies.

Methods: Thirty-four people with severe aphasia with a post onset time of at least 1 year and their partners participated in this study using APPUTE and were evaluated three times during the rehabilitation process. The study was done in Finland. Couples participated in a 3-day evaluation, two 14-day intensive rehabilitation periods at 6-month intervals, and a follow-up 6 months later.

Results: Communication and linguistic skills both improved significantly during rehabilitation and were retained when measured 6 months post-intervention. Communication efficiency was also noted to have improved significantly. Communication skills of partners also improved significantly.

Conclusion: The outcome of this study indicated that people with non-fluent aphasia and their partners improved as a result of the APPUTE intervention as their communication skills increased. Guidance for both the person with aphasia and their partner was instrumental in therapy.

Relevance to current work: This article adds further evidence for communication partner training and the importance of including the spouse in therapy. This is important for my project because I will be examining if doing this kind of similar therapy falls within an MFTs scope of practice.

Rasmus, A., & Orłowska, E. (2020). Marriage and post-stroke aphasia: The long-time effects of group therapy of fluent and non-fluent aphasic patients and their spouses. *Frontiers in Psychology*, *11*, 1574. https://doi.org/10.3389/fpsyg.2020.01574

Objective: The purpose of this study was to evaluate marital adjustment based on psychoeducation and social support.

Methods: Ten, 90-minute sessions were given to two groups of couples with both fluent and non-fluent aphasic partners in Polish neurology hospitals. Eighty couples split into four experimental groups completed a therapy program focusing on sharing personal experiences and psychoeducation. Participants were interviewed and completed neuropsychological assessment. This study involved both speech therapists and family therapists.

Results: There are significant differences in quality of marriage between those who received treatment and those who did not. Changes are different depending on type of aphasia and being the patient of caregiver in the relationship.

Conclusion: Counselors should be mindful of including relationship difficulties in rehabilitation and adjust therapy and goals as needed. Counselors should also consider using an educational approach as benefits were demonstrated from the study.

Relevance to current work: This study demonstrated the benefits of working with relationship partners together during therapy. This is important for my research because I will be looking at how MFTs feel about incorporating similar tactics within their scope of practice.

Santo Pietro, M. J., Marks, D. R., & Mullen, A. (2019). When words fail: Providing effective psychological treatment for depression in persons with aphasia. *Journal of Clinical Psychology in Medical Settings*, *26*(4), 483–494. https://doi.org/10.1007/s10880-019-09608-4

Objective: The purpose of this paper was to look at the psychological challenges that people living with aphasia face and explore compatibility between life participation intervention and cognitive-behavioral intervention for depression.

Conclusion: Consideration of both behavioral sources and the life participation intervention approach could contribute to effective treatment for people with aphasia.

Relevance to current work: This paper is relevant to my study because it explores considerations for depression in psychological treatment such as the use of behavioral activation and life participation interventions. Depression can result in the loss of relationships and opportunities for reinforcement as well as feelings of helplessness which can carry over into marriage, something that seems to fall in MFT scope of practice and will be explored in my study.

Schaffer, K. M., Evans, W. S., Dutcher, C. D., Philburn, C., & Henry, M. L. (2021). Embedding aphasia-modified cognitive behavioral therapy in script training for primary progressive aphasia: A single-case pilot study. *American Journal of Speech-Language Pathology*, *30*(5), 2053–2068. https://doi.org/10.1044/2021_AJSLP-20-00361

Objective: The purpose of this study was to examine if combining speech-language treatment with counseling treatment was feasible for an individual with aphasia.

Methods: This study was a single-case experimental design which used a multiple baseline design across scripts and a mixed methods approach. The participant was English speaking and the study was reviewed by UT at Austin.

Results: The participant met criterion for trained scripts post-treatment and demonstrated maintenance or improvement in both psychosocial and communicative functioning. Themes of loss and resilience were maintained, but post treatment other themes such as positive self-perception, sense of agency, and emotional attunement emerged.

Conclusion: A combination of script training and modified CBT is feasible and has shown benefits for both speech and language as well as psychosocial improvements. Benefits were determined to be both immediate and lasting.

Relevance to current work: This study includes important considerations and rationale for working on speech and language therapy and counseling conjointly, which is something I will be asking MFTs about. This article also included qualitative research and analysis, something we will be doing in my project.

Sekhon, J., Oates, J., Kneebone, I., & Rose, M. (2019). Counselling training for speech-language therapists working with people affected by post-stroke aphasia: A systematic review. *International Journal of Language & Communication Disorders*, *54*(3), 321–346. https://doi.org/10.1111/1460-6984.12455

Objective: This study explored current counseling training for SLTs and sought to gain an understanding of what training they receive in counseling psychological needs for PWA.

Methods: This article was a systematic review that searched eleven databases and included 9 studies which were reviewed using a SALSA framework (Search, Appraisal, Synthesis, and Analysis).

Results: Counseling training and levels of SLT knowledge, comfort, confidence, and preparedness for counseling PWA post-stroke were found to have moderate correlations.

Conclusion: When SLTs received training for counseling and psychological approaches from mental health professionals, they felt more confident, knowledgeable, and skilled to be able to address the psychological well-being of PWA post-stroke.

Relevance to current work: This article discusses the importance of interprofessional collaboration for both SLTs and MHPs. The goal of my study is to explore further how MFTs feel about the implementation of relationship centered communication partner training and to get further insight into their scope of practice. Hopefully, this will help increase collaboration between SLTs and MHPs further.

Simmons-Mackie, N., & Damico, J. (2011). Counseling and aphasia treatment: Missed opportunities. *Top Lang Disorders*, *31*(4), 336–351. https://doi.org/10.1097/TLD.0b013e318234ea9f

Objective: This article sought to define missed opportunities of SLPs to counsel people with aphasia. This study identifies and describes avoidance strategies.

Methods: Four treatment sessions for people with aphasia were analyzed and data was collected from the interactions between patients and SLPs. Two of the SLPs that participated in the treatment sessions were also given qualitative interviews.

Results: Engaging in superficial conversation, focusing on facts, shifting to therapy tasks, and deflection through humor were all strategies used by SLPs to avoid counseling opportunities in order to avoid awkwardness. These strategies were also used to cope with a narrow view of scope of practice and learned professional values.

Conclusion: SLPs understand aphasia and are communication facilitators, so they should support PWA in communicating feelings and psychological needs. Counseling falls within the SLP scope of practice and we have a responsibility to counsel patients as it relates to communication deficits.

Relevance to current work: This study gives insight to how SLPs miss counseling opportunities and will help me to ask how MFTs might be able to help fill in that gap or further educate SLPs on how to take advantage of counseling opportunities.

Stead, A., & White, J. (2019). Loss of intimacy: a cost of caregiving in aphasia. *Topics in Language Disorders, 39*(1), 55–70. https://doi.org/10.1097/TLD.0000000000000175

Objective: This article discusses current literature about intimacy in aphasia and solutions to address it. This article also explores the Aphasia Couples Retreat.

Relevance to current work: This article includes many important factors relevant to my current work such as interdisciplinary counseling groups, discussion of cotreatment, couples counseling groups all focused on how relationship roles and routines can change and how couples can adapt and use strategies. These will be important things to discuss with MFTs to see how they feel about implementing similar ideas in therapy.

Strong, K. A., & Randolph, J. (2021). How do you do talk therapy with someone who can't talk? Perspectives from mental health providers on delivering services to individuals with aphasia. *American Journal of Speech-Language Pathology*, *30*(6), 2681–2692. https://doi.org/10.1044/2021_AJSLP-21-00040

Objective: The purpose of this study was to figure out mental health providers' experiences with providing services to people living with aphasia.

Methods: Six mental health providers within the state of Michigan who had some experience in working with people with aphasia were interviewed. An interpretative phenomenological analysis was used to analyze the interviews.

Results: The mental health providers noted three main themes in providing services to people with aphasia. These themes included barriers, interprofessional collaboration, and therapy looks different for people with aphasia. Common barriers mentioned were a lack of training/knowledge, mental health services stigmas, and accessibility to services. Lack of knowledge and awareness, strategies and tools, and referrals were themes of Interdisciplinary Collaboration. Aspects of the theme 'therapy looks different' were new approaches and challenges.

Conclusion: A nontraditional approach to talk therapy should be used alongside increased collaboration with speech-language pathologists. There should be future research to explore further collaboration between SLPs and mental health providers.

Relevance to current work: This article is relevant to my study in that I will be interviewing Marriage and Family Therapists and analyzing those interviews in a hope to better understand what kinds of training or support they would need to increase their confidence in treating people with aphasia and their relationship partners. In addition, I want to better explore the future collaboration with SLPs.

Tanner, D. C. (2003). Eclectic perspectives on the psychology of aphasia. *Journal of Allied Health*, *32*(4), 256–260. https://pubmed.ncbi.nlm.nih.gov/14714599/

Objective: The aim of this study is to explore necessary adjustments and psychological changes that have occurred after a patient has a stroke and needs to learn how to cope and deal with aphasia.

Relevance to current work: This article is important to my study because it further informs on psychological aspects of aphasia and the impact it can have on a couple and their family. This article includes important considerations for couples with aphasia and relationship communication partner training.

Worrall, L., Ryan, B., Hudson, K., Kneebone, I., Simmons-Mackie, N., Khan, A., Hoffman, T., Power, E., Togher, L., & Rose, M. (2016). Reducing the psychosocial impact of aphasia on mood and quality of life in people with aphasia and the impact of caregiving in family members through the Aphasia Action Success Knowledge (Aphasia ASK) program: Study protocol for a randomized controlled trial. *Trials*, *17*(1), 1–7. https://doi.org/10.1186/s13063-016-1257-9

Objective: The aim of this article was to determine if the program Aphasia Action Success Knowledge leads to better mood and quality of life outcomes for people with aphasia and their families.

Methods: This study was a multicenter, cluster-randomized controlled trial in Australia. People with aphasia and their family members were blinded to the study design and treatment allocation. 344 people with aphasia and their family members were recruited and were put into 20 clusters.

Relevance to current work: This article is tailored for people with aphasia and their families to help improve quality of life and functional outcomes that are impacted by mood. The feasibility study that we will interview MFTs about also sought to tailor to couples and their relationship to improve their quality of life.

APPENDIX B

Consent/Institutional Review Board Approval Letter

Memorandum

To: Tyson Harmon
Department: BYU - EDUC - Communications
DisordersFrom: Sandee Aina, MPA, HRPP
Associate Director
Wayne Larsen, MAcc, IRB
AdministratorDate: August 21, 2023
IRB#: IRB2023-247
Title: Speech-language pathologists' and marriage and family therapists' perspectives about working with couplesimpacted by aphasia

Brigham Young University's IRB has approved the research study referenced in the subject heading as
exempt, category 2. This study does not require an annual continuing review. Each year near the anniversary of theapproval date, you will receive an email reminding you of your obligations as an investigator and to check on the status of the study. You will receive this email each year until you close the study.

The study is approved as of 08/21/2023. Please reference your assigned IRB identification number in anycorrespondence with the IRB.

Continued approval is conditional upon your compliance with the following requirements:

1. A copy of the approved informed consent statement can be found in iRIS. No other consent statementshould be used. Each research subject must be provided with a copy or a way to access the consent statement.
2. Any modifications to the approved protocol must be submitted, reviewed, and approved by the IRB beforemodifications are incorporated into the study.
3. All recruiting tools must be submitted and approved by the IRB prior to use.
4. Instructions to access approved documents, submit modifications, and report adverse events can be foundon the IRB website, iRIS guide: https://irb.byu.edu/iris-training-resources
5. All non-serious unanticipated problems should be reported to the IRB within 2 weeks of the first awareness of the problem by the PI. Prompt reporting is important, as unanticipated problems often require some modification of study procedures, protocols, and/or informed consent processes. Such modifications requirethe review and approval of the IRB. Please refer to the IRB website for more information.

APPENDIX C

Survey

Pre-Video Questions

Title of the Research Study: Marriage and Family Therapists Perspectives of Working With Couples Impacted by Aphasia: General Perceptions and Response to Relationship- Centered Communication Partner Training

My name is Madie Christensen. I am a graduate student at Brigham Young University, and I am conducting this research under the supervision of Dr. Harmon from the Department of Communication Disorders. You are being invited to participate in this research study about Marriage and Family Therapists' perceptions and experiences working with couples impacted by aphasia. As part of this study you will learn about aphasia and be introduced to a conceptualized approach for addressing psychosocial impacts of aphasia when working with couples. Being in this study is optional.

If you choose to be in the study, you will be asked to complete a survey that should take approximately 15-30 minutes of your time. You will be compensated with a $50 Amazon Gift Card for completing this survey. Please follow the link at the end of the survey to provide your email if you wish to receive gift card compensation.

You can skip questions that you do not want to answer or stop the survey at any time. The survey is anonymous, and no one will be able to link your answers back to you. Please do not include your name or other information that could be used to identify you in the survey responses.

Questions? Please contact Madie Christensen at mfreeze2@byu.edu. If you have questions or concerns about your rights as a research participant, you can call the BYU Human Research Protections Program at 801-422-1461 or BYU.HRPP@byu.edu.

If you want to participate in this study, click the Agree button to start the survey.

a. Agree

The following criteria must be met before proceeding with the survey.

1) You must be currently practicing and licensed in the United States
2) You must have at least 3 years' experience as a Marriage and Family Therapist.
3) English is your primary language.

Before you proceed to the survey, please complete the captcha below.

Are you currently a marriage and family therapist that is practicing and licensed in the United States?

a. No
b. Yes

Do you have at least 3 years' experience as a Marriage and Family Therapist?
a. No
b. Yes

Is English your primary language?
a. No
b. Yes

What is your age?
a. Under 20 years
b. 20-29 years
c. 30-39 years
d. 40-49 years
e. 50-59 years
f. 60 years or older

What is your gender?
a. Female
b. Male
c. Do not wish to provide

What is your ethnicity?
a. Hispanic/Latino
b. Non-Hispanic
c. Do not wish to provide

What is your race? Select all that apply.
a. American Indian or Alaska Native
b. Asian
c. Black or African American
d. White
e. Native Hawaiian or Other Pacific Islander
f. Other
g. Do not wish to provide

In what state do you currently practice?

____

What is your highest degree earned?
a. Master’s degree
b. Doctoral degree

How many years of experience do you have as an MFT?
a. 3 to 5
b. 6 to 10
c. 11 to 20
d. 21 to 30
e. 31+

Which of the following best describes your primary population of clinical focus? Select all that apply.
a. Marital
b. Parent-child
c. Adolescents
d. Individual adults
e. Other (please explain)

Which of the following best describes your clinical practice? Select all that apply.
a. Marriage and family
b. Mental health (e.g., depression, anxiety)
c. Substance abuse
d. Trauma
e. Domestic violence
f. Other (please explain)

I have heard of aphasia.
a. No
b. Yes

Given your current knowledge, what is aphasia?
a. An eating disorder
b. A sleep/wake disorder
c. A language disorder
d. A swallowing disorder
e. A speech disorder
f. A hearing disorder
g. A dissociative disorder

How confident are you in your selection to the previous question?
a. Very doubtful
b. Somewhat doubtful
c. Neither confident nor doubtful
d. Somewhat confident
e. Very confident

To your knowledge, have you ever provided services to a person with aphasia?
a. No
b. I don't know

c. Yes

I am knowledgeable about working with people or couples impacted by aphasia.

a. Strongly disagree
b. Somewhat disagree
c. Neither agree nor disagree
d. Somewhat agree
e. Strongly agree

I feel confident working with people or couples impacted by aphasia.

a. Strongly disagree
b. Somewhat disagree
c. Neither agree nor disagree
d. Somewhat agree
e. Strongly agree

I am experienced in working with people or couples impacted by aphasia.

a. Strongly disagree
b. Somewhat disagree
c. Neither agree nor disagree
d. Somewhat agree
e. Strongly agree

How did you first learn about aphasia?

a. Academic coursework
b. Clinical practice (e.g., approached by a person with aphasia for services)
c. Personal experience
d. Media source
e. Continuing education opportunity
f. I have not learned about aphasia
g. Other (please specify)

How confident are you that you could provide services to a person with aphasia in an ethical manner given your present knowledge of the disorder.

a. Very doubtful
b. Somewhat doubtful
c. Neither confident nor doubtful
d. Somewhat confident
e. Very confident

I know what a speech-language pathologist (SLP) is.

a. No
b. Yes

I have worked professionally with an SLP before.

a. No
b. Yes

Which of the following best describes your previous professional interactions with speech-language pathology? Select all that apply.
a. I have referred a client to a speech language pathologist
b. I have worked collaboratively with a speech language pathologist
c. I have consulted with a speech language pathologist in relation to one of their clients
d. I have received consultation from a speech language pathologist for one of my clients
e. Not applicable

I have referred a client to a speech-language pathologist (SLP) before.
a. Never
b. Rarely
c. Occasionally
d. Frequently
e. Very frequently

I have worked collaboratively with a speech-language pathologist (SLP) before.
a. Never
b. Rarely
c. Occasionally
d. Frequently
e. Very frequently

I have consulted with a speech-language pathologist (SLP) before.
a. Never
b. Rarely
c. Occasionally
d. Frequently
e. Very frequently

I have received consultation from a speech-language pathologist (SLP) before.
a. Never
b. Rarely
c. Occasionally
d. Frequently
e. Very frequently

What are or would be the main barriers for you in delivering therapy for couples impacted by aphasia? Please select all that apply.
a. Time/caseload pressures
b. I feel under-skilled/ have a lack of training
c. Lack of on-going specialist supervision for clients with communication disorders
d. Lack of research evidence on effective approaches for this client group
e. I don’t consider it part of my role

f. I worry that I may get ‘out of my depth’
g. Not the client’s priority
h. Lack of referrals
i. No barriers
j. Other (please specify)

What would help you improve your delivery of therapy to couples impacted by aphasia? Please select all that apply.
a. Provision of more training
b. Being able to access on-going supervision/support from a practitioner skilled in delivering speech-language therapy
c. Recognition from staff of the value of working on psychosocial well-being for individuals or couples impacted by aphasia
d. My role definition encouraging me to address treating couples impacted by aphasia
e. Having adequate time to address psychosocial well-being
f. Regular connection or collaboration with an SLP
g. Referrals from SLPs
h. Not a priority for me
i. Other (please specify)

What are the main barriers to making a referral to an SLP? Please select all that apply.
a. SLPs are under skilled in working on marriage and family therapy related issues
b. Clients decline referral to SLP when I suggest this
c. There is a long waiting list
d. I’m not sure when to make a referral/guidelines unclear
e. SLPs provide only a limited service
f. Not part of what I do
g. Lack of access to SLPs
h. No barriers
i. Other (please specify)

How comfortable would you feel talking to and coaching couples impacted by aphasia on communication strategies such as using eye contact, gestures, and verifying understanding during therapy.
a. Very uncomfortable
b. Somewhat uncomfortable
c. Neither comfortable nor uncomfortable
d. Somewhat comfortable
e. Very comfortable

Discussing communication strategies such as using eye contact, gestures, and verifying understanding falls within my scope of practice.
a. No
b. Unsure
c. Yes

How comfortable would you feel addressing changing roles and responsibilities post-stroke with couples impacted by aphasia?

a. Very uncomfortable
b. Somewhat uncomfortable
c. Neither comfortable nor uncomfortable
d. Somewhat comfortable
e. Very comfortable

Addressing changing roles and responsibilities post-stroke with couples impacted by aphasia falls within my scope of practice.

a. No
b. Unsure
c. Yes

How comfortable would you be helping couples impacted by aphasia set goals and make plans related to relationship roles and responsibilities?

a. Very uncomfortable
b. Somewhat uncomfortable
c. Neither comfortable nor uncomfortable
d. Somewhat comfortable
e. Very comfortable

Helping couples impacted by aphasia set goals and make plans related to relationship roles and responsibilities falls within my scope of practice.

a. No
b. Unsure
c. Yes

Please describe your experiences of working with people or couples impacted by aphasia.

Please describe how treatment could be improved for people or couples impacted by aphasia.

Please feel free to add any further comments on addressing the needs of people or couples impacted by aphasia.

Aphasia is an acquired neurogenic language impairment that affects reception (comprehension) and expression (production) of language across modalities (including reading and writing) and interferes with life activities and participation. Aphasia most often results from stroke or brain injury, but many other etiologies including neurodegenerative disease are possible. Aphasia varies in combination and severity of symptoms. For example, one person with aphasia might present primarily with difficulty finding specific and complex words whereas another may be mostly nonverbal. Relatedly, one person with aphasia might have severe difficulty understanding language and less difficulty producing language and another may understand relatively well but be very limited in their production. Roughly 100,000-180,0000 people acquire aphasia each year in the United States and 2-4 million people in the United States are living with aphasia.

Video Segment
Speech-language pathologists are the lead service providers responsible for evaluating and managing the communication problems of people with aphasia.

The following videos are focused on a relationship-centered communication partner training program that was piloted with three couples impacted by aphasia and a Speech- Language Pathology (SLP) graduate student under the supervision of a certified SLP.

During the training, each couple participated in a brief intervention that included two sessions designed to help them learn and practice conversing together in the context of marital roles and responsibilities. During the first session, couples completed a communication partner training module that incorporated communication strategies such as adjusting their language, using gestures and writing to supplement verbal communication, and verifying understanding. During the second session, the person with aphasia and his/her spouse individually completed a questionnaire regarding roles and responsibilities across six different categories. A conversation was then facilitated wherein they selected one role and responsibility category for which to set goals and make plans for improvement. The clinician supported the communication as needed during this discussion and explained that if certain emotions or problems came up that would be better addressed by an MFT or mental health professional, they would refer the couple for other resources.

Previous to the clips that will be shown, the person with aphasia was given a comprehensive language test to determine the type and severity of their aphasia profile. During the first session, a communication partner training module is given in which the clinician walks the couple through one of four areas they would like to work on including: adjusting language used, gestures/body language, writing/graphics, and verifying understanding. Following an explanation of the strategies, a video example will be shown and the couple is asked to identify the strategies they saw during the video. Then, the couple practices using the strategies themselves in a real-life conversation.

During the second session, the couples fills out a Relationship Roles Questionnaire separately. The following are topics included in the relationship roles questionnaire: Household chores, meal preparation, financial management, childcare and transportation, medical and legal decisions, and relationship and intimacy. For each area, the couple is asked the following questions: 1) Since the onset of your spouse’s aphasia, how much have your responsibilities in this area changed? 2) How distressing has distributing responsibilities in this area been to you personally? 3) How important is it for you to see change in how you and your spouse divide responsibilities in this area? The clinician then brings the couple together to have a conversation about the results and the couple chooses an area(s) to work on. The clinician helps support the couple’s conversation by providing and modeling communication strategies as they facilitate a conversation about the changes the couple is experiencing as it relates to aphasia. The strategies the couple previously selected during the first session such as adjusting language used, gestures/body language, writing/graphics, and/or verifying understanding are practiced in the context of the couples’ discussion regarding roles and responsibilities within marriage.

Should you experience any technical difficulties while watching the video (i.e., the video pauses without resuming, the video looks blank), please refresh the page and fast forward to the last place you previously watched. Follow the link to watch the video: click here

Post-video questions

Given your current knowledge, what is aphasia?
a. An eating disorder
b. A sleep/wake disorder
c. A language disorder
d. A swallowing disorder
e. A speech disorder
f. A hearing disorder
g. A dissociative disorder

Considering the previous question regarding the aphasia definition, how confident are you in your selection?
a. Very doubtful
b. Somewhat doubtful
c. Neither confident nor doubtful
d. Somewhat confident
e. Very confident

To your knowledge, have you ever provided services to a person with aphasia?
a. No
b. I don't know
c. Yes

To your knowledge, have you provided services to a caregiver, spouse, or family member of a person with aphasia?
a. No
b. I don't know
c. Yes

I am knowledgeable about working with people or couples impacted by aphasia.
a. Strongly disagree
b. Somewhat disagree
c. Neither agree nor disagree
d. Somewhat agree
e. Strongly agree

I feel confident working with people or couples impacted by aphasia.
a. Strongly disagree
b. Somewhat disagree
c. Neither agree nor disagree
d. Somewhat agree

e. Strongly agree

Implementing the type of program just presented would fall within my scope of practice.
a. Strongly disagree
b. Somewhat disagree
c. Neither agree nor disagree
d. Somewhat agree
e. Strongly agree

What are or would be the main barriers for you in delivering therapy for couples impacted by aphasia? Please select all that apply.
a. Time/caseload pressures
b. I feel under-skilled/ lack of training
c. Lack of on-going specialist supervision for clients with communication disorders
d. Lack of research evidence on effective approaches for this client group
e. I don’t consider it part of my role
f. I worry that I may get ‘out of my depth’
g. Not the client’s priority
h. Lack of referrals
i. No barriers
j. Other (please specify)

What would help you to improve your delivery of therapy to couples impacted by aphasia? Please select all that apply.
a. Provision of more training
b. Being able to access on-going supervision/support from a practitioner skilled in delivering speech-language therapy
c. Recognition from staff of the value of working on psychosocial well-being for individuals or couples impacted by aphasia
d. My role definition encouraging me to address treating couples impacted by aphasia
e. Having adequate time to address psychosocial well-being
f. Regular connection or collaboration with an SLP
g. Referrals from SLPs
h. Not a priority for me
i. Other (please specify)

What are the main barriers to making a referral to an SLP? Please select all that apply.
a. SLPs are under skilled in working on marriage and family therapy related issues
b. Clients decline referral to SLP when I suggest this
c. There is a long waiting list
d. I’m not sure when to make a referral/guidelines unclear
e. SLPs provide only a limited service
f. Not part of what I do
g. Lack of access to SLPs
h. No barriers
i. Other (please specify)

I would collaborate with a speech language pathologist to do a therapy program like the one just described.

a. No
b. Unsure
c. Yes

I would consult with a speech language pathologist for a therapy program like the one just described.

a. No
b. Unsure
c. Yes

How comfortable would you feel talking to and coaching couples impacted by aphasia on communication strategies such as using eye contact, gestures, and verifying understanding during therapy.

a. Very uncomfortable
b. Somewhat uncomfortable
c. Neither comfortable nor uncomfortable
d. Somewhat comfortable
e. Very comfortable

Discussing communication strategies such as using eye contact, gestures, and verifying understanding falls within my scope of practice.

a. No
b. Unsure
c. Yes

How comfortable would you feel addressing changing roles and responsibilities post- stroke with couples impacted by aphasia.

a. Very uncomfortable
b. Somewhat uncomfortable
c. Neither comfortable nor uncomfortable
d. Somewhat comfortable
e. Very comfortable

Addressing changing roles and responsibilities post-stroke with couples impacted by aphasia falls within my scope of practice.

a. No
b. Unsure
c. Yes

How comfortable would you be helping couples impacted by aphasia set goals and make plans related to relationship roles and responsibilities?

a. Very uncomfortable

b. Somewhat uncomfortable
c. Neither comfortable nor uncomfortable
d. Somewhat comfortable
e. Very comfortable

Helping couples impacted by aphasia set goals and make plans related to relationship roles and responsibilities falls within my scope of practice.
a. No
b. Unsure
c. Yes

Did you watch a video as part of this survey?
a. No
b. Yes

Please describe how this relationship-centered communication partner training might be improved.

Please feel free to add any further comments on addressing the needs of couples impacted by aphasia.

If you wish to receive compensation for your participation in the form of a $50 Amazon Gift Card, click here. Please return to this survey after entering your email at the link so that your survey registers as completed.