

Title: Current Australian speech-language pathology practice in addressing psychological well-being in people with aphasia after stroke

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Key words: Aphasia, Psychological well-being, Stroke, Speech-language pathology

Running head: Addressing psychological well-being in aphasia

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Abstract

Psychological well-being (Ψ wb) in people with aphasia (PWA) is essential to overall health, however there is a paucity of research on how to address Ψ wb in stroke survivors with aphasia. This study describes the current beliefs, attitudes and practices of Australian speech-language pathologists (SLPs) in addressing Ψ wb in PWA after stroke. Results of a 26-item web based survey found Australian SLPs ($n=111$) utilised counselling and clinical approaches to address Ψ wb in people with post stroke aphasia. The majority of SLPs did not feel comfortable with addressing Ψ wb in PWA and sought support from other health professionals in this practice. Self perception of being underskilled was the main barrier identified to adequate practice in this domain, followed by inadequate time, inadequate staffing and PWA declining referral to counselling. The main facilitators reported by SLPs to address Ψ wb included personal interest, personal and professional experience and availability of counselling health professionals to refer PWA to. There were small to medium statistically significant correlations between SLPs' reporting additional training in counselling and perceived knowledge of, confidence in and satisfaction with managing Ψ wb in people with aphasia. This study identifies factors requiring attention in order to enable SLPs to facilitate improved Ψ wb in PWA.

Introduction

In Australia in 2012 approximately 65% of the 420,000 people affected by stroke were living with a disability that impeded their ability to carry out activities of daily living unassisted. (Deloitte Access Economics Report, National Stroke Foundation (NSF), 2013). Aphasia, a language and communication disability, occurs in approximately 30-35% of people after first ever stroke (Dickey, Kagan, Lindsay, Fang, Rowland, & Black, 2010; Engelter et al., 2006). Aphasia can affect all language modalities in communication, and thus impacts on full

participation in daily life (Byng, Pound & Parr, 2000; Davidson, Worrall, & Hickson, 2010).

For many people, aphasia is a chronic condition (Parr, 2001).

Defining psychological health and well-being

Psychological well-being (Ψ_{wb}) is a key component to overall (biopsychosocial) health (World Health Organization (WHO), 1948). Ryff's (1995) definition of Ψ_{wb} encompasses six dimensions: self-acceptance, positive relationships, autonomy, environmental mastery, purpose of life and personal growth. It is a theoretically grounded model with research within the field of health and aging relevant to the stroke population (Ryff, 1995). It is concerned with the development and self-realisation of the individual (Ryff & Singer, 2008) which relates to the WHO definition of psychological health (WHO, 2011). Ryff's model (1995) has also been used with PWA (Hoen, Thelander & Worsley, 1997) and commonly appears in the psychology literature in the field of trauma, personal growth and transformation (Tedeschi & Calhoun, 1995) relating to the well-being equilibrium affected by a life challenge (Dodge et al., 2012). In a recent review of research studies investigating Ψ_{wb} , Ryff and Singer (2008) concluded that "psychological well-being is profoundly influenced by the surrounding contexts of people's lives" (p.14) and that addressing Ψ_{wb} "may be consequential for health by promoting effective regulation of multiple physiological systems" (p.14). It is therefore logical to hypothesise that the Ψ_{wb} of PWA will be profoundly influenced by the rehabilitation context and that addressing Ψ_{wb} may be consequential for positive health outcomes.

Psychological health after stroke and aphasia.

Biographical, observational and empirical studies have shown that stroke often results in significant psychological upheaval and strain for the survivors (Brumfitt, 1993; Gainotti, 1997; Herrmann & Wallesch, 1989; LaFond, 1993; Lincoln & Kneebone, 2012; Robinson,

2010; Tanner, 2003). In a systematic review of studies on Health Related Quality of Life (HRQOL) of PWA, Hilari, Needle, and Harrison (2012) concluded that emotional distress, depression, aphasia severity, communication and activity limitations, social network and support, and other medical problems were important factors related to HRQOL.

Communication disability prevents engagement and participation in activities of choice and thus impact on Ψ_{wb} (Cruice, Worrall, Hickson, & Murison, 2003; Hackett, Anderson, House, & Halteh, 2008; Hilari & Byng, 2009; Hilari, Wiggins, Roy, Byng, & Smith, 2003) and conversely poor Ψ_{wb} reduces frequency of activities, activity participation, functional communication, participation in rehabilitation and adjustment (Brown, Worrall, Davidson, & Howe, 2012; Carota, Staub, & Bogousslavsky, 2002; Code & Hermann, 2003; Cruice, Worrall, & Hickson, 2011; Fucetola et al., 2006). Many studies show that psychological health and recovery in PWA is variable over time, may take a long time and is individually experienced (Brown, Worrall, Davidson, & Howe, 2011; Brown et al., 2012; Carota et al., 2002; Cruice et al., 2003; Grohn, Worrall, Simmons-Mackie, and Brown, 2012; Hilari et al., 2012; Ross, Winslow, Marchant, & Brumfitt, 2006).

SLP role in managing psychological health and well-being in PWA after stroke

There is little reported research on the management of psychological problems after stroke in people with communication disabilities (Kneebone & Dunmore, 2000; Lincoln & Kneebone, 2012; Townend, Brady & McLaughlan, 2007). A variety of key frameworks and clinical guidelines for stroke and aphasia rehabilitation recommend addressing the psychological health and well-being of stroke survivors including the International Classification of Functioning, Disability and Health (ICF, WHO, 2001), Living with Aphasia: Framework for Outcome Measurement (A-FROM) (Kagan et al., 2008), Life Participation Approach to Aphasia (LPAA) (LPAA group, 2001), National Stroke Foundation Clinical

Guidelines for Stroke Management (NSF, 2013) and the social model to aphasia therapy (Byng et al., 2000).

The Clinical Guidelines for Stroke Management (NSF, 2010, p. 47) suggest that ‘counselling services should be available to all stroke survivors and their families / carers and suggest a combination of informational and supportive counselling approaches. However, in the National Stroke Foundation Audit of Rehabilitation Services (NSF, 2012, p. 37) only 31 % of stroke survivors (without cognitive difficulties) were offered formal targeted counselling in preparation for life in the community. It is not known if this figure includes PWA or people with communication disabilities.

Seven themes were found to be important to PWA, their families and SLPs when living successfully with aphasia (Brown et al., 2012). These included participation, meaningful relationships, support, communication, positivity, independence, and autonomy and that successful living with aphasia is a journey over time. In view of these seven themes, Grohn et al. (2012) suggested SLPs should facilitate personally meaningful engagement and development of a positive outlook through counselling, identity negotiation and self-management (Holland, 2007; Shadden, Hagstrom & Koski, 2008). Further, attention should be focused on maintenance of social resources (peer friendships and providing communication partner training to family and close others) to promote ‘successful living with aphasia’. There is preliminary evidence of the impact of group therapy on psychosocial benefits, and improved social participation and social connection from a recent systematic review (Lanyon, Rose, & Worrall, 2013). Factors such as depression, communication disability, engagement in activities and diminishing social networks in PWA should be specifically targeted (Hilari et al., 2012). Importantly, depression rates in PWA post stroke are twice as high as those of people without aphasia post stroke, and thus requires specific attention (Kauhanen et al., 2000).

Clinical guidelines by SLP professional bodies state the use of information and affective counselling skills are within the SLP's role with clients with communication difficulties (The Royal College of Speech Language Therapists (RCSLT), Communicating Quality 3 Handbook, 2006, p. 235; Scope of Practice in Speech Pathology, Speech Pathology Australia (SPA), 2003). However, the use of counselling skills for addressing emotional and psychological well-being in PWA are underspecified. Most SLPs working with PWA, believe that psychological and social dimensions are important and essential to achieve positive rehabilitation outcomes (including QOL) (Brumfitt, 2006; Brown et al., 2011; Gibson & Purdy, 2012) and report practicing counselling frequently (Rose, Ferguson, Power, Togher, & Worrall, 2014). However, SLPs report feeling uncomfortable and unskilled in counselling (Brown et al., 2011; Brumfitt, 2006; Gibson & Purdy, 2012, Rose et al., 2014). Often the psychological needs of the PWA are noted by SLPs but circumvented (Simmons-Mackie & Damico, 2011).

Systematic Literature Search

A systematic search of the literature for studies where the aim was to improve the psychological well-being of PWA after stroke was conducted in OVID (including Medline, Embase, PsycInfo); AMED; Cochrane Library; CINAHL; SpeechBite; Health and Medical Complete; CSA Social Sciences; ProQuest complete and Google Scholar databases, up to October 2012 and five relevant studies were retrieved (Bronken, Kirkvold, Martinsen, & Kvigne, 2012; Hoen et al., 1997; Ireland & Wotton, 1996; Ross et al., 2006; Volkmer, 2006). Ψwb was primarily addressed in the post-acute stage of rehabilitation and often within a community setting. The duration of the intervention varied but was typically provided for one to two hours, weekly, or over many weeks, ranging from approximately four sessions (Volkmer, 2006) to over one year (Bronken et al., 2012).

The ideal attributes or health profession discipline to address Ψ_{wb} with PWA is unclear. Although SLPs were involved in all five of the identified studies, the Ψ_{wb} of PWA was addressed by various health professionals including occupational therapists (Volkmer, 2006), nurses (Bronken et al., 2012), social disability workers (Ross et al., 2006), trained counsellors (PWA and SP) (Ireland & Wotton, 1996) and volunteers (Hoen et al., 1997). Ireland and Wotton (1996) recommended SLPs provide specialist training to counsellors on the communication needs of PWA, that PWA may benefit from counsellors who have personal experience with aphasia and that SLPs need training in providing counselling to PWA. The authors also reported that PWA varied in their individual choice of who they thought would best provide counselling: SLP, PWA trained in counselling, or a professional counsellor who is neither. Two studies focused on group therapy as the intervention approach (Hoen et al., 1997; Ross et al., 2006) and three articles described various counselling approaches (Bronken et al., 2012; Ireland & Wotton, 1996; Volkmer, 2006).

Counselling and Group Therapy.

Counselling approaches described the use of general counselling skills including metaphors, health narratives and guided self determination to support adjustment (Bronken et al. 2012) and specific psychotherapeutic approaches including cognitive behaviour therapy (Volkmer, 2006) and brief focus psychotherapy (Ireland & Wotton, 1996). In Hoen et al. (1997) PWA suggested a number of program attributes which they felt facilitated changes in behaviour, emotion, attitude and communication and improvement in psychosocial well-being. In Ross et al. (2006) group intervention followed a social disability model.

Adapting the counselling process for PWA

All five studies reviewed (Bronken et al., 2012; Hoen et al., 1997; Ireland & Wotton, 1996; Ross et al., 2006; Volkmer, 2006) described the use of adaptive resources and

strategies in providing counselling or group therapy to PWA to address Ψ_{wb} . Hoen et al. (1997) suggested communication effectiveness (with adaption, and communication strategies for communication success) contributed to well-being and also suggested that attitude or self-acceptance of aphasia may be precursor to the use of adaptations for improving communication in PWA.

The paucity of literature, significant differences in terms and definition, study design, sample sizes and other methodological variations provided limited information for SLPs for best practice in addressing Ψ_{wb} in PWA. It is unclear the extent to which Ψ_{wb} of PWA is addressed in stroke rehabilitation and how SLPs address this given they are likely to be the key health professional involved with PWA.

Aims

Therefore this study aimed to describe current practices utilised by SLPs in directly addressing Ψ_{wb} in PWA after stroke. We aimed to investigate the reported use of various approaches identified in the post stroke aphasia literature addressing psychological health and well being, including the use of specific psychotherapeutic and general counselling skills, identity negotiation and self management, approaches including group therapy to promote maintenance of social resources, and participation and engagement in meaningful activities to the PWA. We aimed to identify SLPs' perception of their role and feelings in addressing Ψ_{wb} and if other health professionals were involved in this practice. We sought to identify any additional training and preparedness for addressing Ψ_{wb} in PWA and also to identify barriers and facilitators to this practice.

Method

Australian SLPs with recent experience working with PWA after stroke were invited to participate in an online survey (SurveyMonkey.com). The survey consisted of 26 open and

closed ended questions and was open for 1 month (see the survey in supplemental materials available online). The survey was piloted on ten SLPs from a variety of states across Australia (Western Australia, Queensland, New South Wales, Victoria and South Australia) across acute, subacute, academic, public and private settings. Positive feedback on content and reliability of the responses in the pilot indicated good content and construct validity of the survey instrument.

The survey was distributed across four data bases of SLPs in Australia including Speech Pathology Australia – SPA (the national professional body of SLPs with approximately 6,000 members), SLPs Electronic Chats, (SPECS) (a Google chat group with approximately 1104 members), SLPs in Adult Rehabilitation (SPAR) a special interest group in Victoria with approximately 83 memberships, and the Centre of Clinical Excellence in Research – Aphasia (CCRE-Aphasia) a database of clinicians, academics and researchers with approximately 236 members.

Ethics approval was obtained from the Human Ethics Committee of the Faculty of Health Sciences, La Trobe University (FHEC13/116).

The questionnaire collected the following information:

- Demographic information about the SLPs including years since graduating, perceived experience with PWA, workplace setting and any additional training (outside of SLP qualifications) in counselling
- The SLPs clinical caseload of PWA, specifically time after stroke and perceived frequency of poor psychological health of PWA in the caseload
- SLP's beliefs about Ψ_{wb} in PWA and perceived role in addressing Ψ_{wb} in PWA

- SLP's perceived knowledge, confidence and satisfaction in assessing and addressing Ψ_{wb} in PWA and with providing informational and supportive counselling
- Current clinical practice in assessing and addressing Ψ_{wb} in people with aphasia
- The health professionals that commonly provide intervention in addressing Ψ_{wb} in PWA
- Barriers and facilitators in addressing Ψ_{wb} in people with aphasia.

Data Analysis

Categorical data (both rank order and nominal data) was collected on closed questions. Raw counts and percentage counts were computed and descriptive statistics provided using SPSS version 21. Chi Square tests (X^2) were used to examine the relationship between additional training in counselling and perceived knowledge of, confidence in and satisfaction with managing Ψ_{wb} in PWA. The option to provide comments in open ended questions was available in many questions including the final question (Question 26) where respondents had the opportunity to provide any further comment about their experience in this area and about the survey. This paper reports mainly on the quantitative data collected from the survey. SLP's optional open ended data will be reported in a companion paper.

Results

Participants and Response Rate

The survey required compulsory consent but otherwise all questions were optional. A total of 123 respondents attempted the survey. Twelve surveys that were less than half complete were discarded and 111 surveys were analysed. Recently, Rose et al. (2014) conducted a survey of SLP general practice in aphasia rehabilitation targeting the same population as this survey and analysed 188 surveys which they estimated to be approximately

33% of the population. The response rate in the current study was slightly lower than this estimate which may be due to the pool of Australian SLPs experiencing response fatigue after a high amount of research surveys at the time (nine surveys over two years) emanating from the Centre for Clinical Research Excellence in Aphasia Rehabilitation (ccreaphasia.org.au).

Demographic Information

Years since graduating as a SLP ranged from 1 to ‘40 and over’, with a mean of 11.7 years (SD: 11 years), a mode of 4.0 years, and a median of 7.0 years. Responses were collected from all state and territories of Australia except the Australian Capital Territory with the three most populous states of Australia being strongly represented: 40.1% from Victoria; 26.4% from New South Wales and 17.0 % from Queensland. The majority of SLPs worked in capital cities (68.5 %) followed by regional cities (26.1%) and regional towns (5.4%) and worked across multiple settings (table 1). There were no responses from remote or very remote areas. Workplace settings across the continuum of health care and from the private and public services were represented.

(insert table 1 about here)

Table 2 displays the percentage of SLPs treating PWA at various times post onset of aphasia, with the most frequent time (66%) being from one month to six months post stroke.

(insert table 2 about here)

SLP’s Beliefs about Addressing Psychological Well-Being in People with Aphasia

Nearly all SLPs (99.1%) believed PWA were at a high risk of experiencing psychological difficulties after a stroke and the majority (85.4%) felt that at least 50% or more PWA on their caseload had poor psychological health. A majority (98.2%) of SLPs (*n*

=110) felt they have a role to play in addressing Ψ_{wb} in PWA. When asked how frequently SLPs addressed Ψ_{wb} in PWA (on a five point scale; 1=never, 2=rarely, 3=sometimes, 4=most of the time, 5=always), 47.3% (mode) of SLPs reported addressing Ψ_{wb} ‘most of the time’ and 28.2% reported ‘always’ addressing Ψ_{wb} in PWA.

SLPs were asked when it would be important to address Ψ_{wb} in PWA. 87.4% of SLPs believed it important to address Ψ_{wb} at any point of time after aphasia; 50.5% for many years after aphasia; 65.8% when the PWA requires it; 47.7% when the PWA do not have adequate social support. 40.5% of SLPs believed Ψ_{wb} was important to address especially in people with moderate or severe aphasia.

Usual Practices in Assessing and Managing Psychological Well Being

All respondents informally assessed Ψ_{wb} and selected more than one type of informal assessment. They reported using formal assessments for Ψ_{wb} infrequently as described in table 3.

(Insert table 3 about here)

Clinical approaches including group therapy

SLPs reported frequently using all the listed therapeutic approaches with some approaches being used more frequently than others. Training staff and significant others in supportive conversation strategies to enable them to address Ψ_{wb} in the PWA and referral to peer support groups were the two most *infrequent* approaches. See figure 1.

(Insert figure 1 about here)

Counselling

SLPs reported very frequently practicing a range of counselling strategies identified from the literature (See figure 2).

(Insert figure 2 about here)

Most SLPs (84.3%) reported not or rarely using specific psychotherapeutic techniques with PWA. The most commonly reported techniques were motivational interviewing (19.8%), narrative therapy (18.8%), and coaching (14.4%).

Use of the multidisciplinary team

All but one SLP referred to or sought support from a range of other health professionals to address Ψ wb in PWA ($n=111$), most frequently from social workers (81.1%), clinical psychologists (66.7%), doctors (63.1%) or neuropsychologists (48.6%). See table 4.

(insert table 4 about here)

Barriers and Facilitators to Addressing Psychological Well-Being in People with Aphasia

Table 5 and 6 list the perceived barriers and facilitators to addressing Ψ wb in PWA.

(insert table 5 and 6 about here)

SLPs perceptions of knowledge, confidence and satisfaction in addressing Psychological Well-Being

SLPs were asked to rate their self perceived knowledge of, confidence in and satisfaction with assessing and managing Ψ wb in PWA and in providing informational counselling and supportive counselling to PWA. Earlier in the survey, SLPs were asked to rate their self perceived knowledge of, confidence in and *experience in working with PWA*. These factors were rated on a four point scale; 1=strongly disagree; 2=disagree, 3=agree; and

4=strongly agree which were collapsed into 2 points; 1 (disagree) = SLPs who reported strongly disagreeing or disagreeing with feeling knowledgeable or confident or experienced and 2 (agree) = SLPs who reported strongly agreeing or agreeing with feeling knowledgeable, confident or experienced working with PWA.

The majority (95.5 %) of SLPs agreed with feeling knowledgeable and confident working with PWA and 88.3 % ($n = 111$) felt experienced working with PWA. The results are displayed in figure 5.

(insert figure 3 about here)

Relationship between Counselling Training and Knowledge of, Confidence in, and Satisfaction with Addressing Psychological Well-Being

SLPs were asked to identify any additional training they had undertaken beyond their speech pathology qualifications that may inform or assist them to provide counselling to PWA. The highest qualification selected by each participant was then coded into one of two categories: Group 1- no formal training in counselling (no additional qualifications or training in counselling outside of SLP qualifications; professional development or education less than one day); Group 2 - some formal training in counselling (short courses one day to three months; graduate certificate or diploma in counselling, psychology or related fields; post graduate degree or higher in counselling, psychology or related fields). See table 7.

(insert table 7 about here)

In order to explore the hypothesis that SLPs who had formal counselling training would feel more able to address Ψ_{wb} , a series of Chi Square tests for independence were used. A significant association was found between having additional qualifications in counselling and knowledge of ($X^2 (1, n=105) = 7.24, p = 0.007, \phi = 0.285$), confidence in

(X^2 (1, n=105) = 7.50, $p=0.006$, $\phi = 0.291$), and satisfaction with (X^2 (1, n=105) = 8.33, $p=0.004$, $\phi = 0.306$) managing Ψ_{wb} in PWA. The effect sizes (ϕ coefficient value) using Cohen's criteria (1988) indicate small - medium effects.

Discussion

SLP Practice in Addressing Psychological Well-Being in People with Aphasia

SLPs were united in the belief that PWA are at high risk of poor psychological health which affects rehabilitation outcomes and that Ψ_{wb} in PWA is important to address, consistent with findings from previous studies (Brumfitt, 2006; Gibson & Purdy, 2012). Although 95.5% of respondents reported feeling knowledgeable and confident to work with PWA after stroke, the majority did not feel knowledgeable (58.3%), confident (68.5 %) and satisfied (69.4 %) managing Ψ_{wb} in PWA. Indeed 63.7% SLPs reported their feelings of being underskilled in managing Ψ_{wb} to be the primary barrier to this practice. SLPs reported more frequent practice in providing *informational* counselling than *supportive* counselling with PWA. However, somewhat surprisingly, SLPs also reported very frequently practicing a range of counselling approaches. This discrepancy may reflect practitioners' misunderstanding of terms and definitions of counselling (Brumfitt, 2006; Carota et al., 2002; Herrmann, 1997; Parr, 2001), such that they associate many of the supportive practices they reported with *informational* rather than *supportive* counselling. In this study we attempted to minimise misunderstanding by provision of definitions of relevant terms at the start of the questionnaire.

Support from the Multidisciplinary Team

Consistent with the literature review and in the Australian survey by Rose et al. (2014), the current study found that SLP practice of addressing Ψ_{wb} appears to be largely with the support from other health professionals who were seen to be better equipped to assess and

manage Ψ_{wb} . However, 37.2% of SLPs identified that a barrier for PWA to receive psychological support from relevant health professionals in the team is that ‘The relevant staff who can address psychological health feel under skilled to manage PWA’. This point is supported by Rowland and McDonald (2009) who acknowledged that social workers required specialised communication skills when working with aphasia and argued for inclusion of this training in undergraduate social work programmes to enable PWA to engage in ‘healing conversations’ or gain access to other social work services. It is therefore a concern that only 32% of SLPs very frequently (‘most of the time’ and always) trained staff involved in counselling strategies to support conversation.

Recommendations

The barriers and facilitators listed highlight various attributes of SLPs, professional practice guidelines, rehabilitation services, counselling staff and PWA (and families) which warrant further investigation. For example, the two most frequent facilitators (personal or professional interest and experience) to addressing Ψ_{wb} in PWA may indicate the positive relationship of training or clinical ‘maturity’ to this practice. Limited service resources including time, appropriate staff availability and skill (to work with PWA) were key barriers in addressing Ψ_{wb} . This is consistent with findings by Rose et al. (2014) as major service challenges in aphasia rehabilitation.

Themes from studies in HRQOL and ‘successful living’ in people with aphasia (Brown et al., 2012; Grohn et al., 2012; Hilari et al., 2012) appear consistent with aspects of Ryff’s (1995) six dimensions of Ψ_{wb} . Thus Ryff’s (1995) Ψ_{wb} model may provide a framework for health care workers in stroke rehabilitation to address Ψ_{wb} in PWA. Research into the practical application of each dimension of self-acceptance, purpose in life, environmental mastery, positive relationships, personal growth and autonomy is warranted.

Group therapy where peer support is readily available is likely to be beneficial for Ψ_{wb} (Elman & Bernstein-Ellis, 1999, Hilari et al., 2012; Lanyon et al., 2013). SLPs need to ensure that the opportunity to promote Ψ_{wb} is available to PWA either via family members (by training family members to effectively communicate with PWA), peer support (e.g., via community aphasia groups, individual peer support meetings and social media).

This study concurs with a number of other studies which identify that SLPs feel under skilled in addressing psychological health in or providing counselling to PWA and suggest further training in counselling PWA may be useful (Brumfitt, 2006; Gibson & Purdy, 2012; Phillips & Mendel, 2008; Rose et al., 2014). More research is required on the specific training needs of SLPs to better prepare them to address Ψ_{wb} in PWA after stroke.

Shipley and Roseberry-McKibbin (2006, p. 144) note that most SLPs due to a lack of formal training in counselling, are uncertain of the boundaries between counselling, guidance and psychotherapy. Unclear role definition and clinical practice boundaries were frequently noted in this study to be a key component of SLPs practice in addressing Ψ_{wb} in PWA. Thirty-one percent of SLPs reported that a facilitator to addressing PWB is if the 'definition in my role encourages me to' and conversely 13.3 % of SLPs reported that the definition of their role does not include addressing Ψ_{wb} . Clinical guidelines are required which include appropriate SLP support and supervision, and role definition that values and supports SLPs to directly address Ψ_{wb} in their clients with aphasia.

SLPs also need to support staff involved in counselling and psychotherapy so that counselling may occur despite communication impairments. Adaptation of the context to address Ψ_{wb} , for example with the use of supportive communication aids, resources and training, is essential. Collaboration between the counselling professions, SLP and PWA to investigate how the delivery of counselling or psychotherapy is different with PWA, is recommended.

Declaration of interest: This study was undertaken as requirements towards post graduate qualifications by Jasvinder Sekhon. The second author was supported by an Australian Research Council Future Fellowship (FT 100100446). The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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Figure 1. Frequency of clinical approaches used to manage Ψ_{wb} in PWA. (Comm. = Communication)

Figure 2. Frequency of counselling approaches used by SLPs to address Ψ_{wb} .

Figure 3. Self perceived ratings of knowledge in, confidence of and experience working with People with aphasia (PWA), $n = 111$. Self perceived ratings of knowledge in, confidence of and satisfaction with assessing and managing PWB and in providing informational and supportive counselling to PWA, $n = 108$.

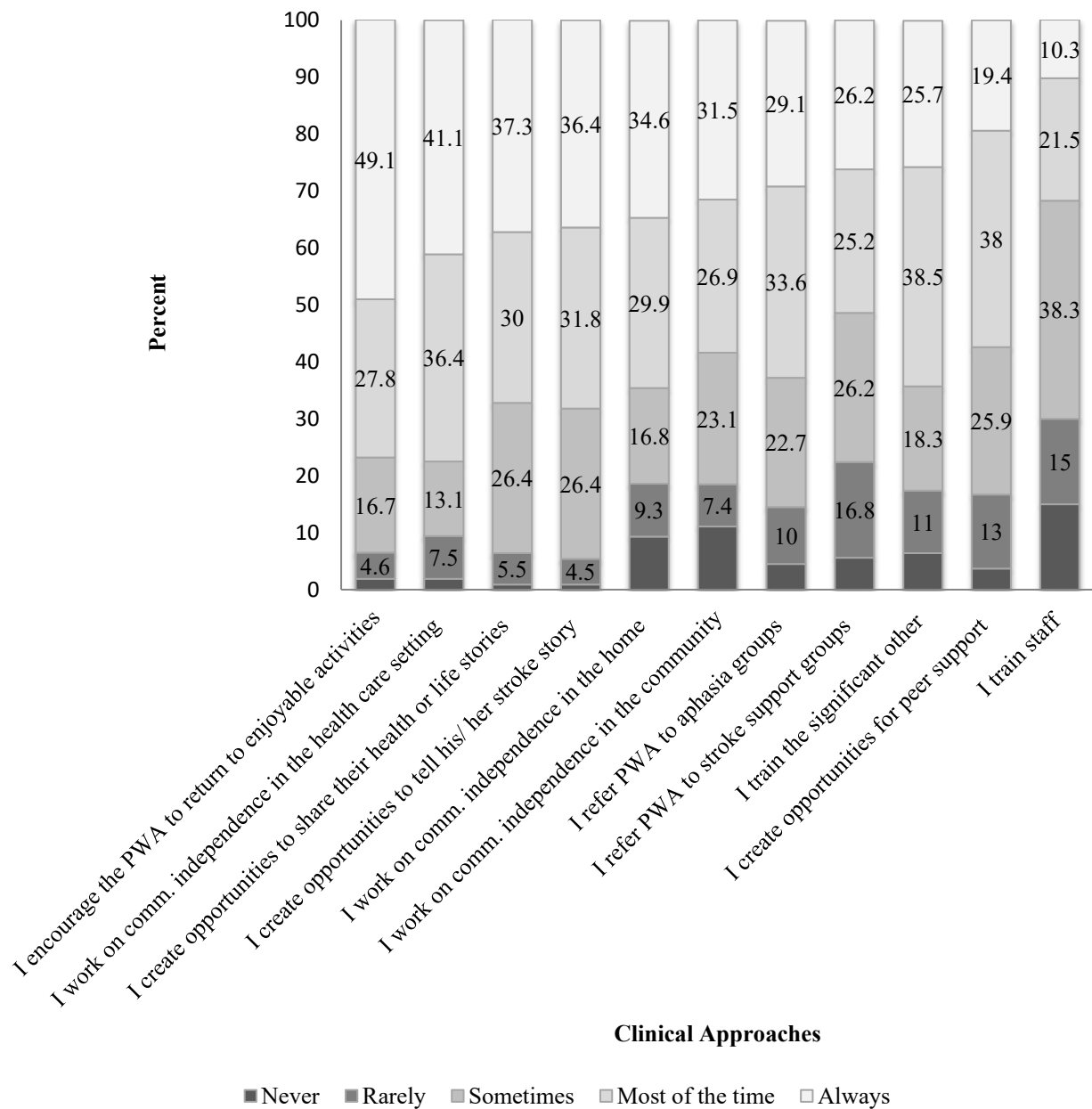


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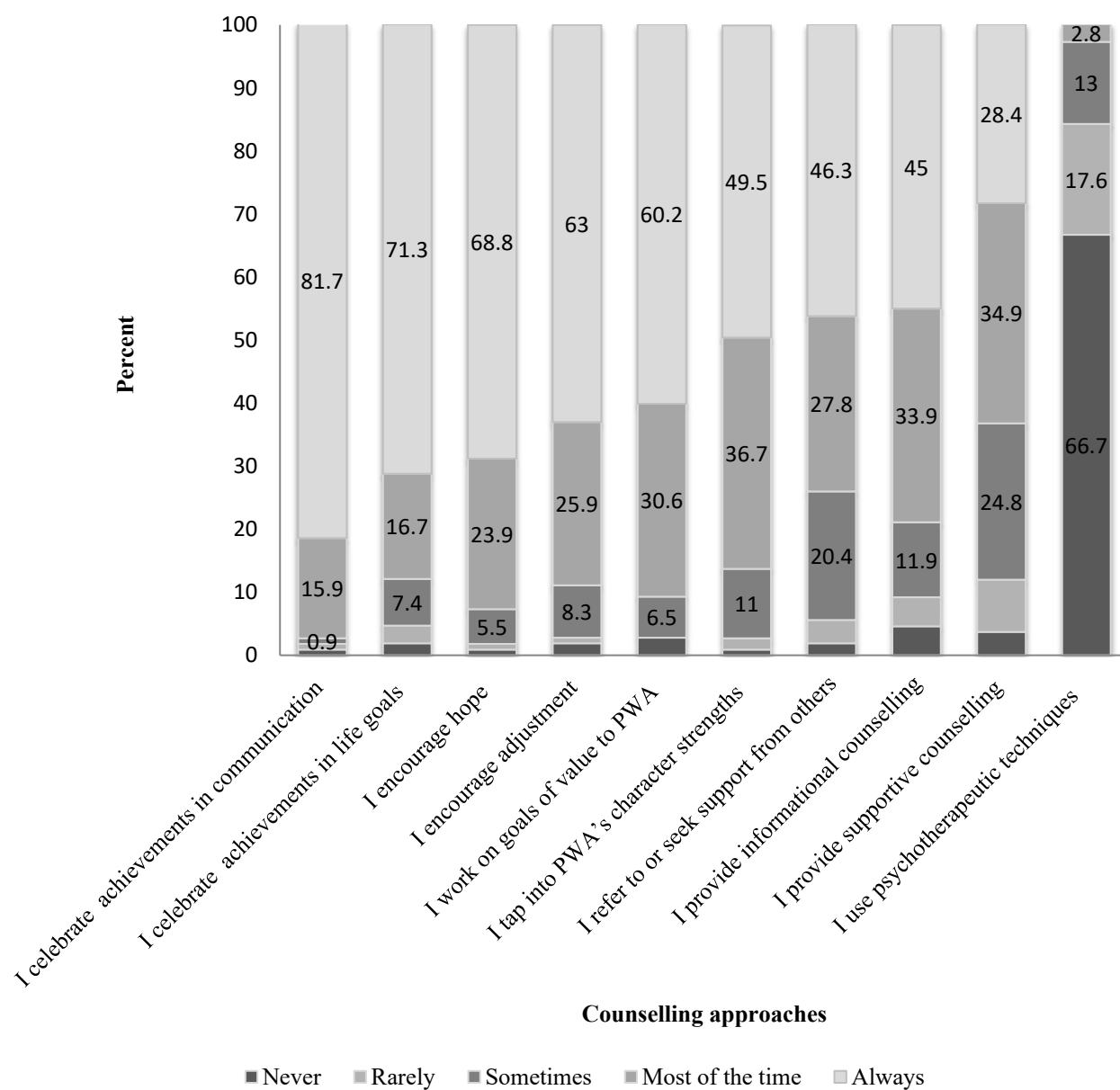


Figure 2. Frequency of counselling approaches used by SLPs to address Ψwb.

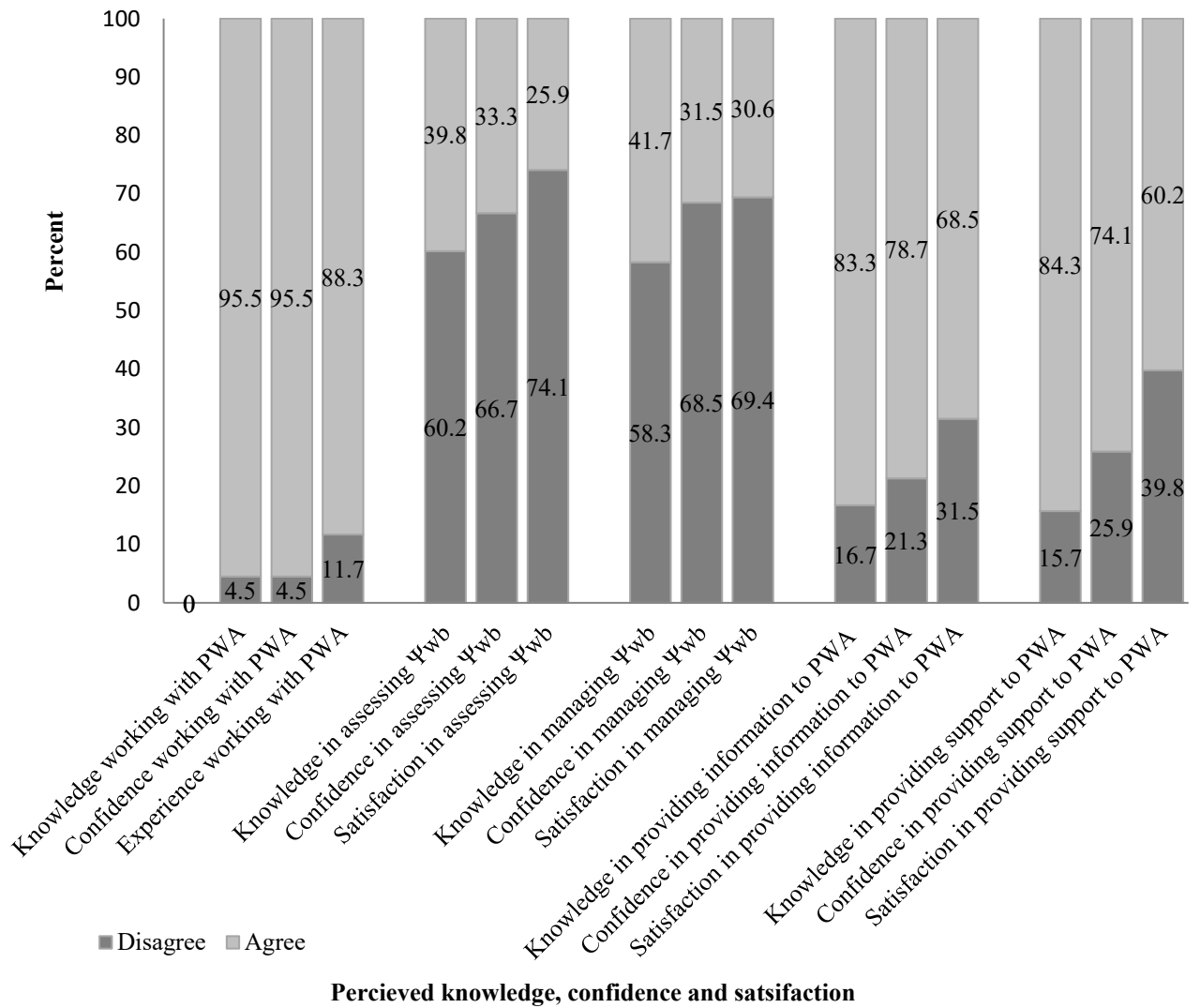


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Table 1

Reported workplace settings (multiple settings allowed)

Workplace setting	% (n= 111)
Acute hospital	62.2
Subacute hospital	69.4
Ambulatory community	41.4
Community health	22.5
Teaching facility	7.2
Residential facility	9.9
Private organisation	9.0
Public organisation	5.4

Table 2

Time post onset of people with aphasia on SLP caseload

Time post onset of PWA	% (n=111)
Less than 1 week	33.3
1 week to 1 month	45
1 month to 6 months	65.8
6 months to 1 year	47.7
1 year to 3 years	43.2
Over 3 years	30.6

Note. SLP=Speech language pathologist; PWA= person/ people with aphasia

Table 3

Highest additional counselling training outside of SLP qualifications

Additional training in counselling				
% (n=108)				
No additional training	^a Professional development less than 1 day	^b Short courses 1 day to 3 months	^c Graduate certificate/ diploma	^d Postgraduate degree / Masters/ PhD
62.0	11.1	16.7	2.8	7.4
No formal counselling training (1)		Some formal counselling training (2)		
73.1		26.9		

Note. SLPs = speech-language pathologists; SLPs were asked to list any additional training or education they have over and above their SLP qualifications. *a* includes continuing education, personal reading, seminars etc of less than 1 day. *b*, *c* and *d* relate to additional training or education (including similar to those listed) in counselling, psychology or related fields.

Table 4

Frequency of informal and formal assessments used by SLPs to address Ψ wb in PWA in order of most frequent to least frequent

Informal	%	Formal	%
By Observation	95.5	I do not formally assess Ψ wb	44.1
The PWA tells me	94.6	AusTOMS	25.2
Using clinical judgment	91.0	SAQOL	19.8
Significant other tells me	89.2	VAMS	18.9
From team discussion	82.0	CAT Disability Questionnaire	18.2
From case history	65.8	VASES	15.3
Gut feeling	55.0	Communication Disability Profile	13.5
I do not informally assess Ψ wb	0.0	HADS	8.1
		ADRS	6.3
		SDAQ	5.4
		GHQ -12	0.0

Note. SLPs = speech-language pathologists; Ψ wb = Psychological well – being; PWA = people with aphasia; AusTOMS = Australian Therapy Outcome Measure (Perry et al., 2004); SAQOL = Stroke and Aphasia Quality of Life Scale (Hilari, Byng et al., 2003); VAMS =

Visual Analogue Mood Scale (Folstein & Luria, 1973); CAT = Comprehensive Aphasia Test (Swinburn, Porter, & Howard, 2005); VASES = Visual Analogue Self Esteem Scale (Brumfitt & Sheeran, 1999); HADS = Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983); ADRS = Anxiety and Depression Rating Scale (Hamilton, 1960); SDAQ = Stroke and Depression Aphasia Questionnaire (Lincoln, Sutcliffe & Unsworth., 2000); GHQ - 12 = General Health Questionnaire (Goldberg & Hillier, 1979).

Table 5

Health Professionals that SLPs seek support from or refer to in addressing Ψwb in PWA

Health professionals that SLPs seek support from or refer to	% (n=111)
Social worker	81.1
Clinical psychologist	66.7
Doctor	63.1
Neuropsychologist	48.6
Senior speech pathologist	25.2
Occupational therapist	21.6
Nurse	20.7
Case manager	14.4
Other counsellor	12.6
Psychiatrist	9.9

Stroke case coordinator	7.2
I do not refer or seek support from other health professionals to address PWB	0.9

Note. SLP=Speech-language pathologist; PWA= person/ people with aphasia;
 Ψ wb=psychological well-being.

Table 6

Barriers to addressing Ψ wb as perceived by SLPs, in order of frequency

Barriers	% <i>n</i>=111
I feel under skilled in addressing Ψ wb	63.7
The allowed length of stay of the service limits my time to address Ψ wb	42.5

The relevant staff who can address psychological health feel under skilled to manage PWA.	37.2
PWA often decline to seek professional help to address Ψwb	35.4
I do not have adequate time in my job to address Ψwb	34.5
There are few appropriate staff to refer the PWA to	34.5
I have limited experience in addressing Ψwb	23.9
The relevant staff who can address psychological health are resistant to manage PWA	18.6
The definition of my role does not include addressing Ψwb	13.3
I do not have appropriate supervision to address Ψwb	8.8
I do not have adequate supervision to address Ψwb	8.0
I have no personal interest in Ψwb	0.0

Note. SLP=Speech-language pathologist; PWA= person/ people with aphasia;
Ψwb=psychological well-being.

Table 7

Facilitators to addressing Ψwb as perceived by SLPs, in order of frequency

Facilitators	% <i>n</i>=111
I have a personal interest in Ψwb in PWA	66.4
I have personal and /or professional experience that helps me address Ψwb	49.6
There are appropriate staff who can address Ψwb to who I can refer	38.9
The definition in my role encourages me to address Ψwb	30.1
The length of stay of my service allows for adequate time to address Ψwb in PWA	23.0
I have adequate time to address Ψwb in PWA	21.2
The relevant staff who can address Ψwb are easily available	20.4
I have appropriate supervision to address Ψwb	20.4
I have adequate supervision to address Ψwb	16.8
The relevant staff who can address Ψwb feel confident in managing PWA	13.3
The relevant staff who can address Ψwb are skilled in managing PWA	11.5
I have extra training in addressing Ψwb	10.6

Note. SLP=Speech-language pathologist; PWA= person/ people with aphasia;
Ψwb=psychological well-being