



**Show Notes - Episode #35**  
**Therapy in Transit using LPAA in Acute and Sub-Acute Settings:**  
**A Conversation with Deborah Hersh, Ph.D.**

During this episode, Dr. Katie Strong, Assistant Professor in the Department of Communication Sciences and Disorders at Central Michigan University talks with Dr. Deborah Hersh about Meeting in the Middle: Augmenting Person-Centeredness in Acute and Sub-Acute Post-stroke Aphasia. Material from today's episode was first presented at the 2018 ASHA Convention in Boston, MA. There was such a great response to this talk that we invited Deborah to join us on the show to share this material with those who weren't able to attend this session.

*Deborah Hersh, Ph.D., is an Associate Professor in Speech Pathology at Edith Cowan University in Perth, Western Australia. She is a Fellow of Speech Pathology Australia and Deputy Chair of the Australian Aphasia Association. She has 30 years of clinical, research and teaching experience in speech pathology in the UK and Australia. She has published and presented extensively in the areas of discharge from aphasia therapy, professional client relationships, aphasia groups, rehabilitation goal setting, aphasia assessment and acquired communication disorders in Aboriginal Australians following stroke and brain injury. Deborah is interested in how people with aphasia experience rehabilitation and how SLPs can make their recovery journey more person-centered, inclusive and successful.*

**In this episode you will:**

- hear the analogy of 'therapy in transit' as applied to acute and subacute aphasia care and how LPAA applies to participation in hospital settings
- learn how therapeutic assessment differs from traditional assessment
- expand your collaborative skills through the SMARTER goal setting framework
- learn how to approach discharge in a collaborative manner

**Deborah, to start off with, could you tell us a bit about what you mean by 'meeting in the middle?' and how that relates to person-centered care?**

DH: I was interested in that idea of person-centered, with the person with aphasia and their family being absolutely in the *middle* of everything happening in acute and subacute care, conveying that the speech-language pathologist (SLP) would accommodate the client and their family as being absolutely central. However, in addition to that, I felt there was a need



for SLPs to metaphorically move toward the patient, giving them much more opportunity, and meeting them half-way or in the middle. It's very much a partnership idea.

**In your 2016 *Aphasiology* article you beautifully describe post-stroke rehab as 'therapy in transit'. Could you tell our listeners about what you mean by this?**

DH: In that paper, I was really drawing on this analogy of somebody taking a flight where they think they're going to a particular destination in a particular way and finding that they are derailed. The flight is canceled. And the analogy with that was people who have just had a stroke. Earlier that day, think they're doing something and suddenly this thing happens, and they are totally derailed. There seem to be some interesting parallels between that and the idea of being caught an airport when it wasn't your plan to be there. And you don't know when you're flying out. And in some cases, you don't know where you're flying to. And that uncertainty, that disruption has a parallel to what happens to people when they find themselves in hospital. It wasn't what they were planning, it wasn't what they were expecting. They don't know when they're going to leave. And in some cases, they don't know where they're going to be discharged to. There are major issues there often for people who think that they're going to be going home and then find that either they're going for several months into rehabilitation or may not actually be going home at all which is incredibly frightening, I think, and disturbing for people.

But on top of that, there are other things that happen. And in this paper, I try and describe the parallels by talking about, for example, we all know that when we're sitting in an airport, waiting for connection that may not be there when we expected it to be there. Everybody around you is rushing. Everyone around you is rushing from place to place. And there's an awful lot of sense of being in the middle of busy, busy people running around. And that's very similar to a hospital ward where people are watching nurses running from place to place, or therapists dashing in and then dashing out again. And, at the same time as everyone looking very busy, and they are very busy, there's that sense that that you, as the person post stroke, are waiting for that plane.

There were some very interesting papers that I cited in that 2016 article which said that people were exhausted by waiting around. That uncertainty, that feeling that you don't know when something is going to happen, is actually very cognitive tiring. So, patients may be waiting a lot for things to happen. They're very uncertain in this midst of people rushing about. And so there were just these interesting parallels with being in transit. That's what I was really trying to capture.

And the other thing is it ties in with some research, again, that suggests that people with aphasia actually have less communication in the hospital setting than those without. They may spend a lot of time alone. And a lot of time just waiting for things to happen. Another



study that I did that was also published in that 2016 special issue in *Aphasiology* was looking at how nurses interact with people with aphasia on the wards. Nurses are often quite stuck, very task focused, and they don't hang around for a lot of conversations. They're very busy. So, I think that just compounds that notion that people are waiting around, and they're not sure what their destination is. So, the message in there is really that we as SLPs need to look harder at how to support people's sense of control, and to help them to know at least as much as is known about the plan for them, and to help offset that unsettling feeling of being in transit.

**Often clinicians think of the life participation approach to aphasia as being implemented later in the recovery process, like in outpatient or community-based services, but your message really speaks about how LPAA can be applied directly to acute and sub-acute settings.**

DH: What's interesting there is that there's so much more work to do in acute and subacute settings because people do feel so disempowered. So, to assume that a participation approach to life only starts after the hospital is a bit weird, because life is still in the hospital. And there is so much more that we could be doing in that essentially very disempowering context for people. In fact, it's all the more necessary to bring a life participation approach to that context, because that's when people need it most. I suppose it's the most overwhelming, everything is new, people that are in shock. I'm not suggesting that people bound in, you know, immediately and say, 'I can take control', because, obviously, they're in shock, and often very, very unwell in that context and need an awful lot of support, and also an awful lot of rest. I know that fatigue is a major issue.

However, having said all that, I think that the lack of information that people experience in hospital and sub-acute environments is quite profound. And it just exacerbates that feeling that they don't have control in that context. So, there are things that can be done to help explain, to give people a little bit of time, to really orient them to where they are. And if I took the transit analogy even further, you know, it would be the equivalent, perhaps, of being landed unexpectedly at an airport or not being told which country you're in. People will often say which hospital am I in? You know, it's that unsettling. So, there's no reason why an LPAA approach to intervention, to assessment, shouldn't apply in that context.

**During this transit, patients move from setting to setting, and clinician to clinician and at each point they are reassessed. What are some of the consequences of focusing on assessment during these early stages of recovery?**

DH: The whole assessment thing is really interesting. We know that if we're in a context, again, where we are being assessed, or example if you're going in for an exam or some kind of medical test, it's a worrying thing, because you know that that the reason you're there is



because something is wrong. And so essentially, you know that the health professional is usually looking for deficit. They're looking for what you're doing wrong. And if everybody who comes to see you comes to do this, so do the assessments over and over again, which they do, (and we all know why we have to do that), they're being shown their deficits over and over and over again.

A number of people have said to me, during interviews looking at experiences of being in hospital, that they just get fed up, you know, "why haven't these health professionals spoken to each other? I told the last person that." There's a feeling of irritation about being exposed in that way, over and over again. So, on top of what we've already discussed about that feeling of powerlessness, you also that when somebody does come and see you, having hung around waiting for something to happen, when they do come and see you, they find out, you know, something wrong. They find out that you have an impairment. And sometimes they will expose an impairment that you didn't even know you had. Because if you haven't had much chance to talk to people, when you finally do get somebody coming to talk to you, it might be only at that point that you realize that your word finding difficulties really are quite profound. And then you're made possibly to feel like you're incompetent. And then the person goes away again, and you're left sitting there for another few hours feeling incompetent. I think there are consequences for that, even though we know why we have to run these assessments.

As a clinician, you know, if I'd found an assessment written up, you know, perhaps an informal assessment or a screen written into the medical notes for somebody who'd been seen yesterday or the day before, knowing that there's quite a lot of change in that early period, I would probably have gone back and run the assessment again, anyway. So, I understand why we do it. But from the patient's perspective, there's that feeling of being assessed all the time.

**You've developed an approach, therapeutic assessment, that offers an alternative to traditional assessment. Could you walk us through what this involves?**

DH: The ideas for this come from a range of different places. But essentially, the ideas in therapeutic assessment are that when you assess somebody, you should effectively be assessing the supports that they that they want and need. So, it's an assessment *of* support. But it should also be an assessment *with* support. And then the idea of assessment as a support. So that, essentially the person with aphasia should come away from that assessment feeling better about the knowledge that they have gained, or better about the way that things have been explained during that assessment, that the assessment itself as an interaction should be a supportive interaction.



And so, sort of digging into that a little bit further, what I've claimed here is that assessment itself needs to be therapeutic. There are some reasons why that's important. One of them is a very pragmatic reason. We actually have very little time seeing people with aphasia in the acute and sub-acute setting. Often the time that we spend in hospital settings is focused on dysphagia work. And Abby Foster and her colleagues have written a lot about this, that you know, that that SLPs are often focusing on the swallowing issues because of the implications for discharge. And the time is very short. That's another issue with assessment that if the time that you do have with a patient is very much focused on assessment, then people may feel 'well where's the therapy?' You've found out what's wrong, but there's no time to provide therapy.

So, in terms of making good use of the time that you do have with somebody with aphasia, I'd be arguing that if you are going to run an assessment, make that assessment session as therapeutic as you can so that you're actually making really good use of your time. So, it should be seen as a positive aspect of intervention. And, currently, I think that a lot of patients don't see the assessments as positive interactions. They don't learn an awful lot from them. And the other thing is that traditionally, assessments are sequential, so you do your assessment, and then you do your therapy. But the idea and therapeutic assessment is that the assessment is part of the therapy. It is a therapeutic process. So normally, formal assessments are fairly controlled. The clinician has a particular thing they have to say, and they have to remain neutral. And it's very much a traditional, controlled kind of environment. And again, often deficit focused as well.

Therapeutic assessment tries to do something different in three main ways.

- Therapeutic assessment should be woven into therapy. Similar to a dynamic assessment approach that we see much more commonly in the pediatric setting. So, you can actually look to see how somebody performs with a task, but then actually weave some therapeutic process into that, in order to see how they manage in that supported context.
- Therapeutic assessment is built on adult learning principles. We know that adults learn best when they can take some responsibility for their learning. In order to do that, they need to know why they're doing what they're doing. And they need to feel that it's relevant to them, that they understand the rationale for that assessment. And they are in the picture, they have some information about it. And we know, from the education world, the adult learning worlds, that you can have summative assessments that basically assess how you manage to learn something, assess how much you know. And then there are formative assessments where you learn through the process of the assessment. By doing the assessment, there is some learning from that. In therapeutic assessment, we could make it formative, so that the process



of doing the assessment with the therapist could itself be the learning opportunity. It's not that anything that I'm saying is new in itself, but we're not applying what we know about how people learn to a rehabilitation context. We could be doing that so much better. It's interesting, with that issue about adult learning theory and assessment, we tend to go into assessments in order to find out about somebody. We go in to look for information on someone. But we very rarely step back and say, "what information did they come away with as the person being assessed from that assessment?" And I would say, you know, from talking to people with aphasia, "so the therapist has just come in and run an assessment with you. What was that like for you? What have you gained from that?" And usually, they look a bit blank. So "well, she showed me some pictures". "And then what?" People with aphasia very rarely know why they did that. And they may not know the results of what they did. Because also we don't often (having run an assessment that's a bit of a WAB or something like that) say, "Okay, now you scored this, that means this. Let me explain that to you. Okay, let's try something slightly different from that". Because, of course, this isn't part of the protocol for running assessments, so we wouldn't leave the protocol. But the person with aphasia is coming away with very little understanding of what they've actually done during the assessment. So, if we were able to move off that and then say, "Okay, you see in that that task, you made this mistake. Or you managed to do that. So, this was really good. What that means is x y z." We tend not to explain things very well during assessment sessions, because they're separate from therapy sessions. But if they were seen as part of therapy, then people might actually gain something different from that experience.

- Therapeutic assessment includes context. It's about seeing people within their environment within that context, and actually looking at the assessment that's context relevant. For example: How is that person functioning with their visitors in the hospital? How are the family managing with them? Is a noisy environment in the ward impacting them, etc. So, it's far more context bound to make assessment very relevant to people to help them understand the rationale behind it and to actually see that what you're doing is directly relevant to how they're functioning in that place.

I think this is because we see assessment sessions as separate from therapy. And so, you'd almost be invalidating your (standardized) assessment if you start mixing it up with other things. And that raises all sorts of interesting issues, then about the relationship between formal and informal assessment, and what is considered robust. I know that the financial situation in the U.S. is that you're having to come up with measures and numbers. And it's important for the information that a clinician is gathering on the patient. But it doesn't necessarily empower the patient within that process in the way that a more fluid assessment approach might be able to do. So that it is a bit of a balance. I understand why we're doing





what we're doing. But it doesn't help "meet in the middle", if you like, I'm going back to that idea of "meeting the middle". It's about us giving something to the patient to allow them to come forward and start collaborating with us. We cannot expect that partnership or collaboration approach, or we can't expect them to participate, going back to an LPAA idea, if we don't give them the information. It's like, again, being stuck at the airport, you don't know where you're going. You have to give people information in a way that's accessible to them at that point with their aphasia, so that they can actually meet you halfway. They can come forward and say, "This is what I want. Or why have you asked me that? Or if you did this, I might be able to do it better?" We're not giving them that opportunity.

**Goal setting is such an important part of the assessment process but also seems to be a big area of challenge. What are some of the challenges that have been identified in goal setting?**

DH: With goal setting, if it's a collaborative process we are expecting people to contribute to their goal setting discussions and negotiations. And some of the work such as Rose William and colleagues who I've cited in my papers on this, some research has suggested that people post stroke may have quite different goals to their therapists. And at that point, that is seen as a challenge, because their goal may be too big, it's difficult to break down into steps or whatever. And so, some clinicians have admitted in research papers that they're quite happy to ignore those goals and work on the things that they think are feasible. And so that's one challenge. It's all very well, if a patient puts forward a goal where you can see you can work on that. If they suggest something that you actually genuinely think you can't work on, then what do you do? So, in that context, clinicians often, you know, replace it with their own goals.

And obviously, having aphasia or having memory issues or having cognitive issues is going to impact. Lack of insight particularly is going to impact on people's ability to contribute to goal setting. However, despite that, there are still things that that health professionals do, which make it harder for people to goal set. So very simple things often. For example, a number of studies have been done, which have shown that after a goal setting discussion, very rarely are people given any record of that discussion to go away with. So, they may not be given anything, again, accessible that they can think about or mull over. And if you've already got somebody who's got some issues post stroke, cognitively, then they may have forgotten by the time they see you again what it was that was said because they're not given any information that allows them to hold that record. So, there are some basic things that could be done. The other thing is just those discussions themselves, how aphasia friendly are they? How inclusive are they? Are family members invited? How is the material presented?



Even the word *goal* or the term *goal setting* can be quite foreign to people. Therapists that I've spoken to have often said that they will change the wording with patients because they recognize they're not being understood. So, they might just say, "What's important to you?" Or "what would you like to work on?" And that makes absolute sense, because it's language that people can get at that point.

But if you go back to the transit idea, and you look at the level of disorientation and confusion and change that people have to deal with in that acute and sub-acute setting, people may have difficulty actually knowing what is feasible, what is possible. They may have ideas that change day by day, because they're functioning is changing day by day, and so on. There are lots of things to consider; how accessible the material is; how its presented; how often you go back and revisit those goals; who's involved in setting them; how realistic they are; and so on.

I think one of the key things that challenges that notion of collaborative goal setting is this very pervasive idea of having to have a SMART goal. And I say that as an educator, where we teach our students about smart goals and how important it is to have smart goals. And there's a lot of evidence to support setting SMART goals. So, I'm certainly not saying that we shouldn't be doing that. But if you have a clinician who is looking for something very specific, very measurable, something that they consider to be achievable (and bearing in mind, they may have quite a short time frame to be working in), what's realistic to the therapist may not be realistic to the patient, or vice versa. And then this time-bound notion, which so dominates what we do. We're squeezing the person with aphasia into the time that we have available rather than developing services which meet the needs of a condition like aphasia, which may not fit the time boundaries that we set for it. And so the biggest challenge, I think, to goal setting is that SMART goals may actually not fit the concepts of change and desire for the future that people hold when they are disorientated and when they're in an environment where we understand rehab, but they may have never thought of it before and need to time to understand this new context that they're in.

**Deborah, what I love is that you don't stop with just identifying challenges, but you offer up solutions! I'm excited for our listeners to have you share the collaborative, patient-centered SMARTER goal framework that you and your colleagues have developed.**

DH: This work was published back in 2012. In that paper I introduced a framework, which I called SMARTER, or SMARTER goal setting. So, to help explain this, some people talk about SMARTER goals but we are not actually talking about the goals themselves at this point. And the idea of the SMARTER framework is not to replace SMART goals. What the framework is suggesting is that any goal you want, and it could be a SMART goal or not,





can be set in a SMARTER way. So it's really about the process of goal setting, rather than the goals themselves.

The idea behind SMARTER goal setting follows the acronym.

- **Shared:** The S represents a shared decision-making process where those goals are set in a discussion where people are given real choices. Often, those discussions may involve people from different professions on the multidisciplinary team so that that they're not only shared with the patient and family, but also they are goals that everybody on the team can see and understand. There's an expectation that a shared goal is useful. It is holistic if you like. There's less of this siloed approach of the speech therapists will do this, and the OT will do that, and physio will do that. So hopefully, goals set are negotiated and shared with the patient and family, but also understood across the team. In order to get that shared goal setting some of that the ideas in that paper talk about how you prepare the patient for that shared decision making around what they want to work on. So, you might spend a bit of time talking about their ideas about what they would like and talking realistically about what you can achieve or what people might do when they leave there, what it might look like longer term. They might have a goal setting folder. Because I mentioned before, the people don't always get some paperwork or a record of that discussion. But that goal setting folder might contain some aphasia friendly materials that help to contextualize what they want to achieve and why. You definitely make sure that people with aphasia are included, and their families are included in goal setting meetings, because you still hear about those meetings, again, professional meetings, the patient isn't there. So, it really is a shared process.
- **Monitored:** You don't necessarily measure numerically, you might have a goal that is hard to measure, but you can certainly monitor it. So, M is looking at a range of ways of monitoring whether you can achieve that goal. And they might be qualitative ways, they might be quantitative. But you're looking not just a single measure, but hopefully some kind of continuous evaluation of how that person is doing. And that the monitored includes lots of feedback to the patient and opportunities for them to participate in again, helping to change and alter how they're doing. So again, the dynamic approach of assessment. In other words, when we measure whether a goal is being achieved or not, in effect, it's another form of assessment. So this is where the therapeutic assessment concept pops back again, because you're actually looking for outcome measures, which may be a little bit more sensitive to the goals they've chosen.



- **Accessible**: The goal setting process needs to be aphasia friendly. I'm a strong supporter of supported conversation for aphasia and Aura Kagan's work. Not only is the information accessible, but the therapist is accessible. And it's very much a process where people feel that they can engage.
- **Relevant**: You don't make assumptions about what people might want, you actually try and find ways to get them to tell you. One suggestion in that paper is that you might want, in the same way as an occupational therapist will do a home visit to look at adjustments to the house, we could perhaps do a bit more goal setting in the home environment before people are going home. Because you can actually then see far more effectively what it is they might need to achieve in their own settings. So running goal setting at home would be really quite useful.
- **Transparent**: The idea of being transparent in the SMARTER goal setting process is a big one as we don't tend to do this very well. So by transparent, I mean that there are very clear links between somebody's major life goals, the big goals, long term goals, and between the small short term goals that you often set in rehab, the steps to something bigger. Therapists do a lot of task analysis and they break goals down. There are links then between the big goals, the little goals, (the session goals, you know, the short-term goals) and the actual tasks and activities that you do in the therapy. And that we make those links between those three steps very transparent. And at the moment, I think we don't do that. So, the actual tasks that people do in therapy may feel totally unrelated to what they said they want to work on. One of the reasons for that is that in aphasia therapy, people cannot really see the connections between that in the same way that they can in physio. So, with physio, say "I want to walk". And so, the therapy is practicing walking. But in aphasia therapy, they might say, I want to, you know, be able to meet my friends again and have conversations. Then you find out that you're doing stuff on comprehension that they may not totally connect to their desire to talk. So, we don't always have quite such transparent links between the steps of what we're doing.
- **Evolving**: A really important idea is that goals change in time. And we don't do that enough, we don't recognize that enough.
- **Relationship-Centered**: The best goal setting is done when the person trusts you, they know you, you know them, you know the family and you can really work out what it is that drives that family and what they want to work on. And that it's based within the trusting relationships.

**You've done a lot of work on the discharge process. Could you provide some ideas for how SLPs might approach this transition in the rehabilitation process?**



DH: So this is like the going back to this transit idea. The idea that a plane has come in, and you might be able to get on it and leave the transit lounge. I did my Ph.D. on this area. People with aphasia, often for them the discharge point, the discussions around discharge on what happened at the end of therapy, was often the thing that was most prominent in their stories about the whole experience of being in hospital or rehab or being in outpatient therapy. If you have had a collaborative process through that you're far more likely to naturally have a collaborative process of discharge.

And if people have gained a level of confidence and empowerment or autonomy through therapy, they're much more able to assert what they want in terms of how much therapy they would like, when it should stop, whether they can come back, what the follow up might look like, what kinds of supports they might need at home, how easy it is for them to come back into the system later if they decide to. And again, we understand that aphasia is a chronic condition and that our services are often geared to acute episodes of care, and then discharge. And even the word *discharge* is problematic because it's like, "Off you go, shoo somebody off, and that's it, they've gone." But that doesn't fit aphasia.

In terms of some ideas about how we could make the process better: A lot of it is about how you inform somebody and share the process and really a good negotiation, really clear negotiation with people, a collaborative, but realistic negotiation is important. And that you don't just leave it to the last five minutes. You give people opportunity to talk about this earlier. And there's one caveat to that. It's recognized that discharge planning should start very early in treatment. And I do agree with that, however, the way it's done is crucial. Because what that could be, people could then say, very early on in treatment, understanding when discharge is going to happen, and it becomes like a *fait accompli*, you know, there's no, there's no option for change or no option to influence that. So yes, you can start the process early, but don't do it in such way that people feel they can't have any input later. It's a difficult balance. Yes, you need to give people time to adjust and think about and plan in advance. You certainly shouldn't discharge someone without discussing it first. But don't make them feel that they can't influence it. So it's a power issue. If you're working in a collaborative way that shouldn't arise, but if people feel that they actually can't influence a previously discussed decision, then that would be problematic.

And the second thing is that if therapy has been a process of shared decision making, then the discharge decisions will probably reflect that. In addition, the therapist needs to have good information, a good evidence-base about how much therapy is recommended. We have more and more really good evidence about the intensity of the therapy you need, how long it should go for before you might get a change, whether people need top ups and that kind of thing. We need evidence and information about how the improvements are



generalized, whether they're maintained, those kinds of things. So discharge negotiations need to consider follow up.

And last, the thing I suppose we need to be working with are service delivery models that are flexible enough to respond to people with aphasia. And a little sort of plug here would be particularly to consider those with severe aphasia, because, especially if they end up in residential care, that group of people very rarely get offered more therapy later. We know people change over time, and yet, six months a year after being in a residential care facility, it would be very hard for somebody to initiate and say, "I want more therapy." So, there has to be a way for services to be responsive and to recognize the chronicity of aphasia and to have sufficient flexibility to allow people to come back into the system if they want to.

One thing I would say, that is very clear is that clinicians did not like discharging people with aphasia with a chronic aphasia to nothing. This is down the track to no service at all. One of the things that made it possible for them to suggest stopping outpatient therapy, was having aphasia groups available in the community that people could then go on to. That made it much better. I think clinicians are very worried about discharging people with aphasia to no service at all. Yeah, and I'm an absolute advocate for community aphasia groups. And I think that they should be available to people who are still in therapy. They should be available to people very, very early on, if they wish, or people who are 25 years post or more. Community groups have a role, because, again, going back to LPAA, it's all about participation. Whether it's assessment, therapy, goal setting, you know, or discharge planning, what we should be doing is preparing equally to manage, engage, participate in a satisfying successful life, a quality of life. And that means having social connection and feeling a part of a community, and so on. Fundamental to the whole discharge discussion on something which is chronic like aphasia, is to be able to support ongoing social opportunities for people in the longer term. And community aphasia groups and community aphasia centers are fantastic in providing that. There needs to be very, very close relationships between therapists and then groups. So that definitely is part of the whole discharge debate.

**Deborah, we typically ask a standard question of each of our podcast guests. My question for you today is "What do you think an aphasia ambassador should consider as clear evidence of having had an impact on their community?"**

DH: All right, so if it were an aphasia ambassador, who's a therapist, or somebody who's working to support people with aphasia. The evidence they've had a positive impact that they've made a real difference, would be seeing people with aphasia and their family members displaying confidence. The ability to engage confidently in life. It really is about people feeling that they can move on, they have flown out on the right plane to the right place, that they're out of that feeling of being disempowered. That they are confident and able to start challenging negative attitudes, challenging the barriers themselves. That they



are back to a level of autonomy and of successful participation.

People with aphasia who display confidence within groups are those who may have been through quite tremendously challenging experiences with their stroke, but who then start supporting others. They become mentors to other people who are more newly aphasic. And that is a very interesting process. And that displays that confidence where they feel they have something very unique to offer. They become the teachers and the supporters themselves. And I think when you have people doing that, and that's actually also people answering back to us and saying, "No, you're wrong, this is what it should be like, this is what we need" that is a sign of having done it right, I think.

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