CULTURAL CONSIDERATIONS: A FOCUS ON THE SOCIAL APPROACH FOR ARAB PATIENTS WITH APHASIA

by

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Abstract

There is an increasing demographic change in the United States, and a higher demand is now being placed on Speech Language Pathologists (SLPs) to provide culturally competent services to patients of different backgrounds. It is important that SLPs employ evidence-based practices to better support their patients and their families. This includes actively learning about the cultures of their clients, adjusting the evaluation process, and choosing interventions that meet the patients’ needs. To support clinician’s effectiveness with diverse clients, the purpose of this paper is to shed light on the Arab culture and potential problems that Arab patients with aphasia may face. In addition, this paper will provide the reader with information regarding two interventions, partner training and conversation therapy, specifically for patients with aphasia.
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Introduction

The World Health Organization (WHO) International Classification of Functioning, Disability and Health (ICF) framework provides a unifying framework for classifying the consequences of disease. The ICF is the WHO framework for measuring health and disability at both individual and population levels (World Health Organization, n.d.). This framework was officially endorsed in May 2001 by 191 nations, including the United States as the international standard to depict and measure health and disability (World Health Organization, n.d.). The American Physical Therapy Association (APTA), American Occupational Therapy Association (AOTA), and American Speech-Language-Hearing Association (ASHA), as well as other American healthcare organizations have endorsed the ICF framework. Two parts of the ICF framework include functioning and disability and contextual factors. Functioning and disability include body functions and structures, activity, and participation, whereas contextual factors include environmental factors and personal factors. The body functions and structure domain classifies the health condition as impairment based; therefore, the aphasia treatment approach considered based on this domain focuses on the impairment itself (Galletta & Barrett, 2014). The activity domain focuses on how the health condition affects an individual’s activities and the various life activities in which an individual engages in (Galletta & Barrett, 2014). The participation domain focuses on the effects of aphasia on social roles and life situations (Galletta & Barrett, 2014). The focus of this paper will be on the social approach for people with aphasia due to the fact that the population discussed in this paper includes individuals from diverse cultural and linguistic backgrounds. This is based on the WHO’s ICF that emphasizes the
importance of increasing participation for individuals with disabilities and chronic health conditions (WHO, 2001).

The ICF model provides an arrangement that enables SLPs to include both impairment-based and functionally oriented components for intervention; in addition, it acknowledges that all rehabilitation must be person-centered (Galletta & Barrett, 2014). The framework was adapted and expanded to serve as a guide for assessment and intervention, which has resulted in the Living with Aphasia: Framework for Outcome Measurement (A-FROM). According to Kagan, A-FROM is a user-friendly version of the ICF that has been adapted for aphasia (2011). The Living with Aphasia: Framework for Outcome Measurement makes an open statement about the contribution of four domains to Quality of Life (QOL) with aphasia (Kagan, 2011). It uses overlapping circles rather than separate boxes with arrows to put forward the real-life overlap and interaction between the four domains and overall QOL with aphasia.

Source: adapted from Simmons-Mackie (2008).
Culture

SLPs are required to practice and provide services by considering the impact of cultural variables and language exposure and acquisition on their clients. ASHA certified SLPs are required to have met certain standards that include knowledge of cultural variables and how they influence communication. As such, the ASHA Code of Ethics (ASHA, 2010) states:

Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience. These principles of ethics are not intended to serve as justification for the refusal of services or discrimination in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability. (ASHA, 2010)
There are limited resources on the subject of cultural and linguistic considerations for Arab individuals within the field of speech-language pathology. Therefore, this paper will provide professionals with a condensed guide for providing culturally competent services to Arab individuals, and will also shed light on intervention provided to persons with aphasia within the context of the social approach. According to the Merriam Webster dictionary, the term “Arab” refers to “a member of the people who are originally from the Arabian Peninsula and who now live mostly in the Middle East and northern Africa” (Arab, n.d.). The term “Arab” can also be defined as a member of any Arabic speaking people (Arab, n.d.).

Arabs in the United States.

Due to the increasing demographic changes in the United States, it is important for healthcare professionals, including SLPs, to provide culturally competent services to patients of diverse racial, ethnic, and cultural backgrounds (ASHA, n.d.b). According to the Arab American Institute Foundation (2014), 66% of Arabs are distributed within 10 states: California, Michigan, New York, Florida, Texas, New Jersey, Illinois, Ohio, Pennsylvania, and Virginia. The Arab American Institute Foundation reports that Arab Americans live in all 50 states. However, up to 94% of Arab Americans live in metropolitan areas. The top five metropolitan areas with Arab American populations include Los Angeles, Detroit, New York, Chicago, and Washington D.C. In addition, there are large numbers of Arab Americans in Florida, Texas, New Jersey, Ohio, Massachusetts, Pennsylvania, and Virginia. Data from the Census Bureau reveals that roughly 35% of Arab Americans in the United States have Lebanese or Syrian roots (Arab American Institute Foundation, 2014). The Arab American Institute Foundation discusses that primary ethnic identification is derived through the ancestry question on the American Community Survey. It is worth mentioning that research
suggests that the Census Bureau estimate is significantly lower than the actual number of Arab Americans in the United States due to multiple reasons, including high levels of interethnic marriage among the third and fourth generations and distrust/misunderstanding of government surveys among new immigrants (Arab American Institute Foundation, 2014).

Due to growing population of Arab Americans in the United States, healthcare providers must be knowledgeable and ready to provide culturally competent services for their patients and their families. Healthcare providers, including SLPs, need to be aware of the patient’s background before assessing him/her to avoid any misinterpretation or misunderstanding during the assessment. Clinicians cannot make quick judgements and must consider possible reasons for certain behaviors observed (Roberts, 2008). It is important for the clinician to keep in mind that flexibility, a non-judgemental view, and good problem-solving skills are essential in the working field, especially when working with persons with aphasia (PWA) (Roberts, 2008). This paper will provide SLPs and other healthcare providers with information regarding the Arab population and cultural considerations to guide the evaluation and intervention process and to avoid common misconceptions and stereotypes (see Table 1). It is important to note that no two cases are alike, as patients from one country who share a culture may have different values, beliefs, and priorities. Therefore, the clinician should seek to provide individualized therapy that meets the patient’s needs.

Table 1

<table>
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<th>Arab Culture</th>
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<td><strong>General information</strong></td>
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<td>Muslims all around the world range from the very liberal to the extremely fundamentalist. In the US, of an estimated 6–7 million Muslims, the three largest ethnic subgroups are of South Asian (32%), Arab (26%) and US-born African American (20%) origin. Simplified summaries of people from different religious backgrounds/ethnic backgrounds risk reinforcing stereotypes and prejudices. Healthcare professionals may formulate a tentative hypothesis regarding a patient but should never assume that a particular patient is like all other patients (Laird, Amer, Barnett, &amp; Barnes, 2007).</td>
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The Census Bureau estimates that at least 1.9 million Americans are of Arab descent (Arab American Institute Foundation, 2012). Arabs may share the same language and similar cultures, but there are different ethnic streams (Al-Krenawi & Jackson, 2014). Sixty-six percent of Arabs are distributed within 10 states: California, Michigan, New York, Florida, Texas, New Jersey, Illinois, Ohio, Pennsylvania, and Virginia (Arab American Institute, 2012).

The Arab culture may be considered a high-context culture; people are highly influenced by the family members, community, and institutions that surround them. High-context cultures value the collective over the individual (Al-Krenawi & Jackson, 2014).

Muslims believe that God gave them their bodies as gifts to be cared for and that they will be asked about how they took care of their bodies on the day of judgment (Odeh Yosef, 2008). For some Muslims, illness may be viewed as a test or an opportunity to purify the soul (Laird et al., 2007).

Family roles

Arabs have strong family orientation. It is usually unimaginable for a teenager to consider leaving their parents’ home (i.e., in Syria there are few nursing homes). Some consider it to be shameful and culturally unacceptable to place elderly parents in a nursing home (Wehbe-Alamah, 2008b). Parents and the extended family may be involved in medical decision-making, speaking on behalf of even older youth (Laird et al., 2007). There are strong expectations of both the mother and father within a family, and the loss of either one can affect the family profoundly (Al-Krenawi & Jackson, 2014). Men are usually in charge of financial care (Wehbe-Alamah, 2008b).

Gender roles

Some women may wear a headscarf, veil, raincoat/jilbab, black from head to toe, etc, while some may not. It is rare to wear very short hair. Some men wear gowns called kaftans, while others wear Western type clothing. In Islam, modesty is the key (Wehbe-Alamah, 2008b).

In Islam, women are regarded as independent members of society who are equal to men in human rights, pursuit of education and knowledge, freedom of expression, initiating enterprise, and owning property independently (Wehbe-Alamah, 2008b).

Men who are related to the woman (i.e., father, uncle, son, husband, and nephews) can see her without her scarf on. Other men may not, that would include cousins, doctors, therapists, etc. However, not all Muslim women wear a scarf. For female patients who do wear a scarf, it is important to allow them time to cover up. Wehbe-Alamah mentions a case in the U.S. in which the physician and five residents came into a patient’s room without knocking on her door causing her to yell “no men” which later on made her feel embarrassed for two reasons: the first being that she was seen without her scarf on and her arms were bare and the second being the way that she reacted (2008b).

Segregation of space and activities by gender to prevent potential illicit contact between the sexes leads many Muslim post-pubertal adolescents to prefer same-sex providers, especially for genital examination (Laird et al., 2007).

In Islam, sexual relationships between men and women are reserved for marriage (Al-Krenawi & Jackson, 2014). However, many do not adhere to this.

Cultural considerations

Arabs: Invest a lot of energy into personal relationships. Greetings are lengthy in nature and physical closeness is emphasized (Wehbe-Alamah, 2008b).

Health is viewed as a blessing from God (Wehbe-Alamah, 2008b). In most Arab and Islamic countries, contracting HIV or AIDS is perceived negatively. It may be associated with sexual promiscuity, gay–lesbian relationships, and/or unlawful drug use (Wehbe-Alamahah, 2008a).

Arabs who are Muslim:

There are different sects in Islam, which include Sunni and Shia. Both sects have a strong belief in fate. When planning future activities, the term “Inshallah” (God willing) is almost always used. The Quran is the highest authority for information on Islam. Islam views all aspects of life within the context of religion. The basis of Islam is that God is one and that there is only one creator who deserves to be worshipped (Wehbe-Alamah, 2008b).
The articles of faith are believing in:
1) God
2) Angels of God
3) Prophets of God (from Adam to Jesus and then Muhammad, peace be upon them all)
4) Books of God (i.e., Torah, Bible, and Quran)
5) The Hereafter
6) The Day of Judgement

Five pillars of Islam:
1- The confession of faith (Shahada)
2- Praying five times a day (Salat)
3- Giving money to charity (Zakat)
4- Fasting during the month of Ramadan (Sawm)
5- Pilgrimage to the city of Mecca (Hajj)

There are two major holidays, Eid Al-Fitr and Eid Al-Adha (Wehbe-Alamah, 2008b). Eid Al-Fitr is the first holiday which lasts three days. It marks the end of Ramadan, which is the holy month of fasting from dawn until sunset. Eid Al-Adha is the second holiday, which occurs after Hajj (pilgrimage to Mecca). Muslims celebrate this holiday for four days to commemorate the sacrifice of Abraham. The Islamic calendar is lunar. Therefore, the holidays’ corresponding dates in the Gregorian calendar change each year.

Wehbe-Alamah (2008b) discusses Muslim women’s expectations for professional nursing care:
1- Preserve modesty and privacy
2- Provide same sex providers
3- Provide pork and alcohol free diet and medications
4- Avoid stereotypes

This information can also be taken into consideration by SLPs when providing therapy to those who are Muslim. Some ways of providing culturally congruent care to Muslim female patients include, posting signs at the door (upon request) and asking men to knock on the door and seek permission before entering the room to allow time for the patient to cover the hair and secure patient modesty (Wehbe-Alamah, 2008a).

To maintain the culture care of traditional Muslims, healthcare professionals can maintain the privacy of these patients by avoiding unnecessary body exposure, prolonged direct eye contact, and male–female touching. If permissible, professionals can ask the patient if they would be more comfortable if they were assigned to a same sex healthcare provider. Healthcare professionals should avoid the initiation of hand shaking or hugging of patients of the opposite sex (Wehbe-Alamah, 2008a). Many Muslim women and men may refrain from eye contact with the opposite sex if they are not related. That is important to note, because sometimes professionals consider such body language a sign of resistance to treatment (Al-Krenawi & Jackson, 2014).

Wedding parties are characterized by gender separation, singing, dancing, and eating. With death, the norm is to attempt to bury the person within hours of death, clothed only in a shroud. Three days of mourning follow the burial. Friends, neighbors, and relatives visit the family of the deceased (Wehbe-Alamah, 2008b).

Foods

The Maghreb: couscous is very famous and served at all important social gatherings, holidays and celebrations (J. Campo & M. Campo, 2015). Other famous dishes include sweet and savory meat stews simmered in a spice mixture over charcoal in special pots. Cooking with aromatics, nuts, fruits, and sweet and sour flavorings is also a key component.

Egypt: grains, meat from cattle, poultry, fish, shellfish, and fruits and vegetables. A very popular dish is mulukhiyya, a green herb (Egyptian spinach), mashed fava bean dish, stuffed pigeon, and grilled meat (lamb and chicken). Kushari is a popular street food made of pasta, rice, and lentils, topped by onions and tomato sauce.

The Arab Levant: tabuleh (parsley salad), garden salads with olive oil dressing, stuffed grape leaves, falafel, filo pastries, and grilled meatballs. Popular street foods include shawarma, layers of marinated beef or chicken. As for sweets, nut filled cookies, rice pudding, baklawa, and date pastries are popular.

The Arabian Peninsula and the Gulf: dependent on camels, sheep, and goats. There is a preference for meat, especially lamb, and combination of meat and grains among all Arabs. Major beverages include coffee and tea (J. Campo & M. Campo, 2015).
Muslims:
It has been mentioned, whether in the Quran, or by the prophet that the following are important and are also healthy foods: Black seed, figs, olives, honey, dates, squash, and Zam Zam water (holy water) (J. Campo & M. Campo, 2015).

During the month of Ramadan, Muslims who have reached the age of puberty, who are cognitively-able, and who are in good health fast from sunrise to sunset. They refrain from eating or drinking anything during that time. Women who are breastfeeding or pregnant do not have to fast, but do have to make up the days by fasting later during the year. Women who are on their period are excused from fasting but also need to make up the days after Ramadan. Anyone who is sick or who is unable to fast is not required to fast, but they must make up the days or provide food for the poor if they cannot make-up the days (J. Campo & M. Campo, 2015).

Things that are prohibited in Islam include alcohol, drugs, and pork products (i.e., pepperoni, lard, sausage, gelatin, and bacon) (Wehbe-Alamah, 2008). Prohibitions against ingesting alcohol and pork products may cause patients to refuse taking some medications, although many Islamic authorities indicate that medical "necessity overrides prohibition’’ in emergency cases. It is important to consult with parents and/or the patients regarding their preferences (Laird et al., 2007). To accommodate Muslims who adhere to religious rules, professionals may consider prescribing gelatine and alcohol-free alternatives to medications and vitamins (Wehbe-Alamah, 2008a).

**Religious activities**

Muslims who reach puberty have to pray 5 times a day as a way of connecting with God. There are certain times for prayer in a day, and Muslims pray facing Mecca. The first prayer, called “Fajr” is performed before sunrise; the second prayer, “Thuhr” comes just after noon; the third prayer, “Asr,” arrives during mid-afternoon; the fourth prayer, “Maghrib,” is just after sunset; and the last prayer, “Isha,” is performed at night. Each prayer includes a series of movements, supplications, and recitations from the Quran in Arabic.

There are applications that can be downloaded on the phone to remind a person when it is time for prayer, and which way to face when praying. Muslims have to pray in a clean area and have to be clean before praying. Therefore, they perform a ritual ablution called “wudu”. When making “wudu”, they have to wash their hands, face, arms, and feet. In addition, men are expected to go to Friday prayer, a congregational prayer that is held every Friday, usually at a mosque. Women do not have to pray at the mosque, but have the choice of doing so if they preferred to.

**Social routines**

When Arabs have guests over, they find it necessary to serve them with a drink (i.e., coffee, tea, juice, etc), sweets, or food. As it is considered rude not to serve anything. Arabs in general place an emphasis on family and friend gatherings. Gatherings tend to be a routine for Muslims in Ramadan, where they break their fast together.

Visiting and praying for the sick is important to Lebanese, Syrian and other Muslims and is considered a cultural, social and religious obligation as well as a source of blessing (Halligan 2006, Rashidi & Rajaram 2001, as cited in Wehbe-Alamah, 2008a).

**Misconceptions/assumptions to be aware of**

There is an assumption that all Arabs are Muslim. Many Arabs are Muslim, but there are also many Christians and atheists who are Arab.

Arabs fear of stigmatization in the family and community and that is why many Arabs are discouraged from committing crimes or other misbehaviors such as substance abuse and sexual deviance; it is not just for religious reasons (Al-Krenawi & Jackson, 2014).

Religion may often be blamed for motivating marriage traditions or practices that are in fact part of cultural heritage rather than religion (Al-Krenawi & Jackson, 2014). Professionals need to be able to differentiate between culture and religion to avoid stereotyping.

Many Arab Americans do not seek professional help from marriage counselors, psychiatrists, and/or social workers because they feel that they might be misunderstood (misperceptions). Family problems are usually taken care of privately (Al-Krenawi & Jackson, 2014).

The ability to maintain a good marriage in the eyes of a high-context community is essential to maintaining a sense of honor for the bride, the groom, and their families. In a high-context community, such as the Arab community, the ability to maintain a good marriage in the eyes of the community is an essential component. A person with marital problems and illness can be isolated.
Health disparities

Few data exist regarding health disparities for Muslim minorities. US census data do not include religious affiliation. Instead, Muslims are often included under ethnic categories such as “Arab Americans”, “African Americans” and “Asian Americans” (Laird et al., 2007).

Weller and colleagues identify six levels of discrimination which affect access and quality of care for Muslim patients:

1. Religious prejudice is an individually held attitude that may result in exclusionary or discriminatory behavior. (2) Religious hatred is a more entrenched attitude that may be used to justify actual violence on ideological grounds. (3) Direct religious discrimination involves deliberate unfair treatment and exclusion. (4) Indirect religious discrimination results from individuals or groups not taking into account how their routine practices fail to reflect changes in the social and religious fabric of a community. (5) Religious disadvantage occurs when only some religious groups have privileged arrangements with state or institutional power and policy and others do not. (6) Institutional “religionism” involves combinations of the other five dimensions.

Other reasons for lack of access to healthcare services include the fear of being misunderstood by professionals. For example, clinicians may perceive a girl in a headscarf that consults with a male family member/relative when making a decision as oppressed, abused, or traditional. The same might be true if the girl requests a same-gender provider. Programs in cultural competence or transcultural healthcare can help guide healthcare professionals when working with people from different religious/ethnic backgrounds (Laird et al., 2007).

In a survey done by Laffery, Meleis, Lipson, Solomon, and Omidian (1989), common health problems for this population were identified. In addition, other health-related problems were identified, including family stress, the difficulty of adjusting to the American culture, handling adolescents, and marital stress. To address such problems, it would be necessary to provide health services that include health education, availability of Arabic-speaking health care providers, and technical assistance in referrals for appropriate treatment (Laffrey et al., 1989).

In study done by Kulwicki (1991) using an ethnographic approach, 30 female Yemeni Americans were asked to name some terms used in their culture that relate to illness and to talk about the causes of the illness. The approach included community observations and face-to-face interviews. During the interviews, the researcher asked participants to name some terms used in their culture to refer to illness and to talk about the causes of illness. Based on the participants’ responses, the researcher classified reported causes of illness into four categories and provided the frequency of reporting as follows: supernatural causes (God 47 times, devil 20 times), social causes (evil eye 22 times, stress 19 times), natural causes (cold 30 times, dirty environment 6 times), and hereditary causes 9 times (Kulwicki, 1991). Thus, it is important to take into consideration what the patient might think the underlying cause of the illness is because it is our role to inform them.

For the SLP

Based on the information discussed above, there are some key points for SLPs to keep in mind when working with Arab and/or Arab-American clients:

Clinicians need to keep in mind that although Arabs share a similar language and cultural background, they also have many differences.

Nonjudgmental listening is important, as it allows the client to feel more comfortable and willing to share information with the clinician.

When working with Muslim patients, clinicians should try to avoid initiating the handshaking with a person from the opposite gender. There is some discrepancy between Muslims regarding handshaking with the opposite gender; therefore the clinician should wait to see if the patient initiates it first.

During therapy, clinicians could provide patients from the opposite gender some space to avoid being too close.

Sometimes, therapy may coincide with the time frame for prayer. Muslims pray five times a day. The time periods for the five prayers change based on the condition of the sun.

When handling an oral-mechanism examination with a patient from an opposite gender, the clinician should explain what is going to be done. The clinician may want to ask for permission to touch the
patient’s face (i.e., “Would it be alright if I touched your face for this examination?”). Not all Arab and/or Muslim patients will have the same response.

To better understand the patient and the family, the clinician may want to start out with a small interview. The clinician may want to explain that he/she would like to know more about their culture and their preferences for therapy to provide them with high-quality service that meets their needs. Some patients may state that they would like a clinician of the same gender, while other patients may feel reluctant to express their needs. Therefore, providing them with an option to discuss their preferences could result in better communication and exchange of information.

Clinical Scenarios

Scenario 1.

Cindy is a Caucasian American SLP who has been working in the medical field for less than 3 years. Cindy recently moved to Chicago and has been working at her current hospital for less than a year. Cindy received an order to evaluate a new Arab-American patient with a recent onset of a left-hemispheric ischemic stroke. The patient, Dana, a 40 year old female, was 2 weeks post stroke and her family members were very concerned about her ability to speak and walk again. After conducting the evaluation, Cindy concluded that Dana’s symptoms aligned with a moderate Broca’s aphasia characterized by word finding difficulty and difficulty expressing thoughts, ideas, wants, and needs. Dana was added on to Cindy’s caseload for speech and language services. She was also added on to the physical therapist’s caseload for physical therapy services.

Client background: Dana is a Syrian-American Muslim female who has been living in the United States with her husband and family for the past 40 years. Prior to the stroke, Dana worked a part-time job as a secretary in a lawyer’s office and spoke English and Arabic fluently. Dana wore a headscarf as did her mother and sister. Dana’s parents and husband were born in Syria and spoke English as their second language. Her family reported that she communicated mostly in Arabic at home. Dana’s family- husband, children, and parents-
were very involved and wanted the best services possible for Dana. During the evaluation and therapy sessions following the evaluation, Cindy made important observations about the interaction between the patient and her family and some cultural and religious influences on therapy. Although Dana’s family was very involved, they did not tend to question Cindy’s evaluation results and recommendations for therapy. Cindy’s suggestions were always met with head nods. Cindy also noted that much of the family education time was spent with the father and husband who made limited eye-contact with her when speaking. She started to think that the family was uninterested in contributing to the therapy process.

_Treatment approach:_ The approach Cindy took was an impairment-based approach with an emphasis on phonological naming therapy. After providing therapy for two weeks, Cindy felt like she was not getting any positive results, although it was too early to make such a conclusion. Cindy had also noticed that Dana was not motivated for therapy and appeared agitated at times. Cindy wanted to change the approach implemented to see if Dana would respond better to the new treatment approach. Due to her limited experience in working with patients from different cultural backgrounds, and due to the fact that none of her colleagues had worked with Arab patients before, Cindy decided to examine the research literature on the Arab culture, specifically Syrian culture, to enhance the quality of the therapy provided. Cindy also wanted to look further into the social approach to determine whether it was appropriate for her client, Dana.
Scenario 2.

A new patient was added to Kristen’s caseload with a diagnosis of moderate Broca’s aphasia. Kristen had been working as an SLP at a hospital in Detroit, Michigan for the past 10 years. The patient, Jamal Akil, was a 60 year old male who suffered from a left cerebrovascular accident (CVA) and was 2 months post onset.

Client’s background: The patient was born and raised in Saudi Arabia. He and his wife were visiting their daughter in the United States at the time of the stroke. Jamal’s native language was Arabic, and English was his second language. His wife, Mrs. Akil, was his primary caregiver. She was very involved in his case and always pushed him to do his best. Mrs. Akil was not fluent in English, and her daughter worked a full-time job and was not always available for therapy. Therefore, an interpreter was present during the therapy sessions to translate important information to her and to her husband, Jamal, when necessary.

Kristen had worked with an Arab patient before, but she realized that the two cases were very distinct. Her previous patient was a younger male originally from Lebanon. Kristen did not have to do any research with her previous patient as he was born and raised in the U.S. and had assimilated into American culture.

Treatment approach: Kristen took an impairment-based approach for the case. After initiating therapy with Jamal, Kristen noticed that her patient appeared to be uncomfortable at times, and he demonstrated limited eye-contact with her. However, his wife always completed any homework provided. Mrs. Akil was always in touch with her children and distant relatives Saudi and updated them daily on her husband’s condition. In addition, Jamal always had visitors in his room checking up on him, and it was sometimes hard for
Kristen to manage between visitors and therapy. After two weeks of therapy, Mrs. Akil’s interpreter informed Kristen that Mrs. Akil did not feel like therapy was benefitting her husband and she was not seeing any significant improvements as she had hoped. She also mentioned that many of the topics discussed in therapy were not common to her or her husband. Mrs. Akil was convinced that his participation was limited due to his unfamiliarity and limited interest in the topics provided. To make an evidence-based decision, Kristen explored the literature on social approaches that may be more beneficial for her client due to the various cultural and religious variables influencing therapy. She realized that it would be wise to do some research on Mr. and Mrs. Akil’s cultural background to gain better insight. Kristen’s search led her to the partner-training approach. According to Simmons-Mackie, training speaking partners often enhances communication of and interactions with the person with aphasia (2008).

**Review of the Literature**

**The Social Approach: Conversational and Partner Training.**

According to the National Institute on Neurological Disorders and Stroke, there are approximately 1 million people in the United States that suffer from aphasia (ASHA, n.d.a). Treatment can focus on several areas depending on the individual’s diagnosis and areas of deficits. In a study conducted by Brown, Worrall, Davidson, and Howe (2011), independence and autonomy emerged as areas of concern for participants diagnosed with aphasia. The study participants described independence as their ability to complete everyday activities by themselves (Brown et al., 2011). Examples of activities that emphasized independence included ordering in restaurants or looking up bus timetables to catch a bus (Brown et al., 2011). Due to the fact that some people with aphasia
(PWA) prefer to focus on communication as a whole rather than parts, SLPs can provide therapy that targets functional communication. Functional communication includes the ability to communicate effectively and independently in a given environment. An appropriate approach that can be used to target functional communication would be a social approach. A social approach encourages membership in a communicating society and therefore promotes functional communication (Simmons-Mackie, 2008). Social approaches focus on personally relevant outcomes, such as meaningful life change, enhanced life participation, or improved quality of life (Simmons-Mackie, Raymer, Armstrong, Holland, & Cherney, 2010). According to Simmons-Mackie et al., there are multiple interventions included under a social approach, and communication partner training is the most prevalent form in the aphasia literature (2010).

A social approach would be ideal for PWA who are looking to be more independent in a community and for those who wish to overcome social isolation, loneliness, loss of autonomy, and restricted activities (Simmons-Mackie, 2008). Objectives with this approach might include the following: enhancing natural communication, increasing successful participation in different events, providing support systems within the community, increasing confidence when communicating, and promoting advocacy (Simmons-Mackie, 2008). The SLP and the patient can also work together to set goals that are relevant to the patient. Intervention within a social approach can be provided through conversation therapy, enhanced compensatory-strategy training, conversational coaching, group therapy, scaffolded and supported conversations, and partner training.

Communication partner training is an intervention directed at the speaking partners with the intent of improving the language, communication, participation, and/or well-being
of the person with aphasia (Simmons-Mackie et al., 2010). Partner training is appropriate for family members, caregivers, friends, and the community at large (Simmons-Mackie, 2008). In addition, Simmons-Mackie reports that training speaking partners results in enhanced communication of the person with aphasia (2008). The skills of the trained speaking partner are important because, when they provide supportive opportunities to the partner with aphasia, it results in a positive communication interaction (Simmons-Mackie, 2008). SLPs provide direct partner training and feedback to be incorporated into their daily routines. Partners are provided with strategies to lead an interactive conversation that feels natural and reinforces the confidence of the partner with aphasia. The goal is to teach the partner to facilitate a pleasing conversation. Some clinicians extend the intervention to the partner with aphasia, as the partner with aphasia is considered responsible for promoting successful communication interactions (Simmons-Mackie, 2008). Some strategies that may be used include slowing the rate of speech, chunking ideas with pauses between, simplifying sentence structure, placing key information at the end of a sentence, rephrasing when necessary, using gestures while talking, verifying understanding, using props, getting information from the patient’s body language, using direct referents, etc (Simmons-Mackie, 2008). Wilkinson, Bryan, Lock, and Sage (2010) suggest that patients with aphasia benefit from strategies that include asking open-ended questions. When patients are provided with questions that require a yes/no answer, their responses are limited to those questions. However, when patients are provided with open-ended questions, they may feel the need to elaborate. According to Simmons-Mackie et al., SLPs need to use their clinical judgement when choosing candidates for this intervention, taking into consideration the individual’s needs, wishes, and situations (2010).
Conversation therapy includes exchanging information to meet social needs, it is goal directed and individualized (Simmons-Mackie, 2008). The goal of the intervention is to enhance the patient’s conversational abilities and confidence during communication exchanges. In addition, conversation therapy focuses on enhancing social communication skills related to specific communicative contexts (Simmons-Mackie, 2008). Conversation therapy focuses on interaction and discourse, which works at the macrolinguistic level. (Savage, Donovan, & Hoffman, 2014, p. 618). The macrolinguistic level focuses on the broad view of language including the way language is acquired and used and the relation between language and society. Please see Table 2 for information regarding conversation therapy and partner training interventions.

Table 2

Description of Studies

<table>
<thead>
<tr>
<th>Participant(s)</th>
<th>Target</th>
<th>Intervention component(s)</th>
<th>Results</th>
<th>References</th>
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<tbody>
<tr>
<td>Multiple-case study design. The criteria for participation included: First-ever stroke, moderate to severe aphasia, over the age of 18 years, motivated, Awake, and communicable. 4 dyads were included in the study, attrition of 1 dyad (they withdrew).</td>
<td>Quantitative and qualitative study, Video recordings, observational measures, and self-assessment questionnaires were utilized.</td>
<td>Communication partner training  Emotional support  Information provided to significant other  3 sessions were directed to the significant other, and the Next 3 sessions were directed to the dyad.</td>
<td>Importance of emotional support and providing individualized and flexible family-oriented services to meet the patients’ diverse needs. Strategies that were used included gestures, drawing, and writing. This was beneficial as it increased one of the patient’s understanding. The strategies were taught to the patient’s significant other. Two dyads did not seem ready to use the communication strategies that they were taught (were focused on other issues). Overall, positive effects were reported in this study with an emphasis on recurrent contact after initiation of services.</td>
<td>Blom Johansson, M., Carlsson, M., Östberg, P., &amp; Sonnander, K. (2013). A multiple-case study of a family-oriented intervention practice in the early rehabilitation phase of persons with aphasia. Aphasiology, 27(2), 201-226.</td>
</tr>
<tr>
<td>Single-case A1-B-A2 design  Phase A, baseline, was a phase that was video recorded. The patients were given a topic, asked</td>
<td>Conversation analysis: 15 minutes of each video were transcribed and analyzed. Clinicians focused on blockages in interaction,</td>
<td>The number of trouble sources initiated by people with aphasia decreased post-intervention. The number of initiated repairs increased for three participants with aphasia. Nonverbal data from video assessment revealed no statistically significant</td>
<td>Cunningham, R., &amp; Ward, C. D. (2003). Evaluation of a training programme to facilitate conversation between people with aphasia and</td>
<td></td>
</tr>
</tbody>
</table>
Inclusion criteria included: aphasia due to brain injury at least 4 months before (between 4 and 18 months). CT results included MCA infarct and hemorrhage, Left intracerebral haemorrhage, LCA infarct, and one participant did not have a CT.

Severe expressive difficulty, moderate/severe comprehension, difficulty following simple conversation with adequate supports, and no major cognitive deficits.

In addition, participants needed a relative or friend available to participate. Participants were also required to terminate speech therapy services provided at the same time of the study.

There were 3 females and 1 male with aphasia. There were 3 male partners and 1 female partner.

| Inclusion criteria included: aphasia due to brain injury at least 4 months before (between 4 and 18 months) | to start their conversation (15 minutes). 6 topics were agreed upon before initiation of study. | aspects of attempted repairs (successful and unsuccessful), initiation, and interruptions. | treatment effects were found when pre and post assessments were compared. | their partners. *Aphasiology, 17*(8), 687. |
| CT results included MCA infarct and hemorrhage, Left intracerebral haemorrhage, LCA infarct, and one participant did not have a CT. | Data was taken on conversational interactions and nonverbal communicative behaviors. Video and conversation were analyzed. | Phase B was the intervention phase. 5 weekly, 1.5 hour sessions were provided. Session 1 & 2 were informative. In session 3, sections from videos were used to provide the patients with feedback regarding ways to improve interaction. In sessions 4 and 5, participants role-played (practiced). | VASES: stable for conversation partners in pre and post intervention | |
| Severe expressive difficulty, moderate/severe comprehension, difficulty following simple conversation with adequate supports, and no major cognitive deficits. | In addition, questionnaires (VASES & HADS) were completed by all participants. | Outcome assessment sessions: In phase A2, 3 sessions were carried out 2-3 weeks after phase B was completed. | Persons with aphasia improved over three sessions, deteriorated immediately post-intervention and then improved again. | |
| In addition, participants needed a relative or friend available to participate. Participants were also required to terminate speech therapy services provided at the same time of the study. | There were 3 females and 1 male with aphasia. There were 3 male partners and 1 female partner. | | HADS: a lot of variability in scores. Anxiety scores were higher than depression scores. | |
| Case study: | Treatment goals were set based on what was observed during baseline measures and based on partners. A rating scale of (0-10) was used to rate satisfaction with conversation. Measure of skill in supported conversation (MSC) and measure of | Conversation treatment: 14 sessions of conversational therapy were provided. There were 4 baseline sessions, and 14 treatment sessions (2 per week for 7 weeks, 60-minutes). 2 follow-up sessions, with a series of 3-minute conversations on any topic. This was followed by self-reflection and clinician feedback. 15-minutes of | Verbal communication: an increase in this area was not expected in this study. 2 participants with aphasia increased their spoken output. However, confounding factors included spontaneous recovery. | Fox, S., Armstrong, E., & Boles, L. (2009). Conversational treatment in mild aphasia: A case study. *Aphasiology, 23*(7/8), 951-964. |
| Mild aphasia Laura; patient with aphasia was 78 years old and was 1 year post stroke. Her spouse, Jim was 71 years old. | | Based on the conversational rating scale, the couple showed improvement in satisfaction with conversation after treatment. | | |
### Control group

- Included 10 male and 10 female participants who were native Italian speakers.
- Ages ranged between 40-75 years with an education level of 13-17 years.

### Experimental group

- Included 8 patients, 5 male and 3 female participants with Broca’s aphasia due to a single left hemisphere stroke, at least six months prior to study.
- Patients with severe word finding difficulties.

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**Conversation therapy**

- 6-week intensive language training, 2 hours per day.
- Before treatment: The control group and experimental group were shown 6 video clips and asked to describe what was going on.
- During treatment: A new video clip was introduced every two weeks.

**Communication training to a spouse**

- Goal is to reduce occurrence of non-facilitative behaviors of the spouse. 3 non-facilitative behaviors were targeted. These included spouse interruptions, excessive use of convergent questions and negative teachings. Chosen because they seemed to interrupt their flow of conversation.

**Interruptions during baseline were at 40%. In the training phase interruptions stabilized around 10%. In the follow-up phase 0% interruptions noted during TV news discussions.**

**Convergent questions were not reduced as required to terminate training. 10 additional sessions were needed until the occurrence of convergent questions was at 27% during TV news discussions.**

**Generalization and maintenance of training effects for both target behaviors were observed in open topic conversations and novel stimuli.**

**Spouse showed fewer interruptions in conversations at home, and her husband’s verbal responses increased from 19.7% to 43% after treatment.**

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**Treatment improved the patients’ ability to communicate, after treatment they were able to sustain an informative conversation. Significant changes after therapy persisted at one week and one month. Participants were observed not only on the video clips used during the treatment. However, no significant changes were found on the standardized aphasia assessments.**

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**Single-subject multiple baseline design.**

- 62-year old couple Husband, 4-years post onset of aphasia, with a left CVA that resulted in Broca’s aphasia. The spouse was a housewife.

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**Time sampling procedure used to score tapes. Video segments were used during this study. (+) for target behavior present and (−) for absent target behavior.**

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**Goal of reducing interruptions during conversations with his spouse. Jim did not increase the use of probe questions when needed during the conversation.**

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**Communication training to a spouse**

- Goal is to reduce occurrence of non-facilitative behaviors of the spouse. 3 non-facilitative behaviors were targeted. These included spouse interruptions, excessive use of convergent questions and negative teachings. Chosen because they seemed to interrupt their flow of conversation.

**Negative teaching behavior was not explicitly targeted; rather it was used to monitor for generalization to untrained behavior.**

**Observed across multiple conditions: spontaneous conversation in the clinic, discussion of TV programs in**

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Case study:
Patient - 66 years old with a left CVA, 18 months post-onset. Patient had Broca’s aphasia, right hemiplegia, however was able to use left hand to write and move. Patient’s wife was 63 years old. Both were retired teachers.

Both the person with aphasia and the spouse received conversation analysis therapy in this study as a couple.
Quantitative and qualitative approaches for evaluation of results.

Conversation analysis (CA) used as a method for intervention. The focus during conversation was on turn taking, turn construction, topic and repair.
8 sessions, once a week for 1-2 hours.
Reducing some of the conversational behaviors used by the patient’s spouse to reduce patient’s frustration in conversations.

Qualitative changes:
Post-intervention conversation:
Participants started to utilize conversational strategies that they were taught. Spouse used non-restrictive forms (topic-elicitor in a form of a statement) to initiate conversation, rather than yes/no questions. The patient used more sentences/Attempts (1-2 sentences) during the conversational turns and initiated more topics during the conversation. He also initiated correction of his wife’s understandings of what he said, 2 times.

Quantitative changes:
The number of turns of the wife asking questions decreased from 78% to 22%. Number of turns that contained at least one sentence or an attempted sentence increased from 41% to 59% for the patient. In addition, the number of turns that contained 2 or more sentences or attempts, increased from 0% to 17%.

Ratings by naïve speech and language therapists:
14 out of 15 therapists Were able to identify which conversation section was from which treatment (pre or post)

Jane noticed how the strategies she used help her husband attempt to form complete sentences. He attempted more conversation with friends and talked with his brother on the phone.

In an impairment-focused program, conversations are enhanced by accomplishing training such as word-finding tasks. The focus in such programs is on generalizing the trained words into conversations. On the other hand, communication-focused intervention
focuses on the transaction of ideas accomplished by the use of communication strategies (Blom Johansson, Carlsson, Östberg, & Sonnander, 2013). In Kong’s study (2011), about 10% of the participating family members received caregiver training during therapy sessions. In Blom Johansson et al.’s study, SLPs provided families with ways to improve conversations, but only 17% conducted conversation partner training (2013). Reasons for not conducting conversation partner training included lack of time and a reduced emphasis on family-oriented interventions.

According to Simmons-Mackie et al., most family-oriented interventions that include conversation partner training have been conducted late in the rehabilitation phase or in a chronic stage of aphasia (Simmons-Mackie et al., 2010). With a late initiation of conversation partner training, patients and their families may be at a phase when they no longer expect full recovery and may be more willing to participate in such training (Blom Johansson et al., 2013). However, by that time, negative communication patterns and attitudes may have been established, resulting in decreased motivation levels from the partner and the patient. Patients’ families have expressed that emotional support in the early rehabilitation phase is needed (Blom Johansson et al., 2013). As such, conversation partner training may be initiated in the early rehabilitation phase.

This research suggests that both partner training and conversation therapy interventions can be implemented based on the individual’s needs and desire. Some patients with aphasia may become more motivated when a social approach is implemented; while others may want a more structured intervention. Thus, an impairment based approach may be taken, as appropriate.
Considerations for the Clinical Scenarios

In some of the studies examined, intervention provided included both conversational therapy and partner training. It is apparent that the two intervention approaches are not mutually exclusive and may be used together. It is the clinician’s role to determine which approach and intervention will meet the patient’s needs. The clinician should consider multiple factors including patient’s needs, motivation level, cultural factors, and patient and family desires to make an informed decision.

In the first scenario, Dana did not seem motivated during therapy and appeared agitated at times. After conducting some research, Cindy decided that the solution would be to discuss possible options with the patient and her family to increase motivation and participation during the session. In addition, Cindy gained insight on Dana’s culture through the research process. Cindy understood that Dana’s husband and father were the ones involved the most possibly because each person had a certain role in the household. The men were the head of the household, and they may have felt responsible for taking on such a role. Within an Arab culture, males and females have certain gender roles. This may differ from family to family, however there is a general idea that males are responsible for their female kin. Laird et al., discuss how Arab parents and the extended family may be involved in medical decision-making, speaking on behalf of even older youth (2007). Cindy also understood that the family may have used limited questioning and eye-contact during their conversations out of respect for her because, she was the professional and/or because she was a female, and they were required to limit their eye-contact following religious obligations. Al-Krenawi and Jackson discuss that Muslim women and men may refrain from eye contact with the opposite sex if they are not related (2014). Such body language may
indicate that the individual is uninterested in the conversation; however that may not always be the case (Al-Krenawi & Jackson, 2014). Other reasons may include the fact that the Arab culture is also a high power distance culture, in which there is a centralized authority. High power distance cultures are characterized by inequality, coercive power, respect/fear of older people, and subordinates being dependent on superiors (Hofstede, 2001). This also includes a high power distance between patients and physicians in which the patients would expect and/or accept authoritative recommendations from the physicians, resulting in the lack of questioning from the family members at times. Cindy decided to engage in a conversation with the family to get a better understanding of their culture and values. Cindy explained her role as an SLP and encouraged them to ask her questions and provide their thoughts and ideas whenever needed. She also asked them about Dana’s limited participation during the session. Her family responded that Dana was upset because she wanted a female physical therapist for therapy, due to religious reasons. Dana always had physical therapy before speech therapy, which affected her performance during speech therapy sessions. Cindy reported the family’s concerns to the adult rehab coordinator, who then made adjustments accordingly. It is apparent how Cindy’s search for evidence resulted in a positive outcome for both the patient and herself. Information gleaned from the research process helped Cindy to better understand her patient and enhance the quality of the therapy provided.

In the second scenario, Kristen faced a problem with her patient, Jamal, regarding the topics presented in therapy. Jamal also appeared to be uninterested and unmotivated. After searching for an appropriate intervention approach for Jamal, Kristen decided that the partner training intervention may be beneficial for Jamal and his wife. Blom Johansson et al.,
discuss the positive effects of emotional support for patients with aphasia and their partners especially in the early rehabilitation phase (2013). In this phase, providing emotional support and tailored information are expressed needs of the patients’ significant others (Le Dorze & Signori, 2010). In addition, Blom Johansson et al., point out that factors such as severity of aphasia, spontaneous recovery, discharge of the person with aphasia from inpatient services appeared to influence the needs for support, information, and readiness to learn conversation strategies (2013). In Jamal’s case, it was apparent that his wife was willing to participate to support the recovery process. Jamal may also become motivated to participate when his wife takes part in the treatment. This made Kristen feel comfortable in the decision made for partner training intervention. Kristen also searched for more information on Jamal’s Arab culture, and she was able to make some connections. The Arab culture is a collectivist culture, and according to Hofstede (2011), collectivist cultures include people from birth onwards who are integrated into strong, cohesive in-groups. This may have explained why Mrs. Akil was often receiving phone calls from close and distant relatives checking up on her and asking her about her husband’s health. It also explained why Jamal had many visitors daily. As visiting and praying for the sick is important to Arabs and is considered a cultural, social and religious obligation as well as a source of blessing (Halligan 2006, Rashidi & Rajaram 2001, as cited in Wehbe-Alamah, 2008a). Kristen also spent some time with Mrs. Akil to address her questions and concerns and to get a better understanding of Mrs. Akil’s expectations for therapy. After the short conversation that they had, Kristen learned that Mrs. Akil was upset because the physician referred Jamal to a psychologist for an evaluation. She was worried that her husband was going to have a diagnosis of a mental disorder and did not want to consult with a psychologist. She insisted that her husband had a strong faith in his religion and had a good connection with God.
through prayer. Kristen let Mrs. Akil know that she understands her point of view and she advised her to talk to Jamal’s physician regarding the evaluation. She also reassured her that all of the information that they share with any healthcare provider is confidential. According to Al-Krenawi and Jackson (2014), some Arabs, both Christian and Muslim, may view schizophrenia, depression, and anxiety as the result of religious failings. Mental illness is often highly stigmatized; many people may relate such disorders to the loss of connection between the human-being and God. Silence is usually preferred when a person needs to seek help or is seeking help for mental health issues. People seeking help for mental health issues may be called “crazy” within the community, and may also imply that the person has a spiritual illness (Al-Krenawi & Jackson, 2014). Some Muslims may prefer private coping and religious strategies for managing depression and symptoms of schizophrenia. Laird et al. suggest that focusing on therapy in relation to somatic complaints may make it easier for families to discuss problems and accept care (2007).

**Discussion**

The main focus of this paper was to provide the reader with information regarding the Arab culture. The scenarios were provided as a means to raise awareness to potential issues that may arise during therapy due to cultural, religious, and/or linguistic factors. In addition, the paper addressed the social approach for aphasia therapy and two interventions that can be implemented within that approach. The aim was to combine the cultural component and the aphasia intervention component to create a well-rounded option for clinicians working with patients from an Arab culture. Determining which intervention was more beneficial for Arab patients with aphasia was beyond the scope of this paper. However, it was apparent that partner training and the conversation therapy
interventions were not mutually exclusive. Clinicians have the option of providing therapy by focusing on one intervention, or by combining both interventions. Individualization of therapy was emphasized due to the variety of patient needs discussed in the studies and the difficulty of meeting all the patients’ needs with the implementation of one intervention only.

**Conclusion**

Due to the increasing demographic changes in the United States, SLPs need to be prepared to provide therapy for patients from different cultures. To do so, SLPs need to explore the cultures of their patients to determine factors that may influence their performance in therapy. The focus of this paper was to provide SLPs and other healthcare professionals with a condensed overview of the Arab culture. Due to the limited empirical research, the author of this paper contacted TRS Learning Center in Jordan to gain access to research from countries in the Middle-East. TRS Learning Center provides services for speech, feeding, occupational, and physical therapy. However, TRS Learning Center stated that they relied on evidence-based research from the United States and the United Kingdom. The studies presented regarding partner training and conversation therapy training suggest that patients may benefit from strategies provided to enhance conversation. Partners may be provided with functional strategies to use during their conversations with their significant others. In conclusion, it is the SLP’s role to determine the patient’s wants, needs, and desires and make an informed decision that would best meet the patient’s needs.
References


