A comparison of client and therapist goals for people with aphasia: A qualitative exploratory study

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To cite this article: Alexia Rohde, Kerry Townley-O'Neill, Karine Trendall, Linda Worrall & Petrea Cornwell (2012): A comparison of client and therapist goals for people with aphasia: A qualitative exploratory study, Aphasiology, 26:10, 1298-1315

To link to this article: http://dx.doi.org/10.1080/02687038.2012.706799

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A comparison of client and therapist goals for people with aphasia: A qualitative exploratory study

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Background: A considerable body of literature attests to the efficacy of client and therapist collaborative goal setting to achieving optimal rehabilitation outcomes. Collaborative goal setting and shared decision making relies on good communication, thus potentially disadvantaging people with aphasia.

Aims: This study aims to identify the similarities and differences between client goals and therapist goals in rehabilitation for people with aphasia and to explore reasons why any differences occur.

Methods & Procedures: Three speech-language pathologists and four people with aphasia participated in in-depth semi-structured interviews to identify rehabilitation goals. All the interviews were transcribed and analysed using qualitative content analysis.

Outcomes & Results: Results indicated both matching and mismatching of goals between the clients and the speech-language pathologists. Matched goals tended to focus on communication outcomes. Mismatched goals were those associated with the client’s desire to return to previously valued activities. Reasons for the mismatching included: impaired communication made collaboration on goal setting difficult, the service-delivery approach, the goal was perceived to be outside the speech-language pathologist’s scope of practice, and the goal was not considered to be appropriate within the confines of the rehabilitative situation.

Conclusions: This study highlights the need for speech-language pathologists to understand their clients’ goals and how these can be incorporated into rehabilitation. A re-examination of some professional beliefs was highlighted. Future research may lead to educational resources that enable better collaborative goal setting between therapist and client so that outcomes of rehabilitation are optimised.

Keywords: Goal setting; Relationship centred; Aphasia; Rehabilitation.

Goal setting is considered to be an essential part of rehabilitation (Cott, 2004; Leach, Cornwell, Fleming, & Haines, 2010; Levack, Dean, McPherson, & Siegert, 2006; Worrall, 2006). Goals and goal setting occur in many domains of life and significant
empirical evidence exists to indicate that goals are an effective means for modifying human behaviour (Emmons, 1996; McPherson, Seigert, & Taylor, 2004). The “Goal Setting Theory” by Locke (1968) proposed that the best way to increase effort was to set specific, challenging goals. If the goals were not reached, performance was still found to improve. The concepts encapsulated by the acronym SMART (i.e., specific, measurable, achievable, realistic, and time-bound) have often been used as a guide in the goal-setting process (Schut & Stam, 1994). Ponte-Allan and Giles (1999) found that clients who made functional and independence-focused goal statements on admission to rehabilitation achieved significantly higher functional outcomes at discharge. Thus, enabling client involvement in the goal-setting process has been shown to have a positive effect on client motivation and participation (Bergquist & Jacket, 1993; Carlson, 1996) and to predict greater client adherence to, and satisfaction with therapy (Cott, 2004; Peri, Kerse, & Halliwell, 2004).

For optimal rehabilitation it is vital that the client and clinician collaborate in the goal-setting process (Law, Polatajko, Baptiste, & Townsend, 2002; Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001; Peri et al., 2004; Wade, 1998) and consequently have the same goals (Andrews & Roy, 1991; Bendz, 2003; King, 1995; Leach et al., 2010; Lewin et al., 2001; McPherson et al., 2004). However, studies have reported that collaborative goal setting in rehabilitation occurs relatively infrequently (McAndrew, McDermott, Vitzakovitch, Warunek, & Holm, 1999). Goals are often not explicitly stated or discussed and are often vague, global, and without definite timelines for achievement (Ottenbacher & Cusick, 1999).

When goals have been specified, research indicates they are frequently clinician-led or dominated (Leach et al., 2010; Levack, Dean, Siegert, & McPherson, 2011; Parr, Pound, & Hewitt, 2006; Worrall, 2006). The client’s desires are often neglected by healthcare professionals (Bendz, 2003; Reich, 1996), and consequently addressing the clients’ concerns is rarely the goal of therapy (Greveson & James, 1991; McLean, Roper-Hall, Mayer, & Main, 1991). In a study of neurological rehabilitation goal-setting practices Barnard, Cruice, and Playford (2010) found that there is rarely a straightforward translation of patient wishes into agreed, written goals. Research has found that, for patients, factors such as loss of control, fear of relapse, and fatigue were important and goals include returning to previously valued activities. For the clinicians, however, studies show that their goals often focus on impairment-based task performance and isolated discrete return of function (Bendz, 2000; Doolittle, 1994; Leach et al., 2010; Murphy, 1987; Toombs, 1992).

Goals devised solely by the clinician constitute a therapist-centred and often impairment-based approach to rehabilitation (Bendz, 2003; Burton, 2000; Doolittle, 1994; Leach et al., 2010) which focuses on the functioning of an individual in terms of disease, illness, abnormality, or trauma (Peri et al., 2004; WHO, 2001; Worrall, 2000) and has been found to be time-efficient for rapid throughput of patients (Meredith, 1993). This medicalised perception of rehabilitation is reflected in the type of goals that are chosen for therapy (Bendz, 2003; Wenestam, 2000). Impairment-based approaches require little or no input from the client regarding goal setting. Consequently the client’s objectives are not included, often resulting in a mismatch of goals (Bendz, 2003; Burton, 2000; Doolittle, 1994; Worrall, 2000).

An alternative approach is the client-centred or relationship-centred approach. In the formation of goals, input is required from the clinician in terms of the type
and severity of impairment, and input from the patient and family is required in terms of needs and desires in relation to therapy targets (Ersser & Atkins, 2000; Henriksson, Eeg-Olofsson, Marcusson, & Wressle, 2002; Law et al., 2002). Research has highlighted the importance of having positive relationships between clients and health professionals (Worrall et al., 2011). Worrall, Davidson, et al. (2010) found that people with aphasia report the need to feel valued and understood in the rehabilitation process. This then allows the clinician and client to work as a team to collaborate and establish the same meaningful goals (Adams & McGrath, 1999; Bendz, 2003; Henriksson et al., 2002; Worrall, 2000) ensuring an optimal environment for effective rehabilitation (Andrews & Roy, 1991; Bendz, 2003; King, 1995; Lewin et al., 2001; McPherson et al., 2004).

One theory that incorporates the concept of collaborative goal setting and values the importance of good therapeutic relationships is the goal-setting theory devised by Bradley, Bogardus, Tinetti, and Inouye (1999). This theory makes several propositions regarding the goal-setting process. First, goals are considered to be generated from embedded values which each individual holds. Values are seen as person-specific and relatively stable across circumstances, however goals vary according to the available alternatives and across situations. Second, goals are considered to be hierarchical in nature, with specific shorter-term goals and longer-term, general goals. Often a number of short-term goals contribute towards a more general overriding goal. Third, a number of factors can modify the goal-setting process, characteristics of the individual, the patient and clinician interactions, and characteristics of the disease or illness. An individual’s degree of risk taking, perceived self-efficacy, and the acceptance and understanding of their disease can all impact on the goals chosen in intervention. The characteristics of the interactions between the patient, family members, and clinicians such as the client’s trust in their clinician and their participation and sense of control also modify the goal-setting process. Bradley et al. (1999) identified the characteristics of the disease as another area influencing the goal setting. Factors such as urgency for intervention and the reversibility of the condition contribute to the prioritisation of certain types of goals. Other factors such as the patient’s ability to participate in the goal setting due to disease characteristics consequently lead to adaptation in the process of how goals are formed.

Many studies have investigated the goals of people with various diseases and disorders including the stroke population but often people with aphasia are excluded from these studies (McAndrew et al., 1999). Aphasia is an impairment either in understanding or in using the components of language (Bhogal, Teasell, & Foley, 2003). As good communication is vital to the goal setting process (Bradley et al., 1999), people with aphasia are disadvantaged compared to other communicatively able patients. While some studies have independently investigated the goals of speech-language pathologists for people with aphasia (Sheratt et al., 2011) or the goals of the people with aphasia themselves (Worrall et al., 2011), studies have yet to compare the goals of the people with aphasia and their speech-language pathologist within the same investigation. Therefore this study aims to answer the following questions: Are there differences between the goals of people with aphasia and their speech-language pathologists in rehabilitation? If mismatches in goals are evident, how did these differences occur? The results will be discussed in terms of the Bradley et al. (1999) model of goal setting in rehabilitation.
METHOD

Study design

The exploratory study consisted of a small cohort design involving qualitative data analysis (Sandelowski, 2000) of semi-structured, in-depth interviews (DiCicco-Bloom & Crabtree, 2006). Supported conversation techniques (Kagan, 1998; Simmons-Mackie & Kagan, 1999) were used to make the interviews accessible for people with aphasia.

Participants

Three registered speech-language pathologists with a minimum of 3 years’ experience working with people with aphasia participated in the study. Each clinician was attached to an inpatient/outpatient rehabilitation unit in a large metropolitan hospital and was asked to nominate people with aphasia whose case and treatment goals they remembered vividly. Four people with aphasia participated. Each person with aphasia had undergone a period of intensive inpatient rehabilitation (ranging from 2 to 5 months) receiving up to five speech-language therapy sessions per week. Once discharged from hospital each person with aphasia participated in weekly outpatient speech-language therapy which was still occurring at the time of the interviews. One clinician was the treating speech-language pathologist for two of the clients. Inclusion criteria for people with aphasia required that they were able to comprehend and take part in a semi-structured interview; they were able to provide reliable yes–no responses and they were attending outpatient rehabilitation at the time of the study. Documented evidence of cognitive decline was an exclusionary criterion.

Participant information forms were sent to each participant. Information for people with aphasia was provided with simplified language, and pictographic and symbolic support. Ethics approval was obtained by hospital and university committees and informed written consent was gained from participants prior to interviews. Participant details for people with aphasia are shown in Table 1.

Data collection

Data were collected through semi-structured interviews conducted at the home of participants with aphasia and at the speech-language pathologists’ place of work. Interviews were conducted by final year speech-language pathology students who had undergone formal training and were experienced with supported conversation techniques. Each interview was video and audio-taped and then transcribed verbatim based on the conventions of Poland (2001).

Client interviews

Three of the four people with aphasia had carers present during the interviews. Two had spouses present and one had an adult child present. Initial client interviews were approximately 1 hour in duration. A second, brief interview of 10 to 20 minutes duration was conducted to member check the data.

The following topics were covered in the interviews with people with aphasia: (1) Experiences of stroke/aphasia (e.g., *Tell me about your stroke.*); (2) Priorities and
<table>
<thead>
<tr>
<th>Client ID</th>
<th>Age (yrs)</th>
<th>Gender</th>
<th>Type of stroke</th>
<th>Time post-stroke</th>
<th>Severity of aphasia</th>
<th>Type of aphasia</th>
<th>WAB score (AQ)</th>
<th>Clinician ID</th>
<th>Experience with aphasia</th>
</tr>
</thead>
<tbody>
<tr>
<td>NT</td>
<td>71</td>
<td>M</td>
<td>Left parietal anterior circulation infarct</td>
<td>14 months</td>
<td>Mild</td>
<td>Mod-Severe</td>
<td>Broca’s</td>
<td>51</td>
<td>1</td>
</tr>
<tr>
<td>LI</td>
<td>54</td>
<td>F</td>
<td>Left basal ganglia and fronto-parietal infarct</td>
<td>9 months</td>
<td>Moderate</td>
<td>Severe</td>
<td>Broca’s</td>
<td>59.5</td>
<td>2</td>
</tr>
<tr>
<td>EY</td>
<td>82</td>
<td>F</td>
<td>Left middle cerebral artery infarct</td>
<td>9 months</td>
<td>Mild</td>
<td>Moderate</td>
<td>Conduction</td>
<td>60.8</td>
<td>2</td>
</tr>
<tr>
<td>TT</td>
<td>34</td>
<td>F</td>
<td>Left middle cerebral artery thrombosis due to internal carotid artery dissection</td>
<td>15 months</td>
<td>Mild</td>
<td>Severe</td>
<td>Broca’s</td>
<td>32.6</td>
<td>3</td>
</tr>
</tbody>
</table>
goals (e.g., *What was important to you then? Now? When did you start seeing a speech-language pathologist?*); (3) Aphasia rehabilitation (e.g., *What sort of things did you do in therapy? Did you find speech therapy useful? In what ways?*); and (4) Goal setting (e.g., *Who decides what you do in speech therapy?*).

Supported conversation techniques (Kagan, 1998; Kagan, Black, Duchan, Simmons-Mackie, & Square, 2001) were used to make the interviews aphasia friendly. Due to the severity of communicative impairment often only yes–no responses were elicited and the people with aphasia used various means of expression such as pointing, showing and miming to respond to questions. Communicative accommodation was also made for the conversational methods and cues of the person with aphasia (Garrett & Beukelman, 1993; Worrall & Hickson, 2003). Topics were returned to multiple times in order to determine the authenticity, consistency and to allow for fullness of response.

**Clinician interviews**

Clinician interviews ranged from 25 to 60 minutes in length. The interviews with the speech-language pathologists included the following: (1) Experiences of providing therapy for the person with aphasia (e.g., *When did therapy start? Tell me about your early impressions. Can you tell me about their background, hobbies and priorities?*); (2) Their goals for therapy (e.g., *What goals were targeted? Why were they targeted? What sort of therapy did you do?*); (3) The person with aphasia’s goals for therapy (e.g., *What do you think the person’s goals were? Did you talk about these? How were these dealt with in therapy?*); and (4) Perceptions of the person’s goals (e.g., *What is your opinion about targeting these goals in therapy?*).

**Data analysis**

The interview transcriptions were analysed through qualitative content analysis to identify and condense meaning units to create codes, categories and themes (Graneheim & Lundman, 2004). Both manifest and latent content were considered. Different research team members coded blank transcripts using the same coding tree to complete coding checks. The coding was then moderated through focused discussion. Member checks were used to evaluate interpretations and constructions of the data. Matrices and cognitive maps (Miles & Huberman, 1994) were used to explore data relationships to identify key concepts and explore reasons behind any differences of experience between interviewees.

**RESULTS**

Systematic content analysis of the interview transcripts revealed that both the speech-language pathologists and the people with aphasia had clear goals for rehabilitation. There were both similarities and differences in the goals identified. As these concepts developed, further explorations in the relationships between the data suggested some reasons for the matched and mismatched goals. Illustrative quotes are provided in italics to encapsulate the meaning in the participants’ own words.
Goals of people with aphasia

All of the people with aphasia were able to express clear goals through supported conversation. Goals consisted of two main categories: goals specifically related to improving communication, and goals associated with the desire to return to previously valued activities.

Regardless of the level of communicative function of the client, all of the people with aphasia had goals focused solely in improving communication. These ranged from the desire to express basic needs (e.g., . . . getting the message across, or finding words) to improving auditory comprehension or reading ability (e.g., . . . understanding better) and being able to have a conversation (e.g., So you can communicate your needs? Yes. That’s OK. But for you, you miss having a conversation? Yes. That is the biggest thing? Yes.)

In addition to priorities associated with improving communicative function, each client had rehabilitation goals focused on returning to valued activities. These involved the desire to sustain or return to pleasurable social contact or hobbies, to return to work, to travel, or to drive. For some clients these goals were listed as being of higher priority than the goals associated with improved communication alone (e.g., . . . So that would be your highest priority? [Points to “driving”] . . . Learning to drive again? Yes, yes).

Often communication formed a component of the client’s goal (e.g., So for reading . . . what is the thing you would like to work on most? . . . gem books. So you want to work on your hobby of gem collecting? Yes), or for the goal of maintaining contact with overseas friends and reliving travel experiences (e.g., Do you keep in contact with them? . . . yes. Do you write letters? No. [typing movements]. Oh email? Yes. Do you write them? [shakes head, points to wife] Your wife sends them? Yes). For some clients the area of greatest importance was to develop ways of coping with the reduced social contact and loneliness (e.g., . . . they want, they want to be able to speak . . . With you? . . . Yes. So the main issue has been this reduced social contact? Yes), while other goals such as returning to work contained a large communicative component.

Speech-language pathologist goals

The speech-language pathologists also had specific goals for their clients. These goals focused primarily on addressing language impairments which were revealed through discussions with the client and through formal and informal assessments. A variety of different goals were identified depending on each individual’s communicative strengths and weaknesses. Many goals targeted language function at an impairment level (e.g., Assessment results indicated weaknesses in the semantic system . . . a cognitive neuropsychological approach was taken . . . we were looking at SS to POL). Another speech-language pathologist targeted higher level impairment based tasks (e.g., We were doing things like low-imageability antonyms and synonyms), while other goals were more general (e.g., My area of highest priority was auditory reception. About 80% of time was spent on this . . . the next priority was verbal expression, which took up 20% of the time). The speech-language pathologists also all had goals associated with improving communication activities in everyday life (e.g., We were working on group communication activities, and encouraging multiword phrases and gestures . . . We worked on functional reading . . . We were looking at functional words and communicative independence . . .). Goals associated with the priorities of the clients
were also included (e.g., We chose functional words that were important... things that she wanted to work on... and... She had expressed to me that she wanted to start writing letters to friends and family. We had started doing a bit of work on that as well, doing a basic template for her and she could copy and change...).

**Matched and mismatched goals**

*Matched goals*

Comparison of the goals of the people with aphasia and those of the speech-language pathologists revealed that many of the goals matched. Goals which had a primary focus on improving communicative function were the goals that were well matched. Speech-language pathologist’s goals such as targeting semantic system function, improving reading ability, or focusing on functional communication all had some correlation with goals expressed by the clients. Often individual priorities of the people with aphasia were incorporated into the speech-language pathologist’s goal of targeting language function. For one client the goal of reducing loneliness and social isolation was targeted through letter writing (I suggested she write what had happened to her, and ask... please can you write back to me and this will help me with my therapy). Another speech-language pathologist and client had a shared goal of improving letter-writing abilities and consequently developed a template to guide therapy. Other goals were linked more indirectly, such as the client’s goal of improving conversational interchanges was targeted through the speech-language pathologist’s goal of targeting antonym and synonym exercises to help improve word-finding skills.

*Mismatched goals*

Analysis of the data indicated that there were also some goals that were unmatched. These tended to be goals of the client which were not shared by the speech-language pathologist. These goals were focused on returning to valued activities such as hobbies, returning to work, to travel, or to driving. When goals were mismatched, the speech-language pathologist gave a range of reasons why particular goals of the client were not addressed in therapy. Factors such as impaired communication made collaboration on goal setting difficult. Other pressures such as the service-delivery approach also impacted on the goal-setting process. For some goals, mismatches occurred as the clients’ goals were perceived to be outside the speech-language pathologists’ scope of practice, or were not considered appropriate within the confines of the rehabilitative situation. These reasons are now explored in more detail.

*Impaired communication made collaboration on goal setting difficult.* Speech-language pathologists reported that the language impairment of the client prevented them from being able to express their goals (e.g., I think that with a lot of these people, expressively they are so impaired they can’t tell you what they want to do. So basically you’ve got them and they’re basically saying they just want to be able to talk now). This barrier to goal setting was reported across speech-language pathologists despite individual differences in the communicative abilities of the clients. Speech-language pathologists also reported that the passivity of people with aphasia may also have contributed to poor communication on goals (e.g.,... I tend to find with these people,
that they are quite passive, they’re happy to come in . . . to do what you sort of set for them . . .).

Service-delivery approach. Speech-language pathologists reported that their institutions’ service approach to healthcare often led to their prioritisation of certain types of goals. Hospital policies regarding length of treatment and the realities of referral processes meant that not all goals could be targeted (There was much to work on all at the one time. With only a couple of months to do that . . . and . . . At case meetings they only want to know the figures from the tests. You have to provide evidence to keep them in therapy. It is a very impairment based service). Most of the speech-language pathologists identified that as a result of working within such a medicalised environment they often did not engage in explicit discussion with the client regarding their goals for therapy, and proposed that this may have contributed to the mismatch between goals.

The client’s goal was perceived to be outside the speech-language pathologist’s scope of practice. Some of the clients’ goals were to return to previously valued activities such as driving, or paying bills. The speech-language pathologists were at times aware of these desires, however they reported that addressing these goals was considered outside their professional scope of practice. Referral to other health professionals such as occupational therapy or physiotherapy was often made on these occasions.

The goal was not considered to be appropriate within the confines of the rehabilitative situation. In some cases the client’s goals were not targeted because the speech-language pathologist considered the client’s level of functioning to be too impaired for the goals to be achievable. For one client, although her treating speech-language pathologist knew of her desire to combat loneliness and social isolation through involvement in an aphasia group, the clinician stated that her co-morbid hearing impairment made group therapy unsuitable (Putting her into the language group really for them wasn’t an option . . . her hearing would impede how she would perform in that).

Physical and cognitive abilities of the client were also considered when deciding on therapy goals. The goal of returning to work for one client was considered by the treating speech-language pathologist to be an unachievable aim due to reduced physical functioning (To return to work you must be managing with ADLs, which she wasn’t). Similarly, where motor planning and cognitive planning problems existed that would interfere with the achievement of the client’s goal (e.g., returning to driving or taking photographs), the treating speech-language pathologist tended not to target the goal in therapy. Opportunities for targeting the communicative aspects of the goal were rarely reported to have been explored by the speech-language pathologist if these other areas of impairment seemed substantial.

Despite the mismatches that occurred between the goals of the people with aphasia and the speech-language pathologists, most of the clients expressed a high degree of approval when asked about how satisfied they were about what was covered in therapy. They reported they were generally inclined to trust the judgement of their speech-language pathologists, even when the clinician’s goals were not overtly matched to their own individual, specific goals. A summary of the client goals, speech-language pathologist’s goals, reasons for goals not being targeted and factors guiding the goal-setting process is summarised in Table 2.
TABLE 2
Summary of client goals, speech-language pathologist goals, reasons for goals not targeted in therapy, and factors guiding the goal-setting process

<table>
<thead>
<tr>
<th>Client ID</th>
<th>Client goal</th>
<th>Speech-language pathologist goal</th>
<th>Reason client goal was not targeted</th>
<th>Factors guiding goal-setting process</th>
</tr>
</thead>
<tbody>
<tr>
<td>NT</td>
<td>Conversation</td>
<td>Encourage communicative independence through multiword phrases and gestures. Improving expressive language. Improve word finding through antonyms and synonyms.</td>
<td>Results of assessment. Client’s strong communicative intent.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintaining social relationships</td>
<td>Encourage participation in group activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Travel</td>
<td>Improving exposure to language.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Driving</td>
<td>No corresponding goal.</td>
<td>Clinician not aware of client’s goal.</td>
<td>Goal setting not explicitly discussed in therapy. Impairment-based service.</td>
</tr>
<tr>
<td></td>
<td>Taking photographs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understanding strangers</td>
<td>Improving auditory reception.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reading gem magazines</td>
<td>Not directly targeted. Functional reading (including reading of general magazines) and writing tasks.</td>
<td>Clinician not aware of client’s goal.</td>
<td>Goals not explicitly discussed in therapy. Communication impairment prevented goal being expressed.</td>
</tr>
<tr>
<td></td>
<td>Writing to friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Walking</td>
<td>No corresponding goal.</td>
<td>Clinician not aware of client’s goal.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Driving</td>
<td></td>
<td>Client already being seen by occupational therapy and physiotherapy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cooking meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gardening</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Client ID</th>
<th>Client goal</th>
<th>Speech-language pathologist goal</th>
<th>Reason client goal was not targeted</th>
<th>Factors guiding goal-setting process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client ID: EY</td>
<td>Addressing loneliness and social isolation (by participating in aphasia groups)</td>
<td>No corresponding goal.</td>
<td>Goal was not considered to be appropriate within the confines of the rehabilitative situation (due to co-morbid hearing impairment).</td>
<td>Speech-language pathologist’s perception of client insight.</td>
</tr>
<tr>
<td></td>
<td>Finding words</td>
<td>Improving verbal communication</td>
<td>Results of assessment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Writing letters and cards</td>
<td>Improving written communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signing to accompany speech (e.g., Makaton)</td>
<td>No corresponding goal.</td>
<td>Clinician not aware of client’s goal.</td>
<td>Client goal of improving written communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Goals not explicitly discussed in therapy. Communication impairment prevented goals being expressed.</td>
</tr>
<tr>
<td>Client ID: TT</td>
<td>Communicating</td>
<td>Improving verbal communication</td>
<td>Results of assessment.</td>
<td>Results of assessment. Client goal.</td>
</tr>
<tr>
<td></td>
<td>Reading and writing (paying bills)</td>
<td>No corresponding goal.</td>
<td>Clinician not aware of client’s goal.</td>
<td>Goals not explicitly discussed in therapy.</td>
</tr>
<tr>
<td></td>
<td>Writing (shopping lists)</td>
<td></td>
<td></td>
<td>Cognitive-neuropsychological impairment-based approach taken.</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>Not considered within scope of practice.</td>
</tr>
<tr>
<td></td>
<td>Driving</td>
<td>No corresponding goal.</td>
<td>Client already being seen by occupational therapy and physiotherapy.</td>
<td>Speech-language pathologist’s perception of client insight.</td>
</tr>
<tr>
<td></td>
<td>Walking and increasing use of arm</td>
<td>No corresponding goal.</td>
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<td></td>
<td>Return to work</td>
<td>No corresponding goal.</td>
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DISCUSSION

This exploratory study examined the differences between client goals and clinician goals for people with aphasia in a rehabilitation setting. Results indicated both matching and mismatching of goals between the four clients and their speech-language pathologists. In general, matched goals were those that tended to focus on remediating communication, such as increasing expressive language abilities. Mismatched goals were those associated with the client’s desire to return to previously valued activities (e.g., driving) which incorporates some element of communication. These client goals tended to not be shared by the speech-language pathologist. These findings correspond to those of previous research which found that clinician goals tended to focus on impairment-based task performance as opposed to the client’s goals which in addition included returning to previously valued activities (Bendz, 2000; Doolittle, 1994; Leach et al., 2010; Levack et al., 2011; Murphy, 1987; Toombs, 1992; Worrall et al., 2011).

A number of reasons were identified for the mismatching of goals; impaired communication made collaboration on goal setting difficult, the service-delivery approach, the goal was perceived to be outside the speech-language pathologist’s scope of practice, and the goal was not considered to be appropriate within the confines of the rehabilitative situation.

Impaired communication made collaboration on goal setting difficult

Good communication between clients and their clinicians is essential to collaborative goal setting (Bradley et al., 1999). In the current study one of the barriers identified by the speech-language pathologists was the communication difficulties of the clients. In Bradley et al.’s (1999) theory of goal setting this breakdown occurs at the level of the disease characteristics of the client. The clinicians indicated that the clients’ disease prevented the people with aphasia from contributing to the goal-setting process. This finding was also found in Leach et al. (2010) where severe communication difficulties of patients was considered to be a significant barrier. In the interviews carried out with the participants with aphasia in this study, however, at least some approximation of goals was able to be elicited. Some of these clients’ goals were not known by the treating speech-language pathologist. Despite the communicative difficulties speech-language pathologists may experience when collaborating with people with aphasia for goal setting, this study has indicated there might have been additional factors involved aside from the disease characteristics which resulted in the mismatching of goals. Other factors might include a lack of priority given to collaborative goal setting, reduced access to conversational support materials and techniques for interviewing people with aphasia, or the client’s reluctance to persevere with communicating their goals.

Service-delivery approach

The model of rehabilitation may provide some answers for the reasons for communication breakdown. The speech-language pathologists in this study reported that goals and goal setting were seldom explicitly discussed with clients, and consequently goals tended to be devised solely by the clinician. Previous research has supported this finding that explicit goal setting occurs infrequently in rehabilitation (McAndrew et al., 1999) and studies have shown that people with aphasia report they rarely participate...
in goal setting (Byng, Cairns, & Duchan, 2002; Parr, Byng, Gilpin, & Ireland, 1997) often resulting in a mismatching of priorities (Bendz, 2003; Burton, 2000; Doolittle, 1994; Worrall, 2000).

The speech-language pathologists within this study reported that their goal selection for the clients was often influenced by the impairment-based service-delivery environment in which they worked. In this approach, collaboration on goals is not encouraged and therapy is targeted on isolated discrete return of function. Again, this finding replicates previous research where the medicalised perception of rehabilitation is reflected in the selection of goals (Bendz, 2003; Wenestam, 2000). Time constraints and the demands of a busy workload (Leach et al., 2010) as well as financial and organisational pressures (e.g., to discharge a patient as quickly as possible) have been found to result in clinicians prioritising impairment based goals for therapy (Levack et al., 2011). In their study investigating speech-language pathologists goals for people with aphasia, Sherratt et al. (2011) also found that workplace orientations (e.g., cognitive neuropsychological approach) encouraged a narrow focus on impairment-based goals. Previous research has found this medicalised perception of the problem is more time efficient (Meredith, 1993), however this results in sub-optimal rehabilitation as collaborative goal setting does not occur (Andrews & Roy, 1991; Bendz, 2003; King, 1995; Lewin et al., 2001; McPherson et al., 2004). In Bradley et al. (1999), this breakdown in the goal-setting process occurs not in the characteristics of the disease of the client, but in poor interaction characteristics between the clinician and client in therapy.

The person with aphasia’s goal was perceived to be outside the speech-language pathologist’s scope of practice

The goal of returning to driving was identified by three of the four clients, however the speech-language pathologists were either unaware of this goal, or they referred this to the occupational therapist. None of the speech-language pathologists targeted this goal. Mackenzie and Paton (2003) found that many drivers who were aphasic experienced difficulties with road signs, reading, and comprehension impediments. They reported it was the speech-language pathologist’s role to include road sign recognition and written road information in their rehabilitation management practices. Previous research has also supported the finding that clinicians tend to not target certain rehabilitation goals. In Levack et al.’s (2011) study on inpatient rehabilitation, clinicians were found to simply ignore goals that were deemed outside the scope of inpatient rehabilitation. In the Bradley et al. (1999) model of goal setting this belief regarding the scope of practice of the clinicians relates to the value system of the therapist which modifies the goal-setting process. Value systems within the profession were one of the factors that speech-language pathologists in the study identified as preventing them from implementing a more client-centred approach to goal setting.

The goal was not considered to be appropriate within the confines of the rehabilitative situation

For some clients in this study their rehabilitation goals were not addressed as their treating speech-language pathologists deemed their impairments too significant to make the goal achievable. For one person with aphasia her goal was to return to her previous work at a hardware store, however her speech-language therapist considered
her physical restrictions too severe to address this goal within the rehabilitation setting. Studies have found that clients often have holistic, broad goals and focus on long-term prognosis (Barnard et al., 2010) whereas professionals tend to focus on specific, contained goals (Hersh, Worrall, Howe, Sherratt, & Davidson, 2012) that are short-term and discrete (Barnard et al., 2010; Hersh et al., 2012; Leach et al., 2010), often due to their accountability for the goal outcome within the multidisciplinary team (Levack et al., 2011). In terms of the model proposed by Bradley et al. (1999) there are a number of factors which may have caused this mismatch of goals.

One important factor is the personal characteristics of the patient, particularly their understanding of the rehabilitative process and of their condition. Studies have found that therapists often report that clients have high expectations for rehabilitation (Worrall, Davidson, et al., 2010) and commonly set goals that are not considered achievable within the constraints of the rehabilitative setting (Fischer, Gauggel, & Trexler, 2004; Leach et al., 2010). Worrall, Brown, et al. (2010) found that as people move though the recovery process from the acute phase, rehabilitation, and to home, their goals changed. Initially patient goals tended to focus on immediate health and survival, while in rehabilitation there is more of a focus on therapy, practice, and homework. Once home, a transition towards getting on with life, keeping busy, active, and social becomes more of the priority. Maclean and Pound (2000) found that therapists aim to maintain motivation throughout therapy by encouraging acceptance and demonstrating an ability to live successfully with residual disabilities. In view of the importance of collaborative goal setting, rehabilitation professionals need to understand and assess a client’s ability to set goals which are suitable for the environment in which they are set (Simmond & Fleming, 2003). Indeed, research has indicated that a client’s participation in activities relevant to their goals (such as explicit discussion regarding goals and goal setting) may serve to increase a client’s understanding of the implications of post-injury changes. This in turn may result in an improved ability to identify achievable goals over time (Godfrey, Partridge, Knight, & Bishara, 1993; Leach et al., 2010; Ownsworth & Fleming, 2005).

Research has indicated that the role of hope in the therapeutic relationship is of significant importance for driving recovery (Worrall, Davidson, et al., 2010). MacLeod and McPherson (2007) stress the importance of investigating alternatives in the goal-setting process as a means for developing hope in clients. In this study the client’s goal of returning to work was deemed impractical, however alternative options appeared to not have been discussed. Research has indicated that for some people returning to work is important: “work fulfils basic human needs, such as financial, societal and intrinsic needs, and returning to work after stroke is of significant importance for quality of life and life satisfaction” (Vestling, Tufvesson, & Iwarsson, 2003, p. 35). Studies have shown that in reality, however, returning to paid employment is relatively rare (Hinckley, 1998; Parr et al., 1997). Caporali and Basso (2003) found in their study only 23% of the people with aphasia returned to employment, and only 13% were able to return to their previous roles (Hinckley, 1998). As few people with aphasia are able to return to paid employment, flexibility in goal setting is needed and investigation is required into alternative avenues to achieve a client’s goal of increasing independence. In Bradley et al. (1999) this absence of formation of alternative therapy goals indicates a breakdown in the interaction characteristics between clinician and client in explicitly discussing and deciding on goals.

A recent publication by Hersh et al. (2012) describes a new framework which may overcome many of the barriers to collaborative goal setting in aphasia rehabilitation.
Historically goals in rehabilitation have often been influenced by the concepts of SMART (specific, measurable, achievable, realistic, and time-bound) (Schut & Stam, 1994). The SMARTER Goal Setting framework devised by Hersh et al. (2012) provides an extension of this concept where SMART goals can be formulated in a way that is SMARTER (i.e., shared, monitored, accessible, relevant, transparent, evolving, and relationship-centred). Whereas SMART guides the nature of the rehabilitation goals, SMARTER guides a collaborative goal-setting process. “For example, a specific, achievable, measurable goal could be negotiated with a client and family in the context of a strong relationship, where the goal is clearly relevant and motivating, where there are transparent links between that goal, broader goals, and therapy tasks, and where that goal could be openly re-negotiated” (Hersh et al., 2012, p. 231). This emphasis on collaborative practice is an important addition to the currently used framework and raises awareness and challenges current goal-setting practices in aphasia rehabilitation. Given the sparsity of collaborative goal setting currently occurring in clinical practice, such a framework is a welcome addition in assisting with optimising rehabilitative outcomes for people with aphasia.

**CLINICAL IMPLICATIONS**

This study has identified areas of breakdown in the goal-setting process at multiple levels in terms of the Bradley et al. (1999) model. Breakdown occurred in the interaction characteristics between the clinician and client in explicitly collaborating on the formation of goals. The value system of the speech-language pathologist and/or health service delivery approach may also hamper the goal-setting process. Finally, characteristics of the client, such as their understanding of the rehabilitative process and their diagnosis, may also influence the goals chosen for therapy. These breakdowns resulted in mismatches of goals between the clients and speech-language pathologists and consequently led to sub-optimal conditions for productive rehabilitation (Andrews & Roy, 1991; Bendz, 2003; King, 1995; Lewin et al., 2001; McPherson et al., 2004).

Although this study offers discussion on the practices of goal setting for people with aphasia in rehabilitation, some limitations apply to interpretation of the findings. This exploratory study included only a small cohort and consequently opinions expressed are representative of only a few clients and clinicians. The study also relied on retrospective accounts of goals and goal-setting processes. While all of the patients were still undergoing speech therapy at the time of the study, the perceptions and priorities of both the clients and their treating speech-language pathologist might have changed during their period of rehabilitation. A future study could involve a larger patient and clinician cohort and avoid these limitations by conducting a series of interviews at different points throughout the recovery period to account for changes in perceptions over time.

**CONCLUSION**

Previous studies have identified the importance of a good relationship and communication between the speech-language pathologist and client in successful aphasia rehabilitation (Worrall, Davidson, et al., 2010). While different areas of potential breakdown in collaborative goal setting were identified in this study, many of these factors could be minimised through the adoption of a more relationship-centred
approach to rehabilitation where clients are encouraged to contribute to the therapeu-
tic process and collaboration on goals is paramount. Speech-language pathologists
need to be aware of the importance of good therapeutic interactions as well as recogn-
ising the value of maintaining hope in motivating recovery. Clients also need to be
educated in order to participate in the formulation of goals as well as recognising
the possible limitations of the rehabilitative setting. Future research could focus on
the role of education and educational resources for both clients and speech-language
pathologists in encouraging a collaborative goal-setting process in rehabilitation.

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