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# Clinician Perspectives of an Intensive Comprehensive Aphasia Program

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**Background:** Intensive comprehensive aphasia programs (ICAPs) have increased in number in recent years in the United States and abroad. **Objective:** To describe the experiences of clinicians working in an ICAP. **Methods:** A phenomenological approach was taken. Seven clinicians from 3 ICAPs were interviewed in person or on the phone. Their interviews were transcribed and coded for themes relating to their experiences. **Results:** Clinicians described 3 major themes. The first theme related to the intensity component of the ICAP that allowed clinicians to provide in-depth treatment and gave them a different perspective with regard to providing treatment and the potential impact on the person with aphasia. The second theme of rewards for the clinicians included learning and support, seeing progress, and developing relationships with their clients and family members. Third, challenges were noted, including the time involved in learning new therapy techniques, patient characteristics such as chronicity of the aphasia, and the difficulty of returning to work in typical clinical settings after having experienced an ICAP. **Conclusions:** Although there is a potential for bias with the small sample size, this pilot study gives insight into the clinician perspective of what makes working in an ICAP both worthwhile and challenging. **Key words:** aphasia, clinician perspective, intensive, treatment

In response to consumer requests for additional services, there has been an increase in the number of intensive comprehensive aphasia programs (ICAPs) over the past several years.<sup>1</sup> ICAPs provide a minimum of 3 hours of therapy a day for 2 weeks, with several programs providing as many as 4 to 6 hours a day over a period of 4 to 5 weeks. Daily therapy typically includes multiple individual sessions, group sessions, computer-based sessions, and/or community outings. This is different from the standard therapy model of outpatient rehabilitation in which a person with aphasia receives 2 to 3 hours of therapy a week over a period of 8 to 12 weeks.<sup>1</sup> A person in an ICAP program may receive as much as 120 hours of focused language therapy over a month, whereas a person in a standard therapy model will receive approximately 8 to 12 hours of therapy in a month. Other studies have described the effects and outcomes of such intensive therapy in people with aphasia.<sup>2-4</sup> What has not been studied is the effect on the speech-language pathology clinicians who deliver this new service. What is their experience with ICAPs?

Only a few studies have begun to explore the clinician's perspective on providing treatment to persons with aphasia. Through interviews,

Hersh<sup>5</sup> highlighted clinicians' struggles with the act of terminating therapy. Hinckley<sup>6</sup> used auto-ethnography to qualitatively analyze her clinical skills and judgments as a method of self-reflection. Sherratt et al<sup>7</sup> interviewed clinicians about how they develop treatment goals. The goals of their patients with aphasia and family members were then compared to the goals of the speech-language pathologists, and tensions or differences between goals were identified. Rohde et al<sup>8</sup> also compared therapist and client treatment goals to explore the similarities and differences in selected cases. In a study by Brown et al,<sup>9</sup> clinicians were interviewed as to what it means to live successfully with aphasia. The clinician perspectives were then included in a meta-analysis of perceptions of persons with aphasia and family members.<sup>10</sup> Although some perspectives were similar, the meta-analysis highlighted the different perspectives clinicians may have and the importance of exploring the perspectives of all stakeholders.

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There are several reasons why the experience of clinicians working in an ICAP may be different from their experience with standard care. These include the intensity of the program and the need for a broad range of competency with the multiple treatment approaches to ensure that the ICAP is comprehensive. Several ICAPs have been developed within the university sector, and these are likely to include more experimental and novel treatment procedures. Exposure to nonstandard but evidence-based therapies may also have an effect on the experience of the ICAP clinicians. Both positive and negative clinician experiences of working in an ICAP need to be explored for the sustainability of the ICAP workforce. Hence, the aim of this study is to describe the clinician experience of working in an ICAP.

**Methods**

This exploratory qualitative study is based on a phenomenological approach that “describes the meaning for several individuals of their *lived experiences* of a concept of a phenomenon.”<sup>11(p57)</sup> This study attempts to understand the commonalities (and possible differences) of several clinicians’ experiences in a nonstandard clinical treatment program. The phenomenological approach allows

clinicians who took part in a particular experience to give their interpretation of events as providers of a specific clinical treatment. Semi-structured interviews allow for the interviewer to guide the discussion, but for the participants to share their thoughts without being constrained.

**Clinician participants**

A purposeful sample of 7 speech-language pathologists is consistent with the number of participants suggested for phenomenological research (ie, 5-25).<sup>11</sup> Speech-language pathologists who had a range of characteristics were sought for these interviews. They differed in the number of years working, previous participation in ICAPs, geographical locations (in the United States and abroad), and type of clinical settings. The clinicians were recruited through the director of each ICAP. All participants signed a consent form approved by the institutional review board. **Table 1** shows the clinician and program characteristics as well as the experience of the interviewer and researcher. Years of experience ranged from 3 to 29 years. Number of times participating in an ICAP program ranged from 1 to more than 15. Clinicians were interviewed from 3 different facilities: 2 in the United States and 1 in Australia.

**Table 1.** Clinician characteristics

Clinician	Years working	Typical work setting	No. of times participated in ICAP	ICAP location and no. of sessions per year
1	9.5	Day rehab	4	Nonprofit rehabilitation hospital 2x/year
2	29	Day rehab	3	Nonprofit rehabilitation hospital 2x/year
3	4	Inpatient	2	Non-profit rehabilitation hospital 2x/year
4	5	Outpatient	1	Non-profit rehabilitation hospital 2x/year
5	3	ICAP; outpatient	>15	VA hospital 6x/year
6	4	ICAP; outpatient	>15	VA hospital 6x/year
7	7	Current: ICAP Previous: Inpatient	1	University clinic 2x/year
E.B. (interviewer)	15	Research; ICAP	7	Nonprofit rehabilitation hospital 2x/year

## Data collection

We developed the interview questions during discussions among ourselves and another experienced clinician from an ICAP (see **Table 2**). A variety of question formats were implemented to encourage clinicians to think about different aspects of working in an intensive program. Both open-ended questions and modified free-listing prompts were given.<sup>12</sup> The interviewer started by obtaining background information about the clinicians, including how long they had been working and in what types of settings and their prior experience with persons with aphasia. Then the clinicians were given the opportunity to talk about their experiences working in an ICAP with an open-ended prompt. Next they were asked to free-list adjectives to describe their experiences. The topics and ideas they generated were used as segues to expand those ideas. The order of the questions served as a guide so that the conversational nature of the interview was preserved. The questions were not sent to the clinicians before the interview. The first author (E.B.) interviewed all 7 clinicians. The interviews ranged from 27 to 62 minutes (mean number of

minutes [SD] = 45 [15]). The interviews were digitally audio-recorded and transcribed by E.B. or a trained volunteer. Each clinician was given the opportunity to review her own transcript and to make changes or add information.

## Analysis

We followed Graneheim and Lundman's<sup>13</sup> guide to methodically review interview data. Each transcript was read through in its entirety by E.B. at least twice to gain familiarity with the content. Responses were chunked into meaning units (responses to each question) and then broken into condensed meaning units (fillers, repetitions, etc, were removed). A condensed meaning unit consisted of a thought or idea. This was further condensed to the "essence" of the thought, that is, the phenomenological unit of analysis.<sup>13</sup>

We chose 4 interview items to analyze and present in this article. Responses to these specific questions summed up the experiences of working in an ICAP and the perspectives of the clinicians. Those questions were:

- Tell me about your experience in an ICAP program.
- What are the challenges?
- What are the rewards?
- Compare the ICAP to your typical clinical workload.

The responses to those core items were extracted and analyzed to determine whether there were common themes across the interviews. The entire transcripts were reviewed again to obtain additional quotes to support the main themes and subthemes.

## Reflexivity and rigor

Houghton<sup>14</sup> describes 4 approaches to reflexivity and rigor: credibility, dependability, confirmability, and transferability. Credibility is enhanced through prolonged engagement, peer debriefing, and member checking. Prolonged engagement occurred as the interview progressed. E.B. would ask the clinician "Anything else?", if the clinician appeared to be finished with a thought. Each clinician had the opportunity to talk as long as she had thoughts regarding the particular question.

**Table 2.** Questions and prompts for interviews

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### General work experience:

- How long have you been working?
- Where and what types of settings?
- Prior experience with aphasia?

### Interview guide:

- Tell me about your experience in ICAP.
  - Give some adjectives to describe working at the ICAP.
  - What are the challenges?
  - What are the rewards?
  - As a clinician, compare the ICAP to your typical clinical workload.
  - Why did you choose to work during this ICAP?
  - Why did you come back?
  - Would you do it again?
  - What did you learn from this experience?
  - Any thoughts about the participants?
  - What do you think are the most important features of the ICAP?
  - Give 3 positives of working at the ICAP.
  - Give 3 negatives of working at the ICAP.
  - What characteristics do you think an SLP should have to be a successful clinician in the program?
- 

*Note:* ICAP = intensive comprehensive aphasia program; SLP = speech-language pathologist.

Clinicians were also given the opportunity to contact the interviewer at any time in the future if they had additional thoughts on their experiences. Peer debriefing took place as the second and third authors (L.W. and L.C.) reviewed the coded interviews for confirmation of E.B.'s interpretation of the data.<sup>13</sup> Member checking was accomplished, as the clinicians were each asked to review their verbatim transcript. Only one clinician had a minor change in her transcript.<sup>15</sup>

Dependability and confirmability were considered throughout the process of analyzing the interview material. E.B. kept an ongoing record of her reflections and experiences to provide a method of practicing reflexivity.<sup>16</sup> Additionally, an audit trail was performed as each interview was transcribed, condensed, condensed further, and then coded for meaning. This type of document was created for each interview and then used for review and analysis by all 3 authors. Transferability was explored by providing thick description (ie, detailed quotes from the interviews and analysis of the shared experiences), which is presented in the following sections of this article. The ability to present a range of viewpoints enhances the rigor of the data and analyses.<sup>16</sup>

## Results

Clinicians described their thoughts about working in an ICAP, the difference from typical clinical settings, and their personal rewards and challenges. Sometimes the subthemes were explicitly stated in response to a question, whereas other times the theme emerged during another line of discussion. The interview format and questions guided the discussion, but clinicians brought up different themes at different points in the interview. For example, one clinician reported that learning and support were rewards in response to the opening inquiry, "Tell me about your experience working in an ICAP." Another clinician described the same rewards in response to the question later in her interview, "What are the rewards for working in an ICAP?" The results below describe the 3 main themes and the subthemes that emerged from the selected interview items: clinicians' thoughts about intensive therapy and their perceived rewards and challenges (see **Figure 1**).

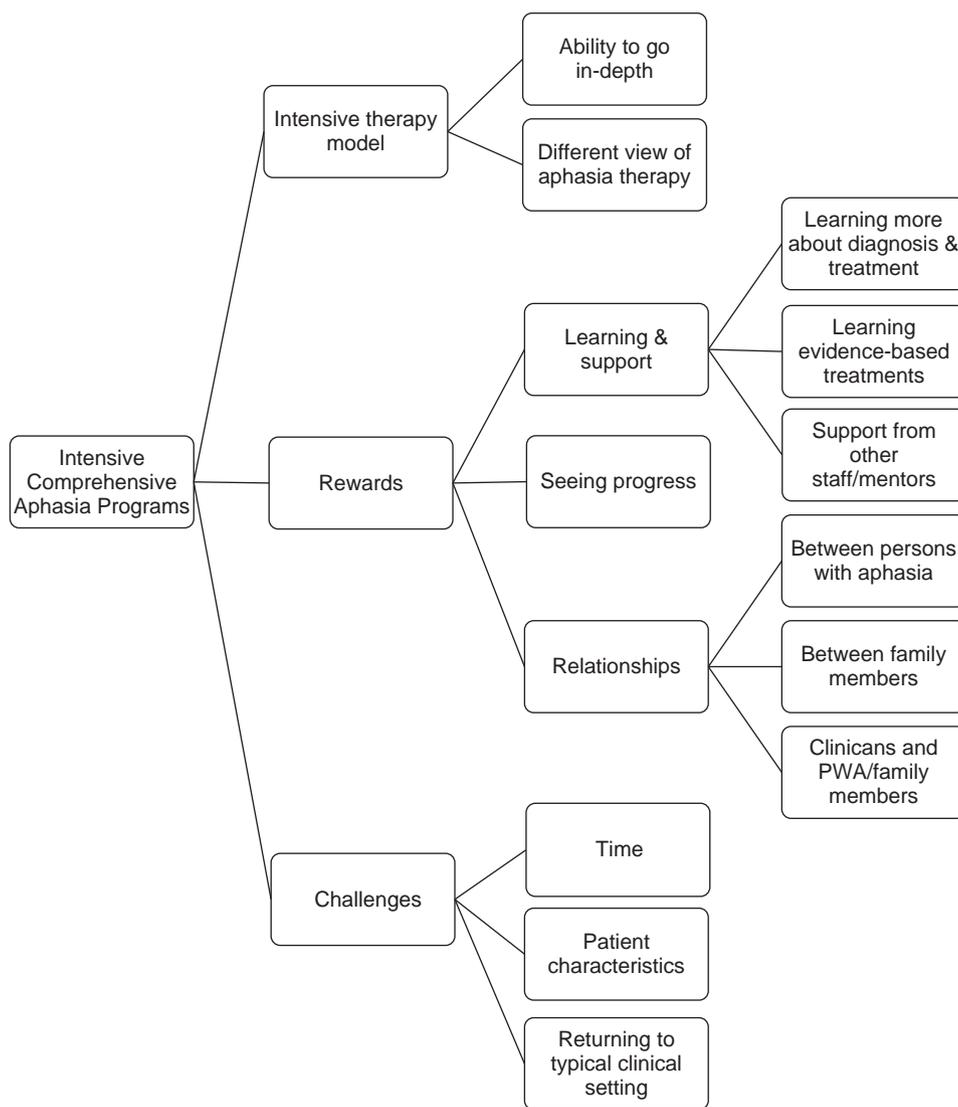
### *Intensive therapy*

In exploring the intensive therapy model from the clinician's perspective, 2 subthemes were discussed that highlighted perceived differences in working in an ICAP versus a typical clinical setting. The ability to go *in-depth* with their therapies was an important subtheme, as clinicians noted that the sheer number of hours of therapy provided a platform for meaningful gains that were seen as a result of the therapy. The clinicians used terms like "dig in," "fine tune," and "a different level of understanding" with regard to the intensity of the treatments they provided (see **Table A1**). Most clinicians stated that they were not able to provide similar in-depth treatment when seeing a client only a few times a week for a few weeks. A second subtheme was that the experience of working in an ICAP provided a *different view* of aphasia and aphasia therapy. Clinicians reported that their views changed regarding patients' ability to make progress at more chronic stages. They also commented on changes that they would make in their clinical practice, including more therapy focused on one task or an increased number of trials per session.

### *Rewards*

The clinicians experienced many rewards in working in the intensive programs. They used the words "honored," "privileged," and "a gift" to describe their experiences working in an ICAP (see **Table A2**). There were several subthemes to support the theme of rewards: *learning and support*, *seeing progress*, and *relationships*. Some clinicians described personal benefits that were not themes across all participants but that provided insight into the experience of working in an ICAP. One clinician stated that being part of something unique and special made her unique as a clinician. A few clinicians felt that working in an ICAP program provided them with variety and a change of pace that led to them feeling "refreshed" when they went back to their "regular" jobs.

Several clinicians identified the rewards of learning about evidence-based therapy techniques and being able to use them in their regular clinical setting. Gaining support from more experienced colleagues was also mentioned as a reward. This



**Figure 1.** Themes extracted from clinician interviews about working in an intensive comprehensive aphasia program (ICAP). PWA = persons with aphasia.

contrasted with time constraints or lack of mentors in their typical clinical settings, which limited their opportunity to collaborate or learn from senior clinicians. One clinician mentioned that access to and collaboration with experienced staff allowed her to grow professionally and become a better clinician. Learning about aphasia in terms of diagnosis and treatment was included in this subtheme. Several clinicians mentioned bringing new therapy techniques back to their clinical practice. Three mentioned that having the time to read research articles, trial and implement the

therapy technique, and ask questions about it were positive factors of the ICAP. Four clinicians were surprised or felt insecure that they did not know about some of the different therapy techniques. One clinician described the fact that she did not know the current evidence-based therapy techniques as humbling. She also reported that working in an ICAP gave her the opportunity to learn how to better implement a therapy technique.

The clinicians indicated that the progress of clients demonstrated that they were “good”

clinicians. They used words like “fulfilling,” “rewarding,” and “gratifying” to describe how they felt when their patients made progress. In that sense, the progress of the clients validated the work they did as clinicians. They commented that it was not only the progress measured during the evaluations, but also the opportunity to see their patients accomplish personal goals that was rewarding. It was also important to clinicians that the persons with aphasia and their families saw progress as well. This was another source of validation that they were doing good work as clinicians.

Clinicians found additional rewards in their relationships with the patients and their family members. Clinicians commented on the different kind of relationship they had with the participants in the ICAPs. Two clinicians remarked that they kept in touch more often with participants from ICAPs. The clinicians indicated that they heard from the participants not only when they were doing well, but also when things were challenging. Additional aspects of relationships that differed from typical clinical settings were the camaraderie and support that the caregivers provided to each other. Clinicians noted that it was difficult for family members to meet or form relationships in typical clinical settings. ICAP settings provided the opportunity for relationships to develop between the participants with aphasia as well as the families. They noted that more “bonding” happened because of the time and proximity factors inherent in the intensive models.

### Challenges

There were many challenges to working in this different clinical model. One major subtheme was *time*. Clinicians needed more time to write reports and they spent more time thinking about their patients or therapy tasks outside of the routine day. However, this was offset by comments such as, “What you get out of it is gonna be so much more than the extra time that you put in.” Another subtheme described the challenges related to *patient characteristics and expectations*. Patients with more severe aphasia and patients and families who had high expectations of recovery after participating in an intensive therapy program were more challenging. A third subtheme related to

clinicians comparing the “ideal” intensive therapy model to typical therapy settings. After seeing the amount of progress that could be made by their clients, clinicians remarked that it was hard to go back to work in typical settings with its many limitations in providing therapy (see **Table A3**).

Challenges with time included the time spent thinking about and planning the therapies, reading current research articles about evidence-based practices, and meeting with other clinicians and mentor staff to discuss patients and treatment approaches. Some clinicians reported thinking more about patients in their off time, including dreaming about their patients. It was evident that these therapists felt that the rewards for putting in the extra time were worth it, as it enhanced their clinical skills and contributed to the gains they saw patients making.

Clinicians talked about difficult patients that challenged their clinical skills even within the framework of an intensive program. Personality clashes that occur in regular clinician settings can also occur in intensive programs, however most clinicians talked about how the ICAP participants were more motivated and willing to work. A few clinicians talked about some of their patients who were more chronic and presented challenges. The expectations for recovery had to be discussed with the participants and the family members. One clinician felt that it was difficult to provide new and different therapy ideas for clients who were farther post onset and had already participated in extensive therapy. Clinicians also described the difficulty in working with aphasia in general, but especially in an intensive program with many hours of treatment. They mentioned the challenge of individualizing the treatment protocol.

Many clinicians reported challenges in returning to a typical clinical setting after working in an intensive program. Many felt that the intensive setting was ideal for providing therapy that maximized progress. Clinicians remarked on the factors that contributed to the greater benefits with the intensive setting. Some of these issues have been mentioned previously. The thread that ran through all the clinicians’ comments was their feeling that the intensive setting was superior to typical settings and the obstacle of not having an intensive program available to all their patients.

## Discussion

These interviews provided a first look at what a small number of clinicians think about the ICAP, especially compared with the typical clinical setting. With the increase in the number of ICAPs, more speech and language pathologists may have the opportunity to experience this different therapy model. The aim for this study was to find out what clinicians think about working in an ICAP. Is their experience different from working in a typical clinical setting? What are some of the rewards and challenges? Common themes from the interviews were that working in an ICAP is hard, but the rewards outweigh the challenges for these clinicians. It was clear that there were many personal and professional benefits and that the intensive model provided a measure of success for the clinicians. Learning evidence-based therapy techniques was important to them; they felt it made them better clinicians. Getting support from and being able to problem solve with and learn from other clinicians and mentors were important benefits. Clinicians reported that they did not have these opportunities in their typical clinical settings due to time constraints. They felt validated as clinicians when they saw significant progress in their patients and when patients and family members noticed that progress as well. Rewarding relationships were also remarked upon. The programs brought people with aphasia and their families together and provided them with opportunities that they would not have had otherwise. Clinicians felt they were doing their best work in the best possible situation.

Previous research on health professionals' job satisfaction highlights many of the same rewards that the clinicians in this study discussed in their interviews. For example, McLaughlin et al<sup>17</sup> interviewed clinicians about attrition and job satisfaction. They reported that having variety in their jobs, interacting with clients, having support and collegiality from working in a team, helping people and making a difference, and learning and expanding their knowledge base were the important factors that led to positive experiences working as speech-language pathologists. Occupational therapists and nurses working in inpatient settings that served patients with eating

disorders also reported that patient interaction and building therapeutic relationships were factors that led to job satisfaction.<sup>18</sup> Randolph<sup>19</sup> found that the intrinsic characteristic of wanting to help people overcome disabilities positively impacted job satisfaction for occupational and physical therapists and speech-language pathologists. The subthemes of learning, having support, seeing progress, and developing relationships contributed to the rewards for the ICAP clinicians and the perception that they were better clinicians because of the experience.

Although challenges were noted, mostly related to the time needed to quickly learn and implement new therapy techniques, clinicians reported that the rewards offset those challenges. Similar themes related to challenges have been noted by other rehabilitation professionals, including speech-language pathologists working in other settings. McLaughlin<sup>17</sup> reported that negative aspects of being a speech-language pathologist included feelings of limited or uncertain clinical efficacy. In contrast, clinicians in our study mentioned that working in the intensive program reduced the feelings of limited efficacy they felt in typical clinical settings. In discussing job satisfaction, school-based speech-language pathologists reported challenges that contribute to their perceived stress: lack of opportunities for professional development, decreased time, and difficulty in workload management.<sup>20</sup> They also reported that additional stressors were related to scheduling and workload issues or limited effectiveness due to client characteristics that led to limited progress. The ICAP clinicians we interviewed felt that working in an ICAP reduced or eliminated those stressors to a certain degree. Although these stressors may be inherent in all therapeutic work environments, the model of intensive therapy may reduce the challenges clinicians face. Clinicians in our interviews noted that they felt they were making a difference and were able to see good progress. They also noted that it was difficult to go back to their "regular" jobs in which they did not see the same degree of progress.

Hence, the predominantly positive experience by clinicians reflects the generally positive outcomes for participants and their families. ICAPs are likely to grow in number. This study suggests

that other clinicians may find working in an ICAP to be a positive experience as well. The challenges experienced by clinicians, however, are not easily overcome. The time pressure is inherent in any intensive therapy program, as is the challenge of responding to all types of participants. Changing models of practice and therapies when clinicians return to their typical work settings can also be a challenge. Clinicians indicated they felt they were better clinicians for having experienced working in an ICAP. Carry-over of their enhanced clinical skills may ultimately improve service delivery for aphasia rehabilitation.

### **Clinical implications**

As several clinicians stated, the ICAP experience was like going back to school. One clinician said, "But it was even better, because you were reading the current evidence-based therapies, implementing them, and then talking about how it went." Clinicians talked about how they altered their clinical practice by emphasizing home practice, providing massed practice during sessions, or teaching others at their sites how to implement some of the evidence-based practice techniques. One clinician mentioned that prior experience with aphasia was important because "you aren't there to learn about aphasia, but to build on what you already know." ICAPs, therefore, have the potential for professional development and specialized skill training for novice and experienced speech-language pathologists. A potential solution to the pressure to quickly learn new treatments is to develop training modules that are related to the ICAP therapy protocols. Discrete skills could be learned and practiced prior to commencement of the ICAP and intensive therapy protocols incorporated into training programs for ICAP clinicians. Clinicians recognized that patients' progress had a direct impact on their feelings of being valued as a therapy provider. It was telling that clinicians used terms like "depressing" and said things were "stacked against" them when talking about returning to typical therapy settings after working in an ICAP. Organizations may want to look at how typical therapy settings can recreate specific factors from ICAPs to enhance patient progress and clinician job satisfaction.

### **Future considerations**

We have reported on themes discussed by clinicians in 3 ICAPs. Although themes were consistent across clinicians, there were some differences among the ICAPs. Future research regarding ICAPs may need to consider how differences in the programs may impact perceptions and outcomes. For instance, of the 3 programs represented by the clinicians in this study, 1 program provides on-site housing for its participants who must be independent in all activities of daily living to attend. Family members do not attend. Therefore, clinicians from this ICAP did not discuss the bonding of family members, but they did have the opportunity to observe more bonding between the participants with aphasia. Furthermore, the clinical population at this ICAP might be different given that the participants are more independent and active in the community. Thus, site-specific factors can influence participant characteristics that, in turn, may influence the clinicians' perceptions of working in an ICAP.

Patients' characteristics may impact the clinicians' ability to see progress and their overall perception of the ICAP. For instance, one clinician reported difficulty with motivating a young patient with a traumatic brain injury who was enrolled in this program by his parents. She found it difficult to motivate and engage this particular client. Another clinician reported that it was a challenge to work with a person with severe chronic aphasia who would have been discharged in a regular setting for reaching a plateau. This notion of plateau was not an important factor to other clinicians who welcomed the opportunity to work with patients with chronic aphasia, as they felt the patients were ready and motivated.

Future research must also consider methods to decrease bias. Results of the current pilot study must be interpreted cautiously because of this potential. For example, all clinicians who were approached agreed to participate in the interview; therefore, we may have excluded clinicians who did not enjoy working in an ICAP. The clinicians may not have revealed their true feelings, because they were interviewed by a colleague who had a perceived investment in

the local ICAP. Similarly, being interviewed by a clinician from another facility may have biased the clinicians to report more positive aspects of their experience. The interviewer may not have followed up on clinician responses, because she felt she knew or inherently understood what the clinician meant because she, herself, had been an ICAP clinician. The language and terminology used in the interviews may have been constrained because the clinicians and interviewer were all speech-language pathologists. On the other hand, this may have been a benefit during analysis of the transcripts, because the first author (E.B.) may have perceived subtle nuances due to shared experiences. A factor that may impact generalization of clinicians' experiences is that clinicians who work in an ICAP as part of their regular job duties may have different experiences than clinicians who participate occasionally. The staffing structure of the intensive program may impact the clinicians' perceptions. Clinician training may be another factor that is specific to an ICAP program.

## Conclusion

This study has described what some clinicians see as important elements in the composition of ICAPs. The structure of an ICAP may provide ways for clinicians to feel they are doing their best work. They reported seeing more progress, developing deeper relationships with their clients and family members, and seeing deeper relationships develop between clients and family members. They also reported administering therapy at a more in-depth level than was possible in typical clinical settings. ICAPs facilitated deeper therapy through evidence-based aphasia treatments and the increased amount of time that the clients participated in those therapy tasks. Further research should include an increased number of sites and clinicians to obtain a larger sample of perspectives so that clinician experiences can be more easily generalized to other newly developing ICAPs. Clinicians should begin to think about how to overcome the challenges inherent in delivering ICAPs, so that more clinicians and participants can reap the rewards.

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## APPENDIX

**Table A1.** Intensive therapy model: clinician comments

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1. *Ability to go in-depth:*

- “When you’re in the intensive, it’s almost the most optimal treatment setting you can ask for so you can really dig in.”
- “Because you’re seeing them intensively, you just have that opportunity to get such a deeper understanding of what’s going on.”
- “You’re really fine tuning... the treatments which is great. It’s something that we never, we don’t get a chance to do, certainly in inpatient when somebody’s there for two weeks or three weeks.”
- “With the time factor, you’re getting in a lot more trials. You have the ability to... shape and fade your cues and modify your protocol on what you’re seeing because you’re seeing them for such a lengthier period of time.”

2. *Different view on aphasia and aphasia therapy:*

- “The concept of... the intensity of a single repeated practice on a certain goal is really important.”
- “If I only ever saw aphasia from an inpatient perspective... even from day rehab or outpatient, I would just have a completely different view of its effect on somebody’s family or effect on that person or the potential for somebody to make really great progress, too.”
- “I’ve learned to focus my treatment... I’ve learned that... intensity is important. I think that will change how much home practice I give patients... I think I will spend more time training caregivers to do things at home because I... saw firsthand what... the intensity component does.”
- “In comparing to... other people with aphasia that you see one or two times a week... people tend to sign off quicker because... the progress is minimal and... speech pathologists might think that their patients are plateauing when it’s just that they haven’t been able to see them often enough to see enough progress to... rationalize to continue the treatment.”
- “We had group sessions every day... it really reinforced [for] me how important groups are for patients.”

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**Table A2.** Rewards: clinician comments

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1. *Learning and support:*

- “I think having the drive to always want to learn more and gain more knowledge and find out what’s new in the field... new and upcoming, is kind of crucial.”
- “It’s something that I felt when I was in grad school. There was this huge emphasis on... really kind of dissecting the person’s impairments and figuring out how to approach it or looking at the evidenced based practice... in the real world it just doesn’t always happen that way... So having this ability to take a step back where you... have to use those thinking skills again... you have to really problem solve and think of things in a different way. I thought was just really great.”
- “All of those treatment techniques we used are things that I didn’t use... I didn’t use them before and now I do... I was...embarrassed or felt bad that I didn’t know about and wasn’t using before.”
- “It just makes you a better clinician, makes you a better professional.”
- “Just talking about... the clinical problem solving... is very useful as well as... having... the ability to go into such depth with each patient and having other speech therapists right there to assist in the planning and determining treatment recommendations.”

2. *Seeing progress:*

- “It’s just also really fulfilling to work with somebody for that period of time, that intensity, and really be able to see some of the changes that they make.”
- “Patients improved so much. It was great to see that. I don’t always see that particularly in outpatient with people who have chronic aphasia... That’s a huge reward to see that on the last day... realizing these improvements, seeing their test scores. Seeing this is where I was, this is where I am.”

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(Continued)

**Table A2.** (Continued)

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- “It’s one of the few times a year I actually see them make improvements within you know that amount of time. Within the month we see them, you definitely see things. I’ve had patients who... wanted to just be able to read something again and they’re reading and for their face to light up and for them to tell you ‘I can finally read again’ and they you know get emotional sometimes... I’ve had family members too who are surprised at the end... when they see their family member write a word and they haven’t been able to write anything for the past five months... being able to see the gratification that our patients feel and their family members feel is huge.”
3. *Relationships:*
- “I didn’t get this in day rehab or inpatient but you have ten people there with aphasia (and you’re really getting a chance to see the variety of difficulties that people have and their family situations and all of the social dynamics that happen as well) as when those people all come together in one group and how rewarding it is for them to be able to have this... bond with each other.”
  - “Aside from the... therapeutic improvements, I think improvements in quality of life... meeting other people with aphasia... it was really rewarding to see some of the first time participants... interact with other people with aphasia... seeing them form new relationships.”
  - “... how [family members] kind of benefit from each other being around as well as just being able to see their family member be so independent in certain situations.”
  - “Clinically, you wouldn’t get a group of family members together to talk... it’s hard, often hard to meet family members... in a really acute environment.”
  - “You develop a bond with somebody when you’re working with them for five and a half or six hours a day... when you’re in a clinic and you’re seeing... anywhere from four to eight patients a day... there’s just less opportunity to really... develop that relationship with your patients and take it that one step further.”
  - “I still talk to so many of these... guys and their family members and just hearing these little things [updates]... it makes your day.”
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**Table A3.** Challenges: clinician comments

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1. *Time spent working or thinking about therapy tasks:*
- “Paperwork and goal setting was time consuming... want them relatable and functional and individualized.”
  - “It took more time to come up with treatment plans and determine the best next step. It was just more time consuming to do that in the intensive program than it is in my everyday treatment. It was challenging learning and then using for the first time these new treatment techniques. All these are good challenges.”
  - “... it’s a really different way of thinking about working with somebody... It’s like my brain has to do so much more for any given day during the during the intensive than it does in inpatient... it’s more just thoughtful in trying to plan and carry out that much therapy for a given person in one day and trying to take some of the evidenced based approaches and incorporate those into sessions... and to really... problem solve and think ‘well my participant can’t do it this way, how could we modify it?’ so that’s where I think the challenge comes from. It’s just much more brain power involved, maybe not more but just a different kind of brain power.”
2. *Patient characteristics:*
- “You have your type A personalities who want perfection. They expect to be cured when they come, especially when they’re coming to this program. Can be challenging to find that balance between having them realize what’s realistic expectations versus in being cured.”
  - “There’s a huge difference in their motivation and ... they bring that to therapy... I’m not waking them up in the morning telling them you have to do therapy right now. They’re coming to see me and this brought it to a whole different level. Patients are paying a lot of money to be there. It’s a big time commitment. They’re motivated. They’re there to work.”
  - “I think they tend to be a little bit more outgoing, a little bit more active, involved in their community, involved... socially. Some of them want to continue to work. Whereas... some patients who I just see as an outpatient one time a week, I think they tend to be a little bit more isolated at times. They’re a little bit more depressed even.”
3. *Returning to work in “typical” clinical setting:*
- “...There are so many things stacked against you sometimes in your day to day job. Sometimes the patients aren’t always invested. Sometimes even when the patient’s invested, you can only get so much because there’s not enough family support at home. But whereas the intensive... they’re gonna have family support and they’re there to work so you just... cut through all that extra stuff.”
  - “Whereas the demographics at day rehab, there’s a lot more lower income people... so that’s too bad because... the intensive is... a really good program that it’s too bad that it can’t be more accessible to everybody.”
  - “I just get a lot more gratification and satisfaction out of that level of therapy versus seeing somebody... for a couple minutes on the floor... I’m happy... if I can get somebody on an advanced diet... but I don’t feel as much it’s something I’ve done to help them. I feel like it’s just more their medical status has improved... [in ICAP] it’s more of what I’m doing and the research I’m doing and our team is doing to... help this patient is... what makes it more rewarding in the end.”
  - “You just can’t provide the same quality of care that you do in the intensive aphasia program.”
  - “That’s also a little bit of a letdown when you do go back to your job because it isn’t always the ideal treatment setting and it’s a little disheartening to sometimes think... [could this person make the same type of gains] if there wasn’t insurance limitations and... if I was able to work with them for two hours individually a day. What could the difference be? So sometimes that’s a little bit depressing.”
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