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ADAPTING APHASIA REHABILITATION: A CULTURALLY SENSITIVE AND COMPREHENSIVE APPROACH FOR URDU-SPEAKING PATIENTS AND THEIR COMMUNICATION PARTNERS

ADAPTANDO A REABILITAÇÃO DA AFASIA: UMA ABORDAGEM CULTURALMENTE SENSÍVEL E ABRANGENTE PARA PACIENTES QUE FALAM URDU E SEUS PARCEIROS DE COMUNICAÇÃO

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Abstract

Background: Chronic aphasia is a neurological disorder that affects language comprehension, expression, reading and writing, with significant consequences for daily functioning, social participation, and quality of life. Rehabilitation approaches aim to maximise functional communication; however, culturally responsive strategies remain underexplored for Urdu-speaking populations. Objective: To develop a culturally sensitive and comprehensive approach for Urdu-speaking patients with chronic aphasia and their communication partners. Methodology: An exploratory qualitative design was employed to identify communication needs. Data were collected from focused structured groups of four speech-language pathologists and three caregivers recruited through convenience sampling. Interviews were culturally adapted and analysed using thematic analysis following Braun and Clarke's framework. Results: Findings highlighted substantial psychosocial impacts of chronic aphasia and emphasised the need for functional, goal-oriented intervention. Key barriers included limited availability of Urdu-language resources and cultural misunderstandings affecting rehabilitation practices. Conclusion: Effective management of chronic aphasia requires culturally competent, integrated approaches that address psychosocial

Resumo

Contexto: A afasia crônica é um distúrbio neurológico que afeta a compreensão, a expressão, a leitura e a escrita da linguagem, com consequências significativas para o funcionamento diário, a participação social e a qualidade de vida. As abordagens de reabilitação visam maximizar a comunicação funcional; no entanto, as estratégias culturalmente sensíveis continuam sendo pouco exploradas para as populações que falam urdu. Objetivo: Desenvolver uma abordagem culturalmente sensível e abrangente para pacientes que falam urdu com afasia crônica e seus parceiros de comunicação. Metodologia: Um desenho qualitativo exploratório foi empregado para identificar as necessidades de comunicação. Os dados foram coletados de grupos estruturados focados de quatro fonoaudiólogos e três cuidadores recrutados por meio de amostragem por conveniência. As entrevistas foram adaptadas culturalmente e analisadas usando análise temática seguindo a estrutura de Braun e Clarke. Resultados: Os resultados destacaram impactos psicossociais substanciais da afasia crônica e enfatizaram a necessidade de intervenção funcional e orientada para objetivos. As principais barreiras incluíram a disponibilidade limitada de recursos em urdu e mal-entendidos culturais que afetam as práticas de reabilitação.

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needs and systemic barriers to improve communication outcomes and quality of life.

Keywords: Chronic Aphasia. Quality of Life. Speech Language Pathology. Melodic Intonation Therapy.

Conclusão: O tratamento eficaz da afasia crônica requer abordagens culturalmente competentes e integradas que atendam às necessidades psicossociais e às barreiras sistêmicas para melhorar os resultados da comunicação e a qualidade de vida.

Palavras-chave: *Afasia Crônica. Qualidade de Vida. Fonoaudiologia. Terapia de Entonação Melódica.*

1 INTRODUCTION

Aphasia is a complicated language disorder which occurs largely due to neurological damage most frequently stroke in the majority of cases. It is characterized by difficulty in speaking, comprehension, reading and writing. Chronic aphasia is one of the most debilitating forms of aphasias since symptoms don't resolve automatically but rather continue to appear after the acute recovery period of the disease and remain resistant to spontaneous recovery (Brady et al., 2016; Papathanasiou et al., 2020). The lifelong impairment not only limits verbal communication but also causes a deep effect on emotional well-being, social integration and quality of life (Hilari & Byng, 2009; Flowers et al., 2016). For many individuals chronic aphasia poses a challenge to effective engagement in meaningful activities. It affects job and educational opportunities. Consequently, it makes family members to face a long-term burden which they have to deal with the shifts in the communication and care dynamics (Northcott et al., 2016; Cruice et al., 2020). The heterogeneous nature of this disorder also makes it complicated as the severity and symptom patterns vary greatly based on the lesions site, cognitive reserve and rehabilitation opportunities (Kiran and Thompson, 2019). Despite advancement in the field of neurosciences and clinical practice, chronic aphasia is one of the most difficult forms of communication disorders to handle.

The effects of chronic aphasia go far beyond the language deficits and encompass the psychosocial, emotional and cognitive dimensions. Social isolation, the inability to interact and build relationships with others is common effects of difficulties engaging in conversations and sustaining relationships (Dalemans et al., 2010; Grohn et al., 2014). Many experience depression, frustration, and increased anxiety especially when they are not able to communicate the most basic needs or opinions (Ayerbe et al., 2013; Cumming et al., 2016). Family members most of the times describe role reversals and emotional strain when they get involved in caregiving responsibilities by pointing out the relational and systemic outcomes of the disorder (Denman, 2019).Practically inability to cope with everyday activities including finances, engaging in social life or using the medical system reduces autonomy and, as a consequence, may result in a prolonged dependency (Cruice et al., 2020). The impaired memory, decreased attention and executive functioning are the cognitive effects, which further complicate rehabilitation (Fonseca et al., 2019). These issues interrelate to highlight the significance of holistic interventions which extend beyond linguistic recovery in order to deal with the broader life impacts of aphasia.

Different treatments methods have been developed over the years to improve language and communication skills in chronic aphasia patients. Constraint-Induced Aphasia Therapy (CIAT) involves extensive practice of spoken language with restriction of compensatory strategies leading to increased neuroplasticity through intensive training (Pulvermuller & Berthier, 2008). The Melodic Intonation Therapy (MIT) exploits the musical ability that has been retained in the brain by engaging the right hemisphere systems with melodies and rhythms in order to stimulate speech production that is particularly beneficial in severe non-fluent aphasia (Stahl et al., 2011; Zumbansen et al., 2014). Semantic Feature Analysis (SFA) enhances word retrieval since it enhances the lexical networks and prompts the patients to describe semantic features of the target words (Boyle, 2010). Augmentative and Alternative Communication (AAC) strategies such as low-tech devices such as picture boards and high tech devices such as speech generating applications offer critical support for individuals with reduced verbal output (Beukelman & Light, 2020). The Life Participation Approach to Aphasia (LPAA) is now a more recent holistic model that emphasizes re-entry into the external world, integration and quality of life in the community rather than just addressing the degree of impairment outcome (Chapey et al., 2008; Simmons-Mackie et al., 2017).

Neuromodulation techniques including transcranial magnetic stimulation and transcranial direct current stimulation represent promising adjuncts by modulating brain activity to enhance recovery (Marangolo et al., 2013; Torres et al., 2013). Because these innovations have significant potential therefore their application often faces numerous challenges. However there are few factors like high costs, limited accessibility and cultural appropriateness that most of the times hinder their usage. Moreover these barriers are particularly obvious in countries with low and middle income where health infrastructure may be limited (Kiran & Gray, 2018).

Despite the range of available interventions a major gap persists. Most therapies have been designed, validated and implemented in English speaking populations with limited adaptation to other linguistic and cultural contexts (Parr et al., 1997; Hersh et al., 2015). Language is deeply embedded in culture. Therefore therapeutic approaches that fail to consider local communication practices, familial structures and sociocultural expectations may risk reduced effectiveness (Mumby & Whitworth, 2012). In Pakistan Urdu is the national language and many individuals are bilingual or multilingual. Therefore speech-language pathologists face unique challenges while dealing these patients. In such situations patients may struggle with therapy materials that are culturally irrelevant or linguistically mismatched. Moreover families experience difficulties in understanding or supporting the rehabilitation process (Khan et al., 2022). Furthermore collectively these cultural norms often position family members as central figures in communication and caregiving. However existing rehabilitation frameworks for chronic aphasic patients rarely consider dynamics. Consequently there is always a need for culturally sensitive approach that incorporate evidence based strategies while respecting the linguistic and cultural realities of the population.

The Learning to Communicate Successfully Approach (LCSA) was developed to address this gap. Based on the evidences of the already existing rehabilitation approaches like the Life Participation Approach to aphasia (LPAA), the concepts of neuroplasticity and person centered models; this approach relies on the established methods of successful recovery. In particular it emphasizes active participation, functional communication and individualized goal setting. Therefore the main objective of this proposed manual is to provide a comprehensive and culturally sensitive resource designed especially for chronic aphasic patients speaking in Urdu language. It focuses on participation in life situations, adaptation of the communication environment and attention to personal and cultural factors instead of language recovery only. The approach is designed to be holistic by addressing impairment level difficulties while promoting reintegration into family, social and community life. It equally emphasizes developing linguistic competence and promoting psychosocial resilience therefore making rehabilitation consistent with the lived experience of patients and their caregivers (Kiran & Thompson, 2019).

In summary chronic aphasia is a complicated disorder that causes significant linguistic, cognitive, emotional and social burdens. While a wide range of therapies exists but their effectiveness is often limited by lack of cultural adaptation particularly in non-English-speaking populations. The introduction of the LCSA is an essential milestone in addressing these limitations in the Pakistani culture.

2 METHODS

This study employed a qualitative research design to explore the experiences, perspectives and needs of patients with chronic aphasia. The objective of the study was to inform the development of the Learning to Communicate Successfully Approach for Urdu-speaking patients with chronic aphasia. Speech Language Pathologists with at least 5 years of experience in dealing patients with chronic aphasia were included in the study. Primary family caregivers who supported patients with this condition were also part of this study. Caregivers were included in the study because they play a crucial role in rehabilitating the communication of patients within our joint family system. Participants were recruited from rehabilitation departments in different hospitals, private speech therapy clinics and community centers located in Multan and Lahore. A total of seven participants took part in the study out of which four were SLPs and three were primary caregivers. This sample size was considered adequate for achieving thematic saturation. Interview guide was developed from existing literature and clinical experience to collect data through semi-structured, in-depth interviews. Each interview lasted between 45 and 90 minutes. The duration of interviews varied according to the participant’s comfort level and the depth of discussion. After taking informed consent all interviews were audio recorded to ensure accuracy. They were conducted both in Urdu by caregivers and English by speech language therapists to support natural expression and cultural authenticity.

Interview recordings were verbatim transcribed and afterwards translated into English. The original Urdu transcripts were kept for cross checking or reference. Manual coding was selected to remain closely involved with the data rather than the use of computer-based software. This approach was useful for the researchers to identify culturally embedded utterances, context-specific meaning and fine-grained linguistic features typical among Urdu speakers. Cultural sensitivity was maintained during the analysis by the researcher since he sought to ensure that these emerging themes would be both theoretically sound and practically relevant within Urdu speaking patients' culture. Thematic analysis was conducted according to Braun and Clarke's (2006) six phase framework. In phase one, a rich understanding of the narratives of participants was achieved by the researchers through several readings of the transcripts. Open coding was subsequently applied to determine significant parts of text in relation to communication barriers, rehabilitation strategies and emotional experiences. The early codes were then organized into subthemes and eventually grouped into main themes that captured similar ideas from interviews. Through ongoing comparison and fine-tuning broad themes were synthesized to capture the commonalities of participants' experience. These themes served as the conceptual framework for the Learning to Communicate Successfully Approach (LCSA) manual.

Reflexivity was maintained throughout the research at each stage. To record interpretations, methodological considerations and ideas to counteract possible biases the research team kept analytic memos. Triangulation was gained by comparing the views of SLPs and caregivers. Moreover, the initial themes were confirmed through clinical experts.

This has guaranteed credibility as well as the strength of the study as an analysis. Member checking was also done on sample participants to confirm validity of interpretations. Openness in data collection and analysis had also been used to create credibility. Moreover, the study has also adhered to the credibility, dependability, conformability, and transferability criteria of the credibility, dependability, conformability and transferability as set by Lincoln and Guba (1985).

Ethical guidelines were followed during the study. All the participants were informed of the study and given an informed written permission prior to data collection. The fact of confidentiality was ensured through the anonymity of the transcripts and the maintenance of all the data as a secret. Delicate or emotional matters were handled carefully and the subjects were told of psychological counseling services whenever necessary. The institutional review board of the university gave its ethical approval. In addition, the study did not violate the provisions of the Declaration of Helsinki.

3 RESULTS

The research presents the demographic details of the participants comprising four speech-language pathologists (SLPs) and three caregivers. Of the SLPs, most were female (75.0%, n = 3) and males made up a smaller percentage (25.0%, n = 1). The majority of the SLPs worked in private practice (75.0%, n = 3), with a single participant working in a public sector facility (25.0%, n = 1). Caseload allocation showed that the majority of SLPs had 10 or more than 10 cases to work on in a month (50.0%, n = 2). Meanwhile, a single respondent accounted for dealing with fewer than 5 cases (25.0%, n = 1), and another handled between 6 and 10 cases in a month (25.0%, n = 1). With respect to professional experience among SLPs, most had between 6-10 years of practice (75.0%, n = 3) with one participant indicating over 10 years of clinical experience (25.0%, n = 1). Unlike the caregiver group, there were three respondents of the caregiver group, and two-thirds of them were female (66.7%, n = 2) with one male caregiver (33.3%, n = 1). All the caregivers lived in rural settlements (100.0%, n = 3), indicating caregiving tasks in this study were solely represented by the people from rural communities as presented in table No.1.

Table 1

Demographic Characteristics of Participants

Variable	*Category*	*Frequency (n)*	*Percent (%)*
SLPs (n = 4)			
Gender	Male	1	25.0
	Female	3	75.0
Type of Practice	Private	3	75.0
	Public	1	25.0
Caseload per Month	< 5 cases	1	25.0
	6–10 cases	1	25.0
	> 10 cases	2	50.0
Years in Practice	6–10 years	3	75.0
	> 10 years	1	25.0
Caregivers (n = 3)			

Variable	***Category***	***Frequency (n)***	***Percent (%)***
Gender	Male	1	33.3
	Female	2	66.7
Residence	Rural	3	100.0

The qualitative interview analysis with speech-language pathologists and caregivers revealed six major themes. These themes indicated the multidimensional experience of patients with chronic aphasia. They went beyond the language impairments themselves. The results concluded the immense psychosocial effect, the coping strategies employed, the cultural barriers encountered and the long term consequences of having aphasia.

3.1 Theme 1: the multifaceted nature of communication impairments

The participants described aphasia as a condition that is involved in expressive and receptive speech. They said that it disrupts pragmatic and social communication too. The general report given by respondents showed that they saw patients with expressive language difficulty. In particular, caregivers observed that aphasic patients simply gave disordered or incomplete sentences. They also made interrupted stops and replacements of words and, in turn, made it even more difficult to interpret and understand (P2, L41–L44). This was determined by clinically SLPs as anomia, agrammatism, and paraphasia in patients with Broca aphasia who spoke in a stilted and spodding manner (P3, L52–L55). Barriers that were receptive were also critical among patients who have problems with instructions. Especially the ones containing several steps such that it would require caregivers to condense their communication into basic units (P1, L33–L36). Pragmatic deficit further complicated such problems because patients failed to stay on track of conversation, change turn or reply in context by continuing to create ongoing communication failures (P4, L60–L63). The most serious shortage was global the aphasia where SLPs stated that a total failure was observed in both the expressive and the receptive domains as patients allowed nearly no other means of communication but the non-verbal ones (P6, L65–L66).

3.2 Theme 2: the profound psychosocial and quality of life impact

Aphasia was not just understood as a disorder of communication. Instead, it was realized as an illness that ruins the psychological and social life of patients. Emotional misery and loss of identity, for example, were explained in great detail. Speech language pathologists predominantly associated aphasia with depression and anxiety (P5, L71–L73). While that was going on, caregivers reported frustration and withdrawal on the part of their loved ones (P2, L45–L47). In addition the loss of roles professionally and socially ensued as a persistent theme. A case in point was that of a scholar who was unable to write or teach anymore (P1, L38–L40). On top of this caregivers themselves carried a large burden. They often complained of stress, burnout, and powerlessness when they could not decipher their patient's needs (P3, L56–L58). As a result communication that was previously spontaneous became time consuming and emotionally taxing. Another of the common themes was social withdrawal. Most of the time patients stayed away from gatherings and social interactions since they were unable to contribute meaningfully (P6, L68–L70). Further, loss of autonomy also added to their burden. Patients found themselves having to rely on caregivers for performing even simple daily activities. Finally, this reliance led to a reduction in their independence and worse their quality of life (P4, L61–L64).

3.3 Theme 3: adaptive strategies and coping mechanisms

Despite the severe challenges both caregivers and patients developed adaptive strategies to manage their communication. For instance caregivers highlighted that they adjusted their own talk to make the messages simpler. Besides, they utilized gestures, images and written messages to facilitate understanding. They also made sure that they provided more time for reactions by facilitating the people with aphasia to communicate easily (P1, L28–L30). Patients learned individual coping strategies like dependence on gestures, facial expressions or notebooks with salient words and symbols (P2, L46–L49). SLPs focused on impairment based therapy in the initial days of aphasia. But with the condition becoming chronic, they focused on functional communication and compensatory strategies rather than impairment based therapy. Specifically they focused on how augmentative and alternative communication (AAC) systems can be used in supporting on-going interaction and engagement in daily life (P3, L53–L55). Group therapy was also cited to provide the social connectivity opportunity (P5, L74-L76). Importantly caregivers emphasized the role of emotional relationship and dignity in making efforts to preserve personhood by involving patients in decision-making and continuing with meaningful activities regardless of verbal communication (P6, L67–L69).

3.4 Theme 4: the role of support systems and the nature of therapy

Support systems became a crucial component of the aphasia management journey. Therapy was deemed as important but non-curative. SLPs noted that improvement was generally slow and incremental. Rather than discovering some form of therapy ideal for language recovery, therapy aimed at maximizing functionality and independence (P2, L44–L46). Likewise, caregivers concurred. They also understood the significance of therapy but knew its supportive instead of restorative character (P4, L63–L66). Furthermore, the necessity of a robust support system was viewed again and again as essential. Professional services, peer groups, and family members were all termed as essential in maintaining long-term care (P6, L70–L73). Additionally, training of caregivers was highlighted as a change-making element. It enabled family members to learn concrete communication skills and feel less helpless (P3, L50–L52). However availability of training resources in Urdu and other local languages was a significant challenge. This lack of available materials was a substantial barrier to practical support and rehabilitation of patients (P5, L77–L79).

3.5 Theme 5: cultural and linguistic contextual barriers

The cultural and linguistic background of Pakistan showed unique barriers in aphasia management. The speech language pathologists reported that standardized assessment materials and therapy resources are not available in the Urdu language. Consequently, they were repeatedly left to adopt unstandardized and non-formal methods in assessing and treating patients (P1, L31–L34). Additionally, cultural beliefs and stigma contributed to these challenges. Families tended to attribute aphasia to cognitive impairment or even spiritual reasons. Such misunderstandings hindered the proper intervention and rehabilitation process. (P4, L59–L61). Caregivers explained how cultural deference norms sometimes made it difficult for patients to be corrected or involved in communication practice thereby decreasing chances for improvement (P2, L48–L50). A lack of awareness and empathy in the clinical and social environment was another feature that further marginalized the patients because families and even some medical practitioners did not quite understand what aphasia is and what it is all about. (P6, L72–L75).

3.6 Theme 6: the realities of chronicity and long-term management

Lastly, participants described the long term nature of aphasia as an ongoing journey rather than a condition with a clear endpoint of recovery. In cases of chronic aphasia success was defined in terms of effective communication. For instance, patients who were capable of expressing the most basic needs and performing daily tasks despite errors were seen as indicators of dramatic improvement (P3, L57–L59). This shift in perspective led to the development of outcomes of therapy that were founded on compensation and adjustment rather than full restoration (P5, L76–L78). The long-term requirements of their work were also emphasized by the caregivers. The caregivers described the process of care giving as a continuous task which involved patience, resourcefulness, and resilience (P2, L47–L49). In addition, patient motivation was also different. It also was inclined to depend on emotional state exhaustion, the level of environmental support (P4, L60-L62). The supportive family and a healthy environment were both noted to be a contributing factor significantly. These aspects helped to keep the engagement in the therapy and promoted the daily attendance of communication (P6, L66 -L68). The combination of these themes creates a general portrait of the lived experience of aphasia and shows that its impact is not confined to the language but it is reflected to identity and relationships, as well as the ordinary functioning as shown in table No.2.

Table 2

Summary of Themes and Subthemes Identified in Thematic Analysis

Themes	***Subthemes***
1. The Multifaceted Nature of Communication Impairments	1.1 Expressive Language Barriers 1.2 Receptive Language Barriers 1.3 Pragmatic and Social Communication Deficits 1.4 Global Communication Breakdown
2. The Profound Psychosocial and Quality of Life Impact	2.1 Emotional Distress and Identity Crisis in the Patient 2.2 Caregiver Burden: Emotional, Practical, and Temporal 2.3 Social Withdrawal and Isolation 2.4 Loss of Autonomy and Compromised Daily Living
3. Adaptive Strategies and Coping Mechanisms	3.1 Caregiver-Led Communication Adaptations 3.2 Patient-Led Coping Strategies 3.3 Therapeutic and Compensatory Interventions 3.4 Fostering Emotional Connection and Maintaining Dignity
4. The Role of Support Systems and the Nature of Therapy	4.1 Realistic Expectations and Evolving Therapeutic Goals 4.2 The Essential Network of Support 4.3 The Critical Role of Caregiver Training
5. Cultural and Linguistic Contextual Barriers	5.1 Scarcity of Culturally and Linguistically Appropriate Resources 5.2 Cultural Beliefs, Stigma, and Misattribution 5.3 Lack of Awareness and Empathy in Clinical and Social Settings
6. The Realities of Chronicity and Long-Term Management	6.1 Redefining Success: Functional Communication over Perfect Language 6.2 The Long-Haul Journey for the Caregiver 6.3 Fluctuating Patient Motivation and the Importance of Environment

4 DISCUSSION

The current study investigated the lived experience of chronic aphasia patients in the views of speech language pathologist (SLP) and their caregivers. The study learned six central themes that are used to explain the intricacies of the disorder. These themes give an insight about the disruption in communication, psycho-social burden, coping, support networks, cultural challenges, and reality of long term management. Together the results highlight the fact that aphasia is more than language impairment. Accordingly, a more cultural and holistic perspective towards rehabilitation gains importance. The first among these themes, the complexity of communication impairments, is consistent with the literature. Aphasia is described as an impairment that hits various aspects of language, such as expressive, receptive as well as pragmatic functions (Goodglass & Kaplan, 2001). The following challenges were explained by participants: anomia, agrammatism, and paraphasia. Global aphasia in some instances resulted in almost complete communication breakdown (P6 L65 L66). Researchers also found the same to happen when pragmatic issues such as turn taking and topic maintenance halted conversation and relationships in cross-cultural settings (Armstrong and Ferguson, 2010). These results point to the necessity for the testing procedures which can treat the linguistic and social pragmatic deficit, especially in chronic cases.

The second main theme was the huge psychosocial impact of aphasia. The condition was associated with depression, anxiety, and social withdrawal by participants (P5 L71 L73 P6 L68 L70). These affective outcomes concur with findings that as many as 70% of people who have aphasia experience depression. Such affect has been found to be often followed by loss of identity and social isolation (Hilari et al., 2010). The caregivers were also stressed by the present evidence. Caring for individuals with aphasia was emotionally and practically challenging, which resulted in stress, fatigue, and impaired well-being (Shadden & Agan, 2004). Thus, the dual impact on both patients and caregivers emphasizes the need to include psychosocial support as an essential part of aphasia management.

The third theme emphasized the dependence on adaptation strategy and coping style. Respondents reported simplified speech, gestures, and augmentative and alternative communication (AAC). They also employed methods of upholding dignity and saving personhood (P1 L28 L30 P2 L46 L49). These results are not new as the earlier studies indicate that compensatory measures are at the centre stage of rehabilitation of chronic aphasia (Kagan et al., 2008). These strategies are useful in ensuring that there is functional communication at a plateau of linguistic recovery. In addition to that, group therapy and caregiver led adaptations are indicators of the social model of aphasia. The focus of this model is participation and quality of life as the main intervention outcomes (Parr Byng and Gilpin, 1997).

The fourth theme emphasized the importance of a support network and therapy. Both SLPs and caregivers viewed therapy as essential but not curative (P2 L44 L46 P4 L63 L66). This point of view aligns with the increasing consensus that realistic and functional goals should be the focus of chronic stage rehabilitation should rather than complete linguistic recovery (Simmons Mackie & Damico, 2008). Caregiver training was considered highly beneficial. However a major barrier was the lack of available therapy resources in Urdu and other local languages (P5 L77 L79). Similar difficulties were reported in non-Western contexts where therapy methods are most of the time difficult to adapt to local cultural and linguistic needs (Williams, 2013). Therefore, there is a strong need for locally relevant and culturally appropriate intervention approaches.

The fifth theme covered the issue of cultural and linguistic barriers. Caregivers and SLPs claimed a lack of assessment and therapy resources in Urdu. They also discussed cultural stigma and misconceptions of aphasia, such as believing that the condition is caused by supernatural factors (P1 L31 L34 P4 L59 L61). These are observations in agreement with other studies in South Asia. In these situations, cultural beliefs and ignorance are the primary issues that find their way to late diagnosis and uneven rehabilitation (Qureshi et al., 2016). Also, social traditions like not wanting to be corrected in the name of respect can unwillingly prevent recovery. Thus, to overcome these obstacles, it is necessary to develop Urdu based therapy material as well as popularize community education campaigns that would create awareness and decrease stigma.

The sixth theme finally summarized the facts of chronicity and long term management. The participants pointed out that success must be redefined with regard to functional communication and not flawless language restoration (P3 L57 L59). This perspective supports the life participation approach to aphasia (Chapey et al., 2008). This model is based on the idea that meaningful engagements in everyday life should be the priority of intervention. According to the caregivers, their work was a long-term commitment that required commitment and innovation (P2 L47 L49). This finding is consistent with international evidence showing that caregivers gradually adapt to the long term demands of aphasia care (Le Dorze & Brassard, 1995). Motivation among patients was also found to fluctuate, depending on emotional state and environmental support (P4 L60 L62). Hence, family encouragement and social inclusion play vital roles in maintaining long term progress.

Summing up, the findings of the given research coincide with the studies of the world but present new information based on the Pakistani context. The results show that chronic aphasia is not just a medical condition, but a disorder, which makes sense by itself in terms of identity and family identification, cultural values and medical restrictions. This study also contributes to the body of evidence concerning the experience and management of aphasia in daily practice by providing a voice to the SLPs and caregivers. Future research ought to take advantage of these findings and come up with culturally sensitive Urdu-based intervention manuals, care giver training, and policy and community-based social education.

5 CONCLUSION

This study determined the experiences of patients with chronic aphasia and their caregivers. The research underlined the far-reaching effects of the disorder on medical care, communication, emotional well-being, caregiving roles, involvement with society and cultural meanings. The research laid down the impact of barriers to rehabilitation, economic factors and unavailability of specialized care on outcomes. Communication challenges were a serious challenge that led to patient's frustration and dependence; on the other hand, caregivers experienced burden and resilience in practice. Furthermore cultural misunderstandings and stigma predominantly increased social isolation and tardy treatment-seeking. Overall these findings demonstrated that aphasia is a disorder more than the linguistic deficit to include psychosocial, cultural and systemic.

5.1 Recommendations

On the basis of the findings of this study, a series of recommendations were put forward in order to improve the management of aphasia in similar sociocultural contexts. Firstly, attempts must be made to provide speech-language pathology services, particularly in rural and remote areas where the patients cannot easily access them, through improved training, deployment, and incorporation of the specialists in healthcare systems. Secondly, holistic intervention-based rehabilitation programs must be instituted so that along with linguistic recovery, psychological adjustment and family support would also be prioritized. In addition, systematic training and counselling of caregivers to minimize anxiety and enhance coping skills would have to be provided. Thirdly, awareness programs across the community would have to be launched to eliminate stigma and misconception. These public awareness campaigns will facilitate increased accommodation and acceptance of chronic aphasia patients. Lastly, culturally sensitive interventions that work within beliefs of the local population but introduce biometrically grounded perspectives can contribute to more successful rehabilitation and foster involvement in the community.

5.2 Limitations

This study had several limitations that should be acknowledged.

1. The sample size of population which included the caregivers and the speech-language pathologists was very small, and this can limit the applicability of the study to larger population.
2. The research was carried out within a particular culture. The themes discovered in the research constrained the direct applicability of the results to other language situations.
3. The study was carried out within specific culture. The discovered themes in the study limited the scope of direct application of results to other language settings.

Nevertheless, the study provided us with an insightful idea of the complexities facing the management of aphasia and offered valuable future research and intervention directions.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflicts of interest related to this work.

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Authors' Contribution

All authors contributed equally to the development of this article.

Data availability

All datasets relevant to this study's findings are fully available within the article.

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