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AJSLP

Review Article

A Qualitative Evidence Synthesis of Communication Partner Training: Exploring the Experiences of Communication Partners and People With Acquired Brain Injury

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ABSTRACT

Purpose: This study aimed to explore the experiences of adult communication partners (CPs) of individuals with acquired brain injury (ABI) who received communication training and, where reported, the experiences of individuals with ABI who attended or participated in the training.
Method: A qualitative evidence synthesis was conducted. Electronic searches were completed in CINAHL Ultimate, APA PsycInfo, APA PsycArticles, Medline, Embase, AMED, Scopus, NeuroBITE, and PubMed for studies published until August 2025. Included studies described an intervention directed at adult CPs where the program focus was on improving communicative participation for adults post-ABI. Relevant data were extracted and inductively synthesized using thematic synthesis. Studies were appraised using the Critical Appraisal Skills Programme Qualitative Checklist, and confidence of the findings was assessed using Grading of Recommendations Assessment, Development and Evaluation and Confidence in the Evidence from Reviews of Qualitative Research.
Results: Nine articles met the eligibility criteria and reported on 66 people with ABI and 179 CPs. Three main analytic themes and nine subthemes were identified: (a) delivery of training—establish dyadic preferences for training, facilitate learning and doing, identify challenges and review engagement, and future steps; (b) making change in dyadic interactions—learning and practicing, and intention to do more and doing more; and (c) outcomes of change—conversation; emotions, relationships, and activities; and identity and independence.
Conclusions: There is a small but informative evidence base on participants' perspective of CP training in ABI. Most change occurred at conversation level with less change reported for emotions, relationships, and independence. Future qualitative studies need to provide in-depth exploration of the impact of training beyond conversation with a greater understanding of how change occurs. This will ensure that therapists deliver tailored training aligned with the needs of the individual.
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There is growing evidence that communication partner training (CPT) can effectively address cognitive-communication disorders (CCDs) following acquired brain injury (ABI; Togher et al., 2023). More than two thirds of individuals who sustain an ABI whether traumatic (e.g., road traffic accidents, assaults, falls) or nontraumatic (e.g., stroke, tumors, encephalitis, anoxia) may experience some form of CCD (Hewetson et al., 2017; M. Kelly et al., 2017; Shorland et al., 2022). These disorders arise primarily from disruption to cognitive processes (i.e., attention, memory, and executive function), which impact communicative competence (College of Audiologists and Speech-Language Pathologists of

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Ontario, 2002). The disorders compromise relationships, return to work, education, social participation, and quality of life for people with ABI and negatively impact emotions and relationships for family members (Dahlberg et al., 2006; Grayson et al., 2021; C. Kelly et al., 2023; Meulenbroek & Turkstra, 2016). Communication partners (CPs), including family members, friends, and carers, play a crucial role in facilitating or hindering communicative success (Christensen et al., 2023; Togher et al., 2023). However, more than 60% of family members report dissatisfaction with how well their training, support, or information needs are being met in the early months to years' postinjury (Grayson et al., 2020). Consequently, national and international guidelines and/or practice standards advocate rehabilitation that trains CPs to use strategies to facilitate interactions (Bayley et al., 2023; National Institute for Health and Care Excellence, 2025; Scottish Intercollegiate Guidelines Network, 2013; Togher et al., 2023).

Existing evidence supports the effectiveness of CPT for improving the communicative competence of both people with traumatic brain injuries and their CPs (Behn et al., 2021; Togher et al., 2023; Wiseman-Hakes et al., 2020). This training is defined as an environmental intervention in which people around the person with CCD (such as life partner, family, friends, and support workers) actively learn to use strategies and communication resources (with or without the person with CCD) to support the conversational interactions involving the person with CCD (Power & Morrow, 2024; Simmons-Mackie et al., 2016). Key elements of training include education, demonstration, active practice and rehearsal of strategies, getting feedback from others, reviewing own performance, and the use of videos (Power & Morrow, 2024). Most studies show positive change in communication skills and perceived communicative ability for the person with brain injury and/or their CPs (Behn et al., 2021). A meta-analysis of two controlled trials that used similar outcomes demonstrated moderate-to-large effects for improving the communicative competence of people with traumatic brain injury (n = 36, standardized mean difference [SMD] = 0.31–0.50) and their CPs (n = 41, SMD = 0.97–1.05; Behn et al., 2021). Mixed results have been reported for broader outcomes of emotional well-being, social participation, and quality of life, which are used less often, despite their association with communicative ability (Dahlberg et al., 2006; Galski et al., 1998; Struchen et al., 2011). There is considerable variability in dosage, duration, and delivery methods of CPT (Behn et al., 2021; Wiseman-Hakes et al., 2020). Training has ranged from a few minutes to 48 hr over a period of a single session to 6 months, with diverse delivery methods including face-to-face, telehealth, DVDs, written information, and individual or group sessions. Both systematic reviews highlighted encouraging, though limited, evidence with an inherent need for larger sample sizes, well-controlled trials, and greater consensus on outcomes. In addition, more information is needed about the impact of CPT, including the changes that occur posttraining for people with both traumatic and nontraumatic injuries, and consideration of the factors that may facilitate or hinder the delivery of training.

Qualitative evidence provides important insights into the impact, delivery, and sustainability of CPT by exploring the participant experience. To date, most studies have focused on quantitative outcomes and efficacy of training. Fewer qualitative studies are known to exist, with one recent review identifying four studies that contained detail on the participant experience (Wiseman-Hakes et al., 2020). Content analysis of the included studies revealed benefits of CPT, such as improved understanding and awareness of communication as well as enhanced strategy use, and how training could be improved with greater role play and less didactic instructional teaching. Some risks were identified including increased awareness of negative communication behaviors and anxiety. While the review by Wiseman-Hakes et al. (2020) provided valuable analysis of qualitative studies, their review primarily offered a broad overview of themes with less attention to the broader outcomes of training and how change occurs.

Therefore, this review article aims to undertake an updated and more in-depth synthesis of the qualitative literature on experiences of CPT for people with ABI and/or their familiar or unfamiliar CPs. This review article will primarily focus on qualitative evidence where participants described their experiences and perspectives. This review article will address the following questions: (a) What factors facilitate or hinder delivery of training? (b) How does change occur from training? (c) What outcomes are described from involvement in training?

Method

To understand the experiences of CPT for people with ABI and/or their CPs, a qualitative evidence synthesis was chosen (Flemming & Noyes, 2021). Thematic synthesis was selected as the most appropriate method for this study. Developed by Thomas and Harden (2008), this approach enables in-depth exploration of the participant experience and is well suited to the synthesis of qualitative findings from intervention studies (see Data Extraction and Synthesis section). This method is also flexible as to the type of data from primary research with inclusion of both descriptive, surface-level ("thin") data and richer, detailed ("thick") data to develop analytical themes (Flemming & Noyes, 2021). The present review protocol was registered with PROSPERO

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(CRD42024519683). To ensure transparency in reporting the synthesis of qualitative research, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Page et al., 2021) and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research Checklist (Tong et al., 2012) were used (see Supplemental Materials S1 and S2). Ethics approval was not required for this review given that all data used were collected from studies that are publicly available.

Search Strategy

Preliminary searches were conducted in selected databases to refine relevant key words and search terms using the sample–phenomenon of interest–design–evaluation–research type method for qualitative systematic searches (Cooke et al., 2012; Methley et al., 2014) and search terms from previous systematic reviews for CPT (Behn et al., 2021; Simmons-Mackie et al., 2010, 2016). A complete list of search terms is shown in Supplemental Material S3. Search terms were entered into nine electronic bibliographic databases. Searches were conducted on EBSCOhost incorporating CINAHL Ultimate, APA PsycInfo, APA PsycArticles, and Medline as well as OVID incorporating Embase and AMED together with Scopus, NeuroBITE, and PubMed. The initial search was conducted in May 2024 and rerun in August 2025 using the limiters of human and adult (18+ years of age). There were no restrictions on language or publication date.

Study Selection

Search results from the nine databases were combined into Rayyan software (Ouzzani et al., 2016) for study selection, with duplicates removed using Deduplicator (Forbes et al., 2024). The titles and abstracts of 1,000 random unique records were screened independently by two authors (N.B. and I.C.) for inclusion for a full-text review. There was 99% agreement between the two authors, with disagreements resolved through consensus. All remaining unique records were then imported for review by the first author. A full-text review was completed by the two authors (N.B. and I.C.). Additional studies were identified through reference list checks of systematic reviews and checked for inclusion into the review. Conflicts were resolved through discussion between the two authors, and where disagreement occurred, a third author (M.C.) was consulted and made the final decision about inclusion.

As an exploratory adjunct to the manual screening, this study explored automation of study selection, and following PRISMA Checklist Item 8 (selection process), the details of automation tools used are reported. To explore the utility of using text mining algorithms in the completion of systematic reviews, the inclusion and exclusion decisions on the first 1,000 records were then used on Rayyan's machine learning prioritization feature (a support vector machine classifier) to "train" the text mining algorithm (i.e., "compute ratings" feature) to recognize and prioritize the most relevant records through finding patterns and similarities in articles included or excluded (Brown et al., 2020). This function models the probability of inclusion for the remaining records by finding patterns in the titles and abstracts of the screened articles (Brown et al., 2020). It then assigns each unscreened record a relevance rating, allowing the review to proceed by screening the most relevant articles first. This feature sorts articles according to one of five labels: most likely to exclude (double thumbs down), likely to exclude (single thumbs down), no recommendation (question mark), likely to include (single thumbs up), and most likely to include (double thumbs up).

Eligibility Criteria

This review only included peer-reviewed qualitative research studies. Eligible studies were required to report on the experience of CPT for ABI. The intervention was broadly defined to include communication skills training as well as educational or counseling programs directed at CPs where the primary focus of the program (> 50%) is on improving communication skills. Training needed to be delivered to adult CPs of adults who had sustained an ABI with CCD (both groups > 18 years of age); those with ABI may or may not have been present for the training. Mixed-methods studies identified were screened to determine if the qualitative component met the inclusion criteria of the review. Mixedpopulation studies were only included if the qualitative component was reported separately for people with ABI. Quantitative studies as well as editorials, conference papers, theses or dissertations, and non–peer-reviewed articles from internet websites were excluded, as well as studies reporting on CPs or people with ABI under 18 years of age.

Quality Appraisal

Included articles were independently assessed by two authors (N.B. and I.C.) using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2023). For the one study authored by N.B., the quality assessment was completed by I.C. Low-quality studies were not automatically excluded, but data from these studies were considered and presented with clear consideration of their quality. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) and Confidence in the Evidence from Reviews of Qualitative Research (CERQual) tool (Lewin et al., 2018) was used to assess the degree of confidence in the findings. The overall assessment of confidence (high, moderate, low, very low) was based on an assessment of four components: methodological limitations, coherence, adequacy, and relevance. The judgment was made independently and discussed by the same two authors (N.B. and I.C.).

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Data Extraction and Synthesis

A data extraction tool was initially developed with one author (N.B.) responsible for extracting the key participant, intervention, and methodological information. For the qualitative synthesis, all contents under the results and/or findings sections, including interpretations and participant quotations, were imported into NVivo 14 (Version 14.23.1, Lumivero) for analysis. A three-stage synthesis approach was used as outlined by Thomas and Harden (2008). First, the first author completed line-by-line coding, whereby every sentence inductively applied to at least one code. Second, the codes were organized into descriptive themes, where similarities and differences between the codes and themes were grouped into a hierarchical tree structure that comprised themes and subthemes. The first two stages were completed for one of the included articles and iteratively reviewed by I.C. before the remaining articles were coded by the first author. Third, once all included articles were coded and organized, analytical themes were initially developed inductively using a mind mapping approach, which produced an interpretation of the data that goes beyond the original studies. These analytical themes were iteratively revised by all members of the author team independently, with themes added or revised. Finally, these themes were discussed with a patient and public involvement group that comprised people with ABI and their family members, and a clinical reference group of academic and clinical advisors. The final analysis was then reviewed once more by all members of the team.

Results

The article selection process is outlined in the PRISMA flow diagram (Page et al., 2021) in Figure 1. A total of 3,139 abstracts were identified. After removal of duplicate records, 2,255 abstracts remained. Following review of titles and abstracts, 42 papers were identified for potential inclusion. The full texts of these were read and assessed for eligibility (see Supplemental Material S4 for excluded studies with reasons for exclusion). Of these, eight papers initially met the inclusion criteria. Reference searching of included systematic reviews was also employed; four further papers were identified, of which one paper was added. A final total of nine papers, reporting on nine studies, were included in the review. The characteristics of these nine papers are presented in Table 1. For two studies, additional information was obtained by contacting the authors directly (Hart et al., 2020; Nielsen et al., 2023). In terms of the Rayyan mining algorithm for the initial search, 495 articles were either labeled as "likely" or "most likely to exclude." None of these articles were included in the final analysis.

Characteristics of the Included Studies

Study characteristics including participant characteristics, details of the intervention, data collection, and analysis methods can be found in Table 1. Almost half of the studies (n = 4) were conducted in Australia (Avramovic et al., 2023; Rietdijk et al., 2019, 2022; Togher et al., 2012); two studies were conducted in the United States (Hall et al., 2025; Hart et al., 2020); and one study each was conducted in Denmark (Nielsen et al., 2023), South Africa (Goldblum & Alant, 2009), and the United Kingdom (Behn et al., 2015). Across all nine studies, there were 66 people with ABI and 179 CPs who were interviewed. There was a broad range of CPs including family members, paid carers, shop assistants and managers, nursing staff, physicians, therapists, student volunteers, and other professions. Five studies trained both people with ABI and CPs who included family members and paid carers (Avramovic et al., 2023; Hall et al., 2025; Rietdijk et al., 2019, 2022; Togher et al., 2012). The remaining four studies trained only the CPs, who included paid carers, shop assistants and managers, nursing staff, physicians, therapists, and other health professionals (Behn et al., 2015; Goldblum & Alant, 2009; Hart et al., 2020; Nielsen et al., 2023).

Training was delivered in person for five studies (Behn et al., 2015; Goldblum & Alant, 2009; Hart et al., 2020; Nielsen et al., 2023; Togher et al., 2012). Three studies delivered training via telehealth (Avramovic et al., 2023; Hall et al., 2025; Rietdijk et al., 2019), while the remaining study involved both in-person and telehealth training (Rietdijk et al., 2022). The same program was reported on in two studies (Rietdijk et al., 2019, 2022). Where reported, training comprised either a single 3- or 4-hr training session (Goldblum & Alant, 2009; Nielsen et al., 2023) or a training program that was delivered in 7–35 hr (average 17 hr) over 7–10 weeks (average 9 weeks; Avramovic et al., 2023; Behn et al., 2015; Rietdijk et al., 2019, 2022; Togher et al., 2012). One study delivered the training over 13–31 weeks (Rietdijk et al., 2022), and a further study provided two follow-up sessions to CPs, each 1 hr in length (Nielsen et al., 2023).

Six of the nine studies used either interview or semi-structured interview (Avramovic et al., 2023; Behn et al., 2015; Hall et al., 2025; Rietdijk et al., 2019, 2022; Togher et al., 2012). The remaining three studies used questionnaires or online surveys that included qualitative open-text responses (Goldblum & Alant, 2009; Hart et al., 2020; Nielsen et al., 2023). Studies used a range of methods to explore and analyze the data including thematic analysis or sorting the data for themes (Hall et al., 2025; Hart et al., 2020; Rietdijk et al., 2022), content analysis (Avramovic et al., 2023; Nielsen et al., 2023), constant comparative analysis (Behn et al., 2015; Togher et al., 2012), or analyzed descriptively (Goldblum & Alant, 2009; Rietdijk et al., 2019).

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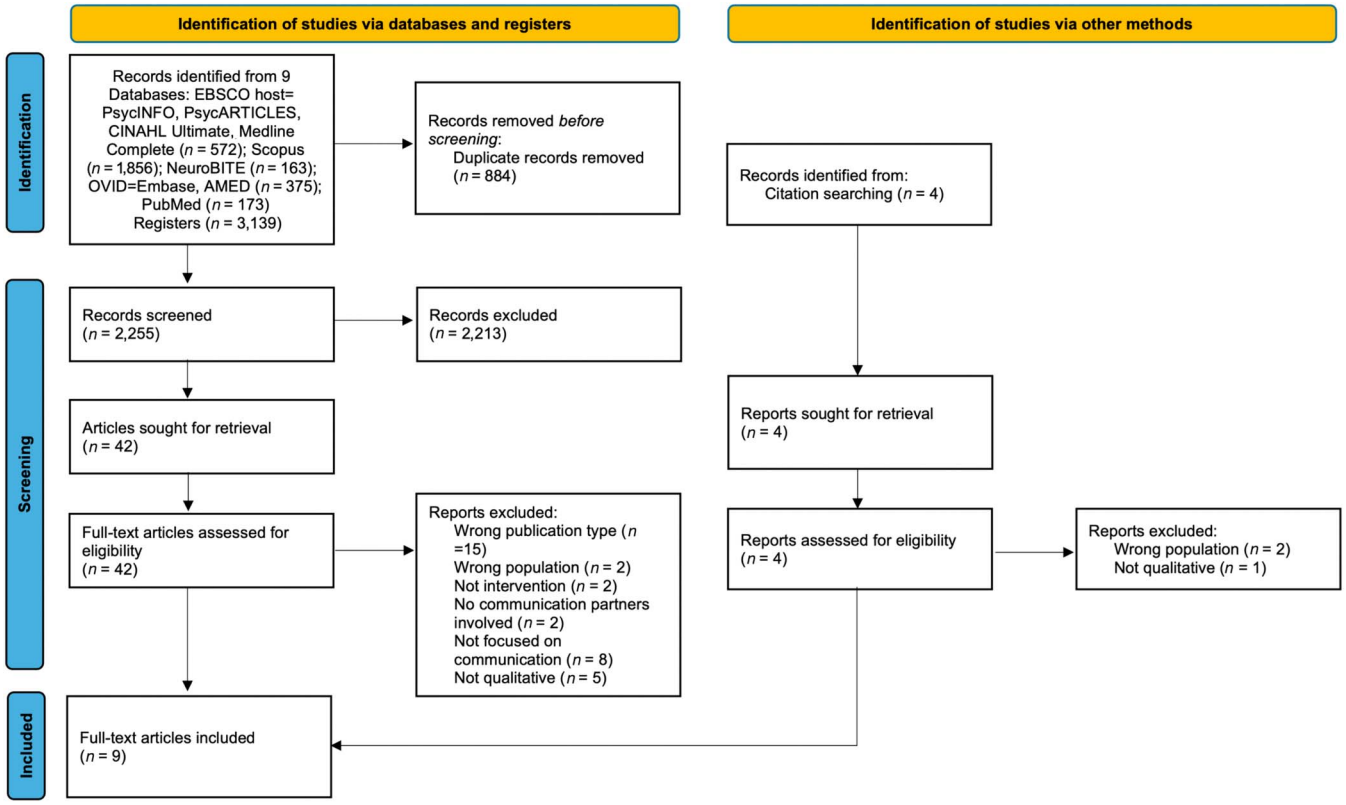
Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram summarizing the search and selection procedures used to identify studies included in the qualitative evidence synthesis.



Most studies (n = 6) were judged to be of high methodological quality for most items on the CASP Checklist with no or very minor concerns (Behn et al., 2015; Hall et al., 2025; Hart et al., 2020; Nielsen et al., 2023; Rietdijk et al., 2022; Togher et al., 2012). The remaining three studies were judged to have minor (Avramovic et al., 2023), moderate (Rietdijk et al., 2019), or serious concerns for methodological quality (Goldblum & Alant, 2009; see Table 2). Across all studies, items that were unclear or not discussed in the study referred to the research design (Item 3, n = 6), relationship between researcher and participant (Item 6, n = 7), or how valuable the research was (Item 10, n = 3). The three studies that were rated the lowest were all mixed-methods designs where the qualitative data were only a small component of the study (Avramovic et al., 2023; Goldblum & Alant, 2009; Rietdijk et al., 2019).

Thematic Synthesis

Three broad analytic themes and nine subthemes are represented in the thematic synthesis. Data from both people with ABI and CPs are reflected across all three analytic themes, though not all included studies contributed to each of the subthemes. The three main analytic themes were (a) delivery of training, (b) making change in dyadic interactions, and (c) outcomes of change. There was high confidence in the review findings for eight of the nine subthemes. For one subtheme (outcomes of change: identity and independence), there was moderate confidence in the findings, which were downgraded due to moderate concerns with the adequacy of rich data. See Supplemental Material S5 for all GRADE-CERQual ratings.

Theme 1: Delivery of Training

This theme was generated predominantly, though not exclusively, from posttraining questions exploring aspects of the training that participants most valued, as well as those they felt could be improved. In this context, participants described how they learned most effectively and reflected on their learning processes throughout the training.

Establish Preferences for Training

Participants received training either as a dyad or as the partner only, while the delivery of training ranged from in-person to remote delivery. Both people with ABI and CPs reported how important it was for partners to be

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Table 1. Characteristics of included studies.

Study name and year, country	ABI included	Provider, setting	Intervention delivery, dosage, duration	ABI participants, *M* ± *SD* (range)	CP participants, *M* ± *SD* (range)	Data collection	Data analysis
Avramovic et al. (2023), Australia	Yes	Self-directed and guided by SLT, telehealth	Weekly 1-hr sessions over 7 weeks	*N* = 3; 1 brain tumor, 2 TBI, 1 very severe, 1 unknown; 2 males, 1 female; ages 22, 31, and 31 years; TPO 5, 5 and 9 years	*N* = 3; 3 females; ages 21, 65, and 67 years; 1 paid carer, 2 mothers	Semistructured interviews	Content analysis
Behn et al. (2012), United Kingdom	No	SLT, residential rehabilitation center	6 group sessions comprising 17 hr over 8 weeks	NA	*N* = 5; 5 females; age 38.6 ± 17.6 years (19–58); all paid carers	Semistructured interviews	Constant comparative analysis
Goldblum & Alant (2009), South Africa	No	Research and research assistant, conference room of large supermarket chain	Single group 4-hr training session	NA	*N* = 31; 30 females, 1 male; age 38.4 ± 9.3 years (23–59); 13 customer service managers, 11 customer care assistants, 7 deli/bakery sales assistants	Questionnaire (open-text responses)	Analyzed descriptively
Hall et al. (2025), United States	Yes	SLT students, telehealth	Weekly, group session of 25 min followed by a 50-min individual session for 10 weeks	*N* = 11; 10 TBI, 1 stroke; 8 males, 3 females; age 56.1 ± 13.9 years (30–72); TPO 13.6 ± 10.0 years (1–34)	*N* = 11; 10 females, 1 male; 5 spouses, 1 mother, 1 friend, 4 student volunteers	Semistructured interview	Thematic analysis
Hart et al. (2020), United States	No	OT, inpatient brain injury unit	NR, protocol description only[b]	NA	*N* = 35; 10 therapists, 22 nursing staff, 3 physicians	Online survey (open-text responses)	Sorted for themes
Nielsen et al. (2023), Denmark	No	SLT, subacute hospital rehabilitation unit	Single 3-hr session followed by two 1-hr follow-up sessions	NA	*N* = 42; age 8.4 ± 7 years; 19 nurses/nurse assistants, 15 therapists, 8 other professions	Questionnaire (open-text responses)	Content analysis
Rietdijk et al. (2019), Australia	Yes	Clinician, telehealth	Weekly individual sessions of 1.5 hr for 10 weeks	*N* = 2; 2 severe TBI; ages 33 and 24 years; 1 male, 1 female; TPO 2 and 6 years	*N* = 2; 2 female; ages 26 and 42 years; 1 friend, 1 mother	Interview	Analyzed descriptively
Rietdijk et al. (2022), Australia	Yes	Clinician, in person in participants' home or telehealth	Ten individual sessions of 1.5 hr over 13–31 weeks	*N* = 36 (17 in-person; 19 telehealth); 36 moderate-to-severe TBI; 30 males (13 in-person, 17 telehealth), 6 females (4 in-person, 2 telehealth); in-person age 50.4 ± 12.8 years, telehealth age 43.7 ± 15 years; TPO in-person 0.5–47 years, telehealth 0.5–28 years	*N* = 36 (17 in-person, 19 telehealth); 5 males (2 in-person, 3 telehealth), 31 females (15 in-person, 16 telehealth); 32 family members (14 in-person, 18 telehealth), 1 friend in-person, 3 paid carers (1 in-person, 2 telehealth)	Semistructured interview	Thematic analysis
Togher et al. (2012)[a], Australia	Yes	SLT, brain injury center(s)	Weekly group sessions of 2.5 hr and an individual session of 1 hr for 10 weeks	*N* = 14; 14 severe TBI; 11 males, 3 females; age 30.3 ± 14 years (18–62); TPO 8.0 ± 5.1 years (1–21)	*N* = 14; 4 males, 10 females; age 50.3 ± 11.26 years (24–64); 4 partners, 8 parents, 2 carers	Semistructured interview	Constant comparative analysis

Note. ABI = acquired brain injury; CP = communication partner; SLT = speech and language therapist; TBI = traumatic brain injury; TPO = time postonset; NA = not applicable; OT = occupational therapist; NR = not reported.

[a]The 15 people with TBI who were trained alone (i.e., solo) were not part of this review. [b]https://rehabilitationresearch.jefferson.edu/innovations/mossrehab-post-traumatic-amnesia-protocol-pta.html.

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Table 2. Critical Appraisal Skills Programme ratings of the included studies.

Criteria	Avramovic et al. (2023)	Behn et al. (2015)	Goldblun & Alant (2009)	Hall et al. (2025)	Hart et al. (2020)	Nielsen et al. (2023)	Rietdijk et al. (2019)	Rietdijk et al. (2022)	Togher et al. (2012)
1. Is there clear description of study aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Is the qualitative methodology appropriate for this study?	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aims of the research?	CT	CT	N	CT	CT	Y	CT	Y	Y
4. Was the recruitment/ sampling strategy appropriate to address the aims of the research?	Y	Y	CT	Y	Y	Y	Y	Y	Y
5. Were the data collected in a way that addressed the research issue?	Y	Y	CT	Y	Y	Y	Y	Y	Y
6. Has the relationship between researcher and participants been adequately considered?	N	Y	N	N	N	N	N	N	Y
7. Have ethical issues been taken into consideration?	Y	Y	N	Y	Y	Y	Y	Y	Y
8. Was the data analysis sufficiently rigorous?	Y	Y	CT	Y	Y	Y	N	Y	Y
9. Is there a clear statement of findings?	Y	Y	CT	Y	Y	Y	N	Y	Y
10. Is the research valuable?	CT	Y	N	Y	Y	Y	CT	Y	Y
Total	7	9	2	8	8	9	5	9	10
Overall rating	Minor concerns	No or very minor concerns	Serious concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	Moderate concerns	No or very minor concerns	No or very minor concerns

Note. Y = yes; CT = can't tell; N = no.

involved in the training, although some partners did not initially realize that a focus of the training was on the skills of the partner until later in the program (Togher et al., 2012).

Participants preferred individual sessions as a dyad, and some described benefits from group sessions, reporting that the combination of individual and group sessions was useful. Two of the included studies explicitly considered the delivery of training in person compared with telehealth (Rietdijk et al., 2019, 2022). Telehealth overcame problems with distance and access to rehabilitation services and offered some participants convenience in their lives. Telehealth delivery of training was acceptable to many, with one partner who described initial apprehension that resolved with experience:

> At first, I thought Skype would be a little daunting because it's a mode that I hadn't explored, but having participated in Skype, it's excellent. (CP; Rietdijk et al., 2022, p. 129)

Some people with ABI and their partners preferred the human interaction linked to in-person delivery, particularly for those of an older age or lacking in technical skills. Some participants suggested a combination of both in-person

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and telehealth delivery methods, while others suggested in-person or telehealth only, highlighting the importance of individual preferences.

Facilitate Learning and Doing

Participants highlighted techniques that facilitated learning. Therapist characteristics described as key included being prepared and able to personalize the training content and form a genuine relationship with the dyad (Avramovic et al., 2023; Goldblum & Alant, 2009; Hall et al., 2025; Hart et al., 2020; Rietdijk et al., 2022). In one study, the presence of two trainers who could present multiple perspectives was described as valuable for group training (Togher et al., 2012). Training content that was engaging, individualized, and relevant to a person's day-to-day needs was important (Avramovic et al., 2023; Hall et al., 2025; Nielsen et al., 2023; Rietdijk et al., 2022).

Active and practical techniques were reported as valuable and beneficial to learning, including the use of role play, demonstration, and modeling (Avramovic et al., 2023; Behn et al., 2015; Nielsen et al., 2023; Rietdijk et al., 2022; Togher et al., 2012).

> Being able to see how [the clinician] responded to [pwTBI] and learn from that. (CP; Rietdijk et al., 2022, p. 129)

Participants preferred being shown and being able to practice what to do rather than just being given instruction and written information (Behn et al., 2015; Togher et al., 2012). Where training was delivered in a group format, the opportunity to share experiences and gain perspectives from others in a similar situation was described as useful and provided an opportunity for people to socially connect with others (Hall et al., 2025; Togher et al., 2012).

> I learned a lot listening to how other people were struggling, and it seemed that everybody has some of the same issues, but they have many of their own separate issues depending on what their brain injury is and how severe it is. (CP; Hall et al., 2025, p. 1778)

Participants described regular opportunities for practice and rehearsal of skills including the review of previously recorded audio and video conversations with feedback as beneficial (Avramovic et al., 2023; Behn et al., 2015; Hall et al., 2025; Nielsen et al., 2023; Togher et al., 2012). This may have occurred within sessions or at home from regular homework exercises:

> We would watch back our videos, and talk about what we did well and what we do to make conversations better … having that visual was really good to then implement those strategies to make conversations better. (CP; Avramovic et al., 2023, p. 21)

Identify Challenges and Review Engagement

Participants described challenges that impact learning, which highlighted the need to review engagement and progress. Some participants requested additional sessions including more one-to-one training (Avramovic et al., 2023; Behn et al., 2015; Goldblum & Alant, 2009; Togher et al., 2012), while some participants wanted fewer sessions due to the repetition of content (Togher et al., 2012). Participants also requested more practice and rehearsal either with the therapist (Behn et al., 2015) or other people outside of the dyad (Togher et al., 2012) including different types of customers (Goldblum & Alant, 2009) and with more relevant workplace examples outside of the training environment (Nielsen et al., 2023). For some participants, group sessions had been challenging if they were long, lacked relevance, and/or were dominated by some participants (Hall et al., 2025).

Participants described being uncomfortable and feeling discomfort from recording conversations (Avramovic et al., 2023; Hall et al., 2025). In one study, receiving instruction and feedback was reported as confrontational by CPs who were mothers:

> It's been probably a bit, was a bit daunting for myself. I thought it was, when I first came in, honestly I could have left … it was just too confronting and the way that I felt in myself I just, because you don't know what, you're doing the best you can and now you're coming and people are going to tell you what you've done may not have been right … I just don't know whether I was ready for criticism but that's not how it was at all but that's how I thought … I actually had a panic attack for the first two things (sessions) … I thought I hope I can make it through the whole session because I just, and I think when it brings it back to you when you see the other families … I wasn't sure what was expected of me. (CP; Togher et al., 2012, p. 1570)

Other challenges related to how participants managed the training schedule and weekly homework tasks in the context of busy lives (Hall et al., 2025; Togher et al., 2012), as well as accommodating fatigue levels of an individual with ABI. Participants reported that training needed to be delivered in an accessible, jargon-free manner (Behn et al., 2015) while also addressing interpersonal dynamics in group settings (Hall et al., 2025; Togher et al., 2012). Additional challenges included ensuring access to materials beyond the training environment to

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real-world contexts (Nielsen et al., 2023) and adapting video content to reflect linguistic and cultural variation across contexts (Hall et al., 2025).

Training delivered via telehealth presented technical problems such as connection issues, problems with video and/or audio quality, and difficulty using platform features such as screen sharing (Avramovic et al., 2023; Rietdijk et al., 2022). Additional challenges included multitasking several online tasks (Avramovic et al., 2023) and missing nonverbal cues.

Future Steps

Participants described the need for follow-up and ongoing support and guidance after the training to maintain the benefits of training and facilitate further learning (Behn et al., 2015; Hall et al., 2025; Hart et al., 2020; Nielsen et al., 2023; Togher et al., 2012). Partners who were health care professionals reported difficulty in transferring skills and strategies to different people with ABI, as what worked with one person did not work with another due to posttraumatic confusion (Nielsen et al., 2023). In that study, the authors described helpful reminders, including posters with staff quotes related to the successful use of techniques and quizzes posted on the bathroom wall opposite staff toilets (Nielsen et al., 2023). Family members needed ongoing support to make further progress through setting new goals and learning how to apply strategies to a broader range of situations (Togher et al., 2012).

> It's a bit like making a cake. You can have all the knowledge, you can have all the ingredients but you've got to be able to cook it and the same thing with that they've got to put it into practice in everyday living and even though we've got the skills now, where do we go? … so that's out next goal. (CP; Togher et al., 2012, p. 1567)

Participants from several studies highlighted the importance of expanding the reach and range of CPs so that the training would be of benefit to other partners, whether health professionals, paid carers, retail managers, or other family members (Avramovic et al., 2023; Behn et al., 2015; Goldblum & Alant, 2009; Hart et al., 2020; Togher et al., 2012).

Theme 2: Making Change in Dyadic Interactions

This theme was generated from descriptions of what changed following training and how participants reported wanting to do more to better their interactions with others and what they did differently.

Learning and Practicing

Participants reported changes to their awareness, knowledge, and skills from attending the training (Avramovic et al., 2023; Behn et al., 2015; Hall et al., 2025; Hart et al., 2020; Nielsen et al., 2023; Togher et al., 2012). This was a process of change particularly for partners who became increasingly more self-aware of their own communication style.

> It's not as hard on us as it is on the patient type of thing so yeah I was happy to go through whatever, I didn't pick up it was actually more about me than him until a few weeks [ago]. (CP; Togher et al., 2012, p. 1570)

Participants developed greater knowledge and understanding of communication and its impact. They were able to reflect on the problems they experienced as individuals and how communication could be used for shared decision making and joint problem solving and to have more interactive conversations. Partners identified the need to make positive changes to their own communication style, to "talk as a team member, not a coach" (CP; Avramovic et al., 2023, p. 21).

The training led to a positive change in attitudes toward communication, and both participants could identify skills and strategies to improve interactions. These included comments to signal collaborative and joint thinking, ask more positive questions, and talk about ways to actively engage people with brain injury in conversation.

> Learning more about different sorts of questions and how to ask questions instead of asking yes/no questions. It helps me to get more out of the clients … elaborate on things. Clients I find hard to communicate with. Got more ideas of how to put like things. (CP; Behn et al., 2015, p. 1557)

Intention to Do More and Doing More

CPs described how changes made to knowledge and understanding led to an intention to communicate (Avramovic et al., 2023; Hart et al., 2020; Nielsen et al., 2023; Togher et al., 2012). Partners reported feelings of greater confidence in making those changes (Behn et al., 2015; Goldblum & Alant, 2009; Hall et al., 2025; Togher et al., 2012).

> When I had the answers [from P2], I didn't ask more. It was enough. But now I can understand it's not enough. I try to ask why, when, how do you think about this. (ABI; Avramovic et al., 2023, p. 21)

Participants described what they did differently (Behn et al., 2015; Hall et al., 2025; Hart et al., 2020; Nielsen et al., 2023; Togher et al., 2012). In one study, paid carers could

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positively compare their skills to what they had done previously in other caring contexts (Behn et al., 2015). Partners could reflect more easily, adapt, and self-monitor their skills for different situations (Behn et al., 2015; Togher et al., 2012) including to stop a heated argument (Togher et al., 2012) or when someone was frustrated (Behn et al., 2015).

> I think I am thinking before I answer, so instead of divebombing into a situation, stopping to think, they are picking up and why are they picking up. What's the reason? … when I can't find a way through, sometimes I think to myself you haven't approached that the right way. (CP; Behn et al., 2015, p. 1557)

Participants described the differences in the skills and strategies that they used in interactions with others (Behn et al., 2015; Hall et al., 2025; Hart et al., 2020; Nielsen et al., 2023; Togher et al., 2012). Some were examples of what they did more or less of, such as listening more, asking fewer inappropriate questions, providing more information to patients, and not demanding information (Behn et al., 2015; Hall et al., 2025; Hart et al., 2020; Togher et al., 2012). In other cases, examples were what participants were doing differently in conversation and included keeping talk short and succinct, slowing down, asking different question types, discussing problems, and using a range of topics (Behn et al., 2015; Nielsen et al., 2023; Togher et al., 2012). Strategies did not always work, and health professionals could describe occasions where this had occurred (Nielsen et al., 2023).

> I guess the biggest thing for me is just listening and just really hearing and understanding what the person is saying, and if I don't, ask clarification questions. (ABI; Hall et al., 2025, p. 1779)

> Patient had difficulties with both understanding speech and producing it. At times, he could say well-chosen words. At rare occasions also very short sentences. I tried with short sentences, gestures and picture support. Nothing worked. (CP; Nielsen et al., 2023, p. 215)

Theme 3: Outcomes of Change

This theme was related to the outcomes of training and what changed within conversation and to emotions, relationships, and activities that the dyad did together. Broader outcomes related to social participation and identity were also reported.

Conversation

Participants described the improvements to conversation from training (Behn et al., 2015; Hall et al., 2025; Nielsen et al., 2023; Togher et al., 2012) including more positive, successful, and enjoyable conversations. Carers described how they could get people with ABI to think and say more, allowing them to elaborate on their thoughts (Behn et al., 2015). Trained health professionals reported how people with ABI had greater and more structured conversations, had increased opportunities to be heard, could express more, and could avoid misunderstandings (Nielsen et al., 2023). Other participants reported more productive conversations from increased patience and a willingness to share information with others (Hall et al., 2025).

> He's listening, reacting to the other person, asking questions at the right time and giving input and having his own opinion. Conversations are more successful. (CP; Togher et al., 2012, p. 1567)

Improvements "in the areas of clarity, organisation and efficiency of communication" were found (Togher et al., 2012, p. 1566). Partners were taking increased responsibility for the conversation and worked collaboratively with the person with ABI to start and share conversations with others and keep conversations going more easily. There were positive changes in planning and organizing communication particularly in challenging situations (Togher et al., 2012). Some CPs reported occasions where struggle in conversation still occurred, either the result of skills and strategies not working or difficulty with the transference of skills and strategies from one person with ABI to another (Behn et al., 2015; Nielsen et al., 2023). In both studies, the CPs (i.e., paid carers and health professionals) managed several people with ABI who presented with a range of communication impairments.

Emotions, Relationships, and Activities

Many participants referred to the emotions and feelings that emerged from conversations (Behn et al., 2015; Goldblum & Alant, 2009; Hart et al., 2020; Nielsen et al., 2023; Togher et al., 2012). These emotions were predominantly positive for both people with ABI and CPs with greater feelings of confidence and optimism for the future, being more relaxed and calmer in their interactions: "big rock lifted off your shoulders" (CP; Togher et al., 2012, p. 1568). Some studies reported a reduction of negative emotions including less frustration and agitation, increased tolerance in situations of strained family relationships, and reduced defensiveness of patients (Behn et al., 2015; Hart et al., 2020; Togher et al., 2012). There were still some reported occasions of frustration despite the training as well as the skills and strategies learned.

> I find it frustrating when I can't get through to a client when I can sit for ages, and I can be so patient … I

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haven't been able to get any conversation, or they are just not interested. (CP; Behn et al., 2015, p. 1558)

Both groups of participants described positive changes to relationships whether that be the health professionals or the dyad (Hall et al., 2025; Hart et al., 2020; Togher et al., 2012). Health professionals were reported to communicate more frequently and effectively, with more consistent interactions between professionals about people with ABI (Hart et al., 2020). There were also improved and strengthened relationships between people with ABI and family or friends who attended the training, with fewer conflicts and arguments (Hall et al., 2025; Togher et al., 2012). Some of these improvements extended beyond those in the training, including improvements in relationships with other friends and family, where new friends were made and other friends expressed a desire to socialize more with the person with ABI. Although this was not consistent:

> [our relationship] has grown since we have been coming to this lesson and we can talk about anything between us now … I think it is going well with me and Mum but with Dad and me that's another story. (ABI; Togher et al., 2012, p. 1567)

Some participants reported positive improvements in daily activities from being able to converse with others including telephone conversations, shopping, and initiating new social activities or reintegrating into pre-injury group settings (Hall et al., 2025; Togher et al., 2012).

Identity and Independence

This subtheme was minor, and there was moderate confidence in the findings. This theme was drawn from participants who reported positive changes in independence of people with ABI and their sense of self and identity (Nielsen et al., 2023; Togher et al., 2012). People with ABI were reported to have greater independence in social situations, requiring less prompting. They were also reported to resume pre-injury roles, be more adultlike in interactions, and regain a sense of self from being able to converse more successfully with others.

> He cooked a barbecue with A [son], A said he had a great conversation and they both had fun. A said he felt like it was "like having his old dad back." (CP; Togher et al., 2012, p. 1568)

Discussion

This qualitative evidence synthesis provides insights into the experiences and perceived impact of CPT for people with ABI and their CPs. Across the nine included studies, participants described how training shaped their communicative behaviors, attitudes, and relationships, highlighting both the potential and limitations of CPT. For CPs, training provided them the support and guidance they desired to facilitate positive, more successful interactions with people with ABI. The findings complement and extend the conclusions of earlier systematic reviews (Behn et al., 2021; Wiseman-Hakes et al., 2020), not least with the addition of five further studies that were not published at the time of the last systematic review. These additional studies provide further support for training CPs, which includes family members and health care professionals, and the inclusion of students as trainers. While the focus of systematic reviews has been predominantly on the quantitative outcomes, this review extends our knowledge of CPT and its impact by providing an in-depth exploration of how change occurs, the contextual factors that facilitate or hinder delivery, and the nature of the outcomes experienced by those trained.

Change appeared to occur primarily through increased knowledge and awareness about one's own communication and that of one's partner. Training enabled dyads to reflect on existing communicative behaviors, identify unhelpful behaviors, and recognize new strategies (e.g., asking positive questions, talking collaboratively) to facilitate more effective conversations. These early changes led to changes in attitude toward communication, fostering a willingness to try things differently and engage in more collaborative conversations. As participants experienced positive outcomes from their conversations, increased confidence was reported. The review highlights that this progression, from enhanced knowledge and awareness, through changed attitudes, to increased confidence, often preceded the more intentional practice that is needed for behavioral change (Prochaska & Velicer, 1997). However, influencing change is rather more complex, and not all dyads had similar experiences. Other factors including relationship dynamics, therapeutic alliance, motivation to engage, and individual readiness may all influence the degree to which learning translates into action. Although the review does clearly show that CPT is more than education and awareness of the need to change, it requires intention or motivation to change and involves the active training and practice of skills and strategies (O'Rourke et al., 2018; Power & Morrow, 2024).

Understanding the mechanisms of change is relatively unexplored with respect to CPT. Certainly, changes in beliefs and attitudes, driven by increased knowledge and understanding, are a key mechanism, as are active practice, repetition, and rehearsal of skills, which require motivation and intention to change. These mechanisms link to learning by doing and cognitive and affective processing, which are key for rehabilitation interventions

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described by the Rehabilitation Treatment Specification System (RTSS; Hart et al., 2019). Understanding the mechanisms impacts the design of program theories and dynamic logic models for complex interventions (Mills et al., 2019). Recently, behavior change theory has been used to systematically and theoretically map out the key mechanisms for a CPT intervention (Behn et al., 2026). In that study, three evidence-based CPT programs designed for people with CCD were coded using behavior change theory. They identified 16 mechanisms of action that may influence change in communicative ability or conversation, including knowledge, skills, beliefs about capabilities, beliefs about consequences, motivation, goals, and behavioral regulation. CPT is a complex intervention with multiple mechanisms that influence change both in the short term, in relation to conversational change, and in the long term, where changes to relationships, social participation, and independence may be desired. Different mechanisms may need to be considered depending on the desired change. For example, behavioral regulation, which uses techniques to reduce negative emotions and improve one's ability to problem solve, may be a key mechanism for improving a person's independence in the long term.

Participants valued CPT that was individualized, context-sensitive, and relevant to their everyday experiences. Training that directly addressed real-life challenges, including managing conversations in family settings, work, or social contexts, was perceived as more meaningful and sustainable. This supports existing recommendations that rehabilitation interventions should be personally relevant and grounded in authentic communicative activities (Behn et al., 2024; Douglas et al., 2019; Togher et al., 2023). The findings also indicate that training must accommodate dyadic preferences regarding the mode of delivery. Participants expressed differing views about whether they preferred group or individual sessions and about the use of telehealth. The growing body of research demonstrating the feasibility of telehealth (Hall et al., 2025; Rietdijk et al., 2022) suggests that clinicians should adopt flexible, hybrid models for the delivery of CPT, as new and novel innovations emerge. Regular checks with the dyad would ensure that the delivery methods used remain relevant and responsive to the dyad's needs and the practical constraints of the clinical service or setting. Regardless of mode, active participation and opportunities for rehearsal were identified as essential ingredients for learning, reinforcing evidence that skill development in CPT depends on experiential practice and feedback rather than didactic instruction alone (O'Rourke et al., 2018; Power & Morrow, 2024).

While training was broadly well received, some participants found some ingredients challenging. For instance, mothers in one study (Togher et al., 2012) perceived direct instruction and feedback as confrontational, illustrating that emotional responses to training may vary across relationships and cultural contexts. These findings indicate the need for clinicians to approach training sensitively, establishing psychological safety and tailoring ingredients to the interpersonal dynamics of each dyad. Moreover, few studies explored how therapist support was maintained beyond the training period. Participants frequently expressed a desire for additional sessions or ongoing support, suggesting that follow-up opportunities could strengthen skill maintenance and generalization to other people and places. Evidence from previous trials indicates that gains in communicative competence can be maintained over time (Behn et al., 2021; Wiseman-Hakes et al., 2020), yet there are limited follow-up data. Longitudinal qualitative research could therefore highlight how dyads may sustain, transfer, or adapt strategies in the long term.

This review highlights the range of CPs trained to support individuals with CCD. Beyond family members (e.g., parents, spouses, friends), CPs included paid carers, shop assistants and managers, health care professionals, and student volunteers. While family members were trained alongside the individual with ABI (i.e., in a dyadic format), less familiar CPs were more often trained separately, commonly in group settings. Findings suggest that unfamiliar CPs may need to adapt and tailor communication strategies for varying cognitive and communicative needs and settings, which can be challenging. Given the emotionally demanding nature of rehabilitation, these challenges are unsurprising. Health care professionals have reported that they struggle with individuals presenting with CCD and have highlighted the need for training that supports flexible strategy use across contexts, alongside opportunities for practice, feedback, and reflection to improve conversational interactions (Christensen et al., 2023). A recent systematic review found that barriers to successful communication among health care professionals included their approach (e.g., style, inefficient strategies, lack of awareness) as well as an unequal relationship, which may lead individuals with ABI to feel patronized or dismissed (Christensen et al., 2024). That review also emphasized the importance of improving knowledge and skills, and the use of strategies that support understanding, expression, and adopting a collaborative approach. Differences between familiar CPs, who interact closely with a single individual with ABI, and less familiar CPs, who interact with multiple individuals with ABI, are likely to shape how CPT is delivered.

Most change in people as reflected in the data in this synthesis was described at the level of conversation, including improved turn-taking, topic management, and collaborative repair, rather than broader psychosocial outcomes. Participants also described an intention to use strategies to support conversations and were able to provide examples of where strategies may (or may not) have been successful.

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This focus on conversational change is consistent with existing research that evaluates change at this level as the primary outcome (Behn et al., 2021; Wiseman-Hakes et al., 2020). In the related field of CPT in aphasia, positive emotional and relational changes were also considered important to people with poststroke aphasia, family members, and clinicians (Palmer et al., 2025). There was less exploration of how CPT may influence identity, independence, or participation, which highlights a gap in understanding the long-term, more distal impacts of training. This may be influenced by the timing of the interviews, which occurred immediately posttraining and not at follow-up. Broader changes to relationships, participation, and identity may be more likely to occur in the months following training rather than immediately post. Additionally, these topics were not consistently addressed in interviews. One study included probe statements about topics such as confidence, relationships, and social life, which may explain why these psychosocial changes were frequently identified in that study (Togher et al., 2012). Given previous studies that have established the links between communication, social participation, and quality of life (Dahlberg et al., 2006; Galski et al., 1998; Snow et al., 1998; Struchen et al., 2011), future qualitative studies should explicitly examine how CPT influences emotional well-being and self-concept and explore whether training outcomes differ between familiar and unfamiliar partners.

In terms of limitations, data are derived from a small number of studies from inpatient and community settings, with variability in how training was delivered. Such variability and heterogeneity can make the findings context specific, lacking transferability to a wide range of settings. Where participants with ABI were included, these were mainly traumatic brain injury, which limits generalizability to individuals with nontraumatic causes of brain injury who may also experience CCDs. There was also a distinct lack of interview studies of clinicians who delivered the training and shared their perspectives of the training and its outcomes. Strengths in the design include the comprehensive search strategy across nine databases, use of dual researchers to complete the screening, and critical appraisal of individual studies (i.e., CASP) and subthemes generated (i.e., GRADE-CERQual). While there was high confidence in most subthemes, less rich data were evident for the identity and independence subtheme, which may require a more intentional focus in future studies. Two further subthemes had minor methodological limitations, but these concerns were not substantial enough to reduce the overall confidence in the findings. There were minor methodological concerns across most studies as determined by the CASP tool. Most studies did not sufficiently consider the relationship between the researchers and participants (CASP Item 6), which negatively affected the quality ratings, and it was difficult to determine whether the authors carefully considered the research design (CASP Item 3). Studies with low CASP ratings (≤ 5) were generally those in which qualitative data were not the primary focus of the research. The inclusion of qualitative data derived from interviews and open-text responses from surveys and questionnaires may be considered a strength. However, the richness of the data was limited and lacked depth compared with data extracted from interview studies.

Findings from this review highlight several important considerations for future research and recommendations for the development and delivery of CPT. There needs to be more detailed reporting of interventions, particularly in relation to the underlying mechanisms of change and the specific techniques used to influence change. The use of theoretical frameworks, including behavior change theory and RTSS, may support clearer specification and understanding of the different intervention components. Greater use of longitudinal qualitative designs is also needed to capture sustained changes over time, rather than immediate posttraining effects alone. Studies should explore a broader range of outcomes, including impacts on relationships, everyday activities, participation, identity, and independence; this may require more in-depth probing during interviews, especially at follow-up when such changes are more likely to emerge. Finally, future work should consider how training may need to be adapted for different types of CPs, particularly distinguishing between familiar and less familiar CPs, as these groups may have differing roles, experiences, and training needs. Clinically, this review highlights the importance of actively involving CPs in training to improve their interactions with people presenting with CCD following ABI. Clinicians should include CPT as part of their treatment planning, including for people with CCD who may have limited awareness of their communication changes. This is supported by the International Group of Cognitive Researchers and Clinicians 2.0 guidelines, which explicitly recommend that CPT be provided, either in person or via telehealth, for people with CCD (Togher et al., 2023). Training should extend beyond education and provision of information to include active rehearsal and practice of skills with CPs, clinician feedback, and ongoing review of progress that considers outcomes beyond conversation alone.

This review highlights a small but informative evidence base demonstrating the value of CPT as a collaborative and relational intervention that enhances communication, relationships, and social participation following ABI. Effective CPT appears to be characterized by flexibility in delivery, individualization to dyadic needs, active skill rehearsal, and ongoing support for maintenance and generalization. Most reported benefits occurred at the level of the conversation, with additional changes to emotions, relationships, and social participation. To optimize outcomes, clinicians should co-construct training goals with the dyad, embed opportunities for practice in everyday contexts, and monitor the maintenance of skills over time. Through

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exploring the lived experience of training, this review was able to identify perceived benefits, risks, and active components of training, which all help to inform the future delivery of CPT to people with ABI.

Data Availability Statement

All relevant data are contained within the review article and its supplemental materials.

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