LITERATURE REVIEW

Factors that influence social dignity in persons with aphasia in their contact with healthcare professionals: a systematic literature review of qualitative studies

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Abstract
Background: Persons living with aphasia have unique needs and challenges that would benefit from greater understanding among all health professionals.
Aim: To explore which factors influence social dignity in persons with aphasia in their contact with healthcare professionals.
Methods: A literature search was conducted in CINAHL, MEDLINE, Embase, PSYCINFO, ProQuest, Web of Science, ERIC and Epistemonikos. A total of 317 studies were read and eight were finally included. Qualitative content analysis methods were applied for data extraction and interpretation.
Results: One overarching theme emerged: enabling person-centred communication among healthcare professionals. This covered two main themes – the experiences of empathy and of empowerment. The first of these is based on the subthemes of openness and awareness of feelings, and being acknowledged as a unique person. The second covers three subthemes: involvement in care and rehabilitation; capacity building to gain control and confidence in communication; and enabling communication in community aphasia groups.
Conclusions: Healthcare professionals' ability to safeguard the social dignity of persons with aphasia is contingent on enabling them to communicate in a person-centred manner. Without such communication, persons with aphasia may perceive that their feelings, uniqueness, involvement and confidence are being disregarded.
Implications for practice:
- Outcomes for persons with aphasia are potentially better when healthcare professionals involve them empathetically and empower them in communication
- To promote person-oriented communication with persons with moderate or severe aphasia, healthcare professionals need to learn tailored skills from competent speech therapists
- Persons with aphasia and healthcare professionals require a supportive organisational environment for person-centred care. Without such support persons with aphasia are often not empowered to participate in communication

Keywords: Aphasia, communication, healthcare professionals, person-centred practice, social dignity, Supported Conversations for Adults with Aphasia

Introduction
As a consequence of brain damage, persons with aphasia have various limitations in relation to activities and participation in which communication is important, making it difficult for them to find their social role in the family, in other relationships and at work, as well as in leisure and community pursuits (Dalemans et al., 2008). Friends do not always know how to communicate with persons with aphasia and, over time, they might drop out of the relationship (Ford et al., 2018). For those with chronic aphasia, friendship loss correlates with a higher risk of depression (Northcott and Hilari, 2011). It can lead to loneliness, which, alongside the inability to function in social networks, can result in psychological distress (Hilari et al., 2010).

The World Health Organization includes body function, activities and participation in the International Classification of Functioning, Disability and Health (ICF), with participation described as involvement in life situations (WHO, 2001). For persons with aphasia, difficulties participating extend to talking and writing messages or letters, due to impaired verbal expression, auditory comprehension and reading ability (Dalemans et al., 2008). Such barriers to communication and interaction raise the issue of their social dignity. The United Nations and the WHO both state that dignity is a fundamental human right (UN, 1948; WHO, 2001) and it has been described as a quality shared by all humans, which cannot be destroyed, weighed or measured (Nordenfelt, 2004; Jacobson, 2007). Social dignity, while it is rooted in human dignity, is experienced through interaction in social contexts. The experience of being integrated and autonomous is a key aspect of social dignity, in combination with self-respect and self-confidence (Jacobson, 2007), which often correlate with identity (Nordenfelt, 2004) although identity may alter with changes to a person's mind and body (Nordenfelt, 2004). Further, as social dignity is contextual and measurable it can be lost, threatened or violated, but it can also be promoted (Jacobson, 2007). Autonomy, or self-determination, is defined as governance over the self and respect for this ethical principal has become more important over time, especially within Western liberalism (Corrigan, 2003). For persons with aphasia, autonomy might be disregarded and threatened; for example, family members might speak on their behalf (Haley et al., 2013). Meanwhile, how healthcare professionals communicate with persons with aphasia has not been sufficiently explored as they often experience being ignored and disempowered in care contexts (Hersh, 2015). When healthcare staff bypass their autonomy by not involving them in planning their rehabilitation processes, the care provided is based on an assumption of what they want (Haley et al., 2013). Not enough attention has been devoted to how healthcare professionals can be enabled to communicate effectively with persons with aphasia, particularly as the effective communication skills are critical when the impairment ranges from moderate to severe (Hersh, 2015).

Few studies have sought to capture the views and experiences of persons with aphasia (Haley et al., 2013; Tomkins et al., 2013). Therefore, this literature review focuses on exploring their experiences of social dignity to shed light on their unique perspectives regarding their contact with healthcare professionals.

Methods
The aim of the study called for an appropriate qualitative method, therefore this literature review applies an explorative approach (Polit and Beck, 2012), and investigates qualitative literature where the voice of persons with aphasia emerges through semi-structured interviews. The contexts of the eight included studies represent different stages of care, rehabilitation in hospitals and in the community, community aphasia groups and cases where persons with aphasia contributed as trainers to help develop aphasia expertise among healthcare staff and others.

Inclusion and exclusion criteria
To qualify for inclusion, studies had to be qualitative research published in the English language, and focus on the experiences and feelings of social dignity of persons with aphasia in their contact with healthcare professionals. The participants in the included studies were persons with aphasia.

Search strategy

The searches for studies published between 1 January 2007 and 25 September 2017 were conducted in electronic databases (MEDLINE, Embase, PsycINFO, CINAHL, ProQuest, Web of Science, ERIC and Epistemonikos). A manual search of the *Aphasiology* journal online for the period from 26 September, 2017 to 31 January, 2018 was also conducted. The search terms aphasia, social dignity, communication and healthcare professionals were systematically searched for, separately and in combination with AND and OR. A total of 315 studies were identified, of which eight were eventually included, as illustrated in the flowchart in Figure 1.

Figure 1. PRISMA flowchart of the included studies
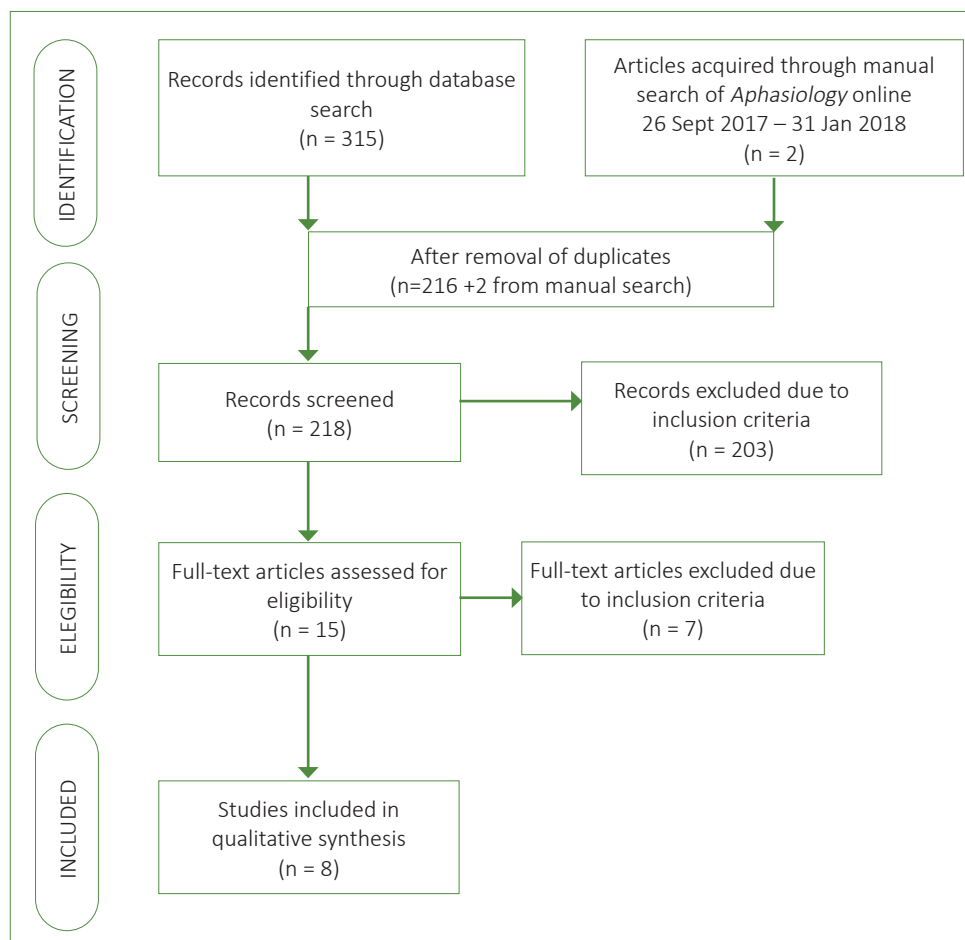
The included studies

The methodological quality and characteristics of each relevant study were assessed by all three authors, first individually and then together before they agreed on the final version, as shown in Table 1. The Johanna Briggs Institute Critical Appraisal Tool for Qualitative Research was applied; this consists of 10 questions to evaluate the qualitative articles included (Lockwood et al., 2015). None of the studies was excluded on the basis of quality.

Table 1: Questions to evaluate the methodological quality and characteristics of included studies										
Author		**Question**	**Study**							
			Lanyon et al. (2018a)	Lanyon et al. (2018b)	Swart and Horton (2014)	Grohn et al. (2014)	Tomkins et al. (2013)	Grohn et al. (2012)	Worrall et al. (2011)	Nystrom (2009)
Author 1 (SV)	1	Is there congruity between the stated philosophical perspective and the research methodology?	✓	✓	✓	✓	✓	✓	✓	✓
	2	Is there congruity between the research methodology and the research question or objectives?	✓	✓	✓	✓	✓	✓	✓	✓
	3	Is there congruity between the research methodology and the methods used to collect data?	✓	✓	✓	✓	✓	✓	✓	✓
	4	Is there congruity between the research methodology and the representation and analysis of data?	✓	✓	✓	✓	✓	✓	✓	✓
Author 2 (AL)	5	Is there congruity between the research methodology and the interpretation of results?	✓	✓	✓	✓	✓	✓	✓	✓
	6	Is there a statement locating the researcher culturally or theoretically?	✓	✓	✓	✓	✓	✓	✓	✓
	7	Is the influence of the researcher on the research, and vice-versa, addressed?	✓	✓	✓	✓	✓	✓	✓	✓
Author 3 (AJ)	8	Are participants, and their voices, adequately represented?	✓	✓	✓	✓	✓	✓	✓	✓
	9	Is the research ethical according to current criteria or, for recent studies, is there evidence of ethical approval by an appropriate body?	✓	✓	✓	✓	~	✓	~	✓
	10	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	✓	✓	✓	✓	✓	✓	✓	✓
Joanna Briggs Institute Critical Appraisal Tool for Qualitative Research. ✓ = Yes ~ = Unclear Critical appraisal of the included studies by the authors working independently in accordance with the criteria Questions: Lookwood, Munn and Porritt, 2015										

Table 2: Description of the eight included qualitative studies of people with aphasia

	Author, year and country	Aim	Data collection and analysis	Sample, time after the stroke and context	Severity of aphasia, age and gender	Main findings
1	Lanyon et al., 2018a Australia	To explore community aphasia group participation from the perspectives of people with severe aphasia	• Semi-structured interviews • Thematic analysis	• Seven PWA* • Two months to nine years • Community aphasia group	• Severe aphasia • 49-79 years • Six male, one female.	The community aphasia group can be a high risk for persons with severe aphasia. They can be excluded from the group conversation. Competent group facilitators, sufficient resources and a relevant structure are prerequisites for interactions for persons with severe aphasia
2	Lanyon et al., 2018 b Australia	To explore community aphasia group participation experiences	• Semi-structured interviews • Thematic analysis	• 22 PWA • Two months to 14 years • Community aphasia group	• Mild, moderate and severe aphasia • 40-83 years • Eight male, 14 female	A community aphasia group might be a place for PWA to belong and have a social life. On the other hand, it can be a place where they experience exclusion
3	Swart and Horton, 2015 England	To explore the experiences of PWA when they take an expert role and teach professionals and volunteers based on their own experiences	• Semi-structured interviews • Thematic analysis	• Eight PWA • One to five years • CVT** or aphasia experts	• Mild to severe aphasia • 38-68 years • Four male, four female	PWA shared previous experiences with health professionals and educated them to improve the way they interact. Expert role beneficial for PWAs' sense of self
4	Grohn et al., 2014 Australia	To describe the perspective of PWA of what is important for them to live successfully with aphasia in the first year post-stroke	• Semi-structured interviews • Thematic analysis	• 15 PWA • Four time points for interviews: three, six, nine and 12 months • At home	• Mild to severe aphasia • At least 18 years of age • Eight male, seven female	A holistic approach, in combination with the delivery of timely service from speech therapists for PWA and their families, is crucial for a successful first year post-stroke
5	Tomkins et al., 2013 Australia	To explore the factors influencing the satisfaction and dissatisfaction of PWA with their healthcare	• Semi-structured, in-depth interviews • Thematic analysis	• 50 PWA • Three to five years • At home	• Mild to moderate aphasia • 53-73 years • 24 male, 26 female	Information and communication, dignity, respect, control and independence were important, as well as trust, support and understanding
6	Grohn et al., 2012 Australia	To explore the perspective of PWA on factors that facilitate successful living during the three months post-stroke	• Semi-structured interviews and self-perceived ratings • Phenomenological analysis	• 15 PWA • Three months • Participants identified from five hospitals	• Mild to severe aphasia • 47-90 years • Eight male, seven female	Early introduction of a service delivery model to support meaningful communication training for PWA, family members and close others by a speech therapist facilitates a positive outlook
7	Worrall et al., 2011 Australia	To gain an understanding of what PWA want from aphasia services	• Semi-structured, in-depth interviews • Thematic analysis	• Fifty PWA • 12 months • Participants with experience of rehabilitation	• Mild to severe aphasia • 63-74 years • 24 male, 26 female	For PWA the most desired goal from the WHO International Classification of Functioning, Disability and Health is activity and participation.
8	Nystrom, 2009 Sweden	Studying professional aphasia care from the patient perspective	• Eight Interviews, four follow-up interviews, two notes from diaries, two biographies • Phenomenological method	• Nine PWA • One to 28 years • Selected from the Swedish National Fellowship	• Mild to severe aphasia • 45-72 years • Four male, five female	PWA need a secure base for caring, where the knowledge of speech and language therapy is integrated in caring situations.

*PWA = Person with aphasia post stroke; **CVT = Volunteered as Conversation Partners Traineers*

Analysis
Qualitative content analysis was used to analyse the studies and carried out in the following stages. First, the results were read by the three authors several times to provide an overall impression – a description of the included studies is presented in Table 2, above. The next stage was to identify the meaning of the text and search for the quality and essence of the content by condensing meaning units into themes and subthemes (Graneheim and Lundman, 2004). Thereafter, each author read the results of the included studies again. They compared and agreed on tentative interpretations and alternative labelling of the themes and subthemes. In the fourth stage, the final overarching theme, main themes and subthemes emerged (Graneheim and Lundman, 2004).

Results
The overarching theme from the analysis of the eight included studies was: enabling person-centred communication among healthcare professionals. This covered two main themes: the experience of empathy and the experience of empowerment, each of which contained subthemes, as shown in Table 3.

Table 3: Overview of overarching theme, main themes and subthemes		
Overarching theme	**Main themes**	**Subthemes**
Enabling person-centred communication among healthcare professionals	The experience of empathy	Openness and awareness of feelings
		Being acknowledged as a unique person
	The experience of empowerment	Involvement in care and rehabilitation
		Capacity building to regain control and confidence in communication
		Enabling communication in community aphasia groups

Enabling person-centred communication among healthcare professionals
The reviewed literature reports the experiences of empathy and of empowerment as being cues for the fulfilment of the components of social dignity for persons with aphasia. The experience of being involved and active participants in communication with healthcare professionals is highlighted as valuable. Furthermore, persons with aphasia appreciate being considered and treated as unique and autonomous persons by staff. The path to reconstructing their former self as far as possible involves being helped and supported to overcome their communication barriers.

The experience of empathy
When healthcare professionals incorporate empathy in their actions and conduct towards persons with aphasia, it is seen as highly valuable in helping to address individual needs and promote the outcome of improved social dignity (Nystrom, 2009; Worrall et al., 2011; Grohn et al., 2012). Two subthemes related to empathy emerged:
- Openness and awareness of feelings
- Being acknowledged as a unique person

Openness and awareness of feelings
When persons with aphasia are admitted to hospital, they appreciate empathy from healthcare professionals and efforts to understand and to be sensitive to their feelings by considering timing and what information they can handle in the acute phase (Nystrom, 2009). Furthermore, they value staff who provide empathetic care by sharing their understanding of factors such as fatigue and physical functioning deficits. When healthcare professionals employ a holistic approach, persons with aphasia are encouraged to have confidence in their abilities in the initial period of rehabilitation (Grohn et al., 2012). Positive relationships and interactions with healthcare professionals are a prerequisite

for creating trust. Moreover, greater hope is engendered when healthcare professionals want to understand, share the person's desire to move towards a normal life and consider how speech therapy can be tailored to individual needs at each stage of the recovery process (Worrall et al., 2011). Furthermore, it is important for staff to draw on the previous competences of persons with aphasia to help safeguard their experience of identity (Nystrom, 2009). In cases of impressive and expressive aphasia, (difficulty understanding what is expressed and written, and difficulty with the use of language when speaking and writing), it is appreciated when staff show they know the person can think, even if their language skills are poor (Nystrom, 2009).

Being acknowledged as a unique person
Persons with aphasia feel safer when speech therapists and other staff exhibit genuine interest in communicating with them, try to understand their personal communicative possibilities and support them (Nystrom, 2009). However, sometimes professionals are task oriented, focusing on their duties and failing to consider the person as a human being, which can lead to feelings of exclusion and humiliation (Nystrom, 2009). Staff can help by showing concern, taking a personalised approach to information, communication and fulfilment of the person's needs, and avoiding medical jargon. If they do not, anxiety, confusion and anger can result (Tomkins et al., 2013). Respect for progress in communication and for the previous skills of persons with aphasia is a key part of a relationship with staff that is crucial for the experience of social dignity (Worrall et al., 2011).

The experience of empowerment
As persons with aphasia experience communication barriers, the support they receive can make the difference between a feeling of power and control, and disempowerment. Many experience being disempowered (Worrall et al., 2011) and interactive communication with healthcare professionals seems to make a difference in terms of autonomy and self-confidence. Three subthemes related to empowerment emerged:
- Involvement in care and rehabilitation
- Capacity building to regain control and confidence in communication
- Enabling communication in community aphasia groups

Involvement in care and rehabilitation
In the reviewed research, persons with aphasia express a strong wish to be active participants in their care and to be involved and supported in all communication and decision making (Nystrom, 2009). They want information about what stroke-related aphasia is, and what kind of therapy and services are planned and at what stages of rehabilitation (Nystrom, 2009; Worrall et al., 2011; Grohn et al., 2012; Tomkins et al., 2013). Persons with expressive and impressive aphasia want healthcare professionals to address factors that hinder communication, and give them sufficient time understand what has been said and to express themselves (Nystrom, 2009; Swart and Horton, 2015). They dislike staff simply telling them what to do and instead want dialogue and greater autonomy in caring situations (Nystrom, 2009). In terms of involvement in their own rehabilitation, they prefer meaningful activities related to leisure and work (Worrall et al., 2011; Tomkins et al., 2013) and goal-oriented rehabilitation that can be continued at home and in social situations (Worrall et al., 2011, Grohn et al., 2014). The experience of not being integrated in decisions and planning makes rehabilitation feel meaningless (Grohn et al., 2012). Persons with aphasia distrust staff who do not acknowledge the severity of their aphasia, but feel satisfied when staff make an effort to understand their situation (Nystrom, 2009).

Capacity building to regain control and confidence in communication
The desire to improve communication capacity remains, irrespective of the severity of aphasia or length of time since the stroke (Worrall et al., 2011; Grohn et al., 2014). The experience of improvement in communication as well as using the phone and reading books increases confidence and optimism (Grohn et al., 2014), facilitates reconstruction of the former self (Swart and Horton, 2015) and is a strong motivation for recovery (Swart and Horton, 2015). Speech therapy is important for persons

with aphasia because they experience it as a path to reintegration and a meaningful life (Grohn et al., 2014). They express enjoyment when all professionals enable them to integrate in the community for recreation, leisure or as volunteers (Grohn et al., 2012). The opportunity to be trainers for student speech therapists, other healthcare professionals and volunteers is also seen as a chance to improve their own communication (Swart and Horton, 2015). For those persons who experience less than optimal speech therapy, becoming a trainer is an opportunity to contribute to better quality therapy for the future, as well as to understand the barriers that lead to social exclusion for persons with aphasia (Swart and Horton, 2015). Furthermore, being a trainer for other persons with aphasia allows for meaningful involvement, where they are included, can contribute and regain some sense of control (Swart and Horton, 2015).

Enabling communication in community aphasia groups
Community aphasia groups are important arenas for persons with aphasia because they might be their only social context for meeting and interacting with others (Lanyon et al., 2018b). In a well-structured community group, persons with aphasia who have made good progress in communication can experience companionship and gain a sense of belonging (Lanyon et al., 2018b). They appreciate the value of the groups in providing a safe place to share experiences of aphasia (Lanyon et al., 2018b). However, some need more time and support to gain the sense of belonging to a group (Lanyon et al., 2018b). Groups with a poor structure – for example, those that are too large or where the facilitators fail to involve all participants – hinder the sense of belonging (Lanyon et al., 2018b). Also, misconceptions about their intellectual capacity can be experienced as a barrier to acceptance, social inclusion and therefore social dignity (Lanyon et al., 2018b). Leaving the home to attend an aphasia group might be considered a high risk, especially for persons with severe aphasia (Lanyon et al., 2018a), who are even more dependent on competent facilitators with sufficient awareness and sensitivity (Lanyon et al., 2018a). They could easily face misunderstanding from other group members, who might mistakenly see them as lazy or less motivated than those with mild or moderate aphasia (Lanyon et al., 2018a). A lack of understanding from facilitators or fellow group members due to less fluent communication is devastating for the identity of persons with aphasia (Lanyon et al., 2018b). In contrast, when they become integrated in a group they are likely to find friends there (Lanyon et al., 2018a, 2018b). They appreciate a positive ambience for communication, where they can trust that nobody will make fun of them (Lanyon et al., 2018b).

Discussion
This study sheds light on the importance of person-centred communication provided by healthcare professionals who are capable of intergrating the components of social dignity by involving persons with aphasia in all communication, thus promoting their autonomy, decision making and self-confidence (Nystrom, 2009; Worrall et al., 2011; Grohn et al., 2012; Tomkins et al., 2013; Grohn et al., 2014; Swart and Horton, 2015; Lanyon et al., 2018b). However, when healthcare professionals do not manage to involve persons with aphasia in this way, they fail to sufficiently respect their self-determination and autonomy, which is primarily interpreted here as a lack of competence.

The study reveals the importance of empathetic relationships and interactions between healthcare professionals and persons with aphasia (Nystrom, 2009; Worall et al., 2011; Tomkins et al., 2013). The relational dimension of empathy in this study harmonises with the definition of empathy as relational, dynamic and multidimensional, where empathetic communication is a co-creative, responsive, two-way process in which both parties are attuned to understand each other and influence each other's experiences (van Dijke et al., 2020). In this way, empathy no longer takes the form of one-sided projection or identification, where healthcare professionals may 'affectively resonate or cognitively imagine' the experiences of the person by 'putting oneself in the other's shoes' (van Dijke et al., 2020, p 2) . However, relational empathy in communication with persons with aphasia is demanding for staff because they need to support the person with aphasia appropriately to participate in this relational dimension. Without such support, the relational empathy is in danger of being reduced to

'false empathy' (van Dijke et al., 2020, p 2), where the person with aphasia is unable to express their feelings and be acknowledged as a unique person.

Further, a central finding in this study is the importance of adaptable communication skills among healthcare professionals. For persons with poor potential for rehabilitation, healthcare professionals' ability to communicate with them may be limited or absent. Stroke-related aphasia can be mild, moderate or severe, and the ability of staff to apply the components of social dignity to their interactions seems to be inversely proportional to the level of communication support needed (Lanyon et al., 2018a). Where the prognosis for improvement in communication, measured by syntax, semantics, semantic memory or phonology, appears to be poor, there is a risk that speech therapy and communication with persons with aphasia will not be prioritised (Kagan, 1998).

Our study reveals that the relationship between persons with aphasia and healthcare professionals is crucial for the experience of social dignity (Worrall et al., 2011). A key question is how best healthcare professionals can be enabled by advice from a speech therapist to support communication for persons with aphasia (Worrall et al., 2011; Tomkins et al., 2013; Aldous et al., 2014). As always, organisational and managerial priorities are a key factor; if efficiency and cost-effectiveness are emphasised, staff will struggle to offer rehabilitation and supportive communication. Therefore, in addition to achieving competence through cooperation strategies with speech therapists, healthcare professionals need realistic schedules that enable communication and rehabilitation with persons with aphasia, as such work is often time consuming. A supportive organisational system that places the emphasis on humanistic values and person-centred care is very important in this respect (McCormack and McCance, 2017).

This study also shows that persons with aphasia experience optimism when they can trust speech therapists and healthcare professionals to help them regain a normal life (Aldous et al., 2014). When rehabilitation seems an insurmountable challenge, the social model of Supported Conversation for Adults with Aphasia (SCA™), promotes possibilities for communication and hence integration, autonomy and self-confidence (Kagan, 1998). The SCA model identifies possibilities in the healthcare environment to help cope with communicative disability, instead of merely addressing the challenge of how the individual person with aphasia can cope with limited communication (Kagan, 1998, 2000). Assessments of the severity of the aphasia and how challenging communication is, and of the strengths and weaknesses in language processing and communication, enable speech therapists to decide how best to apply the SCA (Kagan, 1998). A skilled speech therapist will support the person by employing all language modalities – auditory comprehension, spoken language production, reading and writing – which may be crucial in terms of enabling communication with staff (Kagan, 1998; 2000). Several specific techniques for conversation partners are included in the SCA to harmonise the support to the individual person with aphasia. Different approaches may be applied, including gesture, writing with a pen, writing pads, a speech machine or an eye-blink machine. Healthcare professionals can learn appropriate supportive skills from the speech therapist. This is a way to promote wellbeing given that persons with aphasia are living with an extremely challenging disability and may be devalued, or even ignored, within healthcare practice (Kagan, 1998).

However, healthcare professionals' needs go beyond developing skills in cooperation with speech therapists. They also need supportive organisational systems with the potential for innovative solutions and person-centred approaches to solve the difficult challenges associated with person-centred communication (McCormack and McCance, 2017). Staff competence is often lacking, meaning it is a time-consuming and demanding task, so organisational support is crucial to facilitate a person-centred approach (McCormack and McCance, 2017). Health services and community services could offer more financial and strategic support to organisations to enable them to implement person-centred models and principles such as the SCA.

Empathy and empowerment are highlighted in this article, but for an optimal holistic approach, healthcare professionals should consider a variety of factors in order to give persons with aphasia sufficient time for communication (Nystrom, 2009; van Dijke et al., 2020). Factors that might disrupt communication include other people nearby talking simultaneously and distracting audiovisual devices, but can also include conditions such as fatigue, pain, hunger and lack of sleep. When a competent speech therapist has assessed the strengths and weaknesses of communication and harmonised the conversation approach in accordance with the SCA model (Kagan, 2000), even persons with moderate to severe aphasia can be supported in their conversation. Auditory comprehension, spoken language production, reading and writing can be employed to promote their inclusion and self-confidence, in community aphasia groups and in other contexts with healthcare professionals. The approaches to communication covered in this discussion are effective for promoting social dignity, as they allow the person with aphasia to connect and interact with others or with a small group. This promotes the desired outcomes of active participation and being seen as unique persons. Respecting personhood and person-centred approaches are holistic quality criteria for communication and care (Hummelvoll et al., 2015).

Conclusions and implications for practice

Persons with aphasia are dependent on person-centred communication, and to provide this, healthcare professionals require interdisciplinary cooperation and a supportive healthcare environment. Overall, the experiences of being involved, and seen as unique and autonomous persons are shown to be critical factors affecting the ability of persons with aphasia to experience of social dignity. Policymakers, leaders and staff can promote this outcome by following effective strategies and recommendations for person-centredness.

Strengths and limitations of this study

The electronic searches in this study were carried out with the assistance of a specialist librarian. Although few studies met the inclusion criteria, those that did are based on the experiences and views of persons with aphasia and are of high methodological quality. When conducting the interviews, speech therapists assisted persons with aphasia communication to avoid misunderstandings.

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