TITLE

Communication Partner Training: re-imagining community and learning

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Abstract

Background: Learning is integral to Communication Partner Training (CPT) initiatives. Key theories include experiential learning and adult learning theory. The ways in which these have been applied, however do not consistently address the needs of people with aphasia and other stakeholders in CPT. Participatory, relational and collaborative approaches, subsumed within an expansive learning framework, which provides theoretical principles and scope for critical examination of the 'who', 'why', 'what' and 'how' of learning have the potential to address these shortcomings.

Aims: The objective of this paper is to critically review experiential and adult learning in CPT, subsequently examining participatory and relational approaches within the framework of expansive learning, using an example from a health care context.

Main contribution: Expansive learning is described, and its potential application examined through an example of CPT in a health care context and critical discussion of the literature.

Conclusions: Expansive learning provides a sound theoretical and practical basis for CPT initiatives across a range of contexts, and enhances our understanding of how to achieve goals of communicative access and social participation.

KEY WORDS

Aphasia; Communication Partner Training; experiential learning; adult learning; participatory approaches; expansive learning

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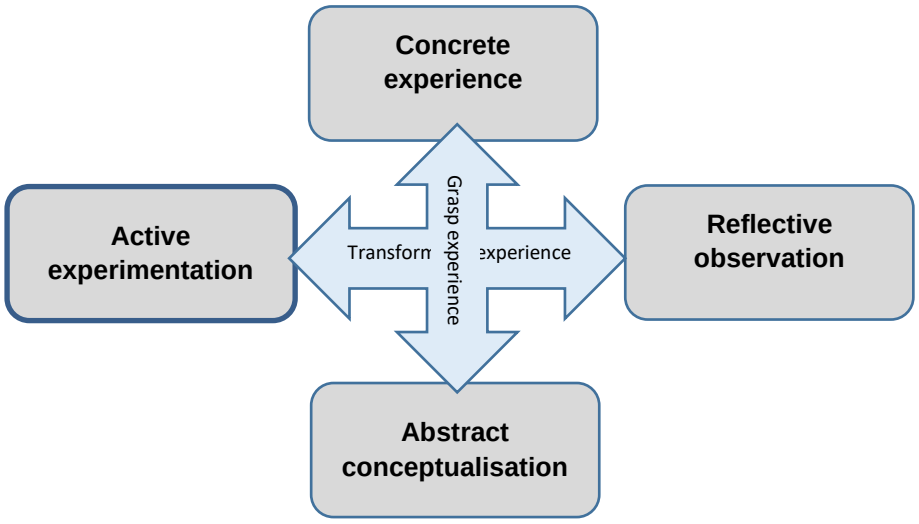
Introduction

Concepts of learning, where an individual or group of individuals acquire some new knowledge or skill resulting in a relatively long-lasting change in behaviour are integral to many Communication Partner Training (CPT) initiatives. The paper by Cruice *et al*. (this issue) shows how such concepts may be set out in terms of 'intervention components' and 'mechanisms of change', which aim to produce a desired outcome. These include some specification of the knowledge or skills to be targeted and – generally – involving an 'expert' who makes decisions about what is to be learned and how. In this paper we will consider some of the learning approaches which have predominated in studies of CPT; we will then go on to explore a range of concepts, practical issues and questions around the notion of transformation and learning in CPT, drawing on a theory of 'expansive learning', a systemic framework, whose object is the entire activity system in which learners are engaged (Engeström, 2001; 2004; 2009; Engeström *et al*., 2006). In so doing, we will introduce key concepts from participatory, relational and collaborative approaches to learning and action, as well as drawing on the work of other authors in this special issue, specifically referring to the humanising values framework (Pound & Jensen, this issue), Activity-based Communication Analysis (ACA) (Ahlsén & Saldert, this issue) and Communication Accommodation Theory (Simmons-Mackie, this issue).

The main goal of most CPT studies reviewed in terms of how interventions are reported (Cruice *et al*. (this issue)) was to increase knowledge (e.g. of communication strategies) and awareness (e.g. of own behaviours), and increase facilitatory behaviours (e.g. supported communication skills) in order to enhance communication between communication partners (CPs) and the person with aphasia (PWA). Key to many of these approaches is Kolb's theory of experiential learning

(e.g. Kolb, 1984; Kolb & Kolb, 2009), a meta-cognitive process, taking its inspiration from William James and Carl Rogers among others. The Kolbian learning cycle (Kolb, 1984) will be very familiar to clinicians generally and practitioners of CPT in particular (see Figure 1). Here, learners are enabled to engage with a 'concrete experience' (CE) on which they are asked to reflect in some way (Reflective Observation, RO), perhaps through discussion or in writing; this is followed by a process of abstraction (Abstract Conceptualisation, AC), through which new implications for action can be derived and subsequently tested (Active Experimentation, AE) (Kolb & Kolb, 2009). Kolb & Kolb (2009) stress how James' (1912) philosophy of radical empiricism, where "everything real must be experiencable somewhere, and every kind of thing experienced must be somewhere real" (pp. 159-60) means that all modes of the learning cycle (i.e. not just simply CE) are part of the experiential learning process. Importantly, a person's consciousness of their own learning process can be used to improve learning, consciousness itself being "an aspect of experience" (Kolb & Kolb, 2009: 301). This leads to a meta-cognitive learning model, which crucially, includes concepts of learning about oneself as a learner. The model operates in a learning spiral (rather than a cycle), implying that experience, enriched by reflection grows continually, and "the new experience created becomes richer, broader, and deeper" (Kolb & Kolb, 2009: 309). Meta-cognitive strategies for learning include practice ("practice makes perfect", p. 313), deployed in individually unique ways (learning style), within both physical and life spaces (learning space) (see Kolb & Kolb, 2009).

Figure 1 The experiential learning cycle (Kolb & Kolb, 2009)



Experiential learning in current approaches to CPT

A number of CPT programmes and research papers make specific or implied reference to experiential approaches as the basis for 'learning' or 'training', including: Supporting Partners of People with Aphasia in Relationships and Conversation (SPPARC) (Lock *et al*. 2001); the Dutch adaptation of SPPARC (Partners of Aphasic Clients Conversation Training [PACT], Wielaert & Wilkinson, 2012); and Supported Conversation for Aphasia (SCA) (Kagan *et al*., 2001).

In the SPPARC programme Kolb's (1984) work is cited as the basis for 'Step six' (the final phase), where the clinician leads participants through a three-stage process: i) gaining awareness of a general area of conversation particular to that partner or couple, through clinician-led explanations or videotaped examples, handouts, written exercises or role plays; ii) gaining or developing awareness of their own patterns of conversation; iii) identifying and using strategies for change. Lock *et*

al. (2001) emphasise the need for participant-driven selection of targets for change, as well as flexibility in the programme, and emphasize the need for participants to test new strategies and reflect on the success of these. The clinician's role is to "instil them with the confidence" to do so (Lock *et al*., 2001: 29), but how this should happen is not explicitly specified.

SCA and related programmes are founded on principles of social participation, with professionals or volunteers trained in techniques for acknowledging and revealing competence of PWA. "Experiential" methods generally consist of hands-on working with PWAs, with opportunities to practice techniques (e.g. Kagan *et al*., 2001); receive feedback from a PWA (e.g. Horton *et al*., 2016; Cameron *et al*., 2015; McVicker *et al*., 2009); and 'reflect' (e.g. Jensen *et al*., 2015; Sorin-Peters *et al*., 2010).

Some CPT programmes have consciously espoused adult learning or learner-centred principles in their approach, including: Conversation Coaching (Hopper, Holland & Rewega, 2002) and the approach to CPT described by Sorin-Peters and colleagues (Sorin-Peters, 2003; 2004; Sorin-Peters & Patterson, 2014). These programmes underline the importance of learning as a consequence of experience through the restructuring of previous knowledge. Principles of adult learning theory (see Holland & Hopper, 2005) such as collaboration, active involvement in the learning process, self-directed learning goals, which are relevant to the specific concerns of the learner underpin conversational coaching (Hopper, Holland & Rewega, 2002) and learner-centred approaches (Sorin-Peters, 2003; 2004; Sorin-Peters & Patterson, 2014). Conversational coaching provides 'live' training within a dyadic conversational context. Coaching, consisting of clinician interventions during dyadic interaction follows a session where participants have selected their own

preferred strategies to facilitate communication. The learner-centred approach reported by Sorin-Peters (2003; 2004) and Sorin-Peters & Patterson (2014) also reflects adult learning principles, framed within a Kolbian learning cycle. Sorin-Peters (2004) highlights the significance of involving the whole person, taking into account emotions, relationships and spiritual capabilities for example, and argues that "a combination of education, communication skills and counselling [would] be beneficial" delivered within an explicitly framed adult education model (Sorin-Peters, 2004: 954).

In general the CPT literature explicitly or implicitly presents the clinician as both expert and the locus of power for change, whose perceptions of what constitutes positive or negative communication behaviour tend to determine training goals and processes (Sorin-Peters, 2003; 2004). However, as Sorin-Peters (2003) argues, it is not just CPs or PWA who are learners in the CPT process – clinicians and researchers themselves need to move through their own learning cycle and should be prepared to enter into an active collaboration of learning with CPs / PWA. At worst, if a clinician is too focused on a fixed programme or does not engage PWA and CP sufficiently, s/he may overlook important concerns, for example: PWA's need to address "social, relational and psychological issues" through appropriate interaction with clinical staff (Loft *et al*., 2017a: 3); or their experiences of over-accommodation (Simmons-Mackie, this issue), where partners talk too loud or over-enunciate to accommodate to the perceived language impairment, may not be foregrounded. CPT may be hard for CPs to engage with due to the use of technical terminology or professional jargon, where concepts are perceived as too theoretical (e.g. CA derived concepts such as 'repair'), with the result that the purpose of the therapy content is not always clear (Johnson, 2015). In addition Johnson *et al*.

(2017) point out that while Kolbian learning theory may help raise awareness of barriers or counterproductive conversational behaviours it is not in itself sufficient to drive change in those behaviours.

In the following section we examine some of the issues entailed in enterprises of collaboration, participatory action and learning, before setting out an illustrative example of CPT within the frame of expansive learning.

Collaborative and transformative learning – exploring alternative paradigms for learning and change

Learning on the part of all participants has been identified as an explicit objective of Action Research (AR). AR approaches to learning are apt in considering approaches to CPT since AR fundamentally encourages a focus on a collaborative, dynamic approach to addressing practical problems in social systems enabling human beings to flourish (Reason & Bradbury, 2006). Core to the pioneering development of AR by Kurt Lewin and colleagues in the 1950s, and including the eclectic family of AR approaches that exist today is an exploration of change through learning. Learning takes place in a dialogue, founded on cooperation between researchers and clients, and transformative action grounded in cycles of open and critical reflection (Reason & Bradbury, 2006; Greenwood & Levin, 1998). One particular style of AR that is relevant to CPT in helping develop and expand understandings of transformative learning is Participatory Action Research (PAR).

PAR is underpinned by the philosophical writings of Paolo Freire, a Brazilian educator and social activist who worked with communities oppressed by poverty and illiteracy in South America. Freire used a banking metaphor of teaching and learning to articulate the need for a more humanising and inclusive way of learning (Freire,

1970). He asserted that for transformative learning and real social change to come about it was insufficient for teachers to ‘gift’ knowledge to learners. Rather learning and change required that students should have agency as critical co-investigators, always in dialogue with ‘the teacher’. Through careful listening, extensive dialogue and continuous cycles of collaborative reflection and action, teachers and learners come together in a space of “mutual humanisation” (Freire, 1970:56), where individual and collective change can take place. This dialogical action creates the opportunity for generative learning rather than just the acquisition of new knowledge and new behaviours, which are constrained by more linear learning processes.

A cornerstone of Freirian ideas about learning is critical consciousness or a deepened consciousness about a situation leading to transformation and social agency. Reviewing applications of a Freirian methodology to teaching and learning, Bates (2016) notes critical steps to be: identification of the nature of the problem; collaborative work to explore the problem; and production of a plan of action based on this collaborative, multi-perspectival analysis.

PAR is gaining in popularity as a methodology for generating change and new knowledge within health research (Koch & Kralik, 2006) and education (Kemmis & McTaggart, 2008). It is one of the cornerstones of experience based co-design (Robert, 2013) since it reinforces the importance of contextualised, collaborative solutions where the experience of all parties is explored and valued. PAR encourages the use of creative methods to expand upon the issues under scrutiny (communication, conversation, social inclusion) and therefore question dominant, professionally owned and informed discourses (Kramer-Roy, 2015; Koch & Kralik, 2006). With an emphasis on empowering participants/co-investigators both at an individual and collective level it reinforces relational approaches to learning and

dialogical processes of change. To echo a familiar concept from CPT programmes, it foregrounds interactional processes of learning, not just the transaction of information (about aphasia and communication techniques).

In summary, current approaches to CPT tend to under-emphasise the need to embed experiential learning in all phases of the Kolbian model, referring to a cycle rather than a spiral of learning; and foreground previous knowledge and experience rather than experience 'in-the-moment'. The clinician, generally cast as expert, teacher or trainer tends not to be considered as a collaborator in the learning process; CPs are generally framed as recipients of information, knowledge and expert advice. With heightened emphasis on the possibility of learning through being present, authentic and vulnerable in a relational context, processes of learning underpinned by PAR and critical consciousness align philosophically with lifeworld-led approaches to healthcare, rehabilitation and learning (Dahlberg *et al*., 2009; Galvin & Todres, 2012).

We argue that CPT will benefit from an approach to workplace learning that is capable of organising such participatory, collaborative and relational approaches within a coherent framework. In the following section we describe how Engestrom's theory of expansive learning may help to provide such a practical framework for conceptualising and operationalising CPT, embodying as it does a heightened focus on key principles of collaboration and context within defined activity systems. We set out a theoretical example of a CPT initiative within a healthcare context, illustrating the opportunities and challenges of an expansive learning approach, through examples from and discussion of selected literature.

Expansive learning: opportunities for enriching CPT in a healthcare context

Engeström (2001) argues that in transformations of personal life or working practices new forms of activity must be learnt that do not yet exist, and which must be learned as they are being created. While Engeström's (2001) frame of reference is not specifically aphasia or CPT, this issue is clearly exemplified in the experiences of people with aphasia, family members or health care professionals, who face numerous uncertainties in the days and months after onset of aphasia, and must continually fashion responses to these uncertainties as they arise. For example, while they may be able to learn certain types of responses, deemed to be 'correct' in any given context (e.g. 'give time for PWA to respond'), and the underlying rules governing these (e.g. 'I know you know'; respect for PWA's competence), they are continuously faced with any number of contradictory demands (e.g. 'give time for PWA to respond' vs need to complete work-based tasks within time constraints) and uncertainties (e.g. making sense of new life conditions). It is in such a context that Engeström proposes a 'collective endeavour' through the systematic framework of expansive learning theory, guided by five key principles: i) a collective activity system, seen as networked to other activity systems, which is the prime focus and unit of analysis; ii) the activity system is a community of multiple points of view, traditions and interests; iii) the activity system, with its problems and potentials must be seen in the context of its own history; iv) contradictions (not 'problems' or 'conflicts') are seen as sources of change and development; v) expansive transformation is possible and is achieved when a radically new horizon of possibilities is embraced (Engeström, 2001, pp.136-137).

These principles are set out in Table 1 with examples from current approaches, contrasted with potential opportunities for enriching CPT.

Table 1 Expansive learning principles, illustrations from current CPT practice and potential opportunities

Principle	Current approaches to CPT	Opportunities
1. Collective activity system prime focus and unit of analysis	Tendency to focus on the individual learner (health care professional; volunteer; or family member), and person with aphasia	Focus on the work place as a whole and its sub-systems
2. Activity system is a community of multiple points of view, traditions and interests	Tendency to have strong SLT voice and dominant professional discourse	Consider ways of involving other learners in shaping theory and practice e.g. people with aphasia, nursing staff, friends etc in a collaborative learning endeavour
3. Activity system seen in the context of its own history	Tendency to assume knowledge developed is static and transferable across settings	What can local organisations and more global history of CPT concepts add to our understandings of commonly held principles?
4. Contradictions as a source of change	Contradictions tend to be seen as conflicts or barriers to implementation	How can contradictions e.g. between views of people with aphasia and professional trainers drive innovation and change?
5. The possibility of expansive transformations in activity systems	CPT 'interventions' tend to centre on individuals, groups of individuals and short time frames	What are the opportunities for collaborative envisioning and collective change across activity systems and networks?

As Engeström (2001, p.133) argues, any theory of learning must ask at least four key questions. These are set out below in Table 2, again with examples from current approaches to CPT, contrasted with potential areas for expansive learning.

Table 2 Key learning questions, illustrations from current CPT practice and potential for expansive learning

Key questions	Current approaches to CPT	Potential areas for expansive learning
Who are the subjects of learning?	HCPs working in health and social care Students in Higher Education Volunteers People with aphasia Families and friends Public service providers	Different roles and motivations of different stakeholders not always articulated or assumptions questioned, particularly: people with aphasia; friends; public / private service providers
Why do they learn; what makes them make the effort?	Improved wellbeing and inclusion of people with aphasia Maintaining and sustaining relationships Developing skills and competence (CPD) Increased efficiency and job satisfaction	Motivations are not always explored, questioned or differentiated according to stakeholder voice and context
What do they learn; what are the contents and outcomes of learning?	Driven by a professionalised, technical discourse: How to engage in communication Knowledge about aphasia Tips and techniques to improve interaction and transaction of information Tips and techniques relevant to the individual learner	Exploration of knowledge about themselves Focus on individual and collective (family / community) assets Implications for broader cultural change
How do they learn; what are the key actions and processes of learning?	Processes of learning not specified, not explicit or ill-defined in CPT programmes – most based on cognitive and behavioural learning of techniques Professional expectations of learning i.e. professional as expert, imparting knowledge	Re-focus attention on relational, reflective and transformational processes; embrace embodied learning, coupled and distributed cognition

Engaging with potential areas for taking an expansive learning approach will require us to re-imagine CPT in terms of these key questions. In so doing, we need to understand and reflect on the embedded practices and assumptions, including guidelines and philosophical positions entailed in current approaches to CPT and be prepared to challenge these. Using Engeström's (2001: 138) matrix to cross-tabulate these four questions against the first four principles, we set out a hypothetical but none-the-less concrete example of CPT within an expansive learning framework. In so doing we will illustrate and discuss the potential for expansive cycles of transformation (the fifth principle) through critical, though not exhaustive examination

of CPT initiatives in various healthcare contexts. The example is summarised in Table 3 below, and further expanded and discussed in the text that follows.

Table 3 Expansive learning matrix: an illustrative example of CPT in a healthcare context

	Activity system	**Multi-voicedness**	**Historicity**	**Contradictions**
Who are learning?	Interconnected activity systems: a hospital-based stroke rehabilitation unit, including medical, nursing, therapy and support staff; patients; patients' family; patients' friends; experts-by-experience (PWA; family members)	Voices of specialists, support staff, managers, PWAs, family and friends	Communication support not part of health care curricula. Historical tendency for CPT where it exists to address individuals or homogeneous groups (i.e. family members; staff; volunteers) rather than taking a systems-based approach	Individuals or stakeholder groups may not perceive the need for learning or change; or may not see themselves as having 'expertise'
Why are they learning?	Stroke unit activity system is driven to improve standards and quality of care; internal and external pressures	Staff want to improve quality of service and job satisfaction Family members and friends wish to support PWA	Poor communicative access; social isolation of PWA; staff struggle to include PWA in decision-making; clinical engagement and safety factors	Externally imposed improvement goals may contradict more local aspirations; people learn new skills but cannot consistently implement them
What are they learning?	New approaches to learning and patterns of activity; co-production of resources and mutual support systems	All participants contribute to the 'learning curriculum'; PWA focus on supporting recovery of self and identity; staff focus on fulfilment of a caring identity	Discourse of SLT-driven, professional expertise; technical terminology; decontextualized approaches	New ways of learning and change mechanisms are at odds with institutional constraints
How are they learning?	Existing meetings (e.g. staff 'handover'; patient case conference) used to flag up issues with communicative access; examples recorded and taken forward to facilitated multi-stakeholder workshops	Participants work together: dialogue, debate and reflection; co-production and action	Members from different activity systems unused to collaborative, participatory learning	Institution requires a skilled workforce, but struggles to release staff for 'training' Aphasia experts are 'too experienced / skilled'

Who are learning?

Our example imagines a hospital-based stroke rehabilitation unit, where the 'learning challenge' (Engeström, 2001: 139) is for stakeholders to acquire new ways of working in order to provide consistent and appropriate communicative access and support for people with aphasia. As Simmons-Mackie *et al*. (2007) point out the ultimate goal for access and participation is at a systems level, for "without support from systems and social institutions, long-term sustainable changes in communicative access are unlikely" (p. 41). However, in line with activity theory's focus on the complex interrelations between an individual and his/her 'community' (see Engeström, 2001: 134-5) we are proposing that our hospital-based stroke rehabilitation unit be conceived in terms of a number of interconnected and interacting activity systems. So, for example, framing PWA-family members; PWA-medical staff; PWA-therapy staff; PWA-nursing and care staff etc. as separate yet interconnected activity systems within the wider stroke unit activity system, allows us to conceive a collaboratively constructed, holistic understanding of a PWA's life situation and communicative access needs. This chimes with the guiding principle of Jensen *et al.*'s (2015) study that "communication is everybody's business" (p.60), a principle designed to give a sense of ownership to all professional groups and stroke unit leaders. While patients and family members were integrated into this systemic approach through SLT 'bedside training' (Jensen *et al.*, 2015) they were not involved in identifying the issues or learning challenges. In Horton et al.'s (2016; 2015) study, where training was based on the UK Connect model, involving PWA as expert trainers (McVicker *et al*., 2009) CPT was developed and adapted to the local context, through involvement of PWA ('experts-by-experience') and some (clinical) staff groups, but neither medical professionals nor family members were involved. While

Horton *et al*. (2015) report how some staff groups continued to learn CP skills ‘on the job’ after the initial one-off training, others felt they already had these skills and would have appreciated more individualised, focused training. In Simmons-Mackie *et al*.’s (2007) study the acute care team in particular noted a number of barriers to achieving the goal of an accessible programme. Although each team was tasked with identifying ‘do-able’ changes, this outcome suggests that greater attention at an early stage to some of the contradictions (e.g. staff turnover; limited time and rapid pace of work; patients who were very ill) relevant to each of the various interconnected activity systems may have helped the team/researchers to more fully understand the particular ‘learning challenges’, and to specify more focused and appropriate ‘what’ and ‘how’ content. In so doing, we may be more mindful of the role that social status or group membership plays in shaping communication characteristics and practices of ‘convergence’ to adopt similar communication patterns or ‘divergence’ to emphasize differences within and across activity systems (Simmons-Mackie, this issue). In our example, we have also included ‘experts-by-experience’ (Table 3), conscious that our imagined CPT initiative may need to draw on the experience and insights of PWA and/or family members from outside the routine operation of the stroke rehabilitation unit. There are a number of issues inherent in the inclusion of ‘experts-by-experience’, which we have highlighted below under ‘How are they learning?’.

Finally, attention to ~~context~~ the contextual importance of goals, roles physical and psychological conditions in Activity-Based Communication Analysis (Ahlsén & Saldert, this issue) suggests how we might usefully understand, analyse and locate the ‘context of communicative access’ in relation to the goals of activities within and between our proposed activity systems. For example, we might use ACA to more

effectively construe the contrasting goals, roles and material circumstances inherent in the PWA-therapist or PWA-family activity systems – what do these activity systems have in common, what are the contrasts or constraints, how do the goals vary from time-to-time?

Why are they learning?

We have proposed that our stroke rehabilitation unit, as an activity system is driven to improve standards and quality of care. External pressures to improve performance generally and communicative access specifically (see Simmons-Mackie *et al*., 2007) in healthcare systems abound, whether they come from government bodies or health insurance companies. Motivation for learning at a smaller unit of analysis (e.g. PWA-therapist/nurse, or PWA-family member activity system) may be about ensuring the best job is done; the greatest support given (Loft *et al*., 2017a;b); or it may be about ensuring it is "all about the person" (Horton *et al*., 2015: 7), and the availability of appropriate interaction between PWA and nursing staff (Loft *et al*., 2017a). CPT initiatives are driven by a general acknowledgement that health care professionals (HCPs) lack the requisite, specialist skills to understand PWAs' needs (McGilton *et al*., 2011), potentially impacting on safety, the experience of care and participation in decision-making (see Horton *et al*., 2016; Jensen *et al*., 2015; McGilton *et al*., 2011; Sorin-Peters *et al*., 2010; Simmons-Mackie et al., 2007). In addition, individual HCPs may be motivated to address their own low confidence or anxiety in communicating with PWA (Burns *et al*., 2012; Cameron *et al*., 2015), and thus improve their own job satisfaction.

Adopting an expansive learning approach explicitly asks us to face and articulate the contradictions inherent in the 'work' that we do. Honestly and openly

addressing these contradictions may be difficult and troublesome (Engeström, 2001), especially within a culture, where the organisational characteristics are not supportive of openness and change through continued learning (see Simmons-Mackie *et al*., 2007). This discomfort is likely to be exacerbated where – as we are advocating here – diverse but interconnected activity systems come together to learn together, and where for example, staff might be asked to 'take more time' in communicating with PWA, while highlighting external demands for faster 'throughput'; or family members experience a lack of support for the PWA due to staff shortages and high turnover. The potential for experimentation and adaptation to an innovation such as CPT is exemplified in the 'fuzzy boundaries' of implementation discussed by Wielaert *et al*. (2018), where an organisation with its interconnected activity systems adapts to the innovation, while the innovation is adapted to the local context, touching on "existing attitudes and expectations about aphasia treatment in service providers as well as service users" (Wielaert *et al*., 2018: 84).

Pound & Jensen (this issue) highlight the possibilities of enriching approaches to CPT through a greater emphasis on humanising relationships and culture, informed through the humanising values framework of Todres *et al*. (2009). Within expansive learning approaches motivations driven by belonging and shared community encapsulated in the humanising dimensions of *Togetherness* might receive more explicit attention. Similarly, exploration of possibilities and priorities associated with finding existential coherence (*Sense-Making*); or the conversational comfort or discomfort (*Insiderness*) not just for PWA, but also for relatives, visitors and HCPs in our rehabilitation unit activity system might influence the 'why' of learning.

What are they learning?

Adopting an expansive learning approach clearly requires the various stakeholders to themselves identify and negotiate the various 'objects of learning' in "an emerging configuration of concepts that [will] define [an] expanded pattern of activity" (Engeström, 2001: 147). This continuous process also implies – as we suggest in Table 3 – that they will need to learn (and embrace) a number of (probably) highly unfamiliar patterns of learning, including dialogue, collaboration and co-production, which may be at odds with institutional culture and constraints. Engeström's (2001) example from children's' healthcare in Helsinki shows just how challenging this can be, with challenges inherent in such 'co-configuration' work (e.g. the need for flexibility; no single actor with sole fixed authority) further highlighted in Engeström (2004). Our stroke rehabilitation unit will need to develop a culture which is open to and enables multiple voices to be heard, even where the message may be uncomfortable, such as the PWA experiences of 'speaking for' behaviours, interruptions and overaccommodation resulting in patronising talk (Simmons-Mackie, this issue). While a certain level of 'ownership' is inherent in many CPT studies – for example, HCP generated 'do-able changes' (Simmons-Mackie *et al*., 2007); "a sense of ownership of the supportive tools and techniques" (Jensen *et al*., 2015: 60); development of individualised communication plans with input from nurses and PWA family (McGilton *et al*., 2011); PWA involved in refining and delivering the intervention (Horton *et al*., 2016) – expansive learning is crucially dependent on the contributions of all users and an ongoing commitment to learning (Engeström, 2004).

ACA (Ahlsén & Saldert, this issue) also has the potential here to help orient learners to the 'what' through careful consideration of context in the diverse goals,

roles, physical and psychological conditions inherent in the range of communicative activities across our imagined rehabilitation unit.

At a more existential level Loft *et al*. (2017a) in their qualitative exploration of the experience of people with aphasia on an in-patient unit encourage more explicit consideration of how learning might address patients' existential thoughts about a need for human contact. Pound & Jensen (this issue) advocate for programme content that might pay more attention to experiences of insiderness for patients, relatives and nursing staff. Within CPT programmes we might consider what aspects encourage a focus on responding to the affront to self and identity resulting from stroke and aphasia, or a nurse's feeling of vulnerability in supporting people with aphasia to "help make the unbearable bearable" (Loft *et al.*, 2017a: 3), so enhancing practices that embody high-convergence accommodations likely to enhance PWA experiences of positive identity and self-esteem (Simmons-Mackie, this issue).

How are they learning?

As we have highlighted (above) expansive learning involves dialogue, debate, co-production and flexible action in ways that require serious, long-term commitment. Many published studies of CPT initiatives are constrained in the sense that they are generally time- and resource-limited and – if using clinical-trials methodology – tend to focus on an unmodified intervention protocol. This is essentially antithetical to the core principles of expansive learning. We have suggested in our example that learning could be located both in existing meetings (e.g. typically: twice daily 'handover'; regular multi-disciplinary meetings; user-involvement meetings; case conferences); and rolled out in bespoke, facilitated multi-stakeholder workshops. This suggests a model of ongoing, continuous learning (see Engeström, 2004),

where stakeholders representing activity systems from our stroke rehabilitation unit might work collaboratively with an experts-by-experience (PWA and family members) group in a learning community. We envisage a number of 'contradictions' inherent in our initiative, not least the need for staff to be 'released' to take part in learning occasions outside existing meetings; and the involvement of confident and experienced aphasia experts, while current PWA in-patients may present quite differently (see issues raised in Simmons-Mackie *et al*., 2007; Horton *et al*., 2015).

Consideration of how to support learning that develops and bolsters a set of learnt skills and techniques within a capacity to care requires support from pedagogies, epistemologies and research methodologies that encourage a coming together of knowing and feeling (Galvin & Todres, 2012). This is particularly the case for HCPs working in increasingly technological cultures of care where rational knowledge of the head, associated with technical know-how and propositional knowledge, will claim higher status than scholarship grounded in more aesthetic, contemplative knowledge of the heart. Galvin & Todres (2011) expand on the concept of embodied relational understanding as a form of more holistic knowing, which values the felt sense or bodily awareness of an experience. Embracing knowledge from the body and sensitizing learners to deeply humanised connections to an experience can expand existing approaches to education and practice by encompassing knowledge for the head, hand and heart (Todres, 2007). Sundin & Jansson (2003: 111), for example show how appreciation and respect for PWA may be embodied through nurses' "acting at the same pace and in mutuality with the patient" in a process of continuous adjustment. Horton *et al*., (2017) have shown how in conceiving rehabilitation as a set of 'collectives', consisting of bodies, objects and technologies "loss and recovery of self can be observed in the accomplishment of

these ongoing heterogeneous arrangements" (p.1538). This expanded way of knowing is well suited to the provision of humanly sensitive care in complex cultures of service provision, where competing priorities can undermine staff wellbeing and a sustained capacity to care (Galvin and Todres, 2012). In practice, embodied relational understanding in a CPT context might be facilitated by reflective practice that encourages exploration of experiences guided by dimensions such as embodiment and insiderness (Pound & Jensen, this issue), including professional development practices, where stakeholders are encouraged to use creative activities and materials to explore complex or taken-for-granted experiences, such as the experiences of conversation and interaction on the rehabilitation unit (see Galvin *et al*., 2016). In learning contexts where time is often in short supply teaching and learning techniques which harness empathic understandings and felt responses may be useful additional ways to expand and fast track learning.

Summary and future directions

Existing approaches to learning in CPT have tended to foreground clinician expertise, with a less-than-critical adoption of experiential learning practices. The need for a holistic appreciation of the experiences of PWA and family members to inform the content of CPT initiatives is often lacking. Few approaches have attempted to engage with the multiplicity of voices present, or acknowledge the learning needs of all stakeholders. We have proposed a model for re-imagining CPT as a learning community, consisting of a diverse, but interconnected set of activity systems. The conceptual framework of expansive learning theory, including attention to participatory, social and relational processes, and collaborative practices provides a practical – albeit challenging – model for practising and researching CPT in a health care setting. Given its inherent flexibility and the unpredictable nature of the

diverse products of expansive learning, standard clinical trials methodology may not be suitable for investigating the efficacy of this approach. Implementation science (e.g. Bauer et al., 2015), which was the basis for the PACT implementation study (Wielaert *et al*., 2018) may provide a more appropriate model for future investigations. In addition, we would argue that the radical exploration of experiences, 'learning what is not yet there' through incremental exploration and ongoing co-configuration work is highly relevant to other contexts such as student healthcare professional training, community work with families, friends and public service providers. Initiatives to enhance the involvement and participation of PWA and/or family members in higher education and community settings have already been exemplified in relation to participatory action and learning (McMenamin *et al*., 2015), and PAR (Horton, 2017; Horton *et al*., 2014).

Conclusion

We are proposing that Engeström's (2001) theory and framework of expansive learning provides rich opportunities to expand the scope and impact of CPT in health care and other relevant settings. Research is needed to examine how this approach may be implemented in a range of practice settings.

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