

Reinventing Speech-Language Pathologists' Approach to Psychosocial Barriers and Dysphagia Management

Ashley Tarpley*, Towino Paramby

Department of The University of Central Arkansas, Conway, United States

Purpose: Speech-language pathologists (SLPs) are responsible for addressing psychosocial factors, such as fear, embarrassment, disgust, anxiety, and depression, as they relate to dysphagia to ensure effective symptom management; however, SLP understanding of such responsibility remains largely unexplored.

Methods: This study was conducted by sharing a survey with SLPs to 1) analyze their awareness and acknowledgment of psychosocial factors experienced by adult clients with dysphagia, and 2) pinpoint whether a need for broader education and awareness of psychosocial symptoms experienced by adults with dysphagia exists in the field of communication sciences and disorders. Qualitative and quantitative data analysis were performed to analyze the survey findings.

Results: Findings regarding SLP education demonstrate that the majority of SLPs did not receive education on the topic of psychosocial factors and their relation to adults with dysphagia. The majority of SLPs actively screen their adult clients with dysphagia for psychosocial symptoms (62.96%), and the most common formal screening tool is the Eating Assessment Tool (47.17%). SLP respondents show a majority preference for increased access to information and education regarding psychosocial symptoms as they relate to adults with dysphagia (92.45%).

Conclusions: The study revealed a general lack of education provided to SLPs by higher education programs, differing preferences in screening tools utilized by SLPs, and a shared desire among SLPs to have increased access to information regarding their professional role and acknowledgement of psychosocial barriers adults with dysphagia may experience.

Keywords: Dysphagia, Psychosocial, Education, Screening



Received: May 11, 2023

Revision: September 22, 2023

Accepted: December 28, 2023

Correspondence:

Ashley Tarpley

201 Donaghey Avenue The University of
Central Arkansas, Conway, United States
Tel: +903-277-9070
Fax: +501-450-5474
E-mail: wallacead77@gmail.com

*This work was supported by the McNiece
Research Fellowship Award-University of
Central Arkansas Foundation.

INTRODUCTION

Dysphagia, known as difficulty swallowing, is “a symptom of an underlying disease or disorder” that “affects individuals across the lifespan, may be transient or chronic, and may arise from congenital abnormalities, acquired neurologic or physical dysfunction, progressive degeneration, and/or psychiatric disorders” [1,2]. Difficulty in one or more of the stages of swallowing, including the oral preparatory, oral transit, pharyngeal, and esophageal stages, signals the presence of dysphagia. Common causes associated with dysphagia include strokes, Parkinson’s Disease, dementia, critical illnesses, such as COVID-19, that require prolonged intubation, head and neck cancer, traumatic brain injury, multiple sclerosis, pulmonary diseases, gastroesophageal reflux disease, and

© 2023 The Korean Association of Speech-
Language Pathologists

This is an Open Access article distributed under the
terms of the Creative Commons Attribution Non-
Commercial License (<https://creativecommons.org/licenses/by-nc/4.0/>) which permits unrestricted non-
commercial use, distribution, and reproduction in any
medium, provided the original work is properly cited.

medication use [1].

In the United States, 1 in 25 adults experiences a swallowing-related issue each year [3]. The prevalence of dysphagia in elderly populations is notably high with estimates of 30% of elderly adults receiving inpatient medical treatment, 68% of adults receiving long-term care, and 13-38% of independently living older adults experiencing symptoms of dysphagia [4]. Symptoms of dysphagia include coughing or a wet, gurgling vocal quality during mealtimes, increased effort required to chew and swallow, increased duration of time needed to complete a meal, drooling, weight loss, dehydration, and recurrent chest congestion after mealtimes [5]. One highly problematic symptom, aspiration, occurs when a substance is improperly swallowed, entering the lungs instead of the stomach. Aspiration pneumonia can develop as a result of foods or liquids entering the lungs and can be detected by symptoms such as “elevated respiratory rate, fever, cough, chills, pleuritic chest pain, crackles, delirium, increased confusion, [or] falls” [6]. While some individuals may present dysphagia symptoms for aspiration, others are asymptomatic and experience silent aspiration: substance passage into the lungs unnoticed [6]. A dysphagia patient’s life may be at risk if their symptoms are not properly detected and managed with the help of a professional, such as a speech-language pathologist (SLP).

SLPs are medical professionals trained to “prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders in children and adults” [7]. Adults who experience dysphagia can work with an SLP to learn how to manage their symptoms and improve their overall quality of life [4]. A symptom of dysphagia that is often overlooked concerns its negative impact on the psychological, social, and emotional wellness of the individual experiencing difficulty swallowing.

Psychosocial symptoms impacting an adult with dysphagia include fear, embarrassment, disgust, anxiety, and depression. Such emotions and their social impact are evident in adults’ fears of choking on foods, embarrassment of physical symptoms such as drooling, and disgust for puréed alternatives of meals, all of which may result in anxiety surrounding social functions and mealtimes—ultimately leading to depression from extended periods of social isolation. Activities once enjoyed regularly, such as religious services, educational programs, social outings, exercise classes, hobbies, and personal errands, can feel overwhelming or impossible after the onset of psychosocial symptoms related to dysphagia. If symptoms are managed inappropriately, adults with dysphagia can experience limitations

to social growth, resulting in a decline in mental health.

Maintaining a positive perspective toward symptom management is vital for the improvement of “an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns,” or an individual’s quality of life [8]. Negative emotions regarding symptoms need to be addressed by SLPs due to the ripple effect they can have on an individual’s confidence, willingness to participate in treatment, and overall quality of life. While screening and assessment tools for patient quality of life exist and are implemented by SLPs, the degree to which practicing SLPs working with adults with dysphagia understand psychosocial symptoms and the importance of their effect on overall symptom management and treatment success remains unclear. Due to the risk of poor quality of life associated with improper management and treatment of dysphagia symptoms in elderly populations, it is vital that practicing SLPs remain informed of the purpose behind screening, assessment, and treatment tools addressing psychosocial symptoms experienced by adults with dysphagia.

Dysphagia: psychosocial symptoms

An appropriate evaluation of symptoms that play a role in the treatment and management of dysphagia requires recognition of the emotional and psychological experiences patients encounter. Consideration of psychosocial reactions and feelings related to the adjustment of social roles and dietary modifications is an important component of evaluation.

Societal expectations regarding a successful mealtime influence a dysphagic individual’s perception of their social status by limiting their ability to fully benefit from mealtime interactions. According to Ochs and Shohet [9], mealtimes are considered “cultural sites for the socialization of persons into competent and appropriate members of society” through the establishment of relationships that “reinforce or modify social order” [9]. Inability to assume one’s expected social role during mealtimes due to physical symptoms of dysphagia can lead to feelings of embarrassment, self-consciousness, and anxiety that encourage self-isolation from public gatherings and shared meals [5,10]. The choice to isolate oneself often intensifies negative emotions, giving rise to feelings of depression as they miss out on special occasions, such as holidays, birthdays, sporting events, and weddings [10].

Dysphagia patients also experience a sense of loss concerning overall mealtime enjoyment “due to slowness of eating, choking or fear of choking, modified diet[s], and guilt for disrupting nor-

mal family lifestyles and burdening caregivers” [11]. The risk of choking commonly leads to diet modifications that alter the texture and consistency of meals, reducing the variety of meal options and taste preferences. According to Egolf and Hartmann [12], individuals with high levels of food disgust sensitivity are more likely to reject foods due to issues with texture, which can lead to dehydration or malnutrition. It is imperative that the emotion of disgust is taken into consideration for dysphagia treatment in order to prevent inadequate nutritional intake.

The effect dysphagia has on one’s quality of life often requires support from a caregiver, especially when a significant underlying disease or disorder is present. Such modifications alter familial and social relationships by adding heavy responsibilities to informal caregivers’ lives that can lead them to experience “emotional and psychosocial burden[s] related to concerns over [their loved ones’] nutritional intake,” risk of choking, inability to eat desired foods, and reliance on a feeding tube [11,13]. According to Ochs and Shohet [9], shared family mealtimes are “central to defining and sustaining the family as a social unit” [9]. Caregiver guilt combined with feelings of sorrow, discomfort, fear, and anxiety regarding the physical changes their loved one is experiencing as a result of dysphagia can lead to disconnection within the family unit [14]. The financial and physical burdens involved in informal caregiving along with decreased time for personal activities can lead to caregivers feeling depressed or experiencing burnout as they feel inadequately prepared to care for their loved ones and sacrifice meaningful parts of their lives to assume the role of caregiver [13,14].

Informal caregivers and patients experience familial and personal changes with limited community resources designed to help manage emotions and lifestyle modifications. A “lack of public awareness and understanding” of dysphagia leads to frustration when dining in the community or with friends if individuals fail to consider the seriousness of dysphagia or mock its effects [10]. Social judgment resulting from assumptions or insufficient knowledge of dysphagia work against the development of confidence in a patient, adding to negative emotions, such as anxiety, embarrassment, and depression. Increasing general public awareness of dysphagia is vital in order to rid the stigma of societal expectations for mealtimes to encourage a positive social environment that instills confidence in all participants of a shared meal.

Role of speech-language pathologist

While caregivers provide vital support for friends and family members, they may lack the knowledge and expertise needed

to provide the exceptional care desired for their loved one’s dysphagia symptoms. With the support of a SLP, the physical symptoms experienced by adults with dysphagia can be assessed and appropriate management strategies can be implemented. Speech therapy involves various treatment protocols that are designed to effectively target the physical symptoms of dysphagia, such as diet modification to prevent aspiration, muscle strengthening exercises, and swallowing technique training.

The emotional and psychological symptoms of dysphagia require unique treatment approaches that differ from physical exercises by targeting the human mind instead of the body. The idea of a “person-specific” treatment approach has been implemented by SLP and owner of Brush Development Company, Jennifer Brush, for individuals with dementia who experienced dysphagia symptoms [15]. Brush utilized individualized care in response to patient inability to learn swallow techniques in a traditional manner and length of time. She modified the physical and social environments of patients to reduce distraction and confusion and incorporated personal choices into therapy sessions to encourage participation and create a space that fostered improvement in swallow function [15].

While the techniques Brush established addressed the human mind, her focus was primarily on memory rather than emotions due to the nature of dementia and its effect on memorization. Underlying disorders, such as Parkinson’s disease, multiple sclerosis, or a stroke, do not always benefit from memory retrieval as dementia is just one aspect of a disorder. Psychosocial barriers exist in all cases of dysphagia, proving the need for a more universal treatment approach that could draw from Brush’s person-specific mindset and concern with patient preferences and environmental obstacles.

In a study performed to gain a better understanding of dysphagia patient emotions regarding their experience of symptoms, Barrera and O’Connor Wells [1] reviewed the results of completed Swallow Related Quality of Life questionnaires from individuals with PD and dysphagia prior to and after therapy. Findings demonstrated “a difference between the [SLP] clinical evaluation of dysphagia and a patient’s self-assessment” with participants sharing that dysphagia had “a strong negative impact on their overall quality of life” [1]. Evidence from the findings suggests the need for increased SLP recognition of emotional and psychological symptoms considering the lack of SLP awareness concerning participants’ negative experiences connected to their symptoms.

Screening tools

Four common self-assessment measures available for SLPs to utilize for their patients with dysphagia that gather information related to psychosocial symptoms include the Swallowing Quality of Life Questionnaire (SWAL-QOL), Eating Assessment Tool (EAT-10), Dysphagia Handicap Index (DHI), and M.D. Anderson Dysphagia Inventory (MDADI).

Due to existing limitations of lengthy administration time, comprehensive detection of the presence and/or degree of psychosocial symptoms in adults with dysphagia, and universal application of an assessment between different populations combined with the influence of individual SLP preference, SWAL-QOL, EAT-10, DHI, and MDADI remain inconsistently adopted by SLPs across workplace settings and patient populations. Such inconsistency may be considered appropriate if the assessment is targeted toward a specific population, evident in MDADI's focus on individuals with head and neck cancers. The problem lies in the inconsistency between assessment tools concerning a comprehensive evaluation of the presence and degree of psychosocial symptoms experienced by adults with dysphagia. Without a consistent assessment protocol, patients will receive different levels of care from SLPs due to a gap in awareness of underlying psychosocial factors that impact an adult patient's participation in the management and treatment of their dysphagia symptoms.

Workplace setting is an influential factor in a clinician's decision regarding which assessment tool to utilize. In fast-paced settings, such as hospitals, SLP's caseloads are high, limiting their ability to conduct lengthy assessments in comparison to a university clinic where graduate students are trained by SLPs and carry small caseloads. One option for increasing SLP awareness of the presence and degree of psychosocial symptoms experienced by adult patients with dysphagia is to combine short assessments with informal assessments. Xia [11] offers an approach to dysphagia treatment referred to as narrative ethics that involves the dysphagia patient sharing personal experiences with an SLP concerning the impact of symptoms and symptom management on their everyday life. By sharing "biological, psychological, and social aspects of [their] illnesses" with an SLP, dysphagia patients are able to "define personal needs and goals" and "identify barriers to adequate self-care" [11].

Similar to Brush, the American Speech-Language-Hearing Association (ASHA) recommends a patient-centered approach to speech therapy for dysphagia with methods such as informational counseling, motivational interviewing, recognition of physical and psychosocial barriers, and creative diet modifica-

tion [15,16]. Such examples of informal screening measures provide SLPs the opportunity to assess adults with dysphagia for psychosocial symptoms in a variety of workplace settings.

Introduction to survey

Despite the numerous recommendations for appropriate acknowledgment of psychosocial and emotional barriers to dysphagia treatment, there is little research demonstrating the application of suggestions in a clinical setting. Our research aims to address the gap in awareness and application of such recommendations within the field of speech-language pathology by confronting practicing SLPs regarding their current knowledge and implementation of assessments and techniques that address psychosocial symptoms experienced by adult dysphagia patients through a shareable survey. Specifically, our study will investigate the perspectives and experiences of a broad range of SLPs working with adults with dysphagia across a variety of settings, with emphasis on the role of psychosocial symptoms, including fear, anxiety, depression, embarrassment, and disgust, as they relate to the role of an SLP.

The research consists of two main goals: 1) Conduct a survey shared with SLPs that analyzes their awareness and acknowledgment of the emotions of fear, anxiety, depression, embarrassment, and disgust experienced by their adult clients with dysphagia, and 3) Analyze survey responses to pinpoint whether a need for broader education and awareness of psychosocial symptoms experienced by adults with dysphagia exists in the field of communication sciences and disorders.

Methodology

A 32-item questionnaire was developed to explore the current education, perspectives, and practice held by SLPs in regard to their awareness and acknowledgement of psychosocial factors experienced by adults with dysphagia. The survey was anonymous and conducted using the online platform, Qualtrics. Survey responses were gathered across three months (December of 2021 through February of 2022). Distribution of the questionnaire consisted of the creation of a shareable link that was posted to a Facebook group for medical SLPs and shared with the American Speech Language Hearing Association's Special Interest Group 13, Swallowing and Swallowing Disorders via an online discussion forum (approximately 6,500 members). We also used snowballing, a method of inviting all who received an email to participate in forwarding the shareable link to other SLPs working with adults with dysphagia. Institutional Review Board (IRB) approval to conduct the

survey was obtained through the University of Central Arkansas (UCA). Informed consent from survey participants was obtained.

Survey

Survey responses were formatted as multiple-choice questions with the frequent option of allowing respondents to add free text. The survey collected information on the following:

- (1) Demographic Information
- (2) Understanding of Psychosocial Factors (anxiety, depression, fear, disgust, and embarrassment)
- (3) Education (undergraduate, graduate, and doctoral levels)
- (4) Understanding of Adverse Effects
- (5) Knowledge of Psychosocial Factors
- (6) Screening
- (7) Desire for Increased Knowledge and Awareness

Data analysis

A download of the raw data was obtained with descriptive statistics of frequency, minimums, maximums, means, standard deviations, variances, and counts included for each question where quantitative data existed. Upon closing the survey, data was gathered from submitted questionnaires.

RESULTS

A total of 63 completed surveys were obtained for the data analysis. In regard to participant demographics, the majority of the survey respondents' primary workplace settings were acute care hospitals (37.9%) and rehabilitation hospitals (16.7%). The primary cause of dysphagia in SLP caseloads in-

Table 1. Survey respondents' primary workplace settings

Workplace	Percentage (%)
Public school	1.52
University clinic	10.61
General outpatient clinic	10.61
Head and neck cancer outpatient clinic	3.03
Rehabilitation hospital	16.67
Acute care hospital	37.88
Long-term acute care facility	1.52
Skilled nursing facility	6.06
Home health	1.52
Other	10.61

cluded strokes (30.5%) and Parkinson's Disease (14.1%). Such findings are represented in Tables 1 and 2.

From the questions pertaining to education, the majority of the survey participants responded that they understood what psychosocial factors (anxiety, depression, fear, disgust, and embarrassment) are; however, only 27% of the participants received undergraduate exposure to psychosocial factors, 39% received graduate-level exposure, 27% received exposure in the swallowing classes of their graduate program, and two out of the eight participants who attended a doctoral program received exposure to psychosocial factors. Therefore, the majority of the participants did not learn about psychosocial factors through their higher-level education, as evidenced by Table 3.

Approximately 90% of the survey participants agreed or somewhat agreed that they understood the adverse effects of psychosocial factors on an adult with dysphagia's symptom management and willingness to participate in evaluation/treatment.

Approximately 97% of the survey participants agreed or somewhat agreed that their knowledge of the presence or absence of psychosocial barriers in adult patients with dysphagia is important in order for them to appropriately evaluate and/or treat such individuals and in order for their adult clients with dysphagia's well-being and ability to participate in evaluation/treatment.

In regard to screening, 63% of survey participants screened their

Table 2. Primary causes of dysphagia in SLP caseload

Cause of dysphagia	Percentage (%)
Head/Neck cancer	7.81
Laryngectomy	2.34
Stroke	30.47
Parkinson's disease	14.06
Amyotrophic lateral sclerosis	3.91
Alzheimer's disease	13.28
Multiple sclerosis	3.13
Transplant patient	2.34
Trauma	7.81
Other	14.84

Table 3. Higher-level education of psychosocial factors

Education level	Exposure to psychosocial factors (%)
Undergraduate	27.12
Graduate	38.98
Graduate swallowing classes	27.12
Doctorate	25

Table 4. Dysphagia screening frequency implemented by SLPs

Screening frequency	Percentage (%)
Prior to developing a treatment plan	62.96
Periodically throughout treatment	63.64
25% of the time	34.04
50% of the time	8.51
75% of the time	36.17
100% of the time	21.28

Table 5. Dysphagia screening tools utilized by SLPs

Screening tools	Percentage (%)
Dysphagia handicap index	3.77
Swallowing quality of life questionnaire	16.98
Eating assessment tool	47.17
MD anderson dysphagia inventory	3.77
Other	28.30

adult patients with dysphagia for psychosocial barriers prior to developing a treatment plan. Approximately 64% of the participants claimed to screen adult patients with dysphagia for psychosocial barriers periodically throughout treatment. Only 21% of the participants claimed to screen their adult clients with dysphagia for psychosocial barriers 100% of the time. The majority of the participants utilized the Eating Assessment Tool or informal measures to screen adults with dysphagia for psychosocial barriers. Such findings are represented in the tables 4, 5.

92% of the participants shared a desire for increased access to education concerning the role psychosocial barriers play in the evaluation/treatment of adults with dysphagia. Approximately 92% of the participants wished psychosocial barriers in the treatment of adults with dysphagia were a larger topic throughout their higher-level education and wished there was more information available to the general public regarding psychosocial barriers experienced by adults with dysphagia. Less than half of the participants had attended a conference, meeting, or assembly where psychosocial factors to the evaluation and/or treatment of adults with dysphagia were discussed; however, the majority of the participants (68%) claimed that they would attend a conference, meeting, or assembly regarding psychosocial barriers if it was offered at their workplace or within their community, evident in Table 6.

Overall, survey results demonstrate the need for increased education within the field of communication sciences and disorders (CSD) on psychosocial factors, greater awareness of the appropriate types of screening tools and frequency of use for adults with dysphagia, and the provision of greater access to resources and

Table 6. SLP participant desires for increased education

Participant desires	Percentage (%)
More information about psychosocial barriers for SLPs	92.45
More education on psychosocial barriers	92.45
More information about psychosocial barriers for general public	92.45

discussions on the topic of psychosocial factors available to SLPs.

DISCUSSION

As professionals involved in the care of individuals' well-being, understanding of psychosocial factors as they relate to adults with dysphagia is necessary for SLPs. It is our belief that the level of education received by clinicians on the topic of psychosocial factors is predictive of their current understanding of such factors and use of screening tools that measure psychosocial factors in adults with dysphagia. In regard to the level of education received, it is evident that higher education programs' efforts to expose students to psychosocial factors can be improved. With many undergraduate programs being gateways to a profession, topics such as psychosocial factors are relevant to student coursework, especially for aspiring healthcare professionals, such as SLPs, who work directly with individuals to overcome physical, mental, social, and emotional barriers.

Graduate programs are designed to equip young professionals with the skills necessary for entry into a profession. If the training students receive at the graduate level neglects awareness of psychological and social barriers clients may experience, students cannot be expected to navigate and appropriately manage the effects of such barriers upon entry into their profession. As a result, the individuals clinicians assess and treat experience unnecessary challenges to their management of symptoms. The ability of clinicians to address the presence of psychosocial barriers enables clients to receive treatment at a level they can adequately participate in.

Despite an overall lack of education received by the participants, the majority (67.24%) agreed that they understood the adverse effects psychosocial factors have on an adult with dysphagia's symptom management and how psychosocial factors could have adverse effects on an adult with dysphagia's willingness to participate in evaluation and/or treatment (70.69%). More research is needed to explore why the remaining 30% of SLP perspectives differ on this matter. Most participants also

agreed that their knowledge of psychosocial factors was important in order for them to appropriately evaluate and/or treat adults with dysphagia (82.76%) and for their clients' well-being and ability to participate in evaluation and/or treatment (84.48%). Without acknowledging the impact of psychosocial factors in evaluation and treatment, adults with dysphagia would not receive well- rounded care from an SLP. It cannot be assumed that the presence of such factors has no impact on a patient's participation in evaluation and treatment.

In regard to screening, 62.96% of the participants selected that they do screen adult patients with dysphagia for psychosocial symptoms prior to developing a treatment plan. Screening patients for the presence of psychosocial factors prior to developing a treatment plan accounts for barriers to patient motivation and mindset. There is an evident difference in clinician opinion on the timing of screening patients for psychosocial factors. The majority of participants claimed to periodically screen their clients (63.64%), however, a substantial number of participants did not (36.36%). Periodic screening would account for any recent changes in a client's psychosocial health, which are highly possible due to normal fluctuations in stress and motivation levels.

The most widely utilized screening tool among participants as a resource for screening clients for psychosocial barriers was the Eating Assessment Tool (47.17%) with the Swallowing Quality of Life Questionnaire as the second most used screening tool (16.98%). A large portion of the participants also entered free-text responses that correlated with informal screening measures (28.3%). It is not surprising that many clinicians prefer the EAT-10 as a screening tool due to it being a quick and reliable tool. EAT-10 is not as comprehensive as other tools, such as the SWAL-QOL, in terms of analyzing the degree to which different psychosocial factors are present in a client [17]. While SWAL-QOL is a 44-item questionnaire assessing quality of life, EAT-10 consists of 10 items, with only four referencing psychosocial concepts [17]. Overall, due to the workplace environment of hospitals and rehabilitation facilities where dysphagia patients are often seen, quick screening tools are more efficient. With the settings of hospitals and rehabilitation facilities limiting screening tool options for SLPs, the question of consistent screening practice for psychosocial factors is raised.

The frequency at which SLPs use screening for psychosocial factors in their adult clients with dysphagia was inconsistent across participants. Only 21.28% claimed to use screening 100% of the time. For individuals with dysphagia that are limited in regard to their access to SLPs, the level of care received

is limited to the preference of the SLP available to them. As a result, screening for psychosocial barriers is not available for everyone. One solution could be the requirement of the inclusion of specific screening tools for specific workplace settings. In settings with high caseloads, specific informal measures could be required in combination with a quick screening tool, such as EAT-10, to ensure consistency for all clients.

With consideration of the questions raised concerning education and screening tools, most participants desired access to more information about psychosocial barriers and the SLP's role in the evaluation and/or treatment of adults with dysphagia (92.45%). A total of 92.45% of the participants also desired for psychosocial barriers in relation to adults with dysphagia to be a larger topic in their education as students, and for greater information available to the general public concerning the psychosocial barriers experienced by adults with dysphagia. The participants' overwhelming desire for access to greater information on this topic demonstrates a need for improvement in education and advocacy, and a general openness among clinicians to receive said improvement.

Most of the participants had not been to a presentation where psychosocial barriers to evaluation and treatment in adults with dysphagia were discussed (52.83%); however, the majority of the participants stated that they would attend such a presentation (67.92%). With most of the participants interested in learning more about psychosocial factors in adults with dysphagia and the role of an SLP in their evaluation and treatment, it can be inferred that efforts to expand education and awareness would be received well by SLPs in the United States.

In all cases, when the findings from this small research study are applied to the broader population of SLPs working within the United States, it can be inferred that change is necessary in regard to expanded education and advocacy for the psychosocial barriers experienced by adults with dysphagia. With SLPs receptive to learning more about psychosocial factors and their role as a professional involved in the evaluation and treatment of adults with dysphagia, it is not a question of if efforts to increase education and awareness will be supported, but rather if these efforts will be made.

Strengths and limitations

One limitation is the self-selecting nature of the survey participants. Due to the survey being online, a shareable link was created to gain participants. It is likely that individuals interested in psychosocial factors as they relate to SLPs chose to participate in the survey while those uninterested did not. Also, the

manner of distributing the survey was not solely restricted to specialty groups, meaning some of the participants may not work primarily with adults who experience dysphagia. Anyone with the survey link could complete the survey. However, it is unlikely that outsiders to the profession gained access to and desired to engage with this research survey.

A further limitation concerns the lack of opportunities for qualitative data from the participants. The survey was structured as multiple-choice with free-text options available for selected questions. Participants utilized a number of the free-text options, but the questions did not prompt detailed explanations of why SLPs held particular perspectives. This qualitative limitation impacts the ability to make a specific assumption about if the participants are effectively acknowledging the psychosocial barriers their adult clients with dysphagia may experience. Nonetheless, the methodology utilized for this study provided data on the existence of a variety of SLP perspectives concerning understanding of psychosocial factors and screening methods. The anonymity of the survey also provided participants the opportunity to boldly share their perspective without fear of a negative outcome.

Future directions and implications

The findings from this study offered data on current SLP's perspectives, raising questions concerning why SLPs hold the viewpoints that they do as well as what can be done to offer SLPs what they desire in regard to education and awareness opportunities. The participants involved in this study were limited in number, specific clientele of adults with dysphagia, and diversity. A future study similar to this one would benefit from obtaining a greater, more diverse pool of participants in regard to their gender and ethnicity.

With findings demonstrating participants of differing ages with a broad range of years of experience, future research could explore how professionals with less experience perspectives' differ from those with more experience. A focus on the education they received on psychosocial factors experienced by adults with dysphagia may point to improvement or a lack thereof within educational programs.

More research is needed on why SLPs hold the perspectives they do in regard to their role as an SLP and the psychosocial factors experienced by adults with dysphagia. In regard to the question raised on the consistency of SLP utilization of screening tools for psychosocial barriers in adults with dysphagia, extended research could look into how SLPs feel about a requirement to incorporate informal screening measures. The per-

spective of patients with dysphagia could also be investigated to explore how adults feel about the evaluation and/or treatment they received from an SLP and if psychosocial factors played a role in their participation in therapy. To support a more comprehensive evaluation on SLP awareness and acknowledgment of psychosocial factors as they relate to dysphagia, a study concerning the pediatric population could be conducted.

CONCLUSION

Dysphagia symptoms can be physical, psychological, emotional, and social in nature. Each adult's experience with dysphagia is different and encompasses a unique set of challenges to their daily living and overall quality of life. Speech-language pathologists must remain aware of the diverse symptoms and barriers adults with dysphagia experience in order to provide appropriate screenings, assessments, and treatments for symptom management. Currently, the degree to which SLPs are aware of and acknowledge psychosocial symptoms in therapy for adults with dysphagia remains largely unclear. Due to this gap in knowledge, we conducted a research study utilizing an online survey to explore the degree to which SLPs are aware of and currently acknowledging the psychosocial factors experienced by adults with dysphagia in their assessment and treatment for such clients.

This research is significant for clinical practice by exposing the degree of education students are provided on psychosocial factors, screening practices currently implemented by SLPs to address such factors as they relate to dysphagia, and present SLP's desires for greater knowledge of such factors within the field and throughout the general public. Gaps in SLP knowledge place clinicians and clients at a disadvantage in regard to appropriate and effective assessment, treatment, and management of dysphagia. Adults with dysphagia deserve the opportunity for success in symptom management and treatment. The clinician's awareness and acknowledgement of their client's psychosocial barriers directly impacts their client's opportunity for success. If clinicians are not provided education on psychosocial barriers and their relation to speech therapy, their ability to fully support clients is diminished. The selection of screening tools, assessment batteries, treatment plans, and management strategies will be representative of clinical knowledge; therefore, research concerning current SLP knowledge of psychosocial factors will provide insight into areas of needed improvement within clinical education, continuing education, and resources available to the general public to support a more com-

prehensive approach to dysphagia assessment, treatment, and management.

The research findings indicate a general lack of education provided to SLPs by higher education programs, differing preferences in screening tools utilized by SLPs, and differences in SLP opinion concerning their professional role as it relates to the psychosocial factors experienced by adults with dysphagia. Overall, the findings demonstrate that SLPs desire to know more about how their professional role should acknowledge the psychosocial barriers adults with dysphagia may experience. Such desires indicate the need for greater education available to SLPs concerning psychosocial symptoms to strengthen their role as professionals involved in symptom management and treatment for adults with dysphagia.

REFERENCES

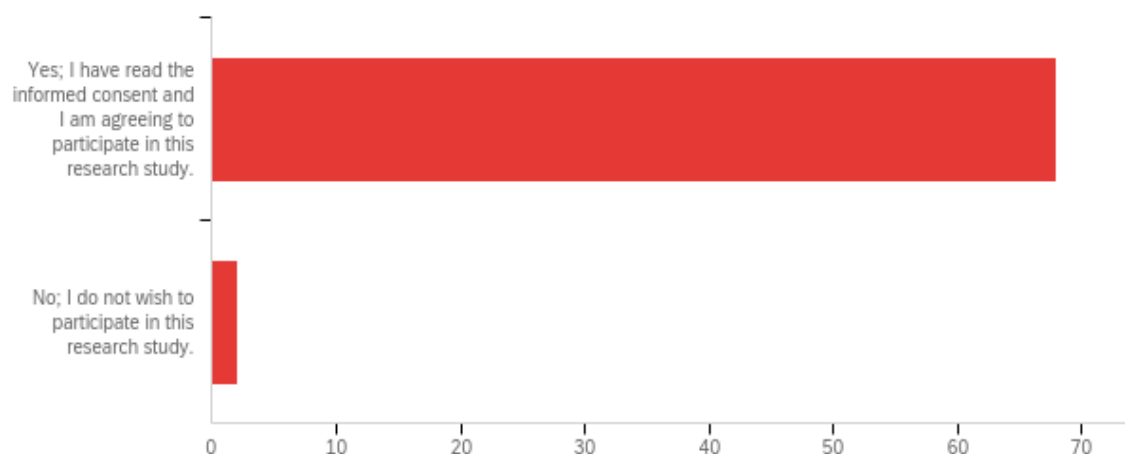
1. Barrera MA, O'Connor Wells B. Presbyphagia versus dysphagia: normal versus abnormal swallowing symptoms in older adults with Parkinson disease and multiple sclerosis. *Topics in Geriatric Rehabilitation*. 2019;35(3):217-223.
2. Swan K, Speyer R, Heijnen B, Wagg B, Cordier R. Living with oropharyngeal dysphagia: effects of bolus modification on health-related quality of life-a systematic review. *Quality of Life Research*. 2015; 24(10):2447-2456. <https://doi-org.ucark.idm.oclc.org/10.1007/s11136-015-0990-y>.
3. Bhattacharyya N. The prevalence of dysphagia among adults in the united states. *Otolaryngology-Head and Neck Surgery: Official Journal of American Academy of Otolaryngology-Head and Neck Surgery*. 2014;151(5):765-769. <https://doi.org/10.1177/0194599814549156>
4. American Speech-Language-Hearing Association. Adult dysphagia. https://www.asha.org/practice-portal/clinical-topics/adult-dysphagia/#collapse_2 [Accessed 4th September 2021].
5. Bradley J. Social aspects of dysphagia. *Today's Caregiver*; 2012.
6. Palmer JL, Metheny NA. Preventing aspiration in older adults with dysphagia: aspiration can lead to aspiration pneumonia, a serious health problem for older adults. *American Journal of Nursing*. 2008;108(2):40-48. <https://doi.org/10.1097/01.naj.0000308961.99857.33>.
7. American Speech-Language-Hearing Association. Speech-language pathologists. <https://www.asha.org/students/speech-language-pathologists/> [Accessed 4th September 2021].
8. World Health Organization. WHOQOL: measuring quality of life. <https://www.who.int/tools/whoqol> [Accessed 15th November 2021].
9. Ochs E, Shohet M. The cultural structuring of mealtime socialization. *New Directions for Child & Adolescent Development*. 2006; (111):35-49. <https://doi.org/10.1002/cd.154>.
10. Howells SR, Cornwell PL, Ward EC, Kuipers P. Client perspectives on living with dysphagia in the community. *International Journal of Speech-Language Pathology*. 2020;23(2):201-212. <https://doi.org/10.1080/17549507.2020.1765020>.
11. Xia JB. The obligation of listening: caring for patients with chronic dysphagia through illness narratives. *Perspectives of the ASHA Special Interest Groups*. 2020;5(1):231-235. https://doi-org.ucark.idm.oclc.org/10.1044/2019_PERSP-19-00030.
12. Egolf A, Siegrist M, Hartmann C. How people's food disgust sensitivity shapes their eating and food behaviour. *Appetite*. 2018;127: 28-36. <https://doi.org/10.1016/j.appet.2018.04.014>.
13. Shune SE, Namasivayam-MacDonald AM. Swallowing impairments increase emotional burden in spousal caregivers of older adults. *Journal of Applied Gerontology*. 2020;39(2):172-180. <https://doi-org.ucark.idm.oclc.org/10.1177/0733464818821787>.
14. Johansson AEM, Johansson U. Relatives' experiences of family members' eating difficulties. *Scandinavian Journal of Occupational Therapy*. 2009;16(1):25-32. <https://doi-org.ucark.idm.oclc.org/10.1080/11038120802257195>.
15. Polovoy C. Stepping up to the plate. *ASHA Leader*. 2015;20(10): 44-53. <https://doi-org.ucark.idm.oclc.org/10.1044/leader.FTR1.20102015.44>.
16. Robinson HL, Smith SLH. Advancing dysphagia care with a participation focus [Presentation]. American Speech-Language Hearing Association (ASHA) National Convention, Chicago, IL. 16th November 2013.
17. Chan K, Carrau R, Murray T. Clinical management of swallowing disorders, fourth edition. Plural Publishing; 2017.

Appendix 1. Survey questions with responses.

Default Report

The Effect of Psychosocial Factors on Dysphagia Management

Introduction - Thank you for taking the time to complete this survey. Please click on the link Informed consent cover letter.docx 1 2 to review the informed consent. Select (Yes) once you have read and understood the informed consent and agree to participate. Select (No) if you do not wish to participate.

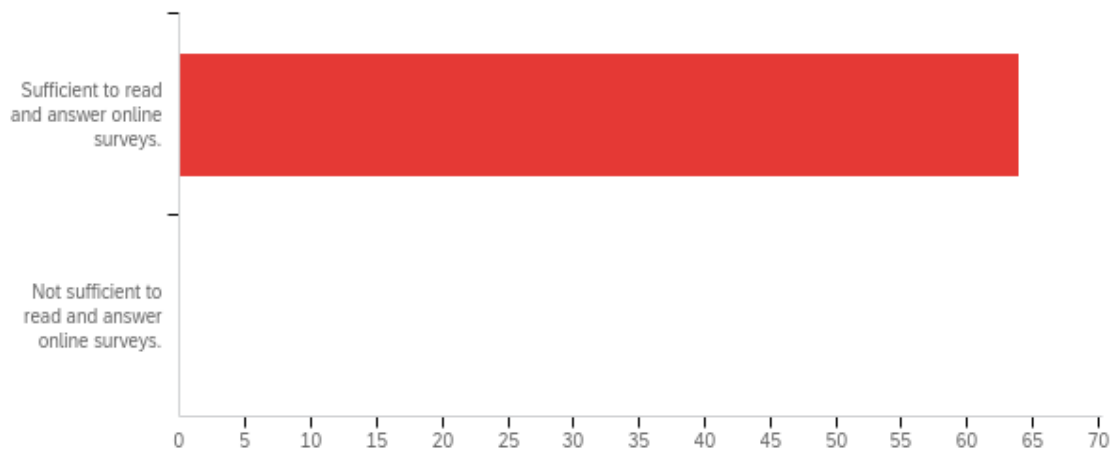


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Thank you for taking the time to complete this survey. Please click on the link Informed consent cover letter.docx 1 2 to review the informed consent. Select (Yes) once you have read and understood the informed consent and agree to participate. Select (No) if you do not wish to participate.	1.00	2.00	1.03	0.17	0.03	70

#	Answer	%	Count
1	Yes; I have read the informed consent and I am agreeing to participate in this research study.	97.14%	68
2	No; I do not wish to participate in this research study.	2.86%	2
	Total	100%	70

(Continued to the next page)

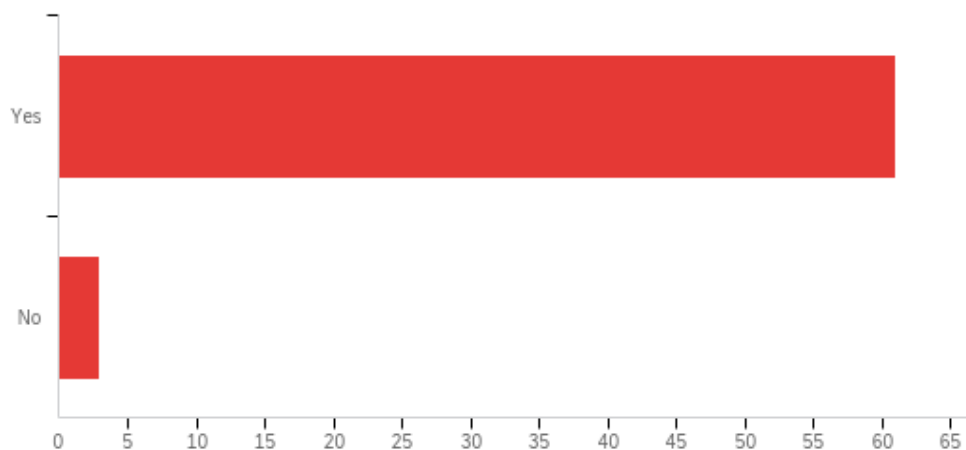
Q1 - What is your English language proficiency?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	What is your English language proficiency?	1.00	1.00	1.00	0.00	0.00	64

#	Answer	%	Count
1	Sufficient to read and answer online surveys.	100.00%	64
2	Not sufficient to read and answer online surveys.	0.00%	0
	Total	100%	64

(Continued to the next page)

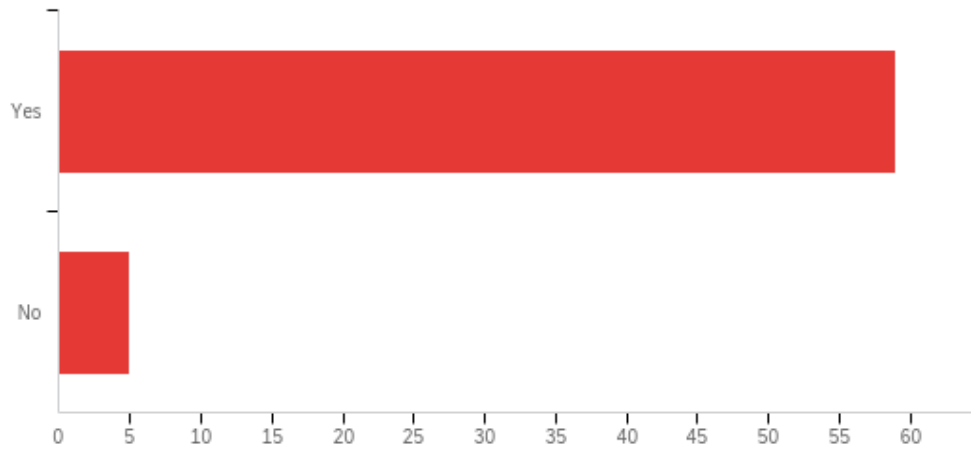
Q2 - Are you a practicing Speech-Language Pathologist?

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Are you a practicing Speech-Language Pathologist?	1.00	2.00	1.05	0.21	0.04	64

#	Answer	%	Count
1	Yes	95.31%	61
2	No	4.69%	3
	Total	100%	64

(Continued to the next page)

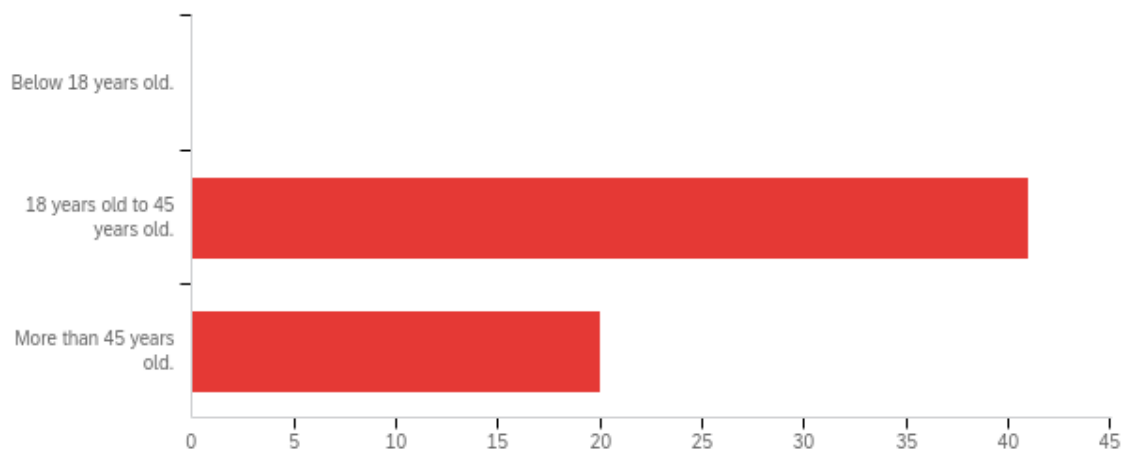
Q3 - Do you have your Certificate of Clinical Competence?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you have your Certificate of Clinical Competence?	1.00	2.00	1.08	0.27	0.07	64

#	Answer	%	Count
1	Yes	92.19%	59
2	No	7.81%	5
	Total	100%	64

(Continued to the next page)

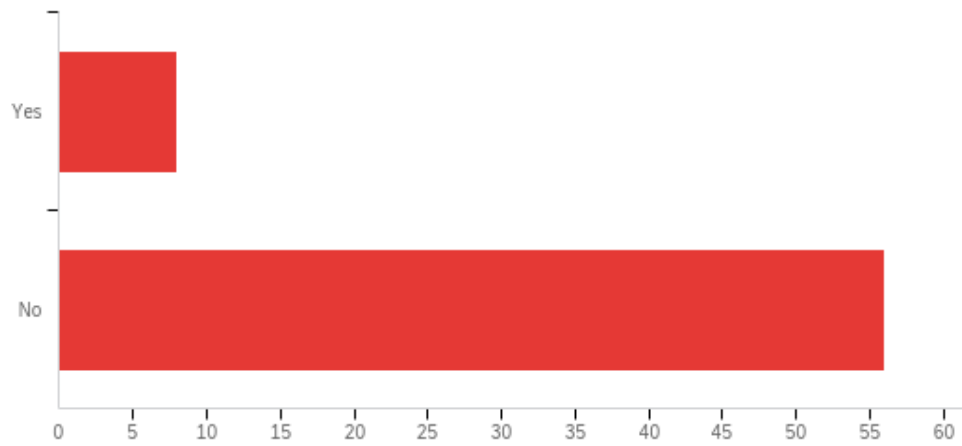
Q4 - What is your age?

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	What is your age?	2.00	3.00	2.33	0.47	0.22	61

#	Answer	%	Count
1	Below 18 years old.	0.00%	0
2	18 years old to 45 years old.	67.21%	41
3	More than 45 years old.	32.79%	20
	Total	100%	61

(Continued to the next page)

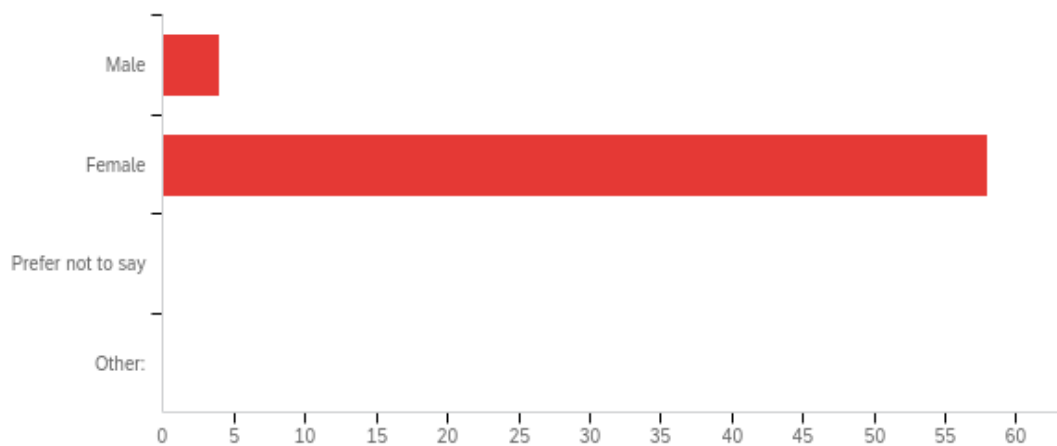
Q5 - Do you have board certification in swallowing?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you have board certification in swallowing?	1.00	2.00	1.88	0.33	0.11	64

#	Answer	%	Count
1	Yes	12.50%	8
2	No	87.50%	56
	Total	100%	64

(Continued to the next page)

Q6 - How would you describe your gender?

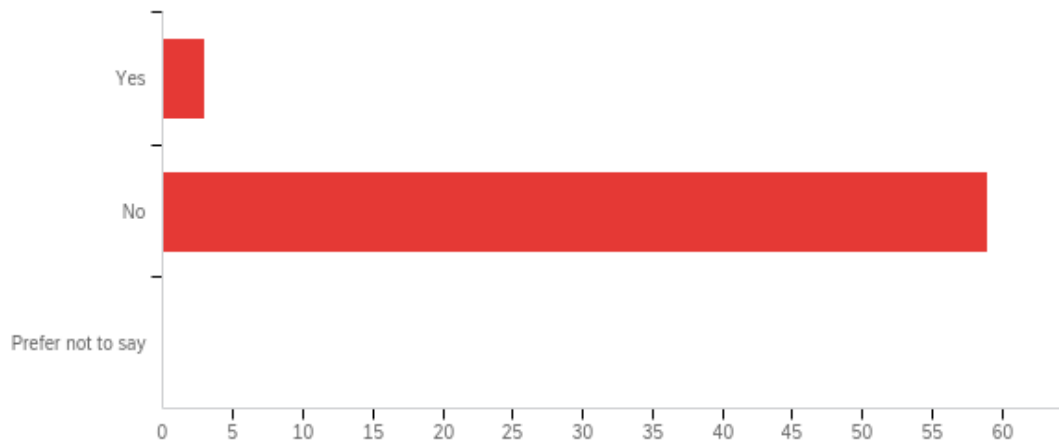
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	How would you describe your gender? - Selected Choice	1.00	2.00	1.94	0.25	0.06	62

#	Answer	%	Count
1	Male	6.45%	4
2	Female	93.55%	58
3	Prefer not to say	0.00%	0
4	Other:	0.00%	0
	Total	100%	62

Q6_4_TEXT - Other:

Other: - Text

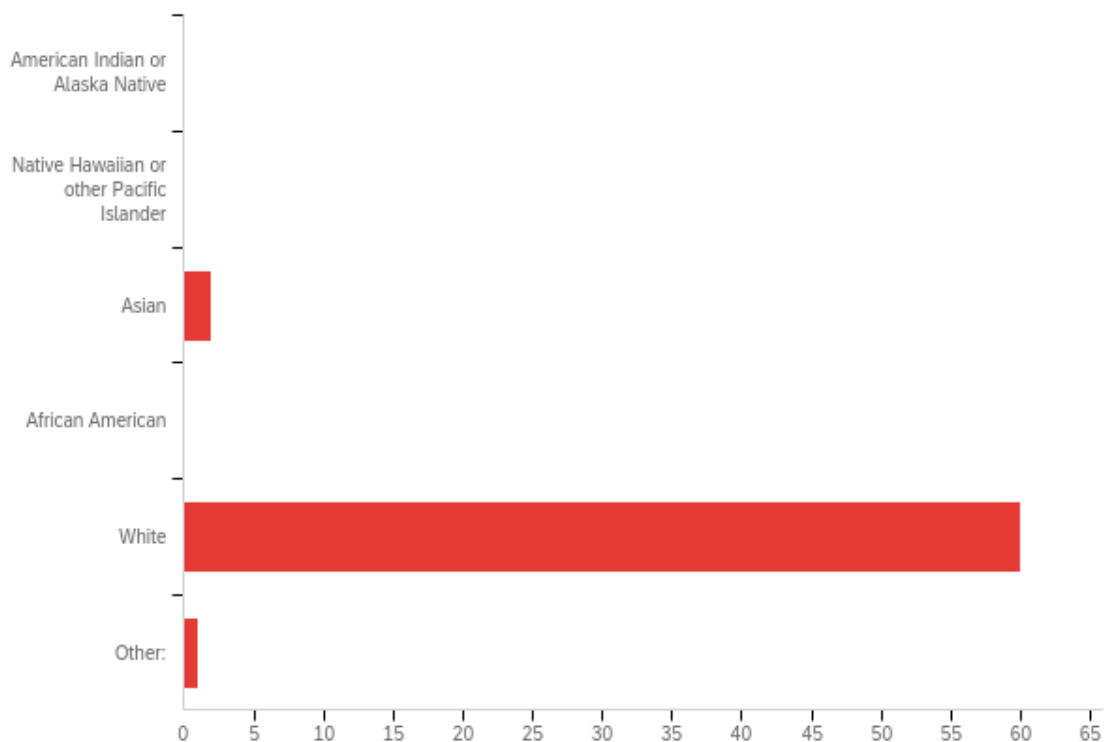
(Continued to the next page)

Q7 - Are you of Hispanic, Latino, or of Spanish origin?

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Are you of Hispanic, Latino, or of Spanish origin?	1.00	2.00	1.95	0.21	0.05	62

#	Answer	%	Count
1	Yes	4.84%	3
2	No	95.16%	59
3	Prefer not to say	0.00%	0
	Total	100%	62

(Continued to the next page)

Q8 - How would you describe yourself?

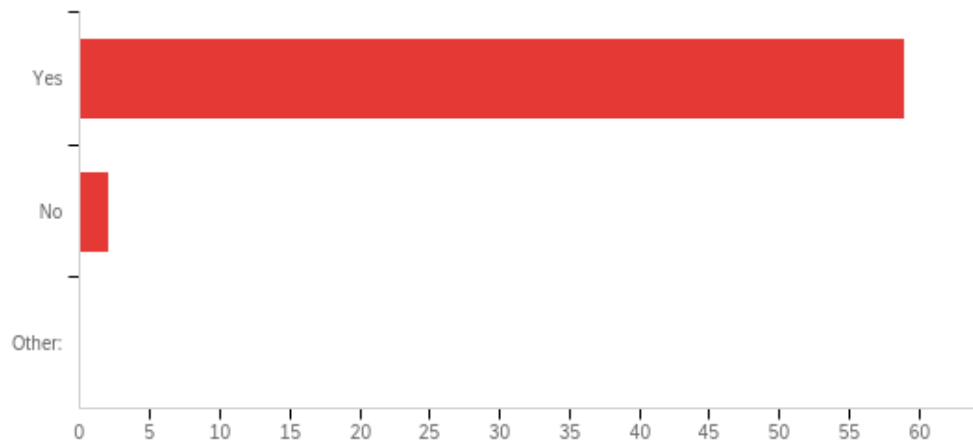
#	Answer	%	Count
1	American Indian or Alaska Native	0.00%	0
2	Native Hawaiian or other Pacific Islander	0.00%	0
3	Asian	3.17%	2
4	African American	0.00%	0
5	White	95.24%	60
6	Other:	1.59%	1
	Total	100%	63

Q8_6_TEXT - Other:

Other: - Text

Indian

(Continued to the next page)

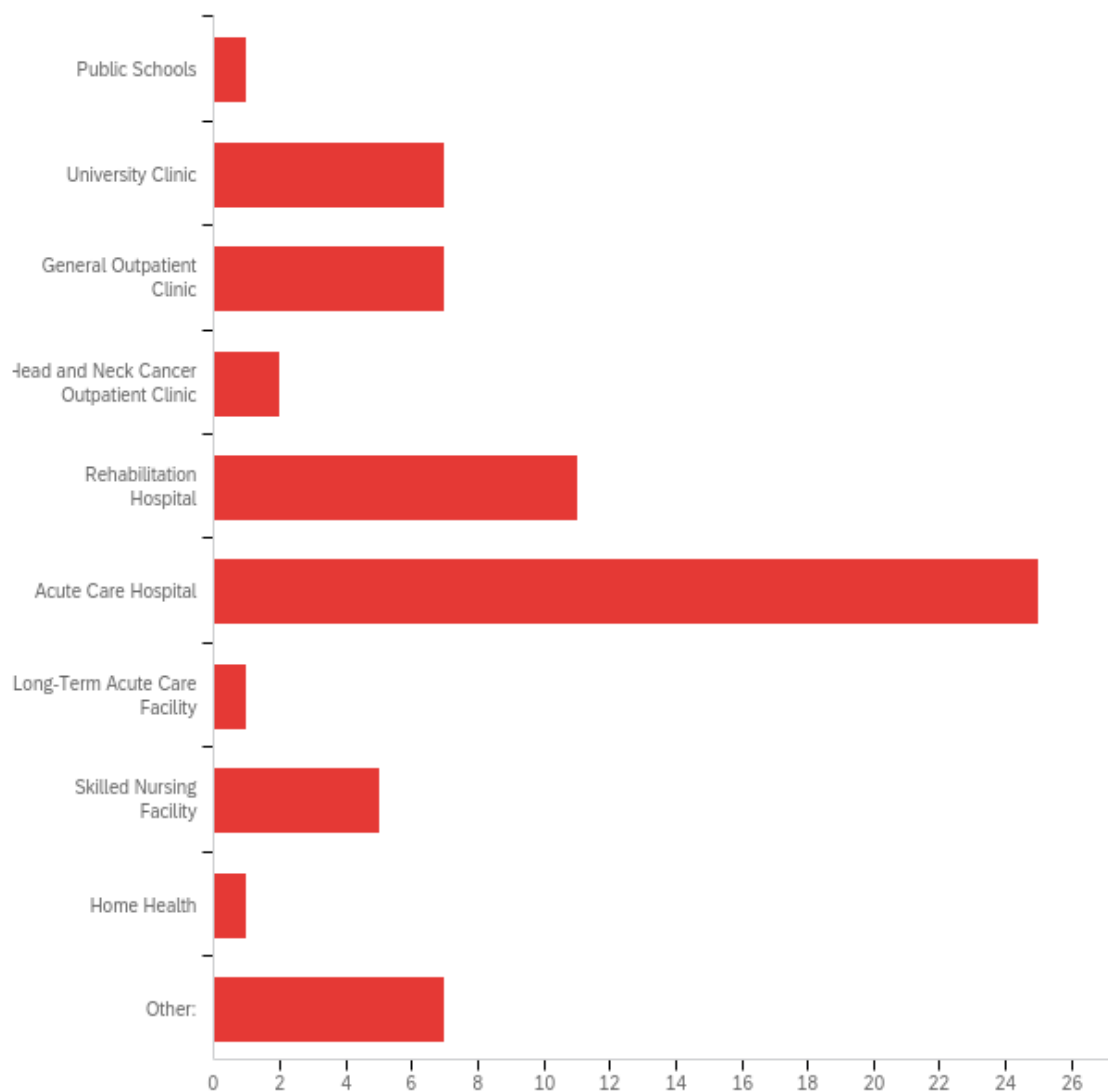
Q9 - Are you currently working in the United States? If not, where are you working?

#	Answer	%	Count
1	Yes	96.72%	59
2	No	3.28%	2
3	Other:	0.00%	0
	Total	100%	61

Q9_3_TEXT - Other:

Other: - Text

(Continued to the next page)

Q10 - What is your primary workplace?

#	Answer	%	Count
1	Public Schools	1.49%	1
2	University Clinic	10.45%	7
3	General Outpatient Clinic	10.45%	7
4	Head and Neck Cancer Outpatient Clinic	2.99%	2
5	Rehabilitation Hospital	16.42%	11

(Continued to the next page)

6	Acute Care Hospital	37.31%	25
7	Long-Term Acute Care Facility	1.49%	1
8	Skilled Nursing Facility	7.46%	5
9	Home Health	1.49%	1
10	Other:	10.45%	7
	Total	100%	67

Q10_10_TEXT - Other:

Other: - Text

Early Intervention

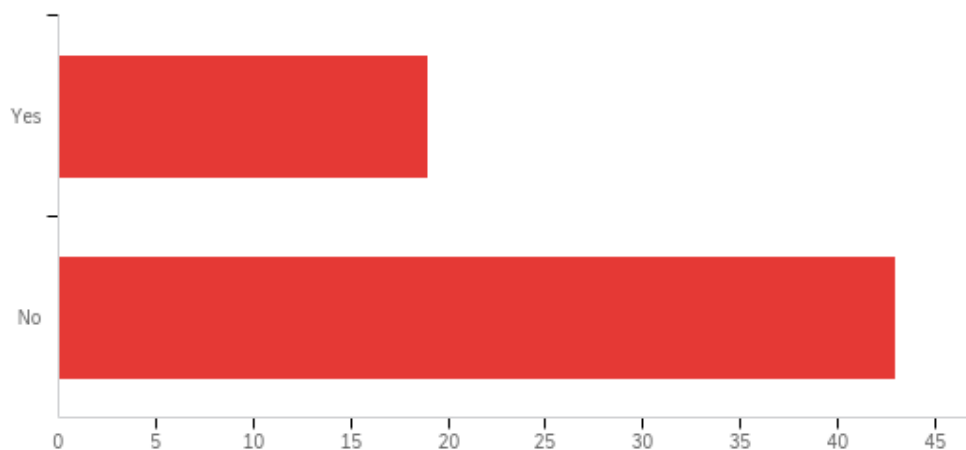
mobile

Pediatric Outpatient Clinic

Acute inpatient rehab

ENT clinic

(Continued to the next page)

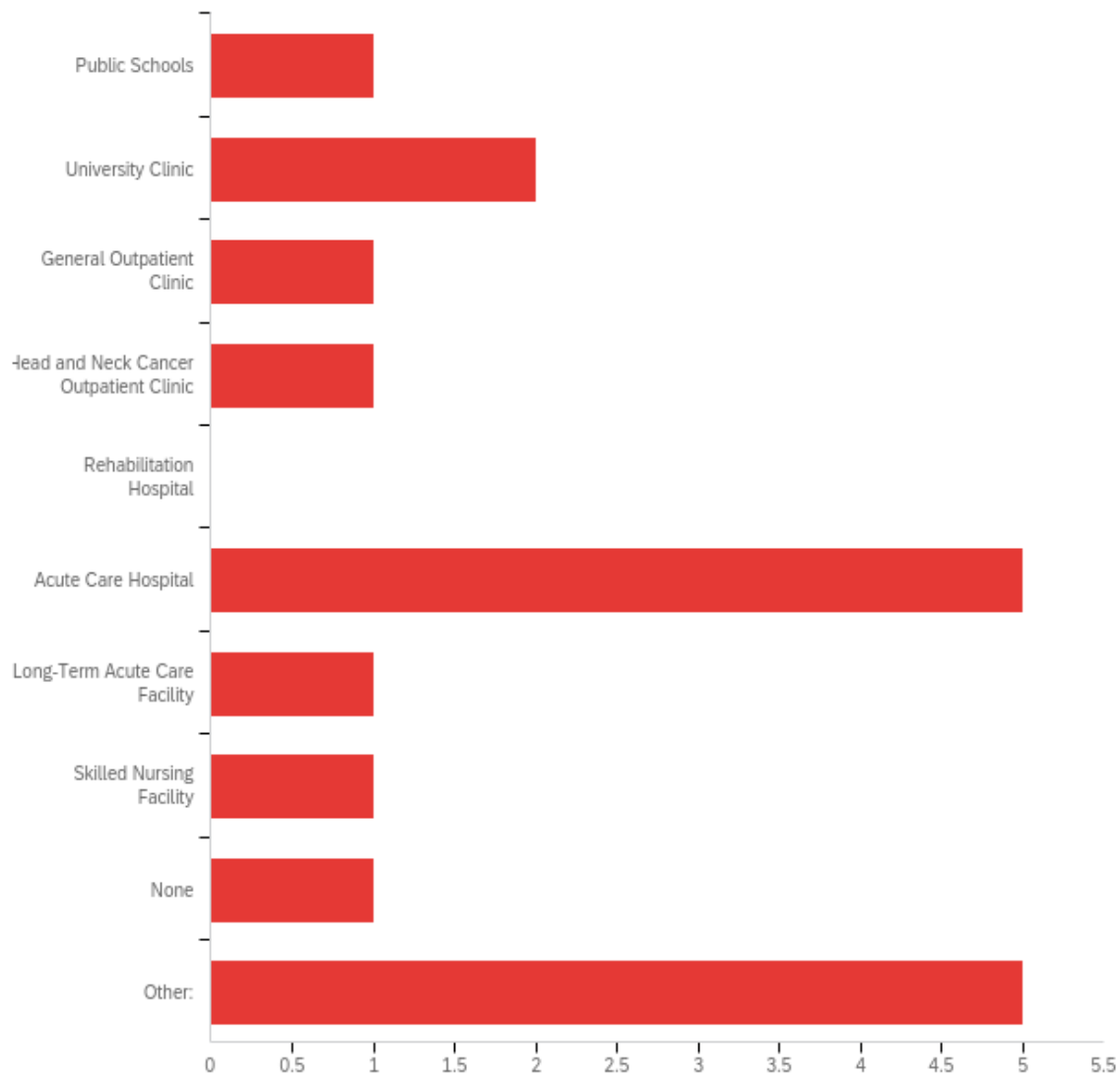
Q11 - Do you have a secondary workplace?

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you have a secondary workplace?	1.00	2.00	1.69	0.46	0.21	62

#	Answer	%	Count
1	Yes	30.65%	19
2	No	69.35%	43
	Total	100%	62

(Continued to the next page)

Q12 - What is your secondary workplace?



#	Answer	%	Count
1	Public Schools	5.56%	1
2	University Clinic	11.11%	2
3	General Outpatient Clinic	5.56%	1
4	Head and Neck Cancer Outpatient Clinic	5.56%	1
5	Rehabilitation Hospital	0.00%	0

(Continued to the next page)

6	Acute Care Hospital	27.78%	5
7	Long-Term Acute Care Facility	5.56%	1
8	Skilled Nursing Facility	5.56%	1
9	None	5.56%	1
10	Other:	27.78%	5
	Total	100%	18

Q12_10_TEXT - Other:

Other: - Text

PhD Student

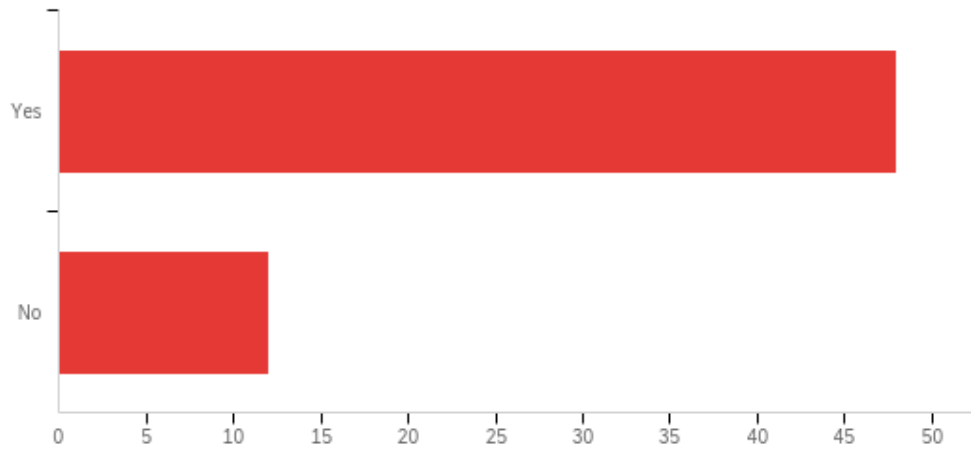
Psychiatric facility

Consultant for Medical company

Research

Private practice

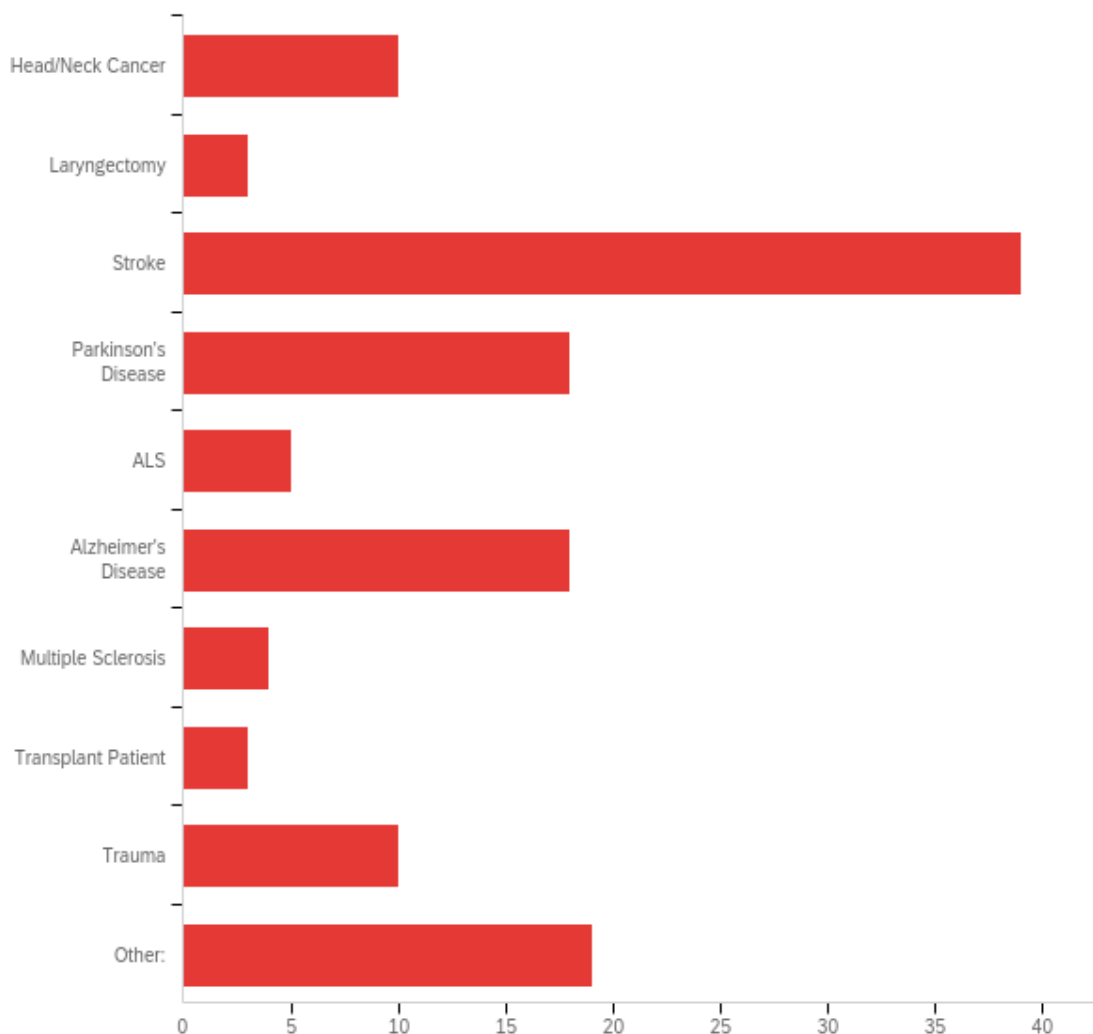
(Continued to the next page)

Q13 - Do you primarily see adult patients?

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you primarily see adult patients?	1.00	2.00	1.20	0.40	0.16	60

#	Answer	%	Count
1	Yes	80.00%	48
2	No	20.00%	12
	Total	100%	60

(Continued to the next page)

Q14 - What is the primary cause of dysphagia in your case load?

#	Answer	%	Count
1	Head/Neck Cancer	7.75%	10
2	Laryngectomy	2.33%	3
3	Stroke	30.23%	39
4	Parkinson's Disease	13.95%	18
5	ALS	3.88%	5
6	Alzheimer's Disease	13.95%	18
7	Multiple Sclerosis	3.10%	4

(Continued to the next page)

8	Transplant Patient	2.33%	3
9	Trauma	7.75%	10
10	Other:	14.73%	19
	Total	100%	129

Q14_10_TEXT - Other:

Other: - Text

Neurodevelopment, Autism, genetic conditions

Prematurity- NICU

developmental

Trauma, acute illness, developmental

Psychiatric Drugs

debilitation, UTI

Muscle Tension Dysphagia

Neurodevelopmental disorders (I work with pediatrics)

N/A

Birth Deficits

Post Extubation

Pediatric diagnoses

peds: neuro, pulm, GI, ENT anomaly

Acquired brain injury

Cardiac

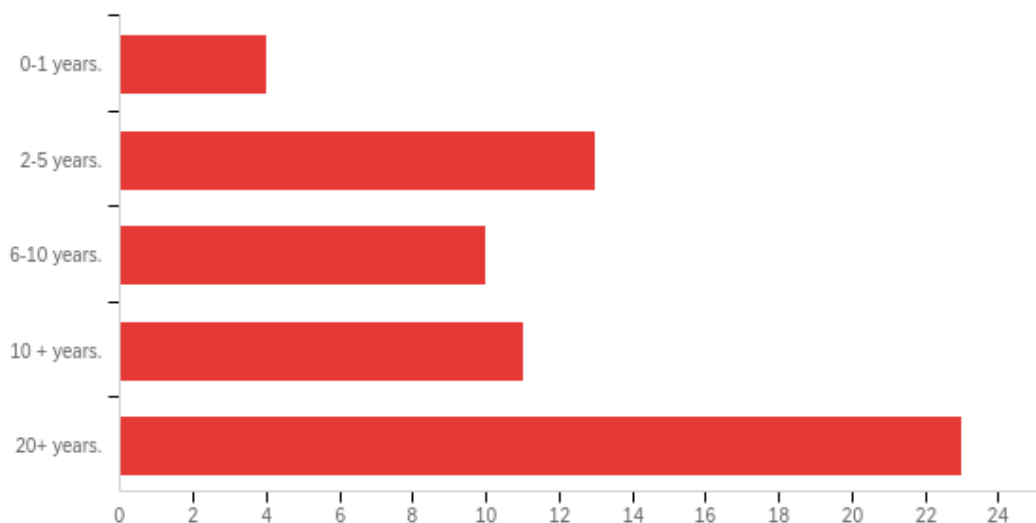
All of these and respiratory failure/prolonged intubation

Brain Injuries

Respiratory failure for various reasons. I get a good mix of diagnoses.

(Continued to the next page)

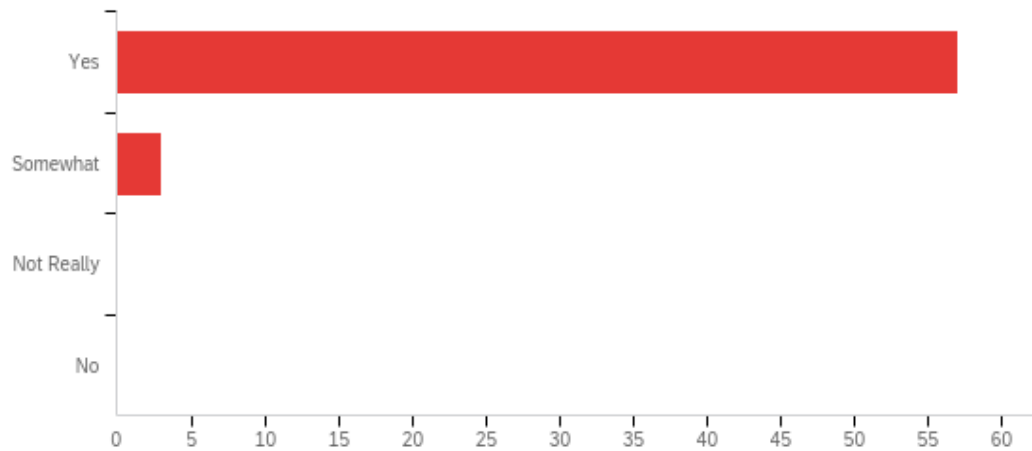
Q15 - How many years of experience do you have as a practicing Speech-Language Pathologist?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	How many years of experience do you have as a practicing Speech-Language Pathologist?	1.00	5.00	3.59	1.35	1.82	61

#	Answer	%	Count
1	0-1 years.	6.56%	4
2	2-5 years.	21.31%	13
3	6-10 years.	16.39%	10
4	10 + years.	18.03%	11
5	20+ years.	37.70%	23
	Total	100%	61

Q16 - I understand what psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment, are.

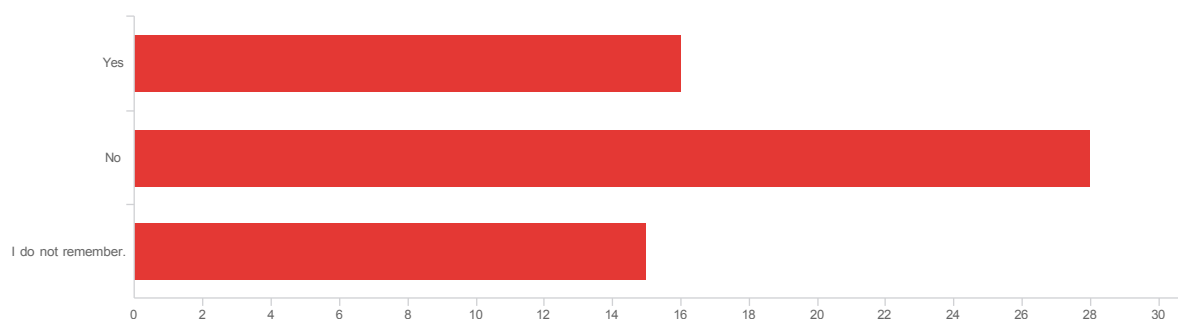


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I understand what psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment, are.	1.00	2.00	1.05	0.22	0.05	60

#	Answer	%	Count
1	Yes	95.00%	57
2	Somewhat	5.00%	3
3	Not Really	0.00%	0
4	No	0.00%	0
	Total	100%	60

(Continued to the next page)

Q17 - During my undergraduate program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment.



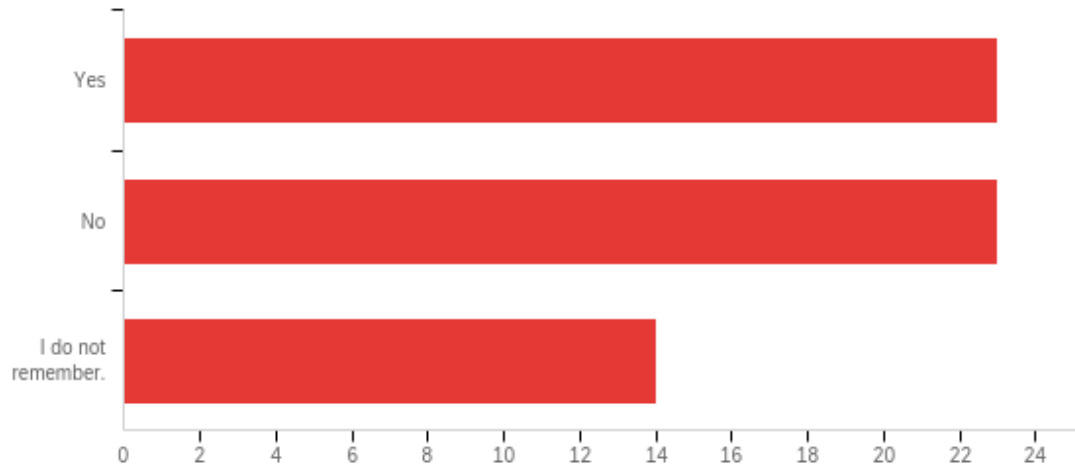
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	During my undergraduate program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment.	1.00	3.00	1.98	0.72	0.53	59

#	Field	Choice Count
1	Yes	27.12% 16
2	No	47.46% 28
3	I do not remember.	25.42% 15
		59

Showing rows 1 - 4 of 4

(Continued to the next page)

Q18 - During my graduate program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment.

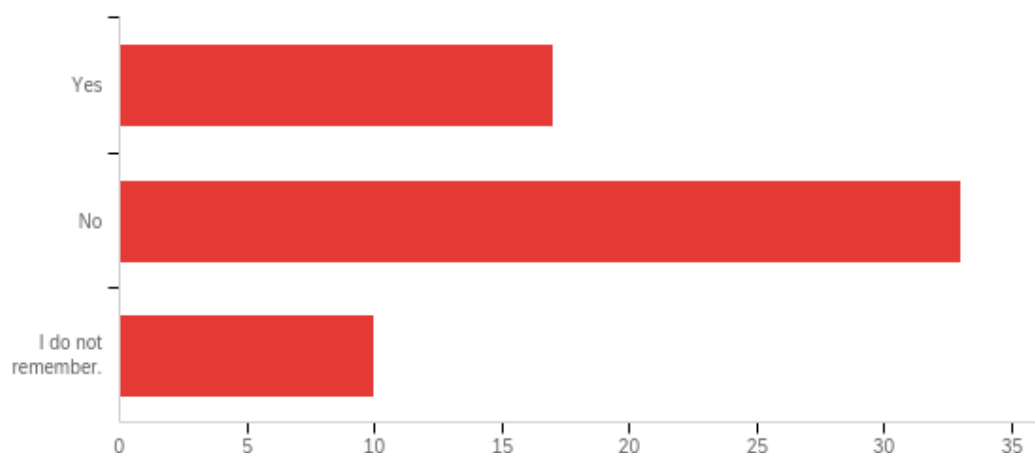


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	During my graduate program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment.	1.00	3.00	1.85	0.77	0.59	60

#	Answer	%	Count
1	Yes	38.33%	23
2	No	38.33%	23
3	I do not remember.	23.33%	14
	Total	100%	60

(Continued to the next page)

Q19 - During my swallowing classes in the graduate program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment, that impact adults with dysphagia.

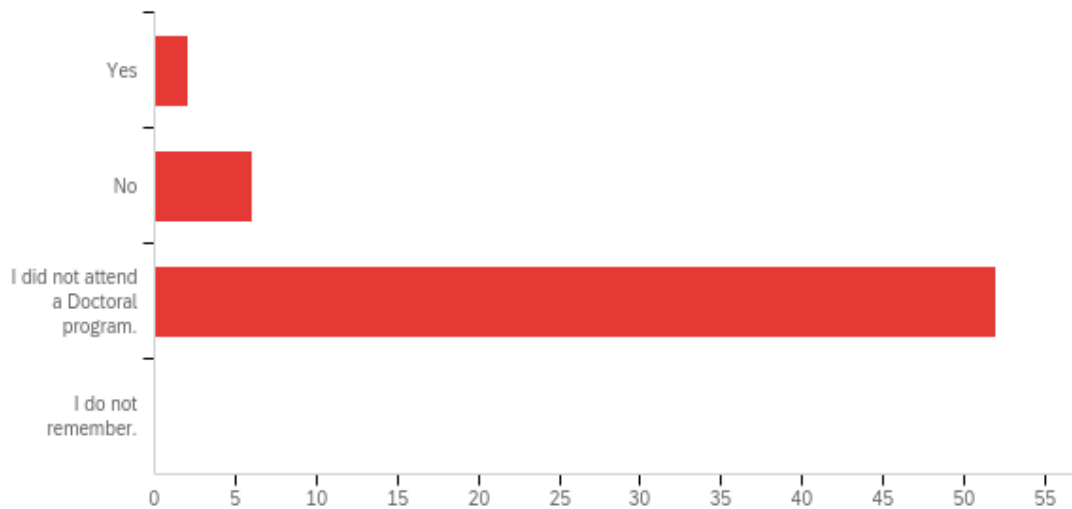


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	During my swallowing classes in the graduate program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment, that impact adults with dysphagia.	1.00	3.00	1.88	0.66	0.44	60

#	Answer	%	Count
1	Yes	28.33%	17
2	No	55.00%	33
3	I do not remember.	16.67%	10
	Total	100%	60

(Continued to the next page)

Q20 - During my Doctoral program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment, that impact adults with dysphagia.

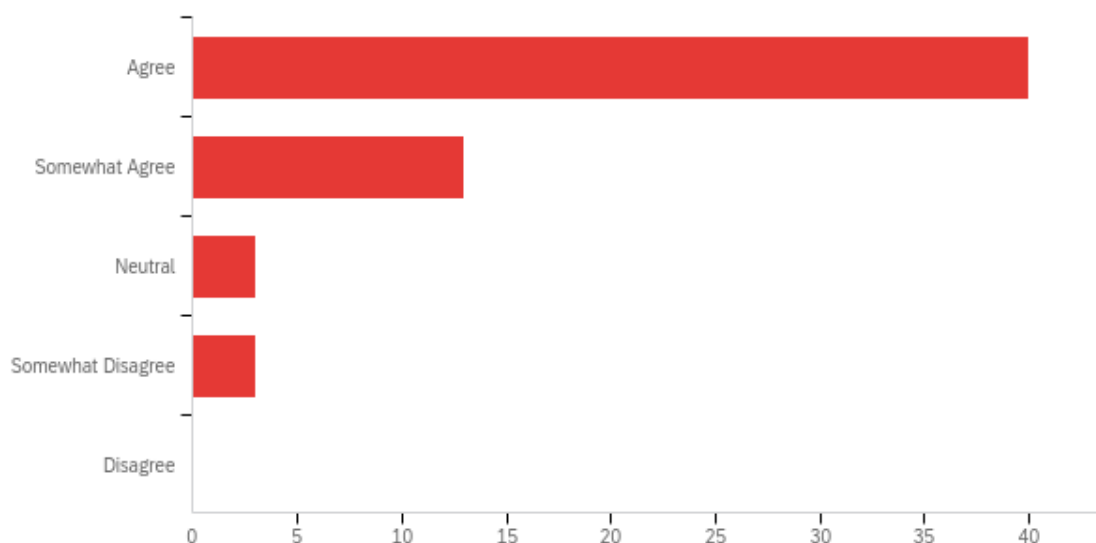


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	During my Doctoral program, I learned about psychosocial factors, such as anxiety, depression, fear, disgust, and embarrassment, that impact adults with dysphagia.	1.00	3.00	2.83	0.45	0.21	60

#	Answer	%	Count
1	Yes	3.33%	2
2	No	10.00%	6
3	I did not attend a Doctoral program.	86.67%	52
4	I do not remember.	0.00%	0
	Total	100%	60

(Continued to the next page)

Q21 - I understand the adverse effect(s) of psychosocial factors (anxiety, depression, fear, disgust, and/or embarrassment) on an adult with dysphagia's management.

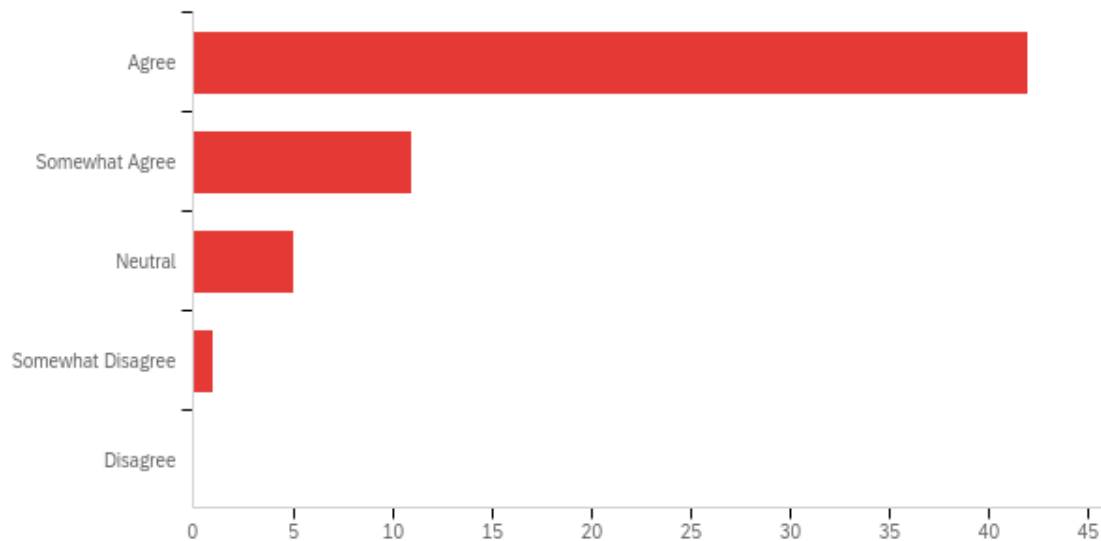


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I understand the adverse effect(s) of psychosocial factors (anxiety, depression, fear, disgust, and/or embarrassment) on an adult with dysphagia's management.	1.00	4.00	1.47	0.81	0.66	59

#	Answer	%	Count
1	Agree	67.80%	40
2	Somewhat Agree	22.03%	13
3	Neutral	5.08%	3
4	Somewhat Disagree	5.08%	3
5	Disagree	0.00%	0
	Total	100%	59

(Continued to the next page)

Q22 - I understand the adverse effect(s) of psychosocial factors (anxiety, depression, fear, disgust, and/or embarrassment) on an adult with dysphagia's willingness to participate in evaluation/treatment.

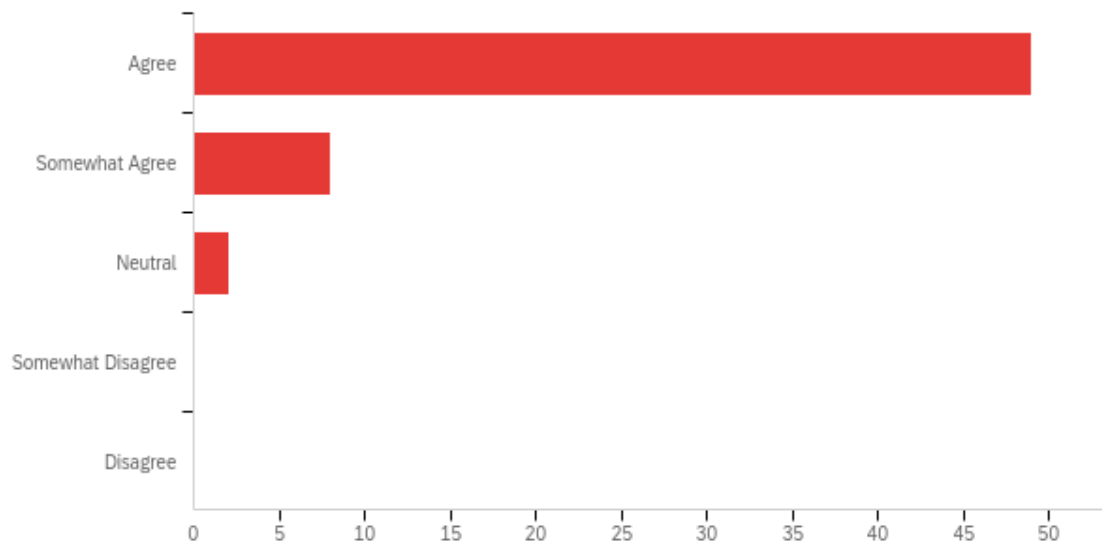


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I understand the adverse effect(s) of psychosocial factors (anxiety, depression, fear, disgust, and/or embarrassment) on an adult with dysphagia's willingness to participate in evaluation/treatment.	1.00	4.00	1.41	0.72	0.51	59

#	Answer	%	Count
1	Agree	71.19%	42
2	Somewhat Agree	18.64%	11
3	Neutral	8.47%	5
4	Somewhat Disagree	1.69%	1

(Continued to the next page)

Q23 - My knowledge of the presence or absence of psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) in adult patients with dysphagia is important in order for me to appropriately evaluate and/or treat such individuals.

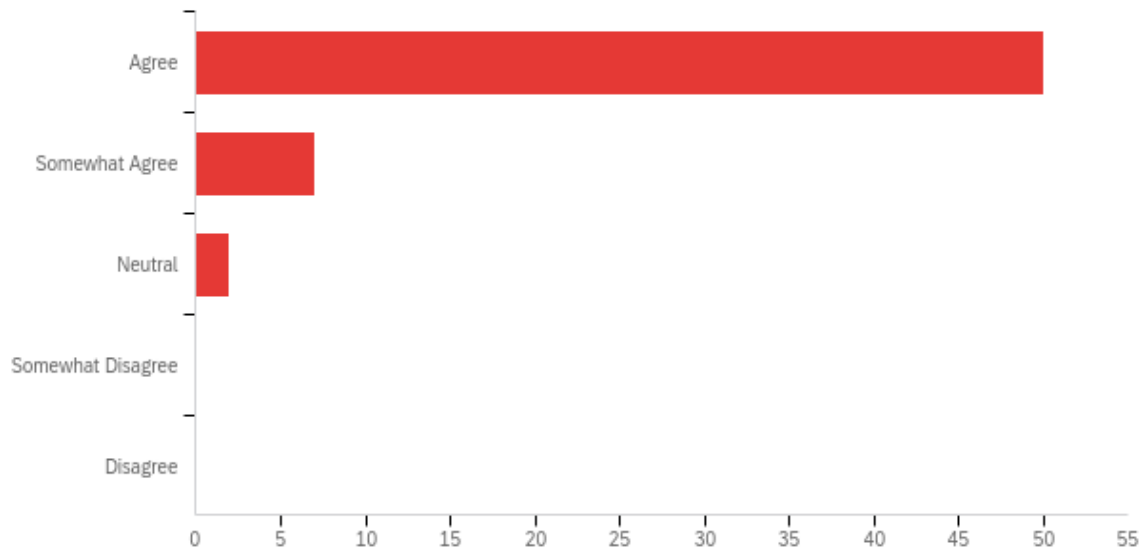


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	My knowledge of the presence or absence of psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) in adult patients with dysphagia is important in order for me to appropriately evaluate and/or treat such individuals.	1.00	3.00	1.20	0.48	0.23	59

#	Answer	%	Count
1	Agree	83.05%	49
2	Somewhat Agree	13.56%	8
3	Neutral	3.39%	2
4	Somewhat Disagree	0.00%	0
5	Disagree	0.00%	0
	Total	100%	59

(Continued to the next page)

Q24 - My knowledge of the presence or absence of psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) is important for my adult clients with dysphagia to have for their well being and ability to participate in evaluation/treatment.

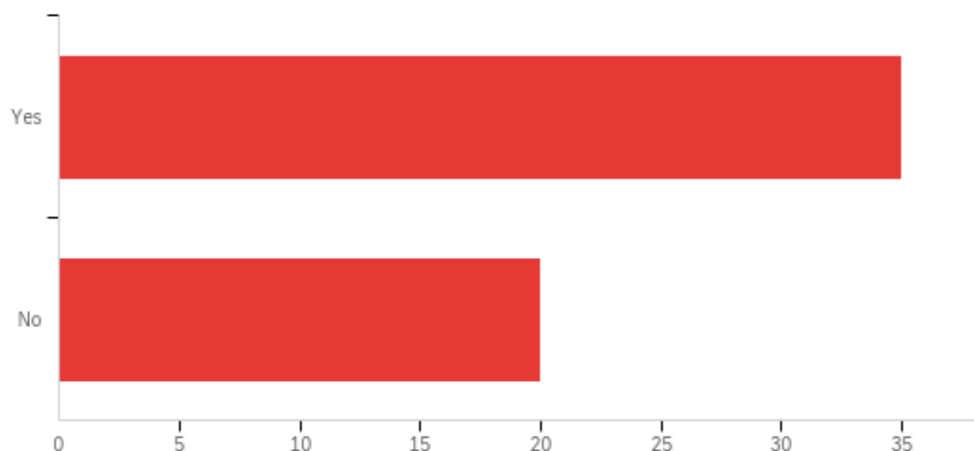


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	My knowledge of the presence or absence of psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) is important for my adult clients with dysphagia to have for their well being and ability to participate in evaluation/treatment.	1.00	3.00	1.19	0.47	0.22	59

#	Answer	%	Count
1	Agree	84.75%	50
2	Somewhat Agree	11.86%	7
3	Neutral	3.39%	2
4	Somewhat Disagree	0.00%	0
5	Disagree	0.00%	0
	Total	100%	59

(Continued to the next page)

Q25 - I screen adult patients with dysphagia for psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) prior to developing a treatment plan.

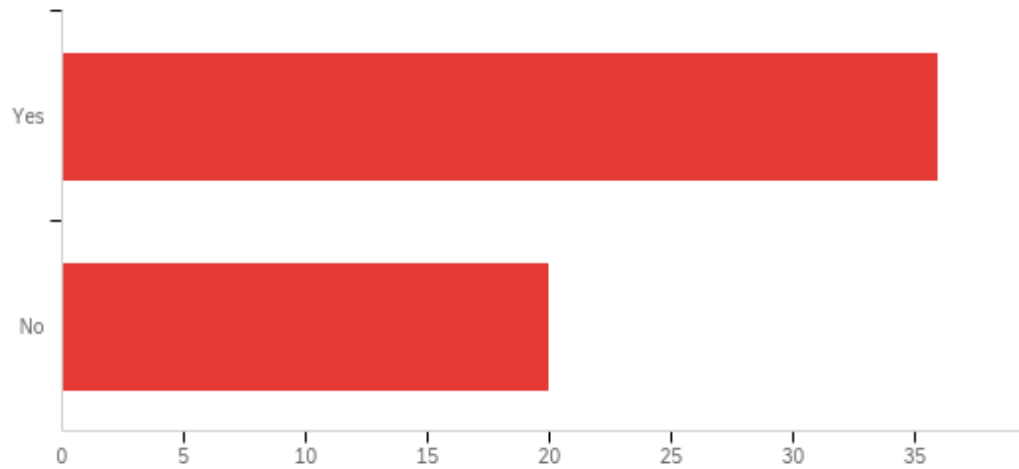


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I screen adult patients with dysphagia for psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) prior to developing a treatment plan.	1.00	2.00	1.36	0.48	0.23	55

#	Answer	%	Count
1	Yes	63.64%	35
2	No	36.36%	20
	Total	100%	55

(Continued to the next page)

Q26 - I screen adult patients with dysphagia for psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) periodically throughout treatment.

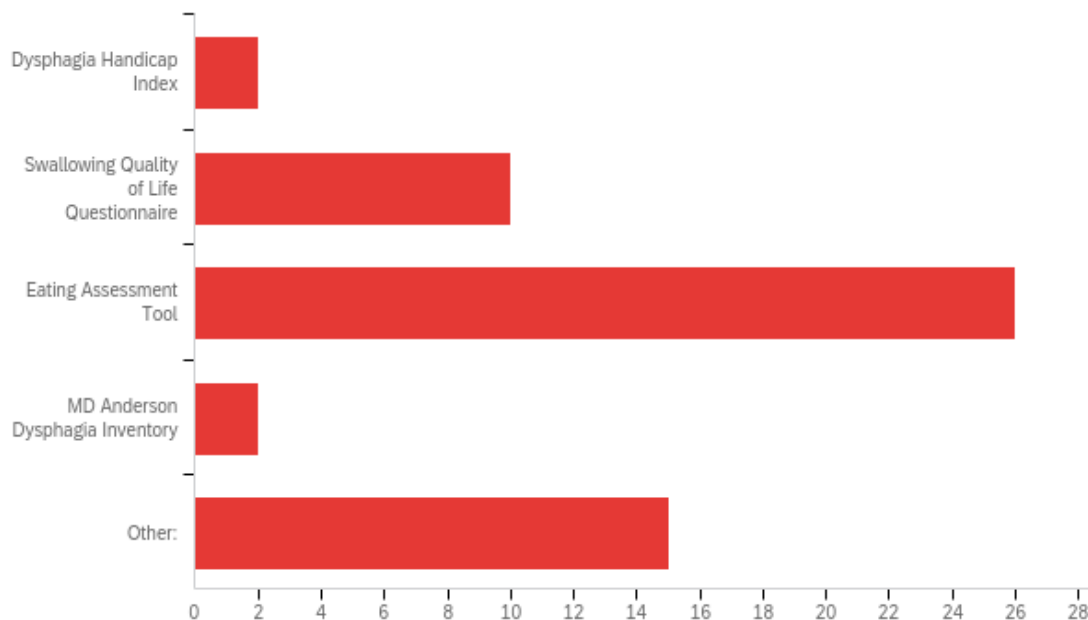


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I screen adult patients with dysphagia for psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) periodically throughout treatment.	1.00	2.00	1.36	0.48	0.23	56

#	Answer	%	Count
1	Yes	64.29%	36
2	No	35.71%	20
	Total	100%	56

(Continued to the next page)

Q27 - I currently use the following resources to screen for psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) for adults with dysphagia (select all that apply):



#	Answer	%	Count
1	Dysphagia Handicap Index	3.64%	2
2	Swallowing Quality of Life Questionnaire	18.18%	10
3	Eating Assessment Tool	47.27%	26
4	MD Anderson Dysphagia Inventory	3.64%	2
5	Other:	27.27%	15
	Total	100%	55

Q27_5_TEXT - Other:

Other: - Text

FAMMfeed from Feeding Flock

specific questions related to psychosocial barriers

(Continued to the next page)

PHQ

informal

only informally

informal

None of the above

These questions are included in general paperwork filled out for physicians and ancillary staff

Clinical Observation

none

Chart review: PO intake, medications for anxiety/depression etc

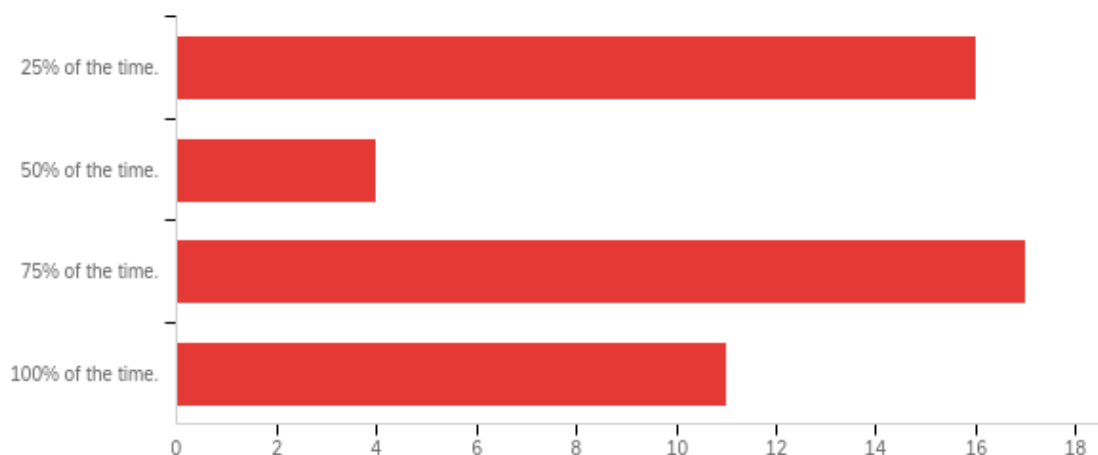
None

Discussion/building of rapport

I make note of any psychosocial symptoms reported by PT or notes by myself during clinical swallow evaluation.

(Continued to the next page)

Q28 - I screen my adult clients with dysphagia for psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment):

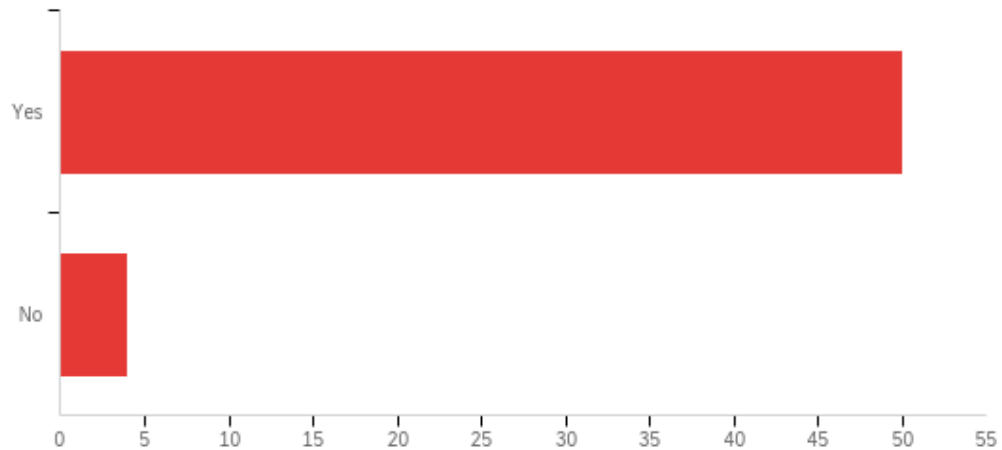


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I screen my adult clients with dysphagia for psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment):	1.00	4.00	2.48	1.17	1.37	48

#	Answer	%	Count
1	25% of the time.	33.33%	16
2	50% of the time.	8.33%	4
3	75% of the time.	35.42%	17
4	100% of the time.	22.92%	11
	Total	100%	48

(Continued to the next page)

Q29 - I wish there was more information available to SLPs regarding education about psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) in the evaluation/treatment of adults with dysphagia.

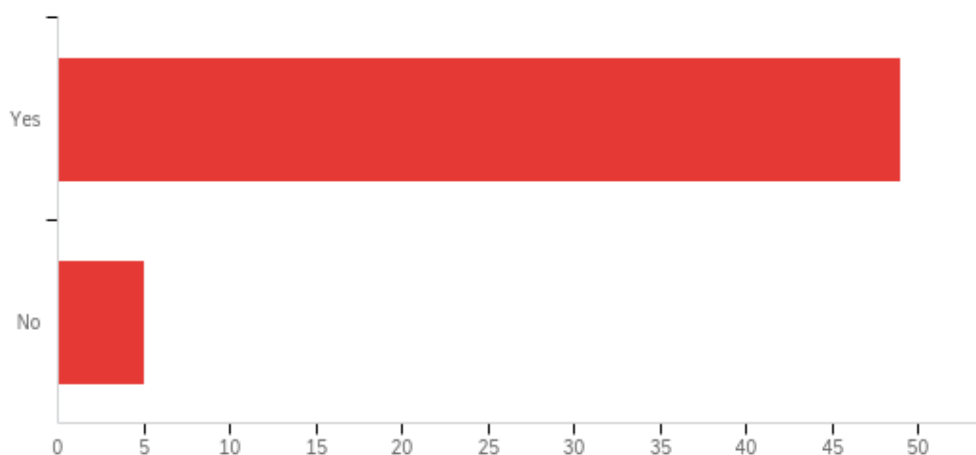


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I wish there was more information available to SLPs regarding education about psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) in the evaluation/treatment of adults with dysphagia.	1.00	2.00	1.07	0.26	0.07	54

#	Answer	%	Count
1	Yes	92.59%	50
2	No	7.41%	4
	Total	100%	54

(Continued to the next page)

Q30 - I wish psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) in the treatment of adults with dysphagia was a larger topic in my education throughout undergraduate, graduate, or Doctoral Programs.

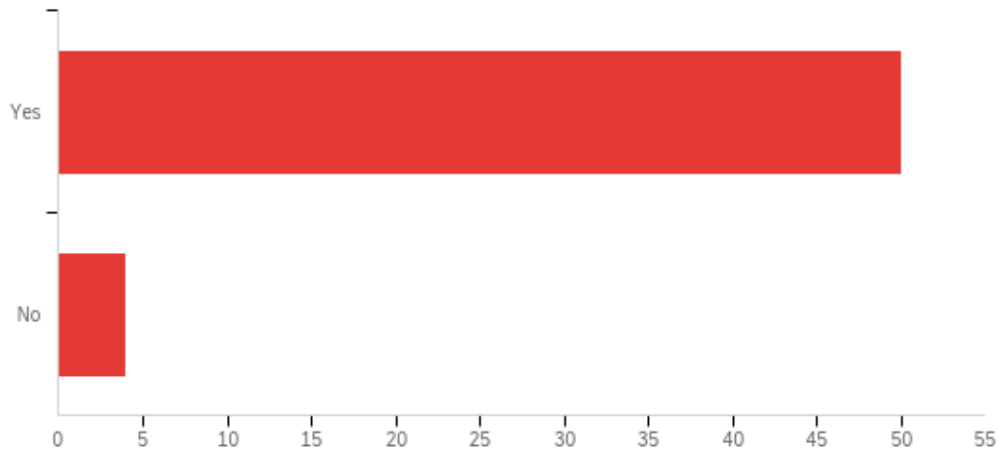


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I wish psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) in the treatment of adults with dysphagia was a larger topic in my education throughout undergraduate, graduate, or Doctoral Programs.	1.00	2.00	1.09	0.29	0.08	54

#	Answer	%	Count
1	Yes	90.74%	49
2	No	9.26%	5
	Total	100%	54

(Continued to the next page)

Q31 - I wish there was more information available to the general public regarding psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) experienced by adults with dysphagia.

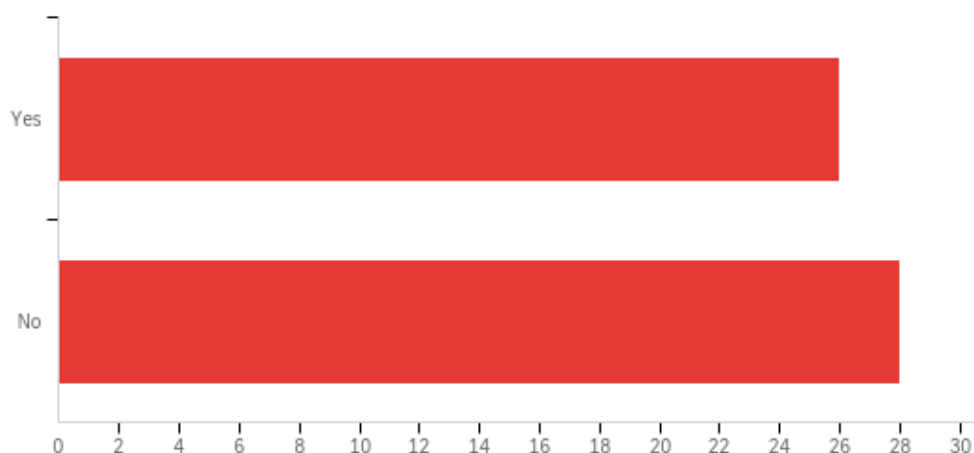


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I wish there was more information available to the general public regarding psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) experienced by adults with dysphagia.	1.00	2.00	1.07	0.26	0.07	54

#	Answer	%	Count
1	Yes	92.59%	50
2	No	7.41%	4
	Total	100%	54

(Continued to the next page)

Q32 - I have attended a conference/meeting/assembly where psychosocial factors/barriers (anxiety, depression, fear, disgust, and/or embarrassment) to evaluation/treatment of dysphagia in adults were discussed.

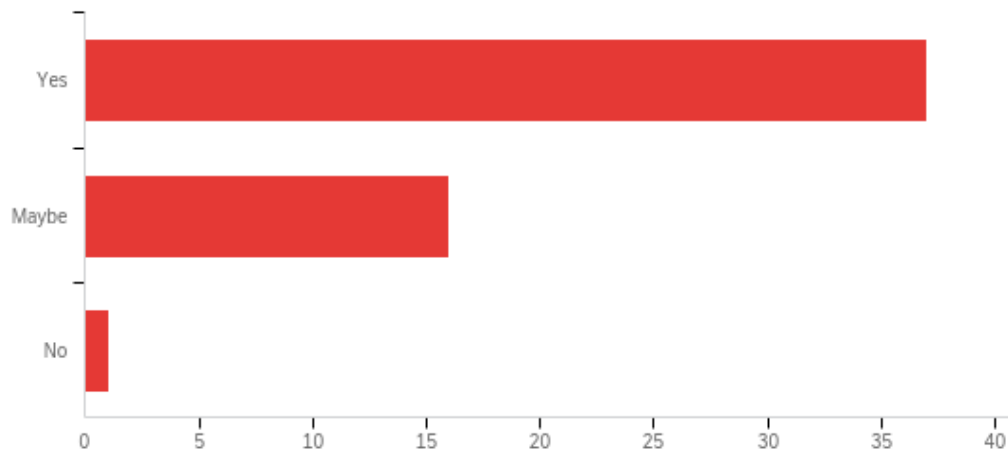


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I have attended a conference/meeting/assembly where psychosocial factors/barriers (anxiety, depression, fear, disgust, and/or embarrassment) to evaluation/treatment of dysphagia in adults were discussed.	1.00	2.00	1.52	0.50	0.25	54

#	Answer	%	Count
1	Yes	48.15%	26
2	No	51.85%	28
	Total	100%	54

(Continued to the next page)

Q33 - I would attend a conference/meeting/assembly regarding psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) if it was offered at my workplace or within my community.



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	I would attend a conference/meeting/assembly regarding psychosocial barriers (anxiety, depression, fear, disgust, and/or embarrassment) if it was offered at my workplace or within my community.	1.00	3.00	1.33	0.51	0.26	54

#	Answer	%	Count
1	Yes	68.52%	37
2	Maybe	29.63%	16
3	No	1.85%	1
	Total	100%	54