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Clinical Focus

Toward Culturally Responsive Clinical Practice: Intercultural Speech-Language Pathology Services for Acquired Pragmatic Communication Disorders in Traumatic Brain Injury and Right-Hemisphere Damage

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ABSTRACT

Purpose: Acquired pragmatic communication disorders following traumatic brain injury and right-hemisphere damage can disrupt patient–provider interactions that are essential for effective health care. This clinical focus article explores how these disorders intersect with sociocultural factors such as race, language access, and health literacy, contributing to disparities in health care engagement and outcomes to offer culturally specific considerations.
Method: This clinical focus article integrates evidence from neurogenic communication disorders, intercultural pragmatics, and health disparities to inform assessment and intervention considerations for acquired pragmatic communication disorders across diverse cultural communication contexts and structural barriers in health care systems.
Results: Impairments in pragmatic communication can affect discourse management, conversational participation, and comprehension, reducing opportunities for shared understanding during clinical encounters. When these impairments intersect with cultural communication differences or limited health literacy, patients may experience greater difficulty navigating health care systems and participating in medical decision making. Current speech-language pathology assessment practices and rehabilitation models often fail to capture these contextual influences on communication. Considerations for speech-language pathology service improvements related to assessment and treatment are offered.
Conclusions: Advancing equitable neurogenic rehabilitation requires integrating intercultural pragmatics and sociocultural perspectives into assessment and treatment. Approaches such as dynamic assessment, holistic assessment, and telehealth offer practical pathways to improve assessment practices for individuals with acquired social communication disorders.

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Effective patient–provider communication is foundational to patient-centered health care and impactful in rehabilitation outcomes (Gormley & Fager, 2021; Jesus & Silva, 2016; World Health Organization, 2016). After traumatic brain injury (TBI) and right-hemisphere brain damage (RHD), acquired pragmatic communication disorders can compromise rehabilitative dialogue, a critical factor in optimizing functional outcomes (Gindri et al., 2014; Katz et al., 2007; Terry & Kayes, 2020). Specifically, disorders in language comprehension, emotional regulation, cognitive flexibility, inhibition, turn-taking, question asking, topic maintenance, and working memory can disrupt shared comprehension and effective language use between the patient and clinician (Finch et al., 2016; Jagoe, 2017; Lê et al., 2022; McDonald et al., 2014; Pei et al., 2026; Togher et al., 2013; Wiseman-Hakes et al., 2018). Thus, these disruptions may reduce therapeutic engagement and limit opportunities for shared clinical decision making, ultimately impacting care quality, patient participation, and long-term health outcomes (Kasambira Fannin et al., 2023; Hoepner & Keegan, 2023; Kwame & Petrucka, 2021; Minga et al., 2021; Pei et al., 2026; Sharkiya, 2023).

Acquired pragmatic communication disorders are defined as the inability to use and comprehend language appropriately in social and communicative contexts (Byom et al., 2020; Guercio & Dixon, 2010; Keegan et al., 2025; Lê et al., 2022; Turkstra et al., 2017). In the literature, the related terms of pragmatic communication and social communication are often used interchangeably due to the overlap of meaning between the two concepts; therefore, these terms will be discussed under the broader umbrella of acquired pragmatic communication throughout this clinical focus article. Although there is no singular, universally accepted framework for pragmatic communication after TBI and RHD, clinical rehabilitation practices must address the patient's cultural and disorder-related needs. Thus, cultural humility toward communication styles, responsiveness to health literacy needs, continuity of follow-up care, and inclusion of caregivers in care discussions are critical to improving positive health care experiences, communication exchanges, and recovery outcomes (Street et al., 2007; Ellis & Jacobs, 2021; Hironaka & Paasche-Orlow, 2008; Coombs et al., 2022; Taylan & Weber, 2023; Kasambira Fannin et al., 2023). Importantly, cultural sensitivity and responsiveness are essential when addressing acquired pragmatic communication disorders, particularly in light of the American Speech-Language-Hearing Association's (ASHA) 2023 revision to its Code of Ethics, which expanded earlier cultural and linguistic competence provisions introduced in 2017 (ASHA, 2023). Although many clinicians have long recognized the importance of culturally informed practice, the formal standardization of cultural responsiveness as an ethical mandate is relatively recent. Consequently, variability likely exists in how clinicians interpret, prioritize, and operationalize cultural responsiveness in daily practice. Those less engaged with evolving policy, continuing education, or professional discourse may not yet possess the conceptual frameworks or clinical tools necessary to meet the sociocultural demands of contemporary neurogenic rehabilitation. Thus, despite policy-level acknowledgment of cultural responsiveness as an ethical imperative, translation into pragmatic assessment, intercultural interactional competence, and equitable neurogenic care remains uneven. With 93% of ASHA members being monolingual English speakers and the U.S. speech-language pathology curriculum primarily focusing on English language development, the workforce's experience and familiarity with cultural variants of communication is sparse (ASHA, 2023; Durán et al., 2016; Getzler et al., 2021; Paz et al., 2023). This leaves clinicians less adept at flexing for interactions with patients with differing cultural–linguistic backgrounds (Bliss & McCabe, 2008; Centeno, 2015; Hyter et al., 2015), thus prompting feelings of discomfort, particularly when assessing patients with acquired neurogenic disorders who are not monolingual English speakers (Alfano et al., 2021; Centeno, 2015; Núñez & Hughes, 2021). Though knowledge has been gathered about pragmatic communication disorders after RHD and TBI (Bosco et al., 2017, Barnes et al., 2022; Bartels-Tobin & Hinckley, 2005; Berube et al., 2022; G. A. Davis et al., 1997; Durfee et al., 2021; Johns et al., 2008; Marini, 2012; Minga et al., 2021; Parola et al., 2019; Rowley et al., 2017), considerations for how cultural characteristics shape communication during clinical encounters with individuals who have acquired pragmatic communication disorders remain limited. This gap in knowledge is particularly consequential for those whose communicative norms may differ from mainstream health care systems (Morris, 2022; Morris et al., 2015; Smedley et al., 2003). Therefore, this clinical focus article outlines critically relevant considerations for how acquired pragmatic communication disorders following TBI and RHD can contribute to inequities in health care engagement, particularly in culturally and linguistically diverse communities, and highlights culturally responsive considerations for service delivery including assessment, intervention, and patient–provider interactions.

Nature of Acquired Pragmatic Communication Disorders

Pragmatic competence arises from the interaction of linguistic, cognitive, and sensorimotor processes within social and cultural contexts (Cummings, 2005; Douglas, 2017; Douglas & Togher, 2017; Perkins, 2005; Snow & Douglas, 2017; Turkstra et al., 1995) and the social communication difficulties reported following TBI overlap with the pragmatic language disturbances observed after RHD. Individuals with TBIs and RHD may have trouble with recognizing and regulating extralinguistic behaviors (e.g.,

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gestures, facial expression, body posture) and managing conversational discourse; turn-taking may be poor and narratives incohesive (Bosco et al., 2017). In addition, linguistic elements (e.g., word choice and syntactic organization) and paralinguistic characteristics (e.g., prosody) may be affected, collectively contributing to a pragmatic communication disorder (Sheppard et al., 2022). These conditions are often described separately after TBI and RHD. For example, apragmatism is the specific diagnostic label proposed for individuals with RHD (Minga et al., 2023).

Impact of Acquired Pragmatic Disorders on Quality of Life

Acquired pragmatic communication disorders after TBI and RHD often persist after the initial injury and can have long-term implications for communication and social participation (Douglas, 2017; Vogel & Ciccia, 2023). The significance of these disorders extends beyond patient–clinician interactions to interpersonal relationships (e.g., friendships, spousal, and coworker relationships) and the negotiation of daily activities (Angeleri et al., 2008; Brown et al., 2025; Hewetson et al., 2018). Successfully navigating these activities and relationships often requires higher level cognitive skills (e.g., attention, memory, organization, reasoning, and executive functioning), many of which may also be compromised following brain injury. Importantly, these impairments are often subtle and may occur in the absence of overt expressive language deficits, which may lead providers to overlook pragmatic communication disorders during clinical evaluation (Blake et al., 2002). Apragmatism therefore remains one of the most underrecognized yet functionally consequential neurological conditions in rehabilitation (Blake, 2017; MacDonald, 2025; Minga et al., 2024). When aberrant social communication intersects with cultural communication differences, health literacy limitations, and social drivers of health, patients are more likely to experience delays in receiving necessary services, rely on emergency department care more than preventative, and encounter difficulties paying medical bills (Mahendra & Spicer, 2014; Park & Kim, 2024). Definitional ambiguity and inconsistent personnel preparation among providers regarding its presentation have led to variability in recognition and management (Minga et al., 2023). As a result, minimization of the impact of this disorder may restrict access to services, resulting in poorer medical outcomes and quality of life.

Pragmatic Communication Through an Intercultural Lens

Limitations in the recognition and management of acquired pragmatic communication differences may be further compounded by the well-documented systemic barriers affecting care of culturally and linguistically diverse populations, but, more specifically, African American adults (Cruz-Flores et al., 2011; Ellis & Egede, 2009; Ellis et al., 2014; Towfighi et al., 2023). Clinicians must recognize and respond to the sociopolitical forces that shape health care access and outcomes; without such engagement, neurogenic rehabilitation risks perpetuating systemic inequities instead of advancing transformative theory and practice. For example, a comprehensive review by Arango-Lasprilla and Kreutzer (2010) found consistent racial and ethnic disparities across treatment access, functional recovery, employment, and community integration outcomes following TBI, suggesting that sociocultural and systemic inequities extend well beyond the acute phase of injury and shape long-term participation and quality of life (Hoepner & Keegan, 2023; Brown et al., 2026). Additionally, Pappadis et al. (2024) reported that adults with TBI who demonstrated limited health literacy were more likely to report poorer perceived physical health and greater depressive symptoms compared to those with adequate health literacy, indicating that these individuals may have reduced capacity to effectively manage chronic health conditions or navigate complex health care systems.

Despite long-standing calls for more inclusive clinical, research, and educational practices, meaningful progress has been incremental within racially stratified U.S. systems and the field of acquired pragmatic communication disorders (Ellis et al., 2021; Ellis & Kendall, 2021; Whitfield, 2023). To address health disparities, rehabilitation must therefore prioritize cultural responsiveness, community-engaged approaches, and inclusive data practices to ensure equitable outcomes for all individuals (Brown & Newkirk-Turner, 2026). Continued reliance on traditional models of neurogenic rehabilitation reflects the field's ongoing failure to apply calls for inclusivity into concrete, theory-informed changes in assessment, patient–clinician interaction, and intervention for acquired pragmatic disorders. One critical yet underexamined avenue for advancing this work lies in understanding how culture shapes pragmatic expectations within clinical encounters. Culture shapes contextually appropriate communication and meaning (Carter et al., 2005; Gumperz & Roberts, 1991; Kecskes, 2014; Kramsch, 2014), making culture a crucial consideration for accurate identification and treatment of acquired pragmatic communication disorders.

Intercultural Pragmatics and Assessment

Intercultural pragmatics concerns how language is used between speakers with differing first languages or cultures, but communicating in a common language (Kecskes, 2014) and understanding the link between intercultural pragmatics and pragmatic assessment are essential to culturally responsive practice. Intercultural pragmatics recognize that communication is influenced not only by linguistic knowledge but also by shared beliefs, values, experiences, and expectations regarding social interaction. These cultural influences shape how individuals construct identity, interpret

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meaning, express intention, negotiate relationships, and participate in discourse (Holliday, 2021). For example, an adult that identifies as African American who is a dialect speaker may use storytelling, indirect responses, or nonverbal gestures during conversational patterns to explain a health concern. An unfamiliar listener of the dialect may perceive these discourse patterns to be tangential, vague, or inaccurate to the context of the message. However, within this patient's community, these forms of expression are accepted, appropriate, and informative. Few standardized assessments have been developed to evaluate acquired pragmatic communication disorders in adult neurogenic populations (Steel & Togher, 2019), and, to date, there is only an International Classification of Diseases, 10th Revision code for developmental social pragmatic disorders (Minga et al., 2024). As a result, speech-language pathologists often assess functional communication and pragmatic abilities within broader speech, language, and cognitive-communication evaluations (Bosco et al., 2017; Togher et al., 2014, 2023; Turkstra et al., 2017). Although this approach can provide useful clinical information, it may limit the ability to fully capture the complex and dynamic nature of acquired pragmatic communication disorders, including regional differences (B. Davis et al., 2016). In particular, standardized assessments may not adequately reflect how individuals navigate real-world communicative interactions, potentially obscuring pragmatic challenges that influence patient engagement, health care communication, and rehabilitation outcomes. Additional considerations regarding language access are important, and validated pragmatic assessments for nonnative English speakers are sparse (Steel & Togher, 2019), with simple translations of assessment measures lacking cultural and linguistic validity (Altarriba & Kazanas, 2017). Moreover, when using an interpreter, subtle pragmatic markers may quite literally be "lost in translation" during the interpretation process whether tied to dialectical, cultural differences, or the lack of knowledge regarding the value of pragmatic communication markers (Altarriba & Kazanas, 2017; Centeno, 2015).

The cultural variances in pragmatic use become particularly visible when traditional standardized assessment practices are implemented. Many commonly used measures operationalize pragmatic and linguistic competence according to dominant, low-context norms, implicitly treating these norms as culturally neutral benchmarks. We know that there is a lack of race-based data being disclosed and collected in the creation of these instruments, which represents a significant limitation (Ellis & Egede, 2009; Omar et al. 2023), where race has been predominantly examined in terms of biological differences between individuals rather than as a social construct reflecting structural inequities (Cerdeña et al., 2020; Yudell et al., 2020). The continued reliance on measures developed within culturally narrow normative frameworks raises important questions about how cultural humility, empathy, and historical awareness are operationalized in neurogenic assessment. When standardized instruments embed dominant sociocultural assumptions, they risk pathologizing culturally congruent communicative behaviors while simultaneously overlooking pragmatic impairments that manifest differently across communities.

Without integrating intercultural pragmatic frameworks into neurogenic assessment, clinicians may misinterpret discourse style, indirectness, prosodic variation, or narrative organization, to name a few, as evidence of impairment or, conversely, fail to detect subtle pragmatic disruptions that interfere with functional participation. Such misalignment is particularly consequential for Black adults and other culturally diverse populations whose communicative norms may diverge from standardized expectations embedded in assessment tools and clinician training. Accordingly, culturally responsive neurogenic rehabilitation requires more than linguistic translation or surface-level cultural awareness; it necessitates theoretical integration of intercultural pragmatics into diagnostic reasoning, interactional analysis, and treatment planning. This integration provides a concrete mechanism through which equity can be operationalized in pragmatic assessment, rather than merely advocated in principle.

Intercultural Pragmatics and Patient–Clinician Communication

Intercultural pragmatics can impact therapeutic interactions and decision making, particularly when patients with high-context communication styles (Hall & Hall, 1990) interact within the typically low-context U.S. medical system. High-context communication, characteristic of many people of the African diaspora, usually favors implicit, nonverbal rich communication with more gestures, eye movements, facial expressions, and vocal nuances, whereas low-context communication is more reliant on direct written or verbal communication (Bates, 1976; Hyter et al., 2015). These high-context communicators also decode clues such as seating arrangements and attire, making observation a primary mechanism through which verbal meanings are determined (Nam, 2015). Many of these communicative patterns are found in African American cultural discourse practices where contextual cues, relational awareness, and nonverbal signaling may play significant roles in shaping interpersonal interactions (Taylor, 1972). Parallel findings have been found across the heterogenous U.S. Latine populations (Altarriba & Kazanas, 2017), and other groups with high-context tendencies include Chinese, Japanese, Arabic-speaking cultures, Indigenous Americans, Mexicans, and Greeks (Hall & Hall, 1990; Nisbett et al., 2001; Varnum et al., 2010).

Interfacing with a patient with an acquired pragmatic communication disorder without consideration for potential intercultural pragmatic discordance (Kecskes, 2014), however,

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might suppress the effectiveness of the patient–clinician interaction. Given that high-context communication relies heavily on nonverbal pragmatics, the presence of acquired pragmatic disorders could amplify communication difficulties, as the ability to effectively use indirect forms of communication may be compromised. Low-context communication dominates most consultative, diagnostic, and therapeutic interactions, and patients with various communication disabilities have reported difficulty interacting with clinicians, feeling ignored, disregarded, underestimated, and experiencing increased preventable adverse medical events (Hemsley & Balandin, 2014; Murphy, 2006; Nordehn et al., 2006). Effective medical decision making relies on approaching the communication interaction with cultural humility, in order to foster mutual understanding. This is most successful when clinicians gain trust and gather information about medical status, which may influence the patient's decision/ability to fulfill treatment recommendations (Hawes & Sanders, 2023; Katz et al., 2007).

Considerations for Culturally Responsive Practice

This discussion has highlighted how pragmatic communication disorders following TBI and RHD might influence care delivery, patient–provider communication, and quality of life. We have also underscored persistent gaps in provider recognition and rehabilitation practices, as well as inequities experienced by patients who must navigate the health care system while managing complex pragmatic communication challenges. To address these issues, providers must move beyond narrow models of traditional service provision and adopt approaches that reflect the lived experiences, cultural contexts, and communication practices of the individuals they serve.

Culturally Responsive Framework for TBI and RHD

This section outlines culturally responsive considerations for service delivery and clinical management of pragmatic communication disorders following TBI and RHD. Emerging frameworks in speech-language pathology, including biopsychosocial, intersectionality-informed approaches, and the Social Communication Implementable and Applicable Lens (SoCIAL), offer more holistic models for assessing and treating pragmatic communication disorders within diverse populations (Brown, 2025; Kasambira Fannin et al., 2023; Keegan et al., 2025; Rose, 2023). For example, translating a conceptual framework such as SoCIAL into practice requires concrete changes in clinical assessment, intervention, and service delivery by emphasizing intersecting variables (i.e., contextual, social, personal, and environmental) that shape social communication, moving beyond impairment-focused models to person-centered care (Keegan et al., 2025). Specifically, operationalizing the SoCIAL framework requires clinicians to consider principles of intercultural pragmatics to evaluate how cultural norms influence communication styles, including indirectness and nonverbal behaviors that may vary across cultural backgrounds. The following recommendations outline actionable steps for clinicians and researchers working with individuals with pragmatic communication disorders following TBI and RHD.

Assessment Considerations

By emphasizing collaborative goal setting guided by patients' personal and environmental contexts, the SoCIAL framework minimizes biases inherent in standardized assessments whose norming samples are not always representative of caseloads. Dynamic assessment offers a complementary approach to evaluating pragmatic communication abilities in individuals with TBI and RHD from culturally and linguistically diverse backgrounds. Given that the subtleties of pragmatic communication disorders are most recognized during discourse exchanges, the use of prompts and scaffolding during dynamic assessment reveals modifiable strengths during real-time discourse, helping distinguish true impairment from cultural or linguistic differences (Doedens & Meteyard, 2020). Rather than relying on standardized measures that assume uniform performance across individuals, dynamic assessment emphasizes the evaluation of a person's current strengths, weaknesses, and learning potential within their existing skill set (Hasson & Joffe, 2007). This approach allows clinicians to observe how individuals respond to prompts, feedback, and mediated learning experiences, providing insight into functional communication abilities that may not be captured through traditional assessments. Implementing dynamic assessment requires clinicians to adopt a broader interpretive lens, such as biopsychosocial, intersectionality-informed, or SoCIAL frameworks to more accurately understand the sociocultural and contextual factors influencing communication performance. Importantly, dynamic assessment is not limited to a single evaluation session but is an ongoing process that spans both the assessment and treatment phases of rehabilitation.

Sensitivity to pragmatic communication disorders after RHD and TBI by clinicians and among caregivers can enhance the effectiveness of dynamic assessment. There are freely available resources that can provide invaluable information. The documentary *RHD Hidden Diagnosis* provides 29 min of insight into the rehabilitative journeys and pragmatic capabilities of individuals in the chronic phase of recovery after right-hemisphere stroke and the experiences of loved ones and students exposed to the population for the first time (Minga et al., 2024; see https://www.pbs.org/show/rhd-hidden-diagnosis/ via RHDBank webpage). TBIBank and RHDBank are two multimedia data repositories of TalkBank that can be used to help caregivers understand pragmatic communication disorders (Elbourn et al.,

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2023; MacWhinney, 2025; Minga et al., 2021). The Grand Rounds sections of TBIBank and RHDBank (https://talkbank.org/tbi/GR/; https://talkbank.org/rhd/GR/index.html) are intended for educational purposes and clinical training, each presenting case studies with video recordings of TBI and RHD survivors completing descriptive, narrative, procedural, and conversational discourse tasks with accompanying discussion questions.

Using the documentary and Grand Rounds video recordings of both banks as real-life exemplars of pragmatic communication after TBI and RHD in various communicative contexts can optimize assessment in two ways. First, clinicians can familiarize themselves with both the discourse tasks that reveal key features of TBI and RHD apragmatic communication profiles across varied cultural and linguistic backgrounds. Exposure to these diverse exemplars builds cultural humility by highlighting how pragmatic characteristics (e.g., indirectness, nonverbal cues, turn-taking) manifest differently, and should a clinician elect to incorporate discourse into their assessment, there are guidelines for the clinical elicitation of discourse (Minga et al., 2022) that can be adapted to elicit culturally relevant samples. Second, RHDBank and TBIBank resources can be used to facilitate discussion of pragmatic language features from a patient-care partner perspective. This dynamic exchange can prove invaluable to determining optimal rehabilitation techniques and motivations for responsiveness to treatment. Additional information on the clinical utility of the RHDBank and TBIBank Grand Rounds is provided by Saylor et al. (2026) in this International Cognitive-Communication Disorders Conference special Issue. Inclusion of care partners in this process can enhance the understanding of the functional impact of apragmatic communication disorders, which may help to maintain relationships and foster rehabilitative participation to optimize functional outcomes that may otherwise go awry.

Intervention Considerations

Intervention and pragmatic communication disorders should be grounded in person-centered care, which recognizes the influence of an individual's communication being shaped by their cultural identity, lived experiences, and everyday communication interactions and environments. Because pragmatic communication is also influenced by cultural norms, intervention strategies should extend beyond the individual to include collaborative training with the patient, family caregivers, and health care providers to promote culturally responsive care across daily contexts. This extension of invention should also include variability in service delivery options. For example, technology-enabled services have the capability to reinforce intervention outside of traditional clinical settings, increase opportunities for participation, and promote continuity of care across the continuum. Such approaches may be particularly beneficial for individuals with TBI or RHD who experience barriers to transportation, health literacy, or limited access to rehabilitation services.

Caregiver training billing code. The use of caregiver training Current Procedural Terminology (CPT) codes can facilitate documentation of the dynamic assessment process while also supporting sustainable intervention. For example, CPT code **97550** allows clinicians to provide billing for caregiver training in strategies and techniques that facilitate improved performance during activities of daily living (ADLs), including communication, swallowing, problem solving, and safety practices. The CPT code **97551** may be used in conjunction with **97550** to facilitate caregiver recognition and documentation of the patient's functional performance in ADLs. The CPT code **97552** allows clinicians to conduct group caregiver training sessions focused on strategies to support functional performance during ADLs. For each code, associated services may be provided with or without the patient present, allowing clinicians to address communication and functional strategies directly with caregivers who support the patient in daily environments (ASHA, 2024).

The use of caregiver training codes can facilitate the delivery of caregiver training, which may have additional impact for culturally linguistically diverse groups that often prioritize family involvement in rehabilitation and life post neurological injury, such as Latine families (Centeno, 2015; Altarriba & Kazanas, 2017). In fact, studies have shown that collectivist TBI caregivers, such as Latine families, experience reduced strain and improved adherence when interventions incorporate extended kin networks, leveraging familial roles to reinforce pragmatic skills such as indirect communication in daily contexts (Centeno, 2015). The cultural orientations of high-context communicators and/or collectivist cultures make group caregiver training a good consideration for more responsive care, as TBI or RHD does not only affect the injured person (Moscote-Salazar et al., 2025) and families coconstruct meaning and support through collective problem solving, mirroring everyday relational dynamics. Moreover, use of the RHDBank and TBIBank can continue when using CPT codes as outlined above with different case presentations for ongoing dynamic pragmatic communication training, while providing clinicians with billable, sustainable opportunities to deliver responsive care into routine practice.

Telehealth and technology-enabled intervention. Barriers such as access to high-speed internet and the need for interstate licensure from providers have constrained the availability of telehealth services in rural communities and disproportionately impact historically underserved populations (Chang et al., 2021; Cortelyou-Ward et al., 2020). However, despite the noted challenges, web-based platforms and telehealth services offer an opportunity to extend access to neurogenic rehabilitation and support more consistent

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follow-up care for a more inclusive group of individuals with TBI and RHD. Telehealth may be particularly beneficial for individuals who are homebound, live in rural or underserved areas, or face barriers to attending in-person therapy sessions. In addition to intervention, telehealth platforms may also facilitate remote screening, assessment, and progress monitoring of cognitive-communication and pragmatic language impairments, enabling clinicians to identify communication needs and track recovery across different stages of rehabilitation. Powell et al. (2016) reported positive outcomes for both caregivers and individuals with moderate-to-severe TBI when telehealth-based discharge support and recommendations were provided following hospital stays. In addition to improving continuity of care, telehealth services may help reduce access barriers experienced by individuals from diverse or underserved communities who often encounter challenges obtaining specialized neurogenic rehabilitation services. Although telehealth is not a comprehensive solution to the broader social drivers of health (Office of Disease Prevention and Health Promotion, n.d.) that shape health care access, it represents a feasible and flexible approach that may enhance rehabilitation engagement and service delivery when implemented thoughtfully.

Conclusions

Acquired pragmatic communication disorders following TBI and RHD present complex challenges that extend beyond linguistic impairments to influence patient–provider communication, health care engagement, and long-term recovery outcomes. When these disorders intersect with sociocultural factors such as race, health literacy, and systemic inequities in health care access, the consequences may be amplified for individuals from culturally diverse communities. This clinical focus article demonstrates the importance of recognizing these complex neurological disorders through both clinical and intercultural lenses, emphasizing that effective rehabilitation requires attention to not only the neurological deficits but also the communication styles, cultural differences, and communication expectations that shape health care interactions. Integrating culturally responsive frameworks, dynamic assessment approaches, tangible evidence-based resources, and extended opportunities toward care accessibility offers multiple pathways toward more equitable rehabilitation. Although this clinical focus article centers on U.S. contexts, the principles described here may be relevant across international and cross-cultural settings. Future work led by researchers with expertise in those cultural contexts is needed to potentially extend and refine this framework globally. Future research and clinical practice should continue to examine the interaction of acquired pragmatic communication disorders with sociocultural factors to sensitive and specific assessment and intervention strategies that better reflect the lived experiences of culturally and linguistically diverse populations.

Author Positionality Statement

All authors acknowledge that the perspectives presented in this clinical focus article are informed by their personal or lived experiences as members of racial and ethnic minority groups; their clinical, research, teaching, and community-engaged experiences working with individuals after acquired brain injury and culturally diverse populations. Together, these experiences with the existing literature have shaped our understanding of culturally responsive practice and the recommendations discussed throughout this clinical focus article.

Data Availability Statement

There were no data to report for this clinical focus article.

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