Translating communication partner training evidence for multilingual aphasia rehabilitation in Malaysia: A structured narrative review

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ABSTRACT

Introduction: Aphasia affects everyday communication, social participation, and caregiver wellbeing. Communication partner training (CPT) is a participation-oriented intervention that equips familiar partners with strategies to support communication in daily interactions. However, most CPT evidence is drawn from monolingual contexts, limiting applicability to multilingual settings such as Malaysia. This structured narrative review synthesised evidence on CPT effectiveness, implementation determinants, delivery modalities including telepractice and hybrid care, and multilingual aphasia rehabilitation, with the aim of translating these findings to the Malaysian rehabilitation context.

Materials and Methods: A structured narrative review was conducted to synthesis the evidence thematically. Evidence was purposively selected to capture CPT effectiveness, caregiver and participation outcomes, implementation determinants, telepractice delivery, multilingual aphasia, and Malaysian service contexts. Findings were synthesised thematically.

Results: CPT consistently improves partner communication behaviours and dyadic conversation outcomes, particularly with trained partners. In contrast, caregiver wellbeing and communication participation outcomes are measured less consistently. Implementation evidence identifies barriers related to time, resources, and service organisation, alongside facilitators such as structured training materials, coaching, and organisational support. Telepractice is a feasible CPT delivery mode, with hybrid approaches offering improved access and flexibility. Multilingual evidence indicates variable cross-language generalisation, highlighting the importance of context-sensitive and flexible CPT designs.

Conclusion: CPT has strong evidence as a participation-focused intervention for improving trained partner behaviours and dyadic communication outcomes in aphasia. Its application to multilingual rehabilitation contexts, including Malaysia, requires careful adaptation to family language use, caregiver readiness, delivery feasibility, and service resources. Integrating implementation strategies, telepractice, and multilingual considerations is essential for translation into routine care. A modular, caregiver-centred CPT framework may provide a practical foundation for future co-design, piloting, and evaluation in Malaysian rehabilitation services.

KEYWORDS:
Aphasia, communication partner training, telepractice, caregiver training, multilingual rehabilitation

INTRODUCTION

Aphasia is an acquired language disorder, often caused by stroke, that can affect understanding, speaking, reading, and writing.[1] It is more than a language impairment; it disrupts conversations, social participation, and identity and has significant repercussions on the wellbeing of people with aphasia (PWA) and their caregivers.[2] Families often serve as primary communication partners and informal co-therapists for PWA. Consequently, caregiver education and training are essential components of aphasia rehabilitation.

Communication partner training (CPT) is a participation-oriented, environmental approach where familiar partners are trained to facilitate everyday communication with a person with aphasia.[3] CPT has a robust evidence base, with systematic reviews showing positive effects on partner communication behaviours and dyadic conversation outcomes, particularly when the person with aphasia converses with the trained partner.[4] More recently, a synthesis of implementation evidence identified barriers and facilitators to real-world CPT uptake, including resource availability, training materials, and service readiness.[5] Simultaneously, emerging studies investigating brief and

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online CPT packages for health professional trainees report improved knowledge and attitudes towards the treatment of PWA and may inform scalable dissemination routes that could supplement family-centred CPT models.[6-7]

Additionally, much of the CPT evidence has emerged from monolingual and high-income contexts, limiting its immediate applicability to multilingual societies in Southeast Asia. Malaysia is a pertinent example. Malaysian households may use Malay, English, Mandarin, Tamil, regional dialects and other languages, often with code-switching and different language preferences across family members, creating additional challenges for caregiver training and clinician-family communication.

CPT can also be delivered virtually through telepractice, which may improve access when travel, caregiver work commitments, geography, or limited specialist services reduce attendance at face-to-face sessions.[8] However, feasibility depends on connectivity, digital confidence, privacy, and appropriate service support.[8-11]

The aim of this structured narrative review was to synthesise evidence on caregiver communication partner training (CPT), including evidence on effectiveness, implementation, delivery modalities, and multilingual aphasia rehabilitation, and to consider how these findings may inform culturally and linguistically responsive caregiver CPT in Malaysia. This review addressed the following questions:(1) What evidence is available regarding the effectiveness and core components of caregiver communication partner training for people with aphasia? (2) What implementation barriers and facilitators influence the delivery of caregiver CPT in clinical, community, and home-based contexts? (3) How can different delivery modalities, including face-to-face, telepractice, and hybrid approaches, support caregiver CPT implementation? (4) What multilingual, cultural, and Malaysian contextual considerations should inform the co-design, piloting, and evaluation of caregiver CPT programmes?

MATERIALS AND METHODS

A structured narrative review was conducted to integrate evidence on caregiver CPT, implementation, telepractice, multilingual aphasia, and Malaysian rehabilitation contexts. The review followed the three phases and nine steps described by Juntunen and Lehenkari.[12]

Selecting the topic

The review focused on caregiver communication partner training for aphasia in multilingual rehabilitation contexts, with Malaysia as the exemplar setting.

Defining the objectives and formulating the review questions
The review objective and questions were formulated to address CPT effectiveness, implementation, delivery modalities, and multilingual adaptation within the Malaysian rehabilitation context.

Developing and validating the review protocol

A review protocol specifying the review aim, conceptual domains, literature sources, selection criteria, and synthesis approach was developed and refined by all authors. The protocol was not registered because this was a narrative rather than systematic review.

Searching the literature

A purposive literature search, last updated in December 2025, was conducted in PubMed, Scopus, Google Scholar, and selected journal portals. Reference lists and key papers were also manually searched. Search terms covered caregiver CPT, implementation and service delivery, delivery modalities, multilingual aphasia, and Malaysian or regional rehabilitation contexts. The search domains and example keywords are presented in Table I.

Selecting the literature

Literature was purposively selected based on relevance to the review questions. Core synthesis sources addressed caregiver CPT or supported conversation, caregiver-mediated intervention, aphasia telepractice, implementation barriers and facilitators, bilingual or multilingual aphasia intervention, cross-language generalisation, or Malaysian and regional speech-language therapy services. Sources focusing exclusively on paediatric populations, non-aphasia communication disorders, impairment-based therapy without partner involvement, unrelated telehealth, or general caregiver support were excluded. Foundational and contextual sources were retained for background but were not included in the thematic synthesis. The final synthesis included 14 core sources, summarised in Table II.

Analysing the literature

Selected literature was organised according to the review questions and conceptual domains. Key information was extracted on study focus, population, intervention or service model, caregiver and participation outcomes, multilingual relevance, and implementation implications.

Synthesising the literature

The literature was synthesised thematically into six domains: CPT effectiveness and dyadic communication outcomes; caregiver and participation outcomes; implementation barriers and facilitators; telepractice and hybrid delivery; multilingual and cross-language considerations; and Malaysia-specific service delivery evidence. Evidence was classified as direct CPT evidence, related evidence, or context-informed interpretation.

Drawing conclusion

Conclusions were drawn by integrating findings across the evidence domains while distinguishing direct CPT evidence from related and context-informed evidence.

Reporting

Findings were reported using an IMRaD structure, with Results organised according to the six synthesis domains and the Discussion interpreting their implications for multilingual Malaysian rehabilitation practice.

RESULTS

The thematic synthesis included 14 core sources spanning CPT effectiveness, implementation, telepractice, multilingual

Table I: Search domains and example keywords used in the narrative review

Search domain	Purpose	Keywords
Caregiver communication partner training	To identify evidence on CPT effectiveness, intervention components, and caregiver-mediated communication support	aphasia, communication partner training, caregiver training, family training, supported conversation, conversation partner, communication strategies
Implementation and service delivery	To identify barriers, facilitators, and practical determinants affecting CPT uptake in routine care	implementation, barriers, facilitators, rehabilitation service delivery, training materials, caregiver engagement, clinician training, fidelity
Delivery modality	To examine face-to-face, telepractice, and hybrid approaches relevant to caregiver CPT delivery	telepractice, telerehabilitation, telehealth, online training, hybrid delivery, remote coaching, aphasia therapy
Multilingual and bilingual aphasia rehabilitation	To identify language-related considerations for adapting CPT to multilingual households To contextualise CPT implementation for	bilingual aphasia, multilingual aphasia, cross-language generalisation, code-switching, translanguaging, language dominance, culturally responsive rehabilitation
Malaysian and regional context	Malaysia and similar multilingual rehabilitation settings	Malaysia, Malaysian speech-language therapy, aphasia Malaysia, caregiver rehabilitation, telepractice Malaysia, multilingual rehabilitation, AAC aphasia

aphasia rehabilitation, and Malaysian service delivery. The characteristics and contributions of these sources are summarised in Table II.

CPT effectiveness and dyadic communication outcomes

Systematic reviews indicate that CPT improves trained partner communication behaviours and dyadic interaction outcomes in people with aphasia.[3-4] The reported benefits are most consistent when outcomes are measured within conversations involving the trained communication partner. This supports CPT as a participation-oriented intervention that modifies the communication environment rather than focusing solely on impairment-level language recovery.[3-4] Despite variation in intervention format and dosage, the overall evidence supports CPT for improving trained partner behaviours and dyadic communication outcomes.[3-4]

Caregiver and participation outcomes

Compared with partner communication behaviours and dyadic conversation outcomes, caregiver-centred outcomes were less consistently reported. Caregiver outcomes were often secondary or exploratory. Where caregiver-related variables were examined, findings suggested potential benefits for caregiver confidence and perceived ease of communication. However, methodological variation limits conclusions regarding caregiver wellbeing.[3-4]

Participation outcomes for people with aphasia were also inconsistently operationalised. Some evidence suggests improved functional communication and participation within trained dyads, but broader participation outcomes were not consistently measured. This highlights the need for a clearer outcome framework, particularly in multilingual contexts. Recommended outcome domains and measures are summarised in Table III.

Implementation barriers and facilitators

Implementation evidence indicates that the uptake of CPT in routine services is influenced by individual, service-level, and system-level determinants. Common barriers include limited clinician time, high caseloads, caregiver availability, insufficient training resources, and competing service demands.[5] In multilingual contexts, language mismatch, limited culturally appropriate materials, literacy, and digital confidence may create additional barriers. Facilitators include structured materials, clinician modelling, coaching, organisational support, and follow-up.[5] Table IV summarises implementation determinants and practical strategies using a theory-informed approach.

Telepractice evidence for aphasia rehabilitation and caregiver training

Telepractice evidence provides related, rather than exclusively CPT-specific, support for alternative modes of aphasia rehabilitation delivery. Remote aphasia rehabilitation appears feasible and may produce outcomes comparable to face-to-face delivery in selected contexts.[9,10,13] For caregiver CPT, telepractice may support home-based coaching, reduce travel demands, and facilitate follow-up. Implementation may be limited by connectivity, privacy, digital confidence, and clinician readiness.[9,10,13] The evidence therefore supports telepractice as one possible delivery modality for CPT, rather than as a replacement for all face-to-face services. Hybrid delivery may combine initial face-to-face assessment and coaching with remote follow-up and booster training.

Multilingual evidence and cross-language considerations

Evidence directly addressing multilingual caregiver CPT remains limited. Most available evidence comes from bilingual or multilingual aphasia intervention rather than caregiver CPT, with cross-language generalisation varying according to language history, dominance, proficiency, and use.[15-16] Caregiver CPT should therefore not assume a single default language for all interactions. Clinicians should consider language history, current abilities, preferred language use, caregiver proficiency, and household communication demands. Strategies may include flexible language choice, code-switching, use of the most functional shared language, and multimodal communication supports. These recommendations should be interpreted as evidence-informed and context-informed adaptations rather than direct evidence of multilingual caregiver CPT effectiveness and require further evaluation in Malaysia.

Malaysia-specific service delivery evidence

Malaysia-specific evidence provides contextual support for the relevance of flexible and culturally responsive CPT

Table II: Core evidence sources informing the thematic synthesis

Study	Study type	Participants / context	Intervention or focus	Caregiver outcomes reported	Participation outcomes reported	Multilingual, telepractice, or implementation relevance
Simmons-Mackie et al., 2010	Systematic review	People with aphasia and communication partners	CPT effectiveness	Caregiver wellbeing not consistently reported; focus was partner behaviour.	Improved communication activity/participation with trained partners.	Direct evidence for CPT improving partner communication and dyadic interaction.
Simmons-Mackie et al., 2016	Updated systematic review	Evidence across 56 studies	Updated CPT evidence	Partner knowledge and skills improved; caregiver wellbeing less prominent.	Some evidence of improved interaction participation with trained partners.	Strengthens evidence for CPT effects on trained partner behaviours and dyadic outcomes.
Shrubsole et al., 2023	Systematic review and theory-informed synthesis	Studies on SLT implementation of CPT with familiar partners	Barriers and facilitators to CPT implementation mapped to TDF	Caregiver-related findings focused on engagement, availability, and feasibility.	Participation was not the main outcome; focus was implementation feasibility and sustainability.	Identifies key barriers such as time, resources, service readiness, training, and caregiver availability; facilitators include materials, coaching, organisational support, and reinforcement.
Power et al., 2024	Training efficacy study	Student healthcare professionals	Online CPT training package	Not a caregiver outcome study; outcomes related to trainee knowledge, attitudes, and confidence.	Not a direct PWA participation outcome study.	Supports potential scalability of brief online CPT training models.
Anjum and Husak, 2025	Pilot study	Informal caregivers and people with aphasia	Telepractice-delivered communication training	Caregivers applied strategies and reported fewer communication breakdowns.	Everyday interaction improved indirectly through fewer breakdowns.	Direct caregiver-focused telepractice evidence, although based on a small pilot sample.
Hall et al., 2013	Systematic review	Aphasia telepractice assessment and treatment studies	Telepractice in aphasia assessment and treatment	Caregiver outcomes not primary.	Telepractice was reported as a viable aphasia service delivery method.	Foundational evidence supporting telepractice as an alternative delivery mode.
Cacciante et al., 2021	Systematic review and meta-analysis	People with aphasia receiving telerehabilitation	Telerehabilitation for aphasia	Caregiver outcomes not primary.	Telerehabilitation may be comparable to face-to-face therapy for selected aphasia outcomes.	Supports feasibility of telepractice delivery in aphasia rehabilitation.
Cetinkaya et al., 2024	Systematic review	Aphasia telerehabilitation studies	Telerehabilitation feasibility, acceptability, and effectiveness	Caregiver outcomes not primary.	Evidence of feasibility and clinical benefit, with variable study designs.	Provides updated telepractice evidence for aphasia rehabilitation.
Dunne et al., 2023	Intervention study	Adults with aphasia receiving telepractice group conversation treatment	Telepractice group conversation treatment	Caregiver outcomes not the focus.	Patient-reported and socially oriented outcomes were examined.	Related evidence for conversation-based aphasia intervention via telepractice; not caregiver CPT-specific.
Peñaloza et al., 2021	Retrospective comparative treatment study	Sixteen Spanish-English bilingual adults with chronic post-stroke aphasia	Semantic feature analysis via telerehabilitation or in-person therapy	Caregiver outcomes not the focus.	Secondary language outcomes examined; participation not primary.	Supports consideration of language choice and cross-language effects in bilingual aphasia rehabilitation.
Goral et al., 2023	Meta-analysis	Multilingual people with post-stroke aphasia across 40 studies	Cross-language generalisation of language treatment	Caregiver outcomes not the focus.	Participation outcomes varied and were not the main focus.	Core multilingual evidence: stronger treated-language effects, weaker but possible cross-language transfer, moderated by language history and context.

Table II: Core evidence sources informing the thematic synthesis

Study	Study type	Participants / context	Intervention	Caregiver outcomes reported	Participation outcomes reported	Multilingual, telepractice, or implementation relevance
Hassan et al., 2023	Comparative service evaluation	Clients and caregivers receiving conventional, virtual, or hybrid SLT in Malaysia	Satisfaction with different SLT delivery modes	Caregiver satisfaction directly examined.	Participation outcomes not primary.	Malaysia-specific support for flexible and hybrid service delivery.
Singh et al., 2022	Survey study	Malaysian speech-language pathologists	Implementation of telepractice during COVID-19	Caregiver outcomes not directly examined.	Participation outcomes not directly examined.	Malaysia-specific evidence on telepractice uptake, service readiness, and practical barriers.
Singh et al., 2024	Qualitative / service experience study	Malaysian SLTs and caregivers of individuals with aphasia	AAC practices and experiences in aphasia care	Caregiver perspectives included.	Participation addressed indirectly through AAC use in daily communication.	Supports culturally and linguistically relevant low-tech and AAC communication supports in Malaysia.

Table III: Recommended outcomes and measures for evaluating multilingual caregiver CPT

Outcome domain	Examples of measures	Respondent	Timing	What improvement looks like	Notes for multilingual contexts
Partner communication skills and supportiveness	Observed conversation rating, MSC/MPC where used, interaction checklist	Clinician rater, dyad video	Baseline, post, follow-up	More supportive partner turns, fewer breakdowns, better verification	Rate mixed-language turns consistently, focus on successful meaning making
Functional communication in daily life	CETI, functional communication questionnaires, goal-based ratings	Caregiver and PWA	Baseline, post, follow-up	Easier everyday exchanges, better completion of routine tasks	Use household language(s) used in the task, include code-switching contexts
Communication participation	CPIB or participation scales, participation goal attainment	PWA (supported), caregiver	Baseline, post, follow-up	More participation in conversations and social situations	Ensure items reflect local participation contexts, family and community settings
Caregiver confidence and self-efficacy	Self-efficacy scales, confidence ratings, training satisfaction	Caregiver	Baseline, post, booster	More confidence managing breakdowns, better strategy use	Provide bilingual forms or audio administration where needed
Caregiver burden and wellbeing	Caregiver strain or burden scales, wellbeing ratings	Caregiver	Baseline, post, follow-up	Reduced perceived burden and stress around communication	Interpret alongside caregiving context, include brief qualitative comments
Feasibility and acceptability	Attendance, completion, dropout, usability, telepractice satisfaction	Caregiver, clinician	During programme, post	High completion, manageable time demands, high satisfaction	Capture tech issues, connectivity, privacy concerns, language matching needs

Table IV: Implementation determinants and practical strategies for CPT delivery (TDF-informed synthesis)

Determinant domain (TDF-aligned)	Common barriers in services	Facilitators	Practical strategies for delivery
Knowledge and skills (clinician and caregiver)	Limited CPT training, uncertainty about coaching, caregiver unfamiliarity	Structured manuals, modelling, supervision	Use standard modules, provide scripts and checklists, train clinicians in coaching and feedback
Environmental context and resources	Time constraints, high caseloads, travel burden, limited materials	Hybrid delivery, ready-to-use resources, telepractice infrastructure	Short sessions with homework, tele-coaching follow-up, reusable handouts and videos
Social influences and roles	Caregiver availability, family dynamics, low engagement	Goal alignment, family champions, peer support	Collaborative goal setting, including another family member, group sessions or buddy system
Beliefs about consequences and motivation	Perceived low benefit, preference for impairment therapy	Early quick wins, visible progress, meaningful goals	Start with high-impact routines, track small changes, share before and after conversation clips
Behaviour regulation and reinforcement	Drop-off over time, inconsistent practice	Booster sessions, reminders, self-monitoring tools	Booster plan for 2 to 6 weeks, caregiver log, prompts, fidelity checklist
Equity and access (contextual)	Digital divide, language mismatch, low literacy	Language matching, culturally adapted materials	Offer bilingual materials, allow audio administration, use visuals, provide tech orientation

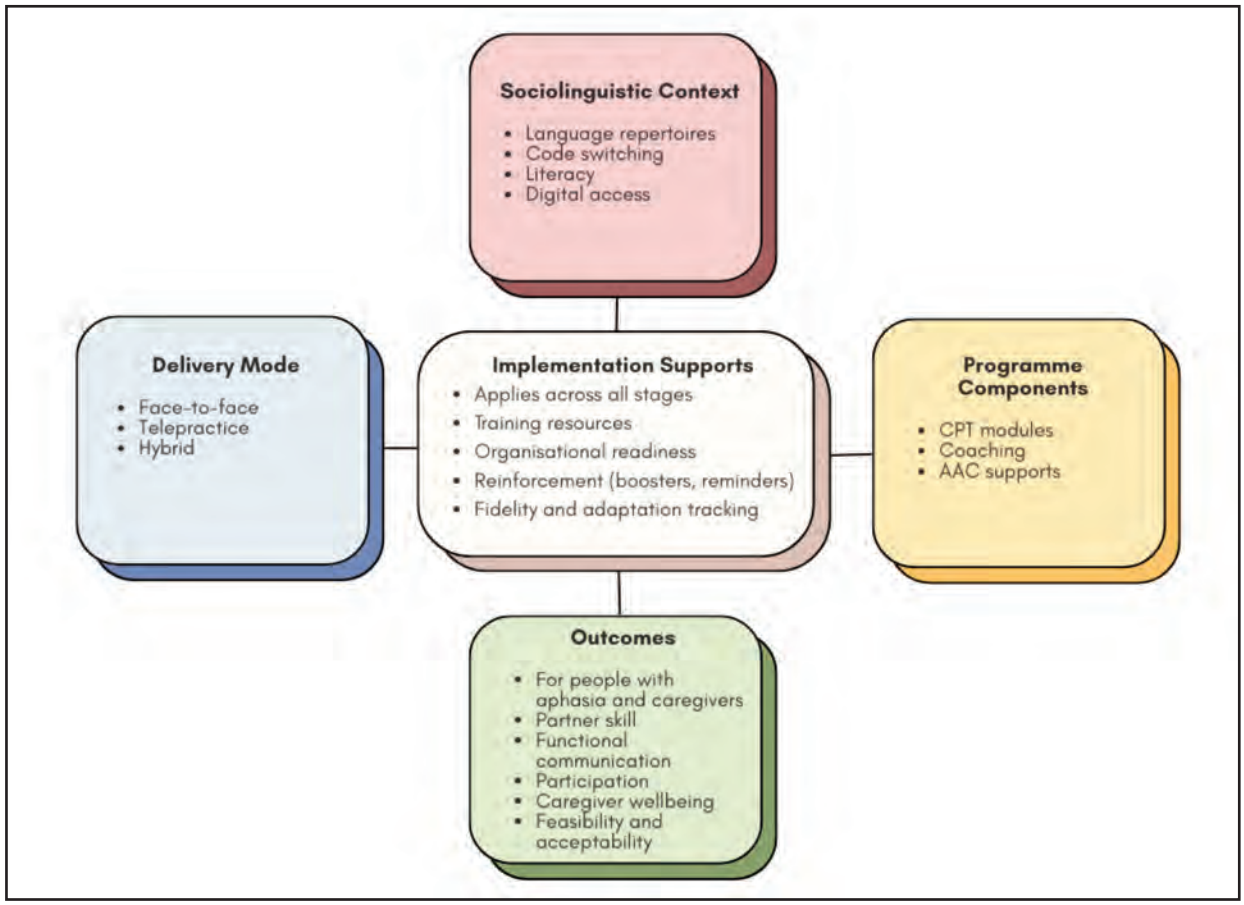

Fig. 1: Conceptual model linking multilingual context, caregiver CPT components, delivery modality, implementation support, and outcome evaluation in aphasia rehabilitation

models. Local studies indicate that Malaysian speech-language therapy services have used conventional, virtual, and hybrid service delivery models, especially during and after the COVID-19 period.[17-18] Local evidence also highlights service access, caregiver involvement, telepractice readiness, and AAC use in aphasia care.[17-19] Hybrid delivery may therefore be appropriate for some Malaysian settings.

DISCUSSION

Principal findings and interpretation

This structured narrative review integrated evidence from caregiver communication partner training (CPT), implementation literature, telepractice and hybrid delivery, multilingual aphasia rehabilitation, and Malaysian service delivery contexts. The strongest and most direct evidence supports CPT as a participation-oriented intervention that improves trained partner communication behaviours and dyadic communication outcomes in aphasia.[3-4]

However, the evidence was uneven across domains. Caregiver wellbeing and broader participation outcomes were clinically important but less consistently measured. Implementation evidence highlighted practical barriers and facilitators related to clinician time, caregiver availability, service organisation, training materials, coaching, and organisational support.[5] Telepractice evidence supported remote and hybrid delivery as feasible service options in selected contexts, but this evidence was not always specific to caregiver CPT.[9-10,13] Similarly, multilingual aphasia evidence provided important guidance on language planning and cross-language considerations, but direct evidence on caregiver CPT specifically designed for multilingual households remained limited.[15-16] Therefore, the recommendations proposed in this review should be interpreted as evidence-informed and context-informed, rather than as a fully validated Malaysian CPT programme.

Clinical implications for caregiver CPT

The findings support the clinical value of training familiar communication partners to use supportive strategies during everyday interactions with people with aphasia. For clinicians, this shifts the focus from therapy tasks alone to the communicative ecology of the person with aphasia, including caregiver behaviours, family routines, conversation demands, and the home environment. Core CPT strategies, such as simplifying language, verifying understanding, using written keywords, allowing additional response time, using gesture, and repairing breakdowns respectfully, are practical and relevant to daily family communication.[3-4]

A key clinical implication is that caregiver CPT should be structured around meaningful routines rather than generic education alone. Training is likely to be more useful when caregivers can practise strategies during high-frequency activities such as meals, medication routines, appointments, family conversations, religious or community activities, and mobile phone communication. This approach may also support caregiver engagement because it allows families to observe immediate and meaningful changes in everyday communication.

In multilingual contexts, clinicians should avoid assuming that one language is always the most appropriate language for communication. Instead, caregiver CPT should include discussion of language history, current language strengths, caregiver language proficiency, preferred household language use, and the communication demands of specific routines. Strategies may need to be practised in the dominant language, in more than one language, or through flexible mixed-language communication, depending on the needs of the person with aphasia and the caregiver.

Proposed modular framework for multilingual caregiver CPT

The proposed modules in Table V should be interpreted as an evidence-informed and context-informed framework rather than as a programme that has already been empirically tested in Malaysia. Core CPT components, such as supported conversation, breakdown repair, partner coaching, and practice within everyday routines, are supported by CPT evidence.[3-4] Recommendations relating to tele-coaching and hybrid delivery are informed by telepractice and implementation literature.[5,9-10,13] Multilingual adaptations, including flexible language choice, code-switching, culturally familiar scenarios, and multilingual low-tech supports, are informed by multilingual aphasia evidence and contextual interpretation for Malaysian households.[15-16] This distinction is important because direct evidence on caregiver CPT specifically designed for multilingual Malaysian families remains limited.

The relationship between the evidence domains and the proposed implementation pathway is illustrated in Figure 1. The model positions multilingual and sociolinguistic context as the starting point for caregiver CPT planning, followed by programme components, delivery modality, implementation support, and outcome evaluation. This structure reflects the main findings of the review: CPT strategies require adaptation to family language use and daily routines, delivery may occur through face-to-face, telepractice, or hybrid formats, and successful implementation depends on practical supports such as caregiver coaching, reusable materials, language-appropriate resources, and follow-up. Figure 1 therefore provides a visual summary of how the thematic findings can be translated into a multilingual caregiver CPT framework for Malaysian rehabilitation practice.

Implementation and service delivery, from efficacy to routine care

Implementation evidence indicates that the main challenges to CPT scale-up are practical rather than conceptual. Barriers include limited clinician time, high caseloads, lack of standardised materials, caregiver availability, travel burden, and service models that prioritise impairment-based therapy over participation-focused intervention.[5] These barriers are especially relevant in settings where speech-language therapy resources are limited and where caregivers may have work, transport, financial, or family responsibilities that reduce attendance.

The implementation determinants summarised in Table IV provide practical guidance for making CPT more deliverable in routine services. A feasible model may include short,

structured sessions, reusable caregiver handouts, video examples, home practice tasks, fidelity checklists, and planned booster sessions. These components may help clinicians integrate CPT into routine rehabilitation without requiring a separate service model.

For multilingual Malaysian practice, implementation should also include documentation of adaptations. Clinicians should record the language or languages used in training, the caregiver's preferred language, the person with aphasia's functional language profile, use of code-switching, literacy considerations, and any culturally specific materials used. Without such documentation, it will be difficult to evaluate which adaptations are useful, which components are essential, and how outcomes should be interpreted across different families.

Telepractice and hybrid delivery, advantages and constraints
Telepractice offers several potential advantages for caregiver CPT, including reduced travel burden, increased caregiver involvement, flexible scheduling, and the opportunity to coach caregivers within the home communication environment.[9,10,13] These advantages are particularly relevant for families who live far from specialist services or who have difficulty attending repeated face-to-face appointments.

However, telepractice should be viewed as one delivery modality rather than the central organising feature of CPT. Its suitability depends on access to devices, internet connectivity, caregiver digital confidence, privacy, family readiness, and clinician skill in remote coaching. If these conditions are not met, telepractice may increase rather than reduce inequity. For this reason, hybrid delivery may be more appropriate for many Malaysian settings. Initial face-to-face sessions can support assessment, rapport building, communication profiling, and early strategy coaching, while telepractice can be used for follow-up, troubleshooting, booster sessions, and reinforcement of home practice.

Malaysia-specific considerations and service relevance
Malaysia provides a highly relevant context for multilingual caregiver CPT because everyday communication often occurs across Malay, English, Mandarin, Tamil, regional Malay dialects, and other community languages. Families may also use code-switching or different languages with different members of the household. This sociolinguistic reality means that caregiver CPT cannot be based only on a monolingual model of communication.

Malaysia-specific service evidence also highlights the importance of flexible delivery. Local studies indicate that Malaysian speech-language therapy services have used conventional, virtual, and hybrid models, with service satisfaction and feasibility influenced by access, support, infrastructure, and family needs.[17-18] Evidence related to augmentative and alternative communication in Malaysian aphasia care also supports the need for culturally and linguistically relevant materials.[19] These findings suggest that caregiver CPT in Malaysia should be family-centred, multilingual, flexible, and responsive to service constraints.

LIMITATIONS

There were several limitations that should be acknowledged. First, this was a structured narrative review rather than a systematic review. Therefore, database-level retrieval counts, formal risk-of-bias assessment, and meta-analysis were not undertaken. Second, the evidence base was uneven. CPT effectiveness is supported by systematic review evidence, while caregiver wellbeing, broader participation outcomes, and multilingual caregiver CPT are less consistently studied. Third, direct evidence on caregiver CPT in multilingual Malaysian households remains limited. As a result, some recommendations in this review are based on related evidence and contextual interpretation rather than direct empirical testing.

Implications for future research
Future research should prioritise the co-design, piloting, and evaluation of caregiver CPT programmes for multilingual Malaysian families. Studies should examine feasibility, acceptability, caregiver confidence, dyadic communication outcomes, communication participation, and caregiver wellbeing. Research should also document language use, code-switching patterns, language dominance, caregiver language proficiency, and the language or languages used during intervention. This would allow future studies to determine whether multilingual adaptations improve clinical relevance, caregiver engagement, and communication outcomes.

Further work is also needed to evaluate hybrid CPT delivery models in Malaysia. Such studies should examine which components are best delivered face-to-face, which can be delivered remotely, and what support caregivers need to participate effectively. A minimum outcome set for multilingual caregiver CPT may also help standardise future evaluation and improve comparison across studies.

CONCLUSION

This structured narrative review supports caregiver communication partner training as a clinically relevant, participation-oriented approach for aphasia rehabilitation. The strongest evidence relates to improvements in trained partner communication behaviours and dyadic communication outcomes. Evidence for caregiver wellbeing, broader participation outcomes, and multilingual caregiver CPT remains less consistently developed, highlighting the need for more targeted research in these areas. For multilingual Malaysia, the findings suggest that caregiver CPT should be adapted carefully to family language use, caregiver readiness, cultural context, service resources, and delivery feasibility. Telepractice and hybrid delivery may improve access and support home-based coaching, but they should be implemented with attention to digital access, privacy, caregiver confidence, and language suitability. The proposed modular framework provides an evidence-informed and context-informed foundation for the co-design, piloting, and evaluation of multilingual caregiver CPT in Malaysian rehabilitation services.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest related to this research.

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