Neurogenic Communication Disorders: A Functional Approach

Edited by

Linda E. Worrall, Ph.D.
Department of Speech Pathology and Audiology
The University of Queensland
Australia

and

Carol M. Frattali, Ph.D.
Research Coordinator
Speech-Language Pathology Section
W.G. Magnuson Clinical Center
National Institutes of Health
Bethesda, Maryland

2000
Thieme
New York • Stuttgart
A social approach is one that promotes an individual's participation in a social world and contrasts to the more traditional medical model of aphasia rehabilitation. Nine principles that guide a social approach to intervention in aphasia are described, and interventions such as conversation therapy, partner training, and developing "prosthetic communities" are detailed. Broader aspects to intervention such as institutional and societal changes are also explored.

The past decade has witnessed significant progress toward socially motivated intervention models for aphasia (e.g., Armstrong, 1993; Parr, 1996; Simmons, 1993; Simmons-Mackie, 1993, 1994). A social model of aphasia management is designed to reduce the social consequences of aphasia and promote social communication within natural contexts. Furthermore, a social model is designed to promote the individual's participation in a social world and reduce barriers to participation. Based on this definition of a social model, it is clear that the concept conforms to the broad definition of a functional approach to management—targeting "real life" communication. Thus, the social model addresses outcomes at the "participation" level of the World Health Organization (WHO, 1997) classification of Impairments, Activities, and Participation (formerly impairment, disability and handicap; WHO, 1980).

Social approaches have arisen in part to address the need for improved functional outcomes in aphasia therapy. Although traditional aphasia research has defined treatment efficacy as intervention resulting in desired modification of a target behavior, "effective treatments" can be irrelevant when the changes fail to
make a difference in the life of the individual. Improved ability to communicate does not necessarily guarantee improved participation in communication events (e.g., Parr et al., 1997; Simmons, 1993). As Penn (1998) notes “... improvement on standard measures often have little clinical relevance in the broader context of the patient and his or her life.” Therefore, pressures for evidence that aphasia therapy makes a difference in the lives of people with aphasia have arisen from funding sources and from our own ranks. The expected outcome of a social approach is to make a difference in the individual’s quality of life, to make living with aphasia more satisfying, and to decrease social isolation.

Another motivation for social intervention relates to the significant pressures from shrinking health-care funding. With cutbacks in the amount of time and money available for treatment of aphasia (Gonzales-Rothi, 1996), alternative service delivery systems must be explored. The social model of treatment provides a philosophical context and clinical rationale for nontraditional intervention approaches and alternative service delivery.

Perhaps the most compelling pressure for attention to a social model of intervention has arisen from the voices of people with aphasia and their families (LeDorze & Brassard, 1995; Parr et al., 1997). The reality of unmet needs among our consumers is difficult to ignore. Interviews with people with aphasia describe discrimination, social isolation, exclusion from work, education and leisure pursuits, and limited community support and benefits (Parr, 1996; Parr et al., 1997). While these pressures to examine traditional intervention methods have been uncomfortable, they have provided an opportunity to explore new models and practices, and strengthen the movement toward more functional, socially motivated management in aphasia.

Shifting from the Medical to the Social Model

A social model of intervention requires a philosophical shift away from the traditional medical model. Traditional aphasia management follows a structured sequence similar to medical care including assessment, diagnosis, treatment, and discharge. Terminology is borrowed from medicine. For example, people receiving aphasia therapy are often called “patients.” Aphasia is viewed from the perspective of an illness, and intervention is geared toward recovery from illness. This focus on “recovery” suggests that people with aphasia will recover. Unfortunately, full recovery is rarely the outcome. Usually discharge from treatment occurs in spite of residual impairments and limitation in activities and participation (Hesch, 1998).

The social model moves away from a focus on illness and toward a focus on health. The social model views aphasia from the “long-term” perspective. There is sensitivity to the chronicity of aphasia—that is, living with aphasia. Within a social model there is no specific “termination” point in the road toward autonomy. Thus, services are likely to be a continuum along which various forms of intervention are available with the ultimate outcome of social membership dictating the services. The service delivery system and individuals with aphasia evolve. While it might be appropriate for assessment and treatment to be directed
at specific impairments and performance of daily activities, a social model requires that goals must enhance the individual’s participation in their social community to the extent that the individual desires.

Principles of a Social Model

A social approach to aphasia management is based on a set of principles that extend beyond traditional impairment-based models. The following principles might be considered relevant to a social approach (Simmons-Mackie, 1993, 1994, 1998a,b). Social approaches should:

1. assume that communication is designed to meet dual goals of social interaction and transaction of messages;
2. view communication as a flexible, dynamic, multidimensional activity;
3. emphasize authentic, relevant, natural contexts;
4. consider conversation as a primary site of human communication;
5. focus on communication as a collaborative achievement;
6. focus on the social and personal consequences of aphasia;
7. focus on adaptations rather than impairments;
8. emphasize the perspectives of the person with aphasia; and
9. embrace qualitative as well as quantitative measures of outcome.

The following sections will address each of these driving principles of a social approach to intervention.

COMMUNICATION SERVES DUAL GOALS

Traditionally aphasiology has advanced an “information exchange” definition of communication. That is, communication has been defined as the ability to receive or convey messages in any way possible (Davis, 1993; Hough & Pierce, 1994). While information exchange is a highly significant goal of communication, most communication is designed not only to transact an exchange of messages, but also to fulfill social needs (Brown & Yule 1983; Goffman, 1967; Gumperz, 1982; Tannen, 1984, 1986). Human communication is an intensely social activity. Through communication we affiliate with other people, assert our individuality, demonstrate our competence, form and maintain relationships and gain membership in social circles. Thus, communication serves dual goals—transaction (the exchange of information) and interaction (the fulfillment of social needs) (Simmons, 1993; Simmons-Mackie & Damico, 1995). When communication fails, one’s ability to exchange messages is reduced, but perhaps more importantly, one’s participation as a member of a social group is often compromised. A social model is designed to address these dual goals of transaction and interaction.

COMMUNICATION IS FLEXIBLE AND DYNAMIC

Traditional, impairment-based approaches to aphasia tend to view the aphasic speaker in relation to an “idealized normal” speaker. In other words, clinicians compare the language of each client to the expected performance of nonaphasic...
speakers. This assumes a sort of invariance or static quality to communication that fails to account for the remarkable variation typical of natural communication. For example, informal social conversation is replete with hesitations, dysfluencies, word production errors, sentence fragments, and incomplete propositions (Button & Lee, 1987; Shiffrin, 1987). The following excerpt is a standard speaker conversing with a colleague.

Oh yea . . . mhm . . . but like I say for some people . . . for me even . . . for some . . . might not be willing to you know to do to do that cause it requires to be willing, to take time and you know sort of like a a a a game out of it or sometha . . . something.

This excerpt would be considered “deviant” when measured according to traditional standards. Yet these “deviations” are typical of “normal” speakers during informal interactions. Do we hold our clients up to higher standards than we ourselves meet in conversation?

Because impairment-based approaches focus on “normal” language, accuracy and efficiency of communication is measured relative to an expected level. Unfortunately this does not account for the flexible and creative use of language to perform various social functions. For example, Goodwin (1987) examines the use of “forgetfulness” (such as forgetting a name) as a strategy used by nonaphasic couples to engage their partners in interaction. Thus, a husband telling a story about a family vacation to a group of friends might “forget” the name of a city and look to his wife to enter the conversation to provide the name; the husband’s strategy elevates his wife from a listener to a participant in telling the story. The involvement of his wife promotes affiliation, demonstrates respect and solidarity, and paves the way for social participation. “Forgetfulness” is viewed as a resource to promote social participation rather than a response deviation.

A social model takes into account the flexibility of communication and requires that communication be viewed from the perspective of achievement of social and communicative goals. It accepts that norms are relative to the situation and the goals of the moment. This requires a philosophical shift away from a traditional normative view of communication to a flexible and context-driven view of communication. This certainly does not mean that the aphasiologist should abandon measures of impairment or forsake consideration of appropriate versus inappropriate behavior. Rather, a social model begs for expansion of assessment to include consideration of individual social actions, communicative goals, vagaries of informal talk, and flexible functions of behavior.

**EMPHASIS ON AUTHENTIC, RELEVANT, NATURAL CONTEXTS**

Much traditional aphasia therapy is conducted in relatively controlled contexts in which the clinician presents stimuli (such as pictures) and elicits responses from the person with aphasia. While this controlled context allows the clinician to manipulate variables believed to influence language, it replaces the rich social context typical of natural, interactive communication. In fact, research has suggested that there are specific therapy discourse structures that differ markedly from natural, social conversation (Simmons-Mackie & Damico, 1997b, 1999). Clearly, traditional therapy, including activities such as picture description or “set up” con-
conversation, does not simulate the demands of natural communication outside of therapy. In fact, some clients demonstrate different communicative strategies outside of therapy when confronted with social demands (Simmons, 1993). The communication differences between therapy contexts and other social contexts must be studied lest we assume that improvements in the traditional context represent the entire constellation of behaviors that constitute social interaction. Furthermore, improvement should be judged relative to the positive changes made in natural, relevant contexts.

A FOCUS ON CONVERSATION

While there has been a growing emphasis on functional communication treatment, natural conversation seems to have been largely ignored in aphasia therapy. In fact, research has suggested that therapists often view conversation as taking a break from the real work of treatment (Armstrong, 1989). Assessment tools rarely sample authentic, natural conversation and few traditional approaches directly target natural conversation. The apparent neglect of conversation in both assessment and treatment is surprising considering the functional relevance of this pervasive communicative event. Each of us would probably freely admit that most of our daily communication is "conversation"—authentic, spontaneous communication associated with social interaction. Our "activities of daily living" are enriched by social conversation. For example, ordering in a restaurant is an important "functional" task, but the enjoyment of dining out is probably more closely related to chit chatting with our dinner partners. In fact, the literature sites conversation as the fundamental site of language use in Western cultures (Clark & Wilkes-Gibbs, 1986). All other forms of communication such as lectures, writing, or interviews are secondary. As Holland (1998) so picturesquely asks "What relegates conversation to some sort of sleazy, shady, unreimbursable Netherlands that must precede or follow the real goods—the therapy?"

Perhaps one answer traces back to traditional impairment-based therapy that focuses on restoring language by working on components such as naming or formulating simple sentences. Impairment-based therapies have typically assumed that improving the individual elements of language results in overall improvement in communication. Improvement is typically measured on standard tests that measure the "components." When spontaneous communication is measured, traditional approaches generally pick out linguistic components such as the number of content words or grammatical completeness. These approaches measure the traditional linguistic aspects of communication, but fail to look at the social devices and strategies that help us craft social interaction. Thus, tradition has focused aphasiologists away from considering communication in its most natural and whole form—social conversation.

FOCUS ON COMMUNICATION AS A COLLABORATIVE ACHIEVEMENT

Research has repeatedly demonstrated that natural conversation is a co-constructed activity in which participants endeavor to make each other understand with as little effort as possible (e.g., Clark & Wilkes-Gibbs, 1986; Goodwin, 1996;
Scx:IAL ApPROACHES TO THE MANAGEMENT OF APHASIA

In addition to sensitive negotiation of meanings, this collaboration involves intricate social negotiations to affiliate or maintain distance, preserve identity, and maintain face (Goffman, 1967; Gumperz, 1982; Tannen, 1984, 1986). Speakers continually modify their speaking style, content, opinions, and discourse structure to accommodate to speaking partners, to context and to communicative goals (Bell, 1984; Giles et al., 1973). Viewing communication as a collaborative achievement forces us to look beyond the individual with aphasia. The focus of the problem is shifted from the individual to the interaction. Responsibility for a successful exchange is placed on speaking partners as well as on the individual with aphasia. This contrasts with impairment-based therapies that focus on the individual with aphasia. The social model shifts the focus to the collaborative nature of communication and away from the concept of achieving independence. Rather there is an emphasis on mutual dependence or interdependence within the social structure of communication (French, 1993; Holland, 1998; Oelshlager & Damico, 1998; Parr & Byng, 1998; Pound, 1998).

FOCUS ON THE SOCIAL CONSEQUENCES OF APHASIA

Asocial model of intervention is concerned with the consequences of aphasia. Individuals will vary greatly in how they experience aphasic impairments and disabilities. Thus, one individual with Broca’s aphasia might find the impairment creates significant vocational, emotional and social problems, while another individual with an identical impairment might experience minimal impact in life. To insure that intervention is efficient and socially valid, the consequences for each individual and their loved ones must be evaluated. This requires sensitivity not only to individual social consequences of aphasia, but also to the social consequences of our therapy.

Much aphasia therapy has focused on improving the individual’s ability to get ideas across in any way possible. Thus, people with aphasia have been trained to use gestures, written cues, picture boards, and drawing to compensate for linguistic deficits. The assumption has been that improved ability to get ideas across will be rewarding to the person with aphasia. Unfortunately, such practices have to some degree failed to take into account social expectations and cultural norms. For example, Simmons (1993) discovered that clients failed to use learned compensatory strategies during situations when the behaviors would be considered “stigmatizing.” Most people with aphasia want to look and act like everybody else—to fit into their social community. While some trained behaviors might be stigmatizing, other successful communication behaviors are too time-consuming to be socially effective. For example, in studies of literacy practices of people with aphasia, Parr (1996) noted that some preferred to delegate literacy activity rather than struggle to do it themselves. The social and personal consequences outweighed the benefits of independence. In addition, the consequences of aphasia on the family and friends of the person with aphasia must be accounted for; consequences such as excess energy consumption or social stigma can impact speaking partners. Again, successful outcomes must be measured relative to reducing personal consequences of aphasia. Thus, intervention is designed to promote communication and quality of life.
In addition to viewing consequences relative to the person with aphasia, it is important to view consequences of aphasia from the perspective of social barriers. Barriers to participation for individuals with disabilities are often created by society (Finkelstein, 1991; LeDorze, 1997; Parr, 1996; Pound, 1998). These barriers represent ignorance of the disorder, lack of appropriate community resources, and lack of skill in facilitating communication. Thus, the "handicap" is a societal problem more than an individual problem. Again, a social approach requires that the focus be shifted away from the individual to the community.

A FOCUS ON ADAPTIVE BEHAVIORS

When communication is disrupted, the communicative skills of the individual often are adapted to compensate. Newhoff and Apel (1990) suggest that some identified "deficits" (such as pragmatic deficits) in aphasia might be compensatory mechanisms or adaptations for dealing with reduced linguistic abilities. For example, a client with severe aphasia was judged by her clinician to be "pragmatically impaired" because she failed to "look at" or exchange greetings with acquaintances in public (a marked change from premorbid behavior). Interviews and observations revealed that the client used these "pragmatic compensations" to avoid being placed in a position where she might have to talk—and fail—resulting in embarrassment to the acquaintance and herself (Simmons, 1993). Thus, the "deficit" was actually a social adaptation to the impairment. Certainly if the person with aphasia is expected to communicate in spite of an impaired language system, then communicative behaviors that are atypical must be expected. A social perspective that focuses on an individual's adaptation to impairments, must shift to a more open minded perspective in which each behavior is viewed in relation to the pragmatic purpose, served and the available alternatives.

The tendency to judge behaviors as either appropriate/normal or inappropriate/abnormal is evident in the cataloging of linguistic impairments. For example, "processing delays" such as hesitations on word retrieval have been discussed as sensitive indicators of aphasic deficits (e.g., Porch, 1981). Thus, a client who says "uh uh uh pen" to identify an object can be viewed as having a word retrieval delay—a problem. This identification of a processing deficit helps to focus restorative therapy. However, a social approach emphasizes attention to adaptations. In the example of word retrieval delay a social approach might focus on the "uh uh uh" as a floor-holding strategy. The floor-holding adaptation is a resource that helps the client stay in the speaker role by alerting the listener that a word search is underway. Because aphasia tend to be a chronic disorder in which most clients retain some degree of impairment, it is important to maintain sensitivity to what is "right" as well as what is "wrong" (Armstrong, 1993; Weniger & Sarno, 1990).

In addition, because many compensations or adaptations tend to be idiosyncratic, each individual is likely to demonstrate unique or individualized patterns of compensation (Simmons-Mackie & Damico, 1997a). Therefore, behavior might be viewed for its purposeful potential rather than relative to a norm or expectation. For example, the aphasic speaker with severely limited ability to elaborate on topics might use "inappropriate topic shifting" as a method of participating in the conversation, exerting conversational control and preserving face. Should
this behavior be judged as inappropriate or as a successful social adaptation? A social model requires that behaviors be viewed from an "adaptive" perspective.

Addressing adaptations is nothing new in aphasia management. Compensatory strategies have been touted for years. However, many approaches tend to emphasize what's wrong so that compensations can be devised to overcome the problem. Trained compensatory strategies tend to focus on "clinician" chosen behaviors that assist in getting ideas across (Simmons, 1993). While these methods certainly have value, research and experience suggest that many trained compensations are not used (e.g., Thompson, 1989). Perhaps we need to revise our conceptions of compensatory training to focus on enhancing what is already going on naturally (Armstrong, 1993; Ferguson, 1994; Weniger & Sarno, 1990; Simmons, 1993; Simmons-Mackie & Damico, 1997a). A social approach builds on existing adaptations and social skills. Furthermore, focusing on ability instead of disability can enhance self-concept as well as function.

Finally and perhaps most importantly, adaptation is not unique to the individual with aphasia. In the process of communicating with people with aphasia, speaking partners adapt to the communicative differences. The adaptive skills of all parties involved in an interaction will determine the success and satisfaction of the exchange. Therefore, clinicians must consider creating a "compensatory" environment that supports communication rather than simply focusing on changing the individual with aphasia.

THE PERSPECTIVE OF THE PERSON WITH APHASIA

As many have pointed out, aphasia management must reflect the customer's perspective of the disability and focus on consumer satisfaction (Frattali, 1992; Parr, 1996; Worrall, 1992). This concept of autonomy and personal choice is a basic tenet of a social model (French, 1993; Parr & Byng, 1998). For example, an individual who is trained to use an augmentative communication device might opt not to use the device when there is potential for social stigma even though it might enhance independence. Clinicians tend to identify "lack of generalization" as therapy failure. When clients choose to avoid communication rather than face embarrassment, this is a personal choice consistent with social needs and social sensitivity. Considering these choices to be "failures" to communicate demonstrates a bias toward the clinician perspective; it allows the clinician to define "success." This does not mean that the social approach takes a hands-off attitude and lets "people be." Rather, it starts with a respectful consideration of the individual and family's social and communicative perspective, then works to build communication and quality of life within that perspective. Instead of dispensing with the idea of training an augmentative system, the therapist would identify the social barriers that inhibit its use outside of therapy and address these barriers.

A FOCUS ON QUALITATIVE AS WELL AS QUANTITATIVE MEASURES

A social model focuses on the experience of a communication disorder rather than the measurement of linguistic performance. The perspective of a social model is decidedly subjective. It requires shifting from a clinician-driven emphasis on
objective measurement to a client-centered focus on subjective experience. Behaviors are viewed relative to the individual’s own abilities and purposes rather than in relation to an objective norm. Because the emphasis is upon quality of life and social membership, measurement does not fit well into traditional quantitative paradigms. Quality of life measures, qualitative approaches, and satisfaction assessment are potential tools for monitoring social intervention.

Implementation of a Social Approach

Hopefully the preceding discussion provided a philosophical context within which the clinician can construct interventions to minimize participation limitations of people with aphasia. Because a social approach is a philosophical construct and a clinical undertaking, the following section will provide suggestions for implementation. Specific objectives of a social approach might include:

1. increasing conversational skill;
2. increasing communicative supports;
3. increasing opportunities for participation in relevant activities;
4. maximizing a healthy identity and promoting empowerment; and
5. promoting advocacy and social action.

Intervention need not be restricted to the “handicap” or participation level to fulfill social goals. Rather, goals are cast in relationship to what is required to enhance participation and membership in the community. Direct intervention might involve focusing at any of the WHO levels including the impairment level, functional activity level (disability) or participation level (see Chapter 1). However, the goal is for the individual to participate as a functioning member of society. The implementation of a social approach will vary considerably depending on the personal goals of the client and family, time post onset, the characteristics of the aphasia and the service provider. It is important that attention to the social outcome not be relegated to the “end” of rehabilitation or when traditional therapy is completed.

CONVERSATION AS THE FOCUS OF INTERVENTION

One objective of a social approach is for those affected by aphasia to experience improved social communication. In some cases, this will entail work at the level of conversation. Although aphasia clinicians seem comfortable with defining goals, choosing appropriate stimuli and manipulating language behavior within the context of impairment-based therapy, many seem confused by conversational management. Perhaps the confusion arises because “conversation” can be the goal, the stimulus, and/or the approach. It has not been clear if conversation therapy refers to therapy that improves conversation or therapy that involves conversation. In this chapter, the term conversation therapy will be reserved for “working on conversation”; in other words, conversation therapy is direct, planned therapy that is overtly designed to enhance conversational skill and confidence. Conversation therapy does not necessarily require “having a conversation” with the client, although conversational stimuli are probably most appropriate.
Direct conversation therapy can be contrasted with simply “having a conversation” with a client. The goal of working on conversation (conversation therapy) is to improve one’s skill and confidence as a conversational participant. The goals of having a conversation are to exchange messages and fulfill social needs. Clients might need both of these. In other words, they profit from working to enhance their conversational skills through conversation therapy, and they also need opportunities to participate in satisfying social conversations. While these goals are distinctly different, socially responsible intervention requires that aphasiologists address both of these needs by improving the individual’s conversation skill and by reducing barriers to participation in actual conversations. Therefore, the clinician might work on providing conversation opportunities for people with aphasia. Successful conversation participation is facilitated when opportunities include appropriate communicative supports. Supported conversation involves promoting successful participation by providing supports such as trained partners. On occasion these conversation approaches will overlap such as using supported conversation to carry-over conversation therapy goals, to practice specific communicative devices or to build interactive confidence.

To work at the level of conversation, conversation must be defined. Based on research findings and intuitions as language users, it is clear that the structure of most traditional, impairment-based therapy is not typical of satisfying adult, social conversation. The phrase “adult, social conversation” is used somewhat loosely to refer to authentic, spontaneous communication associated with social interaction—the everyday, ordinary talk that serves dual goals of exchanging messages and fulfilling social needs. Typically this implies that all parties engaged in social conversation have the potential to offer topics, introduce content, take turns and structure the participation framework. This conversational parity does **not** mean that each person has to share the same amount of information, take the same turn lengths or get an equal number of turns. Rather it means that participants have the power and opportunity to craft a conversational format that they desire. There is collaboration in how the conversation is negotiated. Defining conversation in this way is not meant to imply invariance in the structure of social conversation. Rather, the phrase “social conversation” is being used to contrast with other forms of discourse such as interviews, teaching, and lectures. Although one might argue the huge range of styles, power balances, and structures of social conversation, the primary goal in this chapter is to provide a frame of reference for evaluating interventions.

Comparison of therapy discourse with natural conversation suggests that the structure of most traditional therapy tasks and much therapy “conversation” does not provide clients with experience in generating and structuring natural social discourse. For example, research indicates that a pervasive discourse structure in therapy is the Request–Response–Evaluation (RRE) triad (Simmons-Mackie & Damico, 1997b; Simmons-Mackie & Damico, 1999). This adjacency structure begins with a therapist request to perform (e.g., “What is the name of this?”), followed by a client response (e.g., “cup”), followed by a therapist evaluation (e.g., “good”). This structure is typical of therapy and teaching discourse, but is not typical of adult social conversation. Also, “conversation” that precedes and follows didactic therapy tasks is often structured like “interviews” with thera-
pists asking questions and clients responding to questions (Silvast, 1991; Simmons-Mackie & Damico, 1997b; Wilcox & Davis, 1977). Thus, the structure of traditional impairment-based therapy tend to place clients in a passive role and limit their power as conversation partners. There is little opportunity to practice strategies for controlling discourse, initiating varied structures, using creative devices and varying social stances. In contrast, a social approach to aphasia intervention should provide the client with the skills and confidence to negotiate social conversations.

Study of discourse structure and characteristics of social conversation will assist clinicians in tailoring therapy to more closely approximate natural conversation. For example, for those interested in moving away from the rigid structure of traditional therapy, identifying RRE sequences can signal therapist-centered discourse structure versus more natural interaction. The following examples contrast a traditional RRE-structured naming task to a task more characteristic of conversational interaction.

Ten pictures of common food objects are arranged in front of the client.

#1 Request–Response–Elaboration:
Clinician: *What is this?* (points to a picture of sandwich)
Client: *Sandwich*
Clinician: *Good*

#2 Question–Answer–Comment:
Clinician: *Which of these do you like to eat for lunch?*
Client: *Sandwich* (pointing to picture)
Clinician: *Oh, I like sandwiches too.*

The first example is a structured RRE sequence that is closed by clinician reinforcement of the correct response. The RRE structure places the client in a passive discourse role—simply filling the “response” slot within the dependency structure. The second example includes a clinician request for information and the final clinician turn constitutes a comment rather than a direct evaluation. While the clinician is clearly still in control of the discourse format, the interactive features are slightly more natural. When appropriate to the goals, such simple variations in discourse structure allow clients to engage in more varied discourse experiences within intervention. Thus, similar to the fading of prompts and cues in traditional stimulation therapy (e.g., Davis, 1993), the informed clinician can gradually fade control of discourse and participation structures. Awareness of the structure of discourse within and outside of our sessions can help us move clients toward more discourse variety and control.

CONVERSATION THERAPY

Certainly, the overall goal of conversation therapy is to enhance conversational skill; however, each individual should have goals based on specific skills and strategies needed to manage social conversation. Intervention to increase the client’s skill and confidence as a conversationalist emphasizes transactional and
interactional skills and strategies. These goals are specific to the individual's residual abilities and to the desired outcome. The literature has widely addressed the first of these goals: message transmission (e.g., Davis, 1993; Davis & Wilcox, 1985). Treatment approaches such as Promoting Aphasic's Communicative Effectiveness (Davis & Wilcox, 1985) provide a semistructured approach to encouraging clients to get ideas across and utilize compensatory strategies. Far less emphasis has been placed on enhancing "interactive" skills. Although clients with aphasia are usually considered to be fairly intact interactively, they acquire aphasia with little prior practice in dealing with significant communicative breakdowns. A social approach assists the client in achieving the most effective social strategies. This might include evaluating the effects of message exchange strategies (such as gesture, writing) within real social interaction. It also involves enhancing interactive strategies. For example, one person with aphasia might work on strategies for initiating topics and holding on to turns, while another individual might work on strategies for shifting turns to the speaking partner. Continuers (such as head nods) or interest markers (such as oh really, mhm, nice) can encourage the speaking partner to do the talking and prevent exhaustive rounds of repairs (Simmons-Mackie & Damico, 1996b). The social communication resources of speaking partners will also markedly affect the quality of the interaction. Communication specialists must understand, reinforce, and expand on discourse devices and promote communication that is socially and contextually appropriate. Also, goals should reflect the outcome choices of the individual with aphasia. While the therapist might deem "conversational assertiveness" to be important relative to a particular client's ability to enter conversations, the client might prefer a more passive, listener role. The perspective of the client is critical in insuring success of a social approach. A social model must assist clients in maximizing communication and participation as defined by the client.

When improved conversation is the target, actual conversational stimuli are appropriate, such as using group discussion as the medium for therapy. In addition, direct training of specific component skills or strategies might be appropriate for enhancing one's skill as a conversationalist. The caveat of course, is that skills learned in didactic tasks might not integrate easily into the context of natural social interaction. Thus, the more conversational the medium of therapy, the more likely that the skills will be applicable. In addition, impairment-based approaches run the risk of placing the client in a disempowering interactive arrangement that could undermine social goals. The following sections will present several contexts for introducing conversational goals.

**Group Therapy**

Group therapy is an excellent context for conversational intervention. However, groups must be structured to promote conversation, to address communication goals, and to enhance conversation strategies. Considerable skill is required to ensure that group interactions are "conversational" and not simply traditional therapy overlaid into a multiparty context. The components of interactive group therapy and the potential benefits are reported elsewhere (e.g., Elman, 1999; Elman & Bernstein-Ellis, 1999).
Scaffolded Communication
The child language literature discusses the use of “scaffolded” communication as a method of increasing communication skills (e.g., Damico, 1992). This approach is simply an extension of therapist cueing and facilitation (common in aphasia therapy) into an interactive, conversational framework. The client is placed in an activity requiring conversation, and the therapist provides cues or mediates within context. Criteria for promoting a scaffolded conversation include the following (Damico, 1992):

1. The interaction is client focused rather than clinician focused. In other words, the clinician does not control the topics or rate of the session. Rather the clinician expands on the client’s contributions.

2. Conversation evolves out of a meaningful activity.

3. Feedback is situationally appropriate. Rather than rewarding successful productions with “good” or “Wait, say it like this,” the therapist responds with natural, conversational contingencies including sustaining the talk, elaborating or asking for clarification when something is not understood.

4. The client and clinician work toward specific goals such as improving the ability to elaborate on topics or increasing conversational participation.

Scaffolding is particularly useful when integrated into group therapy or used in role play activities. If properly done, it provides a bridge between clinician controlled therapy discourse and the give and take of natural interaction.

Conversational Coaching
Another method of working on conversational skills is to use conversational coaching as suggested by Holland (1991). The therapist acts as a “coach” providing the client an opportunity to practice a communication “scenario” with support and guidance. This approach can help individuals deal with specific problem situations. For example, a client who attended frequent cocktail parties with her husband felt dependant upon her husband to help her out of communication breakdowns and was embarrassed by her failure at “party talk.” Conversational coaching focused on strategies for dealing with small talk. Thus, scenarios were developed and scripted to practice specific interactive routines. Rather than concentrating on “improving language,” therapy focused on developing strategies for fitting in and preventing failure such as using practiced topic starters, using turn-shifting strategies, and using context to support talk (e.g., using the buffet table to generate talk). These sessions also revealed situational barriers that inhibited this client’s participation in the talk. For example, holding a wine glass inhibited her use of gesture. Thus, barriers could be identified and reduced wherever possible.

Armstrong (1993) uses an approach similar to conversational coaching in which scripts or texts are used to focus on both the social functions and forms of discourse. Her approach is anchored in Halliday’s (1985) systemic-functional grammar framework that takes into account linguistic and social aspects of communication. Clients work on various forms such as questioning and requesting at the discourse level, as well as narrative skills such as telling stories. Such a focus
is important because people with aphasia have reported problems with aspects of interactive discourse such as telling stories, relating a piece of gossip, lodging complaints, or participating in arguments (e.g., Parr et al., 1997).

Strategies for Engagement
Promoting conversation as a therapy medium can be challenging. As noted above many speech–language pathologists use "interview" style discourse to interact with people with aphasia. The following suggestions might promote social interaction, distribute the "power" to negotiate discourse more equitably, and serve as the stimuli for conversation therapy. Using a story prompt, suggested in the child language literature (McCabe, 1994), is one excellent means of starting conversation. The therapist or group leader tells a story such as an embarrassing or scary incident. This often “prompts” others to share similar stories resulting in a round of stories, comments, and sharing. For maximum effectiveness the story prompt should be introduced in a natural, spontaneous fashion—“Wow, guess what happened to me” versus “let me get everyone started talking.” Topics that promote listings (e.g., “What I did on the weekend,” trip descriptions) are less successful in promoting the give and take of conversation (McCabe, 1994). Other potential conversation stimuli include discussion of television shows, jigsaw barrier tasks, and discussion webs (Damico, 1992), and diaries, photo albums, or remnant books (Bernstein-Ellis & Elman, 1995). These activities serve as “stimuli,” which evoke interaction. It is then the therapist’s job to scaffold, coach, or facilitate achievement of individual conversational goals within this interactive context.

Adjusted Compensatory Training
Training in compensatory strategies dates to the origins of intervention in aphasia (e.g., Goldstein, 1939; Zangwill, 1947). The approach is well founded in theory and practice. A social approach extend the focus on compensation to emphasize socially relevant and flexible use of strategies that enhance information exchange and social interaction. Thus, compensatory strategy training is expanded from training specific behaviors to developing creativity, generativity, and interactivity. For example, the individual does not simply learn a set of gestures, but works on generating and creating gestural communication within the context of conversational interaction. Approaches such as Lyon’s (1995) interactive drawing and Demchuk’s (1996) drama therapy are good examples of techniques that build compensation within an interactive and dynamically social framework. For example, Demchuk describes use of a group setting in which the clinician begins acting out a scenario (such as a teenager asking to use the family car) and engages clients in participating in a dramatic role-play. Creative body language, facial expression, pantomime, intonation, vocalizations, and speech are encouraged. The goal is to build skill and confidence in creatively generating ideas and interacting with others.

Compensatory training should focus on strategies that are flexible, identity enhancing, face saving, and socioculturally appropriate for the individual. Finally, compensatory training should be integrated into authentic contexts and take into account the need for speaking partners to collaborate in constructing compensations.
Increasing Participation: Supported Conversation

Ultimately, skills and strategies must be used in the flexible and dynamic context of real conversation. This provides opportunity for practice and confidence building as well as fulfillment of social needs. A subsequent section will address various outlets for increasing the success of and opportunity for communication including training partners to provide support, to provide resources, and to enhance opportunities to participate in relevant activities.

INCREASING COMMUNICATIVE SUPPORTS: PARTNER TRAINING

Beyond ensuring that conversational behaviors of the person with aphasia are maximized, a social model of aphasia intervention must promote successful communicative collaboration between people with aphasia and their communication partners. Communication is inherently “interdependent” (e.g., Holland, 1998; Oelschlaeger & Damico, 1998; Parr & Byng, 1998; Simmons, 1993). Thus, lack of partner skill and support is a barrier to participation for people with aphasia. Conversely, a partner who is skilled in facilitating interaction can enhance the communicative success of the dyad and increase the opportunity for successful social interaction. In fact, research repeatedly demonstrates that training communication partners of people with aphasia improves communication within the dyad (Alarcon et al., 1997; Boles, 1997; Lyon, 1997; Lyon et al., 1997; Simmons et al., 1987). For example, Simmons et al. (1987) demonstrated that the communication between a person with aphasia and his spouse improved after the spouse was taught strategies to facilitate communication, even though the individual with aphasia did not participate in the training. Lyon (1997) demonstrated increased scores on a functional communication measure after intervention targeting the interaction between a person with aphasia and spouse. Garret and Beukelman (1995) demonstrated that varying the type of partner “support” changed the interactive patterns of an individual with severe aphasia. Kagan (1998) is accumulating data demonstrating that training of volunteers to interact with people with aphasia results in increased communication ratings for both the volunteer and the individual with aphasia. The accumulated evidence indicates that training of communicative partners and focusing on communicative collaboration can be effective in improving communication in aphasia.

Partner training serves several goals. First, it provides a potential source of conversational interaction for the person with aphasia. Second, a trained partner is likely to promote a more satisfying and successful communicative exchange, thereby increasing the likelihood that the parties will continue the relationship. Third, the training often decreases negative perceptions about aphasia. “Lay people” sometimes believe that people with aphasia are incompetent, deaf, or mentally ill (Kagan, in press; Parr et al., 1997). The aphasic speaker’s communicative breakdowns and use of stigmatizing strategies probably reinforce these attitudes (Goffman, 1963). Training has the potential for revealing to the partner that the person with aphasia is a competent human being who enjoys social contact. Fourth, a skilled partner can encourage the use of unusual, but successful compensations by capitalizing on the tendency for speakers to accommodate to each other’s speaking style. When people with aphasia interact with nonaphasic peo-
Training Regular Partners
Because communication is a co-constructed event, enhancing the interaction of people with aphasia and their customary communication partners is an appropriate goal of intervention. Thus, family members and friends of people with aphasia can be identified and brought into training.

Expanding Social Networks
For many people with aphasia former jobs or hobbies are no longer viable activities and the associated social relationships are forfeited. Thus, they experience a significant reduction in the number of people that they communicate with on a daily, weekly, or monthly basis. In some cases the nuclear family can become the "focal point" of the person's social life. Training immediate family members does little to address this social isolation or expand the individual's social participation. Furthermore, expecting the family to fulfill social needs could actually increase the burden on an already stressed nuclear family. Thus, efforts might be directed at expanding the social network of the individual with aphasia (Simmons-Mackie & Damico, 1996a).

Expanding social networks involves identifying people with whom the client can establish an ongoing relationship, then working with the identified partner and person with aphasia to maximize their interpersonal communication. Of course the problem is often availability of partner "candidates." Candidates might include existing friends or acquaintances, individuals connected with existing social networks, volunteers, or peer mentors.

Existing family, friends, or acquaintances with the potential for a more active relationship might be recruited for partner training. For example, a client reported that an old friend had stopped calling. An interview with the "former" friend revealed that he felt uncomfortable with the client since the onset of aphasia. The friend agreed to be part of a "pilot" program aimed at improving the client's communication. In fact, this program focused on teaching the friend strategies for communicating with the client. The friend was amazed with the client's "improvement" and their relationship was renewed.

Individuals who are connected to existing social networks of the person with aphasia are also potential partners. For example, a friend at church who is willing to participate in training might recruit additional church members to expand the individual's trained social network.

Volunteers can serve as partners and social contacts (Jordan & Kaiser, 1996; Kagan & Gailey, 1993; Lyon et al., 1997). Lyon pairs people with aphasia with a vol-

ple, the nonaphasic partner typically uses the auditory-verbal mode of communication and is unlikely to write or use a picture board to get their ideas across. It is natural for the speaker with aphasia to accommodate to the prevailing "expected" auditory-verbal mode rather than introduce a novel form of communicating (Giles et al., 1973). When speaking partners introduce multi-modal communication, this minimizes the responsibility on the person with aphasia and reduces a potential barrier to participation (LeDorze, 1997; LeDorze et al., 1993; Simmons-Mackie, 1998b).
unteer and trains them to be an effective communicative dyad. Each volunteer’s training is tailored to the style and skills of the individual with whom he/she is paired. Kagan and Gailey (1993) describe training of volunteers to interact with people with aphasia; however, this training is generic. That is, volunteers are taught general skills required of a good partner. A day-center context is provided in which the trained volunteers run conversation groups. Both approaches have significant benefit in that they expand the social participation of the individual with aphasia by providing supportive, skilled communication partners.

Finally, people with aphasia might serve as and profit from peer mentors trained as communication partners. Peer mentors are colleagues with aphasia who offer communication opportunities, serve as social partners, assist as advocates, or perform identified services. For example, two men with aphasia, G.R. and J.B., were paired as social partners. G.R. could drive a car, while J.B. could not. J.B.’s linguistic skills were superior to G.R.’s. Therefore, the two helped each other participate in community activities. G.R. provided the transportation, while J.B. ran “interference” when activities required higher level language. Peer support, peer counseling, and peer visitation as potential services for people with aphasia hold promise for expanding social networks (Cohen-Schneider, 1996; Jordan & Kaiser, 1996).

A Trained Community

Although a daunting goal, the ultimate communication support system would include a knowledgeable, “prosthetic” community. While it is unlikely that we could train the world to facilitate interaction with people with aphasia, accepting responsibility for public education is a viable and worthy goal for speech-language pathologists and people with aphasia. Thus, community service programs could target generic partner training such as public service programs on television or free workshops at businesses, churches, or schools. Such programs are costly; however, they have the potential for enhancing client referral for funded services and expanding public support for services.

LOGISTICS OF PARTNER TRAINING

The key to successful partner training is to teach the partner how to converse rather than how to work on conversation. Thus, the partner and the person with aphasia learn to create a “seamless” interaction using all available modes. The partner’s use of augmentative systems such as writing, pictures, drawing, and gesture establishes the appropriateness of alternate modes and reduces the potential of social stigma, failure, and embarrassment for the person with aphasia. Developing a skilled partner requires direct “hands-on” training that includes strategies that facilitate transaction and interaction. Counseling, observing therapy, or providing lists of dos and don’ts are not effective methods of training partners (Simmons et al., 1987). In fact, the common practice of having partners observe traditional didactic therapy can create “teacher” partners who engage in inappropriate communicative interactions such as asking for known information, requesting performance, and evaluating responses. The goal of partner training is to provide someone skilled at “having a conversation” with the person with
aphasia, not to enlist another therapist. The approach to direct training will vary from “workshop” settings that train a number of partners in general strategies to dyad training in which a specific partner and individual with aphasia participate in intervention.

Increasing Communicative Supports: Resources

Providing communicative support systems within a speaker’s community can include not only skilled partners, but also access to communication resources. Resources include anything that will potentially enhance an individual’s communication such as picture resource materials, paper and markers, remnant books, or alteration of physical surroundings (Lubinski, 1981). Materials that facilitate the exchange of information such as picture props, maps, communication boards, and books (Kagan et al., 1996a,b) can enhance interaction, particularly when the nonaphasic partner is skilled in the use of such resources. Similarly, a partner’s use of written support such as “thematic written support” can increase the participation of the person in a conversational exchange (Garrett & Beukelman, 1995). Resources that provide a context for communication also are important. For example, LeDorze (1997) has noted that individuals confined to institutions such as nursing homes often have little shared information with caregivers. In such situations “life story” notebooks with a brief life history, family pictures, and relevant life events can provide a living, interesting identity to “the patient in bed 202” (LeDorze, 1997). Similarly, remnant books or photo albums can help initiate and sustain conversational interactions among individuals with aphasia (Bernstein-Ellis & Elman, 1995). These resources provide a shared context for conversation, and remove the burden for verbally introducing new information from the person with aphasia.

Increasing Participation in Relevant Activities

“Communication is facilitated when peoples’ contexts are rich in opportunities to communicate and be understood” (Ferguson, 1994, p. 9). Unfortunately many individuals with aphasia have few opportunities for communication due to decreased participation in relevant activities. Most conversations surround some activity of interest (e.g., eating, shopping, working, and playing cards), yet the number and variety of experiences and activities are often diminished for the individual with aphasia. A social approach facilitates participation in relevant activities.

If a social approach to aphasia management is designed to enhance “participation” in personally relevant activities, what relevant activities should be targeted? As in partner training, the contexts for participation must be defined with each individual by assessing current and past interests and activities and possibly identifying new activities. The target of intervention (or whether to intervene at all) is the choice of the client, not the clinician.

Activity Focused Intervention

One approach is to support the client in identifying activities of interest, developing self-generated goals for participation in the identified activities, then facilitat-
ing participation in the identified activity (Fox, 1997; Lyon et al., 1997; Simmons, 1993). Pachalska (1993) introduces therapeutic outings as part of Social Communication Oriented Treatment (SCOT). These outings provide “real-life” opportunities for people with aphasia and their families to participate in community events and activities. Community volunteers can serve as liasons to enhance participation of individuals with aphasia in chosen community activities (Lyon, 1997; Lyon et al., 1997). Thus, the volunteer becomes a “partner” in promoting participation in a relevant activity. It is also possible for the clinician to work directly with the client to identify potential opportunities for expanding social participation. Activities might be an expansion of existing activities or an entirely new endeavor. Often clinicians find that clients simply shrug when asked in which activities they would like to participate. One possibility is to utilize resource pictures representing a large inventory of potential activities such as going to church, playing cards, sports, politics, painting, gardening, grooming pets, etc. The client then sorts the pictures into those that are appealing and those that are not. The stack of “preferences” can be used as a starting point for identifying potential intervention activities.

Once a potential activity is identified, then the clinician must “pave the way” for participation. Too often, activities are simply suggested—“Why don’t you join the health club?” or “Why don’t you volunteer at the garden center?” Experience suggests that this rarely results in increased participation. Rather, the clinician must identify the specific site(s), visit the site to identify and reduce barriers to participation, work with the client to develop participation goals, then facilitate participation. Similar to the concept of supported employment, “supported” participation in relevant activities must be provided. While activity-based intervention will extend the role of the speech–language pathologist beyond traditional clinical settings, this is a viable expansion of role. The speech–language pathologist is uniquely qualified to analyze the communication requirements of activities, identify potential communication adaptations, and collaborate with involved parties to enhance participation. For example, R.S., a man with moderate aphasia, wanted to participate in watching televised sports events at a local sports bar. Although frequently expressing interest in this activity, R.S. failed to pursue his interest. A visit to the event by his therapist revealed a number of inobtrusive compensatory adaptations to facilitate participation such as placing a blackboard with key words next to the television (e.g., team names, stadium name) and providing “team cards” listing players. Also the bartender, a former friend of R.S., was recruited to support participation. Finally, conversational coaching involved practicing possible communication scenarios to build R.S.’s confidence and skill. Thus, activity-based intervention overlapped with skill training, partner training, and providing resources.

DEVELOPING “PROSTHETIC COMMUNITIES”

In addition to facilitating participation in identified activities, programs can foster and support participation in social activities by providing supportive, “prosthetic” communities. For example, programs that provide aphasia therapy can also offer social activities to bridge intervention and social participation. The
Aphasia Center of California provides group therapy focusing on improving communication and also provides recreational activities and a social outlet for people with aphasia (Elman, 1998). Living with Aphasia, Inc. in Wisconsin (Lyon, Chapter 9) provides direct intervention at the level of social communication and also sponsors a theatre group and a bowling league for people with aphasia. The Pat Arata Aphasia Centre in Toronto provides conversation groups and recreational activities for adults with aphasia in a community center atmosphere, as well as opportunities to work on specific skills such as writing. The "clubhouse model" associated with traumatic brain injury provides a facility with a community center atmosphere as well as intervention. Such programs can potentially fulfill direct intervention needs and serve as a social "community" for people with aphasia.

In addition, existing community centers, recreational facilities, work training centers, and adult education should be made more accessible to individuals with communication impairments. Speech-language pathologists might serve as consultants to identify barriers to participation and adaptations. People with aphasia can form advocacy groups that work on paving the way for participation in community activities. Employees or volunteers of community facilities or programs can be trained to interact positively with people with aphasia and serve as advocates to assist in filling out forms, completing registration procedures, and meeting other participants.

Identity and Membership

A basic tenet of the social model is that the individual with aphasia is a valuable member of society. Unfortunately, aphasia is often associated with a subtle (or not so subtle) constellation of disempowering events and attitudes that undermine this membership. The onset of aphasia often precipitates role changes; thus, a wage earner becomes "unemployed" or a club president becomes a "former" member. Our roles in society help us construct our identities, support healthy egos, and ensure social memberships. Loss of such roles can diminish perceptions of one's worth. Because membership in a social community is intricately tied to one's roles and personal identity, aphasia impacts roles, identity, and ultimately membership.

Although people with aphasia can acquire new roles, some of those associated with the onset of aphasia are not necessarily "identity enhancing." For example, Newhoff and Apel (1990) note that people with aphasia are often assigned a role as "the patient." This "incompetent patient" and inadequate communicator role is reinforced by communication failures (Newhoff & Apel, 1990; Simmons-Mackie & Damico, 1999). Also, the "patient" role can be reinforced by traditional aphasia therapy, which often adopts procedures, jargon, and props from medicine (e.g., charts, diagnosis, prognosis, treatment recommendations). Traditional therapy is largely designed and controlled by the therapist (Simmons-Mackie et al., 1995). The clinician is the expert who is in control of tasks, stimuli, and discourse structures (Simmons-Mackie & Damico, 1999). The client learns quickly to acquiesce to the therapist's authority—"to take the cure." Although therapists attempt to support and encourage their clients, the traditional patient role is
inherently associated with dependency and disempowerment. The emphasis is placed on impairments (what is wrong) and the client is reminded through intervention and assessment of the presence of aphasia. The semantics of incompetence (e.g., the aphasic, the patient, recovery, handicap) reinforce the client’s diminished status. Once the client becomes skilled at the “patient role,” then he or she is often ready for discharge. Hesch (1998) sites feelings of abandonment sometimes associated with discharge from aphasia therapy. As one man described “you work hard to get better, then you get dumped.” Perhaps one aspect of this feeling of loss is that the client is losing yet another social role—that of “the good patient.”

In addition to role changes, people with aphasia are exposed to patronizing and disempowering attitudes (Parr et al., 1997; Simmons, 1993). People often react with surprise or negative emotion to communication differences. Such reactions potentially create the stigma of aphasia and serve to further diminish feelings of self worth (Goffman, 1963). Kagan (1995) identifies communication as the means through which others judge our social, intellectual, and emotional competence. Thus, when communication is impaired, others might perceive the individual as generally incompetent. The effects on identity can be devastating. Analysis of therapy discourse has revealed that subtle attitudes communicated during aphasia therapy might also serve to disempower people with aphasia (Simmons-Mackie & Damico, 1999).

Therefore, a critical aspect of a social approach is to foster a positive identity (Parr, 1996; Pound, 1998; Simmons, 1993). This will necessarily involve a range of adjustments to traditional approaches. One adjustment requires that aphasiologists consciously accept responsibility for that gray area often called “psychosocial adjustment.” Confidence as a communication participant and positive self-perceptions are intricately woven into the tapestry of communication success. We cannot continue to treat the impairment and “expect” the client and family to adjust to the disorder as though one’s adjustment is separate and distinct from one’s communication participation. Improved language without the confidence to participate in communication events is worthless. Therefore, a social approach must foster communicative confidence and empower speakers with aphasia.

Empowerment can be enhanced as therapists critically evaluate their attitudes and interactive behaviors. Perhaps we might redefine our role as “experts” and consider that the real expert on the consequences of aphasia is the client. As Finkelstein (1991) suggests, the professional should accept a role as a resource to the person with a disability rather than assuming the role of the specialist who assesses the client to determine the appropriate interventions. Existing therapies should be studied and practices that promote “incompetent” identities should be eliminated (Simmons-Mackie et al., 1995). Client strengths rather than “problems” can be emphasized; thus, clients can be provided a list of “great adaptations” instead of a catalogue of what’s wrong. This is particularly important for the person with chronic aphasia who does not need a catalog of impairments—this individual has lived the disorder. A focus at this stage is on reinforcing and expanding positive adaptations. Another method of promoting empowerment is to eliminate jargon that implies helplessness, dependence, or inadequacy (e.g., patient, illness, treatment). For example, rather than admit people with aphasia
to university clinics to serve as patients for students, we might consider designating these individuals “client-teachers” who are assuming a leadership role in helping train students. Certainly, they obtain a needed therapy service, but they also provide a service to training institutions. In other words, empowerment is advanced when we facilitate the client’s focus on his or her uniqueness, importance, and individuality as a person.

In addition to examining our own practices and attitudes, services directed specifically at development of a robust identity with aphasia should be provided. Counseling and education are valuable services for people with aphasia beyond the acute phase (Brumfitt & Clark, 1983; Ireland & Wotton, 1993; Wahrborg, 1989). Counseling might be directed at positively emphasizing the individual’s uniqueness as a person (e.g., lover of animals, religious believer, opinionated in politics) (LeDorze, 1997), as well as defining the personal meaning of aphasia (Parr et al., 1997). As Parr (1996, p. 425) explains “The changing interpretations brought to the impairment by the aphasic person and close family members and friends must be understood. Without this knowledge the clinician will not be able to support the chronically impaired person in moving towards a reconciliation of views and towards a strong new identity.”

Self-help groups are another potential identity-enhancing service; individuals with aphasia become their own advocates. Finally, aphasiologists will be expected to practice our own preachings, and truly value the experience and perspective of individuals with aphasia. For example, people with aphasia can assume leadership positions to train volunteers and students, provide insights into the experience of aphasia at conferences, or through client-driven research (such as Parr et al., 1997), and participate in program evaluations or focus groups.

Identity work also involves changing “barriers” such as attitudes of others and enhancing membership. In a discussion of augmentative communication intervention, Ferguson (1994, p. 10) notes that practitioners tend to focus too much on “intervention” and focus too little on membership, “specifically participatory, socially valued, image-enhancing membership.” Membership is enhanced by collaboratively creating cultural identities that attribute competence, individuality, value, and roles. It involves shifting the “problem” away from the person with aphasia and onto the barriers to participation created by society (Parr, 1996; Pound, 1998; LeDorze et al., 1993). Making “differences” commonplace can reduce stigma and attitudinal barriers (Goffman, 1963). This can be done by paving the way for clients to enter an activity, by training partners or by changes at the institutional and societal level (such as public education). Organizations such as the National Aphasia Association (United States) or Action for Dysphasic Adults (Britain) increase the level of public awareness of aphasia and thereby diminish the stigma and barriers.

Institutional and Societal Changes

A social approach dictates that service providers serve as advocates for institutional and social change. If aphasia intervention is to fully address functional communication, then the long-term consequences and the availability of community resources, services, and financial support must be considered and addressed.
This will require considerable adjustment to the institutional structures and service delivery models in most countries.

In the United States the acute stage of aphasia is the locus of most intervention and unfortunately the shrinking health-care dollar continues to limit available services at this stage. Yet, it is during the chronic stage that individuals with aphasia often learn the personal meaning of being aphasic in a communicating world. If a social model is appropriate, then support for managing the long-term consequences of aphasia must be expanded. Systems promoting socially responsible outcomes must not terminate with discharge from acute stage intervention. Rather, Pound’s (1998) suggestion of “therapy for life” must be considered as a model of service delivery; intervention and support are offered at relevant periods as the individual lives with aphasia and encounters barriers to participation.

This ongoing system of intervention and support might entail expanding the responsibility for aphasia management beyond health care and into the realm of social and community services. Thus, supporting life with aphasia becomes the domain of community centers, recreation facilities and adult education, as well as health-care facilities. Such an approach will entail a constellation of services, some recognizable within the realm of therapy, and others falling more appropriately in opportunities for supported participation. Elman (1998) describes the need for an array of services for aphasia from which the individual might pick and choose from choices such as individual therapy, group therapy, supported conversation, recreational classes, counseling, prevocational training, self-help groups, and advocacy groups. Thus, services could be selected to suit the individual’s needs and desires at any given time, rather than following the traditional linear approach.

Clearly the role of the speech-language pathologist must expand beyond traditional confines. Roles as consultants and collaborators will be expanded. To advance social approaches, aphasiologists will necessarily work at the level of community reintegration and define communication in terms of participation.

Effectiveness of Social Approaches

While the tenets of a social approach are intuitively appealing, it is imperative that any approach be subjected to rigorous testing. While evidence of the success of social approaches is accumulating, there is work to be done. Two potential aspects for judging functional intervention include: (1) the approach improves the persons ability to perform activities that reflect physical, psychological, and social well-being and (2) the approach is judged relative to client satisfaction with the outcome and the level of functioning (Frattali, 1997). In addition, functional intervention might be judged by measures of increased participation in relevant activities. Thus, the outcome of a social approach is to improve quality of life and enhance participation in a communicating society. It is important to advocate for services that effectively address the social needs of people with aphasia, and devise methods for judging the outcome of these services. Creative approaches for turning the health-care crisis into an opportunity for change are emerging around the globe (e.g., Elman, 1998; Kagan, 1998; Lyon, 1997; Parr, 1996). Aphasiologists must not be complacent and resigned to do more with less. The movement toward a technology and philosophy dedicated toward functional, social outcomes in aphasia promises an exciting future.