Existing Training Protocols Used for Training Conversation Partners of Persons with Aphasia

Kellan Mallory

Marshall University

As aphasia treatment moves from a solely impairment based model, social approaches are becoming more common as the need for personally relevant goals becomes more of a priority (Simmons-Mackie, Raymer, Armstrong, Holland, & Cherney, 2010). The shift to a more holistic approach to aphasia treatment comes following the development of “Living with Aphasia: Framework for Outcome Measurement (A-FROM),” which is a conceptual framework that considers how an aphasia diagnosis affects various life areas, not just language (Kagan et. al., 2008). Additionally, the “Life Participation Approach to Aphasia (LPAA) is another service-delivery approach that focuses on life participation and allowing individuals with aphasia the ability to achieve their short and long term life goals (Chapey et. al., 2000). As the trend of a social intervention continues to spread, clinicians are creating goals targeting social participation, interaction, initiation of conversation, and overall well-being (Kagan, Black, Duchan, Simmons-Mackle, & Square, 2001). This model with a focus on life activities and participation encompasses many intervention techniques, one of them being Supported Communication Intervention (SCI), also referred to as Supported Conversation for Adults with Aphasia (SCA). This intervention teaches techniques to conversation partners that allow them to communicate and “better reveal the competence of those with aphasia.” According to Kagan, the intervention program relies on the assumption that persons with aphasia (PWA) can act on preserved cognitive and social abilities when given the opportunity with the appropriate supports. Kagan also discusses that many individuals may avoid interaction with this population due to the assumption that there is a lack of competence due to the presence of a language disorder. SCA places importance on conversation as conversation is considered to be a “vehicle for social participation.” Conversation, however, is collaborative. Therefore, importance must be placed on the conversation partners in which persons with aphasia interact. Due to the lack of awareness regarding aphasia in the general population, communication partners must be trained in order to effectively foster a communicative relationship with the person with aphasia. Though there is ample research supporting why conversation partners are trained, there is limited research on how they are trained. Thus, the purpose of this paper is to examine the details of training protocols used in training conversation partners and discuss specific aspects that would be beneficial to include in a training program.

The conversation partners involved in SCA are an integral part of the communicative partnership. Selection of the communication partner is variable as the partner can be anyone the person with aphasia interacts with or is willing to interact with. Ideally, the person with aphasia will have multiple conversation partners in a variety of settings that are trained to allow them to communicate as effectively as possible and participate in the activities of personal importance. This could include spouses, family members, friends, nurses and other professionals involved in his or her care, or volunteers. Ultimately, this is an aspect that will vary depending on personal preference, family support, and whether the PWA is living at home or is in a care facility. Horton, Lane, and Shiggins (2016) discuss the importance of communication training in multidisciplinary care. Training all members of a multidisciplinary team in a rehabilitation setting is important for participation as well as patient safety. It is crucial for all professionals involved in the care of PWA be able to communicate as effectively as possible in order to provide the best quality care for their patients with aphasia.

Currently, a specific training protocol for training communication partners partaking in SCA does not exist. However, training methods can generally be separated into 3 categories: multi-modality communication training, conversation analysis, and experiential learning (Bradley & Douglas, 2008). Multi-modality communication training focuses on training transferable skills used to break down the communication barrier. This method also includes non-verbal strategies and is typically used with patients with moderate to severe language impairments. Conversation analysis is a method of training that focuses on collaborative communication. This method considers turn-taking, sequencing, topic maintenance, conversational repair, as well as non-verbal communication. This method also includes feedback to both participants and behavior modification. Experiential learning is a model that is based on learning from experience. This model places importance on repetition, practice, and incorporating feedback from more experienced persons. This particular model also places an emphasis on self-reflection. Though these approaches vary in their methodology, they are similar in the fact that they place an emphasis on the collaborative nature of communication. All three approaches place equal responsibility on the PWA and the conversation partner for the success or failure of the conversation. Because communication is considered collaborative, the communication partner must evaluate his or her own conversation skills if there is a communication breakdown. As stated above, the multi-modality communication training approach is more appropriate for patients with more severe language deficits. However, due to the generalizability of this approach, it may also be beneficial to use this type of approach when training unfamiliar communication partners such as health professionals and volunteers as the skills can be used with a variety of aphasia diagnoses and severities. Thus, conversation analysis and experiential learning are more appropriate for more familiar partners, such as spouses and close family members. Though a detailed protocol does not yet exist for conversation partner training, using these three categories to assess the needs of PWA can help guide in what approach or approaches to use with a variety of conversation partners.

A study by Sorin-Peters, McGilton, and Rochon (2010) discussed the development of a training program for nurses working in care facilities with persons with aphasia. The training program consisted of 1) a discussion regarding the resources required to ensure success of the intervention, 2) developed communication plans for each resident developed following an evaluation by the SLP, 3) a workshop discussing the communication plans of each resident, 4) support and coaching for staff, 5) a questionnaire about the plan’s usefulness, and 6) a focus group about using the plans in practice. The staff that participated in the workshop stated that it provided useful information for communicating with PWA. Additionally, nurses stated that the strategies learned in the workshop allowed them to manage behavioral issues (e.g., yelling, outbursts, anger) due to unmet needs. Nurses also commented on the frustration PWA must feel when trying to communicate as well as the loneliness, isolation, embarrassment, and depression that may occur as a result of aphasia. Results of this study indicated that using communication plans as part of a training program for professionals involved in the care of PWA were beneficial due to the individualized nature of the disorder. Additionally, nurses stated that some of the knowledge and strategies learned could be transferred to other patients. The nurses that took part in the training also demonstrated the ability to problem-solve with each other in regards to communicative needs rather than requiring significant SLP support. This method of training could be implemented in a variety of settings. The individualized communication plan is crucial for aphasia care due to the variability of the disorder, however many strategies are generalizable and can be transferred to other patients. Ultimately, implementing a training program can help PWA communicate their wants and needs more effectively, thus decreasing negative or agitated behaviors due to communication breakdowns and frustration.

In a similar study, Rayner and Marshall (2003) examine the effects of implementing a training program for volunteers serving as conversation partners for PWA. The training sessions were three morning sessions for a duration of 3 hours each. The aims of the course were to increase knowledge about aphasia and impairments that may occur as a result of the disorder, educate volunteers about the role of communication partners in aphasia therapy, and to increase the skills of volunteers in using supported conversation to reveal competence of PWA. Additionally, the training included video examples of the researcher participating in a conversation with a patient diagnosed with severe aphasia. Results were based off of questionnaires and video analyses gathered from participants. Significant gains in aphasia knowledge and in the ability to utilize strategies during conversation with PWA were indicative of a successful training program. Though the training program used in Rayner and Marshall’s study varied slightly from the program used in the previous study, both training programs included general themes: knowledge about aphasia, increased awareness of psychosocial effects as a result of the disorder, and strategies that can be used to reveal the competence of PWA.

The previously mentioned studies included various strategies used to support conversation for PWA. These strategies generally fall into four major categories: Acknowledging competence, revealing competence (getting a message in), Revealing competence (helping him/her get a message across), and revealing competence (verifying the message) as well as some general techniques and suggestions (Helm-Estabrooks, Albert, & Nicholas, 2014). Strategies used to acknowledge competence include use a natural, non-patronizing voice, choosing adult topics, saying “I know that you know,” and attributing communication breakdowns to oneself rather than the PWA. Strategies that may be used for getting your message in include using simple sentences and using gestures and drawings with verbal output. Strategies that the communication partner can use to help the PWA get his or her message across include asking yes/no questions, asking one thing at a time, giving sufficient time to respond, and asking the PWA to use gestures or draw. Lastly, strategies used to reveal competence verify the message include summarizing what the PWA said, reflect back on what the PWA said, expand on his or her message, and summarize at the end of the discussion. Additionally, it is important for the communication partner to acknowledge that communication breakdown will still occur and that techniques should not be overused. It is also suggested that the communication partner have paper and a writing utensil readily available for the PWA if they need additional support during the conversation.

Though research is beginning to focus more on social implications of aphasia, more research still needs to be done. Many studies indicate that training communication partners is important and yields significant results in overall interaction and participation of the PWA, however very few studies discuss the contents of the training protocols used. Though many studies used similar training programs, a more standardized framework may be a useful resource for facilities looking to educate the professionals that interact with PWA and improve overall patient care. As existing research shows, the framework may include general aphasia awareness/knowledge, psychosocial implications of an aphasia diagnosis, and strategies that can be used when speaking with a PWA. The studies discussed may act as a spring board into future directions of establishing a training protocol or framework that is most effective for training communication partners in supported conversation for adults with aphasia.

References

Bradley, M., & Douglas, J. (2008). Conversation partner training - Its role in aphasia: A review of the literature. *Speech Pathology Australia, 10*(1), 18-21.

Chapey, R., Duchan, J. F., Elman, R. J., Garcia, L. J., Kagan, A., Lyon, J. G., & Simmons-Mackie, N. (2000). Life participation approach to aphasia: A statement of values for the future. *The Asha Leader, 5*(3), 4-6.

Helm-Estabrooks, N., Albert, M. L., & Nicholas, M. (2014). *Manual of aphasia and aphasia therapy* (3rd ed.). Austin, TX: Pro-ed.

Horton, S., Lane, K., & Shiggins, C. (2016). Supporting communication for people with aphasia in stroke rehabilitation: transfer of training in a multidisciplinary stroke team. *Aphasiology, 30*(5), 629-656.

Kagan, A., Black, S. E., Duchan, J. F., Simmons-Mackie, N., & Square, P. (2001). Training volunteers as conversation partners using “supported conversation for adults with aphasia” (SCA): A controlled trial. *Journal of Speech, Language, and Hearing Research, 44*, 624-638.

Kagan, A., Simmons-Mackie, N., Rowland, A., Huijbregts, M., Shumway, E., McEwen, S.,…Sharp, S. (2008). Counting what counts: A framework for capturing real-life outcomes of aphasia intervention. *Aphasiology, 22*(3), 258-290.

Rayner, H., Marshall, J. (2003). Training volunteers as conversation partners for people with aphasia. *International Jounral of Language & Communication Disorders, 38*(2), 149-164.

Simmons-Mackie, N., Raymer, A., Armstrong, E., Holland, A., & Cherney, L. (2010). Communication partner training in aphasia: A systematic review. *Archives of Physical Medicine and Rehabilitation, 91,* 1814-1837.

Sorin-Peters, R., McGilton, K., & Rochon, E. (2010). The development and evaluation of a training programme for nurses working with persons with communication disorders in a complex continuing care facility. *Aphasiology, 24*(12), 1511-1536.