

## The Aphasic's Significant Other:

### Training and Counseling

#### A Round Table Discussion

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Research suggests, and our own clinical studies concur, that using a significant other person (SOP) as an intervention aide will decrease total time in therapy, assist in the generalization process and help the patient make more permanent, durable behavior change. In our clinic, we have trained blind high schoolers to work on articulation problems for blind elementary children, and parents or siblings to work with children presenting stuttering, language, articulation, or voice problems (Florance, 1976; Florance and MacDonald, 1978; Florance and Deal, 1979; Shames and Florance, 1979). In each study we have found that the SOP assisted greatly in the efficacy of our treatment.

When an individual suffers a life-threatening trauma such as a stroke, which may leave him unable to talk, walk, or care for himself, major changes in family equilibrium are created. A spouse may feel that she has lost her husband, provider, lover, friend, confidant and yet she is left to care for a disabled invalid. The feelings experienced by the aphasic person of frustration, anger, pity, or lethargy often compound the interpersonal problems.

Training the spouse of the aphasic patient to serve as an intervention aide in therapy can be a complicated process. Training parents in this capacity may be somewhat easier, as the parent may see himself as the child's tutor and may gradually learn of his child's disability as the child matures. However, the spouse, who is probably not used to serving as teacher for her husband, faces the stroke and its ramifications suddenly, often without warning.

Realizing that the interpersonal dynamics between spouse and aphasic person may be very complex, we still believe that the spouse can be a very significant other person in the rehabilitation program of the aphasic individual. Therefore, we have designed a program for the spouse or SOP in which spouse counseling and training are integrated. Generally in our clinic following pre-treatment evaluation, patients and SOPs work together to develop and implement the therapeutic regime designed to improve the patient's communicative ability. The SOPs may also participate in a group counseling program designed to help them develop coping strategies for problems that have arisen as a result of the stroke. The patient may also be enrolled in group therapy for the clinical transfer of treatment.

#### Patient Treatment Program

Patients and SOPs are enrolled in the speech pathology program outlined in Table 1. The SOP is included as an integral part of each phase of therapy. As the therapist completes a formal evaluation of the patient's behavioral abilities, the SOP evaluates the change in the patient's behavior and the impact of these changes on the family in an interview with the therapist. During phase II, the SOP assists in the selection of training content by helping the therapist determine the type of communicative

interactions which are environmentally significant for the patient with regard to immediate patient needs and subsequent transfer opportunities. In phase III, the SOP is taught to train the patient to produce target responses and keep a home data profile. Next, the SOP learns self-regulatory procedures and assists the patient in developing communicative independence, as fading of the SOP support system is initiated. In phase V, the patient may participate in group therapy sessions with other aphasic persons to practice transfer of communication behaviors within the clinical environment. Throughout the treatment program, the SOP and patient have guided the therapist so that training is directed toward environmental transfer. In phase VI, the spouse assists in creating transfer opportunities for the patient and providing environmental reinforcement. Finally, the therapist and SOP re-evaluate the patient's abilities, assess the patient's progress, and determine subsequent disposition.

Table 1. Summary of patient treatment program.

Phase	Patient	Significant Other Person	Therapist
I	Evaluation of Post Stroke Abilities	Subjective Evaluation	Formal Behavioral Evaluation
II	Selection of Target Behavior	determines environmentally significant training content	develops S-R paradigm
III	Training in Target Behavior	implementation of home program	Trains patient and SOP in training procedures
IV	Training in Self-Regulation	patient begins to assume communicative independence as SOP fades training	Trains patient and SOP in self-regulation paradigm
V	Clinical Transfer of Training	patient participates in group program	
VI	Environmental Transfer of Training	SOP assists in determining and creating transfer	patient and SOP create contracts
VII	Re-Evaluation of Patient's Abilities	Subjective Evaluation	Formal Behavioral Evaluation

### The Counseling Program

Throughout the treatment program both patient and spouse receive counseling to assist them in developing independent problem-solving abilities, together with adequate coping strategies and defensive mechanisms. The patient

and SOP may receive counseling together or individually, or they may be involved in a group counseling paradigm, depending on personal needs and desires. In these counseling sessions, patients and SOPs may discuss the impact the patient's stroke has had on various aspects of the family life system, including sexual, financial, health or interpersonal difficulties.

### Case Reports

The two case descriptions to follow are presented as examples of the impact that the family and the patient's environment can have on the patient's communicative behavior change. These patients were selected because of the short-term nature of treatment so that ample discussion time following the presentation will remain.

#### Patient I

This patient and her family became dissatisfied with her behavior change after 1-1/2 years of therapy in which writing skills, primarily copying, had been stressed, while verbal abilities had not changed. Her son arranged for an evaluation and subsequent treatment strategy design while the patient was visiting him for a 2 week period.

Initial Evaluation. The patient presented with poor auditory processing, imitative, self-monitoring and evaluation abilities. Her aphasia was complicated by oral apraxia, and spontaneous speech samples revealed no intelligible speech, merely the use of the recurrent jargon "fricklenoose." The clinical evaluation, together with family reports suggested that the patient was making very few, if any, successful communicative attempts. She was able to assume responsibility for house cleaning and cooking tasks and had some limited reading ability. Otherwise she was not relating interpersonally or with the environment.

Selection of Target Behavior. During the initial interviews with the patient and her family, we found that meaningful communicative interactions for her centered around meal times and telephone conversations. A corpus of training sentences the patient would be able to use in these types of situations was developed.

Training the Target Behavior. The patient was taught to produce the sentences after gestural, auditory, visual, and graphic stimuli were provided. The patient was required to replicate the gestural cue and attempt to produce the target sentence. The patient's husband, son, daughter-in-law and grandson were trained to provide stimuli and evaluate her performance on Base 10 forms. After 5 hours of therapy, with 10 to 12 5-minute home sessions, the patient could produce over 60 intelligible sentences and was using them appropriately.

Generalization. As therapy continued the patient began to produce novel utterances which did not seem to be similar to the target training sentences such as "It's time to go to the speech therapist," "I'd like to get a blow-set hairdo," or "What a pretty room this is." The family reported that they felt they were now able to interact with her conversationally, although her verbal expressive abilities were still greatly impaired.

Follow-Up. The patient and her husband moved to Europe. In a recent postcard from the patient she wrote that she felt she was doing much better. Further, her husband indicated that reading, writing and understanding abilities had improved [in addition to speech].

## Patient II

The patient's wife requested an evaluation and treatment design from our clinic. The patient was four months post onset and had completely withdrawn from all activities. His only previous therapy took place during his inpatient hospitalization where his wife was given a box of picture cards which he was to practice naming.

The patient's wife reported that because he so frequently became frustrated with his inability to adequately communicate, he gradually continued to withdraw until he was refusing to interact in any way, totally isolating himself from family and friends.

Initial Evaluation. The patient presented with good receptive abilities, severe oral and speech apraxia, and poor imitative ability. He was able to self-monitor his errors, but his attempts to self correct were characterized by multiple off-target productions which were rarely successful.

Selection of Target Behavior. When evaluating the patient's communicative needs, the spouse described three primary situations that she believed to be communicative focal points: (1) cocktail hour each evening (2) poker games at the country club and (3) businessmen's luncheons. Training sentences were created for each of these interactions.

Training the Target Behavior. During the initial training phase, two significant behavioral strategies became apparent. First, after the patient began to produce a repertoire of target responses with ease, he began to circumlocute to produce novel communication. Secondly, the spouse began to stimulate increased novel utterances from the patient. However, the strategies used by the spouse were counterproductive. The spouse generally provided the patient with a one-word opportunity for communicative success. For example, upon arriving at the clinic the spouse said to her husband "Tell her where we went to dinner last night...you know the 38th floor,... you know, we rode in a glass elevator, remember we looked out over the city,..." and so forth. All the while, the patient was making off-target attempts at saying the name of the restaurant, resulting in great frustration. To facilitate the patient's communicative success through circumlocution and to replace the spouse's inappropriate behavior, the spouse was trained to utilize classical interviewing tactics including open invitation to talk, open questions, minimal encouragers, and paraphrasing feeling and content.

Generalization. During the last of five 1-hour sessions, the patient explained how it felt to be unable to communicate, the frustration at being unable to do things he'd always taken for granted. When preparing to leave, the spouse asked for freeway directions but before the therapist had a chance to answer, the patient supplied the necessary information in detail.

Follow-Up. During a follow-up phone call, the spouse reported that the patient's communicative success had increased from 0 to 100 per cent following the five hours of spouse-patient intervention. The patient returned to his card games at the club and generally interpersonal relationships had improved. Further, the spouse reported that she believed the patient's sense of well being and self worth were significantly better.

### Summary

In these treatment paradigms we have attempted to focus not merely on the speech and language behavior of the patient but rather on the communicative ecology within which the patient lives.

### Discussion

Comment. Cheri, it seems that you have a good sample to work with because the people you described were coming in for second opinions. It seems to me that they may have been looking for help, which would signal to me that they had gone through a reaction to the process of their spouse's aphasia. It seems as though they had gotten to the point at which they were accepting the fact that the aphasia was not going to disappear and were saying, essentially, "You tell me what to do, and I can learn it now, because I know that he is not going to be back like he was. Now we need basic communication."

A: We have found that when we see people and their spouses right after the stroke, we can prevent many maladaptive behaviors by training the spouses to do constructive, rather than maladaptive, things.

Q: Do you attempt to supplement behavioral training with some sort of outlet for expression of emotions? I just want to add one other point, and that is that we have found that as a patient gains confidence, even though he may not necessarily have improved in terms of his communication ability, he is more willing to participate in communication activities. I also think it's very common to see patients who don't show improvement on formal tests of communication who do, in fact, improve in terms of their functional communication.

Q: Cheri, what I hear you saying is that you are setting appropriate targets for where the patient should be. Your two examples were of patients who had quite good communication abilities. Would this same type of procedure work for the patient who is not going to reach that level of proficiency?

A: We have used this program with more severe patients. In fact, we're in the process of training a spouse to train a patient to use the Handivoice.

Q: How do you deal with the very low-level patients who are probably never going to communicate conventionally?

A: The best example I can give you is the patient that we trained to use the Handivoice. We trained him and his spouse with a very strict operant paradigm, in which his spouse administered the training and we evaluated his progress. It's been slow, but behavior changes are occurring. I think that if you can get inside the environment and change the contingencies, a lot of things can happen that you wouldn't expect.

Comment. We have adopted the term "principle care giver" instead of "significant other." In most cases, the wife becomes the principle care giver, and in most cases, in addition to being the principle care giver, they're also that person's best friend. We find that communication between the patient and his principle care giver and/or best friend is frequently better than it is with any other person in the patient's environment.