

CHAPTER

3

**Communicative Partners:
Their Value in Reestablishing
Communication with
Aphasic Adults**

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Some time ago, an American Speech-Language-Hearing Association-sponsored workshop detailed novel treatment methodologies for aphasic adults. Rick Bollinger of the Miami Veterans Administration Medical Center presented a creative group activity built around old TV sitcoms (*I Love Lucy*; *Leave it to Beaver*). His inspiration in pursuing this had come from learning that nonacute aphasic adults spend an average of 39 hours a week in front of the television set. His reasoning, which seemed sound at the moment, was to capitalize on an activity that dominated the lives of these adults. Whereas Wertz has maintained that the trained caregiver has yet to be proved an efficacious provider of traditional language stimulation (see Chapter 2), recruited, trained supportive others — that is, communicative partners — may represent a critical link in our efforts to move outside the confines of our treatment cubicles, to ecologize! Furthermore, the transfer to be gained does not rest solely within the realm of communication but rather with the restoration of one's life-style, a psychosocial state of well-being, that returns the importance of wanting to communicate to its user.

Let us begin with one main point, one that is not new to any clinicians, yet one that is not commonly accounted for in management plans. Simply put, the purpose of communication, per se, is not to communicate but rather to satisfy a desire or need within that person to share information and hopefully, in return, to elicit a reply. When that inner drive to communicate has been weakened, blocked, or removed, communication becomes void of intent. It follows that a prime obstacle for remediators may not rest solely within the act of communicating but rather "within" its user. It is not that aphasic adults do not wish to communicate, but they may not see themselves as worthy or capable, especially in those natural environments in which they reside and must participate.

Stroke — and the added impact of aphasia — invariably yields a common denominator. It strikes at the core of one's being. It abruptly removes direction and often purpose to life, not just for the recipient but for all who share and occupy the innermost domains of that person's life. For the aphasic adult, it reduces self-image, self-confidence, and self-worth and in turn breeds dependency, passiveness, and depression. For the significant other, it threatens self-independence, self-acknowledgment, and self-fulfillment while leaving confinement, possible resentment, unmet needs, and ultimately depression. Although these psychosocial adjustments may not appear foremost in magnitude within our clinical domains, we need only look at patients' life-styles outside these walls to be reminded of how present they are. Certainly, not all aphasic adults have withdrawn from an active role in life, but many have. More telling yet, how many have proved themselves independently capable of reestablishing a meaningful course to their lives following stroke? If Bollinger's (1986) figures are even ball-

parkish, our treatment plans need to reflect an effort to stimulate the desire to communicate.

METHOD

Approximately 6 months ago, I contacted United Way in Reno requesting adult volunteers from the community who might be willing to spend 4 to 6 hours a week with an aphasic adult. Underlying this move was the notion to build a resource, a bridge, that might ultimately be used to activate or rekindle communicative desire, not just with me but with others and for reasons outside the clinical setting.

In early February, I began with two volunteers. Both came in separately for 1-hour sessions to overview the purpose and structure of the proposed program. Neither had had any direct contact with an aphasic adult previously, although both possessed some general knowledge of stroke. Neither had any fears or reservations about proceeding, which has not held true with subsequent inquirers. What ensued over the next 2-week period was a series of arranged meetings where each volunteer interacted with several aphasic adults of varying severity. In the end, a 50-year-old woman, 2½ years post-onset, with a nonfluent Broca's aphasia, an overall Porch Index of Communicative Ability (PICA) percentile of 55, married and residing at home, was paired with a 47-year-old, divorced mother of two, a casino gaming executive. The other dyad consisted of a 75-year-old man, 1½ years post-onset, with a fluent conduction aphasia, an overall PICA percentile of 41, married and residing at home, and a 43-year-old, single, male Keno casino runner.

The initial clinical session for both pairs was videotaped. A series of five hypothetical events (e.g., the Sierras will receive 3 inches of snow tonight) and two topics (e.g., tell me about your last job) were given to the aphasic adults. Using a PACE-like format (Davis and Wilcox, 1981), they were told to convey this content to their volunteer. Both of these aphasic adults were relatively successful in verbalizing and pantomiming their intent. On an eight-point ordinal scale for communicative effectiveness, all scores were six or above. In addition, two other assessment forms were devised. One addressed the dyadic communicative skills of the aphasic adult. This form stressed the evaluation of the aphasic adult's ability to initiate and maintain varied conversational topics with familiar and unfamiliar interactants. The other form examined psychosocial wellness, beginning more broadly (e.g., Do you feel you have any direction to your life? A sense of fulfillment? Personal happiness?) and ending with more quantitative inquiries (e.g., How much of your day is occupied constructively? How frequently do you initiate activities? How often do you go out in public?).

RESULTS

Both forms were judged independently under three conditions by aphasic adults and their spouses. The conditions sampled were prestroke status, current status, and optimal expectations. From a grand sampling from two dyads, aphasic adults rated their current communicative skills and psychosocial wellness much lower than did their spouses. Yet, they exceeded spousal ratings of what might be achieved. When communicative partners were asked to evaluate just communicative skills, their scores paralleled the aphasic adults' rating for current status and the spouses' rating for optimal return, perhaps the most realistic of the three raters.

For several weeks, thereafter, each partner was taught those strategies that had been found to be the most beneficial in facilitating communication. Both dyads showed slight gains on a subsequent PACE probe, but more importantly, they began initiating and interjecting their "own" topics spontaneously into sessions. What's worse, they were enjoying their topics more than they were mine. Roughly 1 month post-introduction, we moved out of the clinic. All participants welcomed that graduation. Thereafter, one session weekly was devoted to defining activities within the community that the aphasic adult would like to explore but had hesitated to undertake alone. Over the last couple of months, a partial listing of their joint adventures includes visiting the Nevada Talking Book Library to inspect and select topics of choice, procuring bedding plants for a back patio garden, visiting several old business acquaintances and personal friends who had slipped through the cracks at the time of the stroke, enrolling in an elementary photography class, renting three-wheeled bicycles for an afternoon ride, and volunteering to assist with next winter's Special Olympics at Lake Tahoe.

Communicative partners have reported personal gains as well. Foremost in this respect is the realization that aphasic adults are, after all, only "ordinary people." Also, the Keno runner pulled me aside after their third outing to remark:

I hope you're not offended but I think you're urging me to help Bill more than is necessary. He has had no difficulty managing his communicative burden during these outside trips. Frankly, I can't understand why he's worse in the clinic!

As striking as the outward growth has been for aphasic and normal adults, it has been overshadowed by the aphasic adults' perception that they are viable company with others who are not bound or committed to them. Communicative partners better resemble the man or woman on the street, one who is not as obligated to attend to the aphasic adult's ongoing

needs and wants as a clinician or family member may be. If aphasic adults can successfully communicate and manage their affairs with this unfamiliar person, they've shown a growing willingness to attempt communication with other, unknown interactants.

Spouses have commented on the program's impact too. They report their "significant other" anxiously awaits planned outings and openly expounds on them thereafter. But more selfishly, they have loved having an afternoon free, either to sit in peace and quiet (remember that TV was off) or to pursue personal interests.

More communicative partnerships have been initiated. One of those is a nonverbal aphasic communicator, who is getting along superbly through gestures, limited words, and drawings, with the former Chief of Fisheries for the state of Nevada. Soon a monthly group meeting of aphasic adults and their communicative partners will be added to discuss the pros and cons of their respective outings. In fact, although it sounds a bit risqué, the "swapping of partners" may encourage and assure some ease of interaction with novel interactants.

The two original communicative partners, although procured through United Way, worked for a Reno-based gambling establishment. It happens to be one of the largest in the area, employing approximately 3800 people. Largely through the support and interest of the gaming executive who has championed the importance of this program to executives higher up in the corporation, a meeting is pending to discuss a possible sponsorship. From this, active participation from their employees's association may be established. In return, promotional recognition of this support will be acknowledged in local and national forums.

For those of you without a corporate link, the United Way recently began a national campaign to expand volunteerism vastly in 38 cities across America. It's called the Volunteer Connection. In Dallas, where the concept originated, they have boosted community participation by more than 100 percent. If you live in or near a major metropolitan area, chances are good that these growing resources are available to you.

Nearly 10 years ago, A. D. Martin (1979) spoke before the Clinical Aphasiology Conference on levels of reference for aphasia therapy. He based his remarks on a "general systems theory," purporting that any conceptual entity is but a level built into a much larger system that contains numerous sub- and supra-stratas. Twenty years ago, we were busily attending to the identification and remediation of the aphasic adult's linguistic deficit, seeking to achieve maximal linguistic restitution. About 10 years ago, we supra-shifted upward to another strata. Jeanne Wilcox and Albyn Davis (1978) introduced PACE; Audrey Holland (1982) showed us that aphasic adults communicate better than they talk, and many others undertook courses to further communication even though linguistic skills

were restricted or at their maximum. Yorkston, Beukelman, and Flowers (1980), Newhoff, Bugbee, and Ferreira (1981), and Linebaugh, Margulies, and Mackisack-Morin (1984, 1985), Holland (1987), and Simmons, Kearns, and Potechin (1987) have shown that if we treat the significant other within the communicative dyad, it facilitates total communication.

These remarks, although not strongly data driven, raise the issue that we must shift upward still another strata in our management of aphasic adults, one that incorporates the well-being of patients into those external environments where they reside and communicate — to ecologize! We have such options and resources to pursue these objectives now, although their refinement lies ahead. Yet, as important as is their pursuit, so is the obligation that we begin this process early on in our treatment. It is not getting aphasic adults ready to communicate and then placing them into more natural environments that should govern treatment. Rather we need to seek to normalize psychosocial variables from the beginning so communication can serve its intended purpose, a desire to share and exchange topics of choice. Finally, the gains attainable are not just restricted to the quality of life of our patients. Do remember the lives of those unused TV sets that we will be extending.

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