Conversational Treatments: Aphasia

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The purpose of this segment of the seminar is to review five specific, evidence-based treatments that directly target conversational abilities and yield improvements in conversational participation among adults with aphasia.

All five of these treatments share the following characteristics:

1. Conversational improvements that come as a result of the treatment are specifically linked to the conversational practice that makes up the treatment;
2. The clinician plays the role of a conversational partner and coach, in accordance with principles of the life participation approach to aphasia;
3. Priorities for conversational topics are determined by the client and thus reflects the client’s values;
4. Conversational topics are co-constructed by the client and the clinician;
5. As in all conversation, the exchange of information collaboratively is the goal and purpose. Successful interaction and transmission of information are the rewards.

I. Promoting Aphasics’ Communicative Effectiveness (PACE)

Overview: A conversational treatment in which any modality can be used to communicate ideas from one partner to the other. The client and clinician take equal turns in the sender and receiver roles, and this promotes conversational participation.

Candidacy: Procedures can be adapted to specific linguistic impairments, thus people with a variety of types and severities of aphasia can benefit from this treatment.

Goals and Expected Outcomes: Use appropriate communication modalities (speaking, writing, drawing, gesturing, communication notebook or other AAC strategies) to effectively participate as sender and receiver.
Procedures: The four principles and essential procedures of PACE (Davis & Wilcox, 1985; Davis, 2005, 2007)

<table>
<thead>
<tr>
<th>Principle</th>
<th>Details</th>
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<tr>
<td>1. The clinician and patient exchange new information.</td>
<td>Instead of having a picture of an object or event (called the message) in simultaneous view of the clinician and patient, a stack of message stimuli is placed face down to keep messages from the view of a message receiver. A client selects a card and attempts to convey the message on the card. The Brussels modification is to place a screen about eight inches high between the patient and clinician, and the message receiver chooses the message from options.</td>
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<td>2. The clinician and patient participate equally as senders and receivers of messages.</td>
<td>This principle puts the turn-taking feature of conversation into the interaction. The clinician and client simply alternate in drawing a card and sending messages.</td>
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<td>3. The patient has a free choice as to the communicative modes used to convey a message.</td>
<td>Contrary to training one modality such as gesture or drawing, the patient is left to choose the mode that is used for any message. We do not tell a client to perform in a particular way.</td>
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<td>4. The clinician’s feedback as a receiver is based on the patient’s success in conveying the message.</td>
<td>The new information condition should make this inevitable for both participants. Our feedback should let the client know if he or she got the idea across. If we already know the message, we should respond as if we did not know.</td>
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II. Response Elaboration Training (RET)

**Overview:** A type of “loose training” which works to improve lexical retrieval and the number of content words produced by an individual with aphasia (Conley & Coelho, 2003). Forward chaining, or elaboration, of the client’s utterances is used.

**Candidacy:** A person with aphasia who can benefit from expanding content in conversation; effectiveness shown across types of aphasia including those with aphasia and apraxia.

**Goals and Expected Outcomes:** Improve verbal production in conversation; increase number of content words in conversation; improve word retrieval in conversation; support generalization of expanded utterances across contexts and conversational partners

**Procedures:**

<table>
<thead>
<tr>
<th>RET Steps</th>
<th>Clinician’s stimulus</th>
<th>Patient’s response</th>
<th>Clinician feedback</th>
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<tbody>
<tr>
<td>1) Elicit initial verbal response to picture</td>
<td>Line drawing of simple event (man with a broom) “Tell me what’s happening in this picture.”</td>
<td>“Man…sweeping”</td>
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<tr>
<td>2) Reinforce, model, and shape initial response</td>
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<td></td>
<td>“Great. The man is sweeping”</td>
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<td>3) Wh- cue to elicit elaboration of initial response</td>
<td>“Why is he sweeping?”</td>
<td>“Wife…mad!”</td>
<td></td>
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<td>4) Reinforce, model, and shape the two patient responses combined</td>
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<td></td>
<td>“Way to go! The man is sweeping the floor because his wife is mad.”</td>
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<td>5) Second model and request repetition</td>
<td>“Try and say the whole thing after me. Say ‘The man is sweeping the floor because his wife is mad.’”</td>
<td>“Man…sweeping…wife…mad.”</td>
<td>“Good job!”</td>
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<tr>
<td>6) After reinforcement elicit delayed initiation of the combined response.</td>
<td>“Now, try to say it one more time.”</td>
<td>“The man…sweeping because his wife…mad.”</td>
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</table>

This table is adapted from Davis, 2007.
III. Conversational Coaching

**Overview:** Effective communication strategies for both the person with aphasia and the primary communication partner are targeted. The clinician acts as a communication strategy coach for both partners (with and without aphasia). The primary communication partner plays an equal role in improving conversation.

**Candidacy:** Effective for a variety of types and severities of aphasia. Best outcome will be achieved when there is a primary communication partner who is willing and able to learn and maintain communication strategies.

**Goals & Expected Outcomes:** The desired outcome is the implementation of effective communication strategies in conversation by both the person with aphasia and the primary communication partner.

**Procedures:**

1. Effective strategies for each partner (with and without aphasia) are collaboratively identified. These could be verbal or nonverbal communication strategies.
2. The couple selects the strategies that they are most comfortable with and which ones they will work on using.
3. A communication situation is created, such as viewing a short video clip. One partner views the video and has the job of communicating the information to the other partner. Both partners should be using their identified communication strategies to achieve a collaborative result. Partners take turns exchanging information in each conversational role (sender and receiver).
4. The clinician acts as a coach to each of the two partners as they exchange and build information together.

IV. Reciprocal Scaffolding

**Overview:** Based on an apprenticeship model, communication abilities are embedded in activities that are personally relevant and meaningful to the individual with aphasia. The person with aphasia takes on an instructor role in a domain of expertise, while benefiting from scaffolding and support of linguistic and communication abilities.

**Candidacy:** Effective for a number of different types and severities of aphasia.

**Goals & Expected Outcomes:** Improved content and fluency in conversation, particularly communication that is embedded within personally meaningful contexts. Variety of vocabulary (for example, as measured by type/token ratios) and increase in content in oral and written language (for example, as measured by Correct Information Unit analysis), and improvements in activity and life participation, can be expected.
Procedures:

1. The client and clinician select a personally meaningful context (activity). This could be an activity like teaching science lessons to young children for a former teacher, or teaching graduate students about how to communicate with people with aphasia.

2. Scaffolding techniques are embedded within the activities that facilitate communication. In addition, practice doing the activity fosters expressive abilities and life participation.

V. Script Training

Overview: A co-constructed monologue or dialogue, pertaining to a communication topic or situation that is important to the person with aphasia, is practiced intensively.

Candidacy: Effective for a number of different types and severities of aphasia.

Goals & Expected Outcomes: Fluency of production for the trained script; fluency of production and generalization of particular forms to other contexts; improved social interaction.

Procedures:

1. The client and clinician collaboratively determine the type of script that would be most useful and meaningful to the client. This could be a monologue (for example, about the person’s stroke and aphasia), or a dialogue (asking questions of a new person).

2. Together the client and clinician co-construct the targeted script. This could be with the input and help of a close relative friend, in an effort to get a script that “sounds like” how the person with aphasia would speak prior to stroke.

3. The clinician and client practice the script, using techniques such as phrase repetition and choral reading, until the client is able to produce phrases within the script independently.

4. The script is then practiced repetitively by the client, at least 15 minutes per day 5 days per week. The clinician monitors and facilitates the practice.

5. Practice contexts in which the person with aphasia can use the script are created.
References


