Getting the most out of treatment: the therapeutic relationship

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Objectives

• Discuss benefits and challenges for unfamiliar communication partners in becoming friends with a person with aphasia.

• Provide evidence-based responses to questions from practicing speech-language pathologists regarding the effectiveness of establishing a therapeutic relationship with persons with aphasia on treatment outcomes.

• Describe the steps of personalizing treatment in order to form a therapeutic relationship and enhance client outcomes.

Case study

• A new SLP 22 years old working in outpatient clinic with adults
• Mr. Brown, 70 years old, referred following a stroke (left hemisphere, temporal lobe) s/p 3 months resulting in receptive language deficits
• PMHx significant for DM, HTN, and cataracts.

• Assessment shows
  • Western Aphasia Battery: unable to complete due to reduced auditory comprehension.
  • Functional: Oxenham Questionnaire.
  • Social: He lives with his wife and they have 2 children. Mr. Brown is a retired auto mechanic. He and his wife enjoy dining out and he likes going fishing with friends.

• Where do you begin therapy?

What is aphasia therapy?

• "A relationship between the clinician and the person with aphasia where there is mutual recognition that improving communication is the purpose and the goal."

• Overall goal is to help PWAs be effective communicators and participants in life despite residual language and communicative impairments.

Client/person-centered care

• Morgan and Yoder (2012) define person-centered care as a holistic bio-psychosocial-spiritual approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual (p. 8).

• More engaged = positive outcomes

Therapeutic Relationship

• Association between the speech-language pathologist and person in therapy.

• Purpose: instill mutual trust and respect in a safe, open atmosphere to enhance life participation.

• Result
  • Person in therapy provides more information about his or her concerns and the impact of the cognitive-communication disorders on his life (talking with family, work, friends) which equips the therapist with a better assessment of the disorder. Now the therapist can establish the most effective treatment strategies.


How you view therapy?

<table>
<thead>
<tr>
<th>Medical Model</th>
<th>Social Model</th>
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<tbody>
<tr>
<td>Views disability as a deviation from the norm, needs to be fixed – impairment-based</td>
<td>Identifies social and emotional barriers as the cause of activity and participation restrictions.</td>
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<tr>
<td>Restore Mr. Brown’s communication abilities so he can understand or speak ‘normally’ at the restaurant</td>
<td>Train employees at restaurant to be receptive to alternative communication methods (writing, gestures)</td>
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<tr>
<td>Clinician dictates goals and controls treatment, Client acts in a passive role</td>
<td>Client-centered, emphasis on health rather than illness, Client takes an active role</td>
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<tr>
<td>Met goals = discharged without attention to life participation</td>
<td>Long-term view of aphasia</td>
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Goal of the social approach

- “promote membership in a communicating society and participation in personally relevant activities for those affected by aphasia” (Simmons-Mackie in Chapey, 2008, p. 290)

- Consistent with the Life Participation Approach to Aphasia
  - Aphasia becomes chronic
    - In spite of linguistic gains, individuals with aphasia have residual communication deficits that impact life participation
    - Long-term consequences of aphasia are not addressed in traditional therapy

Life Participation Theory

- PWA are competent but aphasia prevents them from revealing competency
- PWA have a right to access thoughts and feelings
- Obligated to build them communication ramps and provide adequate resources to access this information
- Life goes on in spite of aphasia

Who and when

- All clients, particularly partner-dependent clients
- Begin later in post stroke course
- May target caregiver more than PWA

Communication Partner Training

- “A form of environmental intervention in which people around the person with aphasia learn to use strategies and communication resources to aid the individual with aphasia” (Simmons-Mackie, et al. 2016).

- Partner training aims to
  - Teach strategies to support communication
  - Allows practice with augmentative tools
  - Alters expectations and perceptions of PWA, reveals communication competence
  - Expands communication opportunities.

Communication Partner Training

- Not providing a list of do’s and don’ts
- Not teaching a communication partner to be a ‘therapist’
- Identifying an activity and encouraging participation
General Strategies to facilitate understanding

- Slow rate
- Chunk ideas and use pauses
- Simplify syntax
- Put key information at the end
- Repeat key words: rephrase
- Speak directly

General strategies to keep the PWA on topic

- Repeat and write key words
- Use gesture, body language, and eye gaze to shift topics
- Use verbal terminators
- Use verbal introductions to start a new topic
- Be more redundant

General strategies to obtain the person’s attention

- Use alerting phrases
- Orient topic shift
- Warm up

General strategies to let the PWA know you understand

- Verify and paraphrase what you think has been said
- Backchannel to encourage the person: nod head approvingly
- Reflect feelings communicated non-verbally

Provide needed support

- Topic orientation (thematic support)
- Props (magazines, photo, communication books, meus, programs, newspapers, TV schedule)
- Paper and pencil
- Use the context provided (talk about things in the room, weather, latest happenings)

Save face

- Give the patient some freedom to respond
- Don't make a lot of teaching comments
- Do what you want the patient to do when you can (gesture, writing)
- Allow the PWA a turn.
- Don't ask a lot of WH questions
Tell me more vs ‘wh’ questions

- Client: Chelsea
- Clinician: Kaylee
- Stimulus: a picture of a wedding

Kaylee asks Chelsea

Who got married?
Where was the wedding?
When was the wedding?
Which person gave the bride away?

Types of CPT

- Communication Skills Training
  - Teaches communication partners specific communication strategies
- Educational Programs
  - Provides information about aphasia and communication to the communication partner
- Counseling
  - Psychosocial consequences

Communication Partner Training

<table>
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<tr>
<td>Supported Conversation for Adult with Aphasia</td>
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<tr>
<td>CONNECT + SCA (Cameron et al., 2013)</td>
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<tr>
<td>Total Communication (Rautakoski, 2011; 2012-2014; 2015)</td>
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<tr>
<td>Couples therapy (Boles, 2015)</td>
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<tr>
<td>Language oriented therapy + CPT (Beckley et al., 2012; Boles et al, 2014; 2015; Carragher et al., 2011; Fox et al, 2008; Saldert et al, 2013; 2015)</td>
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Conversational Coaching

- Provide alternative strategies for communicating novel information.
- Phone messages, TV program content
- Allow couple to select strategies of their own choosing.

- Strategies
  - PWA watches 2-3 minute story from TV or reads an article.
  - Spouse creates 4-5 questions to verify story has been understood
  - Spouse joins in and the couple communicates as they usually would
  - SLP develops verbal and nonverbal strategies for the couple to use.
  - Couple and SLP watch together and select strategies based on applicability, willingness to use

CPT findings

- Findings of review
  - Insufficient evidence for CPT with persons with acute aphasia
  - PWA showed improved use of content words, sentences, communication strategies, and topic initiation.
  - Increased confidence, self-perceptions, identity and relations, and decreased depression
  - Partner showed increased use of effective communication strategies or decreased use of negative behaviors
- Most studies in this review (72%) trained familiar partners and 24% trained health care providers or students that have some knowledge of the disorder.
Friendship and aphasia

- Another obstacle faced by PWA is maintaining existing and establishing new friendships with untrained communication partners.

- Who are PWA’s friends?
  - Work and ex-work colleagues, friends who shared a hobby (football, drinking, bridge, walking), neighbors, church friends, friends from the past, new friends from stroke support groups, family members, partners, and pets!

Friendship after stroke

- Lose friends
- Relationships become closer
- Hard work
- Communication barriers

- "I think they have to make an enormous effort because, err, having a conversation with someone who has no speech is not everybody's cup of tea." – quote for a PWA in a research project by Carole Pound


Friendship and Aphasia: Why do people lose their friends after a stroke?

- Concerned with self
- Aphasia
- Loss of shared activities
- Reduced energy levels
- Physical disability
- Environmental barriers
- Unhelpful responses of others.

Purpose of study

- (1) to describe the experiences undergraduate students as they seek to make friends with a person with chronic aphasia and
- (2) describe components and challenges encountered by UGS in ‘making friends’ with a PWA that may be used to develop a communication partner training program

Design

- A phenomenological research design was used to describe the experiences, feelings generated, and perceptions of persons who are “unfamiliar” with PWA as they attempt to establish a friendship with a person with chronic aphasia.

Procedures

- Participants: 7 undergraduate students and 7 persons with chronic aphasia

  Contact caregiver  Met with PWA 7 times  Wrote reflective essay  Focus Group

Analysis

- Thematic Analysis
  - Basic theme
  - Organizing theme
  - Global theme

- Special thank you to Lauren Ramsey (EKU Graduate Student) for assistance with reliability checks
Findings

- Four global themes describe the process of UGS (unfamiliar communication partners) becoming friends with a PWA:

1. Both communication partners felt nervous;
2. personal history facilitated communication comfort;
3. UGS became more confident communication partners; and
4. communication partners became friends.

### Personal history facilitated communication comfort

**Communication and therapy were mentally exhausting for PWA:**

- Exposure to a new reality, often with limited communication opportunities after a stroke.

**Connecting through personal experiences, importance of personal history:**

- "I think meeting the spouse with the spouse to begin with was a really nice ice breaker, just because first off you weren't meeting with the patient with aphasia. So like, getting all of that background information about their personality or what you needed to know in order to have that good communication was definitely beneficial."

### UGS became more confident communication partners

**UGS and PWA react to those differences; background information was key:**

- "I couldn't tell that therapy was stressful for him at times when they were asking him questions and he would get, you know, sometimes upset."

**Direct relationship between communication comfort and confidence:**

- "I could tell the comfort grew just because the more times you meet with someone obviously you become more comfortable with them."

### Both communication partners became friends

**Limited communication partners/important establishing relationship:**

- "I think it's because he doesn't really have many people to talk to so."

**Becoming friends:**

- "I can't wait to tell Gary, he's gonna think this is so funny: I thought about him."

### Table: What did we learn about becoming friends with a PWA?

- UGS and PWA are both nervous.
- Personally relevant context enhanced relationship.
- Conversation-based with no performance criteria.
- PWA want UGS to be successful, they have a desire to communicate and begin to use multi-modalities (those who have received training).
Problems students encountered: generational factor

- Elderspeak
  - "I feel like the age difference kinda made it hard. Because like with, finishing sentences, Audrey is like 84/85 somewhere around there. So I didn't want to help her talk because I felt like I was babying her."
- Role reversal
  - "I don't want to talk down to him, he's older than me"
- Shared interests
  - "The age difference at first you're kind of like oh we have nothing in common"  
  - "You could tell, and so that would mean I'd have to pick up the slack and start putting in more effort. More work than him."
  - "Hard for me to follow"
  - "Even though he does talk a lot, it took a lot more...like..I guess I would call it... effort to try to understand him."
  - "Memories her family tree basically, because it made it so much easier to figure out who she was talking about"
  - "Communicating in general and in therapy is mentally exhausting for PWA."

Discussion: a new CPT

- Establishing a therapeutic relationship for new SLPs
- Adapt assessment and treatment to social model
  - Modify perceptions
  - Obtain personal history and learn about current/previous interests
  - Client-centered (goal setting)
  - Develop supportive, personally-relevant materials
  - Provide supportive conversation-based treatment

Assessment: modifying perception

- How can I modify the communication environment?
- See the person not the impairment
- Therapeutic Presence
  - Welcoming, encouraging and healing
  - Resist compassion fatigue


Social

Assessment: case history

- Get to know the patient/student.
  - Activity Questionnaire
  - Intake Form
  - Personal History Profile
  - The Life Interest and Value Cards
- Adapt treatment using personally relevant stimuli

Assessment: case history

- Establish trust and client will know you are invested in his/her success
- Research shows that patients respond more accurately and faster to personally relevant stimuli.
- Personally relevant treatment tasks promote generalization.
- Increases communication opportunities with caregivers/family/friends.

- Traditional: Name as many food as you can.
- Personally relevant: Name as many food you cook on Thanksgiving.
Personal History Profile

Please help us make ____________ therapy more meaningful by completing the items below and giving us a few facts we can use to communicate with her/her.

1. What does your loved one like to be called?
2. Where did he/she grow up?
3. Describe his/her childhood (parents’ names, siblings).
4. Describe dating experiences
5. Describe educational history
6. Describe current and/or previous occupations
7. Please list the names, gender, and ages or children, grandchildren, great grandchildren
   a. Children
   b. Grandchildren
   c. Great grandchildren
8. Tell me about his/her pets
9. Tell me about his/her travel experiences
10. Tell me about his/her hobbies (music, reading, exercising, favorite restaurants, sports, etc)
11. Is there anything special you would like us to know about your loved one, yourself, or any member of your family?

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Client-centered goals

- Self-determination: difference between activities people engage in freely and activities people feel pressured to do
- Autonomy: independence and individual identity
- Outcomes and satisfaction improve when people are given the opportunity to participate in goal setting.
- Greater overall effectiveness in maintenance of outcomes.


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Client-centered Goal

- Allow PWA to be active participants in goal-writing because this increases their motivation/participation of the therapeutic process.
- They understand the goals and how the treatment will impact life participation which inevitably enhances motivation and outcomes.
- This will alleviate the factors associated with age
  * Ask the client feedback preferences
    * do you want to be corrected, fill-in sentences.

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Client-centered goals

- Persons with aphasia are unsatisfied with
  - amount of information they received about therapy
  - involvement in goal setting
- Persons with aphasia desire
  - more information about therapy
  - autonomy in decision-making
  - greater focus on desired social, hobbies, and vocational interests

The Life Interest and Value Cards

- Allows direct communication with your client, family member, or friend with aphasia (or other language difficulties) about valued life activities
- Facilitate goal-setting in therapeutic sessions, assessments, and everyday conversations
- Contain engaging black-and-white drawings depicting life activities in four categories: Home & Community, Creative & Relaxing, Physical, and Social

Potential Goals

- Ms. Heart will increase the quality of communication interactions with a spouse evident by less than 50% of unintelligible output (jargon) during a 15-minute conversational sample.
- Mr. Sunshine will increase the quality of communicative interactions with a spouse using 7 intelligible words or phrases during a 15-minute conversational sample (baseline 0).
- Ms. Stone will increase communicative efficiency during a 15-minute conversational sample with a designated communication partner by increasing use of word-retrieval strategies such as writing, drawing, gesturing, pointing to pictures within a visual scene, and pointing to the first letter of an alphabet board by 50% or greater.
- Mr. Roberts will participate in 8/10 successful communication exchanges with communication partners using any modality.

Treatment: let’s talk with purpose

- Conversation is the heart of human communication.
- A collaborative event in which both communication partners require skills.
- Communicating wants and needs
- Relating to others
- Negotiating
- Managing emotional health

Treatment: conversation-based

- Address communication within natural, personally relevant contexts.
- Less performance criteria, more relaxed
- Conversation therapy (Simmons-Mackie, 2000)
  - Planned intervention designed to enhance conversational abilities (improve skill and confidence as a conversational participant)
- Communication context with goal of communication, not impairment-based performance criteria
  - If a client makes a lot of errors, this may reduce motivation to participate in therapy and possibly communicate outside of therapy
Treatment: what to address in conversation

- Intervention-focused therapy
- Conversational coaching
- Couples therapy
- Address problems or maladaptive conversational behaviors
  - CPs: reduced test questions, closed questions, engaging in inefficient repair of breakdowns
  - PWA: vague topic introduction, lack of self-repair
- Compensatory strategies
  - Multimodal/total communication
  - Topic Alerts


Treatment: what 'activities'

- CONVERSATION
  - Supports for message exchange
    - Drawing
    - Gestures
    - Writing
    - Facial expressions, body language
    - Graphic choices or written key words
    - Communication books
  - Practicing specific skills
    - role play
    - video feedback

- Promoting conversational participation
  - PWA leads a topic
  - Clinician uses gaze/silence to engage participation
  - Embedded methods used while engaging in conversation
  - Rephrasing/repeating
  - Scaffolding
  - Modeling
  - Reinforcing target behaviors within context of conversation
  - Coaching (pointing out a particular strategy)


Treatment: measurements (discrete)

- Words per utterance
- Initiation in conversation
- Sentence attempts and questions
- Self-repairs
- Nonverbal or multimodality behaviors
- Conversational turns
- Topic initiations
- Appropriate topic alerts (introduction of new topics)
- Rating Scales of participation, communication burden

Context-based approach (Marshall, Robert)

- Used primarily with individuals with Wernicke's aphasia.
  - Severe loss of auditory comprehension which may be related to selective attention deficits.
  - Speech is fluent but empty with circumlocutory phrases, indefinite words and paraphasias.
  - She went to the thing, my friend tood.

- Outcomes of contextual vs noncontextual (testing) scenarios
  - Better performance communicating in a context about something relevant to them than on a standardized test.

- Goal: improve auditory comprehension and information exchange in authentic communicative context = communication


How to use context-based approach

- Obtain biographical information/previous interests (use Activity Questionnaire or personal history profile)
- Establish communication contexts
  - Shared knowledge, items in room
- Be flexible, think conversation-based approach, not impairment-based
  - No drill
  - No repetition
  - Nothing without context
  - Laughter, joy!
  - “What are they doing? It looks like they’re just talking.”

Stimulus Characteristics | Treatment | Example
---|---|---
Auditory; slow rise time (miss initial portion of messages) | Reduce noise; insert strategic pauses within message; wait time between questions/comments; attention getter | Face individual; limit distractions Paul: ...how are you?
Visuospatial Clarity | Use realistic stimuli, operate | Use personal photos/familiar materials
Multimodality stimulation | Auditory, tactile, and visual; too many inputs can overload capacity | Do you want to eat pizza tonight? Pizza tonight?
Length and Redundancy | Reduce message length to facilitate comprehension/retention; apply stress to important words | 1. John hit the ball vs John hit Mary
Linguistic | Use non-reversible, affirmative, present, and directly stated sentences/utterances | 2. John eats cake vs John does not eat cake
  3. stand up vs I would like for you to stand up
How to use context-based approach

- **Linguistic Variables**
  - Highlight main ideas, write down topic
  - Add stress
  - Direct information (time to eat) instead of indirect statements (now it's time for dinner we better go eat).
  - Use repetition, paraphrasing, and expansion.

- **Temporal Variables (rate)**
  - Slightly slower speech but not unnatural
  - Insert pauses/chunks of information
  - Alert patient to topic (now we are going to talk about...)

- Reduce number of ‘wh’ questions, repetitions, retrieval of specific words instead ‘tell me more.’

- Use multimodalities (personal objects, relevant pictures)

- Reduce Garbage-out/garbage-in cycle by re-phrasing the client’s incorrect utterance so he/she hears the correct utterance.

Context-based Approach: Eating

**Clinician:** I would like to talk to you about food (established context and highlighted main idea: I am hungry GESTURE-MULTIMODAL CUE).

**Client:** Me too. Is thing growl?

**Clinician:** No, my stomach isn't growling (rephrased). Good breakfast (added stress).

**Client:** I cereal this morning

**Clinician:** You ONLY ate cereal, you must be hungry. Lunch?

**Client:** After here

**Clinician:** When you leave here, you will eat lunch.

**Client:** Yes.

**Clinician:** I like pizza (have pizza menu).

**Client:** Me too. That's lunch.

**Clinician:** You are eating pizza for lunch (wait 10 seconds) cheese or supreme?

**Client:** Everything

**Clinician:** so you like supreme pizza.

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Intensity vs. context

- Context-based treatment delivered to 12 PWA (non-fluent)
- Groups
  - Intensive = 20 hours of individual and 5 hours of group treatment per week
  - Non-intensive = 4 hours of individual treatment per week
- Outcomes (pre-post intervention)
  - Criterion-based task (catalogue dialing)
  - Communicative Abilities in Daily Living task (CADL-2: Holland, Fromm, & Frattali, 1999)
  - Psycholinguistic Assessment of Language Processing in Aphasia (PALPA; Kay, Lesser, & Cottle, 1999) (oral naming, written naming)
- No differences in outcomes between intense vs non-intensive context-based treatment.

Clinical Application

**Case Study: Mr. Ray**

- **Current Medical history:** LH stroke s/p 6 months
- **Pmhx:** adult-onset DM, HTN, TIA in March of last year.
- **Communication Exam:** Global-Wernicke's aphasia.
  - Listening comprehension: follows very simple commands (close your eyes) and answers yes-no answers with visual cue. Unable to complete complex commands.
  - Reading: unable to identify letters, identifies single words
  - Expressive language: reduced repetition of phrases and naming common objects. Spontaneous speech includes single words and mostly jargon.
  - Writing: single words
- **Personal history:** Mr. Ray is a 55 y/o accountant (college grad). Married with 2 children: son (30), daughter (28), neither living at home. Wife (Sarah) is a middle school teacher. They enjoy watching horse races and visiting children. Employed at time of apparent neurological event.

**Case Study: Mr. Ray (goals)**

- **Client-centered (goal setting)**
  - Using LIV cards, Mr. Ray indicated that he wants to return to work, talk to kids and wife.
  - **Goal:** Mr. Ray will improve auditory comprehension by following directions related to vocational tasks using written cues at 80% accuracy.
  - **Goal:** Mr. Ray will increase the quality of communication interactions with spouse evident by less than 50% of unintelligible output (jargon) during a 15 minute conversational sample.

**Case Study: Mr. Ray (treatment)**

- Personally-relevant materials: Calculator, tax form, number tiles/written numbers, paper, pencil
- SLP: You are an accountant.
  - Mr. Ray: ac… (shakes head yes).
  - SLP: I am pretty bad at math (get out calculator)
  - Mr. Ray: (laughs and takes calculator)
  - SLP: Taxes?
  - Mr. Ray: bu…. (wipes head)
  - SLP: Tax time is busy.
  - Mr. Ray: busy
  - SLP: A lot of information for taxes.
  - Mr. Ray: (shakes head yes)
  - SLP: (shows tax form 1040) Let's fill this out (write down fill out).
  - Mr. Ray: I don't know (looks overwhelmed)
  - SLP: It is a lot of information (covers all but first line). Read this line.
  - Mr. Ray: US Indi…..Ta Return (encourage move forward)
  - SLP: US Individual Tax Return. (continue completing the form)

**Case Study: Ms. Clare**

- **Medical history:** LH stroke in 2017, HTN, depression
- **Communication Exam (linguistic portion of Western Aphasia Battery)**
  - Aphasia Quotient 57.4 (moderate)
  - Spontaneous speech = 8 (less than 3 word responses, effortful speech production)
  - Auditory Verbal Comprehension = 8.7 (unable to complete 4-step commands)
  - Repetition = 5 (difficulty with longer utterances)
  - Naming and word finding = 7
- **Personal history:** 55 year old. Married to Joe and they have 2 children (Sharon (25) and Susy (28)). Works as a registered nurse at a hospital. Enjoys running and dining out with her husband.

**Case Study: Ms. Clare’s goals**

- She informed the clinician that she wants to order at restaurants. She indicated that she will probably just retire from work and volunteer at the library.

- **Goals:** Ms. Clare will increase quality of communication using 4 intelligible phrases/sentences during a 15 minute conversational sample (baseline 0).

**Case Study: Ms. Clare (treatment)**

- **Materials:** menu from O’Charley’s restaurant
  - Ms. Clare: potato soup
  - SLP: I love potato soup but not with sour cream.
  - Ms. Clare: I love sour cream
  - SLP: I like to dip rolls in the potato soup
  - Ms. Clare: good. Chicken (point at chicken)
  - SLP: Yes, I love the chicken strips.
  - Ms. Clare: (makes dipping gesture)
  - SLP: You dip chicken strips in honey mustard.
  - Ms. Clare: chicken …honey mus….ard
  - SLP: Sides (shows picture on menu)
  - Ms. Clare: sa….ran….
  - SLP: salad with ranch dressing
  - Ms. Clare: salad with ranch dressing
  - SLP: Well, we have to drink something too.
  - Ms. Clare: water……lemon

- Ms. Clare: potato soup
Case Study: Mr. Baker

- Mr. Baker is a 60 year old man with Wernicke's aphasia resulting from a stroke 1 year ago.
- Assessment results: reduced auditory comprehension, word finding
- Personal history: He is married to Sue and has 2 children in college. Prior to his stroke, he worked as an auto mechanic and enjoyed playing cards with his friends once a week.
- Client's goals: play cards and return to work
  - Goals: Mr. Baker will improve auditory comprehension for 4/5 conversational exchanges with family/friends given contextual and written cues.

Case Study: Mr. Baker’s treatment session

- Topic: cars (write down), photos of his cars, car magazines
- SLP: Oh, that is your car. It looks like a Chevy.
  - Mr. Baker: Yes, a 57 Chevy. In my garage. We ride on days, not work. I love to drive it. My wife (shakes head no).
  - SLP: The 57 Chevy is in your garage. You drive it on weekends. Why doesn’t your wife like it? (write Chevy)
  - Mr. Baker: drive too fast (raises 3 fingers and frowns). My wife (shakes head no).
  - SLP: You got 3 speeding tickets.
  - Mr. Baker: Most on big road. I need to slow down. Lots of cars on road. Tense, I wrecked one time.
  - SLP: Yes it is dangerous. You wrecked? Damaged car?
  - Mr. Baker: not too bad. Pulled out bumper.

Case study: Mr. Brown

- Mr. Brown, 70 years old, referred following a stroke (left hemisphere, temporal lobe) s/p 3 months resulting in receptive language deficits
- PMHx significant for DM, HTN, and cataracts.
- Assessment shows
  - Western Aphasia Battery: unable to complete due to reduced auditory comprehension.
  - Functional: Oxenham Questionnaire
  - Social: He lives with his wife and they have 2 children. Mr. Brown is a retired pilot. He and his wife enjoy dining out and he likes going fishing with friends.

Mr. Brown (2 volunteers)

- Thoughts of treatment?
- Client’s goals

  - Materials

  - Treatment

Group work

- Use the Communication Partner Training Approach for a current client on your caseload.
- Personal history
- Client’s goals
- Personally, relevant materials
- Write a script for a conversation-based treatment

Conclusion

- During your first encounter with a PWA, begin the therapeutic relationship by learning about the individual.
- Personal relevance enhances motivation and treatment carryover
- Using conversation-based treatment enhances life participation