

From My Perspective: Changing the Aphasia Narrative

Laying down the gauntlet: Our modest proposal for an elevator pitch describing the aphasia services SLPs deliver—and why SLPs are the ones to provide them

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Are speech-language pathologists good at publicizing the benefits of aphasia therapy and the results of their aphasia interventions? No. At least not according to a number of prominent rehabilitation professionals outside our profession.

One was Jeffrey Metter, a neurologist. Back in 1982 he wrote in *Asha* magazine that SLPs' reports of patients' language test scores or percentages of objects named fail to impress physicians and other stakeholders in aphasia treatment. More than 30 years later, a physiatrist reviewing the evidence on aphasia treatment approached us with the same concern. Although a great champion of rehabilitation for aphasia and highly familiar with aphasia research, this physician essentially mirrored Metter's comments. He told us that physicians, policymakers and others rarely understand what SLPs do for people with aphasia—what SLPs are supposed to do for specific types of patients or at specific stages along the health care pathway—and many wonder why other professionals (or even volunteers) cannot do the same thing. He said improved scores on language tests and other such SLP-reported treatment outcomes mean little to many stroke professionals.

The physiatrist then challenged us to develop an "elevator speech" on aphasia and aphasia treatment: a short, clear "lay" description of what SLPs can deliver and why SLPs should be providing these deliverables. We are up for the challenge and, through this article, hope to begin shaping such an elevator pitch with our colleagues.

Communicating our value

In considering how to define the importance of SLPs in aphasia rehabilitation, we might draw from the field of health economics and consider the concept of "value" of a service or product. According to health economist Jeffrey Hoch, [in a chapter in the 2013 book](http://books.google.com/books?id=3D9ZxGAAAQBAJ%26amp%3Bpg%3DPA399%26amp%3Bpg%3DPA399%26amp%3Bdq%3DG.%2BZaric%26amp%3Bhl%3Den%26amp%3Bsa%3DX%26amp%3Bei%3DXoZEUtXtMrXH4APY4oDwDA%26amp%3Bved%3D0CFwQ6/) [Operations Research and Health Care Policy](http://books.google.com/books?id=3D9ZxGAAAQBAJ%26amp%3Bpg%3DPA399%26amp%3Bpg%3DPA399%26amp%3Bdq%3DG.%2BZaric%26amp%3Bhl%3Den%26amp%3Bsa%3DX%26amp%3Bei%3DXoZEUtXtMrXH4APY4oDwDA%26amp%3Bved%3D0CFwQ6/), there are three points to consider regarding value. First, value is the degree to which something is useful for solving a problem or meeting a goal. Second, showing value involves considering a problem from the *stakeholders' view*. And third, if we are not part of the solution to *their* problem, we are irrelevant.

Thus, we need to determine what "problems" we are able to solve from stakeholders' perspectives and describe our solutions in a way that is understandable and relevant to them.

For example, many of us describe our work as remediating language deficits in aphasia. However, the impact of a language disability is not always obvious. While it is apparent to all that physical impairment, such as hemiparesis, affects mobility and physical access, and that physiotherapy, walkers and wheelchairs can help, the relationship of language impairment to reduced life participation is not as easily understood.

Research from the field of knowledge transfer and exchange tells us that merely informing others via articles or conference papers does not change practice. Explanations need to make sense to—and take into account the perspectives of—the stakeholder, whether that be a patient, the patient's family, our medical colleagues, stroke research funders, administrators, policy makers or others.

Thus, our elevator speech needs to:

- Describe aphasia in terms of its consequences for activities involving communication and how it can restrict participation in life.
- Explain that although there is no cure for aphasia, there are solutions that help patients/families live successfully with this chronic problem.
- Use simple, meaningful language to convince those who allocate resources, make referrals and fund services of the need for services for people with aphasia.
- Indicate why aphasia is a problem for health care systems and society, as well as for patients and their families, in terms of lost productivity, increased health care costs and reduced adherence to treatment recommendations.
- Explain the unique contribution of the SLP and relate it to a broader context—the context of health care, stroke services and society.

When advocating for improved services, consider embedding the language impairment in descriptions that highlight the [impact of aphasia](http://www.asha.org/publications/leader/2000/2000215/Life-Participation-Approach-to-Aphasia--A-Statement-of-Values-for-the-Future.htm%231) (<http://www.asha.org/publications/leader/2000/2000215/Life-Participation-Approach-to-Aphasia--A-Statement-of-Values-for-the-Future.htm%231>) on essential aspects of daily life—including key relationships, life roles and activities—and the high cost of resulting social isolation. We typically use the ICF-based A-FROM (Living with Aphasia: Framework for Outcome Measurement schematic) as a reference point so that stakeholders can see the effects of aphasia on key life domains.

Proposed elevator speech

We propose that our elevator speech clearly state why aphasia is a problem, offer solutions to the problem and explain why the SLP is in a position to provide these solutions. In format, the speech could look something like this:

Establish the problem for external stakeholders

- Aphasia is a language problem that masks inherent competence and most dramatically affects conversational interaction (talking and understanding), as well as the ability to read and write
- Conversational interaction is core to the ability to participate in virtually every realm of adult life but is not listed as an essential activity of daily living, as are the more obvious self-care categories. ADLs are seen as a concrete, practical measurable component in stroke care. Patients cannot be discharged without support for what is considered a basic ADL: for example, the ability to care for oneself. However, stroke patients with aphasia are often discharged without the supports needed to engage in conversational interaction with significant others.

- Without the ability to participate in conversation, every relationship, every life role and almost every life activity is at risk. With additional reading and writing difficulties, the impact is devastating. The results are not only barriers to accessing stroke/health care services and information, but also an inevitable loss of self-esteem and a profound sense of social isolation. Research indicates that social isolation and depression have a significant negative impact on health. The resulting costs to patients, families and the health care system are enormous, and the need to pay attention to secondary prevention should not be underestimated.

Offer solutions to the problem

- Communication and conversational interaction should be seen as an essential ADL. As part of a comprehensive communication treatment plan, no patient with aphasia should be discharged without an evaluation of needed communication supports, including training for key family members and ensured availability of appropriate communication resources.
- Assessment should, therefore, include the impact of language impairment on ADLs—including conversational interaction—so that intervention focuses on key areas and is outcome-driven.
- Appropriate intervention can help minimize costly secondary problems such as depression, family burden and more costly care. This intervention needs to begin in acute care and carry through to rehab and beyond. Intervention may include, but is not limited to, direct work on language and functional communication.
- Speech-language pathology expertise in communication and swallowing needs to be recognized and reinstated in order to address the complex problems outlined above. Further, this inclusive notion must be part of SLPs' training. Key intervention areas include addressing language impairment; working directly with families on becoming a good conversation partner; reading; writing; working with assistants and providing training and resources to allied health professionals; providing education and psychosocial support to patients and families; and referring patients to social workers and others with expertise in aphasia.

Make the case for SLPs

- We need consensus on the skill set SLPs need to treat patients with aphasia effectively. However, it is important to differentiate an "approach" from any one single skill. Using a medical analogy, nurse practitioners perform many tasks previously done by physicians, who now fill a more holistic problem-solving role. If we want to comply with cost-effectiveness trends in health care, we also have to ask ourselves what others, such as occupational therapists, can do, what critical element we bring to the table, and how to most effectively blend our expertise.
- We must communicate that aphasia treatment requires a composite of knowledge and skill across areas such as brain and language, evidence-based language assessment and rehabilitation, partner training and communication support for others involved with patients, group treatment, and counseling, including partnering with other professionals in these areas.

As SLPs, we need to communicate these messages effectively if we want to bolster understanding of the value of our language and communication services to patients with aphasia. And close work with our colleagues in allied professions is necessary for this to happen. It would be the cruelest of ironies if investment in aphasia treatment and care continued to diminish because of our field's inability to recognize and communicate our value.

This article is based on Aura Kagan's keynote address at the 2012 International Aphasia Rehab Conference.

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