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Assess for Success

Evidence for Therapeutic Assessment

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In this chapter, our focus is assessment—but we have chosen to approach this topic from a novel perspective. We present evidence that, to consider assessment within the context of a book on communication supports for people with aphasia, we need to employ therapeutic assessment that encompasses assessment of support, assessment with support, and assessment as support. In other words, the process of assessment needs to be therapeutic in itself. It should be a positive part of the overall effect of our intervention and not a separate process on which therapy is subsequently built. We also emphasize that therapeutic assessment has a role in promoting successful living with aphasia in the longer term.

Our exploration of the evidence for therapeutic assessment is structured as follows: First, we present an argument for a fresh look at aphasia assessment and why current practice may not be as supportive as it could be for our clients; then, we describe three principles that underpin therapeutic assessment; and, finally, we look at several ways in which therapeutic assessment might be carried out in practice, enabling the close integration of support into the process.

TRADITIONAL ASSESSMENT PROCESSES

Traditionally, the relationship of assessment and therapy has been sequential. A new client with aphasia undergoes an assessment, and that assessment is followed by therapy. The assessment, particularly when standardized, is synonymous with a test, carried out under controlled conditions by an objective and neutral clinician keen to avoid influencing or leading a response. As a result, clinicians' initial interactions with clients might reflect a particularly formal relationship. Not only do formal as-

assessments require this context of objectivity and neutrality, but they also signify that the clinician is in control, not only marking the boundaries of the clinician's interactions with clients but also informing the direction of therapy itself. As a generalization, assessment in the most traditional sense is a process through which clinicians gain information about their clients. This information may form a base for many things: judging strengths and impairments across modalities, informing theories of levels of breakdown, determining baselines or ceilings, making a diagnosis, judging potential, informing therapy direction, tracking change over time, measuring outcomes, and helping to show when a goal has been reached.

However, what is less certain is whether the clients themselves gain information from the assessment process that is supportive or therapeutic. The degree to which this occurs is dependent on the priorities and skills of the practitioner as well as on the circumstances of the assessment. Research on the experiences of people with aphasia and their families suggests that they often feel that although they are participants in assessment, they are not necessarily supported by it. For example, the following quotes are from an Australian study in which 50 people with aphasia and their family members were interviewed on "What people with aphasia want" (Worrall et al., 2011). Rose, a 79-year-old woman with mild anomia, summarized her assessments as follows: "Sh-sh-she kept—kept on g-g giving me things to look at, that's about it." Tina, who had her stroke in her mid-20s, reported, "That's how I used to feel, that I was always on, um—always taking a test." Another example was from Kylie, whose husband had recently been admitted to a hospital following a stroke that had resulted in aphasia. Kylie described her first encounter with speech pathology in the hospital:

Kylie: There were a few of us there, a few (family) members and casually I said, "Well, we'll go," and she [the speech pathologist] said, "Oh you can stay," so that was interesting, watching that process because he was quite happy for us to be there while she did the tests and things and that was good because we were able to see and also by her reactions because I was there, she said, "That's good, that's good."

Interviewer: So she basically ran an assessment?

Kylie: Mmm.

Interviewer: Did she explain to you what had been the problem or what was the problem with his communication at that point?

Kylie: No, she just kind of just said to (my husband) yeah, he was doing really well and she mentioned the word *dysphasia*. So really we just, we put a name and now it's sort of aphasia and I said to my husband "oh, I thought it was dysphasia, what's the difference between the two?" so we don't really, we haven't had anything really explained on that score. (Worrall et al., 2011)

Kylie's story is of interest because the only piece of information she came away with was a confusing diagnostic label. Although she found it interesting watching the tests, and she may have been pleased that the speech-language pathologist (SLP) judged that her husband was doing well, she was given no other information about the assessment itself, what the SLP was looking for or found, or where the results of the test might lead. Thus, the assessment process itself was not as supportive as it might have been. Kylie's husband, Kevin, who was also interviewed as part of this research, described his bewilderment about the whole assessment experience:

It was, it was, a discussion amounting to, around about 30 minutes....But, really, I don't think we achieved terribly much. She perhaps, she perhaps, through her notes and her giving me this piece of paper to write on....She would discover that I could write the word, but not the numbers. But that's essentially where it finished. (Worrall et al., 2011)

Similar findings were reported by Parr, Byng, Gilpin, and Ireland (1997) in their study of 50 people with aphasia in the United Kingdom. They reported an account by Betty, a participant with aphasia:

The speech therapist came once or twice and gave me one of those tests, you know, with the spelling and everything and I couldn't make head nor tail of it. She came, I think, a week later and suggested I had a speech therapist. But they were a bit short at the time. (1997, p. 77)

Betty described being given an assessment that left her confused but aware of her impairments and her own inability to understand what the assessment was all about. She knew that she really needed more help but that services were not available. Parr and colleagues then reported that Betty “bravely” said that she could manage without more help despite feeling a real desperation for speech therapy. This assessment experience also appears to have been unsupportive—not only because Betty had little information about the results but also because it did not reveal her real desire for assistance.

Parr et al. (1997) also identified that, after strokes, people with aphasia want to know the cause of the stroke, the range and nature of associated impairments, why various impairments occur, how to cope with them, their prospect for recovery, time span for recovery, whether another stroke is likely and how to prevent this, the role of various professionals, what treatments and therapies are available, the nature and effectiveness of the treatments, how long they will be in the hospital, what supports will be available at home, and where to turn for help and advice. Parr et al. wrote, “Obtaining information can bring about a feeling of reassurance, a sense of being in control and able to understand and accept what has happened” (p. 89). We suggest that the assessment process should provide a chance to explore these kinds of issues because it is through the assessment that many of these answers are found. In other words, in addition to providing important diagnostic information, the assessment process should be a fundamental opportunity for support and information exchange. The kind of information that people with aphasia and their families often need in the early period poststroke is summarized in Table 6.1. In reality, people's questions are very individual, but Table 6.1 is a useful reminder that an assessment is an opportunity to explore answers to questions—not just for clinicians but also for clients—and that this discussion is ongoing and a source of support.

At present, the speech-language pathology assessment process does not seem to provide people with aphasia and their families with the information they need to help them begin to understand their aphasia or to help them engage with the process of rehabilitation. There is some evidence from surveys of practice (Katz et al., 2000; Simmons-Mackie, Threats, & Kagan, 2005; Verna, Davidson, & Rose, 2009; Vogel, Maruff, & Morgan, 2010; Worrall & Egan, 2001) that SLPs prioritize assessment of the impairment over other aspects of the International Classification of Functioning, Disability and Health (ICF; World Health Organization, 2001) despite a large number of available formal measures (Patterson & Chapey, 2008; Ross & Wertz, 2005).

Table 6.1. Examples of information that people with aphasia and their significant others might derive from assessment

Examples of information that people with aphasia and their loved ones want	Examples of questions that people with aphasia and their loved ones might want to discuss with the clinician in a supported way as part of assessment and rehabilitation
What is a stroke (or other etiology)?	What has happened to me/my loved one?
What caused the stroke (or other etiology)?	What caused this and why?
Information about health promotion/illness prevention	Is there a possibility of another stroke? How could we prevent this?
Information about associated impairments	Tell us about all these other things that I am experiencing, such as visual field deficits, sensory changes, seizures, and mood change.
Why various impairments or consequences occur	Why is my loved one having trouble forming sentences/writing his address/handling money?
How to cope with impairments	What can we do about these problems?
How to communicate with the person with aphasia	Is there anything I can do to help my loved one talk to me?
Prospects for recovery	How do the assessment results inform treatment, and how will treatment help? What else can I/we do to get better?
Time span for recovery	How long will it all take?
Probable length of hospital stay	How long will I need to be in the hospital or rehabilitation?
Role of various professionals	What do you do, and how can you work together with us (client and family)?
Available treatments and therapies	What treatments are out there that can help? What will they cost? Is there a waiting list?
Nature and effectiveness of treatments	Do these treatments work? What do they involve?
Discharge issues	What will happen after discharge from the hospital?
Ongoing support	What supports will be available at home?
What happens long term (including information on community resources)?	Where can we turn for help and advice?

It may be that current assessment practices reveal a potential discrepancy between the priorities of clinicians and the needs of clients and families. One alternative is for SLPs to consider assessment as a therapeutic activity in and of itself. Through the assessment, people with aphasia and their families can begin to understand the condition, understand the nature of rehabilitation, and feel engaged and supported in this process. The theoretical frameworks that can inform our conceptual development of therapeutic assessment are described in the next section.

THEORETICAL UNDERPINNINGS FOR THERAPEUTIC ASSESSMENT

The idea of a therapeutic assessment is broadly informed by three principles. The first is that assessment should be woven into intervention rather than separate from it and should be part of an iterative process whereby a skill or strategy use

can be tested, trialed, supported, and reviewed in a dynamic assessment (DA) approach. Second, assessment should be guided by adult learning theory principles (Kimbarow, 2007). As is increasingly accepted in educational settings, assessment should be formative as well as summative, meaning that the process itself is a learning opportunity for the client, contributes to rehabilitation, and involves much more two-way exchange than is found in traditional assessment. Third, assessment needs to be closely integrated to the context in which the communication occurs because communication supports have a profound influence on a person's ability to communicate, and these are environment- or context-dependent. These three principles are discussed in more detail in the next three sections.

Principle 1: Assessment as an Intervention

DA is an approach to assessment that enables the clinician to trial interventions with the client during the process of assessment. It emerged from the field of educational psychology as an approach to assessing a child's potential for learning (Hasson & Joffe, 2007). DA is an interactive process involving the learner, the assessor (clinician), and the task. Feuerstein, Feuerstein, Falik, and Rand (2002) described three essential components that are conveyed to the learner during the process of DA: the mediation of intentionality—whereby the learner understands that the assessor intends to help him or her improve; the mediation of meaning—that the learner understands that the purpose of the activity is shared with the assessor; and the mediation of transcendence—that the activity is related to other contexts in which the skill can be used (Hasson & Joffe, 2007).

In contrast to standardized assessments that require the clinician to administer highly structured tasks with predetermined instructions that restrict the clinician's ability to support the learner in responding, DA aims “to reveal an individual's maximum performance, by teaching or mediating within the assessment and evaluating the enhanced performance that results” (Hasson & Joffe, 2007, p. 10). DA provides clinicians with the flexibility to interact with learners to determine their learning strengths and weaknesses, the range of strategies that are useful to them, and how responsive they are to these different strategies (Hasson & Joffe, 2007). But, just as important, this process also supports the learner to experience his or her best response and experience the feeling of competence that comes with that (Hasson & Joffe, 2007).

The principles of DA can be applied to the assessment of adults with communication disability. Whereas DA as applied to children aims to assess the potential for learning, a DA of adults with communication disability would aim to assess the adult's potential for successful communication. As in assessment of learning ability, this would involve revealing the adult's maximum communication ability by mediating within the assessment and evaluating that maximum performance. One example of how this is done in a traditional aphasia assessment is when semantic and phonological cues are used in a confrontation naming test, as in the following example:

Clinician: Tell me the name of this? (pointing to a pen)

Client: Uh...uh...I know it...No.

Clinician: I'll give you some more information. You write with it.

Client: Yes, I know! I have them.

Clinician: I'll give you the first sound and see if that helps. It's a *P*.

Client: Pen!

Giving the client semantic and/or phonological cues and observing whether the client benefits from these provides the clinician with useful information about where the breakdown is occurring. This concept of determining what helps naming can be extended to what communication supports might help in everyday communication, as in the following example:

Clinician: Tell me the name of this. (pointing to a watch)

Client: Uh...uh...that...yes.

Clinician: You use it to tell the time.

Client: Yes...the time.

Clinician: I'll give you the first sound. It's a *W*.

Client: (Pause) No.

Clinician: Okay, can you show me how you use it?

Client: Oh, here. (points to wrist)

In this example, neither phonological nor semantic cues helped the client name the item; however, the simple prompt "Show me how you use it" elicited a communicative gesture that may aid the person with aphasia when communicating in everyday situations. In exploring how different communication strategies help the client communicate, the clinician would need to consider the complexity of the communication task, the range of communication strategies and supports that may assist the adult with the communication disability, and the adult's own communication strengths and responsiveness to the different communication strategies that were made available. However, once the clinician has built an understanding of the kinds of cues that are beneficial, *therapeutic assessment* implies sharing that information with clients in an accessible and supportive way. For example, the clinician might draw a simplified model of how a phonological cue helped to activate the word *pen*, or use an analogy, such as the *P* unlocking a box to the word. Similarly, the gesture of showing where a watch sits on the wrist could be highlighted to a client as a strength and could provide a way for the client to demonstrate his or her competence to others even when the word itself remains elusive. Just as these assessments demonstrate the level of breakdown to a clinician, they also can be a source of information to a client to learn about his or her own disorder and what might be done to improve or compensate.

The Inpatient Functional Communication Interview (IFCI; O'Halloran, Worrall, Toffolo, Code, & Hickson, 2004) is one example of a communication assessment that uses the principles of DA; this assessment is discussed later in the chapter.

Principle 2: Adult Learning Theory and Aphasia Assessment

Kimbarow (2007) pointed out that traditional aphasia therapy has been based on pedagogical learning theory in which teachers make the decisions around what, how, and when something will be learned. Essentially, this translates in our context

to a clinician-directed model that, Kimbarow argued, can foster an expectation that the clinician's instructions should be followed and can therefore encourage a tendency in people with aphasia toward dependence as learners. Kimbarow suggested that the development of the Life Participation Approach to Aphasia (LPAA; Chahey et al., 2008) challenged this traditional learning relationship and set the scene for a partnership model of practice in which people with aphasia were expected to assume far more responsibility in setting their own treatment goals. This shift aligns the LPAA not with pedagogy but, rather, with andragogy or adult learning theory. This approach assumes that adults have life experiences that can be productively tapped to motivate learning, that adults learn best when they take some responsibility for their learning, that they want to know why they are learning something before they undertake it, and that they expect that the learning will be useful and relevant to their lives.

If adult learning theory is applied to the way in which SLPs assess people with aphasia, then it would be important for the assessment itself to be a learning opportunity—that is, the assessment would not simply produce a score or a profile to record in medical notes or a report. Instead, it could be formative and contribute to learning in a similar way as is now encouraged in other educational settings (Boud & Falchikov, 2007). This would entail explaining clearly, in an aphasia-friendly way, what the assessment is for, why it might be useful, why it is relevant to that person, and how the results might contribute to a shared goal-setting process.

Principle 3: Assessment in Context: The Person–Environment Fit

Communication support can be viewed as an interaction between the person and his or her environment. In Chapter 2, Simmons-Mackie framed communication support within the ICF (World Health Organization, 2001) and the Living with Aphasia: Framework for Outcome Measurement (A-FROM; Kagan et al., 2008) but noted that the concept of communication support was not explicitly mentioned in the A-FROM (see Figure 2.2). We interpret communication support as the degree of fit between the person with aphasia (all the functioning components on the ICF as well as personal factors) and his or her environment. The person–environment fit considers how well the demands of the environment accommodate the functional abilities of the person—in this case, the aphasia friendliness of the environment. This may be investigated via the reported environmental barriers and facilitators from the perspective of the person(s) him- or herself (who experiences his or her own functional abilities) or an observer (e.g., a family member or SLP) who is aware of the functional abilities of the person, group, or population. The assessment-of-communication support for people with aphasia by SLPs can therefore be viewed as an assessment of the person–environment fit.

The combination of these three underlying principles to therapeutic assessment paves the way for a more supportive and informative assessment process. In the next section, we outline some practical ways in which aphasia assessment can achieve this. Our suggestions are not necessarily given to advocate for new assessment batteries or materials but, rather, to show how observation and interview can be fundamental assessment processes in themselves and how currently available resources can be used in a more supportive, aware, and responsive way.

THERAPEUTIC ASSESSMENT IN PRACTICE

This section describes two therapeutic assessment processes. The first is suitable for people with aphasia still in the hospital, and the second describes a process that has a strong focus on goals, whether they are established in or out of the hospital setting.

First, the IFCI is a dynamic assessment of adults with communication disability in the hospital setting. The IFCI is a semistructured interview that the SLP conducts at the patient's bedside (O'Halloran et al., 2004). It consists of 15 communication situations, such as patients' ability to "tell you what has happened to bring them into the hospital," "understand the medical diagnosis," "ask questions about their care," and "understand descriptions of what is happening to them." These communication situations were selected because they were identified as important communication situations both to patients and to health care providers in hospital settings (O'Halloran, Worrall, Code, & Hickson, 2007; O'Halloran, Worrall, & Hickson, 2007). Before conducting the interview, the clinician reviews the patient's medical history to determine the patient's medical story, including reason for admission, medical diagnosis, and health management plan. The clinician also looks for evidence of any preexisting medical conditions, such as hearing impairment, or personal factors, such as English as a second language, that may contribute to difficulty communicating. The clinician then goes to the patient's bedside and engages the patient in a semistructured conversation to determine how well the patient is able to communicate in such hospital-related communication situations.

The interview is semistructured so that the clinician can engage the patient in a genuine conversation. However, a suggested script is provided to assist the clinician if required. For example, to investigate how well the patient is able to tell what happened to bring him or her into the hospital (IFCI Item 2), the clinician might ask, "So can you tell me what happened to bring you into the hospital?" To determine how well the patient "understands the medical diagnosis or 'reason for admission'" (IFCI Item 3), the clinician might ask the patient, "So have the doctors told you what they think has happened?" and "Can you tell me what a _____ (medical condition) is?" The clinician can then continue the interview by exploring whether the patient "understands the implications of the current medical condition" (IFCI Item 4) by asking, "Are you having any trouble with anything since _____ (medical condition)?"

If, during the interview, the patient and clinician experience difficulty communicating, then the clinician has the opportunity to intervene and try out different communication strategies to support the patient in communicating. For example, in the following excerpt, the clinician is assessing the patient's ability to "tell what happened to bring him into the hospital" (IFCI Item 2).

Clinician: So...What happened to bring you into the hospital?

Client: Ah (shrugs shoulders) nothing.

Clinician: Hard to say?

Client: (Nods)

Clinician: That's all right. I'll see if there is anything I can do to help. Were you at home and started to feel sick?

Client: Yes.

Clinician: Did you go to your local doctor or come straight into the hospital?

Client: See my local doctor.

Clinician: Oh, okay. Then what happened?

Client: (Long pause, no response, then looks to clinician and shakes his head)

Clinician: That's okay. Did the doctor send you in to the hospital?

Client: Yes.

During this interview, it becomes apparent that this patient is unable to communicate successfully when asked open-ended questions, such as, "Then what happened?" but he is able to respond when provided with a forced choice, such as, "Did you go to your local doctor or come straight into the hospital?" or a question that only requires a *yes* or *no* answer, as in, "Did the doctor send you in to the hospital?" It becomes clear that, with this conversational support, this patient is able to communicate successfully about what happened to bring him into the hospital. A range of communication strategies that clinicians and patients can try to facilitate communication during conversation are provided in the IFCI manual (O'Halloran et al., 2004).

Given communicative support throughout the interview, it is anticipated that the patient will be best able to communicate about his or her health care needs. This information can have direct and immediate consequences for the patient's health care in the hospital. For example, when discussing any concerns the patient might have, the patient may alert the SLP that he or she is not taking some medication in the hospital that he or she usually takes at home. Second, any new information about the type and nature of the communication supports that best assist the patient can be shared with the patient and with the rest of the health care team, thereby helping to create a supportive communicative environment for the patient while in the hospital setting. Finally, through extended, supported conversation, the SLP also gains insight into the type and severity of any underlying, communication-related impairments that may be present, which may inform discussions with the patient about experienced communication difficulties as well as the direction of further assessment. The IFCI is scored on the basis of the patient's best communication response, regardless of the communication support that is required to achieve this. Preliminary investigations of the IFCI indicate that it is a valid and reliable measure of patients' ability to communicate their needs in hospital settings (O'Halloran, Worrall, Code, & Hickson, 2007).

Applying Feuerstein and colleagues' (2002) three essential components of DA to the IFCI, it is evident that the IFCI is a good example of DA for adults with communication disability. There is mediation of intentionality in that the clinician tries different communication strategies and supports to elicit the patient's best communicative response at that time, and therefore the patient experiences the clinician genuinely trying to help him or her communicate to the best of the clinician's ability. There is mediation of meaning in that both the clinician and the patient share the activity of communicating about the patient's health care needs in the hospital.

Finally, there is mediation of transcendence in that the IFCI communication situations are important and relevant health care situations in which the patient will engage with many other health care professionals during his or her inpatient stay. In addition, the communication strategies and supports that are found to facilitate successful communication during the IFCI can be shared with other health care providers so that patients might have the opportunity to communicate successfully with these team members in other health care interactions.

Many people, such as those who have had a stroke, are admitted into the hospital with the sudden onset of a communication disability. The IFCI provides SLPs with the opportunity to assess these patients in a supportive way. The SLP gains insight into the patient's ability to communicate about his or her health care needs in the hospital setting and can determine the patient's need for communication support to do this to the best of his or her ability, but, perhaps more important, by conducting the IFCI, the SLP provides the patient with an experience, very early on in his or her recovery from stroke, that demonstrates that there are professionals who are skilled in assisting with communication. Not only does this enhance patients' ability to understand what has happened to them, to communicate their needs in the hospital, and to ask questions about and be involved in their health care to the extent that they would like to, but it may also provide patients with a feeling of competence and hope, even when their aphasia is severe.

Second, assessment occurs within goal-directed therapy. As mentioned previously, a traditional assessment process begins with administration of tests, which lead to goal setting (typically by the clinician) and initiation of treatment. However, beginning with an evaluation of goals to direct therapy can help clinicians move away from this more sequential (and perhaps less informative and less supportive) way of working to a more integrated therapeutic assessment process. In this next section, we will describe goal-directed therapy and illustrate how assessments can be used therapeutically in this process. Goal-directed therapy involves collaborative problem solving between the SLP and the client and begins with goal setting.

The process of goal setting using a client-centered approach has been described by Hersh, Worrall, Howe, Sherratt, and Davidson (2012). The Shared, Monitored, Accessible, Relevant, Transparent, Evolving, and Relationship-centered (SMARTER) goal-setting framework was developed from the results of the Australian study (mentioned earlier in this chapter) in which 50 people with aphasia and their 48 family members were interviewed about what they wanted in their rehabilitation. This framework was also informed by interviews with 34 treating SLPs about their goal setting and therapy. It encompasses the values and priorities found from analyzing the interviews with these three groups of participants. Although goal setting is not formally considered an assessment process, developing goals is certainly a desired outcome of assessment and may provide direction for further assessment. If goal setting is carried out in a SMARTER way, the SLP also gains considerable, useful knowledge about the client's abilities and difficulties. Perhaps more significant, the process is also one that informs clients about their abilities and how they can plan goals in the short and longer term. Using a SMARTER framework is a DA process, but it also is one that builds on the premises of adult learning theory and attention to the client in context. The results from the study underpinning the SMARTER framework are relevant and useful beyond Australia, and they reflect aspects of other international research (e.g., Chapey et al., 2008; Parr et al., 1997; Rautakoski, 2011). Each aspect

of SMARTER, explained in the following paragraphs, has relevance for therapeutic assessment.

Shared is a key concept because most people with aphasia and family members want to be involved in decisions about therapy and discuss what is possible within the constraints of the service they are receiving. However, to do this, they need to understand their own disorder and the clinician's rationale based on assessment findings. A shared process requires that all parties have enough information to be partners in decisions. On a practical level, this means that any assessments that are carried out should enable clinicians and clients to find out what supports are needed (assessment of support), to use supports themselves (assessment with support), and to be supportive (assessment as support) by being occasions of learning and of affirmation. When clinicians provide feedback about assessments, they can highlight areas of impairment but can also highlight retained ability. If there is an expectation from the start that rehabilitation is a shared process, then the expectation of disability and subsequent dependence on the clinician, noted by Kimbarow (2007), can be minimized.

Monitored encompasses the notion of continuous evaluation, reducing reliance on discrete periods of assessment and instead encouraging an iterative approach in which small changes in performance, or different requests from clients, lead to reevaluation of therapy direction. This is reflected in DA, an ongoing process of testing, trialing intervention, and reviewing. *Monitoring* involves treating the client as a partner, regularly discussing improvement or lack of it, updating on progress toward agreed goals, and making evaluation a part of therapy. In addition, *monitoring* highlights the value of qualitative forms of assessment, including client self-evaluation and family evaluation.

Accessible is of particular importance to therapeutic assessment in aphasia as well as in goal setting generally. Discussion about the need for an assessment (as well as about the results of an assessment) needs to be conducted in an aphasia-friendly way, whether that involves extra time, a total communication approach, supported conversation, or careful adaptations to any written information (Rose, Worrall, Hickson, & Hoffmann, 2011; Rose, Worrall, McKenna, Hickson, & Hoffmann, 2009).

Relevant goals for therapy are important for people with aphasia. There is a tendency for SLPs to begin their therapeutic interactions with new clients by carrying out a range of formal assessments that clients do not always perceive as relevant (Hersh et al., 2012; Kagan & Simmons-Mackie, 2007; Worrall et al., 2011). The results from these assessments then form the basis for therapy reflecting professional rather than client concerns. For therapy to feel relevant for clients, it is useful to begin with a supported, conversational interview, to allow the clinician to find out about his or her client before any formal assessment. At the same time, orienting people with aphasia and their families to the nature and purpose of the assessment may help them to see the relevance of the assessments that are conducted and of any subsequent therapeutic decisions that are proposed.

Transparent is a concept that highlights that people with aphasia need to understand why they are being asked to undertake a particular test. With strategies to enhance accessibility and aphasia friendliness, a clinician could find ways to explain word-finding difficulty or perseveration or even share ideas about where a client's breakdown might be on a model of language processing. We also suggest that the

notion of transparency extends to clear links between the results of an assessment, goal setting, and the therapy tasks that are then recommended.

Evolving within the SMARTER framework also emphasizes that goals are evolving as recovery occurs and that they may change as people become familiar with the realities of rehabilitation or encounter the challenges of living life with aphasia. Reflecting the idea of DA, this means that clinicians need to integrate, review, and reevaluate their clients' goals to keep up with these changes and to find the best ways to promote further improvement. Assessment and therapy are closely interwoven because language impairments—and the consequences of those impairments on activity, participation, and context—are not static, even for those people who are some years poststroke. The wealth of published assessments available for SLPs means that there may be a range of options that are helpful at different times, but it also means that dynamic, shared, and clearly explained appraisal remains a supportive process no matter when it occurs in the course of recovery.

Relationship-centered interactions between clinician and client are paramount (Beach & Inui, 2006; Hughes, Bamford, & May, 2008). At the beginning of the relationship, this involves developing rapport, which is essential to build before formal goal setting and before formal assessment, if possible. A strong, therapeutic relationship continues to develop over time. The relationship is central to all other aspects of the SMARTER framework because, in aphasia therapy, communication is both the focus of therapy and the vehicle for its delivery. Communication is so intrinsically woven into personhood and social connection that it is difficult to conceive of aphasia therapy without relationships. Assessment is perhaps the gateway to decisions about intervention, so if assessment is therapeutic and is experienced as supportive, then it is likely that what follows will also be experienced in this way.

Using a SMARTER philosophy, the process begins with identifying the goals of the client. Through an interview, the clinician can encourage the person with aphasia and his or her family to describe their lives before the aphasia, the impact that the aphasia has had on their lives, and their goals for rehabilitation. Although most people with aphasia and their families are able to do this with open-ended questioning, some people with more severe aphasia may require the supports that are built into a more structured assessment. There are a number of different assessment tools that the clinician can use to identify therapy goals that are meaningful and important to the person with aphasia. Assessments such as the American Speech-Language-Hearing Association Functional Assessment of Communication Skills for Adults (Frattali, Thompson, Holland, Wohl, & Ferketic, 1995), which is a rating of a person's ability to perform various daily living activities based on observation and anecdotal evidence, can be used to identify a person's communicative needs in everyday contexts. Alternatively, the Functional Communication Therapy Planner (Worrall, 1999) offers a step-by-step process to achieve this. The clinician conducts a questionnaire with the client and/or family members to obtain premorbid information about the client's communicative style. Then, in an interview, the client is asked to identify (from a list) the everyday communication activities that are important and meaningful to him or her. A communication needs assessment (Beukelman & Miranda, 2013) identifies current and desired communication partners, topics, and environments to facilitate improved participation. Alternatively, the clinician can compile a contextual inventory, as suggested in the Communicative Profiling System, using qualitative interview, diaries, and observation to determine what peo-

ple do on a regular basis and what they did before aphasia (Simmons-Mackie & Damico, 1996). Pictographic resources, such as the Life Interests and Values Cards (Haley, Womack, Helm-Estabrooks, Caignon, & McCulloch, 2011), the Pictographic Communication Resources from the Aphasia Institute (Kagan, Winckel, & Shumway, 1996), or personalized images, can also be used to guide a client through a discussion about his or her communication needs.

In addition to information about the client's communication needs, other assessments, such as the Communication Disability Profile (Swinburn & Byng, 2006) and the Assessment for Living with Aphasia (ALA; Kagan et al., 2011), also provide the clinician with an understanding of the person's satisfaction with his or her communication abilities. For example, the ALA consists of items across the Aphasia Impairment, Participation, Environment, and Personal domains. The majority of items are self-rated by the person with aphasia on a 1- to 4-point Likert scale. Within the Aphasia Impairment domain, individuals are asked to rate their communication skills in terms of talking, understanding conversations, reading, and writing. The Participation domain includes questions that target functioning in everyday life and measures meaningful aspects related to participation, such as satisfaction with social relationships, one's roles and responsibilities, and level of involvement in managing money and finances or participating in leisure or recreation. The Environment domain captures barriers and facilitators to the communication and language environment, and the Personal domain includes self-ratings of both positive (e.g., confidence) and negative feelings (e.g., depression and loneliness).

The ALA is a good example of a tool that can support therapeutic assessment because

1. It measures across all domains of the ICF or A-FROM. It therefore gathers information from the person about his or her aphasia as well as its real-life consequences.
2. It is a self-report measure. Thus, the perceptions of the person with aphasia are central to the assessment process, and each item can be assessed according to the life context and unique needs of each individual. For example, within the Participation domain, in terms of participation in leisure and recreation activities, the ALA asks, "Are you doing as much as you want in the area of leisure and recreation?" There is no assumption made about the relative importance of leisure and recreation to an individual or about the impact of changes in leisure activities as a result of stroke or aphasia. The assessment is therefore an ideal tool for opening up a dialogue about areas of importance, areas of difficulty or dissatisfaction, and areas that are currently making a positive contribution to life quality.
3. It has been developed in consultation with individuals with aphasia and their families. The items included are therefore relevant and meaningful to the lives of people with aphasia.
4. Communication support is embedded within the assessment. The assessment has been specifically designed to be communicatively accessible for individuals with aphasia. It uses simplified language, pictographic supports, and written prompts for each item. The self-rating scale consists of a person with thumbs down (meaning *No or never*) at one end and a person with thumbs up (meaning *Yes or always*) at the other. Clinicians administering the assessment are encouraged to provide

additional support to assist people with aphasia throughout the assessment when necessary (e.g., using pointing or repeating/rephrasing questions).

Communication assessments can be considered therapeutic assessment as support. That is because they communicate to the person with aphasia and his or her family members that what is important to him or her is of central concern to the SLP, which affirms and strengthens the client–clinician relationship. Second, the process of thinking and talking together about the meaningful and important communication situations in the person’s everyday life can enable the clinician and the client to gain a shared understanding of the person’s goals. Further assessment and therapy to enhance the person’s ability to communicate in these important situations become much more relevant and transparent. Goals of people with aphasia have included reading a storybook to grandchildren, e-mailing friends, shopping independently, buying a present without the knowledge of one’s spouse, telling jokes, using the computer for therapy, and texting on a cell phone. Examples of the overall goals of people with aphasia have been described by Worrall and colleagues (2011), and the goals of family members have been described by Howe et al. (2012).

While conducting these assessments, clinicians are also able to conduct assessments of support. Whenever there is a breakdown in communication, the clinician has an opportunity to explore what communication strategies assist the person in communicating. Common strategies to trial are suggested in the following section.

General Clarification Strategies

The SLP may

- Request a repeat: “Sorry, could you say that again?”
- Request a repeat of just the part that has not been understood: “You want to be able to talk with whom?”
- Ask for a clue: “Can you give me a clue about whom you want to talk with?”

Specific Strategies

The SLP may

- Ask, “Can you show me?” offering a pen and paper for drawing or writing, or indicating immediate environment referents, such as a book or page of pictographs or photographs
- Acknowledge and encourage gestures
- Offer closed-choice questions: “Is the person you want to talk with a friend or family member?”
- Offer *yes/no* questions: “Is he or she a family member?”

Successful and unsuccessful strategies are noted and then tried again at the next communication breakdown. Successful strategies are discussed in an accessible way with clients so that they are encouraged to be aware of what works for them and what they might use, expand on, or practice.

Direct assessment of support can also be evaluated through a formal tool, such as the Multimodal Communication Screening Task for Persons with Aphasia (MCST-A), part of the AAC Assessment Battery for Aphasia (Garrett & Lasker, 2005). This is for people with severe aphasia and has three components (of which the MCST-A is one) that aim to assess their ability to communicate via alternative pictorial symbols and whether they can use communication supports independently or need the assistance of another person.

An assessment of communicative support also needs to include an understanding of the communication partners in the person's life. Tools to understand the nature and extent of the person's social network include the social network analysis of the Communicative Profiling System (Simmons-Mackie & Damico, 1996, 2001), Social Networks (Blackstone & Hunt Berg, 2012), or the Social Network Convoy Model (Antonucci, Ajrouch, & Birditt, 2006). Communication partners are a potentially rich source of support for people with aphasia, and an effective way to understand the nature of their support through interaction is with conversational analysis. This approach to analysis is described by Lock, Wilkinson, and colleagues (Lock et al., 2001; Wilkinson et al., 1998). These authors stress that as well as understanding the type and range of communication strategies that are being used, it is important to explore the perspectives of communication partners because of their role in embedding these strategies in authentic contexts (Lock et al., 2001).

Therapeutic assessment involves conducting assessments that are supportive in and of themselves and that enable clinicians both to understand the range of supports that help people with aphasia communicate successfully and to identify shared, accessible, relevant, transparent, and relationship-centered goals. In addition, the SLP and person with aphasia need to be able to monitor and evaluate their success in achieving these goals. Goal attainment scaling (GAS; Schlosser, 2004; Worrall, 2000) has been advocated as a means of measuring outcomes on the basis of the individual's own goals, so this approach fits well with the goal-driven assessment process described in this chapter. This can be used as a collaborative tool to document and measure outcomes of the assessment, goal-setting, and therapy process. It is a useful record for clients, highlighting achievements as well as areas that need more work. Table 6.2 illustrates the goals and the scaling of each goal used for a client with aphasia.

In this case, four goals were identified by the client: public speaking, advocacy, travel, and speech production. Task analysis was performed on each goal to identify the subcomponents needed to achieve the goal. For example, for public speaking, the tasks included making PowerPoint slides that included not only the formatting but also the writing of the content. In GAS, the expected outcome is allocated a 0 score on the scale. For the PowerPoint example, the expected outcome was determined to be "Opens PowerPoint independently, requires minimal assistance to plan and write content, independently designs the slide." Establishing the expected outcome requires some knowledge of the client's current performance ability on the task; this ability can be assessed through observation or self-report on the actual task. Better outcomes are defined and given scores of +1 and +2, whereas lower-potential outcomes include -1 and -2. Final GAS scores can be obtained through observation or interview on the task but are usually observed during therapy. A total GAS score at the completion of the therapy program is simply the average score

Table 6.2. Example of goal ratings and anchors for a person with aphasia

	Goal 1 Public speaking	Goal 2 Advocacy	Goal 3 Travel	Goal 4 Speech production
-2	Can open the PowerPoint program, but requires full assistance to plan and write content for a single PowerPoint slide	Requires full assistance to contact familiar and unfamiliar people	Requires full assistance to develop travel plans for a holiday using the Internet and brochures	Can produce single word with CCV structures accurately 10% of the time during single-word production
-1	Opens the PowerPoint program; requires moderate assistance to plan, write, and design for a single PowerPoint slide	Can call familiar people on the phone, provide basic details, and ask and respond to simple questions	Requires moderate assistance to develop travel plans for a holiday using the Internet and brochures	Can produce single word with CCV structures accurately 35% of the time during single-word production
0	Opens PowerPoint independently; requires minimal assistance to plan and write content; independently designs the slide	Can call an unfamiliar person on the phone, ask to speak to someone, and provide name and contact details with a script	Requires minimal assistance to develop a travel plan for a holiday using the Internet and brochures	Can produce single word with CCV structures accurately 60% of the time during single-word production
+1	Independently develops a single PowerPoint slide for a presentation	Can call an unfamiliar person on the phone, provide basic details, and respond to questions with assistance (with or without script)	Independently develops a travel plan and contacts a travel agent to book with a written script	Can produce single word with CCV structures accurately 85% of the time during single-word production
+2	Independently develops two PowerPoint slides for a presentation	Can call an unfamiliar person on the phone, provide basic details, and respond to questions without assistance	Independently develops a travel plan and contacts a travel agent to book flights, tours, accommodations, and so forth	Can produce single word with CCV structures accurately 85% of the time in short phrases

Key: CCV, consonant–consonant–vowel.

from all goals. For example, a score of 0.8 across all goals indicates that the person has achieved better-than-expected outcomes on his or her own goals.

To finish this chapter, we would like to present a case study based loosely on the experience of Cath (pseudonym), a middle-age woman with aphasia who lived with her very supportive husband.

Therapeutic Assessment to Support Goal Setting and Therapy

————— At the first session, the clinician developed a relationship with Cath and her husband by engaging them in a discussion about their lives and how they had been affected by aphasia. Cath and her husband had already experienced speech therapy, so their reflections on what they liked and did not like about previous therapy were discussed in the context of what they would like to achieve this time in therapy. This hour-long discussion provided the clinician not only with their prioritized goals but also the context and values underpinning these goals. For example, it was observed that the couple were mutually dependent, but Cath was more assertive and goal-focused than her husband. She wanted more independence from her husband.

One of Cath's goals was to make the travel arrangements to see the Stockman Hall of Fame, a well-known outback tourist destination in Australia. Even before Cath's language impairment was appraised, the clinician worked with her to establish exactly what she wanted to achieve—that is, what the end goal really was. Cath not only wanted to go to the Stockman Hall of Fame but also wanted to make the arrangements as independently as possible—something that the clinician also negotiated carefully with Cath's husband. In line with being transparent and sharing the goal setting, the end goal was broken down with Cath and her husband to show exactly what activities and actions were required to achieve each step toward that goal. This step drew heavily on the knowledge, skills, and abilities of the clinician. Cath, her husband, and the clinician agreed that, initially, she needed to call a travel agent and ask for brochures.

The next step was to reassess Cath's expressive language impairment. Her speech was sometimes unintelligible, and she was hesitant and slow, repeating phrases to cue herself into a word that she was having difficulty retrieving. However, Cath was able to read aloud, and this was observed to improve her pace, fluency, and intelligibility. The assessment therefore became a source of information not only about Cath's impairment but also about her retained abilities, and the clinician pointed this out to Cath. They discussed how reading might be used to support verbal expression when telephoning the travel agent. Cath appreciated having a clear explanation of her aphasia and apraxia of speech, and how her self-cuing strategies and reading could give her some control. She used a range of supports to trial things that might help before actually contacting the travel agent. For example, a written script was prepared in advance and then trialed with the clinician in a role-play before making the call. This was an example of DA, with the clinician reviewing how the addition of supports changed the results of her performance.

Eventually, the couple identified a travel agent that they had used before. Cath had a smartphone that she could use independently, and her husband helped locate the telephone number of the travel agent and enter it into Cath's contacts. The prepared script began with a statement that Cath had had a stroke and with a request that the travel agent be patient. In real life, the script worked well; even though Cath returned to her slow and dysfluent speech when asked a question, the travel agent was sufficiently accommodating to wait patiently for Cath's response, and the transaction was successful. Cath continued to use the process of collabora-

tively finding a telephone number with her husband and then adapting the written script for other telephone calls, but after a while, the script was not needed. She managed to arrange most of the travel and achieve her lifetime ambition of seeing the Stockman Hall of Fame. _____

Table 6.2 shows Cath's four goals and how each goal was scaled. Any required communication supports were embedded into the scales. For example, her husband was the most frequently used communication support available to her, and therefore his assistance (minimal, moderate, or full assistance) was included in the scale. Because her husband only needed to help her put the telephone number of the travel agent into her contacts, this was considered minimal assistance, so Cath scored 0 for her travel goal. More important, the therapeutic assessment process gave her the confidence and tools to achieve other important goals for herself.

Hence, this case example illustrates how communication support was embedded through the entire therapeutic assessment process. In Cath's case, her desire for independence was supported not only by the careful weaving together of assessment and therapy but also by the involvement that she experienced in decision making for therapy.

CONCLUSION

In this chapter, we have shown that real-world therapeutic assessment must involve communication supports through assessment of support, with support, and as support. Current assessment practice is often experienced by clients as confusing and uninformative because SLPs do not always make the assessment process transparent, do not always explain results or how they intend to use them, and therefore miss opportunities to incorporate new learning into the process. It is natural for anybody to be curious about performance on a test, and this is no different for people with aphasia. A therapeutic approach to assessment ensures that clients and their families understand the reasons for assessment and that the process of assessment enables them to learn about the nature of aphasia and the goals of rehabilitation; such an approach also encourages clinicians and clients to identify relevant and meaningful goals together. The approach can be used with the array of published tools already available to clinicians and can inform the assessment of the person's impairment, functional activities, participation, or quality of life. If the assessment is meaningful, accessible, and informative for people with aphasia, it can motivate them to be partners from the start and proactive in achieving their own communicative success.

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