

Viewing couples living with aphasia as adult learners: Implications for promoting quality of life

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Background: Current interventions for addressing the psychosocial consequences of aphasia have been based on professionally driven constructs as opposed to insider accounts of aphasia. An adult learning approach offers the possibility of developing a programme for individuals with aphasia and their families that involves a more holistic and person-centred approach. This approach offers insights about promoting the quality of life of couples living with aphasia.

Aims: The primary objective of this paper is to discuss the implications of adopting an adult learning approach in promoting the quality of life of couples living with chronic aphasia. This paper outlines current interventions for addressing the psychosocial consequences of aphasia. It describes an innovative approach of working with couples with aphasia that explicitly integrates adult education principles and strategies. The basic assumption of this approach is that learning begins with the learner, as opposed to the therapist or treatment plan.

Main Contribution: The main contribution of this paper is to outline an alternative approach to intervention that is based on an adult learning model. This approach suggests that improving quality of life for couples living with aphasia involves more than simply promoting increased participation in conversation. Placing the learner in the central role results in intervention goals that encompass emotional and marital issues, as well as communication.

Conclusions: The implications of the adult learning approach on promoting quality of life in the area of emotions, marital issues, and communication outcomes are discussed. Implications of this approach on the role of the speech-language pathologist are also examined.

The concept of “quality of life” as a scientific outcome measure represents the attempt to describe the overall results of communication assessment and intervention efforts in a way that is meaningful to both individuals with aphasia and speech-language pathologists. General definitions of quality of life vary in the literature and include dimensions related to physical, psychological, social, and spiritual factors (Calman, 1987; LaPointe, 1999; Spilker, 1990). However, there are concepts and ideas common to all definitions. The first is that quality of life is related to the individual’s perception of performance. This represents a person-centred approach in which the individual serves as his/her own control, with comparisons made against expectation of function. The second is that the concept must be broad and cover all areas of life, including physical and occupational function, psychologic state, social interaction, and somatic sensation (Spilker, 1990). Third, all definitions emphasise the importance of personal growth and development to improve quality of life. Implicit in these concepts is the idea that quality of life will

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fluctuate over time as a result of changes in any or all of its component parts. It has also been considered important that such a definition be critically examined and tested.

Intrinsic to a definition of quality of life is a definition of health. The World Health Organisation defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (Spilker, 1990). Translating this definition into more pragmatic terms for quality of life with brain damage that compromises communication is complex (King, 1996; LaPointe, 1999, 2000). Dimensions of quality of life are further complicated by the interactions imposed by individuality and culture. However, recent research has provided insight into some aspects of perceived quality of life after brain damage with communication loss. LeDorze and Brassard (1995) interviewed people with aphasia and their families. During and after discharge from traditional therapy, people with aphasia and their families reported decreased quality of life, social isolation, and inability to access former and new family and community activities. Several investigators have reported the impact of aphasia on psychosocial areas such as identity, self-esteem, relationships, and roles in the family (Byng, Pound, & Parr, 2000; Gainotti, 1997; Herrmann, 1997; Kagan, 1999). Parr (2001) interviewed 50 people living with long-term aphasia. Her "insider" perspective on aphasia suggests that its impacts are extensive and complex (Parr, 2001). Aphasia has an impact across the spectrum of social experience and the "psychosocial" problems associated with aphasia arise from a combination of internal and external factors. In addition, Parr (2001) found that the impacts of aphasia are both direct and indirect. Indirect consequences are evident in the difficulties people with aphasia have negotiating, legitimising, and managing the life changes that occur following stroke. The impacts of aphasia are interconnected; they are not separable, compartmental, or discrete. The impacts are also systemic; they are not experienced by the individual in isolation, but by numerous people in multiple contexts. Finally, the impacts of aphasia are dynamic, diversely experienced and continuous (Parr, 2001).

EXISTING PROGRAMMES FOR FAMILIES OF ADULTS WITH APHASIA

In response to the above, clinical approaches that integrate models of betterment of life quality in aphasia have been suggested (LaPointe, 1999; Parr, 2001). In this regard, family education (Helmick, Watamori, & Palmer, 1976; Williams, 1993), communication skills training (Alarcon, Hickey, Rogers, & Olswang, 1997; Olswang, Hickey, Alarcon, Rogers, Cadwell, & Schlegel, 1998; Simmons, Kearns, & Potechin, 1989; Wilkinson et al., 1998), and supportive counselling programmes (Holland, 2000; Johannsen-Horbach, Crone, & Wallesch, 1999; Nichols, Varchevker, & Pring, 1996; Wahrborg & Borenstein, 1989) have been reported as ways to complement traditional therapy.

Family education has been identified as important because family members tend to view the aphasic person's communication as less impaired than it most likely is (Helmick et al., 1976). This lack of understanding can lead to the establishment of unrealistic expectations for language performance and to the use of inappropriate amounts and types of language when interacting with the person with aphasia. However, although increased knowledge of aphasia may reduce the negative impact of stroke on caregivers (Williams, 1993), knowledge of aphasia alone is inadequate as a basis for coping with the associated problems (Linebaugh & Young-Charles, 1978).

Communication skills training programmes involve a shift from the role of the speech-language pathologist as a "fixer" of linguistic and/or cognitive aspects of communica-

tion deficits, to using speech-language pathology expertise to provide those who have aphasia with mutually satisfying conversation. In offering conversational opportunities, the role of the speech-language pathologist expands to include deliberate attempts to reduce frustration, with the aim of allowing participants to “forget” about the aphasia to the extent possible (Kagan, 1999). The implication of such approaches is that, by improving communication between aphasic adults and their family members, one may help improve social participation and mental well-being.

Lyon, Cariski, Keisler, Rosenbeck, and Levine (1997) have developed and implemented a Communication Partners programme that focuses on enhancing participation in life and communication in natural settings for adults with aphasia using triads of patient, caregiver, and a volunteer communication partner. Although scores on the Boston Diagnostic Aphasia Examination, Communication Abilities for Daily Living, or Affect Balance Scale did not yield statistically significant findings, patients and caregivers reported that the Communication Partners programme had improved their quality of life. Similarly, Kagan (1999) has developed and evaluated a Supported Conversation for Adults with Aphasia (SCA) programme for volunteers interacting with individuals with aphasia. Results have shown that training volunteers as conversation partners using a one-day workshop and 2 hours of hands-on experience is effective in improving the communication of volunteers and their partners with aphasia. However, this programme has not yet been applied to direct training of family members of adults with aphasia.

In this regard, Simmons et al. (1989) examined the effectiveness and generalisation of a spouse training programme for one couple. Results showed decreases in spouse interruptions and use of convergent questions, and suggest the usefulness of an individualised communication-oriented approach. Wilkinson et al. (1998) studied the effects of intervention that attempted to improve communication function between one couple by targeting patterns found in natural conversation between partners. Results showed a decrease in corrections, or “other-repairs”, made by the spouse. Alarcon et al. (1997) have developed a Family Based Intervention for Chronic Aphasia (FICA) in which the person with aphasia and the spouse are more involved in assessment and evaluation. The focus of this intervention is on persistent communication problems between individuals with aphasia and their spouses, and the aim is to treat the disability in the context of typical interaction. Olswang et al. (1998) have found evidence of positive treatment effects of this intervention. These authors suggest that, although conversation involves only a dyad, the effects of aphasia involve the whole family system. Interventions therefore need to encompass the broader impact on the couple’s relationship.

These studies suggest that communication training can help promote quality of life for couples by improving conversation. However, in the studies by Simmons et al. (1989), Wilkinson et al. (1998), and Olswang et al. (1998), participants began with a concrete experience which included a videotaped conversation, but the observations of these videotapes were largely influenced by the speech-language pathologist’s perceptions of what constituted positive and negative communication behaviours. Training goals were determined by the clinicians, as opposed to being initiated by the couples. Clients were not actively involved in designing and evaluating the programme. Moreover, participants’ emotions and marital issues were not explicitly addressed in the above studies.

Supportive counselling programmes have also been suggested in addressing the needs of individuals with aphasia and their families. Holland (2000) advocates the integration of counselling in individual work with adults with various neurogenic communication disorders at various states post-onset. She also discusses the need to provide counselling to families, both individually and in groups. Wahrborg and Borenstein (1989) have

extended this counselling role to include family therapy with families with an aphasic member. Nichols et al. (1996) studied the effects of therapy given jointly by a family therapist and a speech-language pathologist. Johannsen-Horbach et al. (1999) attempted to address the needs of spouses of aphasic patients via both a nondirective counselling group and a group in which leaders used greater amounts of therapeutic interventions such as confrontation, interpretation, and clarification. Although positive changes in emotions and attitudes were documented in the above studies, these authors did not explicitly encourage participants to move from reflection towards the development of concepts about communication patterns that could then lead to applications in everyday life that would further improve quality of life.

Such programmes support the role of the speech-language pathologist in addressing the psychosocial sequelae of the aphasia. However, the alternative models and frameworks have been based on professionally driven constructs as opposed to insider accounts of aphasia. The literature represents the speech-language pathologist as the expert in a directive role. This emphasis on expertise rather than on a more holistic and person-centred approach to learning locates the source and power of change in the therapist, as opposed to in the person with aphasia and his or her family member. It is this very perspective that may be deflecting us from the real source of power to promote increased quality of life for these individuals. Further, the incorporation of a person-centred approach to communication and attitudes needs to be based on an explicit and well-organised theoretical framework.

AN ADULT LEARNING APPROACH

An adult learning approach offers the possibility of developing a programme for individuals with aphasia and their family members on a different basis that addresses the above issues. In this regard, a learner-centred training programme for spouses of adults with chronic aphasia has been developed and evaluated using a qualitative case study methodology (Sorin-Peters, 2002). The basic assumption in the development and implementation of this programme is that learning begins with the learner, as opposed to the therapist or treatment plan. Placing the learner in the central role involves more than a change in terminology and has significant ramifications for strategies to induce change.

The first phase of this learner-centred training programme for spouses of adults with chronic aphasia included the development of a training programme that integrated principles and strategies from speech-language pathology and adult education. One basic assumption of the adult learning approach is that the heart of education is learning, not teaching, so that the focus must shift from what the teacher does to what happens to the learner (Knowles, 1973). This is referred to by Hunt (1987) as “inside-out” learning, as opposed to “outside-in” learning. The programme’s content was guided by adult learning principles and by insights gained from a needs assessment. The needs assessment confirmed that the explicit incorporation of adult education principles in the process of the programme was not only beneficial, but necessary in order to achieve success.

The second phase included the delivery and evaluation of the programme using a qualitative multiple case study methodology. This design resulted in a rich and holistic account of communication in couples with chronic aphasia and was useful in documenting change in complex communication behaviours after the training programme. Using videotaped conversations, the Couple Questionnaire (Olswang et al., 1998), and a semi-structured interview, this study examined changes in attitudes and communication behaviours in five couples immediately after training and at 2 months follow-up. All data

were transcribed and analysed for patterns of change for each couple. An additional step in the data analysis was the development of a cross-case analysis.

Results indicated ways in which the adult learning principles were actualised across the five cases. Themes emerged related to the expression of emotions about aphasia. Themes related to marital issues also emerged and were intertwined with emotions and communication. Communication outcomes included positive changes in conversational repair, more balanced conversational control, the revealing of the competence of the partner with aphasia, and the emergence of different conversational genres that could be organised hierarchically. A paper, describing this study in detail, is currently under preparation (Sorin-Peters, 2003).

Unlike existing programmes, this programme includes all three components of education, communication skill training, and counselling. The data demonstrate that the integration of these three components was important in achieving the observed outcomes because each component was intimately related to the other. Moreover, this programme is unique in its explicit incorporation of adult learning principles as part of the process of the programme. In this approach, unlike in traditional medical model approaches, the client is seen as an experienced and competent adult learner and learning proceeds from his or her needs. Both members of the dyad are involved. Both are given more responsibility for goal selection and programme development. Clients become aware of their preferred learning styles and these preferences are taken into account throughout sessions.

The central role of spouses and partners in the learning process was actualised by using Kolb's experiential learning cycle model (Kolb, 1984) throughout sessions. Kolb's experiential learning cycle is displayed in Figure 1. Kolb's experiential learning cycle involves drawing on concrete experience, having participants engage in reflective observation, having participants engage in abstract conceptualisation, and encouraging participants to practise active experimentation in order to apply what they have learned. Although previous programmes have implicitly included various aspects of Kolb's learning model, none has explicitly incorporated all four activities in a systematic way. This programme began with spouses telling their "stories" about their experiences with

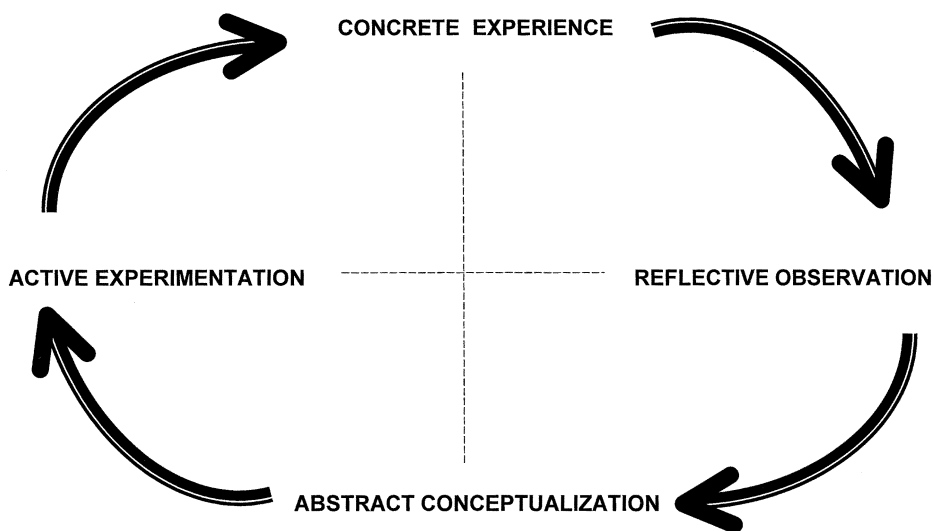


Figure 1. Kolb's experiential learning cycle.

aphasia. Their previous knowledge about aphasia as well as their use of communication techniques that had been working well were affirmed. The use of reflective learning questions helped spouses to systematically review their experiences with aphasia in order to understand how it was impacting communication with their partners. Their reflections served as the basis for them to collaborate in setting goals and designing the programme agenda. They were assisted in developing new or revised concepts about aphasia and ways to facilitate communication with their partners. Spouses were assisted in applying this information to improve the quality of communication with their partners. This involved identifying and addressing their learning styles and diversity of needs. It also involved making adjustments based on their rhythms of learning and building on the unexpected. Self-evaluations helped empower couples to monitor their performance and continue to learn after the programme had ended. By thus incorporating all four processes of experience, reflection, conceptualisation, and application into the programme, more fully integrated and transformational learning was able to occur. This is consistent with the intent of Kolb's learning cycle (Kolb, 1984), which is to promote a process of learning through critical self-reflection on experience. It differs from the traditional approach of having the speech-language pathologist predetermine appropriate techniques and then teach these to spouses.

The incorporation of adult education principles adds a new dimension to intervention. The elements of sharing their experience, reflecting on their experience, and conceptualising and applying what had been learned resulted in the surfacing of emotions and marital issues that impacted on communication. Adult education principles appeared to help bridge these three components of intervention naturally, in a way that could not have been attained without their use. Placing the learner in the central role also prompted the development of a broad and holistic scope of intervention. More than one aspect of spouses' and partners' learning capacities were tapped throughout the training. These included emotional, relational, physical, intellectual, and intuitive capabilities. The holistic learning approach in this programme involved looking at communication behaviours in the context of the couple and family system, and treating the structure as a whole.

This approach appeared to offer insights about promoting the quality of life of couples living with aphasia.

PROMOTING THE QUALITY OF LIFE OF COUPLES LIVING WITH APHASIA

The life participation approach to aphasia (Chapey, Duchan, Garcia, Kagan, Lyon, & Simmons-Mackie, 2000) refers to a general philosophy and model of service delivery that focuses on re-engagement in life. It represents a shift from the remedial approach, which involves focusing on the impairment and disability of the person with aphasia's speech and language skills. It goes beyond compensatory instruction where one tries to counterbalance or substitute one skill for another. It involves a focus on the real-life goals of people affected by aphasia. It recommends that the dual function of communication including transmitting and receiving messages, as well as establishing and maintaining social links, be considered. In order to promote communication changes consistent with the life participation approach, we need to place the learner in the central role and integrate adult learning strategies into our work with couples living with aphasia.

Moreover, the approach described above showed that improving quality of life for couples living with aphasia involves more than simply promoting increased participation

in conversation. Placing the learner in the central role resulted in intervention goals that encompassed emotional and marital issues, as well as communication.

EXPRESSING EMOTIONS

The adult learning approach begins with people sharing their experiences of living with a partner with aphasia and reflecting on this experience. This facilitates the expression of feelings about the aphasia. These emotions may include anger, sadness and grief, and acceptance.

The expression of anger

Several couples initially expressed feelings of anger and resentment related to the consequences of the aphasia. For example, one partner with aphasia overtly expressed intense anger and shouted at his partner during initial sessions. These emotions were acknowledged and this partner was made aware of how his anger was negatively impacting on his relationship with his wife. He was encouraged to reflect on these feelings and to express his feelings to his wife in a respectful and loving way.

Being aware of the possibility that couples may have angry feelings can prepare speech-language pathologists for the outpouring of anger and resentment that may accompany the exploration of new communication techniques. It is important to see the expression of such emotions as a natural accompaniment to change, and to allow time for their expression. If feelings of anger in learners are repressed, they may fester until they represent a much larger block to learning (Brookfield, 1990). Recognising that anger can block learning suggests the importance of emotional support throughout a communication training programme.

The expression of sadness and grief

In addition to anger, all spouses expressed sadness about the consequences of the aphasia and alluded to feeling grief because of losses. For example, one spouse commented that it was harder to live with a partner with aphasia than to cope with the death of one's partner. While the partners were still physically present, their inability to communicate with their spouses in the same way as before the stroke had produced a gap in the relationship. This is consistent with the concept of "ambiguous loss" (Boss, 1991), which includes the psychological loss of a family member even though they are physically present. For these spouses, dealing with the consequences of the stroke and resulting aphasia was not a transitory process, but a permanent state and lifestyle. It would be helpful for clinicians to acknowledge this ambiguity to spouses and families of adults with aphasia. Moreover, it is important to help couples move beyond these feelings by explaining and demonstrating to spouses how the partner with aphasia can still be included in conversations, thus promoting his or her inclusion in the family system. This, in turn, may help spouses to set new boundaries, reassign roles, and take charge in new ways, thereby promoting resiliency and the reconstruction of family life.

Increased acceptance of the aphasia after training

Luterman (1995) describes four phases in the acceptance process of chronic illness. These include denial, resistance, affirmation, and integration. By agreeing to participate in the training, couples implicitly acknowledged that their partners had aphasia and that they

were willing to accept help; they had thereby reached the affirmation phase. Luterman points out that this stage is characterised by a great deal of pain, as there is an acceptance of the notion that things will never be as they previously had been. In turn, this implies that, even when couples are willing to accept help, it is important to support them emotionally. Moreover, there is a need for intervention in the “affirmation” phase as it is possible to help couples move beyond this phase via a learner-centred programme. With training, couples developed new or modified ways of communicating. They were then able to move towards the “integration” stage where they could deal with the aphasia and participate in other activities. This involved the need for them to come to a deeper acceptance of the aphasia, learning to live with it by integrating the new communication strategies into their conversations, and then moving on to focus on other matters.

To promote quality of life for couples living with aphasia, we need to address emotional issues that may block learning. We need to allow couples to express feelings of anger and grief. We can also systematically help them move towards an increased acceptance of the consequences of aphasia.

MARITAL ISSUES

The adoption of an adult learning approach requires the application of a systems approach whereby each couple is viewed as more than the sum of its two parts. The whole consists of all the parts *plus* the way the parts operate in relation to one another. The couple is seen as an interacting network in which each member influences the nature of the entire system and in turn is influenced by it. One implication of such an approach is that when one part of a family system is “damaged” in some way, then every part is affected. This means that when one member of a family has aphasia, all members of the family are influenced by it.

The use of the adult learning strategies consistent with this systems approach resulted in the surfacing of marital issues. Such issues were intertwined with feelings about aphasia and with communication. These issues were dealt with because they appeared to have an impact on communication issues, and progress in communication would be limited if they were not addressed. It seemed as though the communication issues were superficial and that the emotions and marital issues were deeply rooted but intimately connected to the communication problems. Once these deeper issues were addressed in some way, the communication training flowed smoothly. Examples of intervention goals involving marital issues include couples finding new ways of spending time with each other, couples setting aside time for conversation, couples wanting to have their partners express appreciation or gratitude to each other, and couples needing to have their partners show affection towards them.

To promote quality of life for couples with aphasia, we need to address marital issues that are intertwined with communication. Research in marital therapy has outlined five types of relationship maintenance behaviours that function to preserve ongoing relationships (Canary & Stafford, 1992). These include positivity, openness, assurances, network, and the sharing of tasks (Canary & Stafford, 1992). The use of these maintenance behaviours is associated with higher perceptions of satisfaction, commitment, and liking which are all key indicators of relationship quality (Canary & Stafford, 1994). The present approach demonstrated that learner-centred training can promote the development of relationship maintenance behaviours for couples who are willing to commit to interventions such as this one.

COMMUNICATION OUTCOMES

Viewing couples as adult learners warrants the modification of supported conversation programmes, such as that developed by Kagan (1999) for volunteers. In contrast to Kagan's group format for training volunteers (1999), spouses need to be seen either individually or with their partners in order to address couples' specific needs. Adult learning principles should be explicitly incorporated. In the current example, it involved using Kolb's experiential learning cycle throughout sessions. Emotional and marital issues may surface and need to be addressed. Follow-up is beneficial to monitor progress and to maintain or further improve the quality of communication between couples.

The approach described here demonstrated that the wider scope of a learner-centred programme can promote a wider scope of communication changes for couples living with aphasia. These include, first, improvements in interaction and the transaction of information in conversation as well as increases in aphasic partners' participation in conversation. Second, the cognitive competence of the partner with aphasia was revealed through the skill of the trained spouse in conversation. Third, communication changes using an adult learning approach included more balanced topic, turn, and response control in conversation. Finally, a hierarchy of different conversation genres emerged, moving from conversation that was focused on the performance of the partner to conversation with more topic elaboration. All spouses initially "tested" their partners. After intervention, communication developed to include reminiscences and discussions. Such reminiscences included both members of the couple sharing a memory of an experience. These reminiscences changed the whole tenor of the conversation. This suggests that reminiscence, when used with appropriate conversation strategies, can be a powerful conversation tool for couples. A higher level of conversation included discussions of ideas and opinions or new information, such as gardening issues, issues related to children, and issues about relatives.

By improving the quality of communication between couples, the quality of the relationship also seems to improve, thereby promoting improved quality of life. For example, one spouse said afterwards that not only was her partner communicating better, but also there was a smaller gap between them and between her partner and their children. Her improved ability to communicate with him also resulted in him helping more with errands and domestic chores, thereby reducing her domestic responsibilities. Another spouse said that, as a result of improved communication with his partner, he was more like the way he used to be before the stroke; he was demonstrating his sense of humour and beginning to joke more with his wife.

IMPLICATIONS REGARDING THE ROLE OF THE SPEECH-LANGUAGE PATHOLOGIST

The adoption of an adult learning approach expands the speech-language pathologist's role to one of helping spouses and couples make their own meaning of the consequences of the aphasia, by moving them through the four phases of the experiential learning cycle (Figure 1). This can foster a growing acceptance and ability to develop creative solutions that can be applied at home and, eventually, can be developed and applied without the speech-language pathologist's direct involvement. These changes can promote increased quality of life for couples living with aphasia.

The adult learning approach of aphasia thus extends the existing psychosocial model by focusing on the importance of communication for the expression of emotions and the maintenance and development of marital relations. This philosophy of practice represents

a more comprehensive approach in our work and explicitly acknowledges the influence of communication on the expression of emotions and marital issues. When any aspect of communication, emotion, or marital relations is addressed, it impacts on the other in a holistic way. This results in outcomes that include more than increased participation in communication—the outcome is characterised by a more global feeling of overall well-being. Thus, rather than aiming intervention at the impairment, activity, or even participation levels, the adult learning model approach promotes a broader and deeper approach to the couple system and results in more comprehensive changes of wellness.

We need to get to know the learner's world; his/her feelings, experiences, and perceptions of his/her experiences. When we begin our interventions by listening to individuals' stories and experiences, and acknowledging their feelings and challenges, we can help individuals to reflect on these experiences so that they can become critically aware of their old assumptions and perspectives. We can acknowledge attitudes and behaviours that are serving them well and help them see options for dealing with the constraints imposed by the aphasia which may have previously been perceived as beyond their control. By adding knowledge, skills, or increasing competencies to these new perspectives, we increase the possibility for a plan of action that results in more holistic and lasting changes. We thereby encourage individuals with aphasia and their spouses to move forward to new perspectives and behaviours, while building competence and confidence in these new roles and relationships.

We suggest here the expansion of the speech-language pathologist's role from a conversation partner or facilitator in enhancing access to life participation via conversation, to that of a more active participant in the change process. The use of the adult learning approach requires the speech-language pathologist to be open to a broad range of client behaviour, such as emotions and marital issues. It requires that one be nonjudgmental and to maintain one's regard for the couple despite their particular choices and characteristics.

Such increased personal involvement will permit the speech-language pathologist's own feelings and issues to arise. He/she will become more involved subjectively and will need to use feelings and intuition as guides to the change process. In fact, speech-language pathologists themselves will be involved in their own experiential learning cycles when adopting this approach. This implies that in order to help spouses and adults with aphasia move through the experiential learning cycle, we need to become comfortable and confident in our own movement through this cycle. Similarly, just as the adult learning approach permits couples to become aware of and use the learning potential of their emotional, relational, physical, and intuitive capabilities in their own learning, speech-language pathologists can become more aware of these learning capabilities within themselves and thereby tap into these capabilities to promote more comprehensive and meaningful changes in spouses and adults with aphasia.

CONCLUSION

Parr's (2001) qualitative work on the psychosocial aspects of aphasia suggests the advantage of an "insider", versus an "outsider", perspective. An "insider" approach focuses on the perspectives of people with aphasia and addresses the "illness", not the "disease" of aphasia. The adult learning approach to intervention described in this paper represents an alternative model to intervention that is based on insider accounts of aphasia. The learner-centred approach is not prescriptive, but rather represents an alternate process of intervention. The central role of the learner results in goals, activities,

and outcomes that are developed by the learner. This results in changes in emotions and marital issues, as well as communication, that are specific and meaningful to the individual learners. The competence of the individual with aphasia and his/her family to learn is explicitly acknowledged in this approach, thereby enhancing self-esteem and the ability to continue learning after intervention.

The adult learning model suggests a relationship in which the speech-language pathologist and couple are active collaborators in the learning process. For speech-language pathologists to utilise this approach, we may need to widen our technical expertise and learn more about adult education principles and their application to our work. We may also need to learn more about family systems and marital interactions and ways of dealing with interactions in families in intervention programmes. We also need to trust and develop our intuitive capabilities and “inner wisdom”. In order to do this, clinicians may need to rely on the “art” of their work and trust their interpretations. By widening our technical expertise and also trusting and developing our own inner wisdom, we may better share some of the “walk” with our clients and facilitate more meaningful changes, thereby promoting improved quality of life.

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