Writing and using life-participation goals with people affected by aphasia
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Background
People set goals to achieve outcomes that matter. When goals and objectives work well, they help prioritize our time and effort. When achieved, we expect improvements in our lives and a sense of accomplishment. Similarly, clinical goals for people with aphasia (PWA) determine how speech language pathologists (SLPs) and their clients spend precious treatment time, what is accomplished, and how both parties envision the next steps. Everything flows from goals.

Conceptual frameworks structure our planning and remind us about the larger picture. The World Health Organization International Classification of Functioning, Disability and Health offers a broad framework for diverse domains and categories of health (ICF; WHO, 2001). The aphasia-specific Living with Aphasia: Framework for Outcome Measurement (A-FROM) guides outcome evaluation, advocacy efforts, and research focus for living with aphasia (Kagan et al., 2008).

Here, we present an adaptation of the ICF and A-FROM for the purpose of writing life participation goals that help people with aphasia and their families. We also introduce an initiative for continued collaborative development to support SLPs and their clients to develop meaningful and reimbursable treatment goals.

Communicative Life Participation (CLP)
In the adapted model, Communicative Life Participation is the intended focus of all aphasia intervention and a barometer for all long-term (and often short-term) goal achievement. The adaptation considers only mechanisms that affect communicative life participation and can be realistically modified. Change mechanisms are organized in four categories: Person, Environment, Language, and Strategy. Short-term treatment goals should consider all four mechanisms.

CLP through Person (P)
The first change mechanism to increase CLP is personal factors. Poor support of person can have far-reaching consequences on motivation to communicate and learn. The model considers only those mechanisms that respond to individual or small group interventions and rationally affect orientation to communication and to learning.

Examples include knowledge about aphasia and one's situation, confidence about identity and future, connectedness to the world and to other people, recognition of mood and feelings, and the experience of problem-solving around new circumstances. Short-term goals can be educational in nature, but could also include other forms of counseling, targeted experiences, and practice opportunities.

CLP through Environment (E)
The second change mechanism is environmental modification. Intervention through this mechanism can target the health care setting, family members, or the larger community. Sometimes little direct involvement may be necessary for the PWA. Other times, modification requires personal training or continued input. Effects on CLP are sometimes immediate, sometimes realized after practice.

Examples include accessible health information, knowledgeable health care staff, conversation partner training, augmentative communication systems, and opportunities to communicate as a competent adult.

CLP through Language and Speech (L)
There is no shortage of goals written for the speech and language mechanism. Behaviors and outcomes are relatively easy to operationalize and document quantitatively. Sometimes goals are determined through theoretical models of language (e.g. psycholinguistic, neurolinguistic). Other times, they flow from observed impairments and/or areas of relative strength.

When the logical and practical extension to CLP is unclear, generalization of language and speech learning is poor or unknown. In the adapted model, progression to CLP is mandatory, because all language goals must be expressed with anticipated application to real life. A logical sequence of short-term goals may be needed to achieve the stated long-term goals.

CLP through Strategy (S)
The fourth and final change mechanism for improved CLP is not specifically addressed in the ICF or A-FROM. Because aphasia rehabilitation requires continuous adaptation to circumstance, motivation to address challenges, and a need for continued involvement far beyond formal rehabilitation, we believe it is necessary to consider intentional strategy as a powerful change mechanism.

Examples of intentional strategy include a self-determined and understandable treatment plan, resources for independent practice, self-cueing, communication preparation, and plans for handling communication breakdown.

Interactions among change mechanisms
The four change mechanisms are strongly interconnected. By considering interactions, the SLP and PWA can develop more holistic and effective interventions and write goals that address several mechanisms at once.

Examples of productive effects of one mechanism on another
• Confidence increases risk-taking in new communication opportunities (P → E)
• Resilience strengthens motivation to practice language targets (P → L)
• Active goal setting increases functionality and therefore generalization (L → P)
• Mechanisms for autonomous practice may take on AAC function (E → P)
• Improved language access is recognized and strengthens confidence (P → E)
• Language practice uses materials that also modifies the environment (E → P)
• Partner training increases connectedness (P → S)
• Accessible writing facilitates goal development and evaluation (E → S)

When insufficiently addressed, there can also be undesirable effects across change mechanisms. Sometimes, even the treatment itself can have unintended consequences.

Examples of counter-productive effects of one mechanism on another
• Limited understanding leads to passive role in treatment planning (P → L)
• Hopelessness and fear promotes avoidance of practice (P → L)
• Passive treatment participation reduces confidence (L → P)
• Lack of independent practice opportunities reduces amount of practice (L → P)
• Language drills suppress moods by highlighting impairment (E → P)
• Language practice is perceived as an alternative to AAC (E → P)
• Limited interaction reduces need for communicative strategies (S → P)
• Inaccessible health communication prevents learning about condition (P → E)

Goal Writing Resource
Effective clinical goal writing requires more than a valid conceptual framework and strategic implementation of priorities. It must also be financially feasible. Our experience is that speech-language pathologists sometimes are unsure about institutional acceptance and financial feasibility of participation-oriented interventions. This is a valid concern and one that must be addressed before we can expect broad clinical implementation of the life participation philosophy.

On the assumption that SLPs will benefit from concrete examples and solutions for varied settings and scenarios, we invite SLPs to join us in developing an online resource for aphasia treatment goals. One of the first features of this resource is a collective sample of goals used by SLPs. We anticipate that collective problem-solving will empower SLPs to help their clients with aphasia achieve meaningful life-participation goals during rehabilitation and beyond.

Building on our adapted goal-writing model, colleagues can collectively identify examples of how CLP outcomes can be approximated for clinical documentation, how short-term goals through person and environment can be expressed in quantifiable terms, and how short-term goals for language and strategy might build successively to improved CLP. We anticipate lively discussion in an welcoming online environment. Please join us!

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References