INTRODUCTION

It is critical for effective clinical practice, as well as public policy, that sound efficacy data are available on augmentative and alternative communication (AAC) intervention with persons with aphasia. With the advent of evidence-based practice (EBP) in health care, funding agencies are increasingly requiring data that demonstrate interventions actually work. Schlosser and Raghavendra (2003) define EBP in AAC as “the integration of best and current research evidence with clinical/educational expertise and relevant stakeholders perspectives, in order to facilitate decisions about assessment and intervention that are deemed effective and efficient for a given direct stakeholder” (p.3). The purpose of this chapter is to apply concepts presented in previous chapters to clinical contexts and to further examine the data on the efficacy of AAC intervention for persons with aphasia using an EBP process as proposed by Schlosser and Raghavendra (2003). It is important to consider evidence from the available research when selecting an AAC intervention approach for an individual with chronic severe
aphasia. The integration of the best research evidence with clinical expertise and the perspectives of stakeholders is the key to bridge the gap between research and clinical practice.

AAC INTERVENTION WITH APHASIA: AN EBP ILLUSTRATION

While working with a client who has chronic severe Broca’s aphasia in our clinic, we applied the seven steps identified by Schlosser and Raghavendra (2003) to illustrate the use of EBP for AAC intervention with persons with aphasia. These steps are described below.

Step 1: Asking a Well-Built Question

The first step in the EBP process is the formulation of a well-built question that can enable a systematic search of the available evidence so that clinically relevant answers can be found (Schlosser, Koul, & Costello, 2007). A case report followed by the EBP question is listed below.

Clara is a 65 year-old woman who sustained a left hemisphere stroke (anterior middle cerebral artery distribution) 4 years ago, resulting in chronic severe Broca’s aphasia and apraxia of speech. Associated impairments included right hemiplegia that caused her to use a wheelchair. At the time of her stroke, Clara had recently retired from operating a clothing store. She had been widowed for 3 years and was living in her home independently. Following her stroke and subsequent hospitalization, she returned to her home, and her daughter and son-in-law moved in with her. She received speech-language treatment through a home health agency for 5 months. Treatment techniques included melodic intonation therapy and mapping therapy (Helm-Estabrooks & Albert, 2004; Thompson, 2001). She now communicates through pointing, gestures, and head movements accompanied by speech output in the form of “yes” and “no.” Most other verbalization attempts result in perseveration of approximation of her daughter’s name (i.e., “Sarah Sarah Sarah”) rather than the target word. She typically makes her basic wants and needs known to her son-in-law and daughter using the previously mentioned nonverbal communication strategies; although, her daughter expressed that they often “have to play 20 questions” before arriving at Clara’s actual thought/request. Clara enjoys playing card games and has friends over approximately once every couple of months for a “game night.” Her daughter would like her to be able to express her needs, wants, and thoughts more clearly/efficiently with both familiar and unfamiliar communication partners. Clara would like to fly to visit her son who lives out-of-state, but she has expressed concern due to her lack of ability to communicate with others (e.g., flight attendants, cab drivers). To prepare Clara to communicate more effectively in her home and community settings, we considered aided AAC intervention.