

Found Opportunities for Social Participation

Facilitating Inclusion of Adults With Aphasia

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Lack of communicatively supportive opportunities for social participation is a critical barrier for many people with aphasia. Speech-language pathologists need to address this barrier by playing a key role in ensuring that adults with aphasia have appropriate social participation choices in their communities. Speech-language pathologists may provide these services themselves or may draw on their unique expertise in communication and aphasia to work with people with aphasia, family, friends, other health care professionals, and disability support organizations to advocate for and/or develop opportunities. This article provides examples of specific approaches that can help achieve this important goal in relation to 4 levels of social participation: interacting with others without doing a specific activity with them (e.g., having satisfying conversations), interacting with others during activities in which there is a common goal (e.g., participating in enjoyable recreational activities), interacting with others to help a specific person or group of people (e.g., volunteering), and interacting with others to make a contribution to society (e.g., being involved in an aphasia advocacy organization). **Key words:** *aphasia, barriers, environmental factors, facilitators, ICF, inclusion, participation, social participation, stroke*

“I’VE GOT no one to talk to me.” These were the words of Phyllis,¹ a 65-year-old woman who had aphasia caused by a stroke 7 years earlier. She had just been asked by the qualitative researcher to identify barriers to participating in the community with her aphasia (Howe, Worrall, & Hickson, 2008a). She stated, “It is hard. Before I was so good before. Before I had the stroke, ’cause I had so many people. . . . I had a lot of people where

we used to go out. . . . I don’t even see those people now. Once you’ve had a stroke.”

Later, the researcher made this field note observation of Phyllis at a weight loss group in a follow-up participant observation study (Howe, 2006; Howe, Worrall, & Hickson, 2008b):

Before the weight loss group meeting starts, [Phyllis] sits down in a chair. . . . There are more than 20 other people in the room. . . . Besides [Phyllis], there is one other woman. . . . who is not talking to anyone. . . . A woman sits down in the empty chair [beside Phyllis] and turns to face another woman seated on the other side of her, placing her back to [Phyllis]. The two women laugh a lot. There are now nine small conversational groups going on in the room. . . . There is laughter periodically coming from various people. . . . After the observation at the meeting, [Phyllis] reported to the researcher, “See two people there. They’re talking and they’re talking. Sometimes I get really down. They can talk and have a conversation, but I can’t. I can watch.”

At the time of the studies, Phyllis indicated that she had no physical impairments and was

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able to drive. In addition, she reported that she had several sessions of speech-language therapy during her first year poststroke but that she was not receiving therapy services at the time of the study. For Phyllis, the main barrier to participating in the community was that she lacked communicatively supportive opportunities for social participation.

Over the years, researchers have highlighted the importance of opportunities for social participation as a critical environmental factor for adults with aphasia (LPAA Project Group, 2008; Parr, Byng, Gilpin, & Ireland, 1997; Simmons-Mackie, 2008). More than 20 years ago, Kagan and Gailey (1993) identified “reduced opportunities for conversation” (p. 202) as a distinct barrier (i.e., a negative environmental factor) experienced by individuals with aphasia. To overcome this barrier, Kagan and Gailey developed programs at their Aphasia Institute in Toronto that provided opportunities for adults with aphasia to have conversations with skilled communication partners. In a qualitative research study in the United Kingdom, Parr et al. (1997) similarly identified “opportunities and resources [that] are inappropriate, inadequate, or simply not available” (p. 128) as a key type of structural barrier faced by adults with aphasia. Parr et al. further proposed that this barrier could be removed by establishing appropriate and adequate services and resources to meet the changing needs and requirements of adults with aphasia.

In the current article, I argue that a lack of communicatively supportive opportunities for social participation is a critical barrier for many adults with aphasia. In this article, I also contend that speech-language pathologists (SLPs) need to use their unique expertise in communication and aphasia to play a key role in ensuring that people with aphasia have opportunities for social participation. Clinicians can achieve this by working with people with aphasia, their family members, other health care professionals, and disability support organizations to ensure that the appropriate services and resources are available in their communities. The article begins with a

discussion of the importance of opportunities for social participation for adults with aphasia and follows with an overview of the key concepts related to this environmental factor. The article then outlines why it is important for SLPs to play a role in addressing the negative environmental factor (i.e., barrier) of a lack of opportunities for social participation for people with aphasia. It concludes with examples of “found opportunities” that can help overcome this barrier.

WHY OPPORTUNITIES FOR SOCIAL PARTICIPATION ARE IMPORTANT FOR ADULTS WITH APHASIA

Ensuring that individuals with aphasia have opportunities for social participation is important for a number of reasons. Within the general population, strong social relationships are associated with better psychological health, improved well-being, lower morbidity, and reduced mortality (House, Landis, & Umberson, 1988). However, after the onset of aphasia, individuals often report a reduction in the size of their social networks (Vickers, 2010) and a loss of and reduced contact with friends (Hilari & Northcott, 2006; Parr et al., 1997). Compared with healthy controls, people with aphasia have significantly smaller social networks and take part in significantly fewer social activities (Cruice, Worrall, & Hickson, 2006). Compared with people without aphasia poststroke, adults with aphasia participate in significantly fewer extended activities of daily living such as social and leisure activities (Hilari, 2011). Furthermore, at 6 months poststroke, aphasia severity was the only stroke-related factor that predicted the extent of decline in a person’s social network (Northcott, Marshall, & Hilari, 2016). These types of social changes poststroke may influence an individual’s health-related quality of life. Evidence for this can be found in a recent systematic review that showed that a reduced social network and poor social support contributed to poor health-related quality of life in individuals with aphasia (Hilari, Needle, & Harrison, 2012).

Qualitative research also has highlighted the importance of social participation for adults with aphasia. A longitudinal qualitative study revealed that engaging in social and leisure activities with family and friends, as well as in the community, was perceived to be important for living successfully with aphasia during the first year poststroke (Grohn, Worrall, Simmons-Mackie, & Hudson, 2014). Similarly, a meta-analysis of three qualitative investigations showed that social companionship, connectedness, and positive interactions with others were perceived by individuals with aphasia, SLPs, and family members to be important for living successfully with aphasia in the long term (Brown, Worrall, Davidson, & Howe, 2012).

CONCEPTUALIZATION OF A LACK OF OPPORTUNITIES FOR SOCIAL PARTICIPATION

Before discussing the concept of lack of opportunities for social participation, it is important to define key terms. The key term *opportunity* can be defined generically as a “set of circumstances that makes it possible to do something” (Oxford Living Dictionary, 2016). Inherent within this definition is the assumption that the necessary “circumstances” exist and are available in which an individual may choose to participate.

The second key term is *social participation*. Participation is defined by the World Health Organization (2001) in the *International Classification of Functioning, Disability, and Health (ICF)* as “involvement in a life situation” (p. 10); however, social participation is not explicitly defined within the ICF framework, and there is a lack of agreement on the definition of the concept in the literature. To address this lack of consensus, Levasseur, Richard, Gauvin, and Raymond (2010) developed a definition of social participation based on a content analysis of the concept in the gerontology literature. These authors defined social participation as “a person’s involvement in activities that provide

interaction with others in society or the community” (Levasseur et al., 2010, p. 2148).

Levasseur et al. (2010) also used content analysis to develop a six-level taxonomy that encompassed four proximal-to-distal levels of social participation. These levels of social participation can be useful for understanding the concept in relation to adults with aphasia: (1) interacting with others without doing a specific activity with them; (2) interacting with others during activities in which there is a common goal; (3) interacting with others to help a specific person or people; and (4) interacting with others to make a contribution to society (more broadly). In addition, it is noted that social participation is usually associated with positive experiences (Levasseur et al., 2010; Mars, Kempen, Mesters, Proot, & Van Eijk, 2008). This is congruent with the finding in the aphasia literature that providing multiple occurrences for interacting with others, in and of itself, without ensuring that the occurrences are positive and satisfying, is insufficient. In one qualitative investigation, Dalemans, de Witte, Wade, and van den Heuvel (2010) found that people with aphasia perceived that the quality of their social activities was more important than the quantity of activities in which they were involved.

Another important aspect of the environmental factor of opportunity for social participation is the extent of its influence. Specific negative and positive environmental factors (i.e., barriers and facilitators) may differ in the degree to which they affect an individual’s participation (Magasi et al., 2015). Rather than being summative, some environmental factors may be “deal breakers,” in that they are significant enough to preclude participation regardless of the presence of other facilitators (Magasi et al., 2015).

Related to the deal-breaker concept, Whiteneck and Dijkers (2009) have suggested that participation in an environment may be ultimately determined by some environmental factors that are “akin to the weakest link determining the strength of a chain” (p. S30). For some adults with aphasia, a lack of appropriate opportunities for social participation

may be a barrier that may function as “the weakest link in the chain” or a “deal-breaker.” For example, if there is no communicatively supportive leisure class available in a particular community center, it might not matter how many other facilitators (e.g., reduced background noise, accessible information, aphasia-friendly signs, easy access to pen and paper for written language support) are available at the center. In this case, the absence of a specific opportunity for social participation for adults with aphasia in the center could be considered a “deal-breaker.”

Finally, to enhance opportunities for social participation for adults with aphasia, clinicians can consider differences between “found” and “created opportunities” as conceptualized by Wehmeyer and Little (2013). According to these authors, *found opportunities* are unanticipated opportunities that a person happens upon through no effort of his or her own. They would include opportunities for social participation that other people such as SLPs or family members arrange and set up for a person with aphasia. For example, an SLP may provide aphasia-friendly information to a client with aphasia about a peer-led aphasia group in his community. If the man chooses to participate in the group, the clinician may accompany him on his first visit to introduce him and identify any support needs. In contrast, *created opportunities* are ones in which an individual actively creates the favorable circumstances for himself or herself. Created opportunities for social participation are those that the person with aphasia would create independently without support from others. For example, a woman with aphasia might contact the Red Cross after her stroke, make arrangements to volunteer for the organization, and then commence work as a Red Cross volunteer in a hospital.

Adults who have had a stroke but who do not have significant communication difficulties may readily set up created opportunities for themselves by adapting and developing new leisure and social activities that match their poststroke abilities (Häggström & Lund, 2008; Pound, Gompertz, & Ebrahim, 1999).

Ideally, adults with aphasia should feel empowered to develop their own created opportunities for social participation as well, perhaps as a result of their aphasia rehabilitation (Jordan & Kaiser, 1996). However, it may be difficult for individuals with aphasia to set up created opportunities for social participation after the onset of their stroke because of their language difficulties (Howe et al., 2008a; Nätterlund, 2010; Parr et al., 1997).

Language is required for many of the tasks that are involved in organizing created opportunities for social participation. Examples of these language tasks include having to text to meet a friend, use the Internet to obtain information about a walking group, complete written forms to register for a photography class, and advise instructors of communication and/or physical modifications that the individual requires to participate in a floral arranging class. As a result, adults with aphasia may rely more on found opportunities (i.e., ones that have been organized by others such as family members, SLPs, and disability support organization members) for social participation. Ideally, satisfying participation in these found opportunities may help these individuals with aphasia to become empowered to develop alternative methods for setting up their own created opportunities for social participation.

WHY SLPs NEED TO PLAY A ROLE IN DEVELOPING FOUND OPPORTUNITIES FOR SOCIAL PARTICIPATION

SLPs may need to play an important role in developing found opportunities for social participation for adults with aphasia. Although family members may also play a key role (Barry & Douglas, 2000), it may be difficult for many family members to do this for several reasons. First, it may be challenging for them because of the other roles that they must frequently take on after their relative has had a stroke (Grawburg, Howe, Worrall, & Scarinci, 2013; Howe, Davidson, Worrall, Hersh, Ferguson, et al., 2012; Howe, Davidson, Worrall, Hersh, Sherratt, et al., 2012). Furthermore,

developing new social networks involving individuals who are living with aphasia may be challenging for family members who may have difficulties locating others in their communities who also have aphasia. Finally, it may be difficult because family members may not be aware of the resources for social participation that are available or that could be set up in their communities for their family member to choose from. Therefore, SLPs may need to play a more prominent role in helping individuals with aphasia have access to found opportunities for participation and to help develop communicative supports within them.

Clinical practice guidelines often highlight the need for this role. For example, a systematic review of stroke and speech-language pathology-specific clinical practice guidelines by Shrubsole, Worrall, Power, and O'Connor (2016) revealed strong evidence for the recommendation to “provide opportunities for people with communication difficulties after stroke to have conversation and social enrichment with people who have the training, knowledge, skills, and behaviors to support communication. This should be in addition to the opportunities provided by families, carers, and friends” (p. 13).

Similarly, in a recent international consensus study, aphasia clinicians and managers emphasized the importance of opportunities for social participation in aphasia rehabilitation (Wallace, Worrall, Rose, & Le Dorze, 2016). Participants deemed essential treatment outcomes to include “opportunities to communicate” and “to participate in family/community/pre-stroke roles” (Wallace et al., 2016, p. 21). Qualitative research about goal setting in aphasia rehabilitation also identified goals in this area as being important to people with aphasia (Worrall et al., 2011) and to family members (Howe, Davidson, Worrall, Hersh, Ferguson, et al., 2012; Howe, Davidson, Worrall, Hersh, Sherratt, et al., 2012).

Playing a role in working with others to develop found opportunities for adults with aphasia falls within the SLP's scope of practice. The American Speech-Language-Hearing Association Scope of Practice (2016)

states that speech-language pathology service delivery includes “shar[ing] responsibilities to achieve functional outcomes” and “partner[ing] with other professions/organizations to enhance the value of speech-language pathology services” (p. 8). As communication experts, SLPs can play an important role in working with others to support the development and maintenance of found opportunities for social participation for adults with aphasia.

Simmons-Mackie (2000) argued that “the speech-language pathologist is uniquely qualified to analyze the communication requirements of activities, identify potential communication adaptations, and collaborate with involved parties to enhance participation” (p. 180). SLPs need to use and highlight this unique expertise in the area of communication and aphasia to support the development of found opportunities for social participation for adults with aphasia in addition to providing treatment that prepares these individuals to participate and have successful interactions within them.

HOW SLPs CAN SUPPORT THE DEVELOPMENT OF FOUND OPPORTUNITIES

The following sections highlight examples from the literature of found opportunities for adults with aphasia based on the four levels of social participation proposed by Levasseur et al. (2010). Table 1 presents a description of each of these levels with an example of a found opportunity that an SLP could consider implementing with a client such as Phyllis, the woman described at the beginning of the article. Many of these examples overcome the issue of limited clinical resources by using these resources strategically. In addition, SLPs do not necessarily need to provide these systems and services but can use their expertise to work with people with aphasia, family members, friends, other health care professionals, volunteers, and disability support organizations to advocate for and/or develop them.

Table 1. Examples of found opportunities for social participation

Social Participation Level (From Proximal to More Distal) (Levasseur et al. 2010)	Example of a Found Opportunity That a Speech–Language Pathologist Could Implement With a Client Such as Phyllis (Case Described at the Beginning of the Article)
1. Interacting with others without doing a specific activity with them	Suggest Phyllis become involved in a local peer-led aphasia group. The clinician could accompany and introduce Phyllis on her first visit to the group. After a trial period, the clinician could follow-up with Phyllis to problem-solve about any difficulties that might have arisen.
2. Interacting with others during activities in which there is a common goal	With Phyllis, meet with the leader of her weight loss group and briefly explain aphasia and its impact on everyday life. Ask the leader to identify a member who would be interested in volunteering to become Phyllis’s communication support person within the group. If a volunteer from the group is not available, an outside volunteer could be recruited. The clinician, in conjunction with Phyllis, would then train this volunteer to use effective communication partner training strategies. The clinician would also brainstorm strategies for facilitating Phyllis’s participation in the group with Phyllis, the communication support person, and the group leader. After a trial period, the clinician could follow-up with Phyllis and the communication support person to problem-solve about any difficulties that might have arisen.
3. Interacting with others to help a specific person or group of people	With Phyllis, meet with the head of a volunteer organization that Phyllis is interested in becoming involved with (e.g., a local food bank). Repeat the steps as listed earlier for the weight loss group. The clinician could also help Phyllis become more aware of her own communication support needs so that she could advocate on her own behalf within the volunteer organization.
4. Interacting with others to make a contribution to society (more broadly)	Suggest Phyllis become involved with the local aphasia advocacy group and provide her with aphasia-friendly information about the group.

Found opportunities for interacting with others without doing a specific activity with them

There are a several descriptions in the aphasia literature for providing found opportunities for interacting with others in conversations. One approach involves training the friends of adults with aphasia to become better communication partners. Power, Hudson, Davidson, Togher, and Frostell (2015) conducted a communication partner training program that focused on the friends of seven participants with aphasia. Each individual with

aphasia invited two to three friends to his or her home to participate in four 2-hr training modules. The modules included information about stroke and aphasia, the components of a satisfying conversation, and sustaining knowledge and friendship, as well as training in client-specific communication strategies. Initial findings from the study revealed that post-training, six of the seven participants with aphasia had improved scores on social and participation-based measures.

Another approach to providing found opportunities for conversations involves

ensuring that individuals with aphasia have the option to meet others who also have the communication disorder (Parr et al., 1997) such as by participating in a group. Groups include conversation (Vickers, 2010), inpatient (Fama, Baron, Hatfield, & Turkeltaub, 2016), and outpatient therapy groups (Elman & Bernstein-Ellis, 1999). Such groups provide opportunities for individuals with aphasia to meet others with aphasia, obtain social support, establish new friendships, and develop their social networks (Lanyon, Rose, & Worrall, 2013; Rotherham, Howe, & Tillard, 2015). Peer-led groups are another option that may provide long-term opportunities for social participation with minimal use of professional resources (Pound, 2011; Rotherham, et al., 2015; Tregoe & Brown, 2013).

SLPs also can support the development of found opportunities for social participation by facilitating informal meetings between pairs of clients with aphasia. For example, in a case study on friendship in aphasia, one individual described how his close friendship with another woman who also had aphasia began when he offered to push her wheelchair back to her room when they were both in the inpatient ward in the hospital poststroke (Davidson, Lyons, Chiang, & Howe, 2011; Lyons, 2008). Ensuring that adults with aphasia are located in close proximity to one another during hospital stays poststroke and, with the permission of the individuals, facilitating informal meetings between clients with aphasia are examples of simple strategies that clinicians can use to support found opportunities for social participation.

Clinicians also can develop found opportunities for interacting with others by training volunteers to become conversation partners for clients with aphasia. Organizations around the world have developed a variety of volunteer conversation partner programs (Hintgen, Radichel, Clark, Sather, & Johnson, 2000; McMenamin, Tierney, & MacFarlane, 2015; McVicker, Parr, Pound, & Duchan, 2009; Waitemata District Health Board, New Zealand, n.d.). For example, in the United Kingdom, volunteers initially participated

in a 6-hr training session that focused on conversation partner skills, health and safety information, and the concept of disability equality (McVicker et al., 2009). After the training, potential matches between volunteers and individuals with aphasia who had been referred by an SLP were identified. The referring SLP then accompanied the matched volunteer on his or her first visit to the home of the person with aphasia and made the introduction. After the initial meeting, the volunteer and the SLP were contacted to confirm that both the person with aphasia and the volunteer wanted to continue with the match. The volunteer then visited the individual with aphasia weekly for 6 months, completed and submitted feedback sheets about the weekly meetings, and attended other regular support meetings. The feedback sheets allowed the volunteer project managers to address any issues that the volunteers identified. Researchers in a follow-up qualitative study found that this program contributed to reducing social exclusion and promoting successful communication, confidence, identity, and independence in the participants with aphasia (McMenamin et al., 2015).

Found opportunities for interacting with others during activities in which there is a common goal

Approaches for providing found opportunities for interacting with others while participating in activities with a common goal include clinicians (1) training communication partners who can support the person to participate in chosen leisure and recreational activities and (2) working with other health care professionals and service providers to develop communicatively accessible leisure programs. One innovative approach for working with communication partners involves the development of a Communication Support Team (CST; Silverman, 2011; Silverman, 2015). In the first stage of this approach, the clinician brainstorms with the client with aphasia and his or her family members to identify people within the client's social networks who might be interested in helping the individual use

preserved language skills to reengage in everyday life activities. These CST members can include neighbors; colleagues; friends through children, work, or church; people to whom the person sends holiday cards; club or team members; and civic organization or social group members. The potential CST members are then contacted by group e-mail, a letter, bulletin message, or announcement and asked to identify their interests, availability, and willingness to assist the person with aphasia 1–2 hr per week. The clinician then trains each CST member to communicate effectively with the person with aphasia and sets up ground rules and agreements for the meetings including a system for regular communication (e.g., a CST Web site). In one example, Silverman (2011) described training several members of a doll club to take turns supporting an individual with aphasia at each of the monthly meetings. The success experienced by the individual with aphasia at these meetings reportedly motivated her to participate in other activities such as church committees.

The CST communication partner training includes the person with aphasia and may focus on strategies similar to those used in other programs such as the friend training program (Power et al., 2015) described earlier. However, the CST partner training may involve less time than the 8 hr of skill development provided in the friend training program. It is also noted that it may be important to initiate the identification of potential CST members early on in a person's rehabilitation, given that individuals with aphasia often have reduced contact with friends as time elapses after their stroke (Hilari & Northcott, 2006; Kagan & Gailey, 1993).

Another approach involves training community volunteers to support individuals with aphasia to participate in a chosen leisure activity (Lyon et al., 1997). Like the CST approach, the first step is for the SLP to train a volunteer to become an effective communication partner for the individual with aphasia. Once the dyad is comfortable with communicating with one another, the clinician meets with the pair to identify a list of personally relevant activi-

ties in which the person with aphasia would like to participate (e.g., taking an art class, playing cards, being a member of a church accounting committee) and to discuss how the volunteer can support the individual to achieve his or her goals. During this meeting, the clinician, the volunteer, and the individual with aphasia also plan how the activities can be carried out safely and within the capabilities of the individual with aphasia. Research has shown that after participating in this training, the participants with aphasia demonstrated significant positive changes on two investigator-constructed measures of well-being and communication (Lyon et al., 1997).

Professional language interpreters can be utilized, as well as friends, to support individuals with aphasia to participate in chosen leisure and social activities. Clinicians can work with disability support organizations, adults with aphasia, and family members to advocate for the development of professional language interpreter services, such as those available in Finland and Sweden. For example, in Finland, individuals with communication disorders such as aphasia receive free services from professional interpreters who have completed a specialized course (Rautakoski, 2014). The interpreters support the individuals to engage in a variety of areas, including recreational and leisure activities (Saarinen, 2013). Similarly, the Swedish Speech Interpretation Service (SSIS) provides interpreters for people with complex communication needs, including aphasia (Larsson & Thorén-Jönsson, 2007). The SSIS interpreters, usually SLPs or occupational therapists, support the individuals to take part in a variety of activities, including those involving social participation. A qualitative study of the perceptions of adults with aphasia who used the SSIS revealed that it contributed to an increased sense of autonomy and privacy for these individuals that was not always possible when they used family members to support them in the activities (Larsson & Thorén-Jönsson, 2007). In addition, the participants reported that using interpreters instead of relatives reduced the strain on the family. The researchers suggested that

it may be important to use role-plays and simulations to train individuals with aphasia to learn how to use professional interpreter services most effectively.

SLPs also can work with other health care professionals to help them develop leisure activities that provide communicatively supportive opportunities for social participation. For example, Tamplin, Baker, Jones, Way, and Lee (2013) developed an aphasia community choir facilitated by a music therapist in conjunction with an SLP. The music therapist and the SLP made communication adaptations for the choir participants, such as modifying song lyrics to increase repetition and including traditional songs to facilitate automatic word retrieval. Qualitative interviews revealed that the participants with aphasia who participated in the choir reported an increased sense of belonging and peer support. Similarly, Tarrant et al. (2016) developed a group singing session for adults with aphasia using a participatory design research approach. A 90-min group singing session was designed with input from people with aphasia, music facilitators, psychologists, health researchers, and an SLP. Qualitative findings revealed that the singing session helped group members develop a sense of belonging as well as a sense of psychological connection with their fellow group members.

Clinicians also may work with art educators (Duchan, Jennings, Barrett, & Butler, 2006) and drama therapists (Cherney, Oehring, Whipple, & Rubenstein, 2011) to develop accessible leisure programs. For example, in one study, an SLP worked with a drama therapist to develop a drama class for individuals with aphasia (Cherney et al., 2011). In the class, the individuals with aphasia conceptualized, wrote, and produced a play focusing on their experiences of living with aphasia. A small study on the effects of participating in the drama class revealed that the participants perceived improvements in their communication and mood; however, there were no perceived changes in social relations. The authors suggested that this lack of perceived change in social relations may be related to the fact

that all the group members had previously attended other community aphasia groups.

Group exercise and yoga classes can provide opportunities for social participation for adults with aphasia as well (Chen & Rimmer, 2011; Lynton, Kligler, & Shiflett, 2007). SLPs can work with physical therapists and exercise instructors to ensure that these classes are communicatively supportive for people with aphasia. One qualitative study showed that community-based exercise programs for adults with aphasia fostered a sense of community in the participants (Blonski et al., 2014). The investigators also identified facilitators that participants perceived to support their participation in exercise programs. These included consistent staff, routine class formats and schedules, multiple exercise instructors to provide cues, and nonverbal communication by the instructors. Perceived barriers included exercise instructors speaking too quickly, other class participants lacking awareness of aphasia, and individuals being unable to attend an exercise program without the support of a family member or communication partner.

More resource-intensive initiatives for involving people with aphasia in communicatively supportive leisure activities include aphasia camps and aphasia centers. Camps provide people with aphasia and their family members with opportunities to participate in therapeutic and recreational activities such as arts and crafts, archery, and canoeing while in a supportive communication environment (Kim, Ruelling, Garcia, & Kajner, 2016). The camps usually last a few days and are often organized through partnerships between health, educational, and nonprofit groups. A preliminary investigation revealed that after attending an aphasia camp, the participants with aphasia made significant improvements on the Assessment of Living with Aphasia (2nd ed.; Kagan et al., 2013), particularly in the personal and participation domains (Kim et al., 2016). Family member participants also reported that they valued the new friendships that the individuals with aphasia and they

themselves developed as the result of participating in the camp.

Aphasia centers are dedicated aphasia programs that provide programming designed for people with aphasia and their families. For example, aphasia centers may offer series such as conversation groups, leisure activities, or similar participation-oriented activities (Simmons-Mackie & Holland, 2011). In 2016, there were 12 independent aphasia centers recognized as charitable organizations in the United States, as well as numerous centers that were affiliated with universities and health care organizations (Elman, 2016). A survey of North American centers revealed that the centers provided a wide range of activities such as theater, art, exercise, writing, and Internet activities (Simmons-Mackie & Holland, 2011). A qualitative analysis of the survey responses revealed themes related to the positive effects of centers such as the potential for improving psychosocial well-being (e.g., making friends, feeling empowered, and having choices) and creating a sense of community for individuals with aphasia.

Found opportunities for interacting with others to help a specific person or group of people

Found opportunities for social participation in a volunteer role include involving people with aphasia as mentors for other individuals with a communication disorder in both inpatient and outpatient settings. For example, Lawrie, Hobson, and Tyson (2007) described an inpatient stroke support visitor program involving an adult with aphasia who, under the guidance of the SLPs, volunteered to provide support, practical information, and advice to individuals with aphasia and their families about living with the communication disorder. Similarly, Coles and Snow (2011) described an outpatient mentorship program in which three former clients with aphasia volunteered to become conversation partners for others with aphasia.

Other volunteer initiatives involve people with aphasia volunteering to train health care professionals and students. Purves, Petersen,

and Puurveen (2013) developed an aphasia mentors' program in which individuals with expertise in living with the communication disorder took an active role in the training of speech-language pathology students. A qualitative descriptive study of the program revealed that the mentors valued being able to give something back to society by helping the students with their training. Similarly, in a U.K. program, individuals with aphasia who volunteered to provide communication training for students, health care professionals, and volunteers reported that they gained a sense of satisfaction in actively helping others (Swart & Horton, 2015). In another program, retired community members were recruited, vetted, and trained to become senior companions for individuals with aphasia (Glista & Polens, 2007). After the training, each community member was matched with an individual with aphasia to provide communication support for the person during activities such as volunteering in a grade school art classroom.

Research also has been conducted to determine the experiences of people with aphasia when volunteering in a broad range of roles (Pearl, Sage, & Young, 2011). Pearl et al. found that volunteering helped reduce the participants' feelings of isolation and provided them with a feeling of purpose in their everyday lives. The investigators noted that the participants with aphasia lacked awareness of the types of support they would require from an organization to volunteer successfully for the group. Therefore, it may be important for clinicians to help individuals with aphasia develop an awareness of their specific support needs, particularly if they wish to volunteer in nonaphasia organizations.

Found opportunities for interacting with others to make a contribution to society

Found opportunities for interacting with others to make a contribution to society include ensuring that individuals with aphasia have a strong voice in disability advocacy organizations (Pound, Duchan, Penman, Hewitt, & Parr, 2007), as well as in other civic

groups. In general, limited research is available about these types of found opportunities, possibly because of the broader nature of this research topic. One study that has been conducted in this area included three participants with aphasia (Mackenzie, Bennett, & Cairney, 2011). This qualitative study investigated the experiences of civically engaged adults with acquired neurological communication difficulties. The investigators found that perceived barriers to civic participation included other people speaking too quickly and a lack of accessible print material.

Found opportunities in this area also include supporting people with aphasia to make a contribution to society by facilitating their involvement in research studies. Further research is required for all the approaches described in this article, as well as for many other areas of inquiry in the fields of aphasia, stroke, and gerontology. People with aphasia, however, are often excluded from research studies (Brady, Fredrick, & Williams, 2013). A number of facilitators that can help people with aphasia to be included in research studies have been highlighted in the literature (Dalemans, Wade, van den Heuvel, & de Witte, 2009; Pearl & Cruice,

2017). Facilitators include providing alternative forms of communication during studies and using quality aphasia-specific research resources.

CONCLUSION

A lack of communicatively supportive opportunities for social participation is a critical barrier for many people with aphasia such as Phyllis, the woman described at the beginning of this article. It precludes them from having the positive experiences and social benefits often associated with interacting with others during conversations, leisure activities, volunteer pursuits, and civic activities. This issue is critical for SLPs because, as Simmons-Mackie (2008) states, "Without opportunities to communicate, improved language is a trivial accomplishment" (p. 304). SLPs need to use their specialized expertise in aphasia and communication to play a key role in working with others to ensure that individuals with aphasia have communicatively supportive social participation choices in their communities. The current article has identified examples of found opportunities that can help achieve this important goal.

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