

The Clinician's Turn: Speech Pathology

"Organizing Treatment Programs for Adults With Aphasia"

The need for more specific information on treatment strategies for adults who are aphasic has been evident from the number of people who have suggested this as a topic for *The Clinician's Turn - Speech Pathology*. The role of the stroke rehabilitation team in an acute care hospital was discussed in September, 1982. This issue explores various aspects of treatment for aphasics. Our three contributors discuss a sequential treatment program for nonfluent adult aphasic patients, describe a unique study centre which focuses on group social skills in conjunction with language learning, and informs us of a team approach which includes a "Stroke Family Education Program."

All three contributors are from Ontario.

Questions about specific issues should be addressed to the authors. Comments on this or previous topics, or suggestions for future topics should be sent to the coordinator:

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"Organizing Treatment Programs for Nonfluent Adult Aphasic Patients"

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Decisions regarding the treatment of Broca's aphasic patients have, until recently, been largely dependent upon one's philosophies regarding the etiology of the "non-fluency" component of the disorder. That is, is the nonfluency due to irretrievable language or a motor speech disorder?

Advances in our knowledge regarding the disorder of Broca's aphasia have done much to minimize treatment decisions. We know that a language impairment as well as apraxia of speech usually coexist. Further, the language impairment is primarily one of irretrievable syntactic and morphosyntactic rules (Caramazza, et al., 1981; Gallagher, 1981). Thus, treatment decisions have been simplified, although they are still far from simple.

My initial therapeutic goal with Broca's patients is to get verbal

output at a functional two-word phrase level with support. Thus the syntax disorder which exists as well as the verbal apraxia must be overcome. Both may be managed simultaneously by using the technique of 'Melodic Intonation Therapy'. I stress that I use MIT not as a therapeutic program but as a facilitating technique. Both faulty syntax and articulation are permitted in that the goal is to increase verbal output with support. It must be stressed that clinicians rigorously adhere to the precise methodology of MIT including a 90% criterion level of performance of humming melodies with supported hand-tapping (Sparks, 1981). This enhances motoric and linguistic intersystemic reorganization (Luria, 1970; Rosenbek, et al., 1974).

The technique of MIT is used for the elicitation of specific syntactical structures - those found to be

relatively easy for Broca's aphasic patients (Gleason, et al., 1975). Helm-Estabrooks, et al., (1981) have recently devised a hierarchical therapeutic program for the retrieval of syntax among Broca's patients, the Syntax Stimulation Program, and I typically pair the technique of MIT with the SSP. Once the patient has motorically-reorganized his system sufficiently to repeat models, the SSP is used without the support of MIT. Faulty apractic articulation is permitted but rarely if ever is so severe as to interfere with SPP if patients are predominately Broca's aphasic patients rather than predominately apraxia-of-speech patients. If the primary disorder is apraxia of speech, then, of course, our therapeutic emphasis is on treatment of the motor speech deficit until it is sufficiently remediated so as not to interfere with syntax training. In the interim, a gestural system such as Amerind (Skelly, 1979) is taught or an alternate mode of communication is used.

Concurrent with the SSP, I administer two other types of therapies. The first is morphosyntactic comprehension training (Vermuelen, 1982) which is based on each individual's pattern of morphosyntactic deficit as gleaned from tests such as the Test of Auditory Comprehension of Sentences (Shewan, 1980) or, if unavailable, the Test of Auditory Comprehension of Language (Carrow, 1975) or the Northwestern Syntax Screening Test, receptive, (Lee, 1971). The second is a group-pragmatic based therapy which may use CADL-type topics (Aten, et al., 1982) but which always employs the principles of PACE (Davis and Wilcox, 1981), and in which clinicians particularly endeavor to model communication behaviors appropriate to each patient. Typically and optimally each patient is seen approximately 75 to 90 minutes five days a week with time equally divided between group and individual therapy.

In the neurogenics clinic at U of T we have been using variations of

this approach for three years. Seeing our patients only one afternoon a week (unfortunately) we have documented great positive changes even in chronic Broca's patients who evolved from global aphasic conditions.

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January 20, 1983.

"Organization of Treatment Pro-
grammes for Adults With Aphasia"

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The adult with aphasia experiences a series of stages or "environments" for which appropriate therapeutic management must be organized. Regardless of the therapy approach employed, the process of intervention must form a continuum, leading from "passive" intervention, through active, aggressive treatment, to re-activation and maintenance.

Acute Hospital: Immediately post-insult to the brain, the patient is usually content to have his needs met by others. He is unaware

of, or disinterested in his environment and unmotivated to communicate. At this stage, treatment is 'passive'. The speech/language pathologist monitors the patient's communication needs and level of awareness and begins to establish a relationship with him.

As awareness increases, attempts to communicate lead the patient to a recognition of his impaired language state, although rarely its extent or severity. Treatment becomes more active, with initial assessment of functional communication, and the establishment of a system to communicate basic needs, whether verbal or non-verbal.

Rehabilitation: Medical stability and increased tolerance to effort permit participation in a rehabilitation programme for those patients who are suitable or who have geographic good fortune. At this point the patient is sharply confronted with reduced or absent ability to communicate, as well as physical impairments. A range of emotions may arise to impair his ability to respond to and co-operate with treatment - frustration, depression, apathy and anger. The involvement of the total rehabilitation team becomes vital in dealing not only with physical but psychosocial problems.

Intensity and frequency of speech therapy becomes an issue. Whereas one patient may benefit from an hour-long treatment session, another may respond to 3 x 20 minute sessions. Daily treatment may be offered in many centres, however, this usually means a maximum of one hour, five days per week -- minimal input for an individual whose aphasia is a 24 hour, 7 day a week fact. It is clear, therefore, that other service options must be explored. While the use of volunteers or aides has been rejected by many speech pathologists, experience and research* suggests

*Reference: David R., Enderby P., Bainton D. "Treatment of acquired aphasia: Speech therapists and volunteers compared." (awaiting publication)

that they can make a significant contribution to a treatment programme provided that they are given adequate training and supervision.

RORRC has recently established a Study Centre for patients with aphasia. Initially modelled after second language learning laboratories, it is a place where up to eight patients may come to participate in therapeutic language activities under the supervision of a qualified speech/language pathologist. The therapeutic activity itself is designed to meet the speech and language needs of the individual patient.

Patients referred to the Study Centre are those considered to be at a level where they could benefit from working in such a setting on a regular basis, either to supplement their on-going individual therapy or to maintain their level of speech and language when individual therapy has ceased.

Studies are presently in progress to determine whether the Study Centre is an effective way of providing service.

Most patients with aphasia experience difficulties in socialization. Social gatherings may be confusing, frustrating or intimidating. Individual treatment does not adequately address these difficulties, therefore group treatment is introduced whenever possible. Activities are centred upon the use of communication skills and strategies within the social structure of the group.

Maintenance: Between 6 and 12 months post-onset, most patients reach a plateau and active, aggressive therapy is no longer indicated. However, a degree of maintenance is often necessary and may be met through a variety of options. Volunteers, friends and family may be ideally suited to take over a well-established treatment programme, with periodic review by the speech/language pathologist. Participation

in maintenance groups and self-help groups may be appropriate. In Ottawa, the Stroke Recovery Association provides invaluable support to (ex)patients and their families. For those patients who have failed to recover functional communication, augmentative systems may be prescribed and implemented.

Treatment options are less aggressive for patients who are unable to participate in an active rehabilitation programme. Out-patient treatment may be available, typically 1-3 times weekly. Patients lacking the tolerance to travel to a clinic may receive treatment at home through one of the increasing numbers of Home Care Programmes or other domiciliary services. Patients in chronic care and nursing homes can benefit from re-activation programmes which include heavy emphasis on verbal and non-verbal communication skills.

Through all stages described, the needs and contribution of family and friends must be accommodated. Individual counselling and group education help the family to understand the nature of the problems faced by the patient, what the expectations and goals are and how to prepare for changes in life-style. Here too, the involvement of the total rehabilitation team is vital.

The literature on non-speech/augmentative communication emphasizes the importance of environmentally appropriate systems and stresses the need for flexibility imposed by varied/changing environments. This same tenet may be applied to the organization of treatment programmes for the adult with aphasia.

January 12, 1983.

"Organizing Treatment Programs for the Adult Aphasics"

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St. Mary's of the Lake Hospital is a 210-bed rehabilitation, geriatric and chronic care teaching facility. Patients are admitted to St. Mary's of the Lake Hospital from a large geographical area. The ages of patients admitted range from 16 to 103, the average age being 65 to 75 years. The patients are usually transferred to this facility from other acute care hospitals.

Most of the referrals for in-patients assessment and treatment came from the Stroke Unit which has 36 beds. All C.V.A. patients admitted to this floor are seen for an assessment by the Speech Pathologist. Approximately 50% or more of the patients admitted to the Unit have little to no functional communication on arrival.

One full-time therapist is responsible for the assessment, treatment and subsequent follow-up after discharge on the Unit. In fact any concerns regarding all aspects of communication such as ENT referrals, in-depth audiological assessments, hearing aid maintenance and repairs, etc. are all done through the Speech Pathologist.

As mentioned earlier, many of the patients come from a large geographical area. Treatments for these patients are often only available at this facility. As a result any program that could be offered begins and ends at this hospital.

A multidisciplinary team is involved in the care and follow-up of the patient admitted to the Unit. Team meetings are held on a regular basis. At least one family conference with all team

members present is arranged subsequent to admission.

The average length of stay on the Unit is approximately three months. Patients stay as long as they continue to steadily progress. Many times patients with severe speech and language deficits remain the longest. Their length of stay is not only determined by degree of progress but also to availability of continuous service subsequent to discharge.

Basically all the C.V.A. patients needing speech and/or language intervention are seen on a daily basis. Individual treatment programs are organized on a two week basis and are revised if needed accordingly. Treatment time averages around one hour per session. Group therapy is scheduled once a week with a mixture of in and out patients with varying degrees of language problems. Unfortunately, although the patients are seen once a day it is not enough. Ideally it would be better if each patient could be seen twice a day for one hour sessions or longer. However it would take another full-time therapist to fulfill this need. Other therapeutic services such as Occupational and Physical Therapy have two full-time therapists on the Stroke Unit which provide this level of intensity.

Family members are encouraged to participate in the therapeutic program when appropriate. It is useful to understand the family dynamics prior to any involvement on their part. Often their assistance can do more harm than good. Members of the family are invited to observe therapy on a regular basis. In this manner they are more knowledgeable in regards to the patient's strengths and weaknesses and can observe progress over time. This is especially important for those patients who are severely involved. Most families measure progress by amount of new verbal output rather than the increased comprehension skills.

A Stroke Family Education Program is run on a continuous four week cycle

in the early evening hours. This is an excellent opportunity to meet those family members who either due to work or distance are unable to observe therapy during the day. Family members are given a general orientation to the types of speech and language deficits following the C.V.A. and types of treatment programs available on an in, and out-patient basis. Furthermore they can pick up a vast array of reading materials.

Once the patient is discharged home he or she is seen for a follow-up visit at the Stroke Clinic one, three and six months

post discharge. All team members involved in the patient's care participate in these clinics. This allows the Speech Pathologist to be certain that any recommendations on discharge have been followed through, that there has been no further regression and to respond to any further concerns of the family.

January 11, 1983.

HEAR HERE

We Get Letters

February 23, 1983

John H.V. Gilbert, Ph.D.
Co-ordinator, Ruminations
Vancouver, B.C.

Dear John:

I just received my January/February issue of Human Communication Canada and read, with great interest, the article "Raise C.S.H.A. Dues to \$350.00!!!" I personally think the article was "right on!!" That is, I agree with Margo Clinker "wholeheartedly!" We people, dedicated to the "helping profession" within the field of "human services" sometimes forget that our profession is kept almost secretive ... low key ... well hidden ... undefined, etc. ... and we do this ourselves! Hence, **MARKETING**, by way of public advertisements is the answer - the only answer! If this **MARKETING** were to occur, I would gladly pay \$350.00/year in Annual dues.

Many thanks to Margo Clinker for expressing something that has been held captive within my mind, and probably many others, for years.

Yours sincerely,

Jim Ursan
Moose Jaw, Saskatchewan



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