

On language, power and gobby-ness

Speech & Language Therapy in Practice editor **Avril Nicoll** looks back on a varied and thought-provoking British Aphasiology Society Research in Progress day (with a little help from a friend).

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A friend who had a stroke a year ago was talking about how it has affected his speech. To be honest, without his disclosure, I would be hard pressed to recognise any change. His inner struggle to use the right word and formulate what he wants to say is rarely visible. The extent of his improvement, ability to laugh about occasional slips, and a strong support network help compensate for the inevitable loss of confidence and reduced participation – however subtle – that such a major life event brings. He has also evidently taken responsibility for his own recovery, and is motivated to push himself to do suggested activities such as word fluency and sentence comprehension, with his wife as practice partner.

I was reminded of a presentation by speech and language therapist and researcher **Fiona Johnson** at a British Aphasiology Society Research in Progress day. Fiona is looking at how couples change their behaviour through conversation-based therapy for aphasia. She is particularly interested in isolating the ‘active ingredients’ of therapy that make change happen. Supported by video footage of a client and his partner, she talked about the two theoretical determinants of behaviour change: knowledge about a behaviour, and beliefs about its outcome.

However, while motivation and the social context for change are key factors, they are not the only ones. **Christos Salis** has the opportunity to research specific interventions

with a client who has received considerable input already, and who is supported to do a lot of home practice. Unfortunately, in spite of this, the client’s aphasia is proving highly resistant to change.

Christos is looking at working memory, a very of-the-moment topic that crosses the adult acquired and developmental fields. He explained that working memory is a component of short-term memory;

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it is where you take the information presented and retain it while you also do something else with it. When people like my friend struggle to take in a long and grammatically complex sentence, Christos is interested in establishing to what extent this is a result of an impairment of language or of memory. This should in theory help to identify the most effective intervention.

Christos’s logic was persuasive. On the Token Test (version not stated), his client scored 7/10 on items such as ‘Touch the black square’. The 3 errors were all on the colour. However, with prompts such as ‘Touch the big black square’, the client only got 2/10 correct and this time the 8 errors

were all on the last word. As colour, shape and size were all understood by the client, and problems only occurred with an increased memory load, Christos devised a memory-based treatment. This involved lists of monosyllabic and polysyllabic words controlled for concreteness, frequency, phonological similarity and semantic relatedness so the client couldn’t use the memory strategy of ‘chunking’. Frustratingly, sentence comprehension did not improve (although minimal pairs did) but, undaunted, Christos and his client will next explore a more linguistic approach to see if that has an impact.

Researchers in Spain, represented at this event by **Xabier Ansorena**, are questioning how the mechanisms supporting language in people with aphasia who make a good recovery – like my friend – differ from those such as Christos’s client who do not. They are comparing people with similar lesions and are investigating the role of the right hemisphere, and the use of technology to inhibit one hemisphere to promote recovery in the other. The extent of the instrumental assessment participants are going through while they are also recovering from a stroke is a reminder of the gratitude we owe our clients as we strive together to discover more about aphasia and effective strategies.

To us ‘aphasia’ is a helpful word, which provides a shorthand for a communication disability that

◀ affects individuals differently but has lifelong social and psychological consequences. However, my friend sees it as a fancy label that no one understands, and particularly dislikes the 'I have aphasia' card he was given to aid communication in pressurised situations with unknown people. He believes that 'trouble with my speech' gets the message across immediately and effectively without intimidating the person he is speaking to.

From a wider perspective, we know that, while jargon and professional language may make communication more efficient for those 'in the know', it can also act as a barrier and means of exclusion. For a profession that is

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all about communication, we should be particularly sensitive to the dangers. In a typically no-nonsense address, Pam Enderby told us that most commissioners are public health doctors, so it is important to translate academic language and avoid the use of acronyms if we want to impress them. We can't assume that commissioners know anything about what we do, in particular the essential component of working with other agencies.

Level of need

At the moment we have a mixed pattern of services, which have often evolved historically through what Pam refers to as the "gobby-ness" and interests of individual therapists. Although she values (and indeed shares) this trait, she says we also need to become "more canny" in the way we relate to commissioners. This should start with knowledge of current local services and the investment required,

as "we don't know about unmet need if we don't know what our need is". We should be familiar with national incidence figures which, for aphasia, are 60 new people out of 100,000 per year, plus 50 out of 100,000 surviving from the previous year. We can use information from the third sector about what families want, assisted by human rights, disability discrimination and equality arguments. This is likely to include the ability to re-access speech and language therapy and other allied health professionals, particularly when there is a lifestyle change.

To present a value for money argument, we also need to appreciate what our service costs (£70 in the community and £97 in hospital for 40 minutes of speech and language therapy time). We should develop a better message of what we are trying to achieve, and offer evidence of improvements in outcomes for individuals, families and society. In particular, we should set our service in the context of local priorities and opportunities.

Pam believes we could get better at targeting the treatment examined in randomised controlled trials to specific clients, as no one form of speech and language therapy will be ideally suited to all people presenting with aphasia. Marian Brady reported on an update of a Cochrane Systematic Review (Kelly *et al.*, 2010) of randomised controlled trials of speech and language therapy for aphasia. She is clearly frustrated that, although 85 per cent provided "promising indications of effect" in the context of small trials and multiple outcome measures, few between group differences reached significance.

The review included 41 qualifying paired randomised comparisons from 30 trials. Since then 6 more trials have been completed and at least 4 more are ongoing, so it is encouraging that people are using this recognised gold standard as a tool to investigate the efficacy of speech and language therapy. Even though we have tiny numbers of participants compared to those available for drug trials, Marian says there are a number of measures the profession can take to make the findings more robust and clear cut:

1. Consistency in use of valid and reliable outcome measures
2. Calculate beforehand the sample size that is needed to produce 'power' in the results
3. Build on what is already known from the 30 plus completed randomised controlled trials
4. Use valid and reliable tools rather than ones developed for a trial
5. Refer to the CONSORT statement (2010) to improve quality of reporting
6. Engage with data sharing initiatives such as the Centre for Speech and Language Intervention Research at University College London or the Virtual International Stroke Trials Archive (VISTA).

Alex Pollock wonders if we should also focus more on disability rather than impairment outcomes, thinking about what we are measuring and what it is likely to impact on. Alex is a physiotherapist by profession but, like Marian, is now with the Nursing, Midwifery and Allied Health Professions Research Unit.

Alex has been undertaking a number of forthcoming systematic reviews, on prevalence and effec-

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tiveness of interventions for visual disorders following stroke (see Pollock *et al.*, in press). She gave a straightforward and practical overview of the findings. Eye movement disorders (maintaining a normal position, and focusing and moving eyes appropriately) and visual field defects are highly prevalent in people who have had a ▶

◀ stroke. When I was in clinical practice, I was aware that clients could have problems such as nystagmus, age related degeneration, visual field defects and visuospatial neglect. However, I didn't really know how to find out or do anything about it, so I don't honestly remember this limited awareness making much difference to my practice. Alex says people often don't mention their symptoms spontaneously, or they describe them vaguely as 'blurred vision' or 'double vision'. Another delegate commented that, where she works, no-one seems to take responsibility for assessing for visual disorders, although there are many opportunities such as when clients are seated at a table for lunch.

"Double whammy"

The decreased quality of life, increased depression, isolation and effect on visual memory and planning decisions that can result from visual disorders have an impact on rehabilitation and, with aphasia, add up to a "double whammy on participation". So, while it deserves to be a priority for the multidisciplinary team, Alex says only 9 per cent of areas in Scotland have a plan for management of visual impairment. A best practice statement is in preparation to address the huge inconsistencies and, according to SIGN 118 guidelines (2010), clients should be referred to an ophthalmologist or orthoptist depending on the problem. Intervention can be restitution (restoring), substitution (optical devices) or compensation (teaching people to live with the loss and use strategies such as looking around). While there is insufficient evidence as yet for the effectiveness of interventions, speech and language therapists may be the first to identify the problem and have a role in advice, support and referral, while occupational therapists can advise about the technique of scanning.

Leigh Fernandez is also concerned with ocular matters. She is looking at eye tracking and its relationship with comprehension of syntax in people with Broca's aphasia. This research is at a very early stage and is removed from the realities of living with

aphasia, but it will be interesting to see if the findings eventually lead to a useful method of assessment.

The British Aphasiology Society is a national interest group which fosters the development of the

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study of aphasia. It has done much to meet its aim of promoting a scientific approach to investigation of aphasia and rehabilitation, and its events bring researchers and clinicians together. I feel the ongoing challenge is to meet its aim of promoting and drawing upon the expertise of people who are living with aphasia – even if, like my (thankfully) gobby friend, they would rather not call it that. SLTP

Avril Nicoll is editor of Speech & Language Therapy in Practice magazine, email avrilnicoll@speechmag.com. She is a member of the British Aphasiology Society and her attendance at the Research in Progress day at Glasgow Caledonian University on 19 April 2011 was self-funded. This article is published with the full knowledge and consent of her friend.

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Resources

- British Aphasiology Society, see www.bas.org.uk (includes a write-up of the Research in Progress day by Helen Kelly in the Summer 2011 newsletter)
- Centre for Speech and Language Intervention Research at University College London - forthcoming website, www.ucl.ac.uk/cslir/
- CONSORT statement, go to www.consort-statement.org/home/
- Virtual International Stroke Trials Archive (VISTA), see www.vista.gla.ac.uk

Speakers

- **Xabier Ansorena** is undertaking a research fellowship at the University of Salamanca in collaboration with the Instituto Gerontológico Matia in Spain.
- **Dr Marian Brady** is Stroke Programme Leader with the Nursing, Midwifery and Allied Health Professions Unit.
- **Pam Enderby** is Professor of Community Rehabilitation at the School of Health and Related Research, University of Sheffield.
- **Leigh Fernandez** is a PhD student based at the Cognition and Communication Research Centre, Northumbria University.
- **Fiona Johnson** is a speech and language therapist and a PhD student at University College London.
- **Dr Alex Pollock** is a research fellow with the Nursing, Midwifery and Allied Health Professions Unit.
- **Dr Christos Salis** is a lecturer at Reading University and Chair of the British Aphasiology Society.