Monitoring therapy for phonological assembly difficulties: A case series

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Background: A key aim of research into the treatment of aphasic language is to be able to determine which therapy is most appropriate to remediate which particular language deficit" (Best & Nickels, 2000, p 232). Predicting which therapy will be most effective for which person is particularly complex for people with phonological assembly difficulties, not least because it is recognised that this is far from a homogenous group. Ouden & Bastiaanse (2005) propose that there may be several subgroups of people who present with phonological assembly difficulties but who actually have different types of linguistic breakdown. Therapy decisions are further complicated by the dearth of intervention studies reported in the literature for people with phonological assembly difficulties. One of the few recent studies to have reported successful therapy with a client with post-lexical phonological assembly difficulties was carried out by Franklin, Buerk and Howard (2002). Therapy was carried out in two phases; the first phase aiming to improve phoneme discrimination and the second aiming to improve self-monitoring skills. This therapy resulted in their client, MB, improving in her naming of both treated and untreated items. Hickin, Best, Herbert, Howard & Osborne (2002) suggest that therapy approaches for post-lexical impairments are most likely to achieve generalisation to untreated items because a strategy is being taught. The relationship between theory and therapy is not, however, straightforward (Hillis & Caramazza, 1994), and it has even been suggested that linguistic measures may not predict outcome of therapy, but rather that patients with high scores on cognitive assessments such as recognition memory, monitoring ability and problem solving skills show the largest immediate effect of therapy (Fillingham, Sage & Lambon Ralph, 2005). With clients with phonological difficulties routinely being referred to the clinical setting, it is clear that further therapy studies need to be undertaken with this client group.

Aims of the Study: To replicate the treatment programme used by Franklin et al (2002) using a case series design and look for any differences in the outcomes for each participant; to explore which factors, including non-linguistic cognitive abilities, might identify the people who will benefit most from this therapy; to examine the relationship between the outcomes of the treatment programme on linguistic measures and on real-life measures.

Method: A series of four single case studies was carried out, to allow in depth comparison of participants, as recommended by Howard (2000). All participants had aphasia subsequent to a stroke, were greater than 3 months post-onset, and made phonological errors in picture naming, word repetition and reading aloud. Assessment was carried out on five occasions; two prior to the start of therapy, once after each therapy phase, and then at two months after the cessation of therapy. A range of linguistic and cognitive assessments was used, and real life change was measured using conversation and a patient questionnaire.
Participants were seen twice a week. Therapy tasks were the same as those described by Franklin et al (2002). The first phase of therapy lasted for six sessions and involved listening tasks such as choosing the initial or final letter for a spoken

word, deciding whether 2 heard words have the same final sound, and choosing a written word that rhymes with spoken word. The second phase lasted for 14 sessions and initially required the participant to listen to the therapist name a picture and decide if the word sounded right or wrong, then make a judgment about whether the phonological error (if present) was at the beginning, middle, or end of the word. In later sessions the participants named the picture then made a decision about the location of their own errors. The only change made to the procedure used by Franklin et al was that participants were given homework, based on the therapy tasks, to carry out between sessions. This was done in order to maximise therapy effects. All participants were keen to do work independently.

Results: Complete sets of data for two out of the four participants have been collected; the remaining two case studies will be completed in June 2008. Data from all four participants will be presented. Pre-therapy assessment has revealed that even though participants have the production of phonological errors in common, there is wide variation in their auditory processing and monitoring skills.
Analysis of the post-therapy assessment data from the first two case studies, SD and PL, has shown that neither responded to the therapy programme in the same way as MB, Franklin et al's original client. SD, who had lexical retrieval difficulties in addition to phonological assembly problems, showed an improvement in naming, repetition and reading aloud of treated items after the first phase of therapy, but made no further improvements after the second therapy phase, with no improvement on untreated items. Even though SD's improvement on linguistic measures was item specific, her post-therapy conversation contained fewer speech errors than pre-therapy, suggesting there may have been some generalisation to real life speech. In contrast, PL, who had apraxia of speech as well as a phonological assembly problem, did not show any improvement on linguistic measures or conversation after either phase of therapy.

Discussion: Franklin et al (2002) concluded that although they had aimed to improve MB's speech by giving her a more effective self monitoring strategy, their therapy actually seemed to have improved the process of phoneme activation. They remained unclear as to how this occurred as so many different tasks were involved. While this also applies to some degree in the current study, it is these issues surrounding which elements of the various therapy tasks might have caused the improvements seen and why, as well as differences in how each participant performed on the therapy tasks, that will be discussed during the presentation. The presentation will also explore issues related to the interface between phonological assembly difficulties and apraxia of speech and the implications this has for therapy, the reliability of conversation analysis as a measure of real life change, and the impact of cognitive difficulties on success of therapy.

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Improving verb production in aphasia: Does it matter whether we treat at the single word level or in sentences?

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Background: Studies have shown that verb retrieval deficits respond in very similar ways as noun deficits to the single word level therapies that target their phonological and semantic properties (Conroy, Sage & Lambon Ralph, 2006). Interestingly, even when verbs are treated at a single word level, sentence production has been shown to improve (e.g. Raymer & Ellsworth, 2002). A series of other studies have focussed more explicitly at the level of the sentence, in particular, the predicate argument structure, when treating verbs (e.g. Fink, Martin, Schwartz, Saffron & Myers, 2002; Webster, Morris & Franklin, 2005). These studies have resulted in generalisation patterns that would not be expected with a single word approach. Bastiaanse, Hurkmans & Links (2006) have gone a step further in suggesting that the sentence level should be the starting context in therapy with verbs. Bastiannase et al trained verbs at the sentence level using their Verb Production at the Word and Sentence Level programme and explicitly omitted the word level tasks. Improved verb and sentence production was also found. Each of the studies above has focussed on a particular approach (or level) to verb retrieval, providing evidence of therapy effects. The question arises, however, as to whether the clients in these studies would have also benefitted (or not) if they had received an approach other than the one that they had been exposed to. Does the context of word or sentence level really matter? Within-subject designs offer an opportunity to explore how the same individual might respond when exposed to different therapy approaches.

Study Aims: To contrast word and sentence level therapy in treating a client with aphasia characterised by severe verb retrieval difficulties.
To explore patterns of generalisation to untreated verbs, constrained sentence production tasks and spontaneous output following each phase of therapy.

Subject: TA is a 46 year old woman who suffered a left temporo-parietal extra-dural haematoma following a traumatic brain injury (TBI). She was in full time employment at the time of her head injury as an administrator working in customer services for a pharmaceutical company. She had been an outgoing sociable person. Following her TBI, TA presented with marked impairments in both comprehension and production of language, but retained good functional comprehension. At the time of the study, TA was 9 months post-onset. She continued to present with word finding problems for both nouns and verbs, but her lack of verbs was particularly striking and significantly lower than nouns. On the Object and Action Naming Battery (Druks & Masterson, 2000), TA scored 27% correct nouns (n=70) and only 12% correct verbs (n=50) (verbs<nouns, chi square(1) =8.70, p=0.003) and on other measures of verb retrieval, performed close to floor. As may be expected, her severe verb retrieval deficit compromised sentence production and communication generally.

Method: TA's difficulties with verb retrieval were considered central to maximising therapy impact. The lack of clear evidence, however, as to whether verb retrieval was best approached at a word or sentence level led us to implement a cross-over therapy design that would enable us to trial different approaches and then monitor her response to these. Therapy involved three therapy phases, each involving 30

verbs (90 verbs in total), and each involving six sessions each (twice a week over three weeks). The first phase aimed to improve verb production of the first set of items using a purely single word approach involving phonological, graphemic and repetition strategies. Drawing on Raymer & Ellsworth's (2002) phonological therapy, an error eliminating/reducing approach was used, i.e. the verb name was presented with the picture, followed by a rhyming word, the initial letter, repetition immediately and then repetition with delay. This was followed by the second phase of therapy which involved a combination of word level (similar to word level therapy on phase 1) and sentence level therapy, involving argument structure generation and increased attention to thematic roles. During the third phase of therapy, only sentence level therapy was provided. Home practice was carried out during all phases. Performance was measured in verb naming, production of verbs within sentences, and sentence complexity involving target verbs, narrative and spontaneous speech following each phase of therapy. Pre- and post-therapy interviews were carried out with TA and her husband to jointly establish goals and to evaluate the impact of therapy. TA was highly motivated throughout the intervention period. She was keen to participate and had good insight into her problems.

Results and Discussion: TA made significant item-specific improvement in verb production in single word and in sentence contexts in all phases of intervention, regardless of whether therapy targeted word or sentence level processes. Measures of correctly realised sentence structure and the spontaneous use of optional arguments also captured improvement across all therapy types, although some differences were seen in sentence production for verbs treated at different levels. Differences in the accuracy and speed with which sentence production improved when verbs were targeted at either word or sentence level suggest that sentence level therapy may have greater impact on sentence production. All gains were maintained at follow-up four weeks after the cessation of therapy. The impact on real life goals was also apparent in the post-therapy interview with TA and her husband, in particular, increased ease of talking, participating more confidently, independently and fluently in conversations, and socialising more independently.
Parallel therapy targeted difficulties in noun retrieval, using a single word approach. Results for noun retrieval mirrored those with verbs; methods and results will also be presented.
The item-specific nature of TA's improvement suggests that both the word and sentence level therapies were independently successful in improving verb and sentence production for those verbs targeted and, equally, did not generalise to non-treated verbs in any of the conditions. The differences seen in sentence production, however, offer some possible insights into the therapy process. This paper explores the factors raised by this client, possible mechanisms for why therapy was successful within each condition and expands on the spontaneous speech patterns following each therapy period.

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The use of narrative as a means of generalising sentence level processes: Taking that next step…

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Background: Over recent years, there have been a number of studies which have shown that improvements can be seen in verb and sentence production in constrained settings (e.g. Marshall, Pring & Chiat, 1998; Webster, Morris & Franklin, 2005), providing the practicing clinician with useful knowledge to underpin therapy targeting verbs, thematic roles and predicate argument structures. Despite this, many clients still show evidence of difficulties in spontaneous speech and report considerable difficulty communicating. Taking that next step to spontaneous speech remains a challenge, contributed to, in no small way, by the limited number of studies that move beyond the level of the sentence and yet build on what we already know. Two approaches have been used effectively with children with language difficulties to facilitate their production of connected speech and have potential application to therapy in aphasia. The first of these is the use of narrative frameworks (Westby, 1999; Norbury & Bishop, 2003). Linked closely to the development of literacy in children (Bishop, 1987), oral narrative skills require planning of ideas, sequential ordering of information, and a structure for inserting vocabulary, each of which have been the focus of narrative therapy by our paediatric colleagues. These skills are not unique to a child population and indeed are often exactly where the person with aphasia experiences difficulties. The ability to narrate stories closely relates to the ability to maintain conversations, recount episodes of the day or verbally plan out coming events; each requiring integration of the syntax and semantics of language, the logical ordering of events and a sensitivity to the listener (Cohen, 2001). Relatively few studies have applied narrative to aphasia (e.g. Weinrich et al., 2002; Ulatowska et al., 2006) and none of these have explicitly attempted to combine this approach with the sentence processing models that have been shown to be useful in aphasia intervention. A second area to have been explored extensively in the paediatric literature is that of mind mapping (Buzan, 1991) where diagrams are used to retrieve and link ideas, events and words in a way that can then lead to the organisation and planning of thoughts for subsequent production. Evidence of applying mind maps in aphasia therapy is limited (despite often forming part of the clinical toolbox), other than in generalised computer software available for stimulating brain performance. This study will consider whether similar approaches may be used to facilitate the connected speech of people with aphasia.

Aims: To develop a replicable therapy procedure that would draw on existing knowledge of the processes involved in sentence production and integrate this with narrative structure. To measure the impact of this therapy with two people with aphasia on both sentence production abilities and real-life communication, exploring a number of existing and novel assessments in measuring therapy effectiveness.

Method: Two clients with aphasia who had received extensive previous sentence level therapy were involved in this study. Both clients had had single CVAs, were greater than 9 months post-onset, highly motivated and lived at home with their partners. Assessments were taken pre- and post-therapy and 4 weeks after therapy ceased. Assessments involved semantic processing, and a variety of word and sentence comprehension and production tasks along with narrative, picture description of sequences, conversation, a standardised functional communication measure and self report. Therapy was offered twice per week for 10 weeks. Therapy

goals were jointly negotiated between the therapist and each of the clients, which were then incorporated into overarching real-life goals constructed using the A-FROM framework (Kagan et al 2006). This formed the structure for the post-therapy where self report of therapy impact was collected. A metalinguistic approach was used in therapy that drew on divergent (mind mapping) and convergent (sentence/narrative structure) processes. Specifically, the therapy aimed to increase the organised structure of connected discourse through focusing on sentence and narrative frameworks in describing, recalling and planning verbal information. Integration of the word (verb), sentence (PAS) and discourse (narrative framework) levels was a key feature, and the centrality of the main event to all levels was reinforced. A range of other discourse genre (e.g. event recall, event planning, conversation) were included in the programme to facilitate generalisation. Self evaluation using rating scales was used throughout the therapy to increase and maintain awareness of performance. Mind mapping played a central role in retrieval and planning sentence structures, encouraging both specificity and diversity (or richness) of lexical selection. The narrative framework then aimed to provide a structure at a level higher than the sentence that would encourage information retrieval more generally.

Results: Both clients made gains in their respective abilities to structure sentences and narrative discourse overall. Measurable gains were apparent in formal testing and, interestingly, were seen in both sentence comprehension and production. Narratives and spontaneous speech samples additionally highlighted improved performance, with narratives providing a framework to support a more diverse vocabulary and amount of information communicated. Differences were observed in the post-therapy performance of the two cases, a factor considered to relate closely to the different communication profiles of the clients at the outset. The different severity of residual lexical retrieval problems, for instance, resulted in some differences in linguistic outcomes. Both clients reported achieving real-life goals established at the outset, including gains in confidence and increased engagement more generally. One client reported that her thoughts and general talking was more organised, she tended to finish off sentences more and complete conversations without stopping - and they both enjoyed the therapy!

Discussion: A number of issues are raised by these two studies. The first relates to the successful integration of often complex sentence processing models with frameworks that mirror more closely natural communication. Further, drawing on the progress made with the paediatric population, successful techniques are shown that they can be carried over to an adult population whilst remaining meaningful and relevant. And finally, the relative strengths (and pitfalls) of using formal measures, analyses of narrative and conversation, and self report as outcome measures are explored here.

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"Oi, I have now got a name - use it!"

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This case study combines the approaches of computer based impairment therapy and conversational training aimed to improve the recall of names of family and friends during conversation for a 61 year old lady, 8 years post stroke.

Background: This case presentation is about SB, a retired solicitor, who suffered a CVA 8 years ago. Clinically she presents as an great communicator, despite a severe anomia. She has excellent "social speech", has a very healthy social life, travels and is involved in many new activities in life. She has an excellent attitude to life and is a great example of somebody "living with her aphasia". What still causes SB great distress, however, is that she has been unable to recall the names of family and friends for the last 8 years. She has developed sophisticated strategies that she uses during conversations to indicate the person she is talking about, but it leads to frequent communication breakdown.

Aims of therapy: This therapy intervention involved targeting specific personal vocabulary based on using photographs of family and friends, that SB frequently wants to talk about. The aim of therapy was that it would lead to being able to recall the names during conversation, something she had not been able to do since her stroke.

Assessment: The following assessments were administered prior to the intervention: Comprehensive Aphasia Test (CAT); Communication Disability Profile (CPD); Video of SA and partner in conversation.

Therapy: Therapy involved 3 phases delivered in blocks over 16 weeks:-
Phase 1: computer based impairment naming therapy containing personal photographs.
Phase 2: constraint induced aphasia therapy (CIAT) to target naming the photographs within a more meaningful context and within a sentence structure.
Phase 3: Conversational training of SB and her partner. It was important to identify current strategies that SB was using to compensate for her anomia, and the role of her communication partner in repair. Conversational training then involved changing these strategies to enable SB to recall the desired name during the conversation. This proved to be a challenging form of therapy!
Details of all therapy tasks will be provided in the presentation. Video footage will be used throughout to show therapy in progress.

Results: The results will be reported in terms of both quantitative and qualitative data. Data will be presented from (1) the computer stored results on usage and naming ability (2) Naming section of CAT monitored for any generalisation in naming to untreated items; (3) conversational analysis of videos taken pre and post therapy will provide qualitative data for any evidence of generalisation to conversations (4) pre and post therapy scores on CDP will report on the psychosocial impact of this therapy (5) in-depth interviews of SB and partner will report on qualitative data on their views about this therapy, what impact they feel it had, and their hopes and aspirations for the future.

Critical Evaluation and discussion: Each therapy phase and its contribution to the outcome will be discussed in detail. The role of the SB, her communicative partner, the therapist and the computer will be discussed in detail. The use of the computer

as a "tool" in providing intensive repetitive word retrieval therapy based on using personal photographs gave SB the opportunity to focus on the recall of family and friends. Something that was really important to her. The self-help approach empowered her to control this phase of therapy. The clinician was able to use the photographs on the computer "tasks" to facilitate meaningful purposeful communication and therefore encourage generalisation to the functional setting. The problems with the constraint induced therapy will be discussed and what we did to try to overcome them. The conversational based therapy will be discussed in terms of demands on resources, i.e it required a commitment from both SB and her communicative partner, and required time to analyse conversations within a busy clinical setting. It will be argued however that this was time well spent. To be successful this therapy required changes in conversation from both SB and her conversational partner. The conversational training phase however, did cause conflict for the therapist at times, because in effect we were encouraging SB to stop using strategies that were working to get her message across, and for her communicative partner to stop being so helpful in keeping the conversational flow going. This felt uncomfortable at times especially during a session when SB's partner was heard to say "Oi, I have now got a name - use it!" thankfully SB replied "Oh yes - Robert!" to the relief of the therapist and the delight of SB and Robert. (name changed)

Conclusions: This case study shows that we now have the clinical "tools" to be able to combine impairment based word retrieval therapy with conversational training which focuses on functionally relevant vocabulary. We cannot underestimate how empowering it is for someone with aphasia to be able to say the names of people they are talking to or about. The relevance of this case study to other people with aphasia will hopefully be evident.

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The Personal Development Plan: supporting activity & participation for people with aphasia

Authors: Gill Pearl (Chief Executive, Speakeasy) & Gill Jackson (chief Executive, Dyscover)

Background: Volunteering as part of the rehabilitation process is currently being given greater attention. The effects of volunteering for both disabled and non-disabled people are well documented, with evidence that the experience is valued (Wilson 2000; Reilly 2005). A recent study, involving a questionnaire to charities in a town in North West England, revealed that there is little voluntary activity by people with aphasia other than in aphasia or stroke specific organisations (Pearl 2007a unpublished). In addition the voluntary activity undertaken by people with aphasia has only recently been explored to any extent from the perspective of people with aphasia themselves (Pearl, Young et al. 2007b). This research has generated a model which explores both the effects of such activity (on self, others and organisations) and the influencing factors for taking part in activity. This recent increased focus on this activity, both as part of therapy and as a measurement of change through participation in valued activity, is currently supported by resources for people with aphasia and for organisations who involve people with aphasia as volunteers (Connect Ideas series www.ukconnect.org.uk) It's measurement is possible using the A-FROM approach (Kagan, Simmons-Mackie et al. 2008). However, there are currently no resources for healthcare professionals or others who work with people who have aphasia which would support their facilitation of such activity.

Drawing on information from the literature and from the research exploring the effects and influences of taking part in voluntary activity for people with aphasia, the Personal Development Programme (PDP) aims to support people working with those who have aphasia to consider options for activity when living with aphasia. The PDP, using quotes from the people with aphasia in the research project, considers the potential negative and positive effects of chosen activity, and the influencing factors which may affect the success of any chosen activity; it has an overall purpose of promoting activity which is likely to be more successful.

The PDP is designed as a manual for healthcare professionals and others working with people who have aphasia, generally in groups; the manual gives attention to the underlying philosophy for this approach, to the practical details for setting up such a group, and a 10 session plan supporting the discussions. (NB The development of the PDP is not a commercial venture as it will be available to buy at cost with no profit margin).

Aims: The pilot study explores the use of the PDP with a group of people who have aphasia from the perspective of the people with aphasia involved in the group, the group facilitator and the manager of the service with the aim of promoting this approach and providing resources for its implementation. The pilot, due to be completed by July 2008, aims to evaluate this approach as part of the rehabilitation process, and contributes towards the development of the draft version.

Method: The pilot study is situated at Dyscover, a voluntary sector organisation in Surrey, which specialises in providing long term therapeutic activity for people with aphasia. The PDP will be carried out in this settling with a group of people who have aphasia who are currently members of Dyscover, facilitated by a member of staff (SLT) with guidance from the Chief Executive of Dyscover liaising with the author of

the PDP. The evaluation of the PDP, ongoing throughout the pilot study, explores qualitatively the perceptions of the people with aphasia involved in the study, the perceptions of the SLT delivering the PDP, and the qualitative and quantitative analysis from the perspective of the manger of Dyscover to identify the resource implications of conducting the PDP. In addition to this exploration of the process, the A-FROM approach will assist with measurement of outcomes in terms of change in activity or attitudes amongst the group participants.

Findings: The findings, which will be more fully available by September 2008, will inform on the impact and value of the PDP to further develop the Programme so that it becomes a more useful and relevant resource for those working with people who have aphasia. The discussions will focus on the underlying philosophical perspective that underpins the approach and the value of this approach as part of the rehabilitation process, the practical issues of implementing the PDP, and the evaluation of the approach from the perspective of the people with aphasia who took part in the pilot project.

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Co-facilitated Conversation Groups: What do you need to train, support, and sustain groups to run long term and at low cost?

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Background: The Department of Health Stroke Strategy (2007) highlights the need for people with stroke to have access to long- term care and support (Quality marker 13), and access to high quality services 'for as long as they need it' (QM 10) to avoid the sense of isolation and abandonment often experienced after acute services stop. This paper will focus on co facilitated conversation groups as a way of extending and enhancing long-term opportunities for people with aphasia, both as co facilitators and group participants. We suggest that involvement in such groups can impact on quality of life, and mental and emotional well-being as highlighted in other recent policy initiatives particularly the NSF for long term conditions and the White Paper – Our Health, Our Care, Our Say (2006). However, the questions that arise are how do you go about setting up co facilitated groups, who should fund such support services and how can we work within existing resource to make such options sustainable?

Aims: The paper will give a brief description of the co facilitated conversation group run at Connect London for people with mild – moderate aphasia over many years. Extrapolating from our experience in London, we describe how we sought to extend such opportunities to reach a broader spectrum of people with aphasia, across different geographic locations, and across the voluntary and statutory sectors.

The paper will explore the methods used to train & support the co-facilitators to fulfil their roles both in a broadly diverse group in London and new groups in rural Cornwall. We will consider the soft outcomes captured by focused group interviews & feedback questionnaires. We will draw upon the story and progression of one of our co-facilitators through this process to illustrate the process and its impact from his perspective.

The paper will address the issue of sustainability and draw on our experience in working with other voluntary sector organisations. We will refer to our recent experience in working with an organisation to promote better conversation between

group members where co-facilitators with aphasia extended their role to be demonstrators of facilitated conversation. We will draw on a series of evaluations, including personal stories, interviews, and video diaries, to describe this journey and consider the implications for us as service providers to maintain such initiatives within our local communities.

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