INTERACTIONAL CHALLENGES TO THE CONSISTENT ENACTMENT OF THERAPY FOR LANGUAGE IMPAIRMENTS IN APHASIA

INTRODUCTION

'Task' or 'information-processing demands' (e.g. Wallach and Miller 1988) are the challenges that essentially set in motion the language and cognitive processing work through which the goals of aphasia language therapy are achieved (Robson and Horton, in press). Therapists operationalise goals by introducing stimuli, getting the client to respond, responding contingently themselves, and then moving on to the next stimulus (McTear and King 1991).

Byng and Black (1995: 311) argue that therapists' contingent responses – "modulating the therapy task" – could be one of the critical aspects in the process of therapy. As Simmons-Mackie *et al* (1999) point out, clients receive feedback from therapists, but therapists also modify their treatment in response to the feedback they receive from clients. It has also been suggested (Horton and Byng 2002) that therapists' increased awareness of consistency in implementing interventions could lead to more efficient and possibly more effective therapy.

A study aimed at developing a systematic and explicit descriptive framework for aphasia language therapy examined therapy between experienced clinicians and people with aphasia in day-to-day practice. One question addressed in this study concerned the type of evidence which might provide explicit definitions of techniques such as those described in the literature as 'cueing', 'facilitation' and 'feedback' – in other words those techniques implicated in the modulation and consistent enactment of therapy tasks.

METHODS

Participants

Fourteen therapists and thirteen people with aphasia formed fifteen therapist-aphasic person dyads. Therapists were working in the UK and registered with the professional body, had at least three years experience of aphasia therapy, and were members of the British Aphasiology Society. Participants with aphasia were at least one month post onset of a left CVA, neurologically stable, and with evidence of moderate-mild expressive aphasia. People with significant cognitive or comprehension difficulties, hearing impairment or concurrent psychiatric difficulties were excluded.

Participating therapists had a mean of 11 years experience of working with people with aphasia. There were ten people with non-fluent aphasia and three with fluent aphasia, described as having "severe" or "neologistic" jargon. Range of time since onset of aphasia is shown in Table 1.

TABLE 1 ABOUT HERE

Time 'known to each other' ranged from 0.25 [one session] to 48 months. This is partly indicative of the different types of location represented. The highest end of the range (D1) – which anecdotal evidence suggests is unusually long – is the only example here of privately funded therapy.

TABLE 2 ABOUT HERE

Table 2 shows data associated with location of sessions and length of time working together for each dyad. It should be noted that two participants with aphasia (D2/3A and D10/11A) worked with more than one therapist, and one therapist (D9/10T) worked with two of the participants with aphasia.

Data production and analysis

Each dyad was asked to contribute three sessions to the study. In all forty one videotapes, varying in length from about thirty minutes to just over an hour formed the data set. The interactions between participants and the social processes of therapy entailed in those interactions were studied through the systematic observation of videotapes. The goal was to construct a data-driven descriptive framework accounting for the organisation of every interaction in the corpus (Mehan 1979: 1, 20).

Data were analysed and evidence constructed using approaches which acknowledge the need to construct a 'big picture' framework (Spradley 1980) as well as examining the detail of moment-by-moment interaction (Mehan 1979), supported by the methodology and specific techniques of Conversational Analysis (CA) (e.g. Sacks *et al* 1974).

RESULTS

A descriptive framework for therapy sessions

The methods described above were used to develop a broad descriptive framework for the structure of therapy sessions. This 'domain' structure was developed through close attention to turn-taking and sequence organisation, lexical choice, pauses and timing, materials and other artefacts. The framework is outlined in Figure 1.

FIGURE 1 ABOUT HERE

The framework of 'domains' is not prescriptive and does not describe an 'ideal session'. This paper focuses on issues arising from the domain 'Doing therapy tasks', which in this study was demonstrably the main business of sessions. Domains have a number of key features, each of which has one or more types of representation. Table 3 gives an overview of the feature 'Task management'.

TABLE 3 ABOUT HERE

'Overall management of tasks' concerns the ways therapists manage tasks across sessions as a whole – which tasks are deployed, when they are introduced or curtailed and so on. 'Task management' is also typified at a moment-by-moment level in 'Enacting tasks', with associated 'Task demands' and their associated dimensions. Both types of 'Task management' feature are implicated in notions of 'modulation' and 'consistency'.

'Modulation' or 'inconsistency'?

The deployment of tasks and routines

Task demands are often modulated from session-to-session. Within sessions tasks of different types or perceived levels of difficulty follow each other in orderly ways. Therapists also make responsive local judgements about introducing unpredicted subtasks in order to steer the main task in the 'right' direction.

Tasks often have associated responding routines, but in actual practice these routines were frequently flaunted. Usually it was the therapist who controlled changes, but there were instances where the aphasic person demonstrably resisted a proposed routine.

"It's getting a bit easy"

The notion of task demands often arose when therapists mentioned "harder" or "a tricky one". Therapists were rarely explicit about reasons for a task or item being 'harder' or 'tricky'. However, there were examples of therapists clearly stating how they proposed to modulate the task. In D8(1) a three second time delay between stimulus presentation and response was introduced. The therapist's count-down soon became highly variable however.

She occasionally reached towards the aphasic person to try and attract his attention to the count, a move which he generally ignored.

In D11(1) the therapist stated that she would withhold feedback until the aphasic person had carried out his own self-evaluation. This tactic was quickly undermined by the aphasic person looking to the therapist for feedback as soon as he responded. The timing of her feedback was highly predictable – when he did get it right her positive evaluation was immediate. The suggestion is that even the split-second absence of a therapist response signalled that there was a problem. Therapist follow-up patterns become quickly established and the aphasic person is quickly attuned and very sensitive to changes in that pattern.

Precision or clarity of responses

Aphasic participants exhibited their own standards of precision, as evidenced by, for example, repeated self-initiated attempts at target words. They also clearly elicited help from the therapist to make necessary corrections.

Requirements for precision or clarity in certain types of task were by no means always explicit, often being decided on a case-by-case basis. Therapist follow-up of the aphasic person's response while not overtly corrective may indicate a 'norm' to be aspired to (Simmons-Mackie *et al* 1999: 224). In D8 (2) for example this occurred once in task-set one (9%); seven times in task-set two (28%); twice in task-set three (15%).

Clinicians demonstrably worked assiduously to achieve the 'correct response' (see van Kleeck and Richardson 1986). However, therapists adjusted their elicitations in ways that sometimes seemed at odds with the apparent goals of therapy. There were several lengthy sequences of semantically-related repair work which failed to elicit the required response, which the therapist concluded with phonetic fragments (e.g. unreleased phonemes) which functioned as phonemic cues to elicit the required response.

"Take your time"

Time allowed for the response to emerge, or before the therapist intervened varied greatly across the data. This variation is clearly due to many different factors. The aphasic person sometimes took an active role in 'claiming' processing time ("seizing the floor": Sacks 1992: Vol II, Part VII, Lecture 13, 497). This enabled him/her to hold off therapist interventions, but led to widely variable within-task timings between elicitation and response.

SUMMARY AND CONCLUSIONS

Task modulation occurs in numerous ways in aphasia language therapy. Therapists clearly strive to maintain the integrity of therapy goals, although the drive to achieve 'the response' may compromise the process through which they are achieved. Various interactive phenomena, such as the person with aphasia soliciting feedback, capitalising on predictable feedback patterns, seizing (and retaining) the floor, or declining to use various task-related procedures may affect the consistent implementation of tasks. It is suggested that close attention to 'technique-in-interaction' has the potential to improve the consistency and hence efficiency and effectiveness of therapy.

TABLES

Table 1
Aphasic person participants: gender, age and time since onset

Aphasic person	**Gender**	**Age (years)**	**Time since onset of aphasia (months)**
D1A	F	53	60
D6A	F	67	8
D7A	F	60	18
D2/3A (with two different therapists)	F	50	24
D9A	F	63	9
D13A	F	59	8
D15A	F	85	3
D14A	F	83	24
N = 8	Women	Mean age = 65 years Range = 53-85 years	Mean time since onset = 19.25 months Range = 3-60 months
D8A	M	63	7
D5A	M	64	19
D10/11A	M	40	5
D12A	M	75	28
D4A	M	59	24
N = 5	Men	Mean age = 53 years Range = 40-75 years	Mean time since onset = 16.6 months Range = 5-28 months
All participants (N = 13)		Mean age = 63.15 years Range = 40-85 years	Mean time since onset = 18.23 months Range = 3-60

Table 2
Therapists and people with aphasia: time working together and location

Therapist code	Aphasic person code	Location of videotaped sessions	Time working together (months)
D1T	D1A	Domiciliary (private)	48
D2T	D2/3A	Out-patient rehabilitation clinic	6
D3T			24
D4T	D4A		4
D5T	D5A	Out-patient rehabilitation clinic	1
D6T	D6A	Out-patient rehabilitation clinic Domiciliary	7
D7T	D7A	Out-patient rehabilitation clinic	0.75
D8T	D8A	In-patient rehabilitation clinic	0.75
D9/10T	D9A		0.75
	D10/11A		0.25
D11T			1
D12T	D12A	Out-patient aphasia rehabilitation clinic	4
D13T	D13A	Out-patient rehabilitation clinic	5
D14T	D14A	Domiciliary	9
D15T	D15A	Out-patient rehabilitation clinic	2.75
14 therapists	13 people with aphasia	11 different individual locations (3 different types of location)	Mean = 7.62 months Range = 0.25 – 48 months

Table 3
'Doing therapy tasks' – 'Task management' types, sub-types and dimensions

Features	Types	Sub-types and dimensions		
B. Task management	Overall management of tasks	• when are tasks introduced? • what tasks are introduced and enacted? • which tasks follow each other? • when are tasks curtailed, prolonged or repeated?		
	Enacting tasks	Task demands	Dimensions associated with task-related responses	• Response mode • Response content • Responding routines • Precision
			Dimensions associated with stimulus items	• Item types and combinations • Numbers of items • Item clarity
			Dimensions associated with enacting routines	• Content and manner of therapist Elicitations • Time and timing in Enacting routines • Elicitation-response – follow-up • Responding process

FIGURES

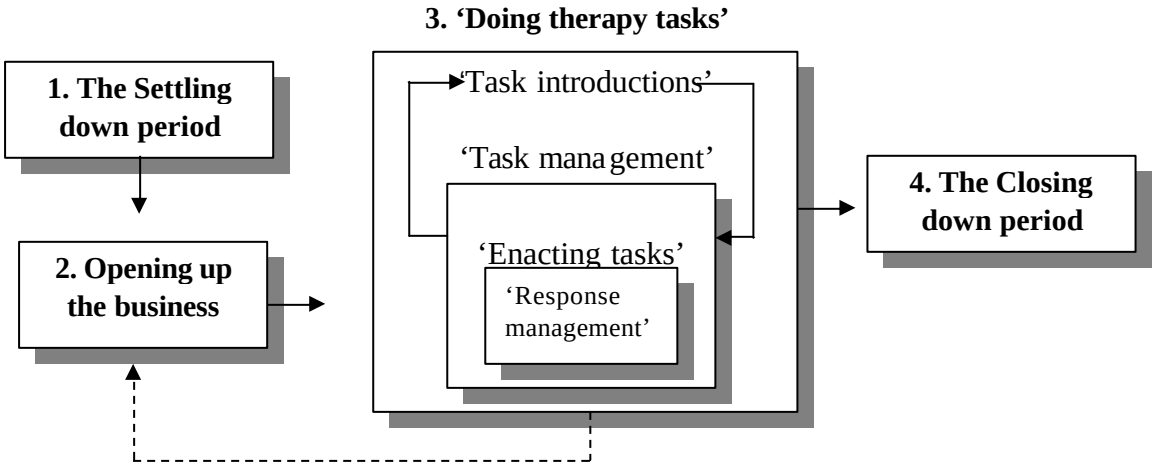

Figure 1 'Domains' – a descriptive framework for therapy sessions

References

Byng, S and Black, M (1995) What makes a therapy? Some parameters of therapeutic intervention in aphasia. *European Journal of Disorders of Communication*, **30**, 3, 303-316.

Mehan, H (1979) *Learning Lessons. Social Organisation in the Classroom*. Massachusetts: Harvard University Press.

McTear, MF and King, F (1991) Miscommunication in Clinical Contexts: The Speech Therapy Interview. (Chapter 10, pp 195-214). In: Coupland, N, Giles, H and Wiemann, JM (Eds) *"Miscommunication" and Problematic Talk*. London: Sage.

Robson, J and Horton, S (in press) Replicating therapy – more than just more of the same. Chapter 10, in: Byng, S, Duchan, J and Pound, C (Eds). *The Aphasia Therapy File – Volume 2*. London: Psychology Press

Sacks, H (1992) Two "floor-seizure" techniques: Appositional expletives and "Uh". Lecture 13, Part VII, Fall 1971 (pp 495-498). In: Jefferson, G (Ed) *Lectures on Conversation, Volume II*. Oxford: Blackwell.

Sacks, H, Schegloff, EA and Jefferson, G (1974) A Simplest Systematics for the Organisation of Turn-Taking in Conversation. *Language*, **50**, 4, 696-735.

Simmons-Mackie, N, Damico, JS and Damico, HL (1999) A Qualitative Study of Feedback in Aphasia Treatment. *American Journal of Speech-Language Pathology*, 8, 218-230.

Spradley, J (1980) *Participant Observation*. New York: Holt, Rinehart and Winston.

Wallach, GP and Miller, L (1988) *Language Intervention and Academic Success*. Boston: Little, Brown and Co.

Van Kleek, A and Richardson, A (1986) What's in an error? Using children's responses as language teaching opportunities. *Journal of the National Student Speech-Language-Hearing Association*, **14**, 25-50.