

## **Abstract**

This is the first study since 1985 to explore the components of group aphasia therapies as identified by practicing clinicians. In this pilot study, 10 American speech-language pathologists were given a standardized open-ended interview about clinical experiences. General themes were found within common treatment components. The findings of the current study provide a comparison to current theoretical discussions on group aphasia therapy and describe the protocols for current therapy approaches. Additionally, the pilot study forms a foundation for a larger interview study aimed at examining what group aphasia therapies are most commonly used and how and why they are implemented.

## **Examining Treatment Components: Interviews about Group Aphasia Therapy**

### **Introduction**

Group aphasia therapy has become more common in the last several years, because it is an evidence-supported intervention (Elman & Bernstein-Ellis, 1999) that is cost-effective (Aten, Caligiuri, & Holland, 1982) and produces both specific communication and psychosocial outcomes (Elman, 2007). However, as Springer observed years ago, “it often remains unclear what exactly clinicians mean by group therapy” (Springer, 1991, p. 563). In spite of the use of aphasia group therapy, its specific procedures, goals, strategies, and implementation remains highly varied and unclear to many practicing clinicians.

In an effort to clarify group aphasia therapy within the Veteran Administrative Medical Centers, Kearns and Simmons (1985) found that the majority of clinicians reported multiple purposes for their aphasia groups. Overall, approximately one-third of a typical session targeted ‘general topic oriented discussion.’ Additionally, approximately 20% of the clinicians reported having no routine evaluations on group members’ performance. The authors recommended continued investigation into the current and most effective practice patterns for group aphasia therapy. Yet since the Kearns and Simmons (1985) survey, the specific components of group aphasia therapy within current clinical practice have been relatively unstudied.

The purpose of this pilot study was to examine the components of the current practice of group aphasia treatment by obtaining information from speech-language pathologists currently engaged in group aphasia therapy; and to utilize these findings as a comparison to the current literature on treatment components and general classifications of group therapies (e.g., Kearns & Elman, 2008).

### **Methods**

#### ***Participants***

Ten practicing clinicians participated in the pilot study. The clinicians were certified speech-language pathologists. Clinicians were required to have had at least three years of experience with group aphasia therapy. Participants whose aphasia group experience was more than two years in the past were excluded in order to assure that participants were current in their skills and knowledge. Participants’ clinical experience ranged from three to over 22 years. Participants were recruited through the American Speech-Language-Hearing Association Division II. The clinicians worked in three different settings, four clinicians at a university, four at an aphasia center, and two in a hospital.

#### ***Procedures***

Data collection consisted of a standardized open-ended interview, shown in Table 1. For standardized open-ended interviews the ‘exact wording and sequence of questions are determined in advance’ (Patton, 2002, p. 349). The questions were asked in an open-ended manner. The standardized open-ended interview was chosen because, according to Patton (2002), the format reduces interviewer bias and facilitates collection and analysis of data. The open-ended interview questions probed current practices in aphasia group therapy, focusing on treatment components considered crucial to all speech-language treatment (Byng & Black, 1995; Hinckley, Patterson, & Carr, 2001). A list of the interview questions appear in Table 1.

The interviews were conducted using a password-protected website, Elluminate Live. Interviews were administered and clinician responses collected using a typed chat session format. The interviewer typed the questions into a chat window. The clinician then was able to read the question and respond by typing back. The live chat interview session lasted up to one hour. Clinicians were able to participate from any quiet location having a computer with internet access. At the end of each session, the interviews (i.e., typed questions/answers) were saved to a word processing document for later analysis.

The qualitative data analysis used for the present study was based on analysis recommendations by Berg (2007). Strategies were used to assure quality data collection and analysis, including bi-weekly investigative research team meetings to discuss data collection and coding schemes.

## Results

Initial themes were coded by all authors based on an open-coding scheme. Responses to some interview questions overlapped. For instance, the activities and implemented strategies (e.g., reading comprehension and the expression of opinions using multimodal communication) were often directly linked to the purpose (e.g., ability to participate in a book club). Across participants, themes have been illustrated in Figures 1-6. Several participants reported more than one *purpose* for their groups (i.e., multipurpose groups). Themes found for purposes of treatment included conversation skills, client values, functional/ life participation and activities, continuation of services, education/training, and psycho-social issues. For example, one clinician reported purposes to “improve functional expressive and receptive language skills and practice and use communication strategies through the exposure and practice of using them in a social setting or a more natural context.” Another clinician stated purposes to “allow for an individual to bring Life Participation Approach to Aphasia goals to the table and problem solve for the level of support he/she will require.”

Themes found to describe common *strategies* for group aphasia treatments included multimodal communication, strategies based on individual sessions/goals, utilizing others, and pragmatics. One clinician said, “I make sure that everyone has the ‘ramps’ or supports they need to participate adequately. For example, if someone can write really well, but as difficulty with verbal expression, we provide wipe boards. If someone uses a communication device, we make sure to set that up.”

*Interactions* were described as clinician/client led, dominating (or equal group participation), supportive, based on the group culture, based on the tasks, and based on the severity of the group members. One clinician reported, “support to each other, assisting each other and cueing each other are all observed or prompted.” Another clinician said that, “occasionally, I have to interject to provide some factual clarification regarding recovery prognosis or risk factors for strokes. I try to hold back as much as I can while just steering the conversation every once and awhile.”

The themes found for *tasks* included unstructured conversation, higher level cognitive skills, structured tasks, based on client values, and functional tasks. For example, one clinician response was “with this group we really don't have tasks, it is conversation based.”

*Materials* were reported to include functional materials, published materials, and augmentative and alternative devices and other technology. For instance, one clinician stated, “I have communication boards with pictures that illustrate different topic interaction ideas to aid with generating topic selection if needed...materials they need to communicate.”

Finally, most respondents used informal measures for *evaluation*. For example, one clinician reported, “I don't formally assess the members.”

### **Discussion**

The current pilot study provides information about what currently occurs in group aphasia therapies, based on a sample of clinicians active in using this treatment approach. We have begun to better understand the components that make up this form of treatment. The themes from the current pilot study will continue to be explored in a larger study with further data collection and revised interview questions, and enhanced with further measures of internal validity, such as member checking. This study can provide an initial comparison to the literature describing the components of group aphasia therapy (Kearns & Elman, 2008), shown in Table 2. The findings may indicate that the ‘indirect language treatment groups’ that have been present in previous literature are no longer utilized today. Client values, utilization of other group members, and group culture seem to be a larger influence on clinical practice today. Future research should consider other forms of data collection, such as group leader or group member focus groups and analysis of videos of group treatment (e.g., Simmons-Mackie, Elman, Holland, & Damico, 2007) to further explore current practice.

### **References**

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### Tables and Figures

<p>Give me an example of a typical aphasia group from the beginning to the end.</p> <ol style="list-style-type: none"> <li>1. What are the purposes of your group therapy?</li> <li>2. Why do you choose those purposes for the group therapy?</li> <li>3. Give me some examples of strategies for your patients that you tried to facilitate during your aphasia group therapy session?</li> <li>4. What kinds of interactions occur within your aphasia group sessions?</li> <li>5. What tasks are used during a typical aphasia group therapy session?</li> <li>6. What materials are used during a typical aphasia group therapy session?</li> <li>7. How do you typically evaluate participants in aphasia group sessions?</li> <li>8. What sorts of changes are you looking for within your group members?</li> </ol>
<p>Additional Questions on Group Dynamics for Future Analysis:</p> <ul style="list-style-type: none"> <li>• How many group members are typically within your group session?</li> <li>• Why are individuals generally enrolled in your group session?</li> <li>• What are the inclusion/exclusion criteria and/or characteristics of participants?</li> <li>• How do you bill for the group aphasia therapy?</li> </ul>

Table 1. Standardized open-ending Interview Questions

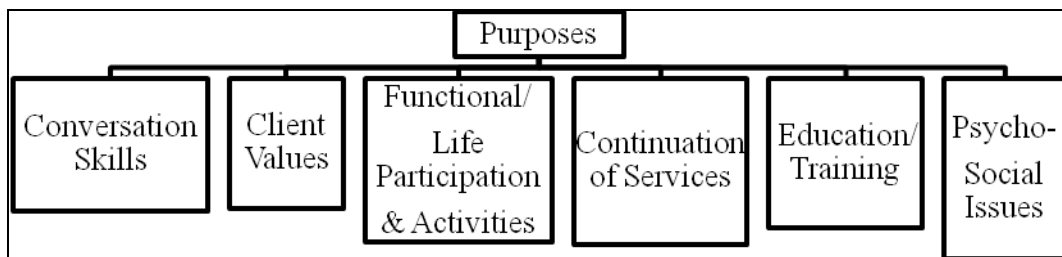


Figure 1. Themes found across participants for purposes

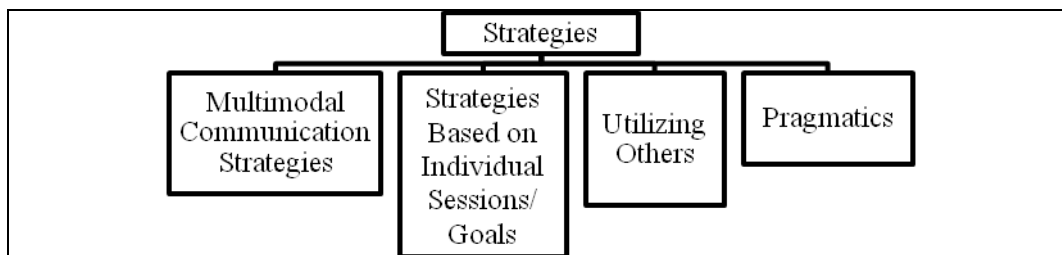


Figure 2. Themes found across participants for strategies

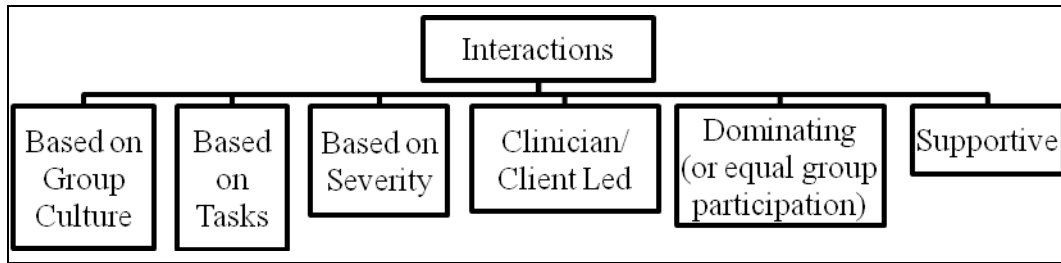


Figure 3. Themes found across participants for interactions

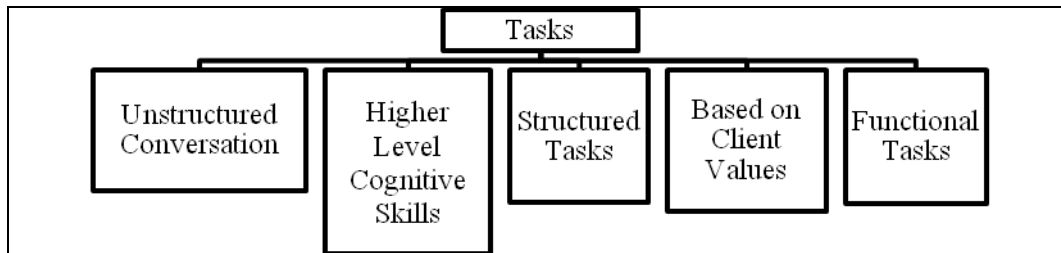


Figure 4. Themes found across participants for tasks

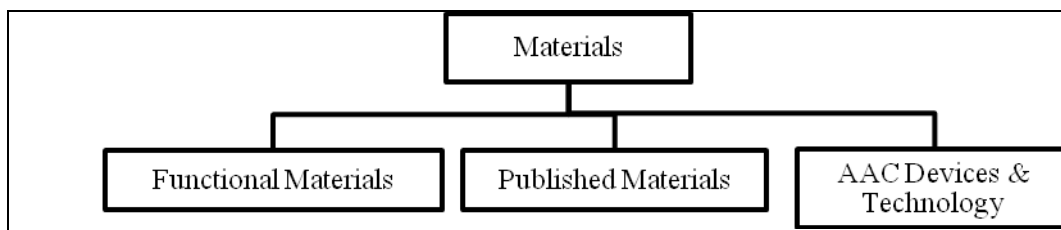


Figure 5. Themes found across participants for materials

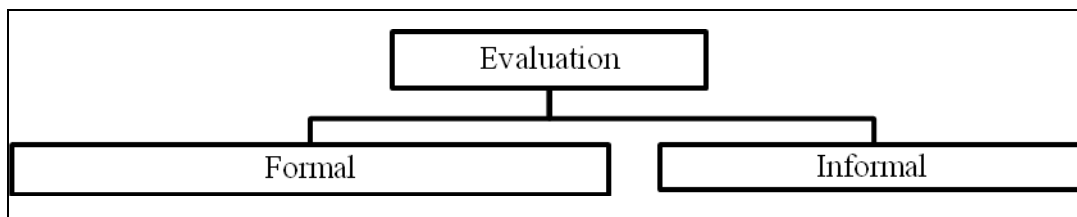


Figure 6. Themes found across participants for evaluation

	<b>Direct Language or Skill-based Treatment (Tx) Groups</b>	<b>Indirect Language Tx Groups</b>	<b>Socio-linguistic or Conversation or Communication Groups</b>	<b>Transition Groups</b>	<b>Maintenance Groups</b>	<b>Multi-purpose Groups</b>	<b>Functional or Context-Based or specialized Groups</b>
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Purposes	To improve language	To improve language, but with no explicit intent or stated goals and with little to no structure;	To increase communication exchanges (e.g., arguing, advising), interpersonal skills (e.g., focus on speech as a social skill); Socialization is a ‘means’ and not the primary focus	To practice communicative skills that are used in daily functions; To practice problem solving skills with communicative strategies	To help individuals retain the communicative skills gained in individual therapy	Aims may be a combination of two or more of the general classifications	To make improvements on a specific skill (e.g., using the internet, reading and discussing books, giving toasts); to make improvements on functional everyday tasks
Strategies	Numerous; Often related to cueing and targeting a specific language modality	Not specified	Often multiple communicative modalities are utilized to reach goals (e.g., gestures, writing, id card in wallet), but usually specific socio-linguistic acts are targeted within a sessions (e.g., requests)	Use of gesture or pantomime or other communicative modalities; Reduce anxiety of a functional task by first practicing it in a role-play scenario	Often multiple communicative modalities are utilized to reach goals (e.g., gestures, writing, id card in wallet)	Strategies from two or more other classifications may be utilized	Often multiple communicative modalities, including alternative and augmentative communication, are utilized to reach goals (e.g., using a script to make a toast or a cue card to order from a catalogue)
Interactions	Clinician led; didactic; Clinicians ask questions and requests; Usually led by one speech-language pathologist (SLP)	Not specified	Exchanges mostly between group members with reduced interactions with group leaders; May be facilitated by a SLP or co-led with other disciplines, and also by students	Exchanges mostly between group members; Reduced interactions with group leaders; May be facilitated by a SLP or co-led with other disciplines (e.g., job coach)	Social exchanges in a natural social contexts	Interactions from two or more of the other classifications may be applied	Interactions are centered on problem-solving; Feedback is provided by clinician or other group members to target goals
Tasks	Structured, drill-like; Stimulus-response with a specific cognitive-communicative target	Vaguely defined unstructured language stimulation, socialization	Conversations	Often involving role-playing or supervised daily communicative activities	Based on clients interests (e.g., watching and discussing movies together, guest speakers)	May be a combination of tasks described in the other group types	Very specific tasks (and task preparation) regarding a functional goal (e.g., reading and discussing a book in a book club)

Table 2. Group Aphasia Speech-Language Treatment General Classifications (after Kearns, 1986, 1994; Kearns & Elman, 2001, 2008)