

Treating Mildly Aphasic Patients:
A Round Table Discussion

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Our group was comprised of clinicians. All treat aphasic patients, and some of these patients are mildly aphasic. All agreed, at the outset, that we have a good deal of work to do on the way we talk about and the way we manage mildly aphasic patients. And all agreed that many questions about the management of mild aphasia are answered with, "That is an individual decision."

Discussion was guided by six questions: How does one define mild aphasia?, What is the prevalence of mild aphasia in our case loads?, How does one appraise mild aphasia?, Where does one focus therapy for mild aphasia?, How does one measure change in mild aphasia?, and What are the ethics involved in treating mild aphasia? These devoured two hours. This is a summary of that repast.

Definition. Attempts at a definition ranged from performance on standardized tests, through attaching the adjective "mild" to any problems displayed, to the necessity of the patient having to report problems for them to be noticed. The group agreed that test performance typically was not definitive of mild aphasia; that "mild" was the best descriptor of any problems observed; and that many patients, like Scott Moss (1972), needed to make their problems known or they would go unidentified. Specific considerations involved in defining mild aphasia are premorbid and present need for language and variability within aphasic and normal language performance. Some patients with moderate aphasia function, return to work, while others with mild aphasia do not have sufficient language skills to take up their former employment. This relative need for language creates a situation where one man's mild is another's moderate, and it creates definitional difficulties. Further, the range of language performance within mild aphasia will overlap with the range of language performance in adults who have not suffered brain injury. Thus, an aphasic patient may perform "normally" however his need for language may render him mildly or even moderately aphasic. Here, the situation is one where one man's normal is another's mildly aphasic, and, again, it creates problems in casting a definition. Finally, the group agreed that mild aphasia resembled other levels of aphasic severity -- problems in auditory comprehension, reading, oral expression, and writing. However, writing deficits may be the most noticeable and create the most concern for the patient.

Prevalance. The number of mild aphasic patients seen appears to be influenced by the clinician's setting. Group members from Veterans Administration Hospitals reported seeing fewer mild aphasic patients than clinicians in private practice, private hospitals, and clinics in academic settings. Those clinicians working closely with Vocational Rehabilitation Services reported working with a large number of mild aphasic patients. Many mild aphasic patients are not referred for treatment, since their

deficits go undetected by referring physicians and other professionals. Some mildly aphasic patients are self-referred and seek help several months postonset when they realize their residual deficits prevent returning to work. Thus, mild aphasia may not be common in the case load of some clinicians, but it occurs frequently in that of others.

Appraisal. Appraising mildly aphasic patients is difficult. Traditional aphasia tests typically do not detect mild deficits. More difficult measures, such as the Token Test (DeRenzi and Vignolo, 1962) and the Word Fluency Measure (Borkowski, Benton, and Spreen, 1967) are suspect because of their "functional" application and the range of performance seen in normals. The Yorkston and Buekelman (1977) measure for quantifying verbal output in high-level aphasic patients was considered an exception to this general, negative feeling toward formal measures. Most group members believed adequate appraisal of mild aphasia is achieved by having the patient identify his problems and elaborate his difficulties. Attention should be given not only to accuracy, but also latency. Finally, appraisal should include the patient's emotional response to his language deficits, especially when such responses interfere with otherwise intact language behavior.

Focusing Therapy. What to do with mildly aphasic patients appears to be directed by the patient's problems and his preferences. Therapy's focus ranges from specific, job-related tasks to reality orientation counseling. Group members advocated individual or group treatment or both. All agreed the mild aphasic patient should have a voice in directing his treatment. Specific treatment tasks should consider vocational needs -- filling out forms, writing business letters -- and environmental needs -- ordering from a menu, taking a phone message. Group therapy was advocated to provide a realistic communication environment and to identify deficits that may go undetected in individual treatment. An analogy between treatment of mild aphasia and treatment of stuttering kept surfacing. Many mildly aphasic patients need to learn to cope, to put more burden on the normal speaker in a communication interaction, and to accept less than perfect performance. A part of treatment might involve application of a "linguistic short-leg brace." We attempt to convince the patient that there is a residual, hard-core amount of aphasia that may not resolve; that they may not be able to "do better" than they actually are; and that there are compensatory techniques that will permit them to cope and function adequately.

Evaluating Change. Determining whether the mild aphasic patient has improved is as difficult, if not more difficult than doing the initial appraisal. The same problems are present -- lack of appropriate measures and aphasic and normal variability. Again, the Yorkston and Buekelman (1977) measure of syllables and concepts per minute may provide useful data to compare with baseline performance. Other measures include highly practical ones -- return to work and job performance -- and highly subjective ones -- clinician and patient qualitative judgments and observed use of coping and compensatory behaviors. Other qualitative measures may include patient attitudes or confidence. For example, the mild patient who feels he no longer needs treatment may be considered "improved," and this improvement may be independent of actual language gains.

Ethical Considerations. Clinicians are concerned about the ethics involved in treating mildly aphasic patients, and those who provide treatment for payment share this concern. The situation is one of providing a treatment that may result in little, if any, measurable gain on quantified measures. However, the gains made, though linguistically limited, may make a difference between returning to work or not, or between being a participant in society or retiring into silence. If ethical reservations can be overcome and the mildly aphasic patient enters treatment, a new concern surfaces, that of criteria for terminating treatment. This problem was explored in previous Clinical Aphasiology Conference Round Tables (Warren, 1976; Deal, 1977), and the present group participants agreed little can be added to these discussions.

Summary. We ended as we began. Clinicians have a good deal of work to do on the way we define, determine the prevalence of, appraise, focus therapy, measure change, and justify treatment for mild aphasia. The final question in this discussion was, "So, it is individual then, do you think"? And, the final answer was, "I think so."

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