

## Clinician-patient Interaction in Aphasia Treatment: A Round Table Discussion

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The round-table discussion concerning the therapeutic interaction between the clinician and the aphasic patient touched upon a variety of topics. There was general agreement that there are important general characteristics of the treatment interaction that cannot, at this time, be reliably measured or quantified by measures such as the Clinical Interaction Analysis System. Such general characteristics include clinician variables such as supportiveness, enthusiasm, and sincerity; task variables such as structure, clarity, and cohesiveness; and patient variables, such as responsiveness, emotional state, and alertness. We agreed that it is important that such variables be considered, and that it appears to be important to devise systems to reliably identify and quantify them. There was also general agreement that it is equally important to quantify more discrete events within treatment sessions, such as clinician requests and patient responses, and the functional relationships among such events. We agreed that such quantification is likely to be necessary to any attempt to carefully evaluate the effects of treatment procedures.

The two-way nature of the treatment interaction received considerable attention. We agreed that in a "good" treatment session, the patient's behavior should be dependent upon the clinician's behavior, and vice-versa. Several participants commented that the clinician should "control" the treatment interaction, but that this control should take into account the patient's abilities, personal characteristics, needs, and desires, as long as this can be accomplished without compromising the therapeutic effectiveness of the treatment session. One participant observed that the most common mistake beginning clinicians make is to abdicate control of the treatment session to the patient, allowing the patient to divert the interaction from treatment activities to social interchange. Another participant commented that such social interchange is not always undesirable, but that, in some cases, it can serve as a vehicle for treatment. We agreed that, in many, if not most cases, the treatment interaction should progress from didactic, materials-centered activities to less didactic, conversational, and spontaneous activities, as the patient approaches the time of discharge from treatment. One participant made the observation that it is probably unrealistic to expect behaviors or responses acquired in treatment sessions to generalize to the patient's environment unless there are similarities between the treatment session and the patient's environment, and unless the responses learned in treatment are also relevant to the patient's environment.

Discussion then turned to the effects of errors on patient performance in treatment sessions, and to the clinician's role in managing errors committed by the patient. We agreed that it is impractical and unwise for the clinician to consider only the "correctness" of the patient's response, because in many cases, the clinician may be content with approximations to a "correct" response. We agreed that "acceptable" is a better term than "correct," because it takes note of the fact that clinicians often accept responses that are not correct, as long as they are consistent with the clinician's intent. There followed a lengthy discussion of how the clinician should behave with regard to unacceptable patient responses. Several participants stated that they attempted to keep unacceptable response rates low -- at from 10 to 30 percent of all responses, and that they would not continue with a task which generated error rates above 30 percent unacceptable responses. Other participants

stated that they felt comfortable with higher unacceptable-response rates, as long as the patient seemed to be successfully working through the unacceptable responses. There appeared to be general agreement that the clinician need be less concerned about the occurrence of unacceptable responses in which the patient is not exhibiting struggle behaviors than unacceptable responses accompanied by struggle. We agreed that it is poor clinical strategy to allow the patient to struggle for an acceptable response for an extended period of time. One participant observed that patients may differ in the error rate that they can tolerate without disruption of performance; that some patients can handle 70% unacceptable responses, while others cannot tolerate even 20% unacceptable responses. Another participant responded that the optimum ratio may depend upon (a) the patient's "style of learning" -- what the patient is most comfortable with, and (b) the clinician's "style of teaching" -- what the clinician feels, by experience or training, is appropriate, either for a given patient, or for aphasic patients in general. It was also suggested that we may do a disservice to patients when we structure treatment so that unacceptable responses rarely occur, because the patient may develop unrealistic expectations about his ability to communicate in daily life, and may not develop the ability to deal with situations in which he or she makes errors. We generally agreed that errors, when they occur, should be treated objectively; that errors should not be given positive reinforcement, and that responsibility for errors should be joint responsibility, and not the patient's sole responsibility. We agreed that the clinician's attitude should not be, "You made an error!", but "We didn't do very well on that one!"

The discussion next turned to the role of feedback provided by the clinician in the treatment interaction. We agreed that it is poor practice to provide positive feedback for unacceptable responses. One participant stated that there is an implicit "contract" between the clinician and the patient in a treatment session, and that the clinician should not violate that part of the contract which involves the clinician's expectations about the patient's response. In a sense, the patient has contracted to try to give the response that the clinician expects (or intends), and the clinician has contracted to tell him whether or not he has succeeded, and if he does not succeed at a given time, to provide instruction to help the patient do better next time. Positive reinforcement for unacceptable responses violates that contract. Another participant added that providing positive reinforcement for unacceptable responses may cause the clinician to seem insincere, because the patient usually knows when his response has fallen short of the mark, and may be puzzled or angered by inappropriate feedback offered by the clinician. The observation was made that good differential feedback may sharpen the patient's ability to discriminate between on-target and off-target responses, and that appropriate feedback can help the patient to become more "comfortable" with errors.

There was general agreement that the clinician who genuinely cares about his or her patient, and who can "put himself or herself in the patient's place" is likely to provide effective and enjoyable treatment, and that caring is a "secret ingredient" which can compensate for appreciable numbers of technical "mistakes" within treatment procedures. We agreed that the caring clinician is likely to be an effective clinician.