

Group Treatment for Aphasia
Panel Discussion

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INTRODUCTION

The literature references to and articles about group therapy for aphasic patients are: a) limited in number; b) inconsistent and inconclusive in recommending group treatment; c) varied and controversial as to treatment objectives; and, d) often fail to provide evidence that would substantiate the efficacy of group treatment. Schuell, Jenkins, and Jimenez-Pabon (1964, p. 343) citing wide individual differences in patients' ability to respond and the need for individualizing stimulus materials, believed that there were no "mass methods" of treatment and additionally stated that "none are possible..." Schuell and her colleagues had little confidence in group therapy as a treatment method in aphasia. If we read on, we note that Schuell (page 344) states, "Group activity may, however, be a good adjunct to individual treatment" helping the patient "to feel less isolated." Conversely, Eisenson (1973, p. 190) stated that despite certain stated warnings and shortcomings, "...our experience with patients working in groups has been generally favorable."

Objectives for groups of aphasic patients have varied from such generic activities as "singing" and "socializing" to some very specialized ones outlined by Agranowitz *et al.* (1954), emphasizing phonics, motor writing, arithmetic, reading, and oral discussion. Holland (1970) carried individualized, programmed instruction into a group context with focus on such specific activities as naming, developing subject-verb agreement, and improving syntactical usage. The breadth of the continuum from loosely conceptualized activities to highly structured objectives is seen when we contrast the aforementioned "singing" groups with the group activities reported by Sparks, Helm, and Albert (1974) in which a program of Melodic Intonation Therapy was conducted with intoned verbal interactions.

The most comprehensive and thorough investigation to document objectively the effectiveness of group therapy was conducted by Wertz and colleagues (1978). The results of that study were perhaps surprising to some. No differences, except in graphic measures, were found between patients who received individual or group treatment, and both groups showed a significant amount of improvement that could be related to the treatment effect beyond a six month period. These findings merit further scrutiny and will be discussed in some detail by Deanie Vogel during this panel hour.

Last year at the Tenth Annual CAC meeting, Aten, Caligiuri, and Holland (1980) presented objective data that showed that chronic aphasic patients who were no longer showing measurable speech and language improvement from individual treatment did as a group reveal significant improvement in communicative abilities from three months of group treatment.

Several earlier reports of group activities have been reviewed and summarized in an article entitled "Group Therapy and Stroke Club Programs for Aphasic Adults" published in the Tennessee Speech and Hearing Association Journal by Marquardt, Tonkovich, and DeVault (1976). The majority of the articles reviewed describe gains made by patients in response to a variety of group activities with the evidence being largely anecdotal. Marquardt et al. (1976, p. 14) state that "Ideally, aphasia group therapy should be structured to meet a triad of goals - speech, socio-therapeutic, and psychotherapeutic." Let us look at each of these major divisions to determine the potential uses a group may serve, what the objectives for various groups might be, when group treatment should be introduced into the total management program, and who should lead these groups. I must also add the question "Who will pay for that treatment outside certain VA and university settings?" In the process, we may prod each other to improve our measures of group treatment efficacy and perhaps eliminate some prejudices and stereotypes some of us may hold regarding the place of group treatment in the management of aphasia rehabilitation.

Speech and Language groups are usually directed by a speech and language pathologist, and often are initiated after the aphasic patient has received a considerable number of individual training sessions. The groups may be direct in that their purpose is to: a) provide a continuation or extension of speech and language training similar in content to that done in individual session; or b) provide a transfer medium for speech and language usage with more than just the individual treatment therapist. The groups may also be indirect, with more generic goals of experiencing speaking and listening with other patients with similar problems where supposedly the demands for exact communication are reduced. The groups may be established with alternative objectives that cannot be met in individual treatment. Ann Haire will discuss some of these in our panel. An example cited by Bloom (1962) would be identifying inappropriate social greeting responses and modifying these in the actual social setting of a group or perhaps helping patients begin a communicative utterance with the appropriate pronoun (e.g., "I" or "You"). Bloom (p. 13) described such groups in stating that,

"In the group situation, it is possible to recreate and structure everyday situations with appropriate verbal behavior which was not only well established in the repertoire of the individual previous to his injury, but which occurs with great frequency in his daily immediate experience. Further, it is possible to reduce such verbal behavior to specific situational language units which can be structured and repeatedly reinforced in the learning environment. It is important to emphasize that this does not involve dialogue learning, play acting, or role taking."
(p. 13)

At Long Beach VA, we have found that even the most severely involved patients quickly acquire and use appropriate greetings and short responses after repeated practice in a group setting. Bloom used pragmatics before the label had become a common household word.

Socialization is probably the more traditional objective of groups, if not the more frequently offered type of group treatment at many centers. It may include the emphases discussed previously to allow a medium for using new speech and language skills, or the focus may be more upon desensitizing patients to commonly experienced problems. The outcome may be sociotherapeutic if well-organized and structured to achieve certain specific, attainable objectives. My fear is that so often the theme, content, and types of interaction are so loosely conceived and the flow of exchanges so nondirective or nonpersonalized that the result is not therapeutic. I recall a young, inexperienced clinician with her first session as a group leader. She began with the question, "Let's see now, how many of you ski?" Needless to say, the hemiplegics in the group felt something less than positive personal relevance and empathy from the question. The latter may have contributed to Schuell's lack of confidence in the group process. Certainly the efficacy of the latter type of treatment (i.e., social gains) is more difficult if not impossible to measure--and that may be just as well.

Effective group therapy which has utilized appropriate and meaningful socialization and speech and language objectives should lead naturally into a psychotherapeutic experience. Aronson, Shatin, and Cook (1956) report on group experiences which lead from socialization to the expression of feelings toward staff, toward the patient's disabilities, and toward society. The need for such opportunities for catharsis are obvious but require a skilled leader to structure the ventilation and provide focus, problem identification, and problem resolution. A psychologist may be needed to guide the patients in problem identification and solution.

To the above I would add a fourth type of group which I term psycho-educational. The major objective is to educate or reeducate the patient to problems typically observed during recovery. One example is providing facts concerning sexual relations following stroke. This area is commonly neglected by many professionals, and yet is an obvious area of concern and can be quite anxiety inducing. We are fortunate in having a clinical psychologist to direct this type of group activity at Long Beach. Additional information can be presented concerning alternate strategies for communicating, such as using a tape recorded message on a telephone answering device when the spouse must be gone from the home, and the aphasic patient desires to answer the phone, but lacks the communicative skill.

At Long Beach VA (under Sandra Baxter's direction) we have developed a variety of group programs. Patients may enter these groups soon after the onset of their aphasia. Entry into other groups may be years after the insult. Each group has specific objectives according to the type and severity of aphasia, and the emotional state of the patient. Additional placement considerations relate to the availability of family and community resources that may be required for the patient or simply to the need for social contact after individual treatments have been completed to maintain skills or offer support. Speech and language objectives may be as simplistic as increasing the mean length of utterance for nonfluent aphasic patients. Such an objective is easily documented and evaluated. Communication exchanges should be subjected to more rigid analyses such as proposed by Wilcox and Davis using Speech Act Analysis (1977). Baxter is refining further the attitude scales and questionnaires originally developed to assess results of the more general group programs.

Let us proceed now to the panel members who may or may not address some of the following issues.

1. To what frequency and extent is group treatment being used in clinical aphasiology treatment programs?
2. Does group treatment merit continued "lack of confidence" as Schuell suggested, or is it a viable, accountable therapeutic tool?
3. Is group treatment just an adjunct to individual treatment?
4. Given demanding case loads, can group therapy replace individual treatment for any type of patient? Could it offer effective help while the patient awaits individual therapy? That is, is some contact better than none for some patients?

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Kushner-Vogel

A COMPARISON OF GROUP AND INDIVIDUAL TREATMENT FOR APHASIC PATIENTS

Five Veterans Administration hospitals participated in an investigation designed to compare individual and group treatment for aphasic patients. All patients met the following criteria: 1) between 40-80 years of age, 2) pre-morbid ability to read and write, 3) first CVA, thromboembolic etiology,

4) damage confined to the left hemisphere, 5) no co-existing major medical complications, 6) auditory acuity no worse than 40 dB SRT in the poorer ear, 7) visual acuity no worse than 20/100 corrected in the poorer eye, 8) tactile function demonstrated by adequate sensory and motor ability in one hand to write and gesture, 9) four weeks post-onset at entry and, 10) language severity at the 15th to the 75th percentile in overall performance on the Porch Index of Communicative Ability (PICA) at four weeks post-onset of aphasia.

All patients agreed to participate in the study for eight hours per week for 44 weeks beginning at four weeks post-onset of aphasia. A battery of measures was administered at intake and at every eleven weeks thereafter until 48 weeks post-onset. These measures included a neurological examination, auditory, visual and tactile screening, the PICA, the Token Test, the Word Fluency Measure, a motor-speech evaluation, the Colored Progressive Matrices, a conversational rating and an informant's rating of the patient's functional language.

Study patients were randomly assigned to one of two treatment groups, Group A or Group B. Group A received traditional individual therapy. Group B received treatment in a group designed to facilitate language use in a social setting with no direct manipulation of speech or language deficits. Group B patients were encouraged to enter into selected activities and to communicate as best they could. No specific tasks were designed and no direct feedback was given for either correct or incorrect responses for Group B patients.

Patients in Group B received direct clinician contact for four hours each week. These four hours were supplemented by four additional hours of group recreational activities. The size of the group was limited to not less than two and not more than seven patients.

Group B Activities

Popular group activities included lectures, for example, by a member of the county election board and by a representative of the local newspaper. Also popular were films with a controversial theme obtained from the public library and games of chance based on films of horse races. A field trip to the Truman Library was discussed in many subsequent group sessions. Singing as a stimulus for facilitation of language also was employed.

Patients spent many sessions helping to solve the problems of particular group members. One aphasic patient could not decide whether or not to marry and if so, which lady to marry. The other group members aided him in making his decision. One day the clinician stumbled into the room where the group was meeting--she had broken the heel of her shoe. A patient who was a former Industrial Arts instructor guided the other patients through the steps needed to repair the broken heel. Later they reported these steps, communicating how they had solved the problem.

In a study presented at this conference in 1979, Faber and Aten used altered stimuli, that is, pictures of broken objects to facilitate verbal output by aphasic patients. Faber and Aten found that presenting pictures of broken objects to nonfluent aphasic subjects generated an increased number of topically related words. At this conference in 1980, Penny Myers challenged aphasiologists to develop therapy materials that express interactions in order to involve the right hemisphere in treatment efforts, advancing from simple action pictures to pictures that set the action in context and require an interpretation of events. Group B patients demonstrated that the above is possible in treating aphasic patients effectively in a group.

Results

It was demonstrated that group treatment can produce accountability data. Table 1 is an example of a check list recorded each week for each patient in Group B. Results of the Aphasia Cooperative Study indicated the following: 1) For groups A and B, the PICA overall mean score increased over time. 2) PICA modality mean scores--gestural, verbal and graphic--increased for Groups A and B. 3) Both groups made significant changes, from four to 48 weeks post-onset, on all measures. 4) Overall significant differences between Group A and Group B were few and were confined to performance on the graphic subtests on the PICA. Group A patients, the aphasic patients who received traditional individual treatment performed significantly better on these graphic subtests than did Group B patients. 5) Cohorts were defined as periods of eleven weeks. On some measures in a few cohorts differences between groups were significant indicating more improvement for Group A--individual treatment, than Group B--group treatment. However, few of these differences were significant. 6) Improvement was demonstrated by both treatment groups on the PICA, the Token Test, the conversational rating and the informant's rating, even after six months post-onset.

These results lead to the conclusion that although individual treatment may be slightly superior to group treatment, both individual and group treated patients recover with treatment even after six months post-onset. For reasons of cost effectiveness, then, group treatment should be considered for management of aphasic patients.

Haire

PRINCIPLES FOR ORGANIZING GROUP TREATMENT

Group therapy as part of speech rehabilitation is not new and as Jim pointed out, objectives have varied from individualized programmed instruction to the more loosely defined objectives.

Today I would like to discuss the objectives of group treatment in an intensive program at Memphis State University. Our patients are seen for three hours a day, four days a week. This includes one hour of individual treatment, one-half hour of small group therapy (2 patients), one-half hour of social activities, and one hour of large group (4 patients).

I see the purpose of group therapy as being one of helping the patient to maximize his communicative strengths in order to improve interpersonal interactions. As Jim has stated, it can be viewed as part of the carryover process or an extension of the speech and language training done in individual therapy. In this way, the patient has an opportunity to communicate with those other than his clinician. And it puts more of a burden on the patient when he has to communicate to less skilled listeners. It makes him work a little harder.

Our group treatment is task oriented. By task oriented, I mean that interaction is centered around a task or a game that is preplanned by the clinician. What is not preplanned are specific responses that the patient is requested to make. Let's take, for example, a task such as Go Fish, which is a simple card game in which one player asks another player for a card to match one the player has in his hand. The object of the game is to get the most matches. This activity lends itself to a wide range of tasks.

TABLE I. EXAMPLE OF WEEKLY CHECK LIST FOR PATIENTS IN GROUP B

	Never 1	Poor 2	Fair 3	Good 4	Normal 5
ACTIVITY - RELATED BEHAVIOR					
1) Did the pt. attend to the activity?					✓
2) Was the pt's behavior appropriate to the task?					✓
3) Did the pt. participate in the activity without clinician assistance?					✓
4) Did the pt. follow through on suggestions given him?					✓
5) Did the pt. generate ideas for future activities?	✓				
LANGUAGE - RELATED BEHAVIOR					
1) Did the pt. attend to what others said?					✓
2) Did the pt. follow the main ideas expressed by others?					✓
3) Did the pt. initiate communication without clinician direction?					✓
4) Were the pt's responses appropriate to the topic?					✓
5) Did the pt. communicate his ideas in a clear manner?			✓		

ACTIVITY DESCRIPTION: Listening to & discussing "Old Time Radio"

PT. NAME: Frank Furbis MEAN SCORE: 4.4

6 WPO April 11, 1975

The cards can be simple object pictures for which the patient asks for an identical match or could include newspaper headlines for which the match could be the main idea related to that headline.

Now, I would like to discuss the five principles around which the tasks are planned.

Principle 1. The task should be one that is conducive to using communicative patterns that will encourage group interaction. One way of doing this is to use the "new information principle" of PACE (Promoting Aphasic's Communicative Effectiveness, Wilcox and Davis, 1981). Here information is hidden from the receiver and therefore forces more natural interaction. To go back to the Go Fish example, the patients are given five cards that they keep concealed and they have to ask someone for a card that would make a match. This principle is further facilitated by encouraging the patients to interact by assisting, supporting, giving feedback, questioning, arguing, etc.

Principle 2. The task should be one that will provide the patient with an opportunity to communicate with success. The patient should have freedom to get messages across by any modality that he chooses. He is encouraged to gesture, write, use a communication notebook, word list, or any other aid that will facilitate communication. Very often the clinician will have available such resources for the patient to use if he needs them. This also facilitates self-discovery by the patient as to his communication options.

Principle 3. The task should be structured so there is decreasing dependence on the clinician. Communication should come spontaneously rather than be clinician directed. Once the task is set up and instructions are given, the clinician should be able to sit back and let the group go with it. This is not to say that the clinician should be totally removed and not intervene at the appropriate time. The clinician should monitor and give feedback and pursue linguistic adequacy. For example, if there is an apraxic in the group who needs some help in improving speech production, the clinician can wait until the message has been attempted and then help with clarifying it.

Principle 4. A motivator should be incorporated, such as a topic from the patients' history or current interests. Examples that could be incorporated in our task of Go Fish would be to select stimuli around a theme such as television programs, World War II, grocery items, shopping, household items, or sports. This could further be facilitated by a competitive component. Other competitive ideas are activities such as Bingo, and various card or betting games.

Principle 5. The task should be kept simple. The patients should not be so confused by the task that they are not able to carry out the communicative interaction. All of the above mentioned principles are useless if the patients are not successful and have to depend on the clinician to keep reminding them how to do the task.

By using guidelines or principles such as these, we have found that we do encourage spontaneous and natural interaction rather than more clinician-directed interaction. Recently we have attempted to measure patient performance in groups. We are looking at several interactional aspects, such as which modalities the patient uses when communicating with 1) another patient, 2) the clinician and to 3) the group. Further questions that might be asked when looking at patient performance could include:

- 1) Is he utilizing tools acquired in individual sessions?
- 2) Is he successful?
- 3) Does he communicate independently?
- 4) Is he bored, frustrated, cooperative, interested, disruptive?
- 5) How does he interact--does he support, assist, joke, argue?

West

Group therapy for the stroke patient has taken various directions within our medical center. On the one hand, it is used as an adjunct to individual therapy for aphasic patients. In this sense the group process serves to facilitate speech and language abilities, and the emphasis within these groups is on maintaining and heightening functional communication skills. Secondly, the group structure is also used with right-brain-damaged patients, helping them to focus their communication skills, using group therapy as a means of reducing their concreteness, verbosity, tendency to neglect, and the like. Finally, we use the group process for a three-stage program that is the focus of this paper: it includes the Discharge Planning Group, Community Involvement Group, and our Stroke Club, VA VALORS.

The Discharge Planning Group and the Community Involvement Group have a special emphasis in our medical center that makes them, we feel, clearly different from our efforts with our other groups. The primary goals of these groups have been (1) to help the stroke patient accept his altered physical and cognitive status; (2) to help the patient view his progress and changed capacities more realistically; (3) to help him find an alternative life style within his family and community; (4) to use the group work to facilitate the individual work the patient might be receiving in his daily therapies; and finally, (5) to help the patient find a community placement suited to his modified abilities. An alternate life style can be defined in many ways depending on the desires and needs of the patient and his family, and it is for this reason that these groups must be multidisciplinary. Thus, the professional staff working with these groups always includes occupational therapy, speech pathology and social work services.

All patients referred to these groups have undergone comprehensive diagnostics. They have been seen by speech pathology, occupational therapy, neuropsychology, physical therapy, and the like. Treatment in all modalities, individually designed for each patient, is a typical outcome of this diagnostic workup and the patient is usually staffed in an interdisciplinary conference. In Speech Pathology, the patient may or may not be participating in other group therapy as an adjunct to his individual therapy. But this group therapy is separate and distinct from the Discharge Planning or the Community Involvement Groups in which he will participate.

A patient is referred to Discharge Planning at about the time he goes home for his first weekend. This is around the period where he is approaching maximal hospital benefit. This group is very "issue" oriented, and its main theme is, "What will your life style be like when you go home?" The emphasis is on very practical, prosaic topics such as, "When you were home for the weekend how did you get from the living room to the bathroom?" "What did you do when the phone rang?" "What happened when company arrived?", and so forth. We are issue oriented in this group because we find that the patients are not really able to accept discussion of their

feelings about the changed life style that is impending at discharge. While the patient is participating in Discharge Planning, the family is simultaneously in a group that is separate but has a similar focus.

Upon discharge, when the patient is actually in the situation, experiencing the problems of living at home with his altered physical and cognitive being, he moves to our Community Involvement Group where the focus is on acceptance of the altered life style and the development of alternative life styles. What do we mean by "development of alternative life styles?" Two examples come to mind. One of our patients was a former policeman. He volunteered to work with his local youth group and was able to sit at the entrance of the youth group's club, checking people in and out. For another patient, it involved a change in his perception of roles within his family structure. His wife needed to begin to work outside of the home and the husband was able to take on, accept, and even find enjoyable, household duties he had previously believed were sexually stereotyped. Our Community Involvement Group does focus on discussions of feelings and attitudes based on incidents that have actually happened at home (i.e., the patient's wife is infantilizing him, "babying" him excessively). To facilitate this psychological venting, we might introduce writing topics such as "write down a schedule of what you did yesterday," so that feelings and attitudes that have not come up in discussion may surface. Role playing activities are stressed; for example, making a sandwich, riding a bus. Or the therapist might begin by saying, "I was in an elevator today and heard a doctor saying to a patient, 'you know it's time you went home; your arm's really not going to get much better.' Do you think the doctor should have said that to the patient? Why? What would you have said?", and so forth. The goal of this group is to "Confront reality without destroying hope," a favorite saying of our Chief of Occupational Therapy.

Concurrently with the Community Involvement Group the therapists involved meet with the patient and the patient's family on an individual basis to determine what he can do and where he can go in his community. We often use the services of Community and Senior Citizen Centers. We help the patient to accept his discharge from the hospital and from outpatient treatment by finding alternative things to occupy him. The focus again is on what he can do, not on what he cannot do. It is our firm belief that continuing to come to the hospital focuses on what the patient cannot do and becomes ultimately counterproductive to good rehabilitation.

The final stage in our group process is our Stroke Club, VA VALORS, which is a monthly meeting with maintenance, supportive and educational goals. It evolved into the above groups because the patients and their families still felt the need for a contact with the hospital. We see it contributing not only to a support network for the patient and his family but we also view it as an ongoing form of treatment. Patients and their families may attend the Stroke Club from the beginning of this three-phase Group Process, but we find that it is most meaningful to them upon discharge from the other groups.

A patient optimally is in our active group treatment programs for four to six months, sometimes up to eight months, depending on his ability to adjust. Thereafter, he attends only the Stroke Club. We believe that the sooner a patient is discharged from all therapies the quicker his adjustment is to what is his particular reality. We have found that as long as a patient is still receiving occupational or physical therapy, treatment from speech pathology, or the like, he tends not to come to grips with what his disability is and will continue to be.

Again, we wish to emphasize that none of these groups are centered on structured speech and language activities, per se. The emphasis is on using remaining abilities. "What will you do when you leave the hospital?" As such the groups tend to be extremely practical. A given patient, for example, may say that he cannot cook lunch for himself because he cannot open jars or cans. The group then will focus on finding alternative ways to open jars and cans.

Aphasic patients tend to function very well in these groups. While there is no doubt that the severely impaired aphasic patient has a more difficult time within a group structure, and we have certainly found it difficult to place him in his community, overall we have had many positive examples of severely aphasic persons doing very well. We emphasize the use of visual aids, the group is maximally supportive, and we've usually managed to integrate the severely impaired aphasic patient quite well within the group structure. It is, on the contrary, the right-brain-damaged patient who is more difficult to manage within the group structure and who makes the poorer adjustment to community placement. The hardest patient to place is the densely hemiplegic right-brain-damaged patient with neglect and inappropriate behavior.

For the left-brain-damaged patient, group therapy of this sort may well tap right hemisphere cognitive skills. A more holistic processing is required, a total communicative effort. Almost every group session gives an illustration of a patient with severe comprehension deficits responding to jokes and innuendos that would seem to be beyond his abilities as indicated on standard aphasia test batteries. We find that the left-brain-damaged patient is much more sympathetic and empathetic to the others in the group, more tuned in to the emotional nuances of what is happening in the group, and so forth, than is the right-brain-damaged patient. Group therapy, we feel, heightens this process. We find that the left-brain-damaged patients do seem to get the point of jokes more often than not, they are aware of the need to participate in a joke or a discussion, and they are aware of their responsibilities to the group as a social participant. Certainly, these are the patients that are sensitive to the physical situation of the group--they will arrange the chairs, assure that the group is set up properly, and the like; right-brain-damaged patients are often oblivious to these "subtleties." A group structure allows the left-brain-damaged patient to see that even though he's unable to talk, to say what he wants to say, he can still participate in a communicative effort. And in real life situations, such as making a sandwich, or even opening a can, these patients often do better than the right-brain-damaged patient.

For the right-brain-damaged patient with his particular sort of concreteness, inappropriateness, lack of humor, verbosity, and insensitivity to the feelings of others, a group with this type of structure can be extremely therapeutic. A right-brain-damaged patient will often deny to his therapists that he has any impairment, and peer pressure from the group will facilitate acknowledgment of his deficits. The group can help him to begin to monitor his inappropriate behavior, sharpen his verbal skills, and make him more aware that others have feelings and sensitivities too.

Overall, we feel that this particular structure of our group therapies "works" because it has evolved over time to suit our patients' particular problems and the problems that exist in our metropolitan community. We feel it contributes in a very positive manner to the total rehabilitative process and is a solution to the "chronic stroke patient" syndrome. Group programs

such as these are cost effective, both in dollars and in improved quality of life, because they integrate the patient into existing family and community structures. This reduces hospital dependency and focuses on health rather than disability.

DISCUSSION

Q: What are we going to do about measuring treatment effects?

A: We're just in the process of it. We don't have anything set up formally. We have just started writing out some things that we do want to measure. However, the patients' overall progress is measured but because the patient is an individual, we can't say that group alone is helping.

Last year to document what was going on in treatment we measured the numbers of times each patient in group responded and how often patients were stimulated. That starts to measure what the group process is. Perhaps we can apply to groups clinical interaction systems ala Brookshire. It's very time consuming. While we don't relish the impracticality of that, at the same time, we have to measure. I think the other way is--maybe it so obvious it doesn't have to be mentioned--is that if the patients are not receiving individual treatment and they are changing on our standard measures over time, something's happening.

Q: Are you continuing these measures?

A: We are continuing to measure patients monthly. I'm not proud of the frequency of it. I'm glad we're able to do it with socialized medicine at least monthly on patients who are in various stages within groups. Now, unfortunately, those patients who are in earlier groups are contaminated by getting individual therapy and ways to sort it out is difficult. Do you have any ideas about this?

I wonder if we should change some of our notions about the purpose of this conference

We made an interesting observation by chance when two aphasia groups of very similar patients were approached in different ways. One group was treated in a standard language therapy structure with clinician directed tasks; the other group followed a PACE therapy format requiring the patients to assume equal responsibility for "directing" activities. When the groups were started, the patients would simply sit quietly in the room until the clinician arrived, then respond to questioning such as "How was your weekend?" etc. Soon we noticed the room where the PACE group met would become awfully noisy as this group gathered to await the session. I started observing the groups and noticed that this group had started to initiate conversation and encouraged each other to use other channels, guess, etc., while the other group continued to sit quietly with no interaction. Keeping a count of the number of "communications" in each channel during these pre-therapy gatherings was very interesting. Obviously, many variables were not controlled here, but the question of using groups to promote interaction skills rather than duplicate what we do in individual sessions and the needs to study what happens seems indicated.

Q: Ann, do you believe what you did was efficacious?

A: Yes, I felt it was a treatment--it wasn't a stimulus-response kind of treatment. For example, we have one patient in a group who had phoneme transpositions--when he would try to say group, he'd say gripe and grape. Then we had a man, who at the time was anomic. He had a lot of word-finding problems. If he heard what was said by the patient with the phoneme transposition problem and patient A got close (to target word), patient B (anomic) would say, "Oh, what he means is group." And then that patient, hearing patient B say "group" would respond, "yes, group." Well, I felt like that was a form of treatment, even though I was not included. I would encourage them to do this sort of thing, but I wouldn't do it. I felt like it was treatment.

I just wanted to add that I think we have a false dichotomy--the beliefs that "something sacred goes on in individual treatment" or "if auditory comprehension improves, all language improves." We just heard a paper about some questionable generalizations across groups and across treatment modes. I'm wondering if we don't have to take some good measures and evaluate some of these myths and say that maybe some treatment occurs outside the individual hour. And if it occurs in groups, it should be measurable. I would think that the children's language area would offer guidelines. That's why I quoted Bloom's Pragmatic Thinking. She said she got better results with the severe patient than the mild-moderate ones. But some of the severe ones might not have been in treatment, or they might not have been in treatment at the correct point in time. Individual programmed instruction and the data show fairly clearly that individual instruction doesn't make it too well with some severe patients. So, I don't know. Maybe we have to rethink total approaches to treatment.

Q: First of all, when you say group therapy, I'm sure it's going to mean a lot of different things to different people... If we're going to talk about group therapy, you have to classify what kind of group therapy we're talking about, especially because there's very little literature to fall back on. The goals can be the same goals that we have in individual therapy and in that respect, we do have some data. I think that, to some degree group therapy gets at aspects of communication that are qualitatively different and are exercised only in the context of group therapy. Now, it's fine to challenge us to get data, but I think that first we've got to articulate goals and develop procedures. It's important first to ask if we have a procedure for group therapy and to articulate particular goals, and then we can develop attacks of measurement.

I think the goal of our therapy is to help people to be able to communicate in their real lives in multiple ways.

In our clinic, we offer individual therapy because we find that when a patient has a communication problem, it's very profound. And we try to take all the risks that are involved in changing a lot of customs.

But certain goals are planned (individually) by the psychologists, pathologists, and all of these have their own check lists.

I think there are many kinds of group therapy. At the San Antonio VA Hospital, we have individual therapy and group, and I'm involved in a

group with psychologists and a social worker. And, I think, when you talk about group therapy you really have to define what you mean by group therapy, because we have individual therapists, psychologists who work with an individual within a group setting, and it's not group therapy. Although we encourage group interaction, that doesn't always happen. They might go from one patient to the next patient, to the next and try to involve everybody, but it's actually an interchange between the therapist and the patient. But, it's done in a group setting.