Assessment Of Family Attitudes Toward Aphasic Patients With Severe Auditory Processing Disorders

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In a community hospital rehabilitation center setting, it is often possible to maintain maximal contact with families of post-CVA patients and thus be in a position to explain the patient's status and request the family's assistance. We concur with other speech pathologists (Eisenson, 1973, Keith 1972, Newport Language and Speech Center Symposium, 1977, and Longerich, 1958) that the family can be an extremely useful adjunct to a successful aphasia therapy program. Because it has been observed that aphasics with auditory processing problems do not progress noticeably without improvement in auditory skills, families are frequently called upon to assist in developing auditory recognition, retention, and comprehension. Although Schuell (1974) establishes a poor prognosis for Class I aphasic patients (with impaired auditory recognition ability) we have observed moderate success with such patients when we have been able to elicit assistance from their immediate families. In order to achieve maximum benefit from the use of the family as a reinforcement agent, it has been standard procedure to (1) have an initial interview with the family, at which time an explanation of the patient's auditory processing problem is presented, and (2) invite each family to observe a therapy demonstration session so that they will more adequately comprehend the extent of the deficit and how to deal with it. During the years 1973 through 1976, family reactions were recorded in two situations: the initial interview and the demonstration session. It had been our observation that most families remained unrealistic in their attitudes about the stricken member, and thus a decision was made to thoroughly research previous records.

Purpose

The purpose of this investigation was to study the reactions of family members of aphasic patients with severe auditory processing problems during (1) the initial interview and (2) following the therapy demonstration. The research questions were: (A) Do most CVA families deny processing deficits while admitting that the patient has a severe speech production problem? and (B) Does any change in attitude toward the patient's processing deficit evolve following a demonstration session designed to emphasize the severity of the disorder? Based upon superficial observations, it appeared to be reasonable to hypothesize that answers to these questions would be (A) positive, and (B) negative, but it was necessary to analyze previous records before making definite conclusions.

Procedure

Twenty left CVA patients between 30 and 45 days post-onset (ages 50-68) were selected for this study. None could perform at a level higher than 40 per cent on auditory recognition tasks which required locating one item upon request from a field of six, thus indicating an extremely severe auditory deficit (Class I, Schuell, 1974). All patients were considered medically stable by their attending physicians and there was no presence of hemianopsia.

During the initial interview, families were informed of the results of testing. Emphasis was placed upon the auditory disturbances and families were informed of the difficulty that the patient would encounter in progressing beyond the single word stage of speech formulation without improvement in the auditory area. While the major focus of the demonstration session was the exhibition of auditory deficits and procedures for remediation, other therapeutic techniques were shown also.

Reactions of each family during the interview and following the demonstration were recorded through careful notation by the speech pathologist. The use of a tape recorder was ruled out because it was feared that this might inhibit the families' responses.

Discussion

An analysis of the family reactions showed that responses occurred in one of the following categories (Table I):

1. Depression: This included those families who stated that the patient was capable of performing but was too depressed by his illness to respond appropriately.

2. Fatigue or Illness: This category was comprised of those members who implied that the patient was capable of performing, but was hindered by either extreme fatigue or severe illness. As was noted previously, all patients used in this study were considered medically stable.

3. Resistant: In this group were those persons who emphasized that the patient was stubborn and using his illness as a technique for punishing the spouse and/or other family member.

4. Foolish Task: Included here were those families who believed that the patient was rejecting the task because he regarded it as insulting and inappropriate to his intelligence.

5. Agree: This class contained those persons who agreed with the examiner's evaluation of the patient.

At this point, two additional questions present themselves: (1) When more than one person was involved in the discussion, how did we determine which opinion to use? and (2) How did we decide into which category to place the results of the family discussion?

Regarding question 1, in all the cases upon which we reported, there appeared to be a spokesman, i.e., a dominant figure who spoke more than the other members. In 15/20 cases, this person was the spouse, in 3 situations it was the son, and in 2 instances the daughter was the dominant person. As

TABLE I. Distribution Of Family Attitudes During Interview And Demonstration Session

Subject	Interview					Demonstration				
	Fatigue or Illness	Depres-sion	Resistant	Foolish Task	Agree	Fatigue or Illness	Depres-sion	Resistant	Foolish Task	Agree
1	X					X				
2			X					X		
3		X							X	
4					X					X
5	X					X				
6			X					X		
7			X					X		
8		X							X	
9		X							X	
10	X						X			
11					X					X
12		X					X			
13			X					X		
14		X							X	
15		X							X	
16		X							X	
17			X					X		
18		X							X	
19		X							X	
20		X							X	

soon as the spokesman for the group expressed an opinion, the other members concurred, although in 3 cases involving the resistant group, a family battle ensued following the interview session. However, these arguments dealt with who was initially at fault, the patient or the spouse, and did not reflect differing opinions with regard to the categories designated in this report.

As we spoke with the families, we attempted to write down pertinent quotations, as well as general feelings. Thus, based upon our notes, it was not difficult to determine the proper category. In order to exemplify this, a quotation from each category is presented:

1. Depression: "She knew that she might have a stroke when she was faced with the carotid artery surgery. I think that she is very depressed because she decided to have the surgery. She will be better when she feels less depressed. She was always as sharp as a tack."

2. Fatigue or Illness: "You have to realize that she is a very sick lady. She understands everything on days that she is feeling better."

3. Resistant: "We had an argument the night before his stroke and he is doing this to punish me. He is trying to get sympathy and he is tearing the children away from me. He is a stupid man anyway and can't even read. The stroke didn't make him any worse than he was before."

4. Foolish Task: (this type of comment only appeared following the demonstration) "I really hate to say this, I guess you know your business, but I think Mom felt stupid doing those things you asked her to do. She was a first grade teacher for 37 years and it seems to me that she probably thought she was being treated like one of her pupils."

5. Agree: "I've really been wondering about how much he understands. He does such odd things sometimes when I tell him something or ask him to do something. Is there anything that I can do to help him improve?"

Families responded as follows:

A. Interview

(1) Fatigue or illness--3
(2) Depression---------10
(3) Resistant-----------5
(4) Foolish Task--------0
(5) Agree---------------2

B. Demonstration

(1) Fatigue or Illness--2
(2) Depression----------2
(3) Resistant-----------5
(4) Foolish Task--------9
(5) Agree---------------2

The reactions of the family members demonstrated that (1) during the interview, only two of the twenty families reported upon agreed with the speech pathologist's evaluation of the patient's auditory problem and (2) no change in attitude regarding the auditory processing problem resulted from the demonstration session. Although no agreement with the examiner took place, i.e., the families continued to believe that the patient's auditory processing was adequate, it was interesting to note that in many instances there was a shift in category following the demonstration session: Three post-interview responses were fatigue or illness, but one of these shifted to depression after the demonstration, 10 post-interview responses were depression, but nine of these shifted to foolish task after observing the demonstration session. The fact that there was no shift in the resistant category was interpreted as an indication of a poor pre-morbid relationship. Although tasks used in testing were explained to the families during the interview, no one considered them foolish until the actual observation.

The intent of this paper is to assess the denial of auditory processing deficits on the part of the families of severely involved aphasics. Nevertheless, we believe that it is important to consider very carefully the manner in which many families viewed the tasks which they observed. While it has been our experience that persons who are capable of performing an auditory recognition task will do so, it also appears that the impaired person would be more highly motivated if the task were designed to seem more meaningful. Traditional first-step auditory tasks (as suggested by Agranowitz and McKeown, 1973; Keenan, 1975; Longerich, 1958; Stryker, 1975; and Keith 1972, to name a few) are pointing tasks such as "point to your nose, point to the cup, etc". Our attention became much more fully focused upon the auditory tasks as the result of this paper, and we immediately began experimenting with alternative auditory recognition tasks. We decided upon auditory training activities in a simulated natural setting such as eating or grooming. We are just beginning to set up our tasks, trying to contain them in a natural setting but without verbally overloading the patient. As a result of my concern for verbally overloading a patient, we experimented with a limited materials auditory approach last year (Clinical Aphasiology Conference Proceedings, 1976), but would truly like to devise an auditory program that is more meaningful to the patient. The recommendation that we work with our patients in a more normal environment is very easy to discuss, but far less simple to plan and carry out. As clinicians, we have a tendency to remain in the clinic room because we feel comfortable there and also believe that we can accomplish the most in the limited amount of time which we have available, but we must evaluate whether this is quality therapy. While this is not a new technique, we believe that it has been underemphasized in clinician training and in the literature.

With regard to families who have attributed auditory processing difficulties to depression, while we do not deny that depression is often a serious post-CVA condition, again it has been our observation that depressed patients without deficits are able to perform auditory recognition tasks. Our present method for dealing with families who consider the patient's problem as one of depression is to allow them several additional weeks of time. Then we again discuss the auditory processing difficulty with the family. Following this, we present another demonstration session using more realistic tasks, at which time we assign these tasks for home practice. We also treat in the above manner the families who consider the patients fatigued or ill and the families who believe that the patient is resistant. Despite denial of auditory problems, it appears that the inclusion of a time variable aids in family cooperation. The efficacy of our altered techniques will be discussed more completely in a later paper.

Conclusions

Reactions of each family during the interview and following demonstration were recorded. A summary of the reactions of family members demonstrated that (1) during the interview, only two of the twenty family members reported upon in this study agreed with the speech pathologist's evaluation of the patient's auditory problem and (2) no change in attitude regarding the patient's auditory processing difficulty resulted from the demonstration session. Thus we conclude that an auditory processing problem is viewed as a deficit of intellectual functioning and consequently carries a social stigma comparable to that of mental retardation, reflecting a prevailing attitude among the generation in which most strokes are now occurring. Consequently, these families have felt the need to attribute the patient's poor performance to other more acceptable causes. On the contrary, none of the aforementioned families denied the existence of a speech formulation problem, indicating that a "speech production" difficulty in a CVA patient is equated with hemiplegia by the families and is therefore considered an acceptable by-product of the stroke.

We have attempted to discuss briefly methods and solutions for this problem, as we strongly believe that better family acceptance of this very common concomitant of aphasia is essential in order to gain maximum results from treatment, as well as to aid the family in understanding why the patient does not regain speech if treatment is unsuccessful. It should be emphasized that we are attempting to assist families in recognizing these deficits for treatment purposes only and are not trying to present the patient as a helpless, childlike individual, a problem reported upon by Dabul and Porter, ASHA, 1977. During the consultations we consistently emphasized that the patient is essentially the same person that he was before his stroke, but with reduced speech and language functioning.

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