

Terminating Treatment
A Round Table Discussion

Martha M. Dixon
Regional Rehabilitation Center, Greenville, North Carolina

As Speech and Language Pathologists, we constantly encounter the multi-faceted issue of determining when to terminate treatment for the severely aphasic patient. Recovery studies by Kertesz, 1979, indicate that (1) significantly more recovery occurs in the first three months post-onset, (2) global aphasia often improves to become severe persistent Broca's aphasia and (3) initial severity is the most important prognostic indicator for the aphasic population. Marshall et al. in a paper presented before the CAC in May, 1979 ("Speech and Language Services for Severely Aphasic Patients: Some Professional Considerations") asked the question: Are severely aphasic patients spending too much time in treatment? "The results achieved with a small number of patients who received more than two months of treatment suggest this may be true." (Marshall, et al. 1979)

The purpose of the round table discussion was to consider termination criteria for the severely aphasic patient. The discussion encompassed such issues as the validity of current assessment tools, new trends for functional communication assessment and treatment, avoidance of patient-clinician dependency roles, and the need for further research.

The current "state of the art" for termination criteria was examined critically. It was the group's consensus that most speech and language pathologists use standardized test batteries for reassessment purposes. Additionally, many clinicians are looking at the patients' functional communication status and assessing potential for change in this area. However, a method for systematically documenting these functional behaviors is often lacking. Some dissatisfaction regarding the prevailing mode of determining discharge criteria was expressed. As one participant stated, "I think we've got the cart before the horse if we're discharging on the basis of some of our formal tests." He illustrated his point by relating a common clinical dilemma:

"We've all had the experience of finishing a test with a patient who shows no gain or does not respond to test items and then we turn and say, "Well, Joe, what do you think?" and we get a meaningful response from him. I think there ought to be ways of measuring that."

The need for documentation of spontaneous meaningful utterances which patients emit focused the discussion on functional assessment and treatment. One of the newest and recently standardized functional assessment protocols, Communication in Activities of Daily Living (CADL) had been used experimentally by some of the group members. Comparative results using traditional tests and the CADL indicated conflicting termination decisions. It was reported that testing chronic aphasic patients with traditional test batteries might yield no reasonable data for continuing these patients in a therapy program, while assessment with CADL rendered data supporting of continued treatment. Changes in patients' communicative status most often occurred in functional areas such as social greetings or the ability to indicate one's name and address by providing the examiner with a card

containing this information when the severely aphasic patient could not convey it by speaking or writing. It was noted that many of the areas assessed by the CADL had received attention in therapy. The opinion was expressed that perhaps the CADL may begin to fill a void by providing systematic and objective protocols to assess functional communication behavior.

It was the group's consensus that a severe patient should not be discharged if he demonstrates any potential for achieving increased functional skills or if he can be taught some ultimate strategies for use in everyday settings. If this is the case, do we focus our treatment accordingly? Do we attempt to create functional communication situations as stimuli rather than relying on the formal type of treatment that is traditionally done? One participant offered as a suggestion the idea of taking a verbal aphasic patient fishing and coming back and talking about the experience. What would the language sample be like in this situation versus one obtained from showing the patient a picture of two people fishing? Other suggestions focused on teaching severely aphasic patients basic communication techniques for use in everyday situations. For example, one clinician stated that if a patient demonstrates confused yes/no responses, this is where she initiates treatment. The ability to accurately indicate "yes" and "no" is highly functional and easily reinforced in all settings. The correct response allows for the patient's needs to be met, thus keeping incentive high. Assessment of the rate of change with which patients learn to use appropriate yes/no responses allows the clinician to make a prognostic judgment, thereby better establishing termination criteria.

Several questions regarding establishment of functional communication strategies prior to discharging severely aphasic patients were raised. These included the issues of intensity of treatment, normalization of the language and rate of change. It was the group consensus that clinical aphasiologists need to take advantage of the inpatient stay and schedule patients for speech therapy as often as possible. However, if patients are scheduled for intensive speech therapy (two to three hours daily) do they progress faster? Is the patient's progress directly related to the amount of time spent in therapy or to other neurological factors beyond the clinician's control? Although certainly not new questions, these were key questions which remained unresolved. One participant expressed the need to obtain more research in the area of functional communication among normal subjects. "Once we get into functional communication, language use and functions in everyday life, we get into an area where there hasn't been a firm foundation set up normally. We're limited by what we don't know." Group members stated other limitations such as the lack of research regarding the rate of change for chronic aphasic patients. It was suggested that perhaps many of the Veterans Administration Medical Centers might have access to chronic aphasic patients and could pursue this research topic. Such a longitudinal study would provide valuable objective data allowing clinical aphasiologists to more accurately predict rate and nature of change, thus being able to objectively determine discharge criteria.

When severely aphasic patients receive appropriate speech and language therapy on an optimal schedule and fail to exhibit significant progress as measured by nonachievement of treatment goals as well as poor scores on reassessment batteries and functional measures, it was the group consensus that termination criteria had been met. An additional but important factor to be considered is time post onset. The fact that many aphasic patients

display severe deficits which show little recovery, particularly during the early months post onset, was discussed. With the exception of these acute patients, it was the group consensus that a patient should be discharged from treatment if he fails to exhibit significant change following a two-month treatment period, or otherwise meets termination criteria.