What Is Aphasia?
A Discussion Session

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The title of this session invited an exercise in transcendental aphasiology. In keeping with the clinical emphasis of the conference, however, the discussion focused on issues related to specifying and narrowing the "grey area" between mild aphasia and normal language ability. In a sense, the session represented another chapter in a continuing saga of attempts at C.A.C. Round Tables to address some of the diagnostic and treatment dilemmas presented by patients with mild aphasia (Darley, 1980; Wertz, 1978; Deal, 1977; Warren, 1976).

The questions addressed were initially generated by Terry Wertz who summarized a practical problem encountered in the current Veterans Administration cooperative treatment study. The principal language criterion for admission to that study is an overall PICA performance between the 9th and 81st percentile. The problem occurs when a patient meets that criterion (and all others) but does not impress the investigator as being aphasic (i.e., the patient seems normal). The discussion departed from the practical issues raised by this problem.

It was suggested that mild aphasia may be overidentified or underidentified depending on the data base used (e.g., objective tests, clinician's impression, patient's report). On the PICA (Porch, 1967) for example, it has been determined that scores achieved by left-brain-injured patients above approximately the 90th percentile overlap with scores achieved by normal subjects (Duffy and Keith, 1980). Yet, there are certainly patients who score above the 90th percentile who have clinically apparent aphasic symptoms or significant subjective complaints which are aphasic in nature. Using the 81st percentile, as in the V.A. cooperative study, certainly eliminates an even greater number of mildly impaired patients, but this is necessary to avoid a ceiling effect which might preclude the objective detection of treatment-induced improvement. And, in spite of this conservative admission criterion, some patients with left hemisphere damage impress the investigator as not being aphasic; in fact, it was noted that the problem is often solved by the patients themselves, who do not think they are aphasic either, and withdraw from the study.

Tests other than the PICA have shortcomings with regard to identifying mild aphasia. For example, several participants pointed out that the Token Test (DeRenzi and Vignolo, 1962)—noted for its sensitivity to mild receptive problems—is occasionally responded to with 100 percent accuracy by left-brain-damaged patients who, nonetheless, report that their auditory processing is not what it was before their brain injury. While the Word Fluency Test (Borkowski, Benton, and Spreen, 1967) is generally sensitive to the presence of brain damage, some concern was voiced over the wide variability of performance of normal individuals on the test; others pointed out that this variability is reduced when the effects of education are accounted for. It also was suggested that the Word Fluency Test may be

a more satisfactory and sensitive index of change in aphasic behavior than it is as a test for the presence of the disorder. Of tangential relevance to the discussion of formal test measures, there was general agreement that measures critical for identifying "type" of aphasia also lack sensitivity at the mild end of the severity continuum; specifically, it was felt that scales for assessing the fluency characteristics of speech, like the fluency scale in the Boston Diagnostic Aphasia Examination (Goodglass and Kaplan, 1972), often yield unclassifiable (neither fluent nor nonfluent) profiles when aphasia severity is mild.

Less frequently used measures of language performance were reviewed for their sensitivity to mild aphasic deficits. Reference was made to Halpern, Darley, and Brown's (1973) study of differential diagnostic characteristics among aphasic, apraxic, intellectually impaired, and confused patients, in which auditory retention span and speech fluency characteristics were found to be especially sensitive to the presence of aphasia. It was suggested that measures of auditory retention span and speech fluency may warrant greater attention when attempts are made to identify mild aphasia.

Some participants felt that writing performance should receive more emphasis because of the typically greater difficulty encountered by aphasic patients in that modality. Also, Duffy and Keith (1980) found less overlap and a higher index of determination between the PICA performance of Porch's (1971) sample of aphasic patients and their sample of normal adults in the Graphic modality and Graphic subtests (particularly subtests B through E) than in any other modality or subtest. Because they also found that the time needed to complete the PICA yielded less overlap between the normal and aphasic group than the overall PICA score or any subtest or modality score, it was felt that greater emphasis might be placed on speed tests for the identification of mild aphasic problems. It also was suggested that performance on response switching tasks (cf. Brookshire, 1978) deserves investigation as a measure potentially sensitive to mild deficits. (Although not discussed, it should be noted that Yorkston and Beukelman's (1980) measure for quantifying the verbal output of aphasic patients has received praise as a useful measure for identifying mild problems (Wertz, 1978).)

The discussion went beyond formal measures of language. There was general agreement that it is valid and important to consider patients' complaints about their language abilities when considering a diagnosis of aphasia. Several participants felt that if patients say they're aphasic, then they are. It was emphasized, however, that the patient's complaint about communication difficulty cannot be attributed to nonaphasic deficits (e.g., sensory or motor problems). In addition, it is clear that the patient's report of aphasic problems, in the absence of other confirmatory evidence, is not sufficient for admitting them to a formal treatment study. Although an impractical criterion for many treatment studies, it was suggested that the distinction between aphasic and normal performance is often resolved when observation of the patient can be repeated over time (i.e., the larger sample of behavior and/or resolution of the problem clarifies the diagnostic dilemma). Finally, the importance of the clinician's opinion was stressed, particularly for diagnosis in day-to-day clinical practice. We need, however, to objectify those opinions and examine their validity and reliability.

"Can you have a left hemisphere lesion and not be aphasic?" This question implies that the presence of a single left hemisphere lesion may be sufficient for the diagnosis of aphasia. Some participants, however, answered yes to the question, citing, for example, pre-frontal lesions as often being "aphasia-free." But there was little debate that confirmation of a left hemisphere lesion (at least for treatment studies) is an important criterion for helping to fix the diagnosis.

The state of the art was perhaps best summarized by the comment that, when diagnosing mild aphasia, we are not dealing with absolutes and perhaps never can. It is apparent that the criteria for identifying mild aphasia may vary according to the purpose for making the diagnosis (e.g., admission to a treatment study versus diagnosis for more routine clinical purposes), and that these varying purposes demand different degrees of reliance on data from formal test measures, neurological tests, clinical intuition, and the patient's complaint. While we perhaps never can be absolute in establishing a diagnostically unambiguous definition of mild aphasia, the challenge to clinical aphasiologists is to improve our assessment tools and criteria so that they are as absolute as they can be for the given diagnostic goals.

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