Some Faulty Assumptions In Aphasia: Implications For Counseling

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Speech pathologists have been taught to look at the aphasic patient as an individual with individual strengths and individual weaknesses. We have been told—and hopefully, have learned—that while there is an aphasia syndrome, the similarities must not be permitted to mask the differences. Nevertheless, at times our behavior conflicts with our knowledge. Occasionally a perceptive patient reminds us that our generalizations do not apply to him.

At the Houston Veterans Administration Hospital, we filmed separate interviews with a patient and his spouse. Their comments make clear that health professionals must be vigilant in their efforts to avoid the following assumptions:

1. The patient understands nothing. In the video, the patient, using gestures, limited speech, and non-speech oral sounds, relates his reaction when he heard two physicians discussing his impending death.

2. The patient is egocentric. He is unable to plan reasonably. The patient explains the strategy he used to communicate essential information to his wife pertaining to his predicted death.

3. The patient will not worry about the future if we focus his attention on the present. The patient discusses his earliest concerns, primarily his potential ability to make a living.

4. When we provide information, we communicate. The wife explains that she feels an accurate prognosis could have been given in the early stages following onset. She also expresses regret that no one explained that the patient would have problems other than aphasia.

5. The spouse will take the initiative and contact you if she has questions. The patient's wife urges that the speech pathologist initiate a conference in order to explain what lies ahead for the family.

6. The patient is less of a person, because he is less of a communicator. The patient tells of his desire to be thought of as the same person he was before his stroke—"I'm me!"

Discussion

Q. Not only do we lack family education of the patient but also we are very lacking in documentation and evaluation of the results of what we do. Maybe we would be advancing further if we were developing tools based upon interactions like these to evaluate what we do with the family, i.e.,

to know how bad or how good we are. These kinds of testimonies certainly say we have got to start evaluating how we interact with families.

A. I really think the wife was told a lot more than she has indicated to us, but I do not believe that she grasped it in the early stages of her husband's recovery.

Q. Do you have a rehabilitation medicine team?

A. Yes we do.

Q. Does that facilitate any counseling at all and do all of the members sit down together perhaps at staffing, perhaps with a social worker, speech pathologist, physical therapist? Is counselling provided in addition to information?

A. Yes it is. This is a case who came to us, as you can tell from the tape, after having been evaluated and treated elsewhere.

Q. Regarding the negative reaction of the family counselling, perhaps there was an unwillingness to accept a negative prognosis.

A. That may be true in this case, as the patient is no longer with us. When the negative prognosis was presented after five months of treatment, the wife said that she wanted him to get treatment elsewhere.

Q. Do you think that we will always be criticized for giving too little information, especially in the early days, not because we don't, but because people are not ready to listen, or is there so much anxiety and so many roadblocks to understanding that what we have given them is not processed?

A. Yes I do. I am frequently concerned about timing when making a prognosis in counselling. When giving information early, it has such an upsetting effect that I look back and say, "Maybe I should have waited". But if I wait a little while, I think, "I should have prepared them for this".

Q. Are you finding in your hospital, and I am asking this collectively, patients even mildly involved being rejected in psychological group therapy because of the aphasia? The psychologists have taken very few of my aphasic patients. They tend to use the aphasia as a reason for rejection. I can see why they would because of how an aphasic might "pull down the group" because of the language problem. This creates a real dilemma and forces us into the psychological counselling game. I don't know that we are all that qualified.

COMMENT: I believe we may be the best qualified to counsel about aphasia, because we have a better understanding of the problem that do other disciplines. I would like to give an example of a case where the psychologist lacked information about aphasia. This patient's wife said that her husband referred to all three of his sons by the same name. She asked how she could handle this, because her younger child was very upset. The psychologist suggested that the child might ignore the father when that occurred, until he said the right name.