

Remarks on Observing Aphasic People

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In these remarks, I would like to underscore my deep belief that natural observation is a powerful tool for speech and language pathologists. If one intends to analyze language, natural observation provides a vast data base that has both clinical and research utility. If one is interested in learning more about the uses to which a patient might put his language, it has no substitute. If one is trying to become a more sensitive clinician, it is a source of information about a particular patient that can only be inferred from observing in a clinic, or watching completion of clinical assignments across a table.

It is not clear why aphasiologists seem to be among the last to know this. Students of children's language have been aware of it for years, and are sensitive to the issues of language sampling in a very admirable way. Scott and Taylor (1978) for example, point out that the normal children they studied produced significantly longer utterances at home than they did in the clinic. Further, clinic language sampling was "conducive to the description of ongoing or imminent activity, while home sampling stimulated substantially higher frequencies of past tense and modal verb forms, complex utterances and questions." Studying children referred to a speech clinic for language disorders, Kramer, James and Saxman (1979) found that language samples obtained in the home yielded longer MLUs, with resultant higher MLU-stage-placement and higher estimated language ages on the DSS than did samples on the same children obtained in the clinic. Both of these articles suggest that language clinicians who work only with clinically-obtained language samples should at minimum be aware that these samples are likely to underestimate a child's language abilities. I don't know of any such direct comparisons for adult aphasic speakers, but my observations of aphasic people in their home environments would suggest that the data would be similar.

In this context, it is noteworthy that clinical aphasiologists seem to have skipped the stage of language analysis of free speech generated by aphasic patients, moving almost directly from analyzing the picture descriptions that we continually still misconstrue as "spontaneous speech" to discussion of pragmatic aspects of aphasic conversation. I assume that this is primarily because no tool for analyzing adult speech has been very accessible. A recent study of conversational syntactic abilities by Penn (1983) uses the LARSP system designed by Crystal (1976). Kearns and Simmons (this volume) have also used the LARSP system. We are presently adapting Miller and Chapman's SALT system (1982) to do semantic/syntactic analyses of aphasic speech.

But that is an aside. What does observation achieve that test performance, or even grammatical and semantic analysis of free speech does not? Glibly, it results in a better picture of the aphasic person in question--in terms of his or her language capabilities, the contexts in which the person is called upon to use language, the constraints on communication that might obtain, a bird's eye view of actual language use, and (not insignificantly) a bit better insight into who this person is who is coming to you for treatment. Let me give you three examples:

The first was a quiet, agrammatic, tremulous woman who took up space in one of our aphasia groups, speaking only when spoken to, tentatively, and usually with her anomia very apparent. Volunteering information was not her style. I was scheduled for an afternoon session at her house, which I approached with apprehension, not knowing how we were going to make it alone for three hours. By the time I got off the streetcar, where I was surprised to find her waiting for me, I knew I was in for anything but what I had anticipated. She told me that we were getting right back on the streetcar, going downtown and having lunch. Then shopping. When we returned three hours later with all of her new clothes, I was comfortable with my role, assigned by her, as chief culprit, defender, explainer to her husband for her shopping spree. Through it all, she was agrammatic, anomic, nonfluent-- but she ordered lunch, she pointed out flaws in clothes that I hadn't noticed, she was verbally aggressive and about as much in need of the kind of kid-gloves treatment the clinic was giving as Han Solo might be. Or Darth Vader. I knew my patient better.

On a less dramatic scale, haven't you ever worked mightily to increase verbal output in a patient whom you finally realize is your basic strong, silent, non-talker type? My best example is a nun I used to work with, who almost never talked, yet when she went on vacation, sent us glowing, chummy postcards. Finally, we checked through observation. This woman practically never talked anywhere, and further, was known around the convent as a non-talker, even before the stroke. She was a writer, not a talker. No amount of speech therapy would change that.

Finally, through the stroke recovery project on which I presently work, I have the opportunity to see patients in conversational interaction with our group, with their families and sometimes with their physicians or other authority figures. In a nutshell, patients have more severe language production and comprehension problems with them than they do with their families. In fact, physicians must think aphasia is much worse than it really is, and it becomes even harder to explain why so few of them make the appropriate referrals.

These are supposed to be informal remarks, and I think I'd like to end them with a few informal suggestions for getting a fuller picture of the communication of one's aphasic patient.

1. Even though some of the literature would suggest that spouses of aphasic patients wear rose colored glasses about the patient's abilities, take very seriously what these folks might be telling you about the patient's ability. They have the advantage of a pre-aphasia language sample, a longer history of interaction, the data from child-language literature on their side. But they probably won't tell you, the expert, unless you ask. In norming CADL, we asked family members to predict their spouses' performance on a number of tasks, such as reading a building directory, taking phone messages, etc., which CADL directly measured. We correlated their predictions with the actual CADL performance of the patients. Correlations were of the order of .89. And for those who vastly overestimated or underestimated their spouse's abilities, a problem of clinical significance, worthy of work, had been isolated. So ask families to describe their aphasic family member's abilities, and listen to their answers.

2. Observe your aphasic patient with at least one other person beside yourself. Preferably, of course, a family member should be chosen. But in interaction with friends, or with physicians, or with strangers, look for differences that might exist from his or her interactions with you.

3. Observe your aphasic patient in at least one other environment. Try to make it the environment in which s/he spends the most time--to look for opportunities to communicate as well as differences in the nature and form of the communication behaviors. If that can't be arranged, anywhere else is better than nowhere else. When's the last time you took your patient to the canteen for a cup of coffee?

4. I'm not sure I need to mention this last one, but if there's anybody here who hasn't tried it, I would be remiss if I failed to bring it up. Try TALKING to your patients occasionally, instead of Working on Their Language Problems. I once asked a group of advanced graduate students to converse with aphasic patients. It was an incredibly difficult assignment. Patients didn't seem to be having any trouble with the role shifts. The clinicians were. In effect, be a participant--not merely an observer or a participant observer. You need the data.

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