

Group Therapy for Aphasia: A Survey
of V.A. Medical Centers

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The history of group therapy for aphasia has been long and unremarkable. Although reports of group treatment have been prevalent since the second World War (Backus and Dunn, 1947; Sheehan, 1946, 1948; Wepman, 1947), this area of rehabilitation has received little investigative attention and it has been practically ignored in clinical texts. The available literature consists primarily of advocacy reports which provide loose descriptions of various approaches to group intervention and claim benefits derived from it (Wepman, 1947; Corbin, 1951; Bloom, 1962). While the results of recent studies which have examined the effectiveness of group treatment are encouraging (Wertz *et al.*, 1981; Aten *et al.*, 1982), group therapy remains largely an unexplored and undefined entity (Kearns, 1985).

The literature abounds with examples of the various types of therapy groups (Brookshire, 1978; Fawcus, 1983; Kearns, 1985; Marquardt *et al.*, 1976), but it is not all clear that current classifications of treatment and nontreatment groups bear any relationship to clinical reality. Clinical experience suggests, for example, that many groups serve psychosocial, counseling and treatment goals. In addition, groups which are specifically labelled 'treatment' often serve multiple purposes. At the present time, there is little information available regarding what actually occurs in the group setting.

Given the dearth of information available, and the variability among approaches which have been reported, a survey of group therapy for aphasia was conducted within Veterans Administration Medical Centers. The purpose of this paper will be to summarize the results of this survey and to discuss implications for group management.

METHOD

Survey Construction. The 27-question survey sampled current clinical practices for both treatment and nontreatment groups. For our purposes, aphasia treatment groups were defined as groups which focused on improving speech and language or communicative functioning. We defined nontreatment groups as those in which the emphasis is on counseling, education, support or improving psychosocial adjustment to aphasia. The majority of questions (19) related directly to speech and language treatment groups and we will focus on this portion of the survey in this paper. Group treatment questions probed the following areas.

1. Mechanics of the group (e.g., group size, frequency of sessions, length of sessions).
2. Descriptive patient and clinician information.
3. Treatment (e.g., goals, activities, stimuli, efficacy).
4. Measurement issues (e.g., entrance criteria, evaluation, dismissal).

Survey Sample. The survey was sent to 130 VA Medical Center Speech Pathology Services in 45 states. Ninety-one of the 130 surveys were completed and returned. Of the completed surveys, 59% of the respondents reported that

treatment groups were available in their facility and 54% of the respondents indicated that counseling or support group were available.

RESULTS

Group Mechanics. An important goal of the questions on group mechanics was to determine the overall characteristics of aphasia treatment groups. The mean number of patients in aphasia groups was approximately 6 (5.5). Eighty-nine percent of the groups included eight or fewer patients. Most groups met once or twice weekly (89%; \bar{x} = 1.8) for sessions lasting from 30 to 90 minutes (89%; \bar{x} = 62 min.).

The characteristics of clinicians and patients who participate in treatment groups were of interest. Group leaders were most often described as experienced M.A. level clinicians (64%). Two-thirds of the respondents reported having from 6 to 15 years experience (\bar{x} = 10 yr, 10 mo) working with aphasia and related disorders. One respondent indicated that a student trainee directed their aphasia group.

The results of the survey also revealed several interesting characteristics of the patients who participate in aphasia groups. For example, on the average, respondents estimated that one-half (49%) of the patients participate in both group and individual treatment. An equal number of patients had previously been dismissed from individual therapy and a few patients received group therapy as their only treatment regime.

Treatment groups generally included chronic patients. The average time post onset of aphasia was more than one year for 78% of the group members. Additionally, the average time post onset was more than 3 years for over one-half (53%) of the group members. It was not uncommon for patients to be beyond 10 years post onset of aphasia, and there was considerable variability among patients within given groups regarding time post onset.

Treatment. When asked to describe the primary goal(s) of treatment, the vast majority of respondents (80%) listed several goals. As one might expect, language stimulation, often in combination with support or social goals, was the goal most frequently mentioned (84%). Interestingly, all respondents listed language stimulation or carryover as a primary group treatment goal. Following language stimulation, the next most frequently listed goals were emotional support (59%), carryover (47%) and socialization (45%).

Clinicians were also asked to estimate the percentage of time spent on various clinical tasks during typical group treatment sessions. Specifically, they estimated the amount of time spent on: 1) general topic oriented discussion, 2) structured tasks which are individualized to the patients' level of responding, 3) non-directed, social interactions, 4) multimodality stimulation. Overall, clinicians estimated that they spent nearly one-third (31%) of their session on "general topic oriented discussion". Group leaders also reportedly spent less than a quarter of their time (22%) on "structured tasks which are individualized to the patients' level of responding" and slightly less time (18%) was devoted to "non-directed social interactions." Surprisingly, only 14% of group time was allotted to "multimodality stimulation" and, an equal proportion of time (14%) was used to "teach compensatory communicative strategies." Perhaps the most noteworthy trend from these data is the amount of time which is dedicated to seemingly nontherapeutic activities. Approximately one-half (49%) of group therapy time was spent on "general, topic oriented discussions" and "social interactions."

Table 1 summarizes the percent of respondents who reported spending various proportions of group time on each of the clinical activities.

Table 1. Percent of respondents reporting various proportions of group time spent on five clinical activities.

Proportion of Group Time	Activities				
	Discussion	Structured Tasks	Social Inter-action	Multi-Modality Stimulation	Strategies
0%	10	26	15	41*	30
≤10%	20	15	30	15	49
10-25%	21	28	38	23	7
26-50%	39*	20	16	18	11
≥50%	10	11	--	3	3

Thirty-nine percent of respondents spent one-quarter to one-half of group sessions on "general, topic oriented discussion." Forty-one percent of clinicians stated that no group time was spent on "multimodal stimulation." The data in the table support the general trends reported earlier for the average amount of time spent on the five clinical activities. That is, a disproportionate amount of group time is reportedly spent on seemingly non-therapeutic activities, while considerably less time is devoted to traditional approaches to aphasia management.

Measurement. The criteria for selecting patients for group treatment varied considerably across and within departments, and several selection criteria often are simultaneously employed. Patients were most frequently enrolled in group therapy because of "clinician discretion" (84%), or, because they had "plateaued in individual therapy" (51%). It is interesting to note that only 17% of respondents reported using standardized test performance as a criteria for patient participation in group therapy.

Despite what appears to be somewhat loose entrance criteria, 73% indicated that "periodic formal testing" was used to evaluate the performance of group patients. Behavioral ratings of task performance were often used in conjunction with formal testing. In general, behavioral ratings were used by 57% of the clinicians as a measure of performance. It is noteworthy that 20% of respondents reportedly do not routinely evaluate the progress of group members.

One final and important issue concerns the dismissal criteria used by clinicians who direct treatment groups. While multiple criteria often were listed, 59% of respondents stated that patients were dismissed from treatment when they met individual goals. A bit more disturbing, however, was the fact that an additional 28% of the clinicians indicated that patients were dismissed from group "when they choose to stop coming." A nearly equal number of patients (24%) were released after their performance plateaued on standardized tests.

The final question of this survey asked respondents to state their opinion regarding the efficacy of aphasia group treatment. Multiple responses again predominated. However, 74% of respondents stated that they viewed group treatment as a supplement to individual treatment. Less than one-half of the clinicians expressed confidence in group treatment per se. Only 41% indicated that group therapy was an "efficient and effective" treatment method. Another

21% stated that group treatment provides a legitimate means of expressing emotions but it is not an efficacious form of treatment.

SUMMARY

The majority of VA respondents offer group therapy of one form or another. Both treatment and nontreatment, counseling and support groups are available. Separate groups often are available to serve these two functions, but there is considerable overlap in the stated purposes of treatment and nontreatment groups.

The professionals who direct group therapy are experienced, and usually masters-level clinicians. Group members are usually chronic. Members of the groups are often well beyond the recognized period of spontaneous recovery, and groups are heterogeneous regarding time post onset.

As expected, language stimulation or carryover are the primary goals of group therapy. Emotional support was also prominently mentioned as a primary goal. This latter fact may help explain the finding that two seemingly non-therapeutic tasks, general discussion and nondirected social activities, accounted for approximately one-half of the time spent during group sessions. However, a more likely conclusion is that there is a true discrepancy between the stated goals of therapy and what actually occurs in group sessions.

Several interesting results were also found regarding measurement issues. First, criteria for admitting patients to groups are, at best, ill-defined. Patients usually enter a group at a clinician's discretion or because they plateau in individual treatment. Although most patients are routinely evaluated during group therapy, clinicians seldom use these evaluations to determine when patients should be dismissed from therapy.

Finally, we found that clinicians do not have a great deal of confidence in group therapy as a primary therapeutic mode. Most group clinicians continue their efforts despite skepticism about the therapeutic value of group intervention.

DISCUSSION

Holland (1975) challenged us to define the parameters of group therapy and determine if, and how, group treatment differs from individual treatment. As yet, this challenge has not been met. If the majority of clinicians, in V.A. settings at least, are conducting aphasia treatment groups, we must become more accountable with regard to this form of therapy. We must begin to apply the same rigorous definitions to group treatment that we have for individual treatment. To accomplish this, several aspects of group intervention need further refinement.

First, the overall goal of groups must be clearly specified. The current tendency toward having multipurpose, eclectic groups may not be the most effective form of patient management. Specific types of groups, such as maintenance or direct treatment groups, probably require different goals, criteria and mechanics.

Second, we must be careful to define how group treatment will enhance goals established for individual group members. We must routinely ask how individual patients will benefit from group intervention and how progress can be measured. Accountability for group treatment cannot be measured by attendance records alone. Measurement must be appropriate to the group setting and relevant to individual goals. As goals are more clearly defined, we can move in the direction of more standard selection and dismissal criteria.

Finally, Marquardt et al. (1976) have indicated that group therapy has a history of longevity that has helped to establish it as a bonafide method of intervention. We must remember, however, that historical precedence alone does not establish treatment effectiveness. Group treatment approaches continue to be perpetuated and passed along with little critical evaluation. We are reminded here of the story of the "ham and the pan" in which three generations of cooks trimmed the ends of the holiday ham to enhance its flavor and have it taste like "grandmas" - only to discover that grandmother trimmed her hams because her pan was too small. Perhaps, with regard to group therapy, we should continue to investigate and trim our group intervention procedures and determine just how much "meat" there is to this form of therapy.

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DISCUSSION

Q: In our Aphasia Clinic, 75% of our patient therapy time is in groups. Everybody's in a group, all of the time, and it works. We can document the progress that our people are making. I think we ought not dismiss the value of group therapy just because of the way groups are working in the VA. There are some differences in our program and your V.A. data, as well as some similarities. All of our people are chronic. We almost never have patients less than a year post onset and patients are typically 3 to 4 and up to 10-12 years post onset. One apparent difference between our

groups and the V.A. is that our group therapy clinicians are invariably students. They're beginning clinicians. My impression of group therapy is that it's bloody awful hard to do. I think it takes some of the most experienced clinicians you can find and we don't have them doing it. But still they get along and they need an awful lot of help, but they get it done.

A: I can't say everybody in the world does group therapy the V.A. way. Our data are also obviously subject to the problems of survey research. However, I will say that the V.A. is one of the largest providers of care for aphasic patients. We sampled nearly 100 clinics. If you have data that your groups are effective, I hope we'll see it soon because there's not much out there.

Q: I'm really glad you made the point that to lump all of group therapy into one category probably does all of us a disservice. There are support groups, maintenance groups, and direct intervention groups and they should not be mixed up.

A: We tried to separate treatment from nontreatment groups. I believe the survey was constructed in such a way that it was fairly clear when we were asking questions about treatment groups per se. Despite that, however, we got a lot of responses which implied that a lot of nontreatment activities were occurring in fairly big percentages.

Q: I too feel very strongly about the value of group therapy but I think you point out that it's very important to specify exactly what it is you are doing in group therapy. I think there are some very specific principles and procedures that can be unique to group therapy. Groups can be communication goal-directed and somewhat systematic. The problem was we haven't been telling everyone about it.

A: I'm not saying or implying that group intervention can't be an effective form of treatment. Obviously, we don't know that from this study but we came away with the impression so consistently from looking across all these centers and all these questions, that there is a great deal of ambiguity about how people feel about groups and what they do about it. That was reflected most dramatically for us in the types of activities and the amount of time spent on each. There was an inconsistency between what people said they were doing and what they were actually doing. I think there is an incongruity that needs to be resolved.

Q: We have been doing large government studies with about 79 or 80 kids that are in groups and I think I should give you some of my information. One of the things that I have found about groups is that you have to be committed to the group. Being committed to the group means being thorough, being consistent, doing pretesting, doing target testing for all of your groups and really delineating the types of groups you are doing. We run nine different types of treatment groups. All of them have very specific goals. All of the goals are predetermined before the kids come in and each of the goals within the groups are very specific. We do very direct treatment with up to 5 individuals in a group. Results of the large studies done on these 70 kids have shown that it works and it works very well, but you have to have very defined goals, very defined objectives, and you just can't admit kids or admit adults into just any treatment group. They have to be preselected and the goals have to be predetermined and then you get results.

A: I agree.

- Q: Is it possible to study the effectiveness of group therapy with single-case designs? If so, could you give us a couple of minutes on the special problems and some of the answers for those problems in such designs.
- A: I think single-case designs can be applied to group settings. The principles are the same but the biggest problems concern measurement. When you get into groups, you get into compromising, particularly in the area of measurement. That is, you compromise on the amount of individual data you take and you have to start treating the group somewhat like an individual. Hart, for example, combined several things we have been talking about here today. She took an interactive language model in which clinicians treated language-delayed children in a school setting. She took the kids out of the clinic because her data showed that they weren't doing too well there and she targeted specific areas for intervention within a preschool setting. She came up with good, positive results using basically single-case methodology. The compromises come particularly in measurement and specifically in terms of having to treat the group like an individual and having to do a lot of averaging.
- Q: If you're interested in measuring the effect of group therapy on language ability, you can use a measurement like the PICA to see if the client is getting better in his language ability. What is the problem with measurement?
- A: Standardized testing is traditionally used for group methodology but if you apply single-subject methodology, you are talking about targeting specific behaviors, baselining those behaviors in well-defined conditions, and following those specific behaviors over time. For example, you might be looking at the number of interactions initiated from a communicative standpoint or specific syntactic forms which are poorly or seldom tested in our standardized testing. The formal standardized test gives us a lot of information but I think we're kidding ourselves if we think we get all the information out of formal tests--we simply don't. Standardized tests are necessary but not sufficient, particularly when you are talking about studying specific behaviors from a within-subject paradigm.
- Q: When group therapy was planned in the V.A., as was the case in the first V.A. Cooperative Study, group therapy worked as well as individual therapy did.
- A: Wertz's study provided some good data in that regard and so did Jim Aten's. I am not sure, however, that the procedures used in those group studies are representative of what is happening in other V.A. settings.
- Q: I think that we get really good at developing euphemistic terminology for some of the kinds of things that we are doing so that we can come up with a fancy term like "nondirective social interactive projects" or "multi-modality interaction stimulation."
- A: Right. The earlier literature on groups was impressive because it drove home several points. One, that group therapy should be goal-directed and second, it should be intense, an hour or more daily. Wepman's groups, for example, lasted all day long. He also had input from a multitude of professionals. So there are some good principles out there, but I think what happened was that for 40 years or so, most of the reports were advocacy reports which claimed that what was being done in groups was wonderful. I think there was an accumulation of opinions which became stated as fact. I think it is time to go back and see what we're doing in groups and determine if group therapy is effective.

- Q: I want to talk about data collection as far as standardized and target testing go. Within our groups, six objectives are formulated for each client. Three of those are treatment objectives and three of those are nontreatment or placebo objectives. They are all the things the client needs to work on. An outside clinician evaluates selected videotapes and the standardized data to provide reliability on whether the selected goals are indeed legitimate treatment objectives. The judges do not know which goals are going to be treatment objectives. Then the clinician begins treating the treatment objectives and not treating the placebo or nontreatment objectives. By evaluating pre-, during, post-, and follow-up data as well as standardized material one can get some objective data.
- A: It's difficult to measure the progress of 6 or so patients, no matter what type of therapy you are doing, if only one clinician is involved with the group. Perhaps we need to start measuring patient progress via videotaping, or include other clinicians in the room as nonparticipant observers.
- Q: I just want to support the last point you made. We found that it was a lot of work to keep track of the numbers of stimulations given per session and the numbers of responses each patient gave. Doing exactly what you said would reduce the work on the lead clinician, who probably should not be engaged in data gathering anyway. Perhaps we should have an observer who just tabulates.
- Q: I noticed that the range was from about two to six patients. I don't think you can do much that is systematic and goal-directed with aphasic people with a group of much more than four. I think four is a good manageable number. Also, I think there are important communicative activities, specific to groups, such as promoting client independence in communicating, that can be done without the clinician directly involved in the interaction. That can help the clinician by allowing him or her to pay attention to the measurement of what's going on rather than being directly involved in the activity itself.
- Q: I feel that we offer something in the group that we can't offer any place else and I think it is therapeutic. I am not sure we can measure it systematically. I think we allow people to have a social comparison. I think the patients can compare themselves with other people and watch other people with similiar problems struggle with the same tasks. We can't create that any place else. The patient isn't facing that at home, and he isn't facing that with us, but he is seeing that in the group. We try to select patients that add that kind of climate to the group. I think that the group is therapeutic.
- A: I would agree to the first point and question the second one. I think the opportunity for communication, interactive exchange and other types of potentially therapeutic conditions are rich in the group setting. However, I don't feel that we have capitalized on it and, after reviewing the literature extensively, I am sure we haven't documented it. If we are all doing such an effective job, I hope we start showing everybody our data.