

Panel: Aphasia With and Without Adjectives
Remarks on the Problems of
Classifying Aphasic Patients

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I wish to argue that classification of aphasia or perhaps more appropriately, applying adjectives to the noun "aphasia" is indeed necessary for a variety of reasons. Among the most important of these reasons is that classifying increases the potential for furthering our knowledge of brain/behavior relationships, and also highlights similarities and differences among groups of patients so that symptomatically appropriate treatment can result. I will limit these remarks to the latter reason.

Developing appropriate approaches to treatment is more likely to result when we use a higher power microscope through which to view aphasic patients. In this case, the microscope is careful description and often an adjectival shorthand. I will, in fact, argue for two adjectives, one of which apparently doesn't bother anybody; that is, an adjective relating to severity. But at the outset, I must emphasize that I am well aware of the limitations of our present systems of classification, and ultimately expect and hope that new ones, or more dynamic ones, will be developed that have more functional utility. Joe Brown pointed out that we can probably differentiate reliably only up from down, and front from back, in terms of speech and language problems. Joseph Bogen recently described the present classifying process as analogous to standing outside on a clear starry night, looking for constellations. When you find the Big Dipper or Orion's Belt, they are clear enough, but you will have overlooked many stars, some even on the periphery of the constellation itself, to find them. Harold Goodglass estimates that, at maximum, 40% of the aphasias are classifiable by the present Boston system. That is possibly a statement about the imprecision of the system, not necessarily a statement about the uselessness of the classification process itself. And Kertesz' Procrustian approach; i.e., to cut or stretch the patient to fit the existing bed-size, is not a necessarily attractive solution, particularly if one happens to be the cut or stretched patient. In my paper at this conference, which noted discrepancies between WAB classification and our more extended knowledge of the patient, is a good example. I suspect that classification systems sooner or later will change. I expect that they will change dramatically as we introduce neurophysiological and neurochemical notions into our present structural ones. Nonetheless, there is clinical merit, in terms of appropriateness of treatment, if the goal is to fit the patient correctly with what might help.

Let me give an example. If we are told that a patient is "severely aphasic" (or that he is something like a PICA 5) the likeliest presumptive guess is that the patient suffers both comprehension and production deficits, regardless of modality, and that he has the paucity of verbal output that would lead the clinician to treat the patient first perhaps by simple matching-to-sample activities, or by approaches that attempt to reorganize the conceptual systems that underlie language, such as Visual Action Therapy. In short, the severely aphasic patient is most likely to be thought of as "globally aphasic."

But what of the patient who doesn't comprehend very much at all, but has a lot of verbal output? Or the patient who comprehends particularly well

(admittedly not perfectly) but is virtually mute? Are they, too, not severely aphasic? Were the two patients Bond and Ulatowski described earlier in this conference severely aphasic? And would the treatment methods described for the global patient be appropriate for both of them? I think not. In the case of their second patient (whom I would call Wernicke's), activities designed to decrease verbal output, marshall attention, and focus on self-monitoring would strike me as appropriate. Their first patient may be manifesting profound Broca's aphasia, transcortical motor aphasia, may only "look" aphasic, while having a severe apraxia of speech, or may have some exotic combination of those productive difficulties. Different treatment strategies, therefore, would be called for.

The problem at the other end of the severity scale is at least as instructive. The "mildly" aphasic individual may be so called while manifesting anomic aphasia, or some simple comprehension deficits and good fluency that would have me calling him mild Wernicke's, or even some motor speech disorder or Broca's aphasia. And treatment would depend on the behavioral manifestations most parsimoniously described by adjectives other than simply "mild."

"Appropriate treatment" means something akin to fixing up what's wrong or working within the limitations of what's wrong. Until better descriptive terms come along, classifying helps us to determine what's wrong. All of this seems so self-evident to me that these remarks seem trivial. I have no doubt that no one here thinks we could get along without the severity continuum. Nor do I seriously entertain that even Fred Darley would roll up his sleeves or do invariant treatment with a patient who was "aphasic," period. Hildred Schuell used adjectives, once it was determined that "simple aphasia" was not the diagnosis (and even "simple" is an adjective).

There have been 29 papers presented at this conference that deal directly with the behavior of aphasic patients. Seventeen of them described patients using adjectives in addition to the Miss Weathergirl terms mild, moderate and severe. My guess is that the authors who used descriptions (ranging from Nicholas and Brookshire's idiosyncratic disfluent to more conventional, neoclassical terms) were using them for their communicative value and because they were useful in highlighting behavioral differences among the patients who were being so described.

Using adjectives is no substitute for fine grain description. But if one is set (and I think the human mind is so set) to look at similarities and differences, then classifying, categorizing and sorting among relevant dimensions is inevitable and important. It is also important to recognize that some patients will defy categorizing, such as Robin and Scheinberg's patient described earlier in the conference. These patients demand extremely careful scrutiny. For a significant subset, the result of the categorizing process will be that patients group on similarities rather than differences. But even these patients deserve a label, be it mixed, simple or "mild global," if appropriate treatment is a goal.

Let me end by advancing a notion about why we, in 1983, continue to snipe at our colleagues who sit on the other side of the adjective fence, a position not very far advanced from the late 19th century, when Broca and Hughlings Jackson sent their terse notes back and forth across the English Channel. Just as strong as our human penchant for categorizing is our human penchant for bias. And, in this case, the bias is probably magnified by the instruments with which we choose to test our aphasic patients. Brenda Terrill and I recently compared 10 patients, whose BDAE profiles clearly

categorized on the Boston. Using profile analysis, we compared them on the PICA and found their profiles to be virtually undistinguishable in shape, while differing significantly in severity. I think that's a good example of what our instruments can do to us.

This discussion possibly will never really be resolved. Aphasia at its center is a disorder having to do with finding words and comprehending the speech of others. That we see it from different perspectives probably keeps us healthy.