Conversation Therapy for Aphasia: A Survey

There has been a growing interest in the engagement in and management of conversation in aphasia. The literature describes aspects of conversation in aphasia such as nonverbal communication and management of repair (e.g. Ferguson, 1994; Madden, Oelschlaeger & Damico, 2003). Research delineates strategies and resources employed to achieve conversation by people with aphasia and partners (e.g. Beeke, 2003; Beeke, Wilkinson & Maxim, 2001, 2009; Oelschlaeger & Damico, 1998; Wilkinson, Lock, Bryan & Sage, 2011). There is also growing interest in conversation as a target of aphasia treatment. Various approaches related to conversation have been reported such as multimodality training (Purdy & Van Dyke, 2011), discourse treatment for word retrieval (Boyle, 2011), group conversation therapy (Elman & Bernstein-Ellis, 1999; Simmons-Mackie, Elman, Holland & Damico, 2007), interaction-focused intervention (Wilkinson, Lock, Bryan & Sage, 2011), couples therapy (Boles, 2011) and partner training (Kagan et al, 2001). There has also been discussion of the impact of impairment-focused therapy on conversation (Carragher et al. 2012).

Despite this growing knowledge base, there are no data regarding the translation of knowledge into clinical practice. Has conversation therapy become a routine aspect of clinical practice in aphasia? If so, what do clinicians do in conversation therapy for aphasia? In order to explore these questions, a web-based survey was initiated.

Method

A short, 13-question SurveyMonkey survey was designed and posted on the web. The survey included multiple-choice, yes/no and text questions designed to identify clinical views and practices regarding conversation therapy for aphasia. An email inviting survey participation went to members of the ASHA Special Interest Group 2 listserv and a distribution list of Australian aphasia clinicians. Respondents completed the survey online. Data were analyzed using frequency counts (multiple-choice, yes/no questions) and qualitative analysis to identify categories of similar responses for the text responses.

Results

To date a total of 86 responses have been obtained (additional responses are anticipated). Many respondents were experienced aphasia clinicians with more than 10 years of experience (n=49). Respondents were primarily from the USA (n=56) and Australia (n=28). Work settings were varied including inpatient acute hospital (n=20), inpatient rehabilitation (n=28), outpatient rehabilitation (n=32), long term care (n=9), home health (n=10), community program (n=11) and university (n=21) settings. Eight respondents worked in "other" settings such as a combination of settings or in a research program.

The majority of respondents (64/85) reported that their approach to therapy for aphasia consists of a combination of language therapy and functional intervention. Thirteen respondents work primarily on functional tasks or life participation while 6 respondents work primarily on language tasks. No respondents reported working primarily on cognitive processing (e.g. attention, memory).

A majority of respondents (55/85) report that they typically include "conversation therapy" for people with aphasia; an additional 26 respondents "sometimes" include conversation therapy. Only 5 respondents do not conduct conversation therapy. The amount of time spent on conversation therapy varied across respondents (see figure 1) with 10 to 20 minutes per hour of therapy the most frequent response. Eighteen respondents clarified that they

offer conversational experiences outside of aphasia therapy (e.g. support groups, volunteer led conversation groups) or vary time depending on client needs.

Survey respondents were asked to describe what they typically do in conversation therapy for aphasia. Most respondents who provide conversation therapy described an emphasis on training or reinforcement of multimodality communication, communication supports and/or communication strategies (n=29) within actual conversational contexts. Eighteen respondents described tasks associated with conversation (e.g. talk about current events). Eleven (11) respondents described their approach as facilitated practice of conversation with an emphasis on pragmatic skills (e.g. topic management, repair). Thirteen (13) respondents include aspects of partner training. Six (6) respondents cited group therapy as their approach. Seven (7) responses involved expansion of language oriented tasks into conversation (e.g. facilitating word retrieval or sentence production). Explicit references to conversation therapy methods published in the literature included 2 references to "conversational coaching" (Hopper, Holland & Rewega, 2002), 1 reference to SPPARC (Lock et al. 2004) and 4 references to Supported Conversation for Adults with Aphasia (SCA) (Kagan et al 2001). In response to the question "who do you include in conversation therapy" respondents included both people with aphasia and communication partners, individually and in groups (see figure 2).

The majority of respondents (n=55) measure changes in conversation. However, the types of measures were highly varied. Most of the measures reported were "informal" such as self-devised rating scales, patient self-assessment, observation, qualitative measures or frequency counts. For example, informal measures of content and accuracy in conversation included measures of utterance length (n=4), word finding (n=4), utterance accuracy or completeness (n=4), content or information units (n=4) and number of cues required (n=4). Informal measures of pragmatic skills included initiations by the person with aphasia (n=5), number of turns at talk or length of turns (n=7), speech acts (n=3), breakdown and repair management (n=6) and communication modality (n=2). Respondents also listed informal measures of communicative success or effectiveness such as number of "successful" exchanges (n=4), message efficiency (n=2), perceived difficulty or success in meeting communicative needs or goals (n=3) or perceived burden on the communication partner (n=5). Eight (8) respondents measured "strategy" use in conversation such as use of multiple modalities, use of trained strategies or number of strategies initiated in a period of time/number of turns. People with aphasia rated satisfaction with or enjoyment of conversation (n=5) and confidence (n=2). Conversation partners gave global ratings of conversation or satisfaction with conversation (n=3). Two (2) respondents reported using Conversation Analysis procedures. Fifteen (15) respondents reported using published measures including functional measures, a conversational rating scale, quality of life measures or aphasia severity ratings. Two (2) respondents use formal language tests to measure change in conversation.

A majority (52%) of participants reported that they learned their approach from reading the literature. Finally, respondents were asked what they think about the level of evidence for conversation therapy for aphasia. Six (6) of 84 persons answering this question feel there is a high level of evidence; 34 (41%) believe that there is a "moderate" level of evidence supporting conversation therapy; 15 respondents believe that conversation therapy has weak evidence and 29 respondents did not know the level of evidence.

Discussion and Conclusion

To summarise, cconversation therapy for aphasia appears to be an accepted practice among the respondents to this survey. Aphasia therapists reported frequently allocating 10-20

minutes per session to conversation therapy. Descriptions of approaches were highly varied with many aiming to reinforce multimodality communication, communication supports and strategies while others largely listed tasks such as discussion current events. While outcomes are often measured, there is considerable variation in who is targeted, and what is measured in conversation therapy. Despite the lack of any systematic reviews on conversation therapy, many respondents believed there was a moderate or high level of supporting evidence.

Conversation is an important outcome of aphasia rehabilitation. The results of this survey provide interesting implications for clinical practice. For example, the widely varied and informal approach to assessment suggests a need for reliable, valid and consistent methods to measure conversation outcomes. Results also suggest a need for better specification of approaches and clearer evidence of the effectiveness.

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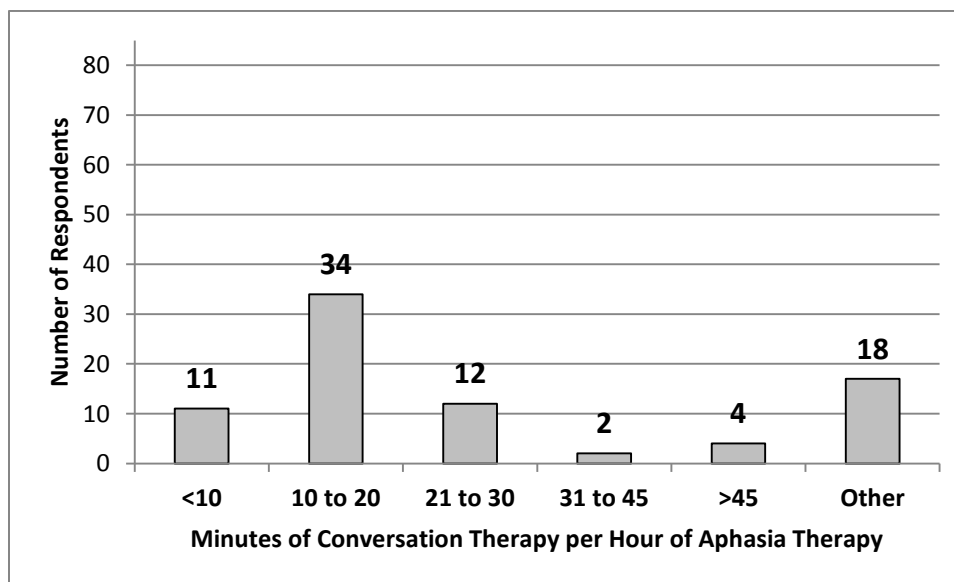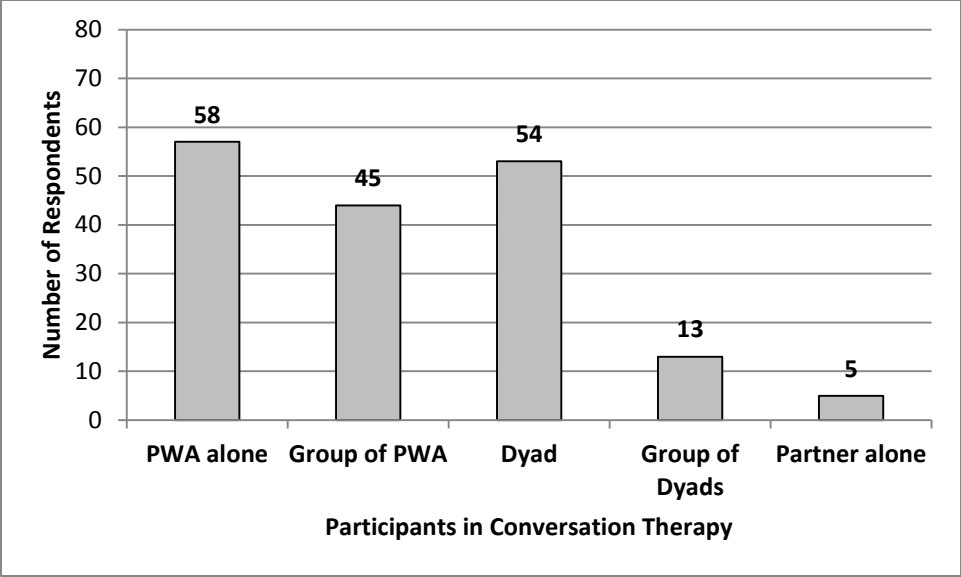
Figure 1. Average amount of time (in minutes) spent on conversation therapy per hour of aphasia therapy.

- PWA= person with aphasia

Figure 2. Who would you typically include in a conversation therapy session?