
Round table discussion at the 17th International Aphasia Rehabilitation Conference, City University London, UK. December, 2016

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The aim of this round table will be twofold. Firstly to identify people who would be willing to collaborate with us in producing a position paper/clinical guidelines for SLTs working with people with mild aphasia. Secondly, we would like to identify useful assessments and treatments to assemble an initial “toolkit” for SLTs.

The round table was attended by 23 people, representing the UK, Norway, Sweden, Finland, Denmark, Ireland, Portugal, the Netherlands and the USA. Email addresses were exchanged and over the coming months we will be collaborating to produce a toolkit for clinicians which will include suggestions for assessing and treating people with mild aphasia. If you are interested in being part of this collaboration, and/or in contributing to the position paper, please contact Julie Hickin or Lucy Dipper on the emails above.

Background.

It is now recognised that people with mild aphasia can experience significant limitations to their communication with consequent effects on activity, participation and well-being (e.g. Cruice, Worrall, & Flickson, 2006). However, clients with mild aphasia are often not seen as priorities for therapy, with limited services being targeted at those with a more severe deficit. In the research literature there is uncertainty about the deficits underlying mild aphasia. Whilst the presenting symptoms may appear to reflect linguistic difficulties, recent research has concentrated on the potential role that cognitive deficits may also play, for example impairments of attention (e.g. Hunting Pompon, Silkes, Kendall, & Bacon Moore, 2010), memory (e.g. Francis, Clark & Humphries, 2003) and executive functioning (e.g. Frankel, Penn & Ormond-Brown, 2007). This research has led to the suggestion that detailed neuropsychological investigation of people with mild aphasia is necessary to identify the possible contribution of cognitive deficits to their difficulties with communication. Indeed, cognitive deficits may underlie difficulty participating in discussion, a common complaint of people with mild aphasia, but research to elucidate the reasons for this has only just begun (e.g. Armstrong, Fox & Wilkinson, 2012).

1. Assessment.

When trying to assess the deficits underlying mild aphasia, we are confronted by the problem of finding sufficiently sensitive assessments. Hunting Pompon et al. (2010) state that people with mild aphasia who “often score within normal limits on traditional assessments of language function . . . . are often underdiagnosed and underserved” as a result (Introduction).

Discussion 1a. Why are language assessments insensitive to the deficits of mild aphasia?
Possible reasons:

- clinical tests do not replicate the **online processing load** of producing language in real life communication
- assessment tasks do not require the use of **complex language** and thus may not expose the difficulties of mild aphasia
- tests which measure the impact of aphasia on wellbeing do not capture the **more subtle impacts** of the communication disability e.g. feelings about the ability to communicate and the impact of this on identity, confidence and self-efficacy.
- Concerns raised during the discussion underlined the difficulty of identifying clients with mild aphasia, and also ensuring that they did not drop out of the healthcare system.

**Discussion 1b.** *What impairment-based assessments have you used for people with mild aphasia? What are their pros and cons? (Are tests designed for people with aphasia, for adults with TBI and/or children with SLI useful?)*

A number of interesting and useful suggestions for assessment were put forward during the discussion, including tasks which aimed to tax the language processing system more to expose mild aphasia, such as assessing word fluency several times in succession rather than just twice (as in the CAT). It would appear that there are some useful, standardized assessments being used in continental Europe (non-English).

<table>
<thead>
<tr>
<th>The Mount Wilga High Level Language Test</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>It potentially taps into higher level language skills</td>
<td><strong>It is not standardised</strong></td>
<td></td>
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<tr>
<td>It assesses a wide range of language skills</td>
<td></td>
<td>It wasn’t developed for people with mild aphasia</td>
</tr>
<tr>
<td>It uses some tasks which may expose the interaction of cognitive and linguistic deficits</td>
<td></td>
<td>?Not sensitive enough to expose mild aphasia</td>
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**Comprehensive Aphasia Test**

Word fluency subtest may expose difficulties  
Most subtests not sensitive to mild aphasia

**Clinical Evaluation of Language Functioning**

Has norms to 22 years of age  
?sensitive to mild aphasia?  
Designed for children/classroom environment

**Discussion 1c.** *What assessments of the impact of mild aphasia on activity, participation and well-being have you found useful? (Again are assessments from other areas of SLT potentially useful/informative e.g. stuttering?)*

The importance of taking a detailed case history exploring difficulties being experienced in the work environment was discussed, as was the need to consider the perspective of the significant others of a person with mild aphasia.
The Communication Confidence Rating Scale for Aphasia (CCRSA) (Babbitt and Cherney, 2011)

<table>
<thead>
<tr>
<th>Pros</th>
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<tbody>
<tr>
<td>It addresses confidence in communication skill which is a significant concern for people with mild aphasia</td>
<td>It only addresses confidence, and not for example anxiety (Cahana-Amitay et al 2011)</td>
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Social Network Analysis (Antonucci & Akiyama, 1987)

Taps into the broader impact of aphasia on social network which may represent a very significant proportion of the impact of mild aphasia

Communication Disability Profile (Swinburn & Byng, 2006)

<table>
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<tr>
<th>Pros</th>
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<tbody>
<tr>
<td>It can identify a range of negative and positive emotions associated with communication</td>
<td>It is perhaps more geared to those with more severe aphasia e.g. aphasia–friendly presentation, includes assessment of basic communication not affected by mild aphasia</td>
</tr>
<tr>
<td>It can identify barriers and facilitators to communication</td>
<td>Not standardised</td>
</tr>
<tr>
<td>It serves as a useful starting point for discussion about the impact of mild aphasia (and an OM)</td>
<td></td>
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Discussion 1d. What assessments of cognitive functioning are useful to give SLTs insight into their role in mild aphasia?

Having access to a neuropsychologist was regarded as extremely helpful to gain insight into the contribution of cognitive impairments to mild aphasia, but attendees reported that this was often problematic.

The Cognitive Linguistic Quick Test (CLQT) (Helm-Estabrooks, 2001)

<table>
<thead>
<tr>
<th>Pros</th>
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<tbody>
<tr>
<td>Quick screening assessment across 5 domains: attention, memory, executive functions, language, and visuospatial skills</td>
<td>?? sensitive to mild deficits??</td>
</tr>
<tr>
<td>Norms from 18-89 years</td>
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| | |
What might be useful tasks to stimulate the production of complex language (i.e. which will be sensitive to the mild deficits of aphasia)?

Attendees reported using innovative tasks to explore the impact of mild aphasia on their clients’ communication. These included asking clients to prepare a resume, and videoing them giving a talk they had prepared and/or whilst engaged in a discussion.

### Cinderella Narrative (e.g. Bird & Franklin, 1996)

<table>
<thead>
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<tr>
<td>Established assessment with some normative data</td>
<td>?cultural issues?</td>
</tr>
<tr>
<td>Potentially sensitive to mild aphasia as it is a more complex task e.g. includes some infrequent vocabulary</td>
<td>? may still not be sensitive to mild aphasia?</td>
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### Video Retell Task (Ramsberger & Rende, 2002; Carragher et al., 2014)

<table>
<thead>
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<th>Pros</th>
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<tr>
<td>Ecologically valid</td>
<td>No norms</td>
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<tr>
<td>Potentially interesting and motivating task therefore likely to stimulate complex language</td>
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Other Comments:

*need for a conversation sample (e.g Armstrong, Wilkinson & Fox, 2012) if so what type?

Assessment of reading:

**RCBA – Lapointe & Horner**

**GORT – 5 (Gray Oral Reading Test)**

**SMOG Readability Rating Scale (Simple Measure of Gobbledygook)**

**Reading Confidence and Emotions Questionnaire (RCEQ) Cocks et al., 2010**
2. Treatment of mild aphasia.

Therapy for mild aphasia has a very limited evidence base to guide clinicians. Additionally, it can be difficult to find appropriate treatment material. The few published therapy studies indicate that an eclectic approach to treatment may be needed in order to address the likely complex interaction between linguistic and cognitive deficits in mild aphasia.

Discussion 2a. What are useful therapy approaches to use with people with mild aphasia?

The discussion about therapy for people with mild aphasia included consideration of the iceberg model used in relation to disorders of fluency: the tip of the iceberg represents the mild nature of the impairment, whilst the bulk of the iceberg beneath the surface represents the widespread ramifications at the other level of the WHO ICF. These need to be addressed in treatment. The role of self-help groups was discussed, including the potential of volunteering as a stepping-stone for people with mild aphasia in returning to work.

- **impairment-based**: psycholinguistic (Graham, 2006; Hickin et al., 2015)
  - microstructural (sentence) level (e.g. colour and shape coding) and macrostructural (narrative) level (e.g. Story Grammar Outline) approaches
  - use of metalinguistic skills/scaffolding of processing limitations (e.g. McCall et al., 2009)
  - use of technology: SentenceShaper (Linebarger et al., 2001; Hickin et al., 2015)

- **compensatory approaches using technology**: Dragon Voice Recognition software (Hickin et al., 2015)

- **conversation/discourse treatments** (Armstrong et al., 2013; Fox et al., 2009)

- **TeFL techniques and materials**

- **SLI – high school language teaching materials**

Selected References.


