

BAS Conference 2007

Speech & Language Therapy in Practice editor Avril Nicoll picks up some key trends and messages from the British Aphasiology Society Biennial International Conference, 10-12 September 2007.

When the British Aphasiology Society was formed 21 years ago to foster the development of the study of aphasia, I was training to be a speech and language therapist. Paralleled by the birth of the journal *Aphasiology*, I remember it as an exciting time for aphasia research and dissemination. Following initial uncertainty about how inclusive the organisation should be, the founders decided to bring together anyone with an interest in aphasia.

Having a British Aphasiology Society conference only 100 miles away at Our Dynamic Earth in Edinburgh was too good an opportunity to miss, and I attended the last two days. For me, there were a number of key trends and messages.

1. Aphasia happens to people

The vast majority of presentations acknowledged that aphasia is not just a fascinating area for study but a life-changing event that happens to people. However, I spoke to delegates who felt uneasy about some of the research reported in a session on language in neuro-degenerative disease. They perceived it as aiming to increase theoretical knowledge about language impairment without any benefit for the clients involved; they also felt little account was taken of the wider impact of a devastating diagnosis. Similarly, they expressed concern about a theoretical debate around a differential diagnosis which is of no practical value.

Through this experience these delegates were reminded of the importance of ethical frameworks and of thinking carefully about the purpose of our questions and actions.

2. fMRI is not the holy grail

A number of researchers are using functional magnetic resonance imaging during specific language tasks and following a period of therapy as an objective measure of change in brain activity. It's easy to get excited about the potential of technology but what I hadn't appreciated was the many drawbacks associated with its use, such as the loud and piercing noise the scanner produces and the way movement interferes with its operation.

Speakers recommended the following paper:

Crosson, B. *et al.* (2007) 'fMRI of language in aphasia: A review of the literature and methodological challenges', *Neuropsychological Review* 17, pp. 157-177.

3. Music to the ear

One researcher who uses fMRI is **Katie Overy**, a lecturer in the Institute for Music in Human and Social Development at Edinburgh University. She has worked with the founders of Melodic Intonation Therapy and wonders why this therapy approach has not really been taken up by speech and language therapists in spite of "clear indications" that it can be

effective. Katie is interested in the action elements of music education and believes the gesture element of Melodic Intonation Therapy could be crucial to its effectiveness.

Katie is keen to find out more about singing as a facilitator of language recovery in aphasia and to explore the wider use of music in speech and language therapy.

4. Look out as well as in

The advantage of networking outside the world of aphasia study was also appreciated by other speakers. **Linda Worrall** finds the paediatric cancer literature excellent for understanding and introducing a family-centred approach. **Carole Pound** of the communication disability network *Connect* chaired a session on ‘engagement’, and referred to similar developments of thinking in parent-child interaction, education, literacy, psychology and disability politics.

Joan Murphy’s *Talking Mats* is a low-tech tool used across different clients groups to help people express their feelings, establish their priorities and make decisions. Joan explained that, even more than a communication tool, it is a thinking tool. **Kukkonen & Korpijaakko-Huuhka** also talked about exploring people’s feelings using Emoticons (search for them on the internet) and **Tony O’Donnell and Carolyn Bruce** discussed how BLISS can support thinking.

Professor Pam Enderby has long argued that we need to look out as well as in. She reassured delegates that every discipline is going through some crisis around its role and evidence base. Pam drew particular attention to the need for benchmarking so that the type of speech and language therapy provided becomes less of a postcode lottery. She says we need to learn about what goes on elsewhere to inform discussion and make us think. Systematically recording what we do with clients, single case studies and longitudinal observation are also essential.

5. Verbs are where the action is

A systematic approach was evident in Clare McCann’s psycholinguistic investigations of verb retrieval in fluent aphasia. For some time now therapists have been considering variables such as word frequency and imageability when selecting verbs for assessment and therapy. However Clare found that, for people with fluent aphasia, the variable we need to concentrate on is argument structure as the more arguments a verb has the more difficult it is for them to produce. She says this reinforces the need to assess verb as well as noun retrieval, to select verbs carefully for therapy and to remember how much we still have to learn about verb deficits. She also suggests therapists make more use of video to track progress.

Although Clare admits to getting “totally obsessed” with psycholinguistics, not everyone shares this fascination and we need to think carefully about how we present it to clients. Janet Webster and Barbara Gordon were working on verb retrieval with a client who was de-

motivated and panicked by an overtly metalinguistic approach. They changed the way they presented therapy by getting the client to

- a) read out a word (an action such as ‘barking’)
- b) find the word that goes with it (‘dog’)
- c) produce a sentence containing both words.

This led to a specific improvement in verb naming which was maintained 6 months later and resulted in improved sentences when talking. Importantly, the client can now use the nouns she has to produce more complete sentences.

6. Read an old paper

In 50 years time aphasia historians will find the late 1990s and early 2000s a rich period for both cognitive neuropsychology and a developing social model. One of the most stimulating presentations for me was **Marjorie Lorch’s** historical perspective on our understanding of aphasia. She says an ‘Applied Historical Approach’ to reviewing published research is useful for getting out of a research impasse and generating novel ideas – and recommends we all “read an old paper”.

Interestingly, Marjorie says that a research paper can have a big impact – even if it is not particularly good - when it is presented at a time that people are ready to hear what it is saying. Conversely, another paper may be very good but have no impact. In these “premature” discoveries, “the implications cannot be connected by a series of logical steps to the standard view of the day”. This must have been reassuring to **David Howard**, who seems frustrated that his views on the value of ‘case for case series’ research first published in 1986 are still not those of the medical establishment.

A case series design underlay **Alison Greenwood’s** small scale research. It was unusual in that it involved full-time clinicians offering ‘normal’ speech and language therapy input of an hour once a week. The results suggest impairment based therapy for anomia can impact on the activity and participation levels of people with aphasia. **David Howard** reminded delegates that evidence based practice has three strands – current best evidence, therapist expertise and what the client wants / needs / requires. In recognition of the third strand, if **Alison Greenwood** was developing a research proposal now she would ideally have greater user involvement.

7. Engage with service users

Engaging service users requires some thought, and NHS structures and territorialism can work against it. Extra time for preparation, planning and every stage of the process is essential when people with aphasia are involved as equal partners in research (**Tony O’Donnell & Carolyn Bruce**).

Alan Hewitt is a person with aphasia who is involved with the communication disability network Connect. He says the boost for him is when he is wanted first and foremost for his skills and what he can offer, not because he is a person with aphasia. He related an anecdote

about a speech and language therapist who, on being told of Alan's aphasia, started drawing pictures; this "got in the way" of engagement. This experience reinforces the need for professionals and service users to meet on an equal level, not one of philanthropy.

Research by **Linda Worrall** and colleagues confirms that people with aphasia and their relatives value health professionals who work with them in this collaborative way. They also like them to be positive, to have the ability to engender hope and reassurance and to communicate effectively with the person with aphasia and family members.

I was interested in Linda's distinction between the health professional's focus on goals and family members' talk about priorities, needs and concerns, for the person with aphasia and for themselves. For the families this includes a need for ongoing information, support and counselling (often from the family and community), services, their own space and time, and an ability to communicate with the person with aphasia. Linda finds it helpful to consider the needs of families within a World Health Organisation third-party disability framework.

8. Get by with a little help from friends

Linda Worrall has also found big differences between controls and older people with aphasia in terms of their contact with friends, acquaintances, service people (other than health professionals) and strangers. She believes speech and language therapists have a role in considering how friendships will be maintained so that people with aphasia can continue to experience the connectedness, humour and opportunity for 'revelation of self' that friendship offers.

Kukkonen & Korpijaakko-Huukha described a novel dimension to client and carer groups, which could provide opportunities for new friendships as well as greater understanding of aphasia and of the shared role of conversation partners. Instead of people with aphasia and their relative being partnered with each other for exercises, the pairs were mixed.

Clare Penn's experience of offering speech and language therapy in South Africa is that groups can contribute towards promoting socialisation - even when an incredible 80 per cent of healthcare interactions are mediated by an 'interpreter' due to multilingualism. She finds it can be empowering for a member of the group to take on an interpreting role.

Clare is particularly interested in how cultural influences impact on a group. In South Africa this includes beliefs about the cause of a condition such as aphasia, help-seeking behaviours and multilingualism. As the group process respects language and cultural differences, therapists can actually use the ambiguity produced by these differences as a tool to drive the group forward. Clare recommends letting a group develop by holding back on yourself and suspending judgement.

Discussion and reflection

Catering for the various priorities of people with aphasia, speech and language therapists, psychologists, cognitive neuroscientists and people from other disciplines is an ambitious task. At this conference the academic, time-pressured style of presentation did not suit every topic, speaker or listener, and the jargon used was at times challenging ('heteroskedasticity' anyone?) Intellectual debate during question periods veered from the stimulating to the tedious. However, it was clear during the breaks that those attending had been provoked into healthy discussion and reflection on their own approach to working with people with aphasia. It will be interesting to see how we have moved on by the next Biennial conference.

The full proceedings of the conference, along with a review of the conference by Rosemary Cunningham, are on the British Aphasiology Society website (www.bas.org.uk).

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