PREFACE

APHASIA THERAPY: PAST, PRESENT AND FUTURE

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For many years, aphasia therapy has been the poor relative of studies in the neuropsychology of language. Like neurology itself (until quite recently), aphasiology has been strong on diagnosis but weak on effective remediation. I write "effective" remediation because speech and language therapists practiced their trade for many years without fully realizing the necessity to submit objective evidence of efficacy.

Consider the situation in the early 70s of the last century. Darley (1972) summarized the state of the art as follows: "Studies of the effect of therapy on the course of recovery from aphasia yield inconsistent results and permit no generalization to the population of aphasic patients". A few years later, Marshall, Holmes and Newcombe (1975) noted that some victims of aphasia recover a reasonable measure of communicative competence and others do not, an undoubted fact that raised two basic questions: "(1) Can the variables which account for the existence of different levels of residual disability be found? (2) Can therapies be devised that will speed rate of recovery and reduce the degree and scope of persistent impairment?". Although the questions were reasonably clear, the answers at that time were anything but.

Nonetheless, the 1970s and 80s did eventually see the beginning of a concerted effort to produce rational therapies and (even more important) rational evaluations of efficacy. Albert, Sparks and Helm (1973) had devised melodic intonation therapy (MIT), a technique that drew upon the (musical) intonation capacities of the intact right hemisphere to improve verbal expression after left hemisphere stroke. For the most part, the results obtained in non-fluent aphasia were highly encouraging (see, for example, Laughlin et al., 1979); Goldfarb and Bader, (1979). On a more general note, Enderby and David (1976) proposed a serious randomized trial of speech therapy for aphasia. The final outcome (David, Enderby, and Bainton, 1982) was somewhat mixed. Patients seen by professional speech therapists and
untrained volunteers seemed to recover at much the same rate; patients who started treatment late made as much progress as those who started earlier. The authors concluded that "the improvement in communication which occurred during treatment may be due both to the appropriate stimulation which was based on detailed and accurate speech therapy assessment, and to the regular support and encouragement provided within the therapeutic relationship."

An unkind critic might suggest that therapy had been shown to be a placebo effect. A related study (albeit without full randomization and with a very large non-random drop out rate) was conducted by Basso, Capitani and Vignolo (1979). They found that time between onset and the first examination was negatively correlated with improvement. But like David et al. (1982) they reported that delay in obtaining language therapy after the onset of language disorder did not reduce the efficacy of rehabilitation. Nonetheless, Basso et al. (1979) wrote, somewhat alarmingly, that with respect to language rehabilitation, "the relationship of type of aphasia to improvement was not significant". Unless the particular type of therapy was closely matched to the specific deficits shown by the patients, this latter finding is susceptible to a less encouraging interpretation than that which the authors wish to uphold.

The issue of specificity was finally seen to be of crucial significance in the 1980s and 90s. Under the influence of the somewhat earlier cognitive revolution in neuropsychology, a major reconsideration of both the structure of language and speech rehabilitation itself, and of how to evaluate the results thereof, was at last undertaken. In brief, it became clear that aphasia therapies must be explicitly tailored to the pattern of impaired and preserved performance in the individual patient. This single-case study approach (Coldheart, 1983) drew heavily upon arguments that had previously been advanced for why the description and theoretical interpretation of neuropsychological symptoms should, for the most part, be based upon the performance of individual patients and case-series (Marshall and Newcombe, 1984; Newcombe and Marshall, 1988). Group studies based upon the polytypic syndromes of traditional aphasia taxonomies are unlikely to be either theoretically revealing or practically useful.

One consequence of this emphasis upon the individual is that randomized controlled trials of aphasia therapy are not the best way to evaluate efficacy (Howard, 1986; Pring, 1986), although such large-scale trials could no doubt be improved by consideration of effect size (as assessed by meta-analysis) rather than statistical significance per se (Fitz-Gibbon, 1986). More importantly, longitudinal single-subject experimental designs are required that can evaluate the efficacy of treatment in the individual. A number of such protocols are now available including reversal and withdrawal designs, multiple baseline designs, and cross-over
treatment designs. Excellent discussion of these issues can be found in Willmes and Deloche (1997) and Franklin (1997). Two key books that outline some preliminary results from the new approach are Seron and Deloche (1989) and Berndt and Mitchum (1995). In order to know what the future may hold for best practice, I recommend the articles that follow, based upon the Euroconference 2000: The Sciences of Aphasia: From Therapy to Theory.

REFERENCES


