Matters arising

Table  Results of three interscorer reliability trials of the FCP

<table>
<thead>
<tr>
<th>FCP subsections</th>
<th>Sarno 1965</th>
<th>1</th>
<th>2</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>0.95</td>
<td>0.97</td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td>Movement</td>
<td>0.95</td>
<td>0.87</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>Speaking</td>
<td>0.92</td>
<td>0.94</td>
<td>0.97</td>
<td></td>
</tr>
<tr>
<td>Understanding</td>
<td>0.95</td>
<td>0.91</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td>not reported</td>
<td>0.90</td>
<td>0.84</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.87</td>
<td>0.98</td>
<td>0.68</td>
<td></td>
</tr>
</tbody>
</table>

1 Agreement between two observers rating 15 patients.
2 Agreement between 15 observers rating 4 patients.
All r values significant (p < 0.01).

patients and then independently completed the profiles. Interobserver agreement was analysed using Pearson’s product moment correlation coefficient. There was significant agreement (p < 0.01) on all subsections and on the Overall scores (see table). (2) Fifteen therapists who were participating in the multicentre trial rated videotaped recordings of FCP interviews with four patients. The patients were selected to demonstrate a variety of types of aphasia and a range of severity. The testers were given an outline of the patients’ social and communicative background and photocopies of the reading material used and of their writing. The profiles were completed independently. Kendall’s Coefficient of Concordance was used to analyse agreement between the 15 observers and the results were converted to Spearman’s rank order coefficients (see table). All subsections and the Overall scores showed significant inter-rater agreement (p < 0.01). In addition, the standard error of the Overall scores obtained by the assessors indicated that approximately 95% fell within 4 points of the mean. The variation in subsection scores was slightly greater.

These findings support the high interscorer agreement reported by the author of the test. It was not possible for us to collect the assessors together again to examine test-retest reliability, but in view of the finding of high interscorer reliability and the high test-retest correlation reported by Sarno and Greenberg, it was considered unlikely that our test-retest reliability would not also be high.

With respect to the change seen between the Baseline assessments, Fig 2 in the paper showed that this was mainly a feature of the High group, the Low group showing significant change only after the start of treatment. A future paper will contain more detailed analysis of the recovery curves of these groups and of other subgroups. However, as Marshall and Golper suggest, it is likely that more intensive treatment would produce more positive changes over a longer period in most patients. Unfortunately, the British speech therapy service is not usually able to provide many patients with more intensive treatment than was investigated in our study.

We are not able to answer Marshall and Golper’s request for more information on the volunteers. We did not collect information on their educational and socio-economic levels. They were not extensively screened before taking part, their own interest and apparent reliability being the main selection criteria. Most volunteers enjoyed the work and many saw several patients. They may indeed, as Marshall and Golper suggest, have become more proficient with increased experience but we would hope that the same can be said for speech therapists.

References


Sir: The study by David et al shows serious weaknesses in many aspects which invalidate the negative conclusions on the efficacy of speech therapy for aphasic patients. In both groups compared, there was a negative selection of subjects. Patient groups with a mean age of 65 to 70 years and a standard deviation of about 10 years can hardly be expected to show consider-
evaluation of individual cases. The analysis of the late referrals unfortunately does not exclude the influence of spontaneous recovery either, as equal increase in mean FCP scores is reported between the two baseline assessments (B1, B2) and between B2 and the first week of treatment (W1). Statistical analyses on main effects of time of assessment are not reported. Furthermore, only the overall FCP performance is considered. The profile of FCP subtest scores would be more informative.

Clearly, the conclusion “any ethical doubts based on the fear that patients seen by untrained volunteers would be at a disadvantage would appear to be groundless”, is not supported by this study. There are numerous comparative studies in the literature on the efficacy of specifically designed therapy programs for aphasia.17-18

W HUBER K POECK L SPRINGER K WILLMES
Department of Neurology, RWTH Aachen, Goethestrasse 27–29, D-5100 Aachen, West Germany

References

6 Sarno MT. The Function Communication Profile. Manual of Directions. Institute of Rehabilitation Medicine, New York; University Medical Center, 1969.

David, Enderby and Bainton reply:

As we understand it, the main theme of the arguments presented by Huber et al is that the reason why we found so little difference between the recovery of patients treated by speech therapists and those treated by volunteers was the inadequacy of the speech therapy which was investigated. They regard it as inadequate in terms of the assessment which was used and the amount of treatment given, as well as in the techniques which they speculate may have been applied. They also present subsidiary arguments based on their evaluation of our selection criteria for entrants to the study and criticise our use of a multicentre design.

We agree with Huber and his colleagues that “Only a rigorous design of therapy can establish the difference between professional therapy by a speech therapist and unspecified stimulation by a volunteer.” Sadly, the rigorous application of therapeutic programmes is rarely possible in most District General Hospital speech therapy departments in this country. The caseload of aphasic, and other, patients is usually heavy, but staffing levels, accommodation and support services are often so inadequate as to restrict severely the intensity of treatment which can be provided. In addition, the majority of aphasic stroke patients have a concurrent need for forms of rehabilitation other than speech therapy and these compete for their time and energy. Thus, the most pressing need in clinical research in aphasia therapy is for investigation of the type of service which is currently available to post-stroke aphasic patients referred to our speech therapy departments so that we can specify its effects as a basis for development of improved organisation of care.

We are of course aware of the numerous reports of the positive effects of specific speech therapy programmes which have been carried out on carefully selected patients in ideal circumstances. Unfortunately, few of these studies have any direct bearing on the organisational problems of the overstretched speech therapy service. Wertz and Rosenbek1 have discussed the necessity for group, as opposed to single-case, designs when investigating this type of problem. We also draw Huber’s attention to our statement that “We attempted to design a study which represented the kind of patients with aphasia and the amounts of treatment normally encountered in speech therapy departments in this country.” (p959). Our attempt to ensure the clinical applicability of our results extended to our selection of subjects. Huber et al comment on the age-group of our patients, suggesting that patients with a mean age of 65 to 70 years could hardly be expected to show considerable effects of therapy. We find this suggestion rather puzzling, carrying as it does the implication that the average stroke patient will not respond to therapy. The mean age for stroke is 73,2 and patients over 65 usually form the major part of the speech therapy caseload. Few studies undertaken more recently than the one quoted by Huber et al have succeeded in finding a relationship between the age of the patient and his response to treatment.”

In response to the remarks on the intensity of treatment given to the patients in our study, we were intrigued by such a strongly positive statement as “In order to be effective, speech therapy must be given to aphasic patients at least three to four times a week over a period of six months and more (up to 12 months)” should appear without supporting references, but agree that more intensive treatment than the two or three sessions per week that we were able to provide might well produce more rapid progress. However, we must
Treatment of acquired aphasia: speech therapists and volunteers compared.
W Huber, K Poeck, L Springer and K Willmes

*J Neurol Neurosurg Psychiatry* 1983 46: 691-693
doi: 10.1136/jnnp.46.7.691

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