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 testes were given an outline of the patients' social and communicative background and photographs 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 inter-rater 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 inter-rater 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**


Sirs: 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 considerable effects of speech therapy. Furthermore, the number of patients with duration of aphasia beyond the period of spontaneous recovery (up to 3 months) is far too small. Recovery patterns depend both on type and severity of aphasia.

No information on the type of aphasia is given. Random allocation of subjects may lead to the effect that patients with poor or good prognosis, for example with Broca's vs. global aphasia, are unevenly distributed across the rather small groups.

The Functional Communication Profile (FCP) can only complement but by no means replace a formal aphasia test. The FCP does assess language systematic abilities but only to a limited extent. It does not provide the speech therapist with the information necessary for planning a therapy programme aimed at the specific language deficit present in a given patient. Only a rigorous design of therapy can establish the difference between professional therapy by a speech therapist and unspecific stimulation by a volunteer. In view of the great variety of specific methods and techniques of aphasia therapy, the multicentre approach is a serious disadvantage because uniformity of methods is not guaranteed. It could well be that some, if not the majority, of speech therapists applied rather nonspecific methods like auditory stimulation. In this case, they would have acted much like the volunteers. Volunteers, on the other hand, who see the patient in the speech therapy department and who get detailed information on FCP test results are likely to act like co-therapists.

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). To see a patient once a week is no better than no treatment.

No explanation is given for the finding that the recovery curves have a steep gradient only during the first two weeks of treatment although both types of treatment were continued over a period of 15 to 20 weeks. In the decisive two weeks the patients received at most four sessions of treatment. In other words, the recovery curves do not demonstrate that volunteer treatment is as good as professional treatment but rather that no continuous effect was obtained either way. This clearly shows the weaknesses of the type of professional speech therapy applied.

The great variation in performances (reported in Table 4) would require the application of statistical methods for the
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 subset 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 defined therapy programs for aphasia. 17-18

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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 multivariate 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.3–5

In response to the remarks on the intensity of treatment given to the patients in our study, we were intrigued that 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 mill be well produce more rapid progress. However, we must
Treatment of acquired aphasia: speech therapists and volunteers compared.

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