CASE STUDY

Counselling someone with severe aphasia: an explorative case study

ROSEMARY CUNNINGHAM

Speech and Language Therapy Department, Southern Derbyshire Community Health Trust, The Grove Hospital, London Road, Shardlow, Derby, DE72 2GT, UK

Accepted for publication: December 1997

Keywords counselling, severe aphasia, personal construct therapy.

Abstract

Purpose: To explore a counselling approach for a client, H.N., with a severe aphasia.

Method: The principles of Personal Construct Therapy were used. Therapy (six sessions) was started and finished by H.N. producing a repertory grid. Sessions were patient-led but the information from the repertory grids was used to help facilitate the process. Each session was video taped.

Results: Analysis of therapy sessions revealed H.N. was following a pattern, if erratic. He used good conversational strategies to control the less structured sessions. The therapist was dominant when the repertory grids were produced. Statistical analysis of the repertory grids was mainly non-significant but there was a shift for the final grid to a greater variety of and more positive responses. General improvement in comprehension was also noted.

Conclusion: A 'counselling' approach with someone with severe aphasia is possible. Using a repertory grid was a useful tool for understanding H.N. better. It seemed to initiate H.N. to discuss things of importance. The changes seen in him could have been due to an improvement in confidence as a communicator. This study has implications for how we can enable people with limited language to adapt to their situations.

Introduction

The last 10–15 years have seen an increasing awareness of the psychosocial impact caused by stroke. Depression, anger, social isolation, economic strain and disruption of normal family functioning have been reported by many investigators.\textsuperscript{1-3} Of these, depression has been the most widely researched. Robinson and Price\textsuperscript{4} followed up 103 patients post-stroke, 30% of whom were found to be depressed at initial interview and many remained depressed 7–8 months later. Feibel and Springer\textsuperscript{5} found a significant relationship between depression and reduced social activity amongst stroke patients and Parikh et al.\textsuperscript{6} reported that depressed patients did not recover as well as non-depressed patients following stroke.

The relationship between depression and aphasia has also received attention. Some investigators have found a connection between depression, left hemisphere infarction and language disorders.\textsuperscript{7-8} However the debate continues as to whether a link exists or if aphasia and depression are in fact separate entities which often coexist.\textsuperscript{9,10}

Despite a growing interest in this area the literature remains sparse on the emotional issues related to stroke and how to tackle them.\textsuperscript{11} Similarly the field of aphasiology has shown little interest in the psychosocial effects of a language disability compared with the vast amount of research on the actual impairment of language.\textsuperscript{12} Of the research which has been published much of it has focused on the impact of aphasia on the carer.\textsuperscript{13-15} Changes in marital satisfaction and leisure activities have commonly been reported.\textsuperscript{16-18} Since the problems of aphasia have been shown to influence the whole family investigators have attempted to tackle these issues by looking at the effects of family therapy for this group.\textsuperscript{19,20} However research into the effects of aphasia on the aphasic is limited. Parr\textsuperscript{21} carried out a qualitative study to look at the coping strategies employed by people with aphasia. Twenty aphasics and their carers were interviewed. Just over half felt that their life satisfaction had deteriorated. Ireland\textsuperscript{22,23} has published personal accounts of how aphasia has affected her life. She describes the anger, chaos and raw emotions she felt and still feels.

Some authors have described the impact of aphasia in terms of loss, linking it with the model of grieving.\textsuperscript{24-27} Brumfit\textsuperscript{28} is particularly interested in how one perceives one's own identity and how aphasia may damage this. She talks about aphasia as the loss of one's self. She sees therapy as comprising of two components; a technical
Counselling someone with severe aphasia

analysis and an exploration of the personal impact. Both she and Sarno agree that therapists acknowledge the personal effects of aphasia but then tend to ignore them. Brumfit suggest that this is because it is difficult to face the aphasic patient's distress.

It is acknowledged, however, that the process of adjustment may be affected if the emotional impact is not addressed. Many feel that the aphasic patient should be allowed to explore and communicate their feelings, but there is little in the literature to guide the therapist on how to approach the situation. Brumfit discusses the use of psychotherapy with aphasics. Wotton and Ireland conducted a project using psychodynamic counselling with aphasics and Dalton has used Personal Construct Therapy (PCT) with aphasics, but the methodology and evaluation is still poorly explored. In particular people with severe aphasia have tended to be ignored because of the inherent difficulties of very limited comprehension and expression. Brumfit acknowledges that the long term use of psychotherapy with this group is probably unrealistic but both she and Dalton have tried a PCT approach with a few severely language impaired people.

Personal construct therapy was developed by George Kelly and helps to explain how one 'goes about the business of trying to make sense of the world in which we live'. It is based on the idea that one construes the world by discriminating experiences and behaviour. This can be done verbally but more importantly preverbally and bodily. Consequently it has an application for people who have limited understanding and are unable to express themselves verbally as they should be able to continue construing events non-verbally.

The author embarked on this project as a result of a particular interest in the emotional impact of aphasia. As a clinician she often feels frustrated by the obvious needs of the clients she sees and her inadequacy in dealing with these needs. The PCT approach appealed because it offered a way of reaching someone who could not easily articulate his/her feelings owing to his/her language difficulties.

The author is not a trained PCT counsellor and therefore was not a strict application of PCT methods. Rather the ideas and philosophy of PCT were adapted for the therapy sessions. Many people may feel that the issue of counselling should not be tackled by an untrained person. However clinicians are often in the position of taking on a 'counselling role' in its broadest sense. The author is probably similar to many experienced therapists interested in this area who are faced by difficult situations and feel that they are not adequately meeting the clients' needs. She wanted to approach this study in the context that many therapists find themselves in.

This case study is taken from a small pilot study carried out to explore the issues of 'counselling' people with severe aphasia. The aim was to look specifically at the response of the person with aphasia and how to approach this response in therapy.

Subject

H.N. (89 years old) was 11 months post-stroke. He had had a left hemisphere stroke resulting in fluent aphasia and some perceptual problems. He had only mild physical signs and he was able to walk independently, carry out simple activities of daily living and was generally still very active. He had had a previous stroke a year before this event which again had mainly affected his speech. These problems had resolved almost completely but some word-finding difficulties had remained. He was noted as having had several transient ischaemic attacks and ischaemic heart disease.

H.N. had been widowed and then remarried 14 years ago. He had two sons from his first marriage and an adopted daughter and two step-daughters from his second marriage. His wife was very caring and he was visited weekly by one of his sons.

His social life consisted mainly of family visits and going to the local pub once a week. He found the latter very difficult initially owing to his communication difficulties but was beginning to get back into the routine.

He enjoyed watching sport on television and looked at a paper every day. Both he and his wife had been very keen ballroom dancers but were no longer able to do this. He had also had to give up working in the garden.

His wife reported that he had never been a great talker whereas she loved to have a 'chit-wag'. She described him as a 'placid man' not at all aggressive. She completed an adapted version of Zuckerman's and Lubin's affect and adjective list which revealed her husband as active, affectionate, devoted and agreeable both pre- and post-stroke.

H.N. was referred to the author because his Speech and Language Therapist at the time felt that he was very frustrated by his communication problems and that his wife was finding the situation more difficult to cope with than appeared superficially.

Prior to the author's involvement H.N. had attended a 6 week assessment group, been put on a waiting list for 4 months and then received 4-5 months of weekly domiciliary therapy. He was found to have severe comprehension problems in verbal, written and non-
verbal modalities, severe word-finding difficulties, paraphasic speech and poor self-monitoring skills. He had been working on semantic understanding, through simple matching and categorization tasks, and non-verbal communication skills in therapy.

Method

H.N. was seen at home by the author (Therapist). The first session involved both H.N. and Mrs N. in an interview to obtain a case history and background information. Mrs N. did not take part in any other session and usually went out to give H.N. some privacy.

H.N. was then seen for six treatment sessions each lasting about 45 minutes. All of the sessions were video taped. Mrs N. was interviewed on the last session to note any changes she had perceived.

Repertory grids

The counselling process was started by producing a repertory grid with H.N. This is a systematic way of recording a person's constructs and analysing the relationships between them mathematically. The repertory grid is not an essential component to using PCT but can be a useful clinical tool in its own right. Here it offered a structure for trying to understand H.N. Although it was unlikely that he would understand the grid itself, it was hoped that the procedure could help to focus his thinking, thus enabling him to express himself in spite of his language limitations.

In order to put a grid together the client's constructs have to be elicited which can be a complicated, semantically demanding task. The constructs are generated by thinking of people, situations, or objects which the client relates to. These are known as the elements. The client tries to express how these elements relate to each other and what it is that creates similarities or differences between them. Often this is done by asking the client to compare two elements and explain how they are different from a third.

The procedure is repeated until all the elements have been compared. It is through this process that the constructs emerge. As a new construct is formed the client is encouraged to think of what would be his/her interpretation of it's opposite. The elements and bipolar constructs are then transposed onto a grid and each construct is rated against each element. The patterns can be teased out statistically using a software program or simply by looking at the grid itself.

H.N.'s aphasia restricted how he could respond to the technique so it was adapted to facilitate the process. Others have done this, for example Beail and Beail worked with client's with learning disabilities using supplied constructs and Fransella adapted the original repertory grid to explore how people deal with certain situations.

For this case various photographs, magazine pictures and black and white drawings were collected. Some of these related to situations which were relevant to H.N. and some were different facial expressions. Written names of those people close to H.N. were also used.

The facial expression pictures came from magazine pictures and photographs taken by the Therapist. These had all been shown to a group of people with dysphasia to try and gain a consensus of what each picture conveyed. The pictures used were those which were recognized in a similar way by most of the group in order to try and reduce discrepancies between the Therapist's and the client's perception of each picture.

The written names and pictures of different situations were used to discover the elements and the facial expression pictures were used to draw out the constructs. Usually when eliciting constructs the therapist encourages the client to develop his/her ideas in order to reveal as much information as possible, some of which may be very abstract. Obviously H.N.'s aphasia would prevent a detailed exploration of his constructs and developing these beyond the emotions that he picked out was not feasible. However, revealing his feelings in relation to things which were important to him would still provide some information about himself, although limited in depth.

H.N. was introduced to the idea by being told that he and the Therapist were going to look at the pictures and words to find out more about him. First he was shown groups of situation pictures, less then ten at a time, and he was encouraged to look through them and choose the ones which meant something to him. These were put to one side. He was then presented with a written name, one at a time. If he recognized the name and indicated that the person was important to him the name was put to one side. Thus the elements were produced. These were: Wife, Stepdaughter, Eldest son, The pub, Shopping, Dining.

H.N. did not have the language skills to make comparisons between the elements and express any relationships between them, so he was encouraged to show how he felt in each situation or with each person using the facial expression pictures. Eight preselected facial expression pictures were put in front of him. The emotions these conveyed were happy, sad, laughing, being with someone/being together (picture of a couple with their arms around each other), frustrated, bored,
angry, surprised. He was given time to look at them and show what he thought the pictures conveyed. For some pictures he described what he thought the person/s looked like, for other pictures he imitated a facial expression accompanied by an appropriate gesture (e.g. for the ‘angry’ picture he screwed up his face and raised his fist). He was then presented with each of the elements he had already chosen one at a time, and was encouraged to choose a facial expression picture which showed how he felt when in that situation or with that person. The emotions he chose were used as his constructs.

As indicated above each construct is bipolar and has an ‘opposite’. However in order to keep the task simple and not overload H.N. with semantic decisions the opposite construct was supplied and labelled as a negative of the chosen construct (i.e. happy versus not happy). Each facial expression picture which was chosen was noted regardless of how frequently it was picked.

The Therapist was also interested to find out how H.N. perceived his communication in each of the situations he had chosen and with each person. She therefore supplied a construct which was ‘able to communicate’. This was conveyed to H.N. as ‘being able to talk’.

Once the elements and constructs had been selected the grid was put together. A three point rating score was used to obtain some limited qualitative information rather than just a yes/no response. Symbols were used: a ‘+’ indicated a positive response, a ‘0’ indicated ‘in-between’ and a ‘-’ indicated a negative response. These were written on a piece of card and presented to H.N. Each symbol was repeated to H.N., with accompanying gestures and facial expressions from the Therapist, at every opportunity to facilitate his understanding.

All the elements and constructs were written down on separate pieces of paper because H.N. seemed to respond better to written material. A written element plus a construct were held up together for H.N. to look at. He had to relate the construct to the element and rate its importance by pointing to the relevant symbol. Every construct was presented with the element until all the constructs had been used. Another element was then picked and the same procedure followed until all the elements had been rated with every construct.

H.N.’s response to producing a repertory grid

The actual process of gathering information for a repertory grid was a useful exercise. It gave some insight into how H.N. related to part of his world and the various emotions he felt. It also provided an introduction for talking about himself and revealing how he felt about things. However H.N. did not find the exercise easy and it was not clear how accurate the information was that he produced. He found it very difficult to comprehend the concept of self-analysis. A major difficulty was that he could not relate the pictures to himself. He demonstrated an understanding of them but could not comprehend the concept of projecting the image to himself. Rating the constructs and elements was also difficult. Clarification had to be repeatedly sought to confirm his meaning, but occasionally he responded clearly and appropriately. For example when choosing facial expression pictures to go with his feelings for his wife, he immediately picked up the ‘happy’ face and then the picture of a couple with their arms around each other. He produced a similar response when thinking about one of his sons.

Although information from the grid did not appear to be consistent or reliable it had provided some material to develop further in the treatment session. For example thinking about how H.N.’s impaired communication affected him in different situations, how different people reacted to his communication difficulties, what his relationship with his family was like.

Treatment sessions

The process of eliciting constructs and elements for the repertory grid and rating them took two sessions. The remaining sessions were very fluid and although the information from the repertory grid provided the Therapist with some openings for further discussion (for example talking about how H.N. felt when communicating in different situations and with different people) it proved to be difficult to follow a plan of therapy in a structured way. However a progression of sorts emerged as H.N. had certain topics he wished to talk about and was very much in control in each session. His pattern of thought tended to jump from one thing to another so that none of the sessions followed a logical sequence but never-the-less he was remarkably consistent in the topics he wished to pursue. His main interests were telling the Therapist about his family, talking about his experiences in the pub, attempting to describe what it was like to have a communication difficulty and the irritability he felt against his wife. These topics could come up at any time. Sometimes seeing a written word (e.g. his wife’s name), or a question asked by the Therapist, triggered a response. Often, however, the topics blended together and it was confusing following his train of thought. Consequently the information derived from the repertory grid, plus the background information from the case history was invaluable in giving the therapist a baseline for understanding H.N.
H.N.’s means of conveying information to the Therapist was to use limited verbal expression, containing social phrases and some relevant content, interspersed with incoherent speech and jargon. He also used a lot of gestures both vague and symbolic. He could make his message quite clear at times, but generally the Therapist had to guess the meaning. She relied heavily on seeking clarification by asking direct questions e.g. ‘do you mean x’ or by paraphrasing what she thought H.N. had said. If H.N. did not give a decisive acknowledgment she asked him if she had deduced his meaning correctly, often repeating the original question or rephrasing it. She also asked quite specific questions such as ‘does this make you angry?’. This is unconventional in the field of counselling as it leads the person and could colour what they are thinking. However, it was important to focus H.N. at times in order to understand what he was saying.

When H.N. was obviously struggling to convey some information the Therapist made suggestions for him to accept or reject. Again, this can be dangerous as too much can be assumed and consequently misinterpreted. Therefore it was important to read his nonverbal signals carefully to try and gauge how accurate the suggestions had been. If it was impossible to interpret the meaning questioning was often discontinued to prevent wild guessing. However H.N. was not stopped from continuing to attempt to communicate his rambling thoughts as new ideas could surface in time and one of the purposes of the sessions was to encourage him to express himself freely. There were occasions, however, when H.N. expressed himself very clearly, for example describing difficulties talking to his wife and his friends in the pub.

Analysis of the videos revealed more detailed information about the interaction between the Therapist and H.N. Each video was watched twice and notes taken to obtain a general impression of the interaction. Three 5 minute sections were then taken from each session and transcribed to look at in more detail.

The sessions which involved choosing pictures and names which were meaningful to H.N. and then working on the repertory grid showed a very different type of interaction compared with the less structured sessions. In the former the Therapist was much more directive and vocal. Exaggerated intonation patterns, gesture and facial expression were used to facilitate H.N.’s understanding. Attempts were also made to keep him focused on the task. H.N. in contrast was relatively silent, except when he could not work out what was expected of him. At these times he appeared exasperated, although he never gave up.

The other sessions, which were much more patient-led, showed that H.N. held the floor by making minimal eye-contact to prevent the listener from taking over and filling gaps with gesture so that, in effect, he was still ‘speaking’. The Therapist used many more minimal turns to give H.N. time to express himself. The number of gestures and body movements were reduced and fewer interruptions were made, possibly enabling H.N. to keep the floor. The Therapist’s eye contact was generally steady and nods and smiles were used as encouragement.

Analysis of the repertory grids

A second repertory grid was completed in the final session to compare it with the first. These were analysed informally as well as statistically using the GAB (grid analysis for beginners) software programme which has been designed to give the relationships between the ratings for the pairs of elements and pairs of constructs from a repertory grid and to show the links between the elements and constructs.

Ratings for the initial repertory grid were almost exclusively ‘0’ (see table 1). One exception was a positive score of frustration with his wife. This preference for the middle rating could be that he did not really understand what the task was, or that the constructs did not have a clear meaning to him. The ratings on the final repertory grid were very different (see table 2). He produced many more positive responses, which related to generally feeling happier with people and in some situations, and a few negative responses, which related to not feeling bored and frustrated with his family. It is perhaps interesting to note that his original positive rating for the construct of frustration with his wife had become a negative, (that is he did not feel frustrated with his wife). The greater variety of response may show a clearer understanding of what was expected, or a more coherent view of his world.

The analysis using the GAB computer programme showed that virtually all the relationships on the initial and final grid were non-significant. Nevertheless, a trend emerged, the majority of the correlations between constructs on the initial grid were all low (except for two constructs) whereas moderate, and some strong, correlations were calculated for the constructs on the final grid. The low correlations indicate that there is no close link between the constructs and therefore predictions cannot be made about them. It is perhaps interesting to note, however, that some of the correlations from each grid did show a predictable trend. For example on the initial grid a moderate negative correlation (−0.53) appeared between the construct for ‘frustration’ and ‘being together with someone’, that is frustration does
Counselling someone with severe aphasia

Table 1 Initial repertory grid

<table>
<thead>
<tr>
<th></th>
<th>Wife</th>
<th>Step-daughter</th>
<th>Eldest son</th>
<th>Pub</th>
<th>Shopping</th>
<th>Dining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Laughing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Being</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Together</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bored</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Frustrated</td>
<td>+</td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Communicating</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Key: ‘+’ = yes, ‘0’ = don’t know, ‘-’ = no.

Table 2 Final repertory grid

<table>
<thead>
<tr>
<th></th>
<th>Wife</th>
<th>Step-daughter</th>
<th>Eldest son</th>
<th>Pub</th>
<th>Shopping</th>
<th>Dining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>Laughing</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>Being</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Together</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>0</td>
</tr>
<tr>
<td>Bored</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>0</td>
</tr>
<tr>
<td>Frustrated</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>0</td>
</tr>
<tr>
<td>Communicating</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Key: ‘+’ = yes, ‘0’ = don’t know, ‘-’ = no.

not occur when you are together with someone. On the final grid strong correlations were found between the construct ‘happy’ and the constructs ‘laughing’, ‘being together with someone’ and ‘communicating’ indicating that happiness is linked with laughing, being with someone and being able to communicate. The same construct ‘happy’ was negatively correlated with the constructs ‘bored’ and ‘frustrated’ indicating that happiness is not linked with boredom and frustration. One of the strongest correlations (0.86) was for the constructs ‘bored’ and ‘frustrated’. The correlation was positive indicating that boredom is linked with frustration.

Discussion

The aim in carrying out this case study was to explore a counselling approach in therapy with someone with limited language. The technique of building a repertory grid was used to see whether this would facilitate the process. The grid itself provided the potential for planning therapy and giving the client a visual aid to help him make sense of his world. In H.N.’s case the actual grid did not mean much to him but the process in building it provided a structure to help him explore how he viewed important parts of his life. It may have opened up a new way of thinking, not previously pursued by anyone, and enabled him to discuss things which meant a great deal to him.

This approach to therapy may have worked as well without putting a grid together but just using the pictures to explore different feelings. It would have revealed useful information to give the Therapist some insight into the person. Never-the-less it was useful to record the information on a grid in order to examine any emerging patterns and look for changes. In the case of H.N. it was often difficult to follow a pattern in therapy and make sense of his thinking. Producing the two grids provided some coherence and a change did appear to occur over time, although any interpretation must be made cautiously.

Even analysing the video tape recordings did not show a particular pattern or progression in H.N.’s thoughts over time. It was not clear that any issues had been resolved but H.N.’s insistence on discussing set themes suggested a need to be able to communicate these things. Some of the topics he brought up related to frustrations he felt, such as not being able to get his words out, feeling irritated by his wife’s chatter, but others involved wanting to talk about his family, who they were, where they lived.

The Therapist tried to encourage H.N. to think about why he felt frustrated or irritated, but this was not very successful. Possibly H.N.’s comprehension problems affected his understanding of the questions or his ability to analyse the problem. Perhaps he chose not to delve too deep. The opportunity to tell someone how he felt may have been sufficient (see appendix).
As mentioned before the results from the analysis of the two grids suggest a shift in thinking over the period of time spent counselling. These must be interpreted cautiously owing to the uncertainty of H.N.'s responses at times but the results from his second repertory grid indicate a more cohesive view of his world. Following the period of treatment H.N.'s wife was interviewed and asked whether she had noted any changes. She commented that he was a little more confident in himself and she felt that she could begin to be a little more independent again.

The changes in the grids could have been owing to a greater familiarity with the concepts. In other words he was used to thinking about his family, about different situations and looking at written cues relating to these things. However he had not had to make comparisons between items during therapy in the systematic way he was required to when rating items for the first grid. Yet when the process was repeated for the second grid H.N. was quicker at making a decision when rating an element with a construct and seemed more confident in his approach (as seen on the video tape). It appeared that his general comprehension had improved. This may have been due to a number of factors; a burst of spontaneous recovery (although he was nearly a year post-stroke), a product of a facilitative approach enabling functional communication, or an increased awareness of being able to be a competent communicator. Kagan describes the nature of aphasia in terms of masking the person's communicative competence. It is possible that by offering H.N. time to communicate what was of importance to him and by facilitating an interactive process he was able to see himself as a competent communicator again and this influenced his general communication skills.

Working with H.N. in this way provided an opportunity for him to explore how he related to his family, how things had changed and how he was dealing with his new situation. He was being listened to, affirmed and acknowledged as a communicative being. This approach was possibly helping him to restore a sense of his own value again, a concept strongly advocated by Dalton.

The nature of H.N.'s aphasia had an inevitable impact on the counselling approach. Certain conventions had to be flouted in order to facilitate the process. For example providing a voice for H.N. to enable a clearer form of expression, making interpretations, which may not have been accurate, because H.N. was unable to communicate his ideas coherently, directing the discussion in order to provide some shape and meaning. These risks have to be taken in order to explore the situation in some depth. In this particular case H.N. was not clinically depressed or severely distressed, as some clients can be. He was experiencing the very common frustrations of impaired communication and the impact of this on his life. For this reason it was felt that it was appropriate for the author to work with him as an experienced speech and language therapist but non-trained counsellor. Some situations are beyond the skills of a speech and language therapist and these need to be identified and referred to an appropriately trained professional. Unfortunately such a professional is rarely available. Clinicians need to build on the skills that they do have in order to deal with the emotional aspects of aphasia and more trained speech and language therapy counsellors are needed to refer on to.

The ideas presented in this study will hopefully provoke discussion about counselling and aphasia, methodology, and appropriate evaluation. It is widely recognized that more rigorous research is needed, particularly in how to evaluate therapy. Exploratory studies are required initially to build up the limited knowledge in this area and help to develop hypotheses which can be investigated further. A wider understanding of what it is like to be aphasic is needed as well as the continued development of training, guidelines and treatment strategies to enable therapists to work more confidently in this area.

Acknowledgements

I would like to thank Professor Fenton and the Stroke Research Unit, Nottingham City Hospital NHS Trust, for supporting me both financially and personally. Many thanks also to Shelagh Brummitt, Penny Standen, Carolyn Desorges, John Cunningham and Eleanor Stout for their time, advice, and support. Finally, and by no means least, thanks to H.N. and his wife without whom this case study would not have happened.

References

Counselling someone with severe aphasia


Appendix

H.N. Of course she [wife] comes (?) talk *Waves both hands looking at T.*

T. Right (.) they natter away do they*  

H.N. And she talk a lot all day *Places hands in lap*  

T. *Laughs*  

H.N. *Smiles looks down fiddles with cuffs Laughs (2) and er Looks back at T. then up at ceiling places arm on couch (3) ah that’s how I was*  

T. *Mhmm Smiles nods*  

H.N. *Hand to face looks at wrist places hand back on arm of couch looks down (7) looks towards T. and away taps hand on couch arm then rubs it*  

T. *Head slightly inclined Do you still feel as if you are getting better*  

H.N. *Rubs couch arm looks at T then down I don’t I don’t Looks at T. and away this morning * no I don’t*  

T. *Nods no * Nods*  

H.N. *Hand to lap sniffs*  

T. *No Nods (2) how often do you get (1) bad days like this*  

H.N. *Looks towards T. not at her looks ahead * Oh no Rubs leg if I Waves hands in front of body turns to T. raises hands in the air laughs turns away dropping hands raises them again turns to T. looks down Earlier on a day day (?) Shakes head (2) she told me tells this morning and told me all things Moves hand towards T. sweeps across body*  

T. *Slight nodding*
R. Cunningham

H.N. In all day and tells me all the Waves one hand in the air then other one too leans forward (2) shifts back in chair crosses legs etc etc Looks at T. and away drops hands to lap she lifts hands again looks at T. nods waves hands emphatically looks away drops hands

T. Mmm

H.N. (?) * Arm on couch arm looks ahead (1) Then that’s all all so Lifts arm off couch and taps leg looks at T. and away

T. She’s telling you a lot of things Slight nod

H.N. Looks at T. Ahhh ‘cos she’s always telling me things Waves hands

T. Mhmm (1) Nods

H.N. Looks away laughs head down

T. Things about what Head inclined

H.B. Turns to T. * Well she (.) Uncrosses legs looks away talks about (.) Moves hand in wave-like motion different things and all the things all the things Looks at T. and away we spoke about Waves hands

T. Mhmm Nods

H.N. (2) And er Sits well forward in chair (3) er it all Sits back crosses legs waves hand looks up then down well it’ll tell me all things she will tell me waves hands looks at T. and down drops hands she will tell me about it Shakes head

T. Nods smiles

H.N. But Looks up holds up both hands pointing at himself I never said ‘aut (2) Drops hands in lap

T. Would you like to say something

H.N. Ah ah ah Wipes mouth leans towards T. touches her arm

T. Right Nods

[ H.N. She might do * Looks ahead crosses legs folds arms

T. But would you Points to H.N. like to say something

H.N. Eh Leans well towards T. hand towards her

T. Leans towards H.N. Would you like sometimes to be able to say something

H.N. Ah Looks down I should think so (.) yes (2) Leans back uncrosses legs ah Sniffs (2) shakes head

T. (1) You’re Points to H.N. saying that J. [wife] Gestures talking talks quite a bit

H.N. Never (1) I don’t think I am Looks across room

T. No listen Taps H.N.’s knee leans forward you’re saying that J. talks Gestures talking quite a bit do you Points to H.N. wish that you Points to H.N. could talk Gestures talking more (1) with her

H.N. Er well Looks away crosses legs laughs I don’t talk a lot

Key: T. = Therapist, (?) = verbal output which cannot be transcribed. (2) = Two second pause, (.) = very brief pause, [= overlap, * = end of overlap. Italics = nonverbal communication.