

COMMENTS AND OPINIONS

Beyond Language Deficits: Working Alliance and Resources as Predictors of Recovery From Aphasia

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ABSTRACT: Large-scale clinical trials and meta-analyses have determined neurobiological and linguistic predictors of recovery from aphasia, while more recent work is opening the field to factors of efficacy previously established in psychiatry—and little known in neurology. To map this evolving area of research, the present essay explores key factors of efficacy in psychotherapy as potential predictors of recovery from aphasia. In particular, the essay addresses (1) working alliance, including consensus between patient and therapist on treatment goals and tasks alongside interpersonal bonds, as well as (2) focus on resources rather than deficits in language performance. Finally, the essay outlines why research on impaired communication ability may help advance and complement existing methods in psychotherapy.

Key Words: poststroke aphasia ■ poststroke depression ■ psychiatry ■ psychotherapy ■ therapeutic relationship

Can aphasiology learn from psychotherapy, and vice versa? At first glance, the two disciplines seem almost mutually exclusive, primarily because loss of communication ability undermines a central premise for language-based treatment of mental health disorders. Even at second glance, this mismatch appears to persist throughout the history of psychotherapy. According to late 19th century psychoanalysis, the “unconscious” manifests in the relationship between patient and therapist—a phenomenon coined “transference”—as well as in metaphors and symbols revealed through unintended utterances, imaginative techniques, and dreams.¹ To convey emotions and thoughts, this method relies on the use of spoken language. Likewise, spoken language remained essential to the practice of psychotherapy in subsequent decades, as clinicians and researchers sought to integrate and transform major claims of psychoanalysis into newer paradigms, the most prominent of them being humanistic,^{2–4} cognitive-behavioral,^{5–7} and family-systems psychotherapy.^{8–10} Although aphasiology and psychotherapy may be difficult to reconcile in terms of spoken language as a tool for communication, there

is a striking parallel in paradigm shifts toward working alliance and resource orientation in both disciplines. The present essay aims to address this parallel.

WORKING ALLIANCE

Years of research have identified working alliance as a common factor¹¹ and the strongest predictor of efficacy in psychotherapy.^{12–14} However, working alliance did not gain universal recognition in psychotherapy until the emergence of cognitive-behavioral “third-wave” treatment programs in the 1980s,^{15,16} inspired mainly by psychodynamic¹ and humanistic theory.^{3,4} By definition, working alliance refers to the quality of interpersonal relationship with respect to (1) shared goals, (2) required tasks to achieve them, and (3) bonds between patient and therapist.¹⁷ Part of this distinction aligns effortlessly with aphasiology, given the need to agree on shared goals (eg, improving verbal expression in everyday life) and required tasks (eg, communicative-pragmatic speech-language therapy). Surprisingly, research in aphasiology has not yet examined whether, and how, consensus

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between patient and therapist on treatment goals and tasks contributes to recovery from acquired communication disorders and concomitant psychopathology. This aspect is critical because stroke survivors with aphasia typically face problems in articulating personal treatment priorities and preferred training strategies. Mediated by parameters such as motivation or self-efficacy, consensual treatment goals and tasks may facilitate progress in speech-language therapy—a hypothesis to be consolidated by randomized controlled trial (RCT) evidence.

As for interpersonal bonds, the picture becomes more nuanced and deserves a closer look. In psychoanalysis, interpersonal bonds are supposed to open a way for corrective experiences between patient and therapist.¹⁸ Such experiences may include, for example, a successfully resolved conflict between patient and therapist, contrary to negative expectations of the client arising from transference (“Unlike in my childhood, when I express anger in our weekly sessions I am not punished but overwhelmed with understanding”). Following the principle of “abstinence,” the therapist in psychoanalysis refrains from deliberate self-disclosure to increase the intensity of transference, and thus, the magnitude of prediction errors and the probability of change for the client—notably, a principle consistent with learning psychology.¹¹ In humanistic psychotherapy, interpersonal bonds reflect the “real” relationship between patient and therapist. In the interest of “genuineness,” the therapist is first and foremost a partner characterized by “empathy” and “unconditional positive regard,” ideally in a state of “congruence” between actual and intended self, and shares personal experiences with the client, if useful for the treatment.³ In cognitive-behavioral and family-systems psychotherapy, bonds constitute no direct means of treatment but rather a precondition for the applicability of tailored methods, such as fear exposure,⁵ cognitive restructuring,⁶ mindfulness-based techniques,⁷ family mapping,⁸ paradoxical prescription⁹ or reframing.¹⁰ In clinical practice, these different perspectives complement each other^{15,16,19,20} and have shown comparable results in meta-analyses.²¹

Arguably, the cognitive-behavioral and family-systems perspective of interpersonal bonds may capture the practice of speech-language therapy most appropriately. Speech-language therapy indeed provides a rich set of methods, some of which proved to enhance communication ability in RCT data.²² For the applicability of these methods, a stable therapeutic relationship is often tacitly assumed as a prerequisite for the feasibility of the treatment, yet without exploring its viability. Aside from the cognitive-behavioral and family-systems perspective, the humanistic notion of interpersonal bonds may be valuable for those who feel that relationship per se represents an integral part of speech-language therapy beyond a distinct set of methods. Moreover, this nondirective approach may carry less risk of patronization than

classical psychoanalysis. In severe aphasia, the psychodynamic perspective of interpersonal bonds obviously demands a great deal of openness by the therapist to the fact that hypotheses may be false but hard to refute in the absence of verbal opposition by the patient. Nonetheless, aphasia does not preclude a potential benefit from corrective experiences in any kind of treatment, if conducted with caution. Although each of these perspectives may be helpful, no quantitative or qualitative study in clinical psychology has ever determined the nature of interpersonal bonds in speech-language pathology.

Attempts to assess therapeutic relationship in speech-language pathology have yielded a 42-item questionnaire for individuals with aphasia (A-STAM).²³ Notwithstanding the merits in developing this instrument, the questionnaire does not distinguish between goals, tasks, and bonds. An economic alternative may be a 12-item questionnaire widely accepted in psychotherapy (WAI-SF),²⁴ with a 3-factorial structure of goals, tasks, and bonds confirmed in individuals without aphasia.²⁵ Future research may adapt this instrument for neurorehabilitation by ensuring content validity for the target sample. What remains thought-provoking in the present context is the previous lack of collaboration between aphasiology and psychotherapy—an observation that does not pertain to working alliance alone. For instance, a frequently used 10-item questionnaire in aphasiology refers to symptoms of “depression” (SADQ-10).²⁶ However, only 5 items of this questionnaire meet official criteria of depression, clustered into standard categories of emotional, cognitive and vegetative function.²⁷ In other words, the questionnaire may not detect symptoms of above-threshold depression rather than subclinical “low mood.” Conversely, established instruments in psychotherapy include self-report (eg, BDI)²⁸ and expert-rated outcomes of depression (eg, HAM-D)²⁹ rarely used in speech-language pathology but sensitive to treatment-induced change in poststroke aphasia.³⁰ Hopefully, aphasiology and psychotherapy will join forces in future research.

In summary, the concept of working alliance in psychotherapy not only converges with treatment goals and tasks in aphasiology but also entails a multifaceted view of interpersonal bonds in speech-language pathology. The Figure illustrates how the purpose of working alliance differs depending on school of psychotherapy. This diagram organizes each school along the following dimensions: (1) content, which ranges from clinical-academic (psychoanalysis and cognitive-behavioral therapy) to holistic-pragmatic (humanistic and family-systems psychotherapy), and (2) form, which ranges from giving space (psychoanalysis and humanistic psychotherapy) to giving impetus (cognitive-behavioral and family-systems psychotherapy). Crucially, variability within each school of psychotherapy tends to obscure the boundaries between them, and the entire field continues to be

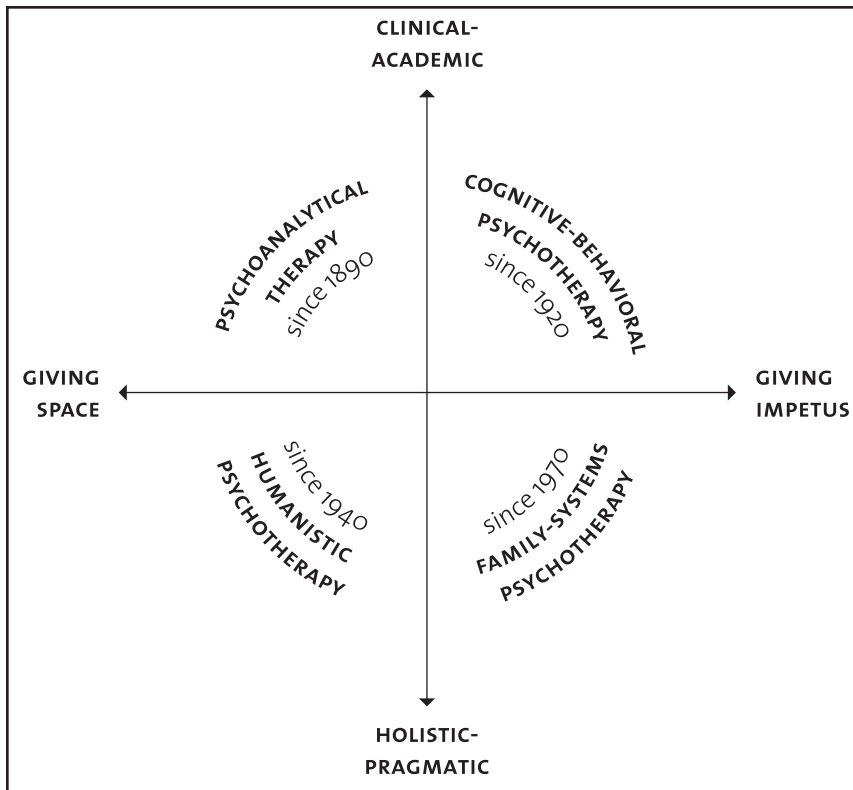


Figure. Heuristic model classifying schools of psychotherapy along the following dimensions: content (clinical-academic vs holistic-pragmatic), and form (giving space vs giving impetus).

dynamic. Therefore, the proposed dimensions depict clinical practice merely as a heuristic model that highlights similar and divisive features of schools in psychotherapy. In their daily practice, speech-language therapists may sense individual degrees of allegiance along these dimensions—possibly a fruitful starting point for qualitative interviews. If aphasiology can learn from psychotherapy, the current work aims to stimulate research on the influence of working alliance on treatment outcome in acquired communication disorders.

RESOURCE ORIENTATION

Resource orientation as a common factor of efficacy in psychotherapy¹¹ has received full attention relatively late, prompted mainly by the advent of family-systems psychotherapy in the 1970s.^{8–10} Similarly, aphasiology was—and in many ways still is—primarily concerned with deficits in verbal expression and comprehension, with less efforts devoted to neurobiological resources, such as right-hemispheric function underlying musical and pragmatic language skills.³¹ Exceptions exist: while meta-analyses indicate that Melodic Intonation Therapy may not directly benefit communication ability on validated outcomes,³² music listening appears to ease “low mood” in stroke survivors without aphasia, even if not consistently.³³ With regard to pragmatic language skills, RCT data demonstrate that intensive use of formulaic expressions embedded in social interaction may improve verbal communication³⁴ and above-threshold poststroke

depression in individuals with aphasia.³⁰ The same holds true for RCT data showing that enjoyable activities and peer companionship may be social resources to relieve “low level of distress”³⁵ and “low mood” in individuals with aphasia,³⁶ as well as subclinical depression in a mixed group of stroke survivors.³⁷

The mentioned resource-centered treatment programs fall mainly into the category of cognitive-behavioral and family-systems psychotherapy, as outlined in the Figure. This classification conforms to the idea that theory and practice of aphasiology may be most akin to cognitive-behavioral and family-systems psychotherapy both in terms of working alliance and resource orientation. Interestingly, treatment programs occasionally meet criteria of resource orientation but have not been designated with this label in the literature. For example, Intensive Language-Action Therapy—better known as Constraint-Induced Aphasia Therapy—is often used as a synonym for massed practice and inhibition of nonverbal communication.³⁸ However, this treatment program takes full advantage of preserved formulaic expressions embedded in social interaction, including gestures to accompany rather than replace spoken language, as detailed in the RCT protocols.³⁹ A starting point for future research may be an expert-rated measure of resource orientation quantifying available methods in aphasiology to obtain a covariate for meta-analyses of treatment efficacy. If aphasiology can learn from psychotherapy, the current work aims to raise awareness of resources in the treatment of acquired communication disorders.

CREATIVITY BEYOND LANGUAGE IN PSYCHOTHERAPY

From a conceptual perspective, it may be equally insightful to reverse the question: can psychotherapy learn from aphasiology? Possible hypotheses are as follows: (1) Suitable psychotherapy methods for individuals with aphasia involve high imagery to circumvent spoken language. (2) This imagery has great potential of “problem actualization,” a term referring to emotional engagement—again, a common factor and predictor of efficacy in psychotherapy.¹¹ (3) Language-competent individuals may benefit especially from psychotherapy methods tailored to stroke survivors with aphasia, since such approaches will automatically diminish the likelihood of using verbal communication as means to avoid emotional engagement. In light of these tentative hypotheses, aphasia may be both indicator and motivator of creativity in psychotherapy beyond spoken language.

Anecdotal evidence for the first and second hypotheses derives from psychotherapy sessions with individuals suffering from aphasia. These sessions emphasize promising features of experience-based methods borrowed from humanistic and family-systems psychotherapy, as shown in the Figure. For example, “focusing” in humanistic psychotherapy is thought to improve the efficacy of the treatment by incorporating bodily perceptions as “felt senses” (eg, concentrating on sadness as an evolutionary-adaptive, physical-emotional mechanism enabling clients to let go and readjust when struggling with a loss).⁴⁰ Moreover, “sculptures” in family-systems psychotherapy are supposed to make interpersonal distress visible in space, and therefore, easier to handle (eg, uncovering unmet needs in social relationships by symbolically placing objects of different shape and color for meaningful individuals on a table).⁴¹ These experience-based methods may potentially compensate for mild-to-moderate deficits in verbal expression and comprehension—a claim to be corroborated by data. As for the third hypothesis, a preliminary answer may be the little known fact that history of psychotherapy has its roots in speech-language pathology. Fascinated by the associative nature of the brain particularly evident in acquired communication disorders, the founding father of psychoanalysis once set out to develop a “talking cure” after completing a treatise on aphasia.⁴² In exploring the interplay of acquired communication disorders and psychotherapy, the current work encourages clinicians to consider research on aphasia as a treasure to spur innovation both within and outside the realm of speech-language pathology.

ARTICLE INFORMATION

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