



weeks of therapy and 6 weeks post-therapy. Appropriate statistical analyses were conducted using t-tests to compare pre and post-treatment performances. Significant improvements were found on the CADL with scores being maintained at six months follow-up. No significant change was found between pre and post-treatment scores on the PICA.

The results of this study support functional communication therapy in improving functional communication abilities. Strengths of the study included clear eligibility criteria that controlled for etiology, gender, and aphasia type, as well as reliable and valid outcome measures. However, due to strict subject selection this study had a small sample size, affecting statistical power and increasing the possibility of a Type I error. As well, there was repeated administration of measures (i.e., CADL administered 4 times in 18 weeks), which may have affected the results.

Given the above concerns, the evidence presented in this study that functional communication group therapy is effective for improving functional communication abilities is suggestive rather than compelling.

Bollinger, Musson & Holland (1993) conducted a follow-up study to Aten et. al., (1982) using a non-randomized mixed clinical trial to examine the effects of group therapy on communication. Ten participants with chronic aphasia from either a left-hemisphere stroke, brain injury, or surgery, completed three-10 week cycles (3 one-hour sessions/week) of contemporary group treatment (CGT), structured television viewing group treatment (STVGT) and no treatment (NT) with counterbalancing of treatment order. The treatment format of each group was given in detail sufficient enough for replication.

Administration of the CADL, PICA, and the *Auditory Comprehension Test for Sentences* (ACTS) was completed at intake and after each 10-week interval until the conclusion of the study. Subjects who scored 105 and below on the CADL at intake were placed in the 'low' level group, while subjects who scored 120 and above were assigned to the 'high' level group.

Appropriate statistical analyses were completed using the Wilcoxon Matched-

types due to a left-hemisphere stroke participated in a 90-minute session once per week for 10 weeks. Therapy consisted of communication activities that involved sharing personal experiences to address linguistic and personal challenges, and videotaping role-play activities to encourage self and group evaluation.

Five measures, administered by 8 final-year speech language pathology students, were taken at intake and again after the last group session. Communication measures included the *Functional Communication Profile* (FCP), and the *Attitude to Communication Scale* (S24). The *Stutterer's Self-Ratings of Reactions to Speech Situations Scale* was also used, as it was believed that individuals with aphasia have similar communicative demands as a long-term stutterer. Measures of psychological adjustment included the *Rosenberg Self-Esteem Scale* (RSE) and the *Hospital Anxiety and Depression Scale* (HADS). The prediction measures (only administered at intake) included the *Recovery Locus of Control Scale* (RLOC), and two statements designed to measure intent using a five-point Likert scale.

Appropriate statistical analyses using t-tests revealed positive effects post treatment for the FCP and the *Stutterer's Self-Ratings of Reactions to Speech Situations Scale*, although all measures (except for self-esteem) showed numerical improvements. A correlation analysis was completed to determine the relationship between communicate

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*Friendship Scale* (FS). All measures were administered at intake and post-therapy and were compared to measures completed by 12 participants in the no-treatment group.

Paired sample t-tests (two-tailed) were completed to

change noted in studies with multiple sessions of therapy per week.

Inconsistent findings could also be explained by the difference in assessment tools and methodology used across the