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First European Conference on Aphasiology

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The type of aphasia therapy is determined by the health-center's primary responsibility for the patients' whole well-being. That places requirements on the rehabilitation team. The aim of the hospital team is to get the patient in such a condition that he can manage at home. The aim of the outpatient department team is to keep the patient in such condition that he can still manage at home. Both teams also organize rehabilitation activities.

In order to direct the rehabilitation procedures at the patient's concrete needs, a two-year follow-up project has been started in the stroke population. The evaluations are to take place just after the stroke and then three, six and twelve months post onset. The evaluation includes all areas of everyday living. The project has started later than planned, so I can present now only some facts but no results. It should have started at the beginning of this year, but it started at the beginning of August. The patients in the project are stroke patients over the age of 60. This far there have been eight patients and one of those is living at home now. About two or three weeks after the stroke, the patients come to the health-center hospital from the district hospital. During these first weeks at the district hospital the basic medical examinations are made, including for example CT-scanning. When the patients have come to the health-center hospital the rehabilitation starts as soon as possible.

During their rehabilitation period at the outpatient department, patients and their family members can participate in an adjustment training course for about two or three weeks, which is organized by the National Aphasia Association.

Following and also during active rehabilitation at the outpatient department the aphasics can also take part in group therapy once a week. There are two so-called "clubs", which have meetings once a week for about four to five hours each time. During that time it is possible to participate in a speech and language therapy group, a physiotherapy group, a hobby crafts group or social groups. The transportation is also organized so that everyone can take part in these "clubs". At the moment there are about 30 aphasics who come regularly to these meetings.

In the coming years the aging of the whole population will cause new problems even in the field of speech and language therapy. But already now, some long-term planning has taken place. It has been planned to get more staff to work with elderly people and fulfill their needs. It is also important to increase the training of this staff. Further, it is also necessary to establish new centers for various activities of elderly people.

In Vantaa we are also trying to do more teamwork with volunteer associations. At the beginning of this year a local aphasia association was founded. By the end of this year some activities will be started. At the moment our rehabilitation organization is sufficient. However, since there will be new patients all the time, the groups will grow bigger and the follow-up project will create more work all the time.

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Occurrence and Care of Aphasia in Sweden

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There is hardly any information in the literature about the incidence of aphasia in Sweden. The most well-known pertinent study was published as long as twenty years ago and refers only to the

¹⁾ The authors wish to express their sincere gratitude to Martha Taylor Sarno, M.D. h.c., New York University, for valuable comments and to Anna Karin Thoresson, Glaxo Pharmaceuticals, Mölndal, for retrieval of reference literature.

urban population of a large town (BROMAN & al., 1967). Since then, logopedic centers have been established in most parts of our country. For the care of aphasics, this means a substantial increase in the diagnostic and therapeutic resources. However, it is not clear, whether these resources are sufficient and whether their geographical distribution is adequate. Furthermore, reports about a decreasing incidence of acute cerebrovascular disease in recent years (GARRAWAY & al., 1979; SOLTERO & al., 1978) are probably of importance also pertaining to the occurrence of aphasia. Therefore, a new investigation about the incidence and care of aphasia in Sweden was considered to be of interest.

Procedure

The routines for referral to our phoniatic department are such that practically all aphasic patients in our district (the town of Malmö) are examined by us and taken care of therapeutically. In an inquiry to all pertinent wards in Malmö we asked about the number of aphasics on one particular day (March 5, 1987). It was substantiated that all aphasics were known to our department already. Thus, occurrence rates based on our observations seem reasonably dependable. They were compared to corresponding reports obtained by an inquiry to all phoniatic and logopedic centers in Sweden, known to be engaged in the diagnostic and therapeutic work with aphasic patients. As a basis for such comparisons, official statistics were obtained about the incidence of acute cerebrovascular disease in the district of Malmö as well as in Sweden in general. The inquiry was sent to 99 institutions, suggested to us by the Association of Swedish Logopedes. Five of them did not have continuous consultations for aphasics during the year under observation, i.e. 1986. Fifteen did not answer. The remaining 79 reports cover all provinces of Sweden except the island of Gotland. Besides statistical figures, the inquiry yielded information about the diagnostic and therapeutic approaches to aphasic patients in different parts of our country.

Results and Discussion

The incidence figures resulting from our study appear in tables 1 and 2. They can be summarized by the following statements. Even if the incidence of cerebrovascular disease is of the same magnitude in the town of Malmö as compared to the rest of the country, viz. about 200 per 100,000 inhabitants, the relative number of new aphasic diagnoses during the year 1986 was somewhat less in the country at large.

In the district of Malmö the incidence was 55 per 100,000 inhabitants, and the average for the entire country was only 50 per 100,000 inhabitants. Furthermore, a more thorough analysis of this latter figure reveals that it probably is somewhat overoptimistic. Certain places have reported incidence rates far greater than the one expected, but it is likely that some patients have been reported more than once, especially if they have been transferred to other hospitals. On the other hand, not less than thirteen out of twenty-five provinces, "landstingsområden", report average incidence rates of 45 or less per 100,000 inhabitants, which is clearly less than what could be expected in the light of the incidence observed in Malmö. Probably it indicates that a certain number of aphasic patients still do not get appropriate diagnostic and therapeutic facilities due to the lack of resources. This conclusion is substantiated by the fact that a weak but statistically significant positive correlation could be shown between the relative number of logopedes in a district and its reported incidence rates of aphasia ($r = 0.43$). On the other hand, our observed incidence of about 55 cases per 100,000 inhabitants in Malmö compares exactly with observations in Gothenburg 1962 (BROMAN & al., 1967), and it corresponds with reports from USA of about 60 per 100,000 inhabitants, caused by acute cerebrovascular disease (ALBERT & al., 1981).

We expected some correlation between the population density of the provinces and the average incidence rates of aphasia reported from these provinces. This was not the case nor did the number of logopedes per 100,000 inhabitants ($\bar{x} = 3.04$, $s = 1.52$) correspond to the population density of the provinces.

Besides the incidence figures, the inquiry provided information about the diagnostic and therapeutic care of the patients. As to the employed diagnostic procedures, one third of the informants reported to use tests, one third relied on informal aphasia examinations and the last third used a combination of informal methods together with selected suitable test items. Asked about the types of test, 87 per cent answered the "Huddinge test", a Swedish test strongly influenced by the Boston Diagnostic Aphasia Examination, whereas 78 per cent reported the use of a Swedish Luria examination. In the geographic distribution of diagnostic methods, some regional preferences for certain national test materials were observed, probably due to different influences from the three different schools for logopedes in our country.

Asked if they considered themselves to rely on any special school of aphasiology, many informants reported a combination of several schools. Among these the dependence on Luria's thinking was acknowledged in 87 per cent of the answers and the Boston school in 33 per cent. Of these, Luria was mentioned exclusively in 47 per cent, whereas the Boston school appeared as an exclusive answer only once. In eight per cent of the answers, the informants declared not to be influenced by any special school at all. From the answers to these questions it can be concluded that the earlier strong American influence on aphasiology in our country has been replaced by a very considerable impact from Luria's ideas.

Asked about their therapeutic approach, 94 per cent of the informants reported individual therapy sessions as their measure of choice, most often combined with special information for the relatives and the nursing personnel. Therapy is given by authorized logopedes but a majority of the logopedic departments reported that other kinds of personnel, mainly occupational therapists, are engaged in individual therapy as well. The overall number of patients reported in our inquiry to have started individual therapy for aphasia during 1986 is 1,936, which implies that such therapy was considered suitable on an average for 48 per cent of the diagnosed cases, although a considerable variation between the different provinces was observed ($s = 19$ per cent).

One third of the departments reported to use group therapy in addition to individual sessions. 260 patients received group therapy during the year 1986. Social and psychological stimulation of the patient was said to be the main motive for group therapy and, only occasionally, it seemed to be used because of lack of therapists. A minority of the answers mentioned the use of supervised training at home. Treatment by logopedes in private practice is not common in Sweden.

The number of sessions reported for each patient was 22 on an average ($s = 17.1$), with a frequency of one to two sessions a week with only few exceptions. Asked about their criteria for starting therapy, most informants mentioned the patient's mental, emotional and physical state, or his capacity to benefit from therapy, in the first place. Others stressed the patient's motivation for therapy, whereas criteria such as the patient's age, his professional state and the type or degree of aphasia were mentioned less frequently.

From the answers to the inquiry it can be concluded that practically no patient considered in need of therapy has been left untreated. On the other hand not less than 70 per cent of the informants complained that their therapeutic resources are insufficient. This seems contrary to the fact that only a minority reported to stop the therapy prematurely because of an insufficient number of logopedes being available. By far the most frequently mentioned criteria to stop are the lack of further progress (68 per cent); the patient's loss of motivation or satisfaction with therapy (41 per cent); or an adequate outcome of therapy according to the opinion of the logopede (27 per cent). At least in later stages of the aphasia syndrome, aphasia clubs tend to be of great help for an increasing number of aphasics. Recently aphasia clubs for patients and their relatives have been founded in every province ("län") of our country. Not less than 77 per cent of our informants reported that their patients can easily join an aphasia club. Those who cannot attend a club, live in smaller, rural places mainly in the North of the country. According to the answers to our inquiry, about one third of the newly diagnosed patients have contact with an aphasia club.

A questionnaire investigation like this greatly depends on the quality of each single answer. Taking this into account as a possible source of error as well as some minor artifacts in the incidence figures, as already pointed out, the general picture emerging from our results is an optimistic one. Even if resources seem inadequate especially in some less densely populated areas in the North of our country, and even if many of our informants complain of lack of positions for therapists, it seems that the vast majority of aphasic patients receive an adequate examination by an author-

ized logopede. Also, as a rule, patients considered in need of therapy receive some kind of treatment, even if this treatment may sometimes be somewhat insufficient. To conclude, in general a homogeneous and adequate provision for aphasic patients can be found in Sweden. Some exceptions, however, where inadequate resources are found, are discussed in detail and explained in the Swedish version of this paper.

Finally, to a non-Swedish auditorium, two peculiar consequences of the Swedish medical system seem worth mentioning: the scarcity of individual treatment in private practice; and the nonexistence of facilities for periodic intensive treatment of aphasia several hours a day.

	Malmö 1984	Sweden 1983*)
Number of inhabitants	229,000	8,187,000
Inhabitants in regions under observation		7,074,249
Incidence of CV disease	497	12,900
CVI per 100,000 inhabitants	217	182
percentage deceased during the year	18.9%	18%
Incidence of aphasia		
number of cases	118	
number relative to 100,000 inhabitants	51.5	
*) for a certain number of regions, no information was available		

Table 1

Incidence of acute cerebrovascular disease in Malmö and in Sweden at large

Place and time of study	Incidence
Malmö 1984	51.5
Malmö 1986	55
Sweden 1983	49.6
according to present study	

Table 2

Incidence of aphasia: number of cases related to 100,000 inhabitants

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