

# APHASIA GUIDE

Stroke of Hope Club, Inc.  
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# **APHASIA GUIDE**

published by  
**The Stroke of Hope Club, Inc.**

The Stroke of Hope Club, Inc., a not-for-profit organization, was founded in October, 1984. Our mission is to work toward increased awareness of stroke prevention, improved community education, and -above all- to provide information, education and support to stroke "victors", their families and friends. The Stroke of Hope Club, Inc. provides information, advocacy, and referral services to all stroke "victors", their families and friends, recognizing that no two strokes are the same and no two families coping with stroke do so in the same way.

This "Aphasia Guide" is provided to you as an educational tool. The information to follow is designed to help you and your family better understand aphasia and other disorders of communication related to stroke. Stroke victors and their families have reported that the Hope Help Guide was instrumental in assisting them in their journey to the "new normal" of life after stroke. We are hoping that this "Aphasia Guide" will offer the same level of support.

On page 23 of this Guide you will find the "APHASIA card". We highly recommend that this card or a copy of this card be placed over the patient's bed and in their chart. This will remind professionals and visitors of the unique communication needs of the stroke victor with aphasia.

Our volunteer "Rehab Buddies" are prepared to help you further. The "Rehab Buddy" program at the Stroke of Hope Club, Inc. involves a weekly telephone contact from a volunteer who provides support for a stroke victor and/or a family member. This program has made a huge impact in the lives of many stroke victors and their families.

If you would like to learn more about our Rehab Buddies program, or have any questions about life after stroke, please contact the Stroke of Hope Club, Inc. at: (561) 627-2202. This is our "virtual" phone number. Simply leave a message and we will return your call as soon as we are available.

We also invite you to visit our website: [www.strokeofhope.com](http://www.strokeofhope.com).

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## the aphasia quiz

Do *you* know the facts?

Please check either true (T) or false (F) for each statement.

1. Most people are familiar with aphasia.  
 True  False
2. Aphasia means a person has difficulty retrieving words for speech and usually has some problems reading, writing and understanding spoken language.  
 True  False
3. The cause of aphasia is usually due to a heart attack.  
 True  False
4. If people have aphasia they will always have significant memory loss as well.  
 True  False
5. Aphasia is more prevalent than Parkinson's Disease or Muscular Dystrophy.  
 True  False
6. A person with aphasia may have no noticeable physical impairment.  
 True  False
7. All individuals with aphasia have very similar symptoms of the same approximate severity.  
 True  False
8. Although most people with aphasia are older than 50 years of age, it is not unusual for younger people to acquire this disability.  
 True  False
9. Some individuals with aphasia return to work, however, most are forced to retire or change jobs and work in a modified capacity.  
 True  False
10. Recovery from aphasia is usually complete within six months of treatment.  
 True  False

## ANSWERS

1. FALSE -- Most people have never heard of aphasia. The general public frequently misinterprets the difficulties an individual with aphasia is experiencing and may react as though the person is psychologically ill or mentally retarded. Feelings of social isolation with resulting emotional effects are common to individuals with aphasia.
2. TRUE -- Aphasia is an acquired communication disorder that impairs an individual's ability to use language. The primary symptom is an inability to express oneself when speaking, however, in some cases, reading and writing or understanding of speech can be the more impaired language modality.
3. FALSE -- The most frequent cause of aphasia is a stroke (but, one can have a stroke without acquiring aphasia). It can also result from head injury, cerebral tumor or other neurological causes. Consequently, the onset is usually sudden, although rare cases of progressive aphasia in adults and childhood/developmental aphasia have been documented.
4. FALSE -- Although a person with aphasia can have difficulty retrieving words and names, memory of situations, appointments, people and general knowledge remain relatively intact. The ability to access ideas and thoughts via language is disrupted.
5. TRUE -- It has been estimated that one million Americans or 1 in 250 people have acquired aphasia. About 2/3 of these are the result of strokes and 1/3 are head injured persons.
6. TRUE -- But most people with aphasia also have right sided weakness or paralysis of the leg and arm. This occurs because the left side of the brain is the side generally damaged when a person has aphasia, and it also controls movements on the right side of the body.
7. FALSE -- There are many types of aphasia. They are generally classified as either non-fluent or fluent. Specific symptoms can vary greatly; however the commonly shared symptom is an impaired ability to use language. The severity of aphasia symptoms can range from very mild to very severe. When there is almost total impairment of all the language modalities (i.e., speaking, writing, reading, listening) the condition is referred to as global aphasia.
8. TRUE -- A widespread misconception is that only older people suffer strokes. In fact, young adults as well as children can sustain strokes, but in such instances it is usually secondary to a pre-existing medical condition.
9. TRUE -- There are very few jobs that do not require speech and language skills. Individuals with mild or even moderate aphasia are sometimes able to return to work, but often with some changes in job responsibilities and a reduced work load.
10. FALSE -- Approximately half of those who initially show symptoms of aphasia recover completely within the first few hours or days. This is known as transient aphasia. If the symptoms of aphasia persist beyond the first 2-3 months after a stroke, a complete recovery is unlikely. Increased functioning is usually achieved through spontaneous recovery and speech therapy. Recovery is a slow process that usually requires a minimum of a year of treatment including helping the individual and family understand and adjust to long term deficits.

*Original Publication Date: 1988*

*For more information contact:* National Aphasia Association (NAA) [www.aphasia.org](http://www.aphasia.org) toll-free (800) 922-4622

## Aphasia and the Law

*Editor's note:* Unnecessary arrests, inappropriate proceedings and misguided decisions have resulted when police officers, attorneys, and judges have been ignorant of aphasia. In addition to the NAA's Fact Sheets about aphasia and its impact, the following resources have proven helpful in some cases:

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities, employment, public accommodations, transportation and other areas. The American Speech-Language Hearing Association (ASHA) has a list of articles that interpret the ADA ([www.asha.org/about/leadership-projects/multicultural/readings/ada~htm](http://www.asha.org/about/leadership-projects/multicultural/readings/ada~htm)). Much of the information relates to other communications disabilities such as deafness, but some is relevant to people with aphasia. Contact ASHA Office of Multicultural Affairs, 10801 Rockville Pike, Rockville, MD 20852, (301) 897-5700, [www.asha.org](http://www.asha.org). For information on filing complaints under the ADA contact the US Department of Justice, [www.usdoj.gov](http://www.usdoj.gov), 800-514-0jOI.

Legal Aspects of Aphasia, American Bar Association and the American Speech-Language Hearing Association, 1983, 23 pages. The paper discusses several cases relating to aphasia. Issues include the competency of people with aphasia to create and change wills, to act as a witness, and the right to serve on a jury. Other issues raised were cases of unethical conduct by attorneys who defrauded people with aphasia. While the article has not been updated, it may serve as the starting point for further research. A copy is available from the NAA.

Law Enforcement Response to Persons with Aphasia, Police Chief Magazine, December 2004. Written by a police officer and the Executive Director of the NAA, the article explains aphasia and sets for appropriate responses when encountering a person with aphasia.

# Understanding Aphasia

## INTRODUCTION

Understanding the plight of the person with aphasia is virtually impossible for most caregivers. But suspend your disbelief for a moment and imagine that you are suddenly stranded in a world where only one language is spoken. You are the only person who cannot speak or understand that language. In addition, you are unable to move one side of your body, and, to make matters worse, you need to locate a bathroom immediately. This fantasy should give you a beginning appreciation of some of the frustrations experienced by individuals with aphasia.

Aphasia, the most common language disorder of adults, is usually caused by a cerebrovascular accident (CVA, or stroke). A stroke is a sudden loss of brain function that occurs when normal brain perfusion is suddenly impaired. Over half of all people who suffer strokes experience speech or language disorders that adversely affect communication.

## WHAT IS APHASIA?

Aphasia is a partial or complete loss of one's ability to speak, gesture, understand spoken words, read, write or calculate. Individuals may be affected in one or more of these areas. In most people, the loss is partial. Stroke (CVA) is the most common cause of aphasia.

## MATCHING IMPAIRMENT TO THE AFFECTED AREA OF THE BRAIN

Two large globes – the right and left cerebral hemispheres – constitute the “thinking” areas of the brain. The cerebral hemispheres sit on top of the cerebellum, a smaller globe that extends down to form the spinal cord. Speech is controlled by the left hemisphere of the brain, and injury to this area results in aphasia. The right cerebral hemisphere is the “nonverbal” area.

Doctors once thought that a left-brain stroke would not produce aphasia in a left-handed person. We now know that between one-third and one-half of all left-brain strokes will produce some degree of aphasia, regardless of whether the afflicted individual is right- or left- handed.

## TYPES OF APHASIA

There are many different ways of classifying aphasia. One method is based on the person's ability to send (express) and receive (understand) information. Speaking, reading, writing and mental competence are all distinct brain functions. A deficit in one function does not necessarily mean a loss in other areas, although they may overlap

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Three of the five language functions affected by aphasia – speaking, gesturing and writing – involve sending or expressing information. Two functions – reading and understanding speech – involve receiving information. Also, understanding gestures and presymbolic communication (such as pictures) may be affected. People with stroke who have difficulty sending information are said to have an expressive aphasia. People with difficulty reading or understanding speech are said to have receptive aphasia.

Although the adjectives *expressive* and *receptive* describe the person's communication problem, these terms do not delineate the nature of the aphasia. There are many different types of expressive and receptive losses, although some types occur more frequently than others.

To achieve a more precise description of the communication loss, aphasia is sometimes classified into *fluent* (receptive), *nonfluent* (expressive) and *mixed* or *global* aphasia, then subclassified further:

- **Fluent (receptive) aphasias.** People with fluent aphasias are most severely impaired in their capacity to understand (receive) information. Visual and auditory functions are unimpaired, but the people find reading and understanding speech difficult or impossible. Wernicke's aphasia is the most common of the fluent aphasias.
- **Nonfluent (expressive) aphasias.** People with nonfluent aphasias have difficulty expressing themselves. Most people think of Broca's aphasia as synonymous with expressive aphasia. Affected people find it difficult to retrieve words. They speak slowly and omit short but important words (such as "by" and "if").
- **Mixed or global aphasias.** People with this type of aphasia have difficulty expressing and receiving information. The designations mixed and global correspond to the severity of the deficit. Global aphasia is the most severe, and people with this disorder have lost most or all of the skills necessary for communication.

Source: Joan K. Blickstein, ed., *Focus on Geriatric Care and Rehabilitation*, Vol. 1:9, Aspen Publishers, ©1988

## Types of Communication Impairments

**Aphasia:** Aphasia refers to the impairment or loss of the power to speak, write, gesture or comprehend spoken, written or gestured language. Most stroke patients will not lose all of their faculties, but many suffer impairment in one or more of these areas.

**Expressive Aphasia:** This disorder refers to impairment in expressed speech. In simply expressive aphasia, the patient knows what he or she wants to say, but cannot find the words to say it. It is as if the patient is continually experiencing a situation in which the word or words are on the tip of the tongue, but the patient is unable to remember the vocabulary necessary to say the thought.

In mild cases, only an occasional word or two is lost, and the communication can proceed fairly normally. In more severe cases, most or all words can be lost, and the person needs to find an alternative means of communication.

**Receptive Aphasia:** This disorder involves an impairment in which the patient cannot understand the spoken word. This can be a very frightening experience for the patients. In mild cases, only an occasional word or two sounds garbled or incomprehensible, and communication can proceed because the patient is able to get the essence of the communication based on the context.

In severe cases, the patient may experience most or all of the communication as if nonsense syllables are being spoken. Many of the so-called behavior problems seen with patients with receptive aphasia occur because of this frightening and disabling condition.

In moderate cases the patient is able to understand part, but not all of the communication. Sometimes, when patients appear to be noncompliant, it is because they have misunderstood the communication in the first place.

**Word salad:** This condition is more formally known as “paragrammatism” or “extended paraphasia” and it refers to running speech that is logically incoherent. That is, the patient’s speech may flow forth without hesitation, and may even have what sounds like appropriate intonation. However, the words and phrases spoken are without meaning.

The difficulty with this disorder is that the patient usually does not realize that his or her spoken language is meaningless to others.

**Written language:** Often, patients experience not only a loss of spoken language, but a loss of written language, as well. Words, letters, or numbers may appear foreign or incomprehensible. Attempts to write may be filled with real or imagined letters that make no sense to others.

With time and training, the person may be able to understand to comprehend more complex written language, like sentences or paragraphs. The extent of the recovery in this and other areas depends in large measure upon the degree of damage sustained in the first place.

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**Apraxia:** Apraxia refers to the loss of voluntary movements as a consequence of the nervous system's breakdown of communication between the brain and the muscles. In this case, the patient may know what he or she wants to say and know the word to use, as well. The difficulty is in knowing what to do with the muscles of the tongue and lips to make the word come out. For example, a patient might say, "I apperterate...I appenterate...oh, you know...your help" in an attempt to say "I *appreciate* your help." Such a patient is unable to get the tongue and lips to formulate the word.

The problem can also make it difficult for patients to use gestures to communicate their needs. For example, a seemingly simple alternative to saying "yes" or "no" is to nod one's head in the affirmative or shake one's head in the negative. Unfortunately, the arrangement of musculature in the head and neck muscles makes it easier to nod the head and shake it. The result is that the patient may nod *yes* when he or she means *no*. (The reliability of a patient's yes/not response is routinely assessed by speech pathologists, and they can evaluate the usefulness of this type of nonverbal communication.)

The presence of apraxia is the main reason that speech pathologists don't routinely attempt to teach aphasic patients sign language to compensate for spoken language difficulties.

## Suggestions for Communicating with Aphasia Patients

- Continue to treat aphasic patients as the mature adults that they are.
- Regard patients as communicating individuals even though they may not understand what you are saying. Don't bombard them with too much speech or too many people talking.
- Do not talk about patients in their presence, even if they appear comatose or show no indication of comprehension of speech. Don't assume that because patients are not reacting or because they can't speak that they do not understand.
- On the other hand, don't assume that patients do understand.
- Remember that aphasic patients get cues from the environment, gestures and facial expressions. The patient's ability to grasp the meaning of what is said may be due to these situational cues rather than to an understanding of the actual words.
- When speaking to a patient, stand on the uninvolved side so you will be within his or her visual field.
- Keep communication short and simple and accompany it with gestures.
- Speak in a natural voice. Unless you know there is a hearing loss, don't assume that by speaking louder the patient will understand better.
- If the aphasic patient's "yes" and "no" responses are reliable, ask direct questions requiring these responses rather than ones necessitating a complex answer.
- Allow the patient to attempt to speak.
- Where there is a word-finding problem, give patients the opportunity to recall the word themselves; supply a word only when you see that a patient is becoming overly frustrated.
- When a patient becomes frustrated at the inability to recall a word and you know the word he or she is searching for, you may help by setting up an automatic speech situation such as sentence completion. If you say, "I want a drink of \_\_\_\_\_" and then pause, the patient may be able to fill in the word.
- If the patient has little or not intelligible speech, play "20 Questions" with words or gestures depending upon his or her comprehension.
- If it is impossible to understand the patient and 20 Questions has not been effective, tactfully change the subject or suggest that the patient skips it for the moment and come back to it later. Availability of vocabulary is often very inconsistent.
- Encourage the use of greetings and other verbal social amenities. Not only do they serve as models for the patient to copy, but also they are automatic speech responses that he or she may be able to make.
- Don't correct the patient's errors. Rather, restate what you think he or she was saying. This will help establish whether you understand what was said and give the patient an opportunity to hear the correct version.

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- Be alert for delayed responses in the patient who can respond if given enough time to do so
- Give increased time to respond; don't push responses.
- Repeat questions; rephrase in a different way.
- Focus on abilities versus disabilities.
- Push self-care and tangible, achievable goals.
- Focus on language for the patient's immediate, specific needs (e.g., help the patient to ask for the bedpan rather than to name body parts).

Courtesy of Hilltop Health Services Corporation, Hilltop Rehabilitation Neuro-Team, 1100 Patterson Road, Grand Junction, CO 81506

# Communication Tips for the CVA Patient with a Speech or Language Disorder

- Attempt to keep the patient oriented to person, time, date, place and events. Mention what is scheduled to happen each day. Since the aphasic patient can be distractible and have low tolerance for abrupt changes, warn him/her in advance of unusual occurrences and treatments. Also, explain to the patient what has happened. The patient may fail to realize the cause of his or her condition and will feel reassured if given intelligent, sincere explanations.
- The patient must be treated as an adult and allowed to maintain his or her former status with the family. Be natural and encourage participation whenever possible.
- Unless the aphasic patient has a definite hearing loss, do not raise your voice to make yourself understood. The aphasic patient has difficulty understanding the meaning of spoken language, and it sounds jumbled or foreign to him/her. Rather than shouting or continually repeating yourself, *simplify* and *rephrase* your statements. Keep things short and to the point. Use appropriate gestures, objects or pictures.
- Do not talk about the patient in his or her presence. Include the patient in conversations and decisions.
- Allow the patient ample time to respond to questions and instructions. Most aphasic patients require more time to process incoming and outgoing messages. Let the patient try to speak *before* you supply the word for him or ask further questions to determine the message.
- Encourage the use of greetings and social conversation, such as “Hello”, “Thank you,” “how are you,” etc. These automatic expressions are relatively easy for the aphasic patient to say and help promote feelings of adequacy.
- Keep the patient in a social world to help prevent withdrawal and depression. Provide access to television, radio, visitor, and other patients. Direct stimulation and continued attempts at communication are extremely important and provide language experiences that can trigger linguistic associations.
- Keep instructions and explanations simple. If the comprehension problem is severe, single-word instructions may help the patient to recall words and make understanding easier. Try to keep your conversations geared to the patient’s immediate needs and surroundings.
- Ask direct questions requiring “yes” or “no” answers. Encourage gestures and pointing whenever possible. Frequently this will enable the patient to say the word, and can help reduce frustration.
- Use routine activities for speaking and reinforcing therapy techniques. Meal, dressing, medication and exercising times are good opportunities to encourage this. Let the patient ask for what he or she wants. Provide the names of the objects in use, and describe the function if patient is unable or has difficulty. Orient the patient to the task.

# Simple Communication Boards for People Who Are Nonverbal

## PREPARATION

1. Select up to four things the person must tell you. *Examples:* I need to use the bathroom; I want a blanket; I am thirsty; I am tired.
2. Find a picture to illustrate each need. The simpler the picture, the better.
3. Paste or mount the pictures on a firm background, such as a file folder, leaving a space between each picture.
4. Using single words, print a response word under each picture. *Example:* under a glass of liquid, write DRINK or THIRSTY.

## USE

1. Place the communication board where the person can see and touch it.
2. Touch one picture, and say the word written underneath.
3. Have the person point to the picture. It is not necessary for the person to repeat the word. The goal is that the person point to the correct word.
4. Repeat for the rest of the pictures.
5. Now have the person point to each picture by saying, "Show me (thirsty)."
6. Once the person can point to the pictures correctly, you can say, "Show me what you need."
7. Use the communication board each time you think the person needs help expressing his or her needs.
8. When the person is able to use the pictures on the board, try adding more pictures.

## More about Patients with Aphasia

- The patient may have trouble expressing his or her own thoughts and feelings or understanding the speech or writing of others.
- The patient often says things automatically (without specific meaning) in certain situations.
- The patient often uses profane language without meaning to.
- The patient is often able to count, recite poems, or sing songs, despite even a severe lack of speech.
- The patient often has to stop after a few words to think of the next word.
- The patient may be able to repeat words once he or she has heard them yet find great difficulty in eliciting these words spontaneously.
- The patient often becomes confused when conversation shifts from person to person quickly.
- The patient may have difficulty understanding television and radio
- The patient usually has a short attention span.
- The patient finds it difficult to shift from one activity to another quickly.
- The patient fluctuates in abilities from day to day.
- The patient often has good memory for events that occurred before the onset of aphasia, but poor memory for recent events.
- The patient is not mentally retarded but may have difficulty thinking as clearly as before.
- The patient may show personality changes.
- The patient usually gets tired more easily than he or she did before the onset of aphasia.
- The patient may lose interest in some of the activities he or she was interested in before the onset of aphasia.
- The patient frequently laughs or cries for no apparent reason.
- The patient may pay greater attention to details of time and cleanliness than he or she did before the onset of aphasia.
- The patient may find it easier to read words written in large type than words written in small type.
- The patient may not wish to learn to write with the left hand.
- The patient may have facial paralysis that causes drooling or food to lodge on the affected side of the mouth.
- The patient may not wish to see many friends and relatives until he or she has made a greater adjustment to the communication disability.
- The patient may continue to perform a task over and over when it is no longer appropriate. This perseveration is usually accentuated by fatigue. It may be verbal or motor.
- The patient may feel inadequate and demand more personal and social attention than in the past.

continued

## REACTIONS OF ADULT PATIENTS WITH APHASIA TO THEIR APHASIA

“The first few months you don’t know what happened. The next few months you begin to wonder what to do.”

“All I wanted to do was sleep at first.”

“I decided I had better find out what was wrong when I couldn’t remember my daughter’s telephone number, and then I couldn’t remember her name to look it up, and then when I was told her name I couldn’t read the numbs.”

“I can’t organize anything.”

“My mind is a catalogue of numbers and I’ve forgotten m catalogues.”

“Aphasia is what someone says who can’t think”.

Q: What brought you to the hospital?

A: “My ‘remembrance’.”

Q: Do you have trouble speaking?

A: “Not exactly, it just takes me longer sometimes to get it out.”

“Sometimes I have a block for the whole idea as well as for a specific word. When it is a block for the whole idea, I may have nothing more than a general feeling what I want to talk about but I don’t know how to start to say it.”

“I have trouble discovering the word.”

“You almost recall the word – you can almost hear it-it’s just two neurons away.”

“I know the word but I can’t use them.”

“My head feels scrambled.”

“That aphasic is like me, he looks good at first.”

“The words are under two layers of dirt and I just have to dig.”

“I always remember but I can’t say it.”

“I am not worried about my syllables – they’ll come on their own-it’s my ideas I am worried about.”

“I can’t remember the picture of the word.”

“It’s harder to talk to children, because adults flatter and children just say, “You don’t talk good.””

“I know what I a going to say but the wrong word comes out.”

“When this came on, I tried to ask the doc, ‘Can a stroke be avoided?’ But I could only grunt like a pig.”

## HELPING THE PATIENT WITH HIS OR HER LANGUAGE AND SPEECH DEFICITS

- It will aid the patient greatly if you assist him/her in recalling the names of his/her body parts. As you help him/he wash an arm, say the word “arm” deliberately. Say it more slowly, but make certain that you say “arm” as a whole word and not as a series to individual sounds.

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- Avoid pressuring a patient to utter a complete sentence. If the patient says only the essential words, show pleasure over such speech efforts. Brief utterances made during early post-traumatic days are most acceptable efforts and should be praised.
- Should the patient indicate a desire to be helped with a word, pronounce it slowly and distinctly. Directions regarding correct use of speech musculature are handled by the speech clinician during the therapy sessions.
- Anticipating what the patient is trying to say by voicing it for them markedly impedes progress in speech and language development. Always encourage patients to speak and do for themselves, but NEVER make an issue over the patient doing it.
- If the patient swears or voices emotional utterances, avoid any show of disapproval. To express annoyance or reprove a patient only inhibits attempts at communication and may cause withdrawal into his or her shell. The patient will then avoid all efforts to speak.
- Try to phrase your questions so that the patient may answer with a “yes”, or “no”, or nod or shake the head. Remember that many patients have these responses confused, so practice in answering yes and no consistently can be helpful. Also, nod your head as you use affirmative and negative phrases to add visual and gestural input.
- Let patients express themselves on their own speech and language level. Exert every effort to understand what the patient is trying to tell you. This may be in words, distorted syllables or pantomime.
- If the patient cannot understand simple, short, single phrases or sentences, use gestures and writing (printing) as well.
- Other means of substitute language than might be effective are visual aids, such as charts, pictures, flip card files, or books especially designed for the purpose with pictures to which the patient and nurse can point.
- Allow ample time to respond to questions. Most patients with aphasia have a reduced response latency and require more time to process incoming and outgoing messages.
- Don't force speech when the patient is fatigued.
- The patient should not be made to perform speech or language activities for an audience or group of visitors. This can be embarrassing for the patient, and the anxiety associated with being on the spot can impair the ability to produce correct responses.'
- Stimulate patient with TV, radio, etc. Exposure to a variety of language forms may trigger linguistic associations in the patient and enable the patient to say a new word.

## **About Dysarthria**

*Dysarthria* is a term used to refer to deficits in muscular control over the speech mechanism which results from damage of the nervous system. The problems of oral communication are due to paralysis, weakness, or incoordination of the speech musculature – which includes the lips, tongue, soft palate, and throat. As a result, speech is impaired to varying degrees, depending upon the severity of the muscular control deficit. Dysarthria may manifest itself in a mild form, such as occasional slurring or certain speech sounds, or a severe deficit that may cause speech to be nearly unintelligible. In addition, the dysarthric patient may experience drooling on the right side because of muscle weakness and decreased sensation.

# Apraxia in Adults

Apraxia (also referred to as apraxia of speech, verbal apraxia, or dyspraxia) is a motor speech disorder caused by damage to the parts of the nervous system related to speaking. It is characterized by problems sequencing the sounds in syllables and words and varies in severity depending on the nature of the nervous system damage. People with apraxia know what words they want to say, but their brains have difficulty coordinating the muscle movements necessary to say those words and they may say something completely different, even nonsensical. For example a person may try to say “kitchen”, but it may come out “bipem”. The person will recognize the error and try again, sometimes getting it right, but sometimes saying something else entirely. This can become quite frustrating for the person.

## Characteristics of Apraxia

- Difficulty imitating speech sounds
- Possible difficulty imitating non-speech movements, such as sticking out their tongue (oral apraxia)
- Groping for sounds
- In severe cases, an inability to produce sound at all
- Inconsistent errors
- Slow rate of speech
- Somewhat preserved ability to produce “automatic speech”, such as greeting like “How are you?”
- Can occur in conjunction with dysarthria (muscle weakness affecting speech production) or aphasia (language difficulties related to neurological damage)

## Treatment

A speech-language pathologist works with people with apraxia to improve speech abilities and overall communication skills. The muscles of speech often need to be “retrained” to produce sounds correctly and sequence sounds into words. This occurs through exercises designed to allow the person to repeat sounds over and over and practice correct mouth movements for sounds. The person with apraxia may need to slow their speech rate down or work on “pacing” their speech so that they can produce all of the sounds necessary for their message. In severe cases, alternative means of communication may be necessary, such as the use of simple gestures or more sophisticated electronic equipment.

# FAMILY ADJUSTMENT TO APHASIA

Richard S. was a senior manager at a small company and next in line for a vice presidency. His wife worked as a free-lance writer. They had three active teenagers. Life had its ups and downs, but overall it was quite comfortable – happy marriage, ice home, occasional travel, and a close circle of friends.

One night that all changed. Richard had a massive stroke that left him with a paralyzed right arm and leg. He also had aphasia. He could not speak intelligibly, and he understood little of what people said to him. He had difficulty reading and writing. He also had trouble swallowing. When his children visited him in the hospital, he couldn't follow their activities and busy schedules. He felt so removed from them.

## **Worries**

Sara was worried about Richard's health but she had other worries, too. How would the mortgage be paid? Would she be able to work, raise the children, and assume her husband's household responsibilities? Who would she rely on? Richard always gave her good support and advice, but he couldn't now. What about the physical intimacy they enjoyed? Sara felt she was being selfish, but she also felt overwhelmed, alone, and angry that this had happened to her. She even blamed Richard – if only he had watched his diet and exercised more!

## **Changes**

Changes that result from aphasia are sudden, unexpected, and unwanted. Adjustment is difficult for the person with aphasia. It also presents a great challenge to the family.

There may be tension among family members and feelings of frustration and helplessness. The condition may seem hopeless. Children may feel neglected and may find it difficult to have a parent dependent on them.

“An individual's aphasia is a family problem.”

*-Davis, G. A. (1983). A survey of adult aphasia. Englewood Cliffs, NJ: Prentice Hall, p. 290*

With problems other than aphasia, conventional advice is to “Open the lines of communication” and “talk it out.” However, diminished communication ability is the defining feature of aphasia. Consequently, the main way to adjust to most problems is blocked.

Despite communication barriers, there are ways that family members can help their loved one with aphasia as well as helping themselves.

continued

## **Information Needs**

Families need information about stroke and aphasia as a first step in the adjustment process. A speech-language pathologist certified by the American Speech-Language-Hearing Association can conduct a comprehensive evaluation of language and related abilities and provide general reading material and information about the specific communication needs of the person with aphasia. The speech-language pathologist can also explain the personality changes that may follow stroke and make referrals to other professionals. Because different problems arise at different times, this information sharing should be an ongoing process.

Family members easily recognize expressive language problems in aphasia – difficulty finding the exact word, using an incorrect or “made-up” word, making mistakes in grammar, or unintentionally using profanity. But they may not realize that problems in understanding language also accompany aphasia. Once they grasp this fact, they may feel less frustrated when their loved one appears inattentive or uncaring.

Following an in-depth evaluation, the speech-language pathologist can provide realistic expectations for the recovery of communication skills. Recovery frequently depends on the severity of the aphasia and the area of the brain that has been damaged.

## **Coping Strategies**

Feelings of frustration at the inability to communicate can lead to anger and depression. Persons with aphasia may tire easily and show extreme emotional fluctuations and inappropriate emotions – laughing when something isn’t funny or crying for no apparent reason, particularly early in the recovery process. They may also seem very self-absorbed and show an intense need for an unchanging routine. Feelings of guilt and embarrassment are common.

Family members may also feel strong emotions – anxiety, anger, confusion, depression, despair. The marriage changes, and partners may feel a sense of loss. It is natural to go through a grieving process when a family member develops aphasia, and family members need to be helped through this process.

There are some strategies that family members can follow to help them cope with such an emotional upheaval:

- Join a self-help group. At the national level, the National Aphasia Association ([www.aphasia.org](http://www.aphasia.org)) is available. At the local level, support groups for spouses and other family members, such as stroke clubs sponsored by the American Heart Association ([www.americanheart.org](http://www.americanheart.org)) can suggest coping strategies and help people feel less alone. Local hospitals also may have stroke clubs. Friends and other family members may be sources of support as well.
- Involve the person in family decision-making as much as possible.
- Give the person time to talk. Don’t speak for him/her.
- Simplify sentence structure, and reduce your own rate of speech.
- Use natural gestures to help the person with aphasia understand you.

continued

- Communicate through touch.
- Acknowledge and verbalize the frustration your loved one feels at not being able to communicate effectively.
- If necessary, make more comments and responses rather than asking questions or making demands. You may need to assume more responsibility for starting a conversation and keeping it going. When a misunderstanding occurs, paraphrase or repeat more simply. A speech-language pathologist can show you ways to help with newly learned communication strategies. If an alternative form of communication is recommended such as a communication board, you should be directly involved in the planning process.
- Be actively involved in continuing evaluation and treatment. Inform the speech-language pathologist about strategies that have worked for you and your family.
- Take care of personal needs – get enough sleep and maintain social contacts.
- Keep up with leisure activities. Consider this necessary rather than selfish.
- Avoid making other major life changes, like moving, at this time.
- Seek additional counseling services as necessary.

### **Communication Skills**

Family members also can help the person with aphasia develop new skills to compensate for the communication problems. Some suggestions include:

- Continue to talk to the family member with aphasia.
- Tell the speech-language pathologist about the means of communication that the family finds best.
- Talk to the person as an adult and not as a child.
- Have appropriate expectations for speech and language, but accept attempts at communication through whatever means possible. The person with aphasia may be able to communicate successfully using gestures instead of speech, or as a supplement to speech.

# **A\*pha' sia** **(uh fay' zhuh)**

**I have Aphasia resulting from a brain attack  
or head injury and it may be hard for  
me to speak, read or write.**

**Please be patient, I have difficulty retrieving  
words, but my intelligence is basically intact.**

**Do not ask me medical questions or  
to sign papers  
without my caregiver present.**

**Remember I may not be able to  
tell you I am in pain.**

