CRRN review
Dysphagia and Communication Disorders

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(based on slides from Lisa Stanley, M.A., CCC-SLP from Tampa General Hospital)

Learning Objectives
Swallowing

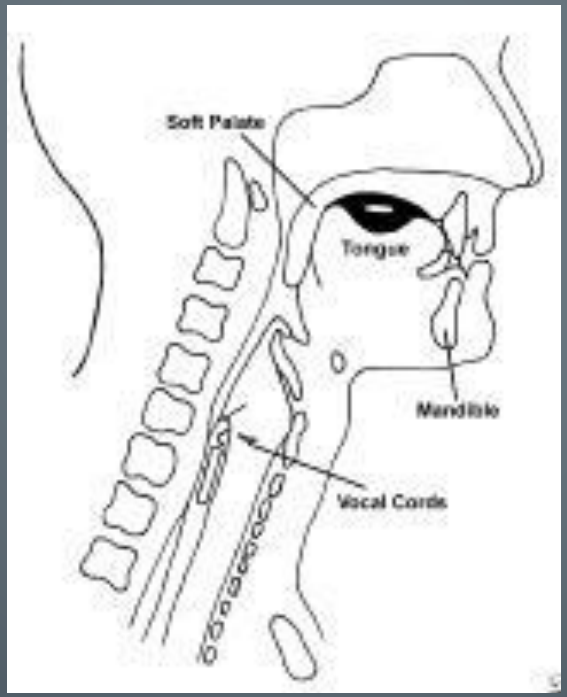
- Describe the normal process of swallowing
- Discuss the assessment process for a patient with a swallowing disorder
- Describe the interventions used in treating swallowing disorders
- Delineate team member roles in managing a swallowing disorder

Normal Swallow Function

- A complex physiologic act in which food and liquid passes from the mouth to the stomach.
- Consists of four stages
  - Oral Preparatory Stage
  - Oral Stage
  - Pharyngeal Stage
  - Esophageal Stage

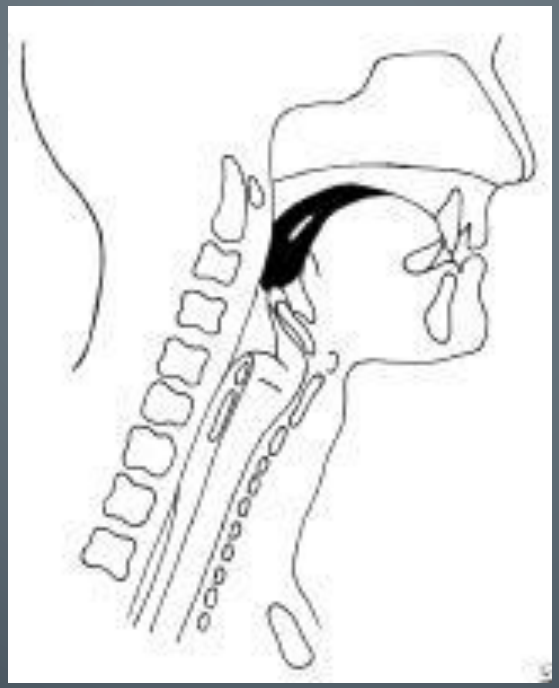
Phases of the Swallow

- 1. Oral Prep Phase-Cognitive awareness or bolus presentation; ability to move bolus to mouth



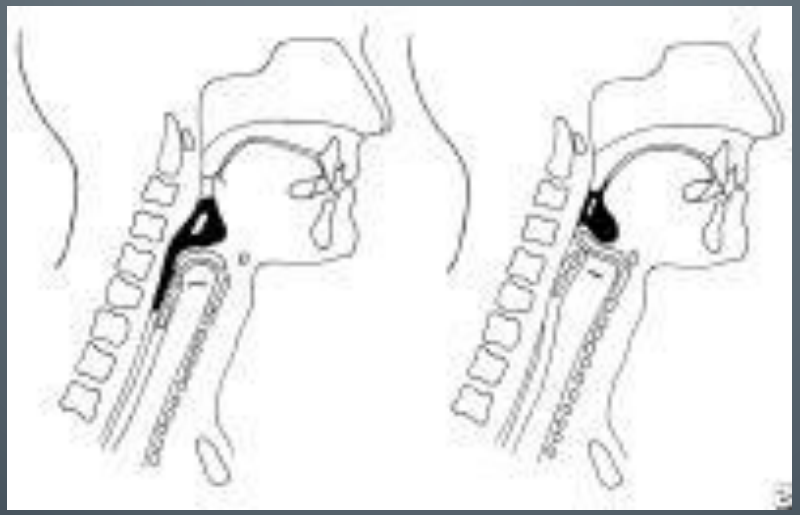
Phases of the Swallow

- 2. Oral Phase- Mastication-rotary chew; salivary glands soften bolus to cohesive texture. Bolus moves back to faucial arches to trigger swallow (3-5 seconds; up to 10 for elderly)



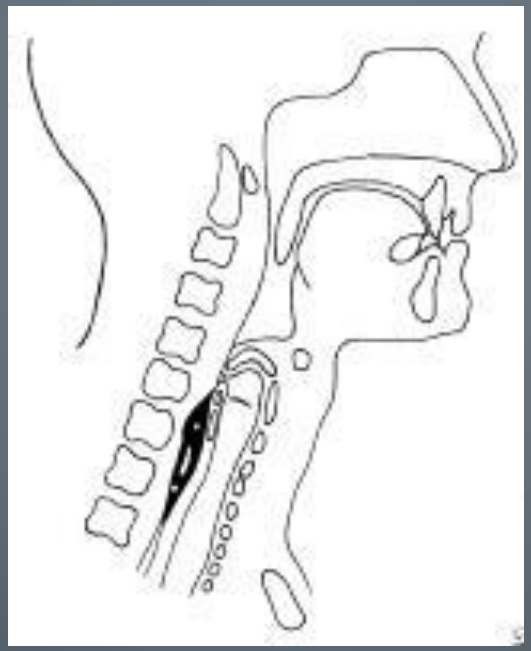
Phases of the Swallow

- 3. Pharyngeal Phase- Hyoid moves larynx up and forward bringing the epiglottis down to cover airway. Closing of vocal cords adds extra protection to airway. Cricopharyngeal sphincter relaxes to allow food to go through esophagus(1 second).



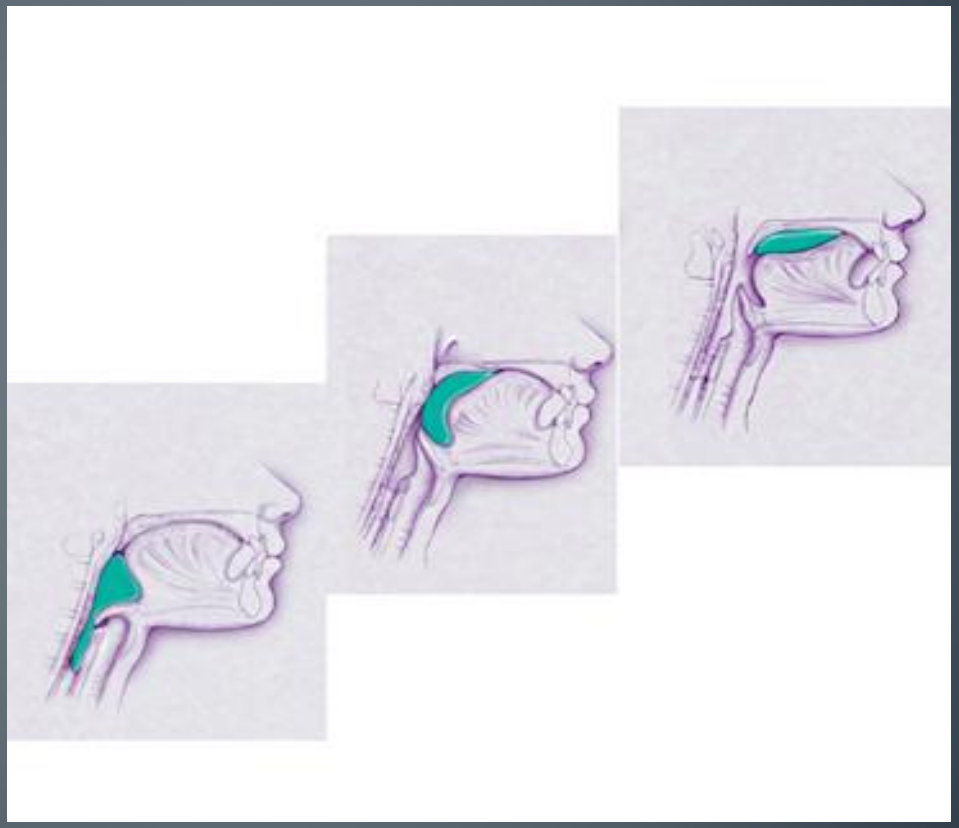
Phases of the Swallow

- 4. Esophageal Phase- Peristalsis moves food through the esophagus to the stomach (8-20 seconds).



Physiology of swallowing

Normal swallow



Dysphagia

- Dysphagia is the inability to swallow or a difficulty with swallowing. Dysphagia is most commonly associated with neurological or structural damage.
- Speech Pathologists evaluate and treat swallowing disorders

Anatomy and Physiology of Swallowing

- Epiglottis

Cartilage covering the airway

- Hyoid

Brings larynx up and forward

- Valleculae

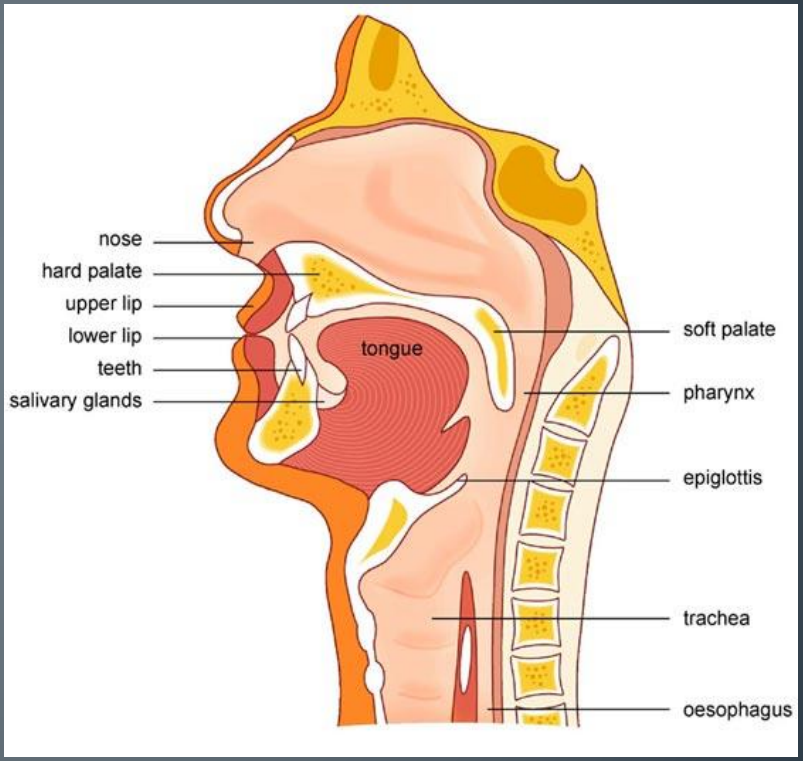
Space or pocket above epiglottis

- Pyriform sinuses

Pockets in pharynx around airway

- Cricopharyngeal sphincter

Opens up the esophagus allowing food to pass through to the stomach



Cranial Nerves Involved in Swallowing

- CN V- Trigeminal
- CN VII-Facial
- CN XII-Hypoglossal
- CN IX-Glossopharyngeal
- CN X-Vagus
- CN XI-Spinal Accessory

Other Neurologic Components

- Cerebral cortex:
  - controls voluntary movement needed for swallowing
- Brainstem:
  - controls involuntary movement needed for swallowing

Who's at Risk?

- Neurological deficits:
  - brainstem strokes / tumors
  - cortical strokes / tumors
  - Acquired brain injury (anoxic, traumatic)
  - ALS
  - MS
  - CP
  - Parkinson's disease
  - Dementia/Alzheimer's Disease
- Head and Neck Cancer
- GERD
- Esophageal Stricture
- Burn victims
- Cardiac
  - CABG: damage to recurrent laryngeal nerve
- Respiratory:
  - trach/vent/COPD-
- Deconditioning:
  - Transplant, ICU or long term patients
- Poisoning
- Burns
- Medication induced
- Normal aging

Signs and Symptoms of Dysphagia

- Difficulty managing oral secretions, drooling
- Weak or absent volitional cough or swallow
- Weak mouth and tongue movements
- Frequent throat clearing
- Choking on food, liquid, saliva
- Food sticking in throat
- Weight loss and/or dehydration
- Frequent chest infections
- Loss of appetite
- C/o heartburn/acid reflux
- Pain when swallowing

Signs and Symptoms of Dysphagia when eating or drinking

- Slow or delayed initiation of swallow
- Uncoordinated chewing or swallowing
- Leakage of food or liquid from lips
- Multiple swallows with each bite
- Coughing or choking (may be delayed)
- Wet or hoarse vocal quality
- Food left in the mouth after eating and/or pocketing food
- Nasal regurgitation of food or liquids
- Extra time to eat or drink
- Fatigue
- Shortness of breath or changes in respiratory patterns

Signs/symptoms of Aspiration

- Aspiration:
  - When food or liquid goes BELOW the level of the vocal folds
- Overt clinical signs
  - Cough
  - Throat clear
  - Choking
- Signs of silent aspiration
  - Watery eyes
  - Nasal discharge
  - Wet vocal quality
  - Increased respiratory rate
  - Fevers of unknown origin, repeat pneumonia in right lower lobe

Consequences of Aspiration

- Aspiration pneumonia
  - Most commonly in right lung
- Silent aspiration
  - NO obvious sign that food or liquid has entered the airway
- Respiratory failure
- Death

What to look for during your Nursing Assessment

- Decreased level of alertness
- Impaired cognition
- Facial and oral motor movements, decreased strength, asymmetry, decreased sensation
- Voice and speech quality
- Strength of volitional cough
- Current medications
- History of swallowing or feeding problems
- History of pneumonia
- Current diet, inability to feed self
- Client complaints
- Reflexes (Gag)
    - Patient may have an absent gag reflex
    - This is NOT a predictor of dysphagia

Patient Behaviors to Consider

- Excessive intake of food
- Holding food in mouth
- Swallowing without chewing solids adequately
- Improper bolus sizes
- Speaking or breathing with food in the mouth
- Not initiating eating
- Eating inappropriate items
- Loss of interest in food, refusal to eat or inability to feed self

Nursing Interventions

- Refer to Speech Pathologist for evaluation
- Aspiration precautions
- Safe swallowing and feeding strategies
- Diet modification
- Compensatory strategies
- NPO, G-tubes, TPN

Evaluation of Swallowing

Bedside Swallow Evaluation

- Patient appropriateness
  - Need to be alert, not head of bed flat, no O_2 mask, or ventimask
- Protocol
  - SLP evaluates each consistency (puree, soft & bite sized, regular, thin, mildly thick, moderately thick)
- Recommendations- SLP writes in progress notes.
  - If diet is recommended, must obtain order.
  - Please remember patients other restrictions (diabetic, cardiac)

Evaluation of Swallow

- Modified Barium Swallow
- If SLP suspects silent aspiration or needs to further evaluate, SLP will ask for an order for an MBS
- MBS is done in radiology to visualize the swallow with different consistencies under fluoroscopy with barium
- Radiologist and SLP evaluate together

Modified Barium Swallow

- Patient appropriateness
  - Able to sit in chair for a period of time, alert, able to follow commands
- Protocol
  - MD orders MBS
  - SLP evaluates appropriateness at bedside first
- Recommendations
  - SLP will write recommendations in progress notes
  - Determine appropriate food and liquid consistency
  - Different strategies to improve swallowing will by recommended if needed (chin tuck, no straw, head tilt/turn, etc.)

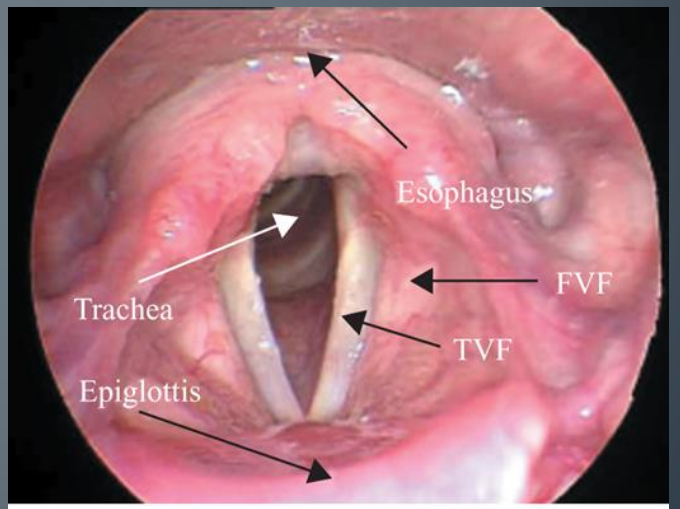
Examples of MBS

- Normal Swallow
- https://www.youtube.com/watch?v=PwVreNrTKBw

- Abnormal Swallow
- https://www.youtube.com/watch?v=huZ6ymeKFd4

Fiberoptic Endoscopic Evaluation of Swallowing FEES

- Provides high definition color video of soft tissue structures of the pharynx and larynx
- Can be completed at bedside
- No x-ray exposure
- Ability to observe secretions



Example of FEES

- Flexible Endoscopic Evaluation of Swallowing - YouTube

Safe Swallowing Strategies

& Other Strategies to Help Prevent Aspiration

In addition to modifying the diet consistency, some additional recommendations may include:

- Pills may need to be placed in puree or thickened liquids
- Eat in a quiet room
- Minimize distractions (close door, turn off TV)
- Minimize conversations when individual has food in their mouth
- Position in upright position
- Cue individual to focus on swallowing
- Cue individual to eat slowly with small bites and sips
- Change head position (turn head, tuck chin)
- Cue for other swallowing strategies (breath hold/cough after swallow)
- Assist with tray set-up as needed (cut up foods, open containers)

Positioning

- Whenever eating or drinking, the patient should be sitting upright.
- Head and trunk in midline.
- Head in neutral position with head slightly flexed.
- Head turned to weak side or head tilted to strong side (per SLP recommendation).
- The patient should remain as upright as possible for 30 minutes after the meal to aid digestion.

Food and Liquid Consistencies

International Dysphagia Diet Standardization Initiative (IDDSI)

- Diet:
  - IDDSI 7 Regular
  - IDDSI 7 ETC
  - IDDSI 6 Soft and Bite Sized
  - IDDSI 5 Minced and Moist
  - IDDSI 4 Pureed
- Liquids
  - IDDSI 0 Thin
  - IDDSI 2 Mildly Thick
  - IDDSI 3 Moderately Thick
  - IDDSI 4 Extremely Thick

Question

1. Complications of the oral phase of swallowing include:

a) Inability to adequately chew food.
b) Failure to form the food into a bolus in the middle of the mouth.
c) Inability to move the bolus from the front of the mouth.
d) All of the above.

Question

2. For a patient without problems in the oral phase of swallowing, this phase of swallowing usually takes:

a) 1. 5-10 seconds
b) 2. 10-20 seconds
c) 3. 5-30 seconds
d) 4. 10-40 seconds

Question

3. The pharyngeal phase is the second phase of swallowing. Which of the following is a successful outcome of this phase?

a) Oral regurgitation
b) Moving the bolus of food into the esophagus
c) Constriction of the pharynx
d) Trapping the food in the valleculae to prevent aspiration

Question

4. During the second phase of swallowing, the role of the epiglottis is to protect:

a) Nasal sinus
b) Opening into the oral cavity
c) Trachea
d) Esophagus

Question

5. The normal duration of the pharyngeal phase of swallowing is

a) 1 second
b) 5 seconds
c) 10 seconds
d) 15 seconds

Question

6. If a swallowing problem is suspected, what interventions can nurses use?
    a) Hyper-elevate chin when swallowing.
    b) Sit upright for meals and meds.
    c) Place food in affected side of mouth.
    d) Avoid thickened liquids.

Question

7. A patient with swallowing dysfunction may have "silent aspiration". This means that the patient might aspirate
   a) After coughing and gagging.
   b) Without coughing and gagging.
   c) In spite of coughing and gagging.
   d) None of the above.

Question

8. Which of the following substances is MOST likely to cause coughing or chocking on initial feeding trials?
   a) Water
   b) Milkshake
   c) Pudding
   d) Baked potato

Communication: Learning Objectives

- Define normal communication process
- Describe typical communication deficits for selected disorders
- Discuss interventions for facilitating communication for persons with aphasia
- Differentiate apraxia/dysarthria from aphasia
- Describe compensatory techniques

What is a Communication Disorder?

- Impairment in the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems.
- May affect:

Speech

Language

American Speech-Language-Hearing Association. (1993). *Definitions of communication disorders and variations* [Relevant Paper]. Available from www.asha.org/policy.

Speech Disorders

Impairment in:
- Articulation ⇨ **Dysarthria of Speech**
- Motor sequencing ⇨ **Apraxia of Speech**
- Voice ⇨ **Aphonia, Dysphonia**
- Fluency ⇨ **Stuttering**

Language Disorders

Impairment in:
- Comprehension and/or use of spoken, written, and/or other symbol systems
  - ➢ **APHASIA**
- May affect social/interactional aspects of language (aka **Pragmatics**)

Dysarthria

- Motor speech disorder
  - Damage to the central or peripheral nervous system
  - Weakness and/or incoordination of the muscle involved in speech production.
  - Most common feature: slurred speech.
- Types:
  - Flaccid, Spastic, Ataxic, Hypokinetic, Hyperkinetic, Mixed

Apraxia

- Impairment in the ability to position muscles and to plan and sequence movements **volitionally.**
  - May be able to do the movements spontaneously or upon imitation
- Person knows what they want to say, but has difficulty coordinating muscle movements necessary to say what they want to say.

Apraxia Characteristics

- Difficulty imitating speech sounds
- Possible difficulty imitating non-speech movements, such as sticking out their tongue (oral apraxia)
- Grouping for sounds
- Verbal apraxia (severe cases); no sound produced
- Inconsistent errors
- Slow rate of speech
- Usually can produce some automatic speech
- Can occur in conjunction with aphasia and/or dysarthria

Dysarthria/Apraxia Management

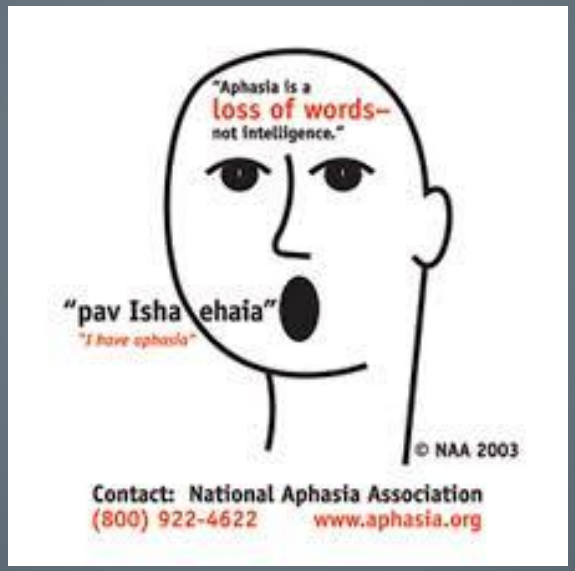
- Words will be slurred and difficult to understand.
- What can you do to help? Ask the person to:
  - Speak at a slower rate and overarticulate
  - Say it in a different way
    - i.e. Find a similar, but easier word
  - Write down the message when you don't understand
  - Draw it
  - Add gestures
    - i.e. "Show me – can you point to it?"
  - Use a communication device if available
    - i.e. Communication board, AAC
- Most importantly: Don't pretend you understand!

Aphasia

"Breakdown in the two-way translation process that establishes the relation between thought and **language**… It is a **defect in linguistic processing**"

It can manifest in…

Verbal Expression



Word Finding (hallmark)

Reading

Auditory Comprehension

Repetition

Writing

Damasio, H. (2001). Neural Basis of Language Disorders. In R. Chapey (Ed.), *Language intervention strategies in aphasia and related neurogenic communication disorders (4th ed., pp. 18-36). Philadelphia: Lippincott Williams and Wilkins.*

Aphasia

- Aphasia is an acquired communication disorder that impairs a person's ability to process language, but does not affect intelligence. (The National Aphasia Association, http://www.aphasia.org)
  - Depends on severity and lesion location

- Etiologies include CVA, TBI (penetrating and non-penetrating), brain tumors, other neurogenic disorders.

Aphasia Statistics

- Most common cause of aphasia is stroke.
- 23-40 percent of stroke survivors acquire aphasia.
- Can occur at any age. Most people with aphasia are in their middle to late years.
- Approximately 80,000 individuals acquire aphasia each year.
- Estimated that approximately1million people in the United States have acquired aphasia (1 in 250 people).
- More common than Parkinson's disease, Cerebral Palsy or Muscular Dystrophy.
- About 1/3 or severely head injured individuals have aphasia.

(Ref: strokeassociation.org; nih.gov)

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Where is language represented?

Table 3.1. Lateralization for Language in a Sample of 262 Subjects, Obtained by Means of the Sodium Amytal Test

Handedness	*Number of Cases*	LANGUAGE REPRESENTATION (%)		
		Left	*Bilateral*	*Right*
Right	140	96	0	4
Left	122	70	15	15

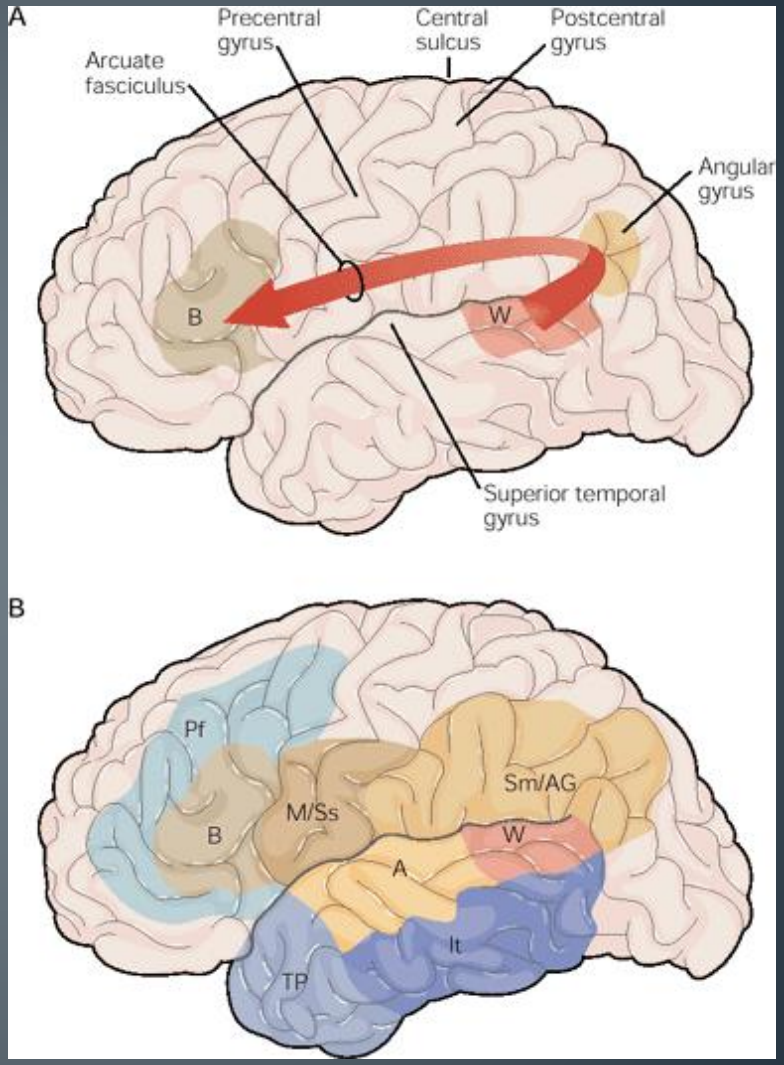
Adapted from Rasmussen and Milner, 1977.

Benson, D. F., & Ardila, A. (1996). Variations within aphasia *Aphasia: A clinical perspective* (pp. 29-45). New York, NY: Oxford University Press.

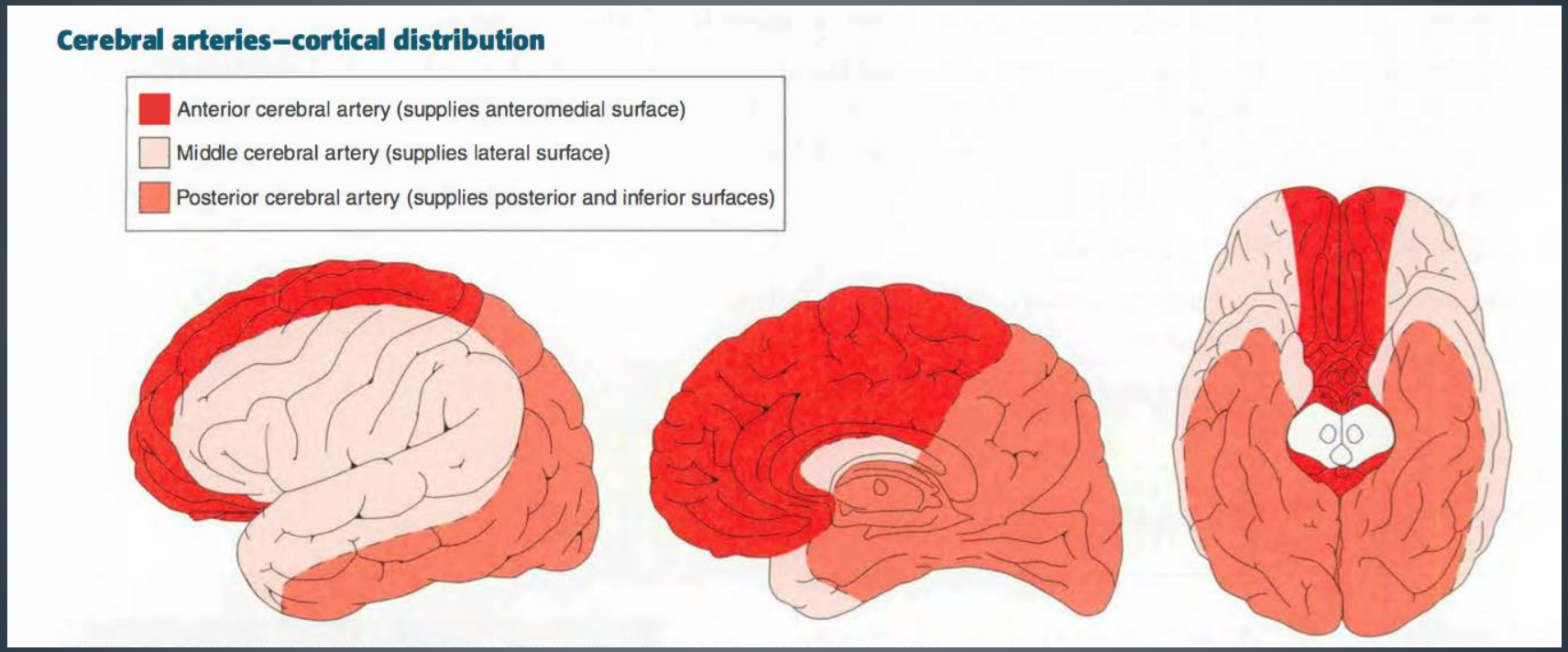
Areas Involved in Language Processing

Sylvian Fissure and Perisylvian Region

Sm = supramarginal gyrus
AG = angular gyrus
B = Broca's area
W = Wernicke's area
M = motor cortex
SS = somatosensory cortex
A = auditory cortex
TP = temporal pole
It = L inferotemporal cortex
Pf = L prefrontal cortex



Blood Supply



Aphasia Classification

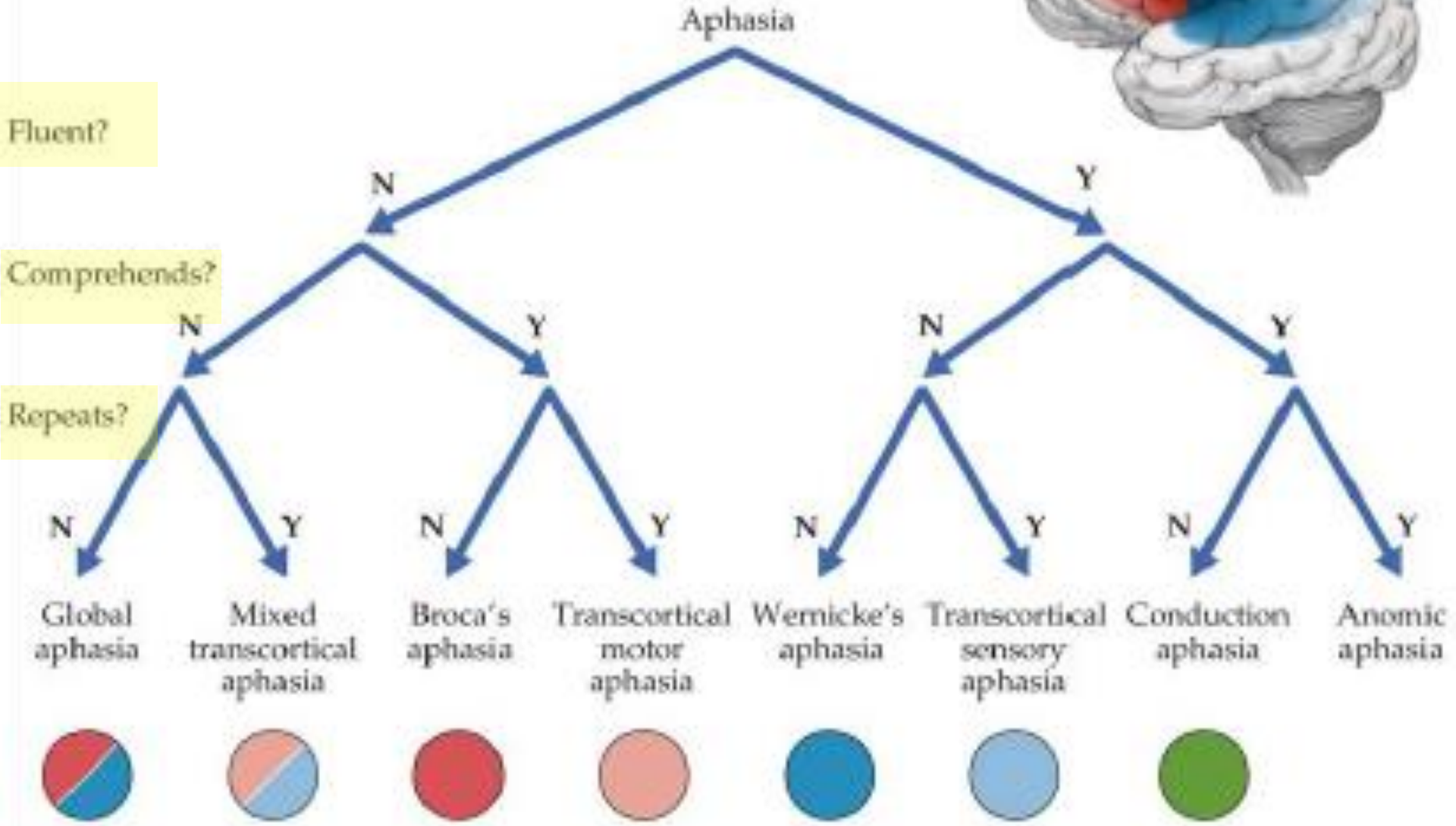


TABLE 4. EVOLUTION OF APHASIA

Classification			*% Recovered completely*
Initial		*Endstage*	
Globals (22)	→	2 Broca's	
		1 Transcortical motor	
		1 Conduction	
		1 Anomic	
Broca's (17)	→	1 Transcortical motor	
		3 Anomic	
Conduction (8)	→	2 Anomic	
		5 Non-aphasic	(62·5)
Wernicke's (13)	→	1 Global	
		1 Transcortical sensory	
		4 Anomic	
Isolation (2)	→	1 Anomic	
Transcortical motor 3	→	2 Anomic	
	(6)	1 Non-aphasic	(50·0)
Transcortical sensory 3	→	2 Non-aphasic	
		1 Anomic	
Anomic (25)	→	12 Non-aphasic	(48·0)
Total 93			21·0

Evolution from initial to endstage classification in each aphasic category is on the left. Percentages of complete recovery on the right.

Kertesz, A., & McCabe, P. (1977). Recovery patterns and prognosis in aphasia. *Brain: a journal of neurology, 100, 1-18.*

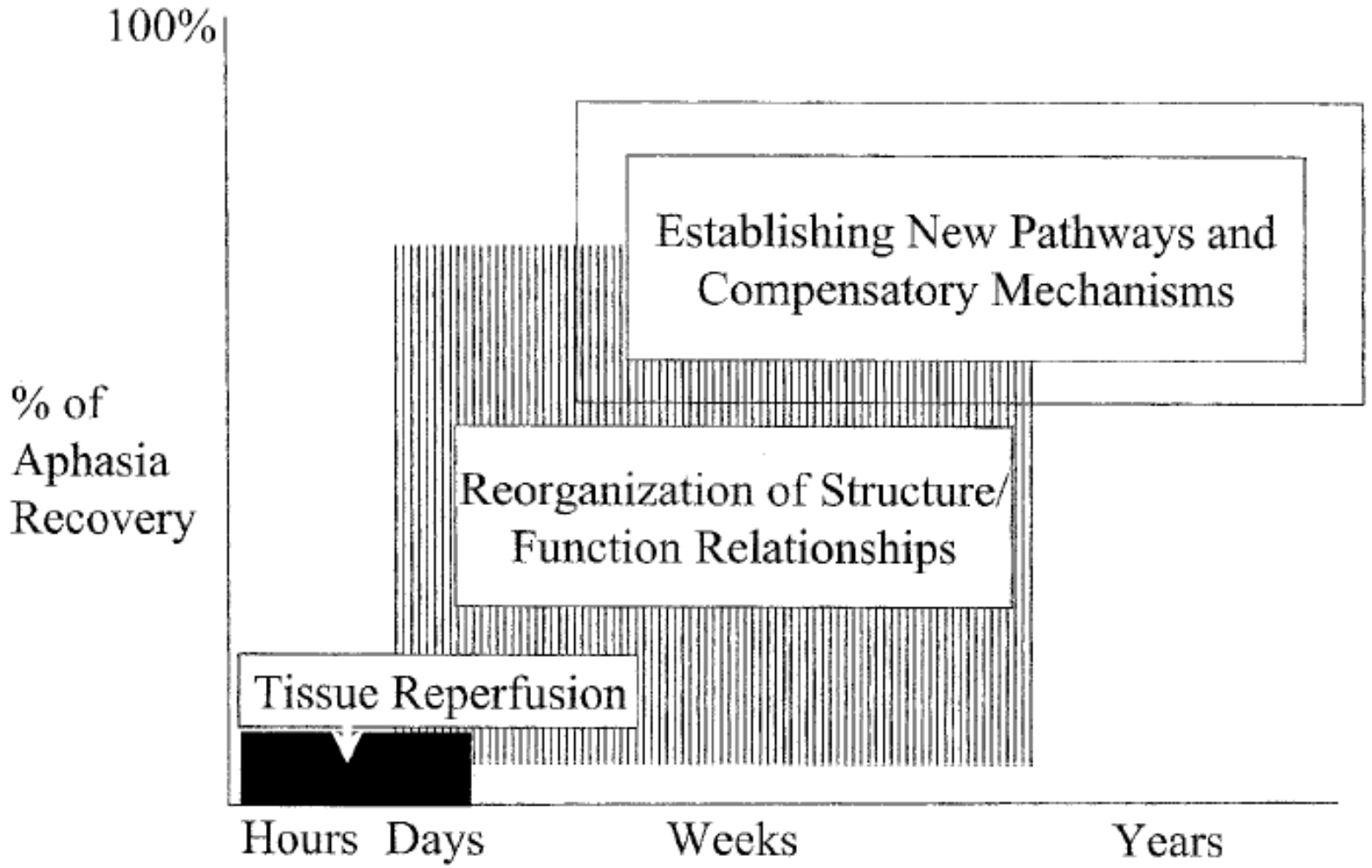


Figure 5. The three stages of functional recovery from aphasia. There are no clear time limits to each stage.

Hillis, A. E., & Heidler, J. (2002). Mechanisms of early aphasia recovery. *Aphasiology, 16(9), 885-895. doi: 10.1080/0268703*

Broca's Aphasia

https://www.youtube.com/watch?v=f2IiMEbMnPM

Areas	Description
Lesion location	Posterior-inferior frontal lobe. Usually present with motor deficits in contralateral side (right hemiparesis or hemiplegia). May also present with apraxia of speech
Spontaneous speech	Nonfluent. May be limited to single words. Telegraphic, Effortful production
Auditory comprehension	Relatively spared. Can follow simple commands, but may have difficulties with commands that are syntactically complex. Aware of deficits.
Repetition	Poorer than spontaneous productions
Naming	Poor. Significant word finding difficulties, but no neologisms. May have frequent perseverations, difficulties switching

Wernicke's Aphasia

http://www.youtube.com/watch?v=aVhYN7NTIKU

Areas	Description
Lesion location	Posterior-superior temporal lobe. Usually present with no motor deficits
Spontaneous speech	Fluent, hyperverbal. Adequate syntactic structure, but poor informational content. Usually present with jargon (make no sense)
Auditory comprehension	Poor for words and sounds. Poor awareness of deficit. Benefit from visual cues and context
Repetition	Poor
Naming	Poor, characterized by frequent phonemic and semantic paraphasias as well as neologistic errors

Anomic Aphasia

http://www.youtube.com/watch?v=xx03Jocla6w

Areas	Description
Lesion location	Angular gyrus. Usually not accompanied by hemiparesis. Often end stage, evolving from other aphasia types
Spontaneous speech	Fluent, but with word finding difficulties, pauses
Auditory comprehension	Relatively well preserved
Repetition	Good
Naming	Word finding difficulties present, with hesitations and circumlocutions

Global Aphasia

http://www.youtube.com/watch?v=6CJWo5TDHLE

Areas	Description
Lesion location	Large lesion affecting perisylvian region (i.e. area around sylvian fissure). Usually related to left middle cerebral artery infarction (in ischemic strokes)
Spontaneous speech	Nonfluent, little or no verbal output. May have stereotypical language, perseverations, automatisms
Auditory comprehension	Poor
Repetition	Poor
Naming	Poor; stereotypical expressions and automatisms

Conduction Aphasia

http://www.youtube.com/watch?v=gVTrva4mwTw

Areas	Description
Lesion Location	Arcuate fasciculus (connection between Broca's and Wernicke's area); supramarginal gyrus; may co-occur with apraxia
Spontaneous speech	Fluent, with phonemic paraphasias
Repetition	Poor
Naming	Poor, with phonemic paraphasias

Transcortical Motor Aphasia

Area	Description
Lesion location	Anterior and superior to Broca's area; supplementary motor area (SMA)
Auditory comprehension	Relatively spared
Repetition	Excellent
Naming	Poor

Transcortical Sensory Aphasia

Area	Description
Lesion location	Border area between middle cerebral artery and posterior cerebral artery, sparing Wernicke's area (usually associated with watershed strokes)
Auditory comprehension	Poor
Repetition	Excellent
Naming	Poor

Transcortical Mixed Aphasia – Mixed Nonfluent

Areas	Description
Lesion Location	Variable –usually entire watershed areas, sparing Broca's and Wernicke's areas
Spontaneous speech	Nonfluent
Repetition	Better as compared with spontaneous speech
Auditory comprehension	Poor
Naming	Poor

Types of Aphasia

	Fluency	Aud Comp	Repetition	Naming
Global	Nonfluent	Poor	Poor	Poor
Broca's	Nonfluent	RelSpared	Poor	Poor
T. Motor	Nonfluent	RelSpared	Excellent	Poor
Wernicke's	Fluent	Poor	Poor	Poor
T.Sensory	Fluent	Poor	Excellent	Poor
Conduction	Fluent	Good	Impaired	Poor
Anomic	Fluent	Good	Good	Poor

Table 1. Classification of language and speech disorders according to the results of the test battery.

Syndrome	Spontaneous speech	Fluency	Comprehension	Repetition	Naming	Other signs	Lesion localization
Broca's aphasia	Poor, effortful, with paraphasias and agrammatism	Impaired	Normal	Impaired	Impaired	Hemiparesis, mouth and hand apraxia	Posterior-inferior frontal (areas 44, 45, sometimes 46)
Wernicke's aphasia	Logorrheic, with paraphasias and neologisms	Normal	Impaired	Impaired	Impaired	Homonymous hemianopia, apraxia, anosognosia	Posterior-superior temporal (area 22)
Conduction aphasia	Normal (phonetic mistakes)	Normal	Normal	Impaired	Normal	Hemi-hypoesthesia, apraxia, hemianopia	Arcuate fasciculus - supramarginal gyrus
Global aphasia	Poor (mutism), with verbal stereotypes	Impaired	Impaired	Impaired	Impaired	Hemiparesis, hemianopia, hemi-hypoesthesia, apraxia	Perisylvian region (middle cerebral artery territory)
Anomic aphasia or amnestic aphasia	Normal (difficulty finding words)	Normal	Normal	Normal	Impaired	Homonymous hemianopia	Inferior parietal (angular gyrus)
Transcortical motor aphasia	Poor (mutism), with great latency to respond, echolalia, perseveration	Impaired	Normal	Normal	Impaired	Eventually hemiparesis (crural involvement) and grasp reflex	Anterior and superior to broca's area (supplementary motor area)
Transcortical sensory aphasia	Normal (semantic jargon)	Normal	Impaired	Normal	Impaired	Eventually hemianopia and visual agnosia	Watershed areas of middle cerebral artery and posterior cerebral artery
Mixed transcortical aphasia	Mutism	Impaired	Impaired	Normal	Impaired	Eventually hemianopia, visual agnosia and hemiparesis	Watershed areas of middle cerebral, anterior cerebral and posterior cerebral arteries

Oliveira, F. F. d., & Damasceno, B. P. (2011). A topographic study on the evaluation of speech and language in the acute phase of a first stroke. *Arquivos de Neuro-Psiquiatria, 69(5). doi: 10.1590/S0004-282X2011000600013*

Expressive vs. Receptive

- NO SUCH THING
- A person with aphasia has impairments in BOTH!!!
- One may be more impaired than the other, but these terms are very confusing!

Facilitating Communication

- Supported Communication for Adults

- USE MULTI-MODAL communication Gesture, Point, Pantomime, Write, Draw, Talk…

Facilitating Communication

- Make sure you have the person's attention before communicating.
- Reduce environmental distractions.
- Try to keep conversation geared to immediate needs and surroundings (SHOW THEM what you are talking about).

Facilitating Communication with Clients with Aphasia

- Speak slowly and simply, but naturally.
- Gesture, WRITE KEY words, have the object with you.
- Don't speak to the person as if they were a child or deaf.
- Simplify or rephrase your wording without shouting.

Communicating with PWA

- Allow extra time for responses
- Give directions one at a time
- Avoid open ended questions
- Don't finish the speaker's sentence for him/her
- Encourage person to respond in whatever way he/she can. Accept all communication attempts!

Communicating with PWA

- Be prepared for inaccurate use of language or swearing. Accept this without amusement, embarrassment or anger.
- They can think, they just can't *say* what they think.
- Talk to your speech pathologist and learn that pt's communication strategies. Not all people with aphasia have the exact same problems!

How does Aphasia impact what YOU do??

- When explaining a diagnosis, testing procedures/purposes, possible treatment options, etc., you will be forced to use language to explain yourself.
- Keep in mind their aphasia type/severity and MODIFY your word choice/sentence structure accordingly.
- Just b/c they are nodding their head does NOT mean they understand you! (social communication)

How does Aphasia impact what YOU do??

- Think about Aphasia as a foreign language.
- Can you understand Japanese?
  - If I place you in Japan and have people give you directions, or tests in Japanese only, how will you do?
  - Does the inability to speak, understand, read or write another language make you incompetent?
  - Will you rely on gestures/facial expressions?

Question #1

Mrs. Y has dysarthric speech as a result of a stroke. Dysarthria occurs due to neurological damage to:

a) the left frontal lobe
b) the left temporal lobe
c) both the left frontal and left temporal lobes
d) the brainstem and/or cranial nerves

Question #2

Mr. T has impaired verbal communication as a result of a left hemisphere stroke. A therapeutic nursing intervention to assist Mr. T with communication is to:

a) increase voice volume when speaking
b) finish sentences when he is unable to do so
c) use short simple sentences
d) consistently correct his speech errors

Question #3

P.T. is just emerging from coma following a brain injury. Which of the following interventions in MOST appropriate to begin establishing communication with P.T.?

a) Use communication or alphabet board
b) Use a head nod or eye blink to communicate
c) Use a voice activated computer system
d) Talk to him frequently to facilitate communication

Question #4

Mr. D has recently had a left hemisphere stroke. He has right sided weakness and Broca's Aphasia. This type of aphasia is characterized by:

a) fluent speech with many mispronounced words
b) Slow, effortful speech with long pauses between words
c) speech that alternates between clear and not understandable
d) nasal voice quality and problems with voice loudness and pitch

Question #5

The primary communication deficit experienced by a person with Wernicke's aphasia is:

a) inability to understand verbal or written language
b) problems with forming and articulating words
c) problems with using correct grammar
d) inability to speak rapidly

Question #6

Which of the following instructions would be MOST appropriate for a person with Wernicke's aphasia?

a) "Show me where you're having pain"
b) "Tell me what the doctor said to you"
c) "Sit down"
d) "Stand up and walk to the door"

Question #7

Which of the following interventions would be least helpful in communicating with a patient who has Wernicke's aphasia?

a) Gesturing
b) Pantomiming
c) Altering tone of voice
d) Using word repetition

Remember…

- "A person with aphasia ***may have difficulty retrieving words and names, but the person's intelligence is basically intact***. For people with aphasia ***it is the ability to access ideas and thoughts through language - not the ideas and thoughts themselves- that is disrupted.***" (The National Aphasia Association, http://www.aphasia.org)

- When unable to express their wants/needs or understand, people become frustrated, irritable, and can be difficult to manage. Take your time and be kind. Try your best to communicate with them. They will certainly appreciate it!