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**Adult Neurogenic Language Disorders**

**Professor Wilkane**

### **Assessment and Treatment Plan Paper**

#### **Part 1: Assessment**

Based on the case history presented, it appears that a care giver and patient interview may have already been conducted; however, if that is not the case then evaluation for this patient should begin with an interview of his caregivers (i.e., daughter, son, and daughter-in-law) in order to get a better sense of the patient's history, strengths, challenges, and family concerns. This caregiver interview may be conducted before the in-person visit in order to save the allotted evaluation time for the patient himself. A patient interview should be the first step during the in-person evaluation session in order to assess the patient's general communication and language skills, any potential concerns they might have, and what is important to them in their day-to-day life, as well as gather information regarding their stimulability and conversational speech. It may be beneficial to informally assess the patient's response to word-finding strategies (e.g., sentence completion, phonemic cues, category cues, etc.) to see what, if any, strategies make an improvement in order to utilize those in therapy. If any motor speech impairment is suspected, an oral mechanism exam can be performed as well. These informal assessment tools will provide us with valuable information that can be used to create functional and salient goals that take into account the patient's current wants and needs.

Following the informal assessment, which can continue throughout the remainder of the session, it is essential to attempt performing a formal assessment to gain data regarding the patient's current level of speech, language, communication, and cognitive function. The clinician

would need to make a decision about which formal test to utilize based on the patient's attention during the informal assessment. Ideally, the Western Aphasia Battery-Revised (WAB-R) would be used in order to determine the severity of aphasia; however, this evaluation can take around an hour, and while breaks can be given between subtests, sustained attention is required to complete the test. If the clinician feels as though the WAB-R is too long of an exam to conduct for this patient, then the Quick Aphasia Battery (QAB) and Cognitive-Linguistic Quick Test (CLQT) may be administered in combination to attain similar data regarding current language and cognition skills. In addition to either of these options, the Functional Assessment of Communication Skills in Adults (ASHA-FACS) should be filled out to determine any potential communication disability in regards to social communication, communication of basic needs, daily planning, and reading and writing. It is important to this patient to remain independent and this evaluation tool will help to establish his ability to do so. No matter what combination of testing performed, it is important to perform some sort of formal evaluation so that definitive strengths and weaknesses can be identified, as well as utilizing these assessments to track progress over time.

According to the information provided regarding this patient's current symptoms, it appears as though he has transcortical sensory aphasia. He presents with a fluent aphasia, narrowing the diagnosis down to four options (anomic, conduction, Wernicke's, or transcortical sensory). Taking into account the patient's impaired comprehension, we can narrow this down further to Wernicke's or transcortical sensory aphasia. Lastly, since the patient is able to repeat 4–5-word sentences with high accuracy, Wernicke's aphasia can be removed from consideration as well. Since this form of aphasia is fluent, it is unlikely that the patient has any accompanying motor-speech deficit, but the oral mech exam would provide more information regarding this

possibility. This leaves transcortical sensory aphasia as our most likely diagnosis, relying solely on the patient history without any data from formal testing. In regards to this diagnosis, the prognosis is that it may evolve to anomic aphasia, which would mean improved comprehension, as well as a more typical pattern of spontaneous speech. The patient is passionate about his daily routine, has the close support of his family, and previously worked in a job that required high cognitive reserve, which will all be beneficial for his therapy outcomes.

Other clinical recommendations for this patient would include a physical therapy evaluation to assess his fall risk and potentially therapy for gait and balance to reduce fall risk. Resources regarding aid with transportation and other daily tasks should be explored. It may also be beneficial to suggest a part-time aid or more frequent visits from family to also assist with daily tasks and transportation. It is evident that independence is extremely important for this patient, but if the clinical team and the patient's family agree that assistance is required then a referral to a psychologist to aid in this transition may be valuable as well. Lastly, the patient should be following-up with their neurologist to determine the cause of stroke and any potential neurological diagnoses or factors that may impact his health and daily function.

## **Part 2: Treatment**

### Long-Term Goals:

1. The patient will improve auditory comprehension in order to participate in social conversation with familiar and unfamiliar communication partners.
2. In order to fill out personal documents (e.g., medical form, check, etc.), the patient will be able to accurately write out basic information (e.g., full name, address, etc.).

### Short-Term Goals:

1. In order to engage in conversation about the Sunday sermon, the patient will respond to various questioning regarding verbally presented information with 80% accuracy given moderate verbal cueing from communication partners.
2. Given moderate verbal cueing from communication partners, the patient will respond to verbally presented Wh questions with 80% accuracy so that he can participate in conversation at their weekly breakfast.
3. In order to write out a check, the patient will copy 4–5-word phrases with 90% accuracy given minimal verbal prompting.
4. Given minimal to moderate verbal cues, the patient will write his full name and the date with 90% accuracy so that he can independently sign for his prescriptions at the pharmacy.

#### Treatment Methods/Approaches:

1. Anagram, Copy, and Recall Treatment (ACRT)

ACRT is a treatment method used to improve the writing skills of people with aphasia. The research regarding ACRT suggests that it is appropriate for all levels of aphasia as long as they do not have any visual problem-solving impairment. The goal of this treatment method is to strengthen the patient's memory of spelling (Beeson, 2003) and to potentially generalize portions of trained words to those that are untrained (Communication Therapies for Adults). In this case, the objective is to improve the patient's ability to independently write words and short phrases regarding personal information so that he can fill out varying documents and sign for his prescriptions at the pharmacy. The client, caregiver and clinician would work together to create a list of salient words and separate them into subsets based on word length. Some examples appropriate targets for this patient would be his first name, last name, son's name, street name,

and month of birth. Starting with the subset containing the shortest words, the clinician would present a picture and request the patient to write out a target word. If he is unsuccessful, he will be presented with letter tiles for each letter of the target word and probed to arrange the letters to spell the word. If required, the clinician should model the spelling. The patient should be instructed to copy the word three times and then all supports are removed, the picture is re-presented, and on a new piece of paper they are again asked to write the target word. This process is to be repeated with every word in the subset. Once subset 1 is mastered, the clinician should move on to subset 2. The patient is currently able to write his first name, so that would be a good target to start with in order to introduce the exercise. It is expected that he will have difficulty writing other target words without support; however, his ability to copy short phrases with minimal errors will be beneficial to the treatment method process.

## 2. Attentive Reading and Constrained Summarization (ARCS)

ARCS is a treatment method that focusses on improving discourse, as well as improving word retrieval and memory in people with aphasia. The research regarding ARCS dictates that this treatment method is beneficial for all types of mild to moderate aphasia as long as the individual can speak and comprehend at the sentence level (Young, 2020). In order to make treatment functional for the patient, the protocol should be modified to include auditory comprehension as opposed to reading. The main goal is for the patient to be able to participate in conversation at church regarding that Sunday's sermon and the combination of the ARCS protocol and auditory comprehension will support that objective. Salient passages, such as those from the Bible or previous sermons, should be selected prior to the session. The only concern with these target texts, is that the language used in the Bible is more complicated to understand, but given the patient's frequency at church, he is familiar with the language and is exposed to it regularly. The

clinician should read 2-3 sentences at a time and probe the patient to summarize them before moving on to the next. The patient should have access to the passage in order to read along and reread as many times as they need for comprehension. While summarizing, the patient should maintain topic and utilize meaningful words. This process is to be repeated throughout the entirety of the passage. Depending on the patient's success, the clinician may reread the whole passage and ask for a summary of the whole text. The patient currently has impaired comprehension with both reading and auditory comprehension; however, the combination of these two modalities used in this exercise should increase his overall comprehension. If there is someone at church that the patient is familiar with, their participation in this activity may increase functionality as well.

### **Part 3: Carry-over**

Most importantly, caregiver education regarding therapy, current goals, and strategies related to treatment methods should be conducted. This could be a phone call or even an entire session dedicated to familiarizing the patient's family with his goals and strategies. In addition, it is recommended that a list of words and short phrases pertaining to documentation (i.e., full name, address, phone number, etc.) be kept wherever the patient completes these forms, such as a desk or office. It may be beneficial to also carry a copy in the car for use at external location like a doctor's office. Along the same lines, an example of a filled-out check should be kept at home to facilitate in paying monthly bills. It is possible that the patient forgets to use these templates or loses them, but keeping them in a fixed location, out in the open should help minimize this risk. In regards to Sunday mass, a print-out version of the sermon should be requested ahead of time so that the patient may follow along and utilize the skills he acquired from ARCS during therapy. Lastly, setting up a carpool with the patient's friends for their

weekly breakfast might be a good way to ensure safer transportation, easing the worries of family, but helping maintain some of the patient's independence. This will also allow the patient to speak one-on-one with a member of the group prior to engaging with multiple people, almost like priming him to the situation. A diner may be a difficult location for the patient to concentrate in, so the group should request a table in a secluded area with the least noise and distraction.

## References

- Attentive Reading & Constrained Summarization (ARCS) for Aphasia. (2020, April 21). Tactus Therapy. <https://tactustherapy.com/arcsattentive-reading-constrained-summarization-aphasia/>
- Beeson, P. M., Rising, K., & Volk, J. (2003). Writing treatment for severe aphasia: Who benefits?. *Journal of Speech, Language, and Hearing Research*, 46, 1038-1060. <https://aphasia.sites.arizona.edu/sites/aphasia.sites.arizona.edu/files/2018-10/Beeson%2C%20Rising%2C%20%26%20Volk%2C%202003.pdf>
- Communication Therapies for Adults. (n.d.). Anagram and Copy Therapy (ACT) & Copy and Recall Therapy (CART). Retrieved from: <https://communicationtherapyforadults.wordpress.com/2014/03/16/anagram-and-copy-therapy-act-copy-and-recall-therapy-cart/>
- Rogalski, Y., Edmonds, L. A., Daly, V. R., & Gardner, M. J. (2013). Attentive Reading and Constrained Summarisation (ARCS) discourse treatment for chronic Wernicke's aphasia. *Aphasiology*, 27(10), 1232–1251. <https://doi.org/10.1080/02687038.2013.810327>
- Sutton, M. S. (n.d.). How To: Anagram, Copy, and Recall Treatment for Writing. Retrieved from: <https://tactustherapy.com/anagram-copy-recall-treatment-writing/>
- Young, L. A. (2020). attentive reading and constrained summarization. Eat Speak Think. <https://eatspeakthink.com/wp-content/uploads/2020/07/ARCStutorial.pdf>