

DIANE'S NGN NCLEX 2026 VISUAL STUDY LIBRARY

Common Types of *Aphasia*

A clinical judgment reference for the language disorders that follow stroke, TBI, brain tumors & neurodegenerative disease — with nursing care and teaching for each type.

NEUROLOGICAL

COMMUNICATION

STROKE SEQUELAE

NGN 2026 TEST PLAN

Source Note: This topic was not in Diane's uploaded flashcard set. Content is drawn from standard NGN NCLEX 2026 references — *Saunders Comprehensive Review*, *ATI Adult Medical-Surgical*, *Lippincott Nursing Concepts*, and the American Stroke Association / National Aphasia Association clinical guidelines.

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Definition & Overview

WHAT APHASIA IS — AND WHAT IT IS NOT

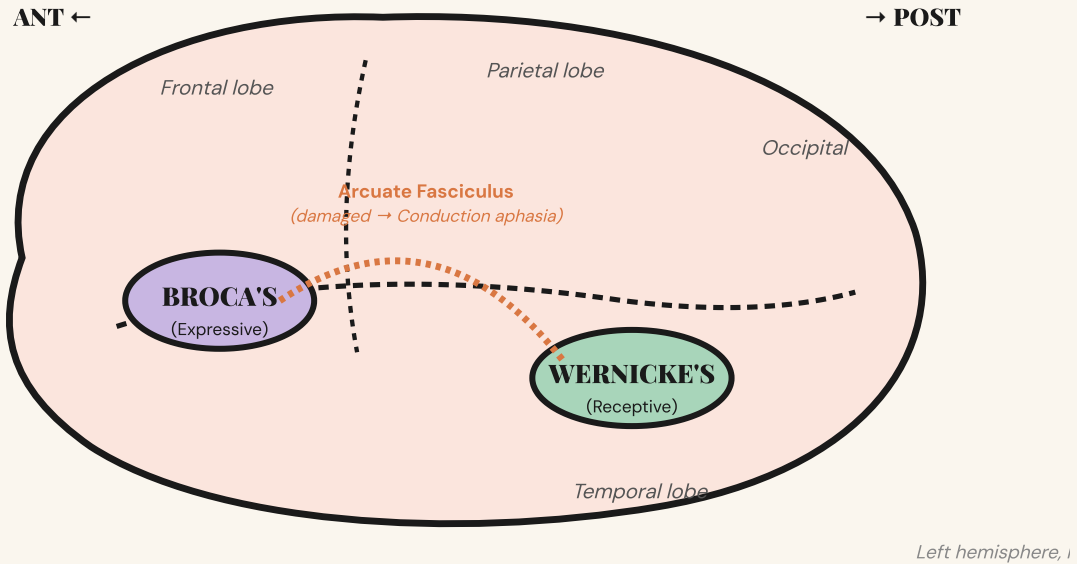
Aphasia is an acquired language disorder caused by injury to the language-dominant hemisphere of the brain (usually the LEFT hemisphere in right-handed clients). It impairs the client's ability to **express** language, **comprehend** language, or both.

- ▶ **It is a LANGUAGE problem** — not a problem of intelligence, hearing, or motor speech.
- ▶ **Most common cause:** ischemic stroke involving the middle cerebral artery (MCA) — also TBI, brain tumor, infection, dementia.
- ▶ **Aphasia ≠ Dysarthria.** Dysarthria is a *motor* speech problem (slurred articulation from weak oral muscles). The language is intact; the speech is slurred. Aphasia is a *language* problem; the client cannot find or process the words.
- ▶ **Aphasia ≠ Apraxia of speech.** Apraxia is the inability to *plan* the motor movements for speech; the muscles work, but the brain cannot sequence them.

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Language Centers of the Brain

KNOW THE MAP — IT PREDICTS THE DEFICIT



Both areas are perfused by the **middle cerebral artery (MCA)** — the most common stroke vessel. Damage to the connecting tract (arcuate fasciculus) produces conduction aphasia.

Broca's Area

Location: Left inferior frontal lobe.

Job: motor planning & production of speech. Damage = expressive aphasia.

Wernicke's Area

Location: Left superior temporal lobe.

Job: comprehension of language. Damage = receptive aphasia.

Arcuate Fasciculus

Location: White-matter tract connecting Broca's & Wernicke's.

Job: repetition. Damage = conduction aphasia.

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Five Types of Aphasia — Side by Side

THE MASTER COMPARISON EVERY NCLEX ITEM DRAWS FROM

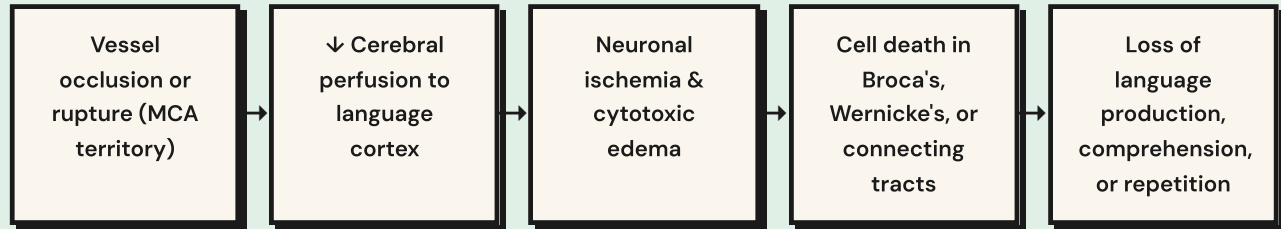
Feature	Broca's (Expressive / Non-fluent / Motor)	Wernicke's (Receptive / Fluent / Sensory)	Global	Anomic (Amnesic)	Conduction
Lesion site	Left frontal lobe (Broca's area)	Left temporal lobe (Wernicke's area)	Large MCA territory — both areas	Angular gyrus / temporo-parietal	Arcuate fasciculus
Speech fluency	Non-fluent, slow, effortful, "telegraphic"	Fluent, normal rhythm but meaningless	Severely non-fluent or absent	Fluent	Fluent
Comprehension	Largely intact ✓	Severely impaired ✗	Severely impaired ✗	Intact ✓	Intact ✓
Repetition	Impaired	Impaired	Impaired	Intact	Severely impaired (hallmark)
Naming	Impaired	Impaired (paraphasias)	Impaired	Severely impaired (hallmark)	Impaired
Client awareness	Aware — frustrated, anxious, may cry	Unaware — may seem unconcerned or confused	Variable; often unaware	Aware — "tip of tongue"	Aware
Classic clue	"Walk... dog... now" — knows what to say, can't get it out	"Word salad" — fluent jargon, neologisms	Cannot speak OR understand	Talks <i>around</i> the word ("the thing you write with...")	Cannot repeat "no ifs, ands, or buts"
Often co-occurs with	Right hemiparesis (face/arm > leg)	Right visual field cut; <i>usually no</i> hemiparesis	Right hemiplegia + sensory loss	Few other deficits	Mild right hemiparesis

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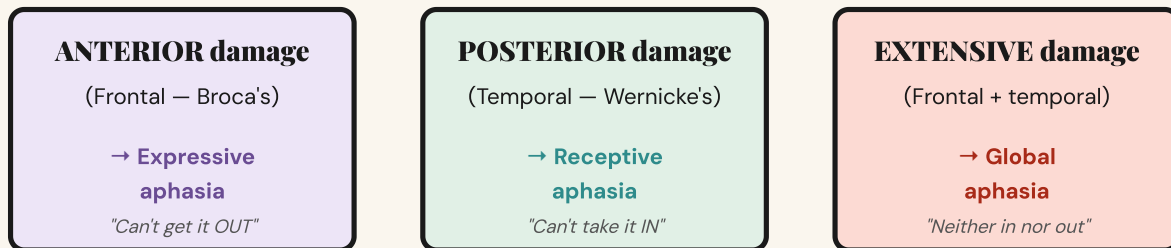
Pathophysiology

FROM INSULT → LANGUAGE DEFICIT

Most aphasia is the downstream consequence of **middle cerebral artery (MCA) ischemia** in the dominant hemisphere. The cascade follows the standard ischemic-stroke pattern, but the *location* of the infarct determines which language network fails.



LOCATION OF MCA INFARCT → APHASIA TYPE



"Front talks, back understands."

A simple anterior-vs-posterior rule covers ~80% of NCLEX aphasia items.

- ▶ **Time-critical:** The same ischemia that produces aphasia is reversible if circulation is restored quickly — driving the urgency of **tPA within 3–4.5 hours** of onset.
- ▶ **Neuroplasticity matters:** Most spontaneous recovery happens in the first 3–6 months; speech-language therapy started early improves long-term outcomes.

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Signs & Symptoms by Type

WHAT YOU'LL SEE AT THE BEDSIDE

BROCA'S — EXPRESSIVE

"Knows what they want to say"

- ▶ Slow, halting, effortful speech
- ▶ Telegraphic: nouns & verbs only ("Want... water")
- ▶ Frustration, tearfulness, anxiety, depression
- ▶ Often able to nod yes/no accurately
- ▶ Writing also impaired (agraphia)

 **Red flag** — frustration can escalate to agitation; assess for safety & suicide risk in stroke recovery.

WERNICKE'S — RECEPTIVE

"Hears words as a foreign language"

- ▶ Fluent, normal-rhythm speech that doesn't make sense
- ▶ Neologisms (made-up words) & paraphasias
- ▶ Cannot follow simple commands
- ▶ May appear euphoric, confused, or psychotic
- ▶ Often **unaware** of the deficit

 **Red flag** — easily mistaken for psychiatric illness or dementia. **Do not assume confusion is baseline.**

GLOBAL

"Locked out of language"

- ▶ Severely impaired production AND comprehension
- ▶ May produce only a few stereotyped utterances
- ▶ Often accompanies dense right hemiplegia
- ▶ Worst prognosis of the five types

 **Red flag** — high risk for unmet pain, hunger, toileting needs. Anticipate & offer scheduled care.

ANOMIC — AMNESIC

"Tip of the tongue, all day"

- ▶ Fluent, comprehensible speech with frequent word-finding pauses
- ▶ Talks *around* the missing word (circumlocution)
- ▶ Reading & comprehension often spared
- ▶ Mildest form — often residual after recovery from other types

★ Best prognosis of the five

CONDUCTION

"Understands and speaks, but cannot repeat"

- ▶ Spontaneous speech relatively fluent & comprehension intact
- ▶ **Hallmark:** profound inability to repeat phrases verbatim — classic NCLEX cue is failure to repeat "*no ifs, ands, or buts*"
- ▶ Frequent phonemic paraphasias (sound substitutions)
- ▶ Client is aware and tries to self-correct

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Priority Nursing Interventions

ABCS FIRST — THEN COMMUNICATION, SAFETY, DIGNITY

Aphasia rarely exists alone. The same MCA stroke that took out language frequently produces dysphagia, hemiparesis, and field cuts — so airway and aspiration always rank above communication strategy.

A Airway / Aspiration

- ▶ **Assess swallow** before any PO intake — NPO until cleared by SLP.
- ▶ **Monitor** for drooling, pocketing, wet voice, cough with swallow.
- ▶ **Position** HOB $\geq 30^\circ$ during and 30 min after meals.

B Breathing & Neuro

- ▶ **Assess** neuro status (NIH Stroke Scale) at scheduled intervals.
- ▶ **Monitor** for $\uparrow$ ICP, seizure, worsening deficit.
- ▶ **Maintain** oxygenation & cerebral perfusion.

C Communication

- ▶ **Speak slowly**, in short sentences, normal volume — do NOT shout.
- ▶ **Face the client**; minimize background noise & distractions.
- ▶ **Allow time** — wait 30+ seconds for a response without interrupting.
- ▶ **Use yes/no questions &** picture/communication boards.
- ▶ **One topic at a time**; announce when topic changes.
- ▶ **Refer** to speech-language pathologist (SLP) early.

D Safety & Dignity

- ▶ **Anticipate needs** (pain, toilet, hunger) — client may not be able to ask.
- ▶ **Establish** a reliable signaling system (call bell within reach on unaffected side).
- ▶ **Treat as an adult** — aphasia is NOT a cognitive deficit.
- ▶ **Screen** for post-stroke depression (very common, especially Broca's).
- ▶ **Implement** fall & aspiration precautions.

Tailoring by type — quick rules:

- ▶ **Broca's**: Give time, use yes/no & picture boards, acknowledge frustration. Don't finish sentences for the client unless asked.
- ▶ **Wernicke's**: Use gestures, demonstrations, and visual cues — words won't land. Reduce stimuli; simplify environment.
- ▶ **Global**: Use touch, facial expression, simple gestures. Maintain routine. Family at bedside often best translator.
- ▶ **Anomic**: Offer descriptive prompts and choices ("Is it for writing or eating?"). Don't rush.

- **Conduction:** Don't ask the client to repeat phrases — use written communication for confirmation.

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Pharmacology & Treatment Context

NO DRUG FIXES APHASIA — BUT TIMELY STROKE CARE PRESERVES LANGUAGE

Aphasia itself is treated with **speech-language therapy**, not medication. NCLEX pharm items in this context test the *underlying stroke or seizure management* that determines how much language returns.

Drug / Class	Mechanism	Key Side Effects	Nursing Considerations
Alteplase (tPA) Fibrinolytic	Dissolves clot in ischemic stroke; restores perfusion to language cortex.	Hemorrhage (intracranial bleeding is the dreaded complication), angioedema.	Window: 3–4.5 hr from symptom onset. Confirm onset time. Rule out hemorrhagic stroke (CT first). Strict BP control (< 185/110 pre-tPA). Bleeding precautions × 24 hr.
Aspirin Antiplatelet	Inhibits platelet aggregation; secondary stroke prevention.	GI bleed, bruising.	Start 24 hr after tPA (never before). Give with food.
Clopidogrel Antiplatelet	Blocks ADP receptor on platelets.	Bleeding, TTP (rare).	Hold before invasive procedures per protocol.
Statins (e.g., atorvastatin)	↓ LDL; plaque stabilization.	Myopathy, ↑LFTs.	Monitor CK if muscle pain; monitor liver enzymes.
Antihypertensives (labetalol, nicardipine)	Acute BP control after stroke.	Bradycardia, hypotension.	Goal BP individualized; avoid rapid drops that worsen ischemia.
Levetiracetam (Keppra)	Anticonvulsant for post-stroke seizures.	Mood changes, somnolence.	Monitor mood; do NOT stop abruptly.

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NCLEX Test Traps ⚠️

THE WRONG-VS-RIGHT CALLS EXAMINERS LOVE

✗ TRAP

Shouting at the client with aphasia. Volume does nothing — the client is not deaf.

✓ CORRECT

Speak at normal volume, slowly, with short sentences. Face the client; eliminate background noise.

✗ TRAP

Finishing the sentence of a client with Broca's aphasia to "help."

✓ CORRECT

Allow 30+ seconds for the client to find the word; offer a yes/no question or picture board if they get stuck.

✗ TRAP

Charting "client is confused" when a Wernicke's client speaks in jargon.

✓ CORRECT

Recognize fluent, meaningless speech as receptive aphasia — a *language* deficit, not a cognitive one. Use gestures & pictures.

✗ TRAP

Confusing aphasia with dysarthria. Choosing "slurred speech" as the defining feature of aphasia.

✓ CORRECT

Aphasia = language loss (can't find or process words). **Dysarthria = motor speech** (words are right, articulation is slurred).

✗ TRAP

"Communication is the priority" on a stroke client who just had a meal and is coughing.

✓ CORRECT

Airway/aspiration always outranks communication. Stop PO, suction, position, then assess swallow.

✗ TRAP

Talking ABOUT the client in front of them ("Does she usually eat lunch by herself?") because they "can't understand anyway."

✓ CORRECT

Always include the client. Speak TO them, not over them. Assume comprehension may be partial — never absent.

✗ TRAP

Giving tPA without confirming time of onset or ruling out hemorrhagic stroke.

✓ CORRECT

Verify onset within 3–4.5 hr AND non-contrast CT first. tPA into a hemorrhagic stroke = catastrophic bleed.

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Patient & Family Education

TEACHING BY TYPE — WHAT TO SAY TO THE FAMILY AT DISCHARGE

BROCA'S (EXPRESSIVE)

- ▶ "Be patient — give them at least 30 seconds to respond."
- ▶ "Don't finish their sentences unless they ask you to."
- ▶ "Use yes/no questions when they're struggling."
- ▶ "They understand you fully — talk TO them as you always did."
- ▶ "Expect frustration and tears. Acknowledge it. Take breaks."

WERNICKE'S (RECEPTIVE)

- ▶ "Use gestures, pictures, and demonstrations — not just words."
- ▶ "Keep the environment calm. Turn off the TV when speaking."
- ▶ "Use one simple instruction at a time."
- ▶ "They may not know they're making errors — don't correct repeatedly."
- ▶ "Their feelings are intact. Use a warm tone."

GLOBAL

- ▶ "Touch, eye contact, and tone carry the meaning."
- ▶ "Maintain familiar routines and faces."
- ▶ "Use a few constant gestures (thumbs up, head shake) consistently."
- ▶ "Anticipate needs on a schedule — pain, toileting, hunger."
- ▶ "Music and singing sometimes break through when speech can't."

ANOMIC

- ▶ "Offer descriptions or choices when they're stuck: 'Is it round or square?'"
- ▶ "Reading and writing are usually still good — use them."
- ▶ "Most people recover further over the first year — keep up with therapy."

CONDUCTION

- ▶ "Don't ask them to repeat phrases — it frustrates them."
- ▶ "Use written notes to confirm important information."
- ▶ "They hear and understand — give them time to self-correct."

UNIVERSAL TEACHING

- ▶ Recognize and call 911 for new stroke signs: **B.E.F.A.S.T.**
- ▶ Adhere to BP, lipid, and antiplatelet regimen — secondary prevention.
- ▶ Continue SLP & therapy after discharge; most recovery happens 0–6 months.
- ▶ Connect with the *National Aphasia Association* & local stroke support groups.
- ▶ Watch for post-stroke depression — seek help; it is treatable.

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Memory Mnemonics

PATTERN RECOGNITION FOR EXAM DAY

"Broca's = BROKEN speech"

The client's speech is BROKEN, halting, telegraphic — but the comprehension circuit is intact. **Broca's** = Broken & Blocked output.

"Wernicke's = WORD salad"

Fluent **Words** but **Wrong** meaning. The client is the chef serving meaningless salad — and doesn't know it.

Front talks · Back understands

Frontal lobe damage = can't **Form** words (expressive). Posterior/temporal damage = can't **Process** words (receptive).

Stroke recognition: **B · E · F · A · S · T**

- **B**alance — sudden loss
- **E**yes — sudden visual change
- **F**ace — drooping on one side
- **A**rms — one arm drifts down
- **S**peech — slurred, garbled, or absent (aphasia or dysarthria)
- **T**ime — call 911 NOW; note onset time

Aphasia care: **SLOW**

Speak slowly & simply · Limit distractions · Offer time (don't finish sentences) · **W**rite, point, or use pictures.

Conduction aphasia tip

"No ifs, ands, or buts" — the classic phrase the client CANNOT repeat. Memorize this exact NCLEX cue.

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NCJMM Clinical Judgment Scenario

SIX-STEP NEXT GENERATION CASE WALK-THROUGH

SCENARIO

A 68-year-old right-handed male is admitted from the ED after an acute ischemic stroke confirmed by CT. NIHSS = 14. On bedside assessment 6 hours after symptom onset, the client speaks fluently in long sentences that contain made-up words and do not answer your questions. When you ask him to point to the call light, he hands you his water cup. He is calm, smiling, and appears unconcerned. Vital signs: BP 162/94, HR 88, RR 18, SpO₂ 96% RA. He has a right visual field cut and right facial droop. He has not yet eaten.

Step 1

Recognize Cues

- ▶ Fluent but meaningless speech with neologisms
- ▶ Cannot follow a one-step command (call light vs water cup)
- ▶ Appears unaware / unconcerned
- ▶ Right facial droop & right visual field cut
- ▶ BP elevated; recent stroke; PO status undetermined

Step 2

Analyze Cues

The fluent jargon, failed comprehension, and lack of awareness localize the lesion to the **left temporal lobe (Wernicke's area)** — a posterior MCA stroke producing **receptive aphasia**. Right facial droop and right field cut are consistent with left hemisphere damage. He has not been swallow-screened; the right facial weakness raises aspiration risk. Elevated BP after ischemic stroke must be managed within target parameters to balance reperfusion against bleeding.

Step 3

Prioritize Hypotheses

- ▶ **#1 — Aspiration risk** (NPO status not confirmed; facial droop; new stroke) — airway priority.
- ▶ **#2 — Communication deficit (receptive aphasia)** — safety implications: he may not understand call-light instructions or pain assessment.
- ▶ **#3 — Hemodynamic management** — BP control to preserve penumbra without hemorrhagic conversion.

- ▶ **#4 — Post-stroke depression / coping** — emerging, lower priority now.

Step 4

Generate Solutions

- ▶ Keep NPO; request urgent bedside swallow screen / SLP consult.
- ▶ Communicate using gestures, pictures, and demonstration; eliminate background noise; one idea at a time.
- ▶ Place call light within reach; teach with demonstration; consider a visual signaling system.
- ▶ Verify BP parameters per stroke protocol; have antihypertensive available.
- ▶ Implement aspiration, fall, and seizure precautions.
- ▶ Family teaching: receptive aphasia is a language deficit, not confusion — use gestures and pictures.

Step 5

Take Action

- ▶ Maintain NPO; HOB at 30°.
- ▶ Demonstrate call light use; place on his unaffected (left) side and have him press it during teaching.
- ▶ Use a picture board and gesture when assessing pain, hunger, and toileting.
- ▶ Speak in short, simple phrases at normal volume; allow processing time.
- ▶ Notify provider of BP 162/94 and confirm acute-stroke BP target.
- ▶ Educate family at bedside on how to communicate; reassure them his intellect is intact.

Step 6

Evaluate Outcomes

- ▶ Client demonstrates use of call light in response to gestured prompt.
- ▶ Swallow screen completed; diet advanced per SLP recommendation; no signs of aspiration.
- ▶ BP trending toward target without rapid drops; no worsening neuro deficit.
- ▶ Family verbalizes understanding that aphasia is a language deficit, not cognitive decline, and demonstrates use of pictures & gestures.

- ▶ No falls; no seizure activity; no signs of bleeding.

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