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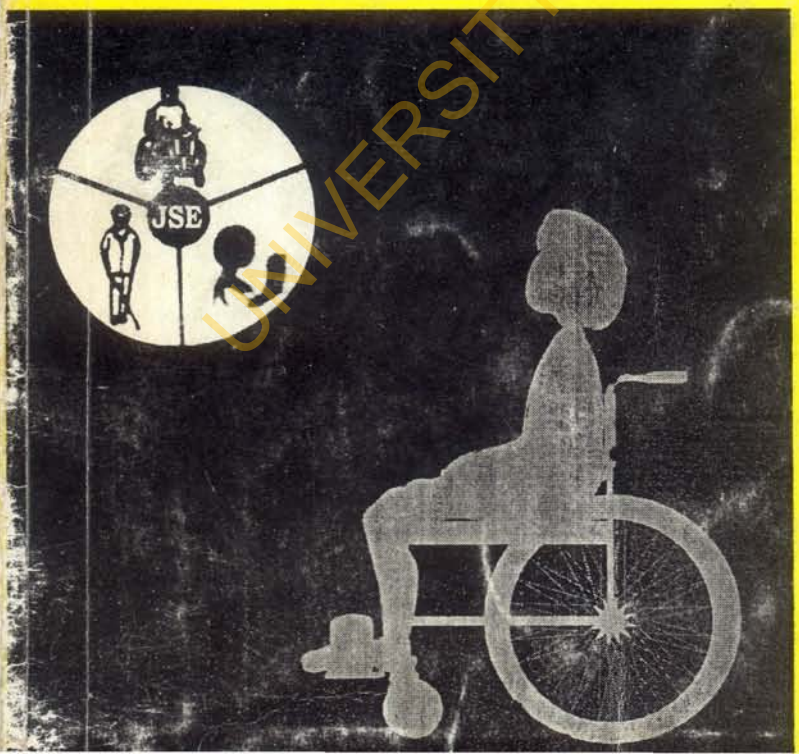

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VERBAL EXPRESSIVE TRAINING: AN ESSENTIAL MANAGEMENT TECHNIQUE OF APHASIC STUDENTS IN NORMAL CLASSROOM SETTINGS

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Abstract

The paper highlights the management technique in rehabilitating the aphasic students in the normal classroom settings. It discusses the need for verbal expressive training as a viable method to facilitate success language responses and shape succeeding language behaviours with increasing complexity. The technique focuses exclusively on the utilisation modalities of a full range of tasks commensurate with the patients areas of deficits, and provides a structured context, for a successful utilisation of an increasing complex nature through assumed auditory-verbal modalities. Based on the discussion, recommendation and suggestions were made.

Introduction

A special loss of ability to correctly receive and utter symbols as a result of brain damage, reception impairment, and transmission of meaning through symbols. This disruption of word formation through impairment of the cortical region is referred to as aphasia.

Aphasia could be defined as a disorder of language with marked communicative disorders. In fact, the condition is characterised by an interference with or absence of internal word formation, and that the disorder produces either distorted words or no word at all, but when words are presented they may appear without any stress or physical disabilities (Duffy and Liles, 1979). Consequently, Holland and Forbes (1993) indicated that aphasic condition is a deviation from biochemical norms of anatomical, physiological, psychiatric and psychological models which enveloped deficits in language, neuro-psychological and motor functions. This could be acquired or development in nature. It also present in both adults and children, and always results to breakdown of already acquired language functions in adults (Bakare, 1991).

The aphasic patients are always unable to use words voluntarily for meaningful

intentional communication, although they frequently retain the ability to produce more automatic verbalizations, such as counting, reciting the days of the week and months of the year, memorised sequences, including prayers or songs, social expressions and emotional speech (Davis, 1983). However, aphasic students are the severely impaired individuals in all language modalities. These set of students neither produce understandable speech or writing, nor comprehend spoken or written language. They also have difficulties in decoding and encoding of verbal symbols. Meanwhile, Aronson (1990) stressed that there are two major types of aphasic students in school settings. These are the non-fluent aphasic students, with expressive and receptive language disturbances. Their problems include brocas, transcortical motor areas and mixed transcortical areas (isolation) syndrome. While the second category is the fluent type with Wemicke's transcortical sensory conditions and anomie aphasic conditions.

To a larger extent, some of these aphasic students in normal classroom setting find it difficult to comprehend spoken words, while some are unable to produce language with relatively preserved comprehensive abilities after hospital care (Osisanya and Oyebola, 1998). A normal classroom setting is exclusively an environment of students without any form of deficits in the area of language, psychomotor, social, sensory and mental behaviours. This classroom setting is not specially arranged to cater for any category of students showing any form of deviation from normal emotional, physical, mental and social behaviours. In other words, its an environment which propels most of the aphasic students to demonstrate a high level of incapabilities in symbolic language, which deprives them of abilities to communicate with other classmates.

Based on the above background, it is imperative to put in place adequate identification and rehabilitative management strategies such as Verbal Expressive Training (VET) which will enable the aphasic students benefit from the normal classroom activities. Also, it shall assist them harness their potential resources in attaining a satisfactory life by realising their achievable targets.

Objectives of the Study

The study aimed at providing a background for the rehabilitation of the students with aphasia in any normal classroom settings, and to draw the attention of teachers and therapists in schools, to the plight of the aphasics and the place of VET in alleviating their language difficulties. It is hoped that this study will facilitate a successful language responses and behaviour through assumed auditory- verbal modalities.

Justification of the Study

This study helps to give a panacea for shaping language behaviours of the aphasics. It provides a structure for successful management of reception impairment in the classroom setting, and it encourages utilisation of management techniques (full range of tasks) that commensurate with the patients' areas of deficits.

Problems of Aphasic Students

Apart from the common difficulties of total deviation from biochemical norms of anatomical, physical, psychological, psychiatric and physiological deficiencies in language, neuro-psychological and motor functions (Holland and Forbes, 1993) encountered by aphasic students globally. Each of the two groups — the fluent and non-fluent patients have a moderate disruption of words formation, transcortical sensory difficulties, reception impairment and transmission of meaning through symbols. They find it difficult to comprehend spoken words and use words voluntarily for meaningful and intentional communication. Also, they show limited ability to repeat patterns set-out for them, and they have difficulties in reproducing digits, nonsense syllables and sentences in the correct order (Holland, 1988). Also, they demonstrate inability to produce some automatics verbalisations. While the non-fluent ones exhibit array of severe losses as a result of problems in the brocas areas, transcortical motor areas and mixed transcortical (isolation) syndrome (Aronson, 1996). This set of children have total breakdown of already acquired language. They have difficulties in perceiving, storing and recalling serial order of information received through auditory channels. Their auditory span is extremely short with demonstrated difficulties in recalling both verbal and non-verbal configurations. Also, they have difficulties with pattern of phonemic detail and conceptual organisation.

Due to the nature and peculiarity of the normal classroom environment to provide the aphasic students with therapeutic orientations. Hence, the situation enforces order on them to demonstrate a high level of limitations in comprehension of visual-auditory events in the classroom. They find it difficult to discharge their tensions and anxieties by the way of the verbal exchanges. Further, they cannot perfectly verbalise their anger and aggression, as a result they are forced to melt into background, because of their conceptual deficits and linguistic difficulties. With their severe difficulties in the communication order of expression and reception, they develop ego functions marked with improper mastery of impulse control and immature central neurons system (CNS) (Holland, 1988). Most times, these children are difficult to teach, for they are more responsive to stimuli from outside than within the classroom environment since there is always a far distance between the sender (classroom teacher)

and the receiver (students). Also, they have difficulties with interpretation of spoken and printed languages.

With the above observations, the aphasic students in any normal classroom settings will surely need rehabilitative orientation and attention as a form of progressive transmission and integration from normal classroom to the larger society which if embedded with verbal exchanges.

Verbal Expressive Training (VET): A Necessity

VET is a kind of management strategy designed to rehabilitate the aphasic children who are totally mute in a classroom setting. VET is a treatment package procedure for patients with difficulties in fluent production of speech to complete mutism, minor grammar problems, impairments in word reception and retrieval or word substitution, or discourse failures (Pearce, 1993). This training exercise channels effort towards establishment of a control phonation of words. The treatment profile of patients is dependent on such factors as the time of onset, type and severity of the condition.

The training is conducted through the use of reflexive coughing or throat-clearing to establish voluntary phonation of words. It always begins with severe non-fluency and continues with increasing levels of speech fluency. The first consideration in treating patients with this model is to establish whether the deficits are due to aphasia, apraxia of speech or both. Thereafter, the training sessions will commence with the total rehabilitation of the patients' auditory and articulartory channels through series of reflexive coughing, varying cue models with different levels of accuracy until successful production and reception of the target is achieved. Although, the therapist classroom teacher will need to impose a delay between the presentation of the stimuli and the patients' responses so as to increase their depth of lexical processing and gain strength for their verbal presentations and associations.

In addition to their verbal process and word recognition gain, the patients receive concurrent auditory comprehension treatment by responding to simple questions. Also, they may be asked to follow directions that require a demonstration of some responses using parts of the body, objects or interesting topics. In fact, the VET methods are through communicative and conversational strategies. By communicative model, the speech therapist/classroom teacher always assist the patients in arranging communication situations. Thus, enabling them to optimise the use of their abilities to development strategies to facilitate information transfer. While the conversational method enables the therapist to monitor the patient's improvement, and after a while the therapist will scan for a communication partner for the patient so as to be facilitated into the use of daily life communicational needs. Here, gesture,

pantomime and other cues are used, while at the same time the patients' family members or friends will be allowed to participate in the training so as to assist the patients with familiar language usage. This procedure will elicit lengthy utterances in excess of the produced discourse abilities which could be sharpened through story-telling and open-ended conversation on unrestricted topics (Helm-Estabrooks and Albert, 1991). But then, it will require the classroom teacher/therapist to double efforts in stimulating the patients properly at the beginning through verbal expressive exercises so as to incorporate humming and production of vowels.

VET as a programme represents a viable method of a sender, a message and a receiver. With this, the sender is required to use various verbal and non-verbal channels of communication in order to achieve comprehension and understanding. It provides a context which facilitate successful language responses as well as shapes succeeding language behaviours with increasing complexity, since it begins with intrinsic auditory stimulation and progresses at the level where language breakdown for each patient. Also, it proceeds systematically from easier to more difficult task. In fact, the beauty of VET is that it focuses exclusively on the modalities of utilisation of a full-range of tasks that are commensurate with the patients areas of deficits, as it provides a structured context for a successful utilisation of an increasing complex nature through assumed auditory-verbal modalities. This in turn will remediate the language behaviours of aphasic students in any normal classroom environment in addition to the ultimate help in understanding, comprehension of verbal messages and ability to speak better.

Since the ultimate communication strategy and understanding of situational cues in any normal classroom are through verbal understanding and exchanges. Verbal expressive training should be the recommended management strategy because of its inherent designs to ameliorate language performances in deficient areas as a way of promoting language stimulation and facilitation. It also incorporates natural face-to-face conversation together with the capability to re-orientate the aphasic patients' communicative abilities in daily living through the involvement of a variety of people (family members and friends). This group of people often facilitates the production of a recounting or expository discourse. They converse with the aphasics better while the therapist only acts as a facilitator where necessary. The use of social communication orientation approach improves the personal communication style of individual patients through naming of objects and parts of body, spontaneous speech, story telling with sensual demonstrations of humours (Pearce, 1993). With VET, patients are trained in sequential word order through repeated naming of objects, representations of simple sentences until an acceptable conversational usage is established. Patients may be asked to simply read aloud or repeat a whole phrase on

sentences presented by the therapist so as to stimulate increased phrase lengths. It enables a transition from simple repetition of more prepositional language usage. In fact, this strategy will go a long way in remediating the aphasic back to the large society embedded with verbal exchanges.

Going by the recent adoption and utilisation of technology in rehabilitating the disabled, VET will serve the aphasic patients in normal classroom better with its accompanied use of computer aided visual communication and alternative visual symbol system for patients whose communication skills would otherwise by severely limited.

Conclusion and Suggestions

The recommendation of VET is a worthwhile strategy to rehabilitate the aphasic students who finds himself/herself in any normal classroom setting. VET performs both the stimulatory and compensatory efforts in remediating the aphasic students. It reinforces the patients to receive and communicate intended messages. It is progressive in shaping the complex behaviour of the aphasic as well as eliminating their maladaptive behaviour.

The strategy enables the classroom teachers/speech therapist to determine easily whether the patient has improved, remained the same or deteriorated, which may even lead to depression and other maladaptive reactions in addition to the complexities of the normal classroom setting.

In recording a successful achievement through the use of VET, it is essential that aphasic patients must be trained individually with a total rehabilitation of their residual capabilities, so as to prevent inflection or secondary and tertiary deficits, promotion of social integration and emotional adaptation, reduction of environmental disruptions and assistance to augment speech order through communication aids.

Suspected patients must be diagnosed properly to ascertain the nature and type of his/her problems before the consideration of a worthwhile management procedure. Hence, the non-fluent aphasic treatment package should include the use of deblocking procedures to improve the volitional imitation of motor responses, self-generation of categories names and complete sentences, and language training using either stimulation or gestural techniques. While, the fluent patient's activities should be directed towards improving word-retrieval abilities through a variety of conformational naming tasks, such as recall of categorised numbers, word associations, antonym and synonym production, descriptions of busy pictures, auditory comprehension tasks and generalisation of ideas, through picture descriptions, monologues story-retelling and role-playing (Holland and Forbes, 1993).

More importantly, the patients should be stimulated and encouraged greatly so as

to develop the required communicational abilities and empowerment. To achieve this the classroom teacher with the assistance of a speech therapist should endeavour to adequately stimulate and re-orientate the patients into a real oral or conventional word through means and materials at his/her disposal so as to restore him/her back to the former position. Efforts should also be geared towards stimulating the client's verbal expression by reinforcing their productive behaviour, which will in turn facilitate the rehabilitative strategy to smoothly progress from simple to complex responses.

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