INTRODUCTION:
Language plays an important role to communicate with other human beings. It is a powerful development tool for learning and an aid to understanding. Language is a vehicle for educational development and is important for apprehension and acquisition of knowledge (Hillman, D. C, 1999). Language is also embedded in cognition. Many neurobiological and computational processes are involved in language processing. Expression requires motor cortical areas, basal ganglia and cerebellum. Language comprehension is carried by several language sub systems such as phonological, semantic syntactic sub systems and is supported by memory and attentional processes (Hickock & Poeppel, 2004). Aphasia is an acquired language deficit which occurs due to brain damage (Code & Petheram, 2011).

i) Concept:
Aphasia is an acquired language disorder in cognitive and communication skills (Drummond 2006). It includes problems of comprehending spoken language, expressing language or both (ASHA, 2014). Actually, it is originated from the Greek word “aphatos” which means speechless, etymologically, it means cognition-communication deficit related to damage involving the left hemisphere of the brain (ASHA, 2005). LaPointe (2005) states that aphasia is distinctly an acquired disorder that can be caused by a Cerebro Vascular Accident (CVA or stroke), Traumatic Brain Injury (TB), or a brain tumor. Another possible cause is neurodegenerative diseases such as Alzheimer's disease, or Parkinson’s disease. These diseases give deficit in specific language functions such as memory, reasoning, and judgment.

ii) Types of Aphasia:
There are seven types of aphasia namely; 1) Broca's aphasia, 2) Wernicke’s aphasia, 3) Conduction aphasia, 4) Anomic aphasia, 5) Global aphasia, 6) Transcortical motor aphasia and 7) Transcortical sensory aphasia. Some other related aphasia are: i) Anomia, ii) Acalculia and iii) Agraphia (ASHA, 2014).

i) Broca's aphasia: Broca's aphasia is characterized by deficit in language production. In this, languages production is not fluent. Individual with Broca's aphasia use only keyword, they express nouns in singular verbs in participle. Individual with Broca's aphasia often eliminates articles, adjectives and the adverbs altogether.

ii) Wernicke's aphasia: Wernicke's aphasia is characterized by deficit in comprehension. Sometimes, individuals with wernicke's aphasia may use wrong word or are wrong combination of words (paraphasia), but speech is fluent, language has normal rhythm and melody. Sometimes, they make new words (neologisms), it means neologistic or word paraphasia distortions mostly occurred in Wernicke's aphasia.

iii) Conduction aphasia: It was predicted by Wernicke. Lesions in arcuate fasciculus give conduction aphasia. Arcuate fasciculus runs in the white matter and connects Wernicke's as well as Broca's areas. Conduction aphasia is having certain characteristics which are consistent with this separation of Broca's and Wernicke's area. Here, naming is severely impaired. Reading aloud is abnormal. Writing may also be disturbed. Spelling is very poor.

iv) Anomic aphasia: In Anomic aphasia, the only disturbance is a difficulty in finding the correct words. This is an unusual form of aphasia that follows lesions in the posterior aspect of the left inferior temporal lobe. Individual with an Anomic aphasia has defect in the right superior quadrant visual field.

v) Global aphasia: Individual with Global aphasia is unable to speak or comprehend language; they cannot read, write, repeat or name objects. It includes deficit in Broca's area, Wernicke's area and the arcuate fasciculus.

vi) Transcortical motor aphasia: It gives rise to a non-fluent aphasia in which the individual cannot produce creative speech. Individual with Transcortical aphasia will attempt conversation but can utter only a few syllables.

vii) Transcortical sensory aphasia: It gives rise to fluent aphasia with defective comprehension, defective thinking or remembering the meaning of words.

Anomia is also associated with aphasia. It is characterized by problems recalling words, names and numbers. Individual with an Anomic aphasia is knows what to do with an object, but still not be able to give a name to the object. There are three type s of Anomia namely – (1) Word selection anomia, (2) Semantic anomia and (3) Disconnection anomia. Individual having more word selection anomia, knows how to use an object, but cannot name the object. For example, individual with word selection anomia can distinguish between colors but cannot identify them by naming the object. An individual semantic anomia has naming deficit which is accompanied by a recognition deficit. Disconnection anomia may exhibit modality-specific anomia, where the anomia is limited to a specific sensory modality, such as hearing. Agraphia includes severe form of writing deficits and Acalculia includes severe form of inability in doing calculations.

iii) Symptoms of Aphasia:
The symptoms of aphasia are not the same in every case. They occur in an unique patterns and cluster. Individual with aphasia has deficit in four language modalities namely; i) auditory comprehension, ii) reading comprehension, iii) verbal expression, and iv) written language. Auditory comprehension deficits consist of difficulties such as understanding speech, providing inaccurate answers to "yes/no" questions, inability to understand complex grammar, and not being aware of their errors. Reading comprehension deficits include difficulty in comprehending written information, difficulty in identifying words by sight, replacing associated words for the word itself, and difficulty in reading function words (e.g., to, from or the). Verbal expression deficits include communicating in fragmented phrases, difficulty in finding words, talking with single words, putting words in the wrong order. Written language deficits include difficulty in writing run-on sentences, and writing sentence with correct grammar, or copying letters, words, and sentences systematically.

Aphasia symptoms are not limited to the speech and language, but also in areas that affect quality of life. Those with aphasia are unable to develop social and personal relationships because these relationships are dependent on the ability to communicate. Depression is the psychological symptom of aphasia (Samo, 2004; ASHA, 2014). A person with aphasia may also have difficulty with tasks such as traffic signals. Townend et al (2007) have listed some of the general characteristics of aphasia such as: i) Lack of understanding, ii) Lack of producing spoken languages (e.g., conversations) and iii) Reading & writing problems. Finally, aphasia seems to have direct impact on personal relationships, employment, and social rehabilitation.

iv) Causes of Aphasia:
Greener et al (2008) reports that 1/3rd of people left with communication disorder (aphasia) following stroke. Greener et al (2008), Baekheit et al (2007), Van der Gaag (2005), RCSLT (2008) reports that aphasia is caused by damage to an area of brain responsible for language. Speakability (2000) listed out that statistically 85% of people with aphasia have suffered from stroke. At all events, the main causes for Aphasia are:

1. Stroke
2. Head/Brain injury
3. Brain tumor
4. Neurosurgery
5. Brain infection (encephalitis)
6. Neurological diseases (e.g. Alzheimer's disease, Parkinson's disease, multiple sclerosis).

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7. Drug misuse
8. Dementia
9. Migraine

The stroke association (2008) depicts that stroke is the common cause of aphasia and it is associated with family history, heart disease, life style, presence of obesity, diabetes and high blood pressure. Life style issues include high cholesterol, smoking, heavy drinking and fatty diet.

v) Assessment, Treatment and Intervention of Aphasia:

1) Assessment:
If signs and symptoms of aphasia are identified after a screening is done, the SLP (Speech Language Pathologist) is responsible for performing a more comprehensive assessment of the individual. His or her accountability is to analyze the receptive and expressive abilities within the four modalities of language, which are speaking, listening, reading, and writing (Byng, Pound, & Fares, 2000). Some main types of impairments due to aphasia include: computer based treatment, Constraint Induced Language Therapy (CILT), Melodic Intonation Therapy (MIT), reading treatment, syntax treatment, treatment of underlying forms, verb network strengthening treatment, word finding treatment, and writing treatment (ASHA, 2014).

Computer-based therapy can be beneficial in treating attention, concentration, visual localization, visual scanning, visual tracking, reaction time, memory, hand-eye coordination, and specific cognitive impairments (Adamovich, 2005). Melodic intonation therapy (MIT) is a treatment method that takes advantage of the musical abilities of the right hemisphere of the brain. This type of therapy is best known for the rehabilitation of nonfluent aphasics who demonstrate deficits in verbal output (Basso, 2003). Reading treatment is designed to improve the ability to decode and comprehend written language (ASHA, 2014). It is a belief that repetition of oral reading will initiate quick and automatic comprehension of written text. Syntax treatment focuses primarily on improving grammatical deficits in spoken utterances (ASHA, 2014). Treatment of Underlying Forms (TUF) is a treatment method that builds on complicated sentence forms. This tactic, based on linguistic theory, is intended to develop sentence production in aphasics with agrammatism (ASHA, 2014). Verb Network Strengthening Treatment (VNSt) is focused on improving the ability to understand and produce meaningful speech. This treatment has a goal of increasing retrieval content words when producing sentences (Edmonds, Nadeau, & Kiran, 2009). There are different types of word finding treatments, including word retrieval cueing strategies, gestural facilitation of naming, response elaboration training, and semantic feature analysis treatment (ASHA, 2014). Writing treatment is a program aimed at improving expressive language skills through the use of written language (ASHA, 2014).

Activities/Participation Based Treatment includes Multimodal Treatment, Partner Approaches, Pragmatic Treatment, Reciprocal scaffolding, and Script training. Intervention that targets activities and participation has been shown to greatly improve the quality of life of many individuals who have aphasia. Multimodal treatment focuses on using alternative forms of communication in an effective and efficient way. As indicated by ASHA (2014), multimodal treatment can include Augmentative and Alternative Communication (AAC), visual action therapy, Promoting Aphasics’ Communication Effectiveness (PACE), and Oral Reading for Language in Aphasia (ORLA). Partner approaches include conversational coaching, Supported Communication Intervention (SCI), and social and life participation effectiveness (ASHA, 2014). Pragmatics are the rules that regulate how we use language when communicating with others. This includes using language to comment, request, warn or acknowledge in conversation. This area of communication involves using both linguistic and non-linguistic strategies to start and continue a conversation, and to take turns speaking while having eye contact and facial expressions that are appropriate within the context of communication (Wright & Newhoff, 2005). Reciprocal scaffolding is a treatment approach that facilitates interactive and natural communication between the aphasic and their communication partner. Script training is a treatment in which people with aphasia rehearse a personalized dialogue or monologue script until it becomes automatic, allowing aphasics to communicate about a topic they are interested in (ASHA, 2014).

Treatment efficacy depends on many factors, aside from the treatment itself. Research has shown that the effectiveness of therapy is based on the quantity and intensity of therapy (Basso et al., 2011). The above treatments are most often provided by SLPs with the primary purpose of recovering speech and language abilities. However, aphasia treatment is not exclusively designed for the rehabilitation of the language modalities. Complications from acquired brain injuries are multifaceted, thus the knowledge and skills of several professionals from different disciplines are necessary to maximize positive outcomes in aphasics (Joint Committee, 2007). SLPs must be aware of their responsibilities on an interdisciplinary team in order to focus on the recovery of language abilities in aphasics.

3) Intervention:
Specifically for aphasia, the basic goal of intervention is to improve a person’s ability to communicate (NIHCD, 2008). Intervention for aphasia treatment should begin as soon as possible because the most positive changes can occur early after the onset of aphasia (ASHA, 2011).

1) Counseling: The SLPs responsibilities extend beyond treatment directly through language therapy. Counseling in these situations would focus more on instilling acceptance of the disorder and fostering realistic and positive expectations (Holland, 2007). Counseling is meant to assist individuals and to decide on appropriate goals that take advantage of strengths and address weaknesses that affect communication. Counseling is also intended to help individuals learn to adapt to their environment in order to effectively communicate.

2) Collaboration & Management: The SLP is responsible for collaborating effectively with and apply strategies of collaboration and management. Case management and collaboration skills also include the ability to manage the use of resources sensibly based on the long-term or immediate needs of aphasics, and their family members or caretakers. Collaboration is a key aspect of assessing cognitive impairments and planning for rehabilitation (ASHA, 2003).

3) Education: Proper education can help aphasics become aware of their disorder and the options they have in treatment and other rehabilitation services (Cameron, 2013).

4) Advocacy: Advocacy for these aphasics can be done at the local, state and national levels (Elman, R.J., Ogar, & Elman, S. H., 2000).

It is very important for professionals in the field of Education, Psychology, Linguistics, Language Education, Medicine and Nursing to raise awareness, to cultivate positive expected behaviours and reducing psychosocial isolation among individuals with aphasia.

Relevance of Aphasia:
Primary Education is a basic foundation for language acquisition and learning. The main objective of the primary education is to achieve 3R’s (reading, writing and arithmetic) among primary school children. Language is an effective tool to attain not only reading and writing skills but also speaking skills. The quality of primary education is also reflected on language learning skills through effective curriculum. Curriculum for primary education should focus on learning by doing for attaining language skills. There is research evident that many of the children at school level have been suffering from language deficits. Some of the children have language expression deficits and some of them have language comprehension deficits. Hence, it is necessary for primary teachers to know about language deficit which is known as aphasia. And teachers have to identify children with aphasia and provide necessary intervention for those children to achieve success academically as well as socially. Teachers have also to follow suitable teaching strategies for children with aphasia for their motor, cognitive and social development. At all events, primary school teachers have to cultivate conscious behaviour on aphasia. Subsequently, they have to frame desirable perceptual behaviour on aphasia so that they can provide appropriate teaching-learning activities to various types of aphasies.

There has been an increase in the interest of aphasia by many fields such as neuropsychology, neuro-linguistics and speech-language pathology (Tesak & Code, 2006). Tabi (2012) has reported that aphasia is described as missing speech. It is common especially amongst elderly people due to some age related factors. Person with aphasia has lots of communication difficulties. Hillis (2007) states that classification of aphasia has shifted from primarily describing...
Transcortical motor aphasia is also a nonfluent type of aphasia similar to Broca's aphasia. As with transcortical sensory aphasia, answering spontaneous questions is difficult for these patients, but their repetition abilities are still intact. The main difference between sensory and motor transcortical aphasia is that auditory comprehension is unaffected in transcortical sensory aphasia, whereas in transcortical motor aphasia, people with transcortical sensory aphasia often express aphasic speech and written output, outside of repetition, shows reduced quantity, variety, and elaboration of speech (ASHA, 2007a). People with transcortical motor aphasia also lack the motor precision needed to properly execute verbalizations (Hollingsworth, Rothi, & Cimino-Knight, 2005).

Mixed transcortical aphasia is a combination of both motor and sensory transcortical aphasia. Severe impairments are present in reception and expression, but people with this type of aphasia will have strong repetition skills (ASHA, 2007a). Mixed transcortical aphasia has been characterized by deficits in auditory comprehension and production of meaningful vocal output (Asher, 1998). People with mixed transcortical aphasia are typically unable to spontaneously produce speech and are often incapable of naming objects (Hollingsworth et al., 2005).

Global aphasia is another type of nonfluent aphasia that damages both expressive and receptive communication. This is usually due to a large left hemisphere lesion (ASHA, 2007a). Because this type of aphasia is so severe, there is no distinctive pattern of preserved language components in comparison to impaired language components (Goodglass & Kaplan, 1983). People with global aphasia may appear to have fairly good auditory comprehension when answering yes or no questions about family members. It has also been found that global aphasics have a surprising ability to locate geographic places and understand place names (Goodglass & Kaplan, 1983). However, people with the type of aphasia have severe deficits across all aspects of language and none of the communicative modalities are preserved (Collins, 2005). Other symptoms experienced by people with global aphasia include difficulties with non-verbal problem solving and oral and gestural apraxia (Collins, 2005).

Crossed Aphasia and Primary Progressive Aphasia are unclassified aphasia. Crossed aphasia is a disorder characterized by the unexpected presence of aphasia following a lesion in the right hemisphere of the brain in an individual who is right-handed. Every major syndrome of aphasia has occurred as a result of crossed aphasia (Coppen & Hungerford, 1998). Primary progressive aphasia (PPA) is characterized by the gradual decline of language function with unaffected cognitive abilities for a period of time. The condition must persist for at least two years in order to acquire a diagnosis of PPA. This type of aphasia is classified as a neurological degenerative form of fluent aphasia and has subcortical lesions. Symptoms of PPA begin with problems in word finding and progress to deficits in grammar and comprehension. PPA can be described as an unusual form of dementia; memory functions remain undisturbed even as language gradually deteriorates (Mesulam, 2003).

Abha Gupta and Gaurav Singhat (2011) have reported that Broca's aphasia is related to non-fluent telegraphic speech. Wernicke's aphasia is related to jargon speech. Conduction aphasia is related to repetition deficit. Nominal aphasia is related to deficit word-finding and naming. Global aphasia is related to severe impairment in all modalities. Transcortical aphasia is similar to motor aphasia having both sensory and motor deficits. Conduction aphasia is similar to sensory aphasia, but with intact repetition. Perkell (2012) views conduction aphasia as disorder of repetition.

Aphasia assessment is to be conducted culturally and linguistically relevant to language and communication (ASHA, 2014). Parr (2007) suggests that family, friends and other services should be considered within the therapy process of aphasia. NIDCD (2008) tells that family involvement is a crucial component of aphasia treatment in order to learn how to adopt communication and how to support a person in treatment. NIDCD (2008) tells that therapy helps in minimizing disability by following alternative means of communication. Aphasia therapy develops social skills and confidence, promotes independence and decision making and also social integration. Aphasia treatment in order to learn how to adopt communication and how to support a person in treatment. NIDCD (2008) tells that therapy helps in minimizing disability by following alternative means of communication. Aphasia therapy develops social skills and confidence, promotes independence and decision making and also social integration. Aphasia assessment is to be conducted culturally and linguistically relevant to language and communication (ASHA, 2014). Parr (2007) suggests that family, friends and other services should be considered within the therapy process of aphasia. NIDCD (2008) tells that family involvement is a crucial component of aphasia treatment in order to learn how to adopt communication and how to support a person in treatment. NIDCD (2008) tells that therapy helps in minimizing disability by following alternative means of communication. Aphasia therapy develops social skills and confidence, promotes independence and decision making and also social integration. Aphasia assessment is to be conducted culturally and linguistically relevant to language and communication (ASHA, 2014).


