

**COMMUNICATION DISORDERS EXPERIENCED BY
GABBY GIFFORDS IN THE DOCUMENTARY MOVIE
'GABBY GIFFORDS WON'T BACK DOWN' 2022**

THESIS

Submitted to the School of Foreign Language – JIA as a partial fulfillment of requirements for the undergraduate degree in English Literature Programme



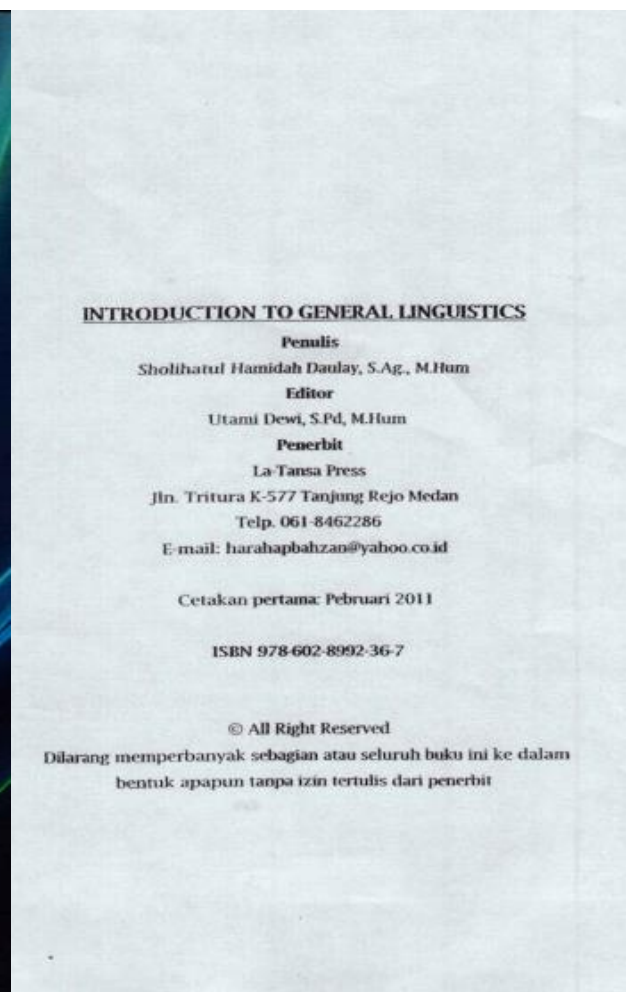
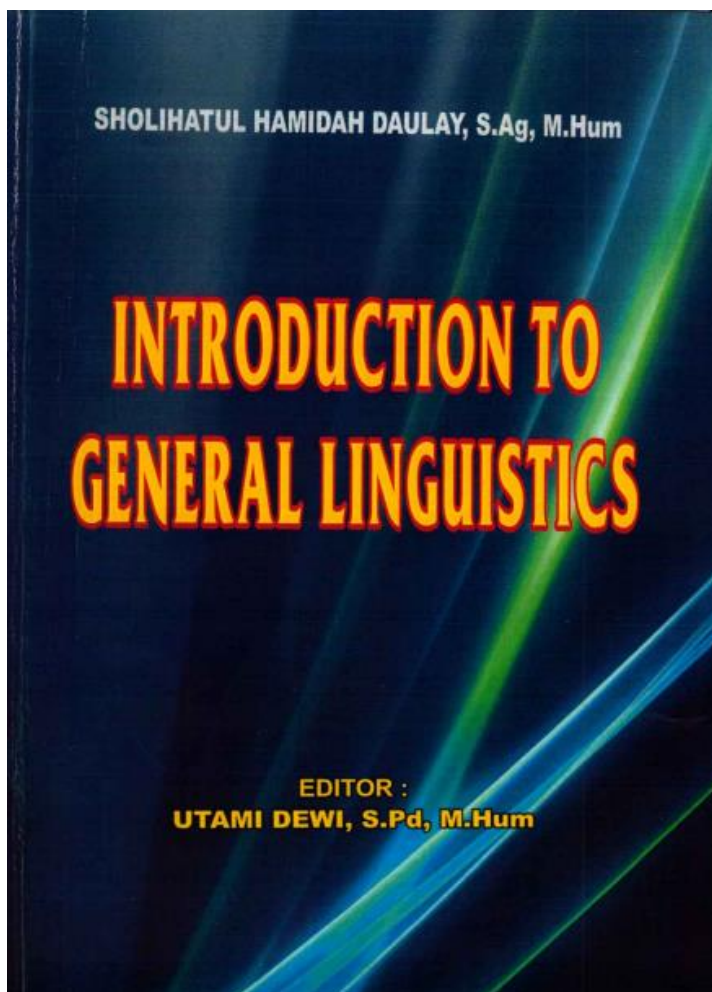
**PUTRI NUR AZIZAH
43131510200036**

**ENGLISH LITERATURE PROGRAMME
SCHOOL OF FOREIGN LANGUAGES - JIA
BEKASI
2024**

CHAPTER I
BACKGROUND OF THE RESEARCH

A. Background of the research

Daulay, S. (2011). *Introduction to General Linguistics*. La-Tansa Press.



WHAT'S LINGUISTICS ?

1.1 Definition of Linguistics

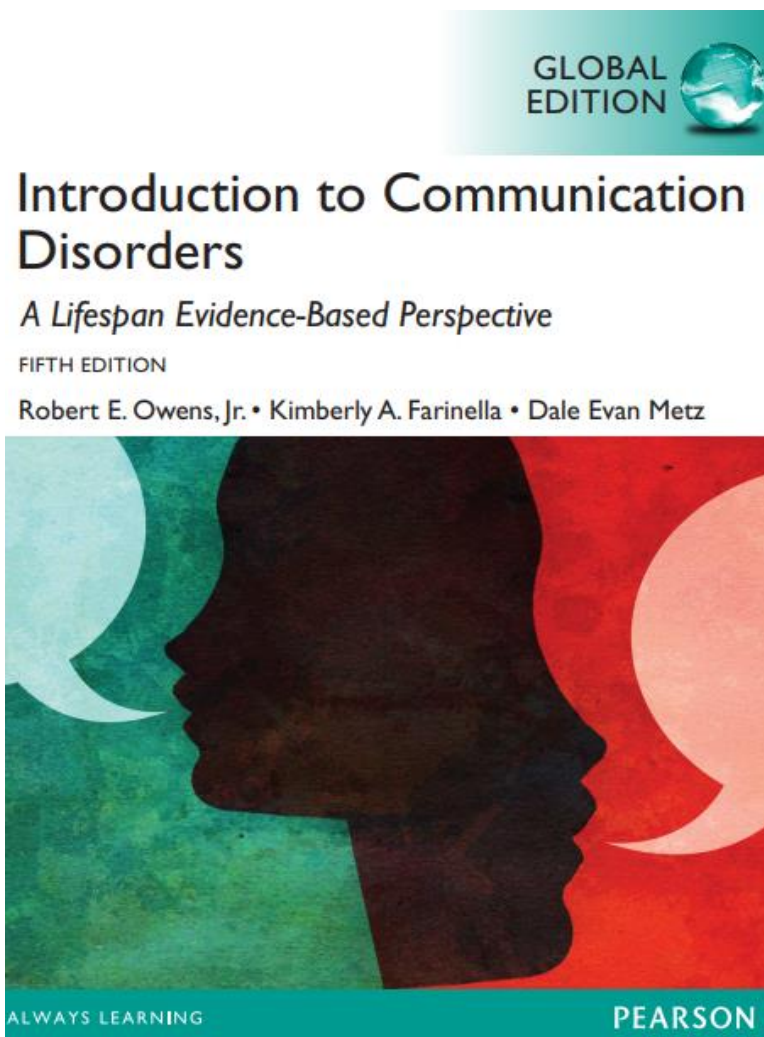
Linguistics is the scientific study of natural language. Linguistics encompasses a number of sub-fields. An important topical division is between the study of language structure (grammar) and the study of meaning (semantics). Grammar encompasses morphology (the formation and composition of words), syntax (the rules that determine how words combine into phrases and sentences) and phonology (the study of sound systems and abstract sound units). Phonetics is a related branch of linguistics concerned with the actual properties of speech sounds (phones), non-speech sounds, and how they are produced and perceived.

B. Question and Scope of the Research

2. Scope of the Research

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*.

Pearson.



Vice President, Editorial Director: Jeffrey W. Johnston
Executive Acquisitions Editor: Ann Davis
Executive Field Marketing Manager: Krista Clark
Senior Product Marketing Manager: Christopher Barry
Project Manager: Annette Joseph
Head of Learning Asset Acquisition, Global Edition: Laura Dent
Acquisitions Editor, Global Edition: Sandhya Ghoshal

Assistant Project Editor, Global Edition: Sinjita Basu
Senior Manufacturing Controller, Production, Global Edition: Trudy Kimber
Full-Service Project Management: Jouve India
Cover Designer: Lumina Datamatics
Cover Photo: Shutterstock/nchluft
Cover Printer: Ashford Colour Press

Pearson Education Limited
Edinburgh Gate
Harlow
Essex CM20 2JE
England

and Associated Companies throughout the world

Visit us on the World Wide Web at:
www.pearsonglobaleditions.com

© Pearson Education Limited 2015

The rights of Robert E. Owens, Jr., Kimberly A. Farinella, and Dale Evan Metz to be identified as the authors of this work have been asserted by them in accordance with the Copyright, Designs and Patents Act 1988.

Authorized adaptation from the United States edition, entitled *Introduction to Communication Disorders: A Lifespan Evidence-Based Perspective*, 5th edition, ISBN 978-0-133-35203-0, by Robert E. Owens, Jr., Kimberly A. Farinella, and Dale Evan Metz, published by Pearson Education © 2015.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without either the prior written permission of the publisher or a license permitting restricted copying in the United Kingdom issued by the Copyright Licensing Agency Ltd, Saffron House, 6-10 Kirby Street, London EC1N 8TS.

All trademarks used herein are the property of their respective owners. The use of any trademark in this text does not vest in the author or publisher any trademark ownership rights in such trademarks, nor does the use of such trademarks imply any affiliation with or endorsement of this book by such owners.

ISBN 10: 1-292-05889-7
ISBN 13: 978-1-292-05889-6

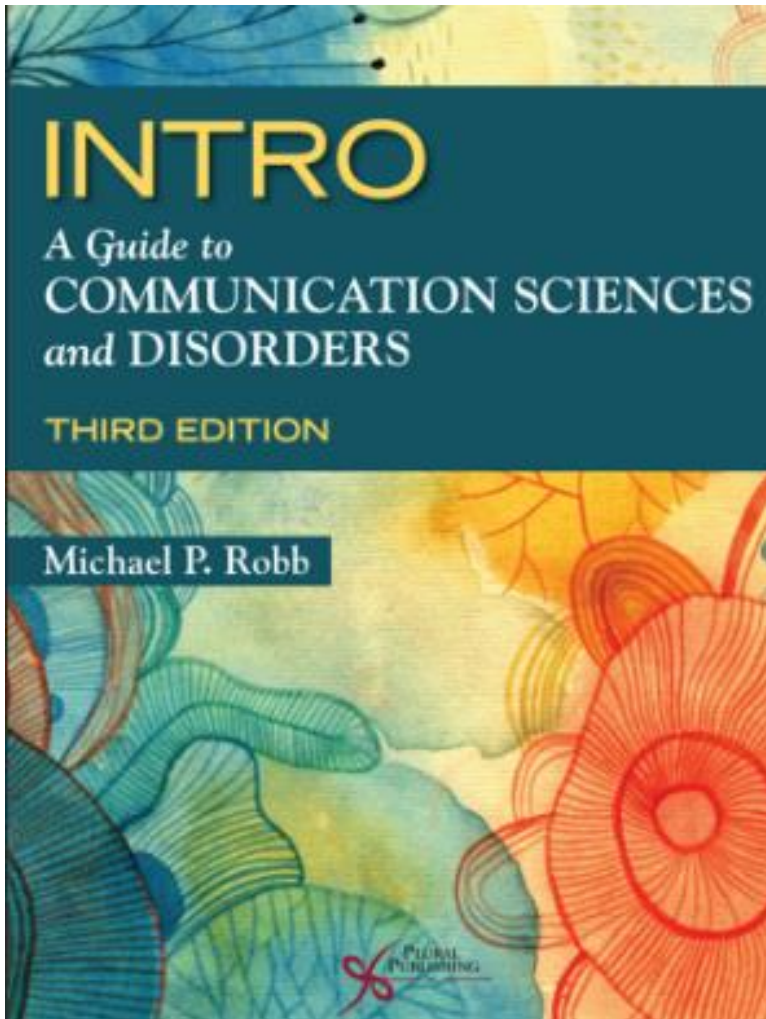
British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

10 9 8 7 6 5 4 3 2 1
14 13 12 11 10

Typeset in ITC Mendoza Roman Std by Jouve India.

Printed in Great Britain By Ashford Colour Press Ltd, Gosport.

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.



5521 Ruffin Road
San Diego, CA 92123

e-mail: information@pluralpublishing.com
website: <http://www.pluralpublishing.com>

Copyright © 2020 by Plural Publishing, Inc.

Typeset in 11/33 Palatino by Flanagan's Publishing Services, Inc.
Printed in Canada by Friesens.

All rights, including that of translation, reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, recording, or otherwise, including photocopying, recording, taping, Web distribution, or information storage and retrieval systems without the prior written consent of the publisher.

For permission to use material from this text, contact us by
Telephone: (866) 758-7251
Fax: (888) 758-7255
e-mail: permissions@pluralpublishing.com

Every attempt has been made to contact the copyright holders for material originally printed in another source. If any have been inadvertently overlooked, the publishers will gladly make the necessary arrangements at the first opportunity.

Disclaimer: Please note that ancillary content (such as documents, audio, and video, etc.) may not be included as published in the original print version of this book.

Library of Congress Cataloging-in-Publication Data

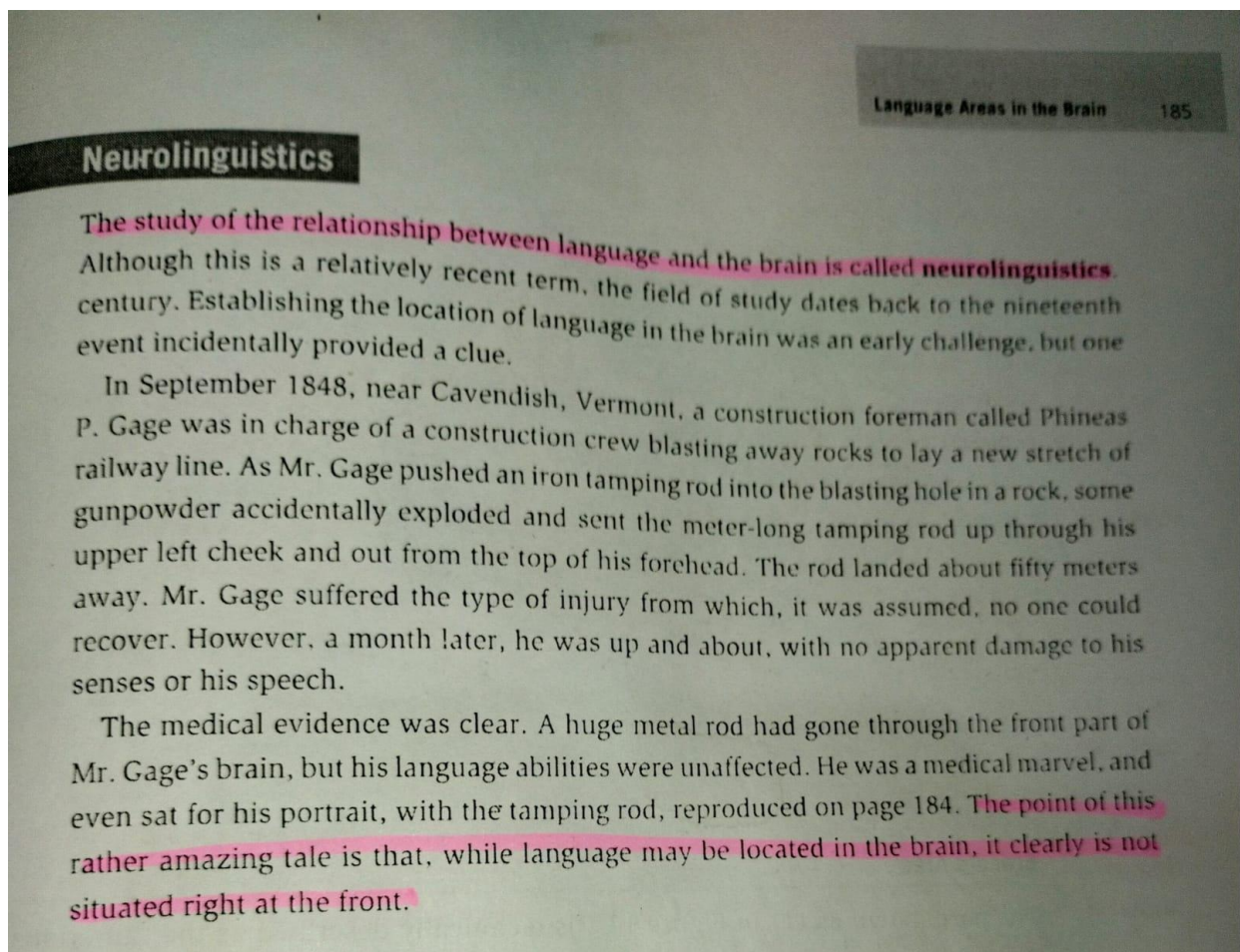
Names: Robb, Michael P., author.
Title: INTRO : a guide to communication sciences and disorders / Michael P. Robb.
Other titles: Guide to communication sciences and disorders
Description: Third edition. | San Diego, CA : Plural, [2020] | Includes bibliographical references and index.
Identifiers: LCCN 2018028843 | ISBN 9781944883669 (alk. paper) | ISBN 1944883665 (alk. paper)
Subjects: | MESH: Communication Disorders | Hearing Disorders
Classification: LCC RC423 | NLM WL 340.2 | DDC 362.196/855—dc23
LC record available at <https://lcn.loc.gov/2018028843>

CHAPTER II

THEORETICAL DEFINITION

A. Neurolinguistics

Yule, G. (2020). *The Study of Language* (7th Edition). Cambridge University Press.



Ingram, J. C. L. (2007). *Neurolinguistics: An Introduction to Spoken Language Processing and its Disorders*. Cambridge University Press.

Introduction

This book is about language processing in the human brain and, more specifically, what happens to spoken language when certain areas of the brain are damaged. Language processing is what takes place whenever we understand or produce speech; a mundane task, but one of extraordinary complexity, whose mysteries have baffled some of the greatest minds across the centuries.

Neurolinguistics is the technical term for this field, introduced into academic usage by Harry Whitaker (1971), who founded the leading journal that bears this title. As Whitaker noted at the time, it is a key assumption of neurolinguistics that 'a proper and adequate understanding of language depends upon correlating information from a variety of fields concerned with the structure and function of both language and brain, minimally neurology and linguistics'. Today, some thirty years later, it seems necessary to add 'cognition' or cognitive science to the list of minimally necessary disciplines. A well-articulated cognitive science is needed to provide the hoped for integration of two otherwise very different fields of study: language and neurobiology.

Considerable progress and a vast body of research have accumulated since then. Yet leading advocates of the cognitive science perspective on language as a biologically grounded human ability (such as Chomsky, Pinker and Deacon, to mention just three) disagree on some fundamental questions. To what extent are our language learning capabilities 'hard-wired' into the human brain and unique to the species? How is 'innate linguistic competence' actually deployed in language

Ahlsén, E. (2006). *Introduction to Neurolinguistics*. John Benjamins Publishing.

What is neurolinguistics?

Neurolinguistics studies the relation of language and communication to different aspects of brain function, in other words it tries to explore how the brain understands and produces language and communication. This involves attempting to combine neurological/neurophysiological theory (how the brain is structured and how it functions) with linguistic theory (how language is structured and how it functions). Apart from neurology and linguistics, psychology is another central source discipline for neurolinguistics. Neurolinguistics has a very close relationship to psycholinguistics, but focuses more on studies of the brain. Studies of language and communication after brain damage are perhaps the most common type of neurolinguistic studies. However, experiments, model construction, computer simulations, and neuroimaging studies are also very frequently used methods today.

B. Brain and Language

Budianingsih, T. (2015). *Peran Neurolinguistik dalam Pengajaran Bahasa*
(Vol. 3, Issue 2).

PENDAHULUAN

Banyak yang tidak tahu tentang hubungannya peran neurolinguistik dalam pengajaran bahasa. Sebenarnya jika kita mengetahui secara baik peran tersebut pengajar bahasa sedikit lebih mudah dalam pengajarannya untuk membuat siswa mengerti dalam mempelajari bahasa sasaran. Penguasaan bahasa manusia berbeda dengan hewan, sebenarnya hal ini dilandasi oleh dua aspek, yaitu aspek biologis dan aspek neurologis. Walaupun peneliti tidak membahas

pada aspek biologis, tapi peneliti hanya menerangkan secara garis besar dari aspek biologis yang dapat diketahui bahwa pertumbuhan bahasa manusia mengikuti jadwal perkembangan genetiknya sehingga suatu unsur bahasa tidak dapat dipaksakan. Sementara itu, aspek neurologis, yaitu kaitan otak dengan bahasa. Chaer mengemukakan bahwa dalam sistem saraf manusia, otak merupakan pusat saraf, pengendali pikiran, dan mekanisme organ tubuh manusia, termasuk mekanisme pemrosesan bahasa. Oleh sebab itu, perkembangan bahasa

manusia terkait dengan perkembangan otak. Berdasarkan uraian di atas, makalah ini membahas peran neurologis dalam pengajaran bahasa.

peredaran darah dari jantung dan 20% dari sumber daya metabolik manusia.

bahasa.

TEORI dan METODOLOGI LANDASAN NEUROLOGIS BAHASA

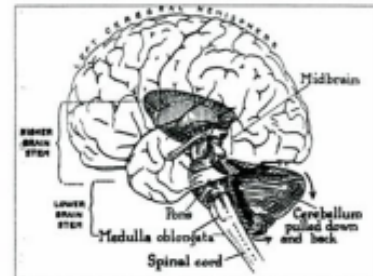
Faktor yang juga penting dalam penguasaan bahasa adalah faktor neurologis, yakni kaitan antara otak manusia dengan bahasa. Landasan neurologis bahasa inilah yang mampu menjawab bahwa manusia memiliki kemampuan berbahasa, tetapi hewan tidak.

STRUKTUR DAN ORGANISASI OTAK MANUSIA

Pertumbuhan manusia menjadi penyelidikan para ahli sejak lama, khususnya tentang penyelidikan oleh para ahli palaoneurologi. Penyelidikan ini sudah berlangsung sekitar 3 juta tahun. Hasil penyelidikan ini setidaknya tampak pada ukuran otak manusia yang membesar dari 400 miligram menjadi 1400 miligram. Meskipun ukuran bukan satu-satunya indikator untuk mengukur perubahan fungsi, paling tidak ukuran itu memungkinkan akan adanya fungsi yang bertambah.

Halloway mengemukakan perkembangan otak ini dapat dibagi menjadi empat tahap, yaitu:

1. Tahap perkembangan ukuran
2. Adanya perubahan reorganisasi pada otak
3. Munculnya system fiber yang berbeda-beda



Gambar 1. Struktur Otak Manusia

Seperti terlihat pada gambar di atas, otak dibagi menjadi empat bagian, yaitu:

- a. Cerebrum (Otak Besar)
- b. Cerebellum (Otak Kecil)
- c. Brainstem (Batang Otak)
- d. Limbic System (Sistem Limbik)

Cerebrum (Otak Besar)

Cerebrum adalah bagian terbesar dari otak manusia yang juga disebut dengan nama Cerebral Cortex, Forebrain atau Otak Depan. Cerebrum merupakan bagian otak yang membedakan manusia dengan binatang. Cerebrum membuat manusia memiliki kemampuan berpikir, analisis, logika, bahasa, kesadaran, perencanaan, memori dan kemampuan visual. Kecerdasan intelektual atau IQ juga ditentukan oleh kualitas bagian ini.

Fromkin, V., Rodman, R., & Hyams, N. (2011). *An Introduction to Language* (9th edition). Wadsworth Cengage Learning.

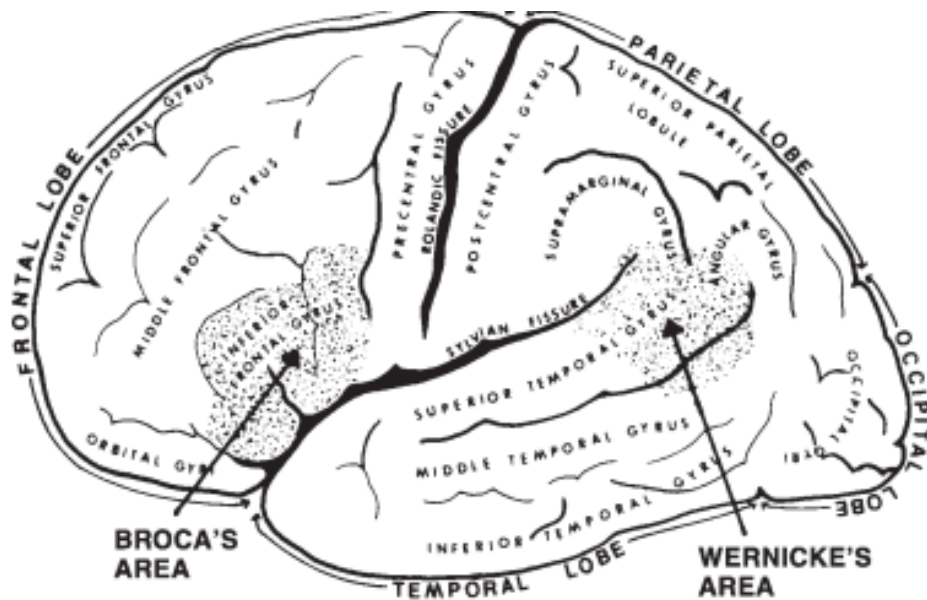


FIGURE I.3 | Lateral (*external*) view of the left hemisphere of the human brain, showing the position of Broca's and Wernicke's areas—two key areas of the cortex related to language processing.

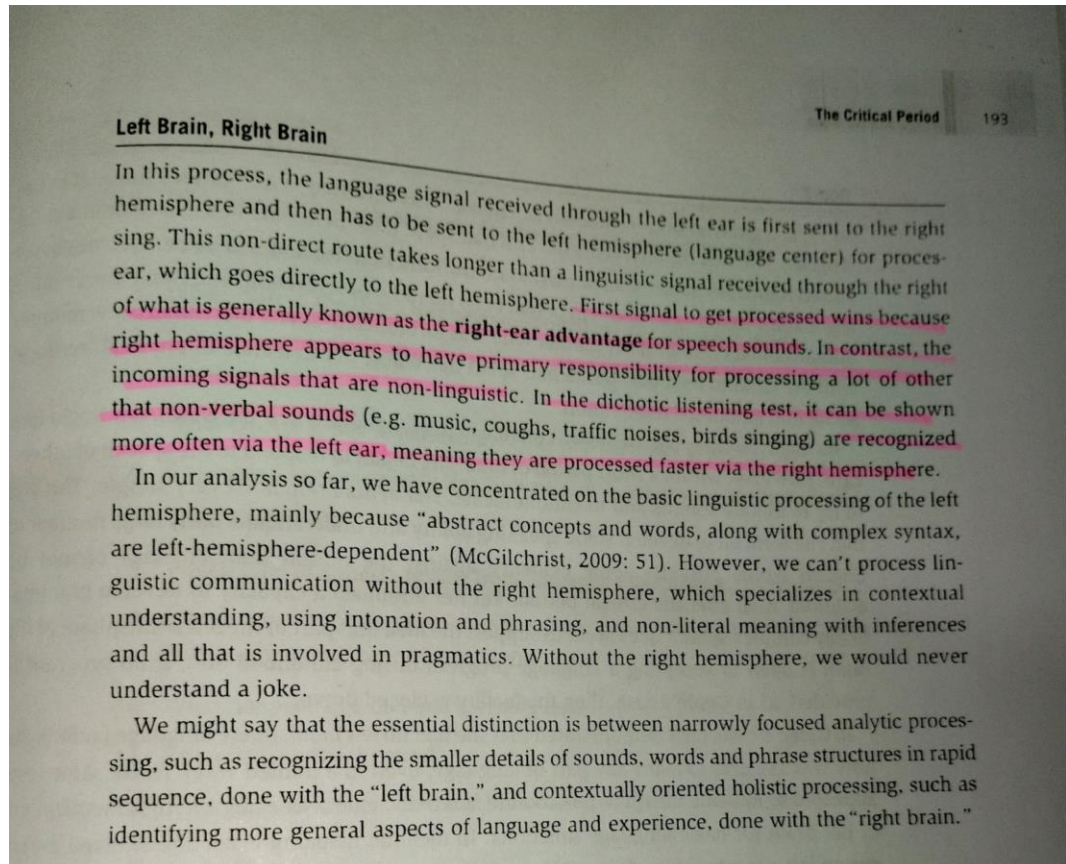
made in localizing language in the brain based on the study of people with aphasia. In the 1860s the French surgeon Paul Broca proposed that language is localized to the left hemisphere of the brain, and more specifically to the front part of the left hemisphere (now called Broca's area). At a scientific meeting in Paris, he claimed that we speak with the left hemisphere. Broca's finding was based on a study of his patients who suffered language deficits after brain injury to the left frontal lobe. A decade later Carl Wernicke, a German neurologist, described another variety of aphasia that occurred in patients with lesions in areas of the left hemisphere temporal lobe, now known as Wernicke's area. Language, then, is lateralized to the left hemisphere, and the left hemisphere appears to be the language hemisphere from infancy on. **Lateralization** is the term used to refer to the localization of function to one hemisphere of the brain. Figure I.3 is a view of the left side of the brain that shows Broca's and Wernicke's areas.

The Linguistic Characterization of Aphasic Syndromes

Most aphasics do not show total language loss. Rather, different aspects of language are selectively impaired, and the kind of impairment is generally related to the location of the brain damage. Because of this damage-deficit correlation, research on patients with aphasia has provided a great deal of information about how language is organized in the brain.

Patients with injuries to Broca's area may have **Broca's aphasia**, as it is often

Yule, G. (2020). *The Study of Language* (7th Edition). Cambridge University Press.



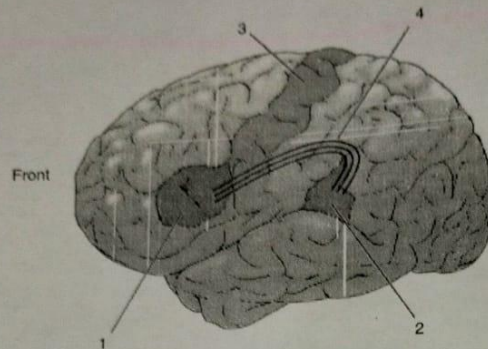


Figure 12.1 Language areas in the brain

Broca's Area

The part shown as (1) in Figure 12.1 is technically described as the "anterior speech cortex" or, more usually, as **Broca's area**. **Paul Broca, a French surgeon, reported in the 1860s that damage to this specific part of the brain was related to extreme difficulty in producing spoken language.** It was noted that damage to the corresponding area on the right hemisphere had no such effect. **This finding was first used to argue that language ability must be located in the left hemisphere and since then has been treated as an indication that Broca's area is crucially involved in the generation of spoken language.**

Wernicke's Area

The part shown as (2) in Figure 12.1 is the "posterior speech cortex," or **Wernicke's area**. **Carl Wernicke was a German doctor who, in the 1870s, reported that damage to this part of the brain was found among patients who had speech comprehension difficulties.** Significantly, this area is close to the part of the brain, the auditory cortex, that processes what we hear. This finding confirmed the left hemisphere location of language ability and led to the view that **Wernicke's area is part of the brain crucially involved in the understanding of spoken language.**

The Motor Cortex and the Arcuate Fasciculus

The part shown as (3) in Figure 12.1 is the **motor cortex**, an area that generally controls **movement of the muscles (for moving hands, feet, arms, etc.)**. The part of the motor cortex that is close to Broca's area controls the articulatory muscles of the face, jaw, tongue and larynx and hence the physical articulation of speech. **In the 1950s, two neurosurgeons, Penfield and Roberts (1959) found that, by applying small amounts of electrical current to specific parts of the brain, they could identify areas where the electrical stimulation would interfere with speech production.**

The part shown as (4) in Figure 12.1 is a bundle of nerve fibers called the **arcuate fasciculus ("the curved bundle")**. This was also one of Wernicke's discoveries and is now known to form a crucial connection between Wernicke's and Broca's areas.

The Localization View

Having identified these four components, it is tempting to conclude that specific aspects of language ability can be accorded specific locations in the brain. This is called the **localization view** and it has been used to suggest that the brain activity involved in hearing a word, understanding it, then saying it, would follow a definite pattern. The word is heard and comprehended via Wernicke's area. This signal is then transferred via the arcuate fasciculus to Broca's area where preparations are made to generate a spoken version of the word. A signal is then sent to part of the motor cortex to physically articulate the word.

This is certainly an oversimplified version of what may actually take place, but it is consistent with much of what we understand about simple language processing in the brain. It is probably best to think of any proposal concerning processing pathways in the brain as some form of metaphor that may turn out to be inadequate once we learn more about how the brain functions. The "pathway" metaphor seems quite appealing in an electronic age when we are familiar with the process of sending signals through electrical circuits. In an earlier age, dominated more by mechanical technology, Sigmund Freud subtly employed a "steam engine" metaphor to account for aspects of the brain's activity when he wrote of the effects of repression "building up pressure" to the point of "sudden release." Even earlier, Aristotle's metaphor was of the brain as a cold sponge that kept the blood cool.

In a sense, we are forced to use metaphors mainly because we cannot obtain direct physical evidence of linguistic processes in the brain. Because we have no direct access, we generally have to rely on what we can discover through indirect methods. Traditionally, these methods have involved attempts to work out how the system is working from clues picked up when the system has problems or malfunctions.

C. Communication Disorders

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*. Pearson.

COMMUNICATION DISORDERS

We've mentioned communication disorders, but we haven't been very specific. It's always good to agree on our topic in any type of communication, so let's begin here.

A communication disorder impairs the ability to both receive and send, and also process and comprehend concepts or verbal, nonverbal and graphic information. A communication disorder may affect hearing, language, and/or speech processes; may range from mild to profound severity; and may be developmental or acquired. One or a combination of communication disorders may be presented by an individual and may result in a primary disability or may be secondary to other disabilities.

That's a lot. In short, a communication disorder may affect any and all aspects of communication, even gesturing. A communication disorder may affect hearing, language (the code we use to communicate), and/or speech (our primary mode or manner of communication). This is reflected in American Speech Language Hearing Association's (ASHA) name. (The Appendix describes ASHA's role in more detail.) But communication impairments can affect much more as you are about to explore through this book and the course you're taking. For example, SLPs are also involved in feeding and swallowing assessment and intervention.

A speech disorder may be evident in the atypical production of speech sounds, interruption in the flow of speaking, or abnormal production and/or

Prastiwi, N. D. (2019). *Communication Disorder of The Autistic Character in the “Fly Away” Movie (Universitas Islam Negeri Maulana Malik Ibrahim Malang)*.

2

disorder they cannot speak, read, write, and think normally it becomes one of the factors of communication disorder.

A communication disorder is a disorder of the ability to receive, transmit, process, and understand the verbal or nonverbal concept. Communication disorder can occur starting from the severity to a mild, communication disorder can occur in primary defect sufferer or possibly secondary defect. The fact in the study done by Lord (2005) stated that 30% of the autistic cannot speak for life. Then, the result stated that there were 60% of autistic can speak but experiencing speech delay and they can produce the first word at the age of six years. It's a factor of communication disorder, so that autistic cannot communicate and interact with the environment. Communication disorder is one of the main factors that determined how broadly an autistic person can develop relationships with others and can following daily activities such as people in general either at school, home or inside the community (Paul and Sutherland, 2005).

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

INTRO: A Guide to Communication Sciences and Disorders

INTRODUCTION

Communication is any act involving the exchange of information related to a person's needs, wants, perceptions, knowledge, or feelings. At birth we are equipped with the physical attributes to communicate. Our earliest forms of communication are quite basic and revolve around fundamental needs and desires between infant and caregiver. As we grow, we learn to communicate more effectively by observing other people communicating. We model our communication on what we see, hear, and experience. Our communication skills grow in complexity and sophistication through formal education, and by practicing those skills and having them evaluated.

Most of us take communication for granted. We tacitly assume that when we speak, we will be understood, or when someone speaks to us, we will understand them. Only when a breakdown in communication occurs do we realize how special and vital this act is to our daily lives. A **communication disorder** is a diagnosed condition in which a person is unable to say correctly what he or she wants to say and/or is unable to understand some or most of what is being said. Some individuals may have an isolated impairment in speech or hearing; others may have impairment

FYI

The most widely used language in the world is Mandarin with more than 1.2 billion speakers. Next on the list is Spanish with more than 700 million speakers. English is the third most widely used language with 500 million speakers.

to adults. In addition, the professions dedicated to helping individuals with communication disorders are profiled.

TERMINOLOGY AND DEFINITIONS

As a prerequisite to understanding various communication disorders, it is important to first have a grasp of normal communication. Knowledge concerning the normal process of communication serves as the foundation for the identification and management of communication disorders. The word **communicate** is related to the word **common**. The word has its origin in the Latin verb *communicare*, which means "to share" or "to make common." When we communicate, we make

1. Language Disorders

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*. Pearson.

absences of voice quality, including pitch, loudness, resonance, and/or duration. **A language disorder**, in contrast, is an impairment in comprehension and/or use of spoken, written, and/or other symbol systems. Finally, a **hearing disorder** is a result of impaired sensitivity of the auditory or hearing system. No doubt you've heard individuals referred to as deaf or hard of hearing. In addition, auditory impairment may include **central auditory processing disorders**, or deficits in the processing of information from audible signals.

It's appropriate to note here that communication disorders do not include communication difference, such as dialectal differences or multilingualism. If you've been to a country where you don't speak the language well, you know that this can impede communication. While these differences may lead to communication difficulties, they are not disorders.

Another communication variation is **augmentative/alternative communication** systems. Far from being communication impairments, these systems, whether signing or the use of digital methods, are attempts often taught by SLPs to compensate and facilitate, on a temporary or permanent basis, for impaired or disabled communication disorders.

As you can see, communication disorders cover a wide range of problems with varying severities and are related to several other disorders. Our purpose in preparing this text is to help you understand and appreciate the many different disorders included in communication impairment. Maybe you began a few pages ago with some vague recollection of an SLP in your elementary school who mostly worked with children correcting their production of difficult speech sounds. That's part of disordered communication, but it's only a small part, as you are about to find out.

American Speech-Language-Hearing Association (ASHA). (1993). *Definitions of Communication Disorders and Variations*. American Speech-Language-Hearing Association (ASHA). <https://www.asha.org/policy/rp1993-00208/>

B. A **language disorder** is impaired comprehension and/or use of spoken, written and/or other symbol systems. The disorder may involve (1) the form of language (phonology, morphology, syntax), (2) the content of language (semantics), and/or (3) the function of language in communication (pragmatics) in any combination.

1. Form of Language

- a. **Phonology** is the sound system of a language and the rules that govern the sound combinations.
- b. **Morphology** is the system that governs the structure of words and the construction of word forms.
- c. **Syntax** is the system governing the order and combination of words to form sentences, and the relationships among the elements within a sentence.

2. Content of Language

- a. **Semantics** is the system that governs the meanings of words and sentences.

3. Function of Language

- a. **Pragmatics** is the system that combines the above language components in

a. Disorder of Form, Content and Use

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*. Pearson.

Language Disorders

Disorders of Form

As explained earlier, language form includes phonology, morphology, and syntax. We speak in sounds (phonemes) that are combined into words (morphemes), which in turn are combined into phrases and sentences (based on syntactical rules). Errors in sound use, such as not producing the ends of words (“hi shi i too sma” for “his shirt is too small”), constitutes a disorder of phonology. Incorrect use of past tense or plural markers (“the girl wented home” for “the girls went home”) is an example of a disorder of morphology. Syntactical errors include incorrect word order and run-on sentences (for example, “I want to go mall and go skate and buy peanuts and you come with me 'cause I want you to but not Jimmy 'cause he's not big enough to go skate”). These errors in school-age children may affect academic achievement and social well-being.

Disorders of form may be due to many factors, including sensory limitations such as hearing problems or perceptual difficulties such as learning disabilities. Limited exposure to correct models may also hinder a child's language development. For many children who are delayed in their production of mature language forms, the cause is not apparent. Patterns that seem like errors at first are sometimes a reflection of a particular speech dialect. An SLP must distinguish between dialectal variations, which do not signify impairment, and disorders.

Disorders of Content

Children and adults with limited vocabularies, those who misuse words, and those with word-finding difficulties may have disorders of content or semantics. Similarly, limited ability to understand and use abstract language, as in metaphors, proverbs, sarcasm, and some humor, suggests semantic difficulties. A persistent pattern of avoiding naming objects and referring instead to “the thing” is another indication of a disorder of content. Although limited experience or a concrete learning style may contribute to this problem in youngsters, among older people, cerebrovascular accidents (strokes), head trauma due to accidents, and certain illnesses may result in word-retrieval problems and other content-related difficulties.

Disorders of Use

Pragmatic language problems may stem from limited or unacceptable conversational, social, and narrative skills; deficits in spoken vocabulary; and/or immature or disordered phonology, morphology, and syntax. Examples of impaired pragmatic language skills might include difficulty staying on topic, providing inappropriate or incongruent responses to questions, and constantly interrupting the conversational partner. Culture, group affiliations, setting, and participants described earlier in this chapter play a major role in judgments regarding pragmatic competence.

c. **Disorder of Use**

Vallie, S. (2022, November 14). *What Is Pragmatic Language Disorder?* WebMD. <https://www.webmd.com/children/what-is-pragmatic-language-disorder>

webmd.com/children/what-is-pragmatic-language-disorder

ADVERTISEMENT

1. SYMPTOMS OF ADENOVIRUS	>	3. LUPUS OF
2. FIRST SIGNS OF RSV	>	4. PRAGMAT

What Is Pragmatic Language Disorder?

Pragmatic language disorder is a condition in which someone has difficulty communicating both verbally and nonverbally in social situations.

Language pragmatics is the use of appropriate communication methods in social settings. This includes things like knowing what to say, how to say it, and when to say it.

Pragmatic language is made up of three major skills:

- Using language for a specific purpose, like to say hello or goodbye or to make a request or statement
- Changing your language depending on the person you're talking to or the situation you're in, like speaking differently to a teacher than to a baby or in a classroom than on the playground

2. Speech Disorders

Lanier, W. Hinote. (2010). *Speech Disorders*. Lucent Books.

CHAPTER ONE

What Is a Speech Disorder?

Speech disorders affect the way a person talks. A person with a speech disorder usually knows exactly what they want to say and what is appropriate for the situation, but they have trouble producing the sounds to communicate it effectively.

Speech disorders include a variety of conditions that affect children and adults alike. They can range from trouble pronouncing a specific letter or sound to the inability to produce any understandable speech. Some are the result of a physical deformity. Others are the result of damage to the speech mechanism (larynx, lips, teeth, tongue, and palate) caused by injury or diseases, such as cancer. Often, however, the cause of a speech disorder is not known.

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*. Pearson.

That's a lot. In short, a communication disorder may affect any and all aspects of communication, even gesturing. A communication disorder may affect hearing, language (the code we use to communicate), and/or speech (our primary mode or manner of communication). This is reflected in American Speech Language Hearing Association's (ASHA) name. (The Appendix describes ASHA's role in more detail.) But communication impairments can affect much more as you are about to explore through this book and the course you're taking. For example, SLPs are also involved in feeding and swallowing assessment and intervention.

A speech disorder may be evident in the atypical production of speech sounds, interruption in the flow of speaking, or abnormal production and/or

THE PROFESSIONALS

absences of voice quality, including pitch, loudness, resonance, and/or duration.

A **language disorder**, in contrast, is an impairment in comprehension and/or use of spoken, written, and/or other symbol systems. Finally, a **hearing disorder** is a result of impaired sensitivity of the auditory or hearing system. No doubt you've heard individuals referred to as deaf or hard of hearing. In addition, auditory impairment may include **central auditory processing disorders**, or deficits in the processing of information from audible signals.

Disorder of Articulation, Fluency, Voice

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*. Pearson.

Speech Disorders

Disorders of speech may involve articulation (the production of speech sounds), fluency (rhythm and rate), or **voice** (pitch, loudness, and quality). They may affect people of all ages, be congenital or acquired, be due to numerous causes, and reflect any degree of severity.

Disorders of Articulation

Production of speech requires perception and conceptualization of the speech sounds in a language as well as motor movements to form these sounds in isolation and in context. You must have both a mental/auditory image of the sound you are going to say and the neuromuscular skills to produce the sound. The cognitive and theoretical concepts of the nature, production, and rules for producing and combining speech sounds in language is known as *phonology*. The actual production of these sounds is called **articulation**.

It is not always easy to determine whether an individual's speech-sound errors indicate an impairment of phonology, which is a language problem, or articulation, which is a speech disorder. To sort this out, SLPs identify the phonemes that are incorrectly produced and look for error patterns that may point to phonological disturbances. The sound system of a language is usually fully in place by age 7 or 8. Children with multiple speech-sound errors past age 4 may have *phonological* difficulties. The causes are often not known but may result from faulty learning due to illness, such as ear infections, hearing or perceptual impairments, or other problems in the early years.

An SLP is interested in a client's ability to move the structures needed in speech, such as the jaw, lips, and tongue. The causes of articulation disorders include neuromotor problems such as cerebral palsy, physical anomalies such as cleft palate, and faulty learning. When paralysis, weakness, or poor coordination of the muscles for speech result in poor speech articulation, the disorder is called **dysarthria**. Apraxia of speech also results in poor articulation due to neuromotor difficulties; however, the difficulty appears to be in programming the speech mechanism, while muscle strength is normal. Dysarthria and apraxia can affect both children and adults. Assessment and treatment of phonological and articulatory disorders are described in Chapter 10.

Disorders of Fluency

As we described earlier, fluency is the smooth, uninterrupted flow of communication. Certain types of fluency disruptions are fairly common at different ages. For example, many 2-year-olds repeat words: "I want-want-want a cookie." Around age 3, youngsters often make false starts and revise their utterances: "Ben took . . . he broked my crayon." Because these speech patterns are so common, they are sometimes referred to as **developmental disfluency**. Typically fluent adults occasionally use **fillers** ("er," "um," "ya know," and so on), **hesitations** (unexpected pauses), **repetitions** ("g-go-go"), and **prolongations** ("www-well"). However, when these speech behaviors exceed or are qualitatively different from the norm or are accompanied by excessive tension, struggle, and fear, they may be identified as **stuttering**. Appropriate diagnosis and intervention when warranted are the task of an SLP (Yairi et al., 2001).

Fluency disorders are generally first noticed before 6 years of age. If remediation efforts are not made or are unsuccessful, this condition might continue

latory disorders are described in Chapter 10.

Disorders of Fluency

As we described earlier, fluency is the smooth, uninterrupted flow of communication. Certain types of fluency disruptions are fairly common at different ages. For example, many 2-year-olds repeat words: "I want-want-want a cookie." Around age 3, youngsters often make false starts and revise their utterances: "Ben took . . . he broked my crayon." Because these speech patterns are so common, they are sometimes referred to as **developmental disfluency**. Typically fluent adults occasionally use **fillers** ("er," "um," "ya know," and so on), **hesitations** (unexpected pauses), **repetitions** ("g-go-go"), and **prolongations** ("www-well"). However, when these speech behaviors exceed or are qualitatively different from the norm or are accompanied by excessive tension, struggle, and fear, they may be identified as **stuttering**. Appropriate diagnosis and intervention when warranted are the task of an SLP (Yairi et al., 2001).

Fluency disorders are generally first noticed before 6 years of age. If remediation efforts are not made or are unsuccessful, this condition might continue

and even worsen by adulthood. Adult onset of disfluency also occurs. Advancing age, accidents, and disease can all disrupt the normal ease, speed, and rhythm of speech. The causes of nonfluent speech are typically unclear; this is explored further in Chapter 7.

Voice Disorders

As in other areas of speech, voice matures as a child gets older. From uncontrolled cries to carefully modulated whispers, shouts, and variations in pitch, the development of voice follows a predictable pattern. Although occasionally children are born with physiological problems that interfere with normal voice, more common is the pattern of **vocal abuse**. It is characterized by excessive yelling, screaming, or even occasional loud singing that results in **hoarseness** or another voice disorder.

Habits such as physical tension, yelling, coughing, throat clearing, smoking, and alcohol consumption can disrupt normal voice production. These behaviors may result in pathology to the vocal folds such as polyps, nodules, or ulcers. Disease, trauma, allergies, and neuromuscular and endocrine disorders may also affect voice quality. For example, individuals with Parkinson's disease, a progressive neurological disorder, may have a soft voice with limited pitch and loudness variation.

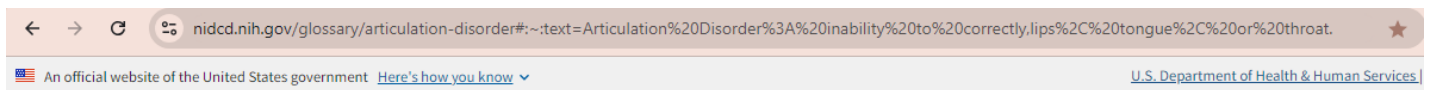
Speech-language pathologists use several indices to differentiate developmental disfluency from early stuttering.

a. **Disorder of Articulation**

National Institute on Deafness and Other Communication Disorders

(NIDCD). (2022, October 11). *Hearing Aids*.

<https://www.nidcd.nih.gov/health/hearing-aids>



[NIDCD Employee Intranet](#) | [A-Z Index](#) | [En español](#)

- HOME
- HEALTH INFO ▾
- RESEARCH ▾
- GRANTS & FUNDING ▾
- TRAINING ▾
- NEWS & EVENTS ▾
- ABOUT US ▾

[Home](#) > [Glossary](#)

Articulation Disorder

Articulation Disorder: inability to correctly produce speech sounds (phonemes) because of imprecise placement, timing, pressure, speed, or flow of movement of the lips, tongue, or throat.

b. Disorder of Fluency

Lavid, N. (2003). *Understanding Stuttering*. University Press of Mississippi.

When People Stutter

In addition to the specific types of dysfluencies found in developmental stuttering, the condition is defined by when these occur. Developmental stuttering is characterized by the occurrence of dysfluencies at the beginning of words and phrases. For example, a person with developmental stuttering would be much more prone to stutter the request, "Please pass the salt," as such:

P-P-P-Please pass the salt.

6 / Stuttering Defined

Whereas it would be quite unusual for the dysfluency to emerge in the latter part of the request:

Please pass the s-s-s-alt.

This aspect of stuttering helps differentiate developmental stuttering. Being tongue-tied does not have this specificity of occurrence. This specificity also contributes to one of the more frustrating manifestations of developmental stuttering: Stuttering occurs at the beginning of sentences. One of the more common times to stutter is when answering the phone; initiating the word "hello" can be difficult for those who stutter. This frustration is common for them, as it is reflective of a definitive symptom of the condition.

In developmental stuttering, the degree of stuttering can vary widely among individuals. Also, no matter if they stutter severely or just mildly, those who stutter tend to have "good days" and "bad days"—that is, a waxing and waning course of dysfluency.

Logan, K. J. (2022). *Fluency Disorders: Stuttering, Cluttering, and Related Fluency Problems* (2nd Edition). Plural Publishing.

appropriate to use in cases where children with well-established histories of typical fluency begin to exhibit atypical fluency, including stutter-like speech that is secondary to acquired brain lesions. Aram, Meyers, and Eckelman (1990) reported on 33 such cases and found that the children demonstrated a number of quantitative and qualitative differences in their fluency when compared to a group of children with typical neurological functioning. Procedures for diagnosis and labeling various types of fluency disorder are discussed later in this book.

Cluttered Speech

Cluttered speech is another type of disfluent speech pattern. It is characterized primarily by a rapid-sounding rate of speech articulation, intermittent bursts of rapid and/or unintelligible speech (particularly in conjunction with multisyllabic words), excessive production of certain disfluency types (particularly *revision* of previously spoken words), and interjection of meaningless filler. For example, revision might sound like this: *She wants, I mean, She ne- She needs to, like she has to find another person who.* And interjection of meaningless filler, which may be mixed in with the revision, might sound like this: *She um um like um She can't find a job she's qualified for.* Stutter-like disfluencies may occur in conjunction with cluttered speech, but in such cases, they usually are not the predominate form of speech disruption. If symptoms of both cluttering and stuttering are prominent enough, however, an individual would be diagnosed with both cluttering and stuttering.

than that for the various of types of stuttering. The reasons for this is that the impairment underlying cluttering seems to affect both the speech and the language production systems.

Providing Clinical Services to People Who Have Fluency Concerns

Speech-language pathologists provide a range of clinical services to people who have fluency disorders. The topic of clinical service provision with this population is addressed extensively in this book.

The Rewards of Being a Fluency Clinician

Many clients and clinicians find their participation in a speech fluency intervention program to be a rewarding experience. As described later in this book, fluency disorders can result in marked difficulty with spoken communication, which in turn, can lead to other difficulties, such as social isolation and self-limiting thoughts and beliefs. One of the greatest joys for a clinician who works with this population is to hear clients describe the important changes they have made in their lives through participation in a fluency intervention program. The changes that clients describe often go beyond those associated with speech mechanics to include improvements in situations that, from the client's perspective, were loaded with personal risk and/or stoked with unpleasant feelings and emotions.

c. Voice Disorder

Johns Hopkins Medicine. (2024). *Voice Disorders*.

<https://www.hopkinsmedicine.org/health/conditions-and-diseases/voice-disorders>



Voice Disorders

Head and Neck Ear Nose and Throat Pediatric ENT (Otolaryngology)

What are voice disorders?

You may have a voice disorder if you have a problem with pitch, volume, tone, and other qualities of your voice. These problems occur when your vocal cords don't move or vibrate normally.

Your voice is the sound that air makes when it is forced out of your lungs and passes between your vocal cords. Vocal cords are the 2 folds of tissue inside your voice box (larynx). The vibration of those cords is what makes your voice.

3. Hearing Disorders

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*. Pearson.

Hearing Disorders

A hearing disorder results from impaired auditory sensitivity in the auditory or hearing system. It may affect the ability to detect sound, to recognize voices or other auditory stimuli, to discriminate between different sounds, such as mistaking the phoneme /s/ for /f/, and to understand speech.

Deafness

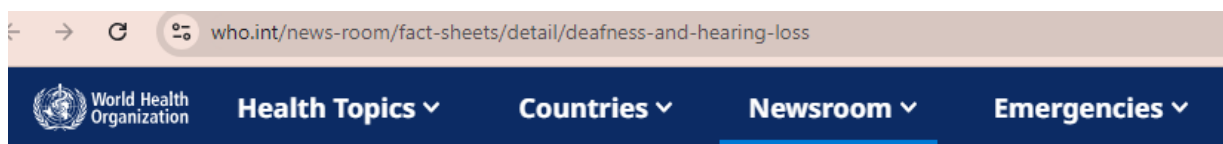
When a person's ability to perceive sound is limited to such an extent that the auditory channel is not the primary sensory input for communication, the individual is considered to have deafness. Deafness may be congenital or acquired.

Total communication, including sign, speech, and speechreading, is often considered the most effective intervention for deafness. **Assistive listening devices (ALD)**, **cochlear implants**, and **auditory training** may be helpful. These are explained in Chapter 12.

Hard of Hearing

A person who is hard of hearing, in contrast to one who is deaf, depends primarily on audition for communication. Hearing loss may be temporary due to an illness, such as an ear infection, or permanent, caused by disease, injury, or advancing age. Hearing loss is usually categorized in terms of severity, laterality, and type. The severity of a hearing loss may range from mild to severe. It may be **bilateral**, involving both ears, or **unilateral**, affecting primarily one ear. Finally, the loss may be **conductive**, **sensorineural**, or **mixed**. A conductive loss is caused by damage to the outer or middle ear; people with this type of loss usually report that sounds are generally too soft. A sensorineural loss involves problems with the inner ear and/or auditory nerve; this type of damage is likely to affect a person's ability to discriminate and consequently understand speech sounds, although they may "hear" them. A typical pattern is older people reporting that they hear just fine but wish others would not mumble. Mixed hearing loss, as the

World Health Organization (WHO). (2024, February 2). *Deafness and hearing loss*. <https://www.who.int/news-room/fact-sheets/detail/deafness-and-hearing-loss>



Hearing loss and deafness

A person who is not able to hear as well as someone with normal hearing – hearing thresholds of 20 dB or better in both ears – is said to have hearing loss. Hearing loss may be mild, moderate, severe or profound. It can affect one ear or both ears and leads to difficulty in hearing conversational speech or loud sounds.

Hard of hearing refers to people with hearing loss ranging from mild to severe. People who are hard of hearing usually communicate through spoken language and can benefit from hearing aids, cochlear implants, and other assistive devices as well as captioning.

Deaf people mostly have profound hearing loss, which implies very little or no hearing. They often use sign language for communication.

Causes of hearing loss and deafness

Although these factors can be encountered at different periods across the life span, individuals are most susceptible to their effects during critical periods in life.

Prenatal period

- genetic factors including hereditary and non-hereditary hearing loss
- intrauterine infections – such as rubella and cytomegalovirus infection.

Perinatal period

- birth asphyxia (a lack of oxygen at the time of birth)

a. Deafness

Ingram, J. C. L. (2007). *Neurolinguistics: An Introduction to Spoken Language Processing and its Disorders*. Cambridge University Press.

(1982) describe a patient with a disorder of 'pre-phonemic auditory acuity' with deficits observable on tasks such as the assessment of temporal auditory skills, as well as with consonant-vowel (CV) identification. We would suggest that the patient reported by Auerbach *et al.* (1982) has deficits with both acoustic-phonetic processing and a non-linguistic auditory processing disorder (as described in the previous section).

More recently, most authors reserve the term word-sound deafness for those cases where the patient has a deficit in linguistic discrimination that is independent of a temporal order acuity problem. Whether word-sound deafness can exist independently of deficits to non-specific auditory processing remains open to debate. For example, Praamstra *et al.* (1991) suggest that word-sound deafness is caused by both phonemic deficits and more general non-linguistic processing deficits.

Much of the research investigating the nature of the acoustic-phonetic processing deficit in aphasia has used two experimental paradigms: phoneme discrimination and phoneme identification tasks. In the former, a subject is presented with two auditory stimuli (e.g. /pa/ /pa/) and must respond as to whether they are the same or different. In the phoneme identification task, however, the subject is asked to label the phoneme and therefore must first classify the stimuli into a

b. Hard of Hearing

National Institute on Deafness and Other Communication Disorders

(NIDCD). (2022, October 11). *Hearing Aids*.

<https://www.nidcd.nih.gov/health/hearing-aids>

nidcd.nih.gov/health/hearing-aids

What is a hearing aid?

A hearing aid is a small electronic device that you wear in or behind your ear. It makes some sounds louder so that a person with hearing loss can listen, communicate, and participate more fully in daily activities. A hearing aid can help people hear more in both quiet and noisy situations. However, only about one out of five people who would benefit from a hearing aid actually uses one.

A hearing aid has three basic parts: a microphone, amplifier, and speaker. The hearing aid receives sound through a microphone, which converts the sound waves to electrical signals and sends them to an amplifier. The amplifier increases the power of the signals and then sends them to the ear through a speaker.

How can hearing aids help?

Hearing aids are primarily useful in improving the hearing and speech comprehension of people who have hearing loss that results from damage to the small sensory cells in the inner ear, called hair cells. This type of hearing loss is called sensorineural hearing loss. The damage can occur as a result of disease, aging, or injury from noise or certain medicines.

A hearing aid magnifies sound vibrations entering the ear. Surviving hair cells detect the larger vibrations and convert them into neural signals that are passed along to the brain. The greater the damage to a person's hair cells, the more severe the hearing loss, and the greater the hearing aid amplification needed to make up the difference. However, there are practical limits to the amount of amplification a hearing aid can provide. In addition, if the inner ear is too damaged, even large vibrations will not be converted into neural signals. In this situation, a hearing aid would be ineffective.

4. Auditory Processing Disorder

Owens, R. E., Farinella, K. A., & Metz, D. Evan. (2015). *Introduction to communication disorders: a lifespan evidence-based perspective*. Pearson.

name implies, is a combination of both conductive and sensorineural loss (see Chapter 12 for further discussion).

Auditory Processing Disorders

An individual with an auditory processing disorder (APD) may have normal hearing but still have difficulty understanding speech. Individuals with APDs struggle to keep up with conversation, understand speech in less-than-optimal listening conditions (i.e., degraded speech signal, presence of background noise), discriminate and identify speech sounds, and integrate what they hear with non-verbal aspects of communication (DeBonis & Moncrieff, 2008). These difficulties are sometimes traced to tumors, disease, or brain injury, but often the cause is unknown. APD can occur in both children and adults. A special battery of auditory diagnostic tests is used to determine or rule out APD; however, there is currently no "gold standard" to ensure correct identification of the disorder (McFarland & Cacase, 2006). APD may coexist with other disorders, including attention-deficit/hyperactivity disorder (ADHD) and speech-language and learning disabilities (ASHA, 2005c).



Thought Question

Kemkes Direktorat Jenderal Pelayanan Kesehatan. (2022, July 28). *Auditory Processing Disorder (APD)*.

https://yankes.kemkes.go.id/view_artikel/654/auditory-prosesing-disorder-apd



The screenshot shows a web browser window with the URL yankes.kemkes.go.id/view_artikel/654/auditory-prosesing-disorder-apd. The page header features the logo of the Indonesian Ministry of Health (Kemenkes) and the text "Direktorat Jenderal Pelayanan Kesehatan". Navigation links include "BERANDA", "PROFIL", "INFORMASI PUBLIK", and "PRODUK". The article content is displayed on a light yellow background. It starts with a view count of 1747 and the author "Tim Promkes RSST - RSUP dr. Soeradji Tirtonegoro Klaten". The main text discusses Auditory Processing Disorder (APD), also known as Central Auditory Processing Disorder (CAPD), as a hearing impairment affecting about 5% of school-aged children. It explains that children with APD cannot process what they hear in the same way as other children because their ears and brains do not fully coordinate. APD can make it difficult for sufferers to distinguish similar words. An example is given: when someone says "Tolong, bagikan kotak ini," a person with APD might hear "Tolong, berikan katak ini." It notes that APD is not the same as deafness or learning disabilities, but rather a brain issue in recognizing and interpreting sounds, especially speech. With proper therapy, children with APD can succeed in school and in life. It emphasizes that early diagnosis is important because if APD is detected late, a child may experience delayed speech and language or other learning problems in school. APD can occur in anyone, but it is more common in children, especially boys.

Mayo Clinic. (2023, September 30). *Auditory processing disorder (APD)*.

<https://www.mayoclinic.org/diseases-conditions/auditory-processing-disorder/symptoms-causes/syc-20555261>

← → ↻ 🔍 mayoclinic.org/diseases-conditions/auditory-processing-disorder/symptoms-causes/syc-20555261

Causes

The cause of auditory processing disorder (APD) is sometimes unknown. APD can be linked to many conditions. In older adults, conditions might include stroke and head trauma. In children, APD can be linked to issues at birth, such as low birth weight or early birth, or repeated ear infections.

In typical hearing, the brain's auditory center takes the sound waves sent from the ears and turns them into sounds you know. But with auditory processing disorder (APD), the auditory part of the brain can't do this.

Risk factors

Factors that increase your risk of auditory processing disorder (APD) include:

- Aging.
- Stroke.
- Head trauma.

D. The Causes of Communication Disorders

1. Dysarthria

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*.

Plural publishing.

Dysarthria

The disorder of dysarthria is an impairment of the motor control for speech caused by weakness, paralysis, slowness, or incoordination of the muscles responsible for producing speech sounds. Dysarthria is not a language disorder; however, a language disorder can often coexist. Individuals with dysarthria understand language and know what they want to say, but may have trouble moving the muscles necessary to clearly produce vowels and consonants. At least six different types of dysarthria have been reported in the research literature. Each type of dysarthria reflects an impairment of a specific location in the nervous system. A detailed description of the various types of dysarthria is shown in Table 8–2. The most frequently seen form of dysarthria is **mixed dysarthria**, resulting from more diffuse damage of the nervous system compared with other forms of dysarthria. Collectively, the six types of dysarthria account for approximately 45% of all neurogenic communication disorders. Common speech problems found in dysarthria are slow and sluggish speech that is often slurred and may be accompanied by drooling. There is also reduced vocal loudness and a lack of intonation (i.e., monotone). Three nervous system diseases that show dysarthria are Parkinson disease, multiple sclerosis, and amyotrophic lateral sclerosis.

Pindzola, R. H., Plexico, L. W., & Haynes, W. O. (2016). *Diagnosis and Evaluation in Speech Pathology, Ninth Edition*. Pearson.

THE ADULT DYSARTHRIAS

Dysarthria, or more accurately the dysarthrias, is a collection of motor speech disorders due to neurological abnormalities in strength, speed, range of motion, steadiness, tone, or accuracy of movement (Duffy, 2013). Dysarthria, particularly in adults and adolescents, may be due to trauma (e.g., automobile wreck, stroke, gunshot or blast explosion to the head, near poisoning) or disease state (e.g., muscular dystrophy, myasthenia gravis, tumor invasion, multiple sclerosis, encephalitis, inherited degenerative disorders, etc.). The same issues may occur in children; in addition, cerebral palsy from infancy is a typical cause of dysarthria. Regardless of the cause or age of onset, damage or disease can affect the neuromotor system and the processes of respiration, phonation, articulation, and resonance (not to mention feeding and swallowing, which will be covered in Chapter 10). More specifically for our purposes, the dysarthrias are neuromuscular speech disorders arising from motor pathway damage at single or multiple sites from the cortex to the muscle. The entire speech production mechanism, including

2. Apraxia

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

Apraxia

The term apraxia is derived from the Greek word *praxis*, which means to work or perform. The condition of apraxia, therefore, refers to an inability to voluntarily perform skilled motor movements that are not a result of muscle weakness. The term *dyspraxia* is probably a more accurate description of the condition because there is not a complete loss of volitional movement, as might be expected in true apraxia. Conditions of apraxia are found for a variety of movement behaviors such as hand and leg movements. Apraxia of speech is a motor speech disorder resulting from impairment in the ability to mentally organize the speech muscles and articulators for volitional production of speech sounds. There are two types of speech apraxia: developmental and acquired. Developmental apraxia of speech occurs in children and is present from birth for most affected individuals. Further details concerning developmental (childhood) apraxia of speech can be found in Chapter 4.

Acquired apraxia is typically found in adults and results from an identifiable neurological impairment. Acquired apraxia of speech accounts for approximately 5% of all neurogenic communication disorders. The condition usually co-occurs with language problems among individuals who have a form of nonfluent aphasia (to be discussed in a following section). The condition is also

Bernthal, J. E., Bankson, N. W., & Flipsen Jr., P. (2017). *Articulation and Phonological Disorders: Speech Sound Disorders in Children* (8th Edition). Pearson.

Apraxia

Apraxia is a motor speech disorder also caused by brain damage, but it is differentiated from the dysarthrias and described as a separate clinical entity. Apraxia of speech is characterized by an impairment of motor speech programming with little or no weakness, paralysis, or incoordination

of the speech musculature. Whereas dysarthrias frequently affect all motor speech processes—respiration, phonation, articulation, resonance, and prosody—apraxia primarily affects articulatory abilities with secondary prosodic alterations.

A description of some of the clinical characteristics of apraxia has been provided by Duffy (2005):

Deviant speech characteristics associated with AOS [apraxia of speech] include a number of abnormalities of articulation, rate, prosody, and fluency. The characteristics that best distinguish it from other motor speech disorders (the dysarthrias) are distorted sound substitutions and additions, decreased phonemic accuracy with increased rate, attempts to correct articulatory errors that cross phonemic boundaries, groping for articulatory postures, greater difficulty on volitional than automatic speech tasks, and greater difficulty on SMR [sequential motion rate] and multisyllabic word tasks than AMR [alternate motion rate] and single syllable tasks. ...Articulatory distortions, reduced rate, and various prosodic abnormalities help distinguish AOS from aphasic phonologic errors. (p. 330)

3. Cognitive Communication Disorder

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

Cognitive Communication Disorders

The term **cognitive communication disorder** is used to describe a broad range of communication problems that are caused by damage to the frontal lobe regions of the brain. The damage can be a result of a stroke, brain trauma, brain infection, brain tumor, or degenerative disease such as multiple sclerosis, Parkinson disease, or Alzheimer disease. Along with controlling motor movement, these regions of the brain also manage our ability to think (i.e., cognition), memory, and problem solving. Damage to these areas of the brain result in an impairment of the verbal ability to transform thoughts into meaningful expressive language. The impairment is also found in a person's nonverbal ability to use gestures, write, and use appropriate social skills. This language disorder should not be confused with aphasia. The American Speech-Language-Hearing Association has defined cognitive communication disorders as difficulty with any aspect of communication that

4. Aphasia

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

Aphasia

Aphasia is a language disorder associated with brain injury, usually a stroke. Aphasia refers to a collection of clinically diverse disorders that affect the production and comprehension of language and the ability to read, write, or calculate. This disorder accounts for roughly one quarter of all neurogenic communication impairments. There are four primary types of aphasia, each of which involves damage to the left hemisphere of the cerebrum; they are categorized according to the fluency of language expression (Table 8–3). People with **fluent aphasia** have major problems understanding spoken and written language, although their language expression seemingly appears to be within normal limits. **Wernicke’s aphasia** and **anomic aphasia** are examples of fluent aphasia. People with **nonfluent aphasia** have difficulty expressing themselves when speaking or writing, although their ability to understand language

E. Aphasia

Bastiaanse, R., & Prins, R. S. (2014). *The Cambridge Handbook of Communication Disorders*. Cambridge University Press.

13.2 Aphasia: some background

13.2.1 Definition of aphasia

Aphasia is a disorder in the production and comprehension of spoken and written language. It is caused by a unilateral localized brain lesion in individuals who had normal language development.

Several features of this definition of aphasia are noteworthy. The first is that aphasia is a *language* disorder. In this chapter, the expression 'language disorder' is used to show that aphasia is a central deficit affecting both comprehension and production and both spoken and written language. Defining aphasia as a language disorder distinguishes it from articulation disorders, such as dysarthria (a motor speech disorder; see [Chapter 11](#), this volume) and apraxia of speech (a disorder in programming and monitoring articulation, see [Chapter 12](#), this volume). Such disorders often accompany aphasia, but can also occur without aphasia. Brain damage may affect articulatory abilities, for example, because the motor area is affected. In such cases, the person will display speech problems (a dysarthria). However, he or she will still be able to write and to understand both spoken and written language, because the language system itself is intact. Also, disorders in auditory and visual perception due to brain damage are excluded by this definition. Such disorders may result in auditory comprehension or reading problems, but these are not the consequence of a language disorder.

Communication disorders as a result of dementia are also excluded by this definition of aphasia. This is because there is no unilateral brain lesion and the language problems in dementia are progressive (see [Chapter 15](#), this volume). Communication disorders due to psychiatric conditions (such as schizophrenia and depression) are also outside the scope of the definition, because in these cases there is no acquired brain lesion ([Chapter 17](#), this volume). Aphasia should also be distinguished from developmental language problems in children. In order to make this distinction, aphasia is defined as an *acquired* language disorder. Developmental language disorders may have several origins: neurological damage that arises perinatally, specific genetic syndromes (as in Down's syndrome; see [Chapter 7](#), this volume), but often there is no known cause (as in specific language impairment; see [Chapter 5](#), this volume). The nature and the development of all these disorders may be very different from those in aphasia and, therefore, they are excluded from the definition of aphasia. If children acquire brain damage during the critical period of language development (e.g. due to a traumatic injury or a stroke), language problems may arise. This is called '(acquired) childhood aphasia'.

Ingram, J. C. L. (2007). *Neurolinguistics: An Introduction to Spoken Language Processing and its Disorders*. Cambridge University Press.

Despite the controversies and profound uncertainties concerning the best way forward, there are good reasons for believing that a special relationship exists between human language on the one hand, and what makes human brains different from those of other mammals or our close primate relatives on the other. In this chapter we offer some arguments intended to establish a direct link between the brain and language, through an appeal to the concept of co-evolution of brain and language (Deacon, 1997a): the idea that language abilities arose as both a consequence and a cause of recent and rapid evolutionary brain changes, resulting in the emergence of homo sapiens. In chapters 2 and 3 we invite you to evaluate the language–brain relationship for yourself, as we describe the language faculty in broad outline from the separate perspectives of the linguist (chapter 2) and the aphasiologist (chapter 3). Linguists are trained to analyse patterns of language production and usage, with the aim of unravelling the complex code which enables speakers and listeners to map between sound and meaning. Aphasiologists observe the great variety of communication disorders that can arise as a consequence of damage to the language areas of the brain by strokes, tumours or traumatic injury. By and large, the classical studies of aphasia were conducted by neurologists and neuropsychologists who had no specialized linguistic training. Similarly, linguists formulated their theories of human language independently of any serious considerations of language loss in aphasia. Thus, Whitaker's (1971) assertion that progress in the study of language depends on some successful synergy between linguistics and neurology has always been controversial, and so the introductory chapters of this book should be regarded as a first approximation at defining a 'problem space' – the language–brain interface. In subsequent chapters, we explore in detail the various stages of language processing, from the decoding of phonological targets in the perception of speech, to word recognition, morphological analysis, syntactic parsing, semantic interpretation and understanding discourse. We consider the production of language and production disorders in aphasia only insofar as they throw light upon the nature of the brain's language processing mechanisms. At the 'higher' levels of language processing, a clear distinction between the mechanisms underlying language comprehension and language production is difficult to maintain, despite the fact that the task demands imposed upon listeners and speakers are

Kemenkes Direktorat Jenderal Pelayanan Kesehatan. (2023, January 19). *Gangguan*

Afasia. https://yankes.kemkes.go.id/view_artikel/2087/gangguan-afasia

← → ↻ 🔍 yankes.kemkes.go.id/view_artikel/2087/gangguan-afasia



BERANDA

PROFIL ▾

INFORMASI PUBLIK ▾

PRODUK HUKUM

Penyebab Afasia

Afasia bukan merupakan suatu penyakit, melainkan gejala yang menandai adanya kerusakan di bagian otak yang mengatur bahasa dan komunikasi.

Salah satu penyebab kerusakan otak yang paling sering memicu afasia adalah *stroke*. Saat terserang *stroke*, tidak adanya aliran darah ke otak menyebabkan kematian sel otak atau kerusakan di bagian otak yang memproses bahasa. Diketahui sekitar 25–40% penderita *stroke* menderita afasia.

Selain *stroke*, kerusakan otak akibat cedera kepala, tumor otak, atau infeksi di otak (ensefalitis) juga bisa menyebabkan afasia. Dalam kondisi tersebut, afasia biasanya disertai dengan gangguan daya ingat dan gangguan kesadaran.

Penyakit yang menyebabkan penurunan fungsi sel-sel otak, seperti demensia dan penyakit Parkinson, juga dapat menyebabkan afasia. Pada kondisi ini, afasia akan berkembang secara bertahap seiring dengan perkembangan penyakit.

Mael, M. R. (2020). *Neurolinguistik dan Penerapannya dalam Teknologi*. Paramasastra: Jurnal Ilmiah Bahasa Sastra Dan Pembelajarannya, 7(1), 59.

PENDAHULUAN

Manusia tidak terlepas dari bahasa yang digunakan sehari-hari dalam berkomunikasi. Dalam memproses bahasa inilah saraf-saraf dalam otak bekerja untuk merangkaikan kata sehingga muncullah sebuah bahasa yang terucap dalam diri seseorang yang digunakan sebagai alat komunikasi. Jika dilihat dari proses cara kerja bahasa yang dihasilkan, terlihat bahwa bahasa sangat berkaitan dengan otak dalam cara pembentukannya. Oleh karena itu, muncullah sebuah ilmu yang membahas kajian hubungan antara cara kerja sistem syaraf otak manusia dalam memproses bahasa yaitu neurolinguistik.

Neurolinguistik merupakan gabungan dari dua bidang keilmuan yaitu neurologi dan linguistik. Neurologi merupakan cabang dari ilmu kedokteran yang menangani kelainan pada sistem saraf yang berpusat di otak, sedangkan linguistik merupakan ilmu yang mengkaji tentang kebahasaan. Menurut Gusdi Sastra (2010: 9) neurolinguistik adalah suatu bidang kajian dalam ilmu linguistik yang membahas struktur otak yang dimiliki seseorang untuk memproses bahasa, termasuk di dalamnya gangguan yang terjadi dalam memproduksi bahasa. Jadi dapat dikatakan bahwa neurolinguistik adalah

Hati, D. A. (2018). *Linguistic Disorder of Aphasia in the Main Character of the Movie My Beautiful Broken Brain*.

20

language may be influenced by physiological inefficiency or impaired recognition, but it cannot be explained by dementia, sensory loss, or motor dysfunction.

Also Damico (2010) described that the classic aphasia types traditionally arising from left hemisphere damage that most often grouped according to whether they are fluent or non-fluent forms of aphasia. The fluency dimension is closely linked to anatomy, fluent forms of aphasia are said to arise from a lesion posterior to the central Rolandic fissure and non-fluent forms from lesions anterior to the Rolandic fissure. It has been suggested that classification of aphasia need go no further than this basic fluency distinction. Still others attempt to upgrade and modernize the classical types. A range of features or aphasic symptoms is associated with this basic fluent–non-fluent division. (p.337)

As stated by Roth and Worthington (2011) said that aphasia is associated with damage to the dominant hemisphere for language in the brain, which is the left hemisphere in most individuals. It is accompanied by motor and sensory deficits. As the left hemisphere controls the contralateral or opposite side of the body, these motors and sensory impairments are most often right-

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

Table 8–3. Various Types of Aphasia	
<i>Type of Aphasia</i>	<i>Language Examples</i>
Fluent aphasia: Wernicke	<ul style="list-style-type: none"> • May say words that make little sense • May use made-up words such as “frangle” and not be aware of doing so • May produce a full-length sentence that has no meaning; sounds like a sentence, but has no content
Fluent aphasia: Anomic	<ul style="list-style-type: none"> • May have difficulty naming certain words • Tend to produce grammatically correct, yet empty, speech • Language comprehension generally preserved
Nonfluent aphasia: Broca	<ul style="list-style-type: none"> • May struggle to say words and form a sentence • Often omit small words such as “is,” “and,” and “the” • Often aware of their difficulties and can become easily frustrated when speaking
Nonfluent aphasia: Mixed (or global)	<ul style="list-style-type: none"> • May be totally nonverbal and/or only use facial expressions and gestures to communicate • May understand some words

1. Wernicke's Aphasia

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

seems to remain relatively intact. **Broca's aphasia** and **mixed (or global) aphasia** are examples of **nonfluent aphasia**.

Wernicke's aphasia is so named because of the location in the brain where damage has occurred. Wernicke's area is found in the temporal lobe of the left hemisphere at Brodmann area 22 (Figure 8-12; also see Figure 8-7). The lesion does not damage the frontal region of the brain, which is responsible for all motor behavior. Therefore, one obvious feature of Wernicke's aphasia is that there are no signs of body paralysis. The condition is characterized by fluent language expression, but impaired language comprehension. To a naïve listener, the individual with Wernicke's aphasia may seem to have no expressive language difficulty because his or her production of speech is effortless. However, when listening closely, it becomes evident that the content of what is being spoken about may be missing. Anomic aphasia generally results from damage to an isolated region in Wernicke's area of the brain. Similar to Wernicke's aphasia, there are no obvious signs of body paralysis. This particular communication disorder is characterized by difficulty with word retrieval. The patient's speech is essentially fluent; however, there are high number

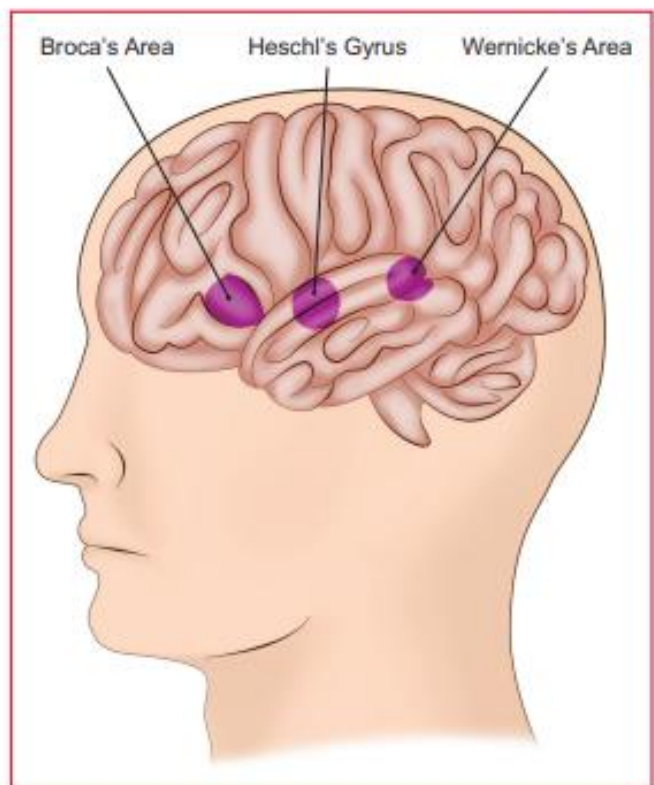


FIGURE 8-12. Location of Broca's area, Heschl's gyrus, and Wernicke's area. Broca's area and Wernicke's area are found only in the left hemisphere of the brain.

Bastiaanse, R., & Prins, R. S. (2014). *The Cambridge Handbook of Communication Disorders*. Cambridge University Press.

13.4.2 Wernicke's aphasia

The main characteristics are impaired auditory comprehension and fluent, well-articulated speech with paraphasias. In severe cases, an individual with Wernicke's aphasia will not understand spoken language and produce so many neologistic, phonological and/or verbal paraphasias that he or she is no longer understandable ('jargon aphasia'). Individuals with Wernicke's aphasia are usually not aware of their speech errors. In milder cases, they only have problems understanding low-frequency and abstract words and complex sentences and they only occasionally use paraphasias.

Although individuals with Wernicke's aphasia can produce long and complex sentences, these are often ungrammatical, because they are incomplete and grammatical constructions are mixed up. This is called 'paragrammatism'. In the following extract, the sentence endings have been marked with full stops, which are mainly based on intonation:

[How are you these days?] I've got the idea that I've been taken better. You can hear that with the talking of course. On one side but I think it's nice, my idea too. But if it does not work then it does not work. I think quite easy about that. We never say it is not possible or it does not work. And that's what I did. That's the way I am, right?

Object and action naming, repetition of words and sentences, silent reading and writing are usually severely affected, while reading aloud can be more or less normal.

produksi tuturan penderita pada dasarnya agak fasih dan tidak tersekat-sekat, tetapi sedikit terhenti dan mempunyai kontur intonasi yang normal

Penderita afasia Wernicke umumnya mempunyai lebih kurang 30 sampai 80 persen istilah neologistik. Istilah tersebut merujuk pada kata-kata baru, dan ujaran yang berpadanan dengan struktur fonologi bahasa penderita dan tidak mempunyai maksud yang bebas. Dengan demikian, afasia Wernicke disebut juga dengan afasia neologistik jargon (afasia jargon). Output tuturan kadang diiringi oleh teka-teki parafasia fonemik yang mengandung pengulangan dan pembalikan fonem. Afasia fonemik disebut juga dengan parafasia literal, yang terjadi karena keliru terhadap isi neurologi yang sudah tersimpan antara fonem dengan huruf dalam abjad. Penderita dikatakan keliru dengan huruf-huruf sehingga ia disebut mengalami parafasia literal. Ketiga, upaya pemahaman penderita pada dasarnya tidak begitu baik, karena seorang penderita afasia Wernicke tidak dapat melakukan pengawasan diri. Penderita tidak menyadari bahwa sebagian besar outputnya merupakan ujaran yang salah dan tidak dapat dipahami.

Di pihak lain, aspek sintaksis penderita relatif normal. Dalam suatu struktur kalimat, kata benda biasanya hadir mengisi ruangan kata benda, ajektif mengisi ruangan ajektif, begitu seterusnya. Brown (1972) mencontohkan jawaban yang diberikan oleh seorang penderita afasia Wernicke:

"She is selfice on purpiten"

Struktur kalimat tersebut normal, mengandung subjek (*she*) yang diikuti oleh satu kata bantu kata kerja (*is*) dan satu pelengkap (*selfice on purpiten*). Masalah yang muncul di sini adalah merujuk pada pelengkap yang diperkirakan sebagai jargon.

Berdasarkan output yang dituturkan oleh seorang penderita afasia Wernicke, Brown memberikan contoh lain ketika seorang penderita memberikan jawaban sesuai dengan pertanyaan yang diajukan padanya:

"What is your speech problem?"

penderita tersebut menjawab:

"Becouse no one gotta scotta gowan thwa, thirst, gell, gerst, derund, gystrol, that's all"

2. Anomic Aphasia

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

seems to remain relatively intact. **Broca's aphasia** and **mixed (or global) aphasia** are examples of nonfluent aphasia.

Wernicke's aphasia is so named because of the location in the brain where damage has occurred. Wernicke's area is found in the temporal lobe of the left hemisphere at Brodmann area 22 (Figure 8-12; also see Figure 8-7). The lesion does not damage the frontal region of the brain, which is responsible for all motor behavior. Therefore, one obvious feature of Wernicke's aphasia is that there are no signs of body paralysis. The condition is characterized by fluent language expression, but impaired language comprehension. To a naïve listener, the individual with Wernicke's aphasia may seem to have no expressive language difficulty because his or her production of speech is effortless. However, when listening closely, it becomes evident that the content of what is being spoken about may be missing. **Anomic aphasia generally results from damage to an isolated region in Wernicke's area of the brain.** Similar to Wernicke's aphasia, there are no obvious signs of body paralysis. This particular communication disorder is characterized by difficulty with word retrieval. The patient's speech is essentially fluent; however, there are high number

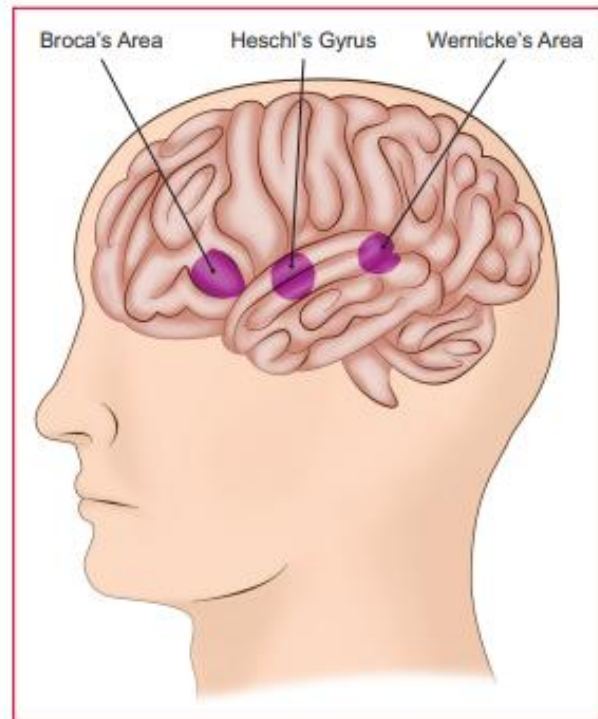


FIGURE 8-12. Location of Broca's area, Heschl's gyrus, and Wernicke's area. Broca's area and Wernicke's area are found only in the left hemisphere of the brain.

Whitaker, H. A. (2010). *Concise Encyclopedia of Brain and Language*
(First edition). Elsevier.

Aphasia, Sudden and Progressive 51

areas. Infarctions in the posterior watershed zone are common causes.

Isolation Aphasia

Isolation aphasia, a rare syndrome, represents a combination of the two transcortical aphasias. Comprehension is severely impaired, and there is no purposeful speech output. The patient may parrot fragments of heard conversations (echolalia), indicating that the neural mechanisms for repetition are at least partially intact. This condition represents the pathologic function of the language network when it is isolated from other regions of the brain. Broca's and Wernicke's areas tend to be spared, but there is damage in surrounding frontal, parietal, and temporal cortex. Lesions are patchy and can be associated with anoxia, carbon monoxide poisoning, or complete watershed zone infarctions.

Anomic Aphasia

Anomic aphasia may be considered the 'minimal dysfunction' syndrome of the language network. Articulation, comprehension, and repetition are intact, but confrontation naming, word finding, and spelling are impaired. Speech is enriched in function words but impoverished in substantive nouns and verbs denoting specific actions. Language output is fluent but paraphasic, circumlocutious, and uninformative. The lesion sites can be anywhere within the left hemisphere language network, including the middle and inferior temporal gyri.

Pure Word Deafness

In pure word deafness, the most common lesions are either bilateral or left-sided in the superior temporal

Yetman, D. (2020, January 29). *What You Need to Know About Anomic Aphasia*. Healthline. <https://www.healthline.com/health/anomic-aphasia>

What You Need to Know About Anomic Aphasia



Medically reviewed by [Heidi Moawad, M.D.](#) — Written by [Daniel Yetman](#) on January 29, 2020

[Causes](#) | [Risk factors](#) | [Characteristics](#) | [Diagnosis](#) | [Treatment](#) | [Prognosis](#) |

Summary

Anomic aphasia causes problems in naming objects when speaking and writing. But it's one of the mildest forms of aphasia, and there are treatments that can help.

Anomic aphasia is a language disorder that leads to trouble naming objects when speaking and writing. Brain damage caused by stroke, traumatic injury, or tumors can lead to anomic aphasia.

Anomic aphasia goes by several other names, like anomia, amnesic aphasia, and anomic dysphasia.

ADVERTISEMENT

Ad closed by Google

3. Broca's Aphasia

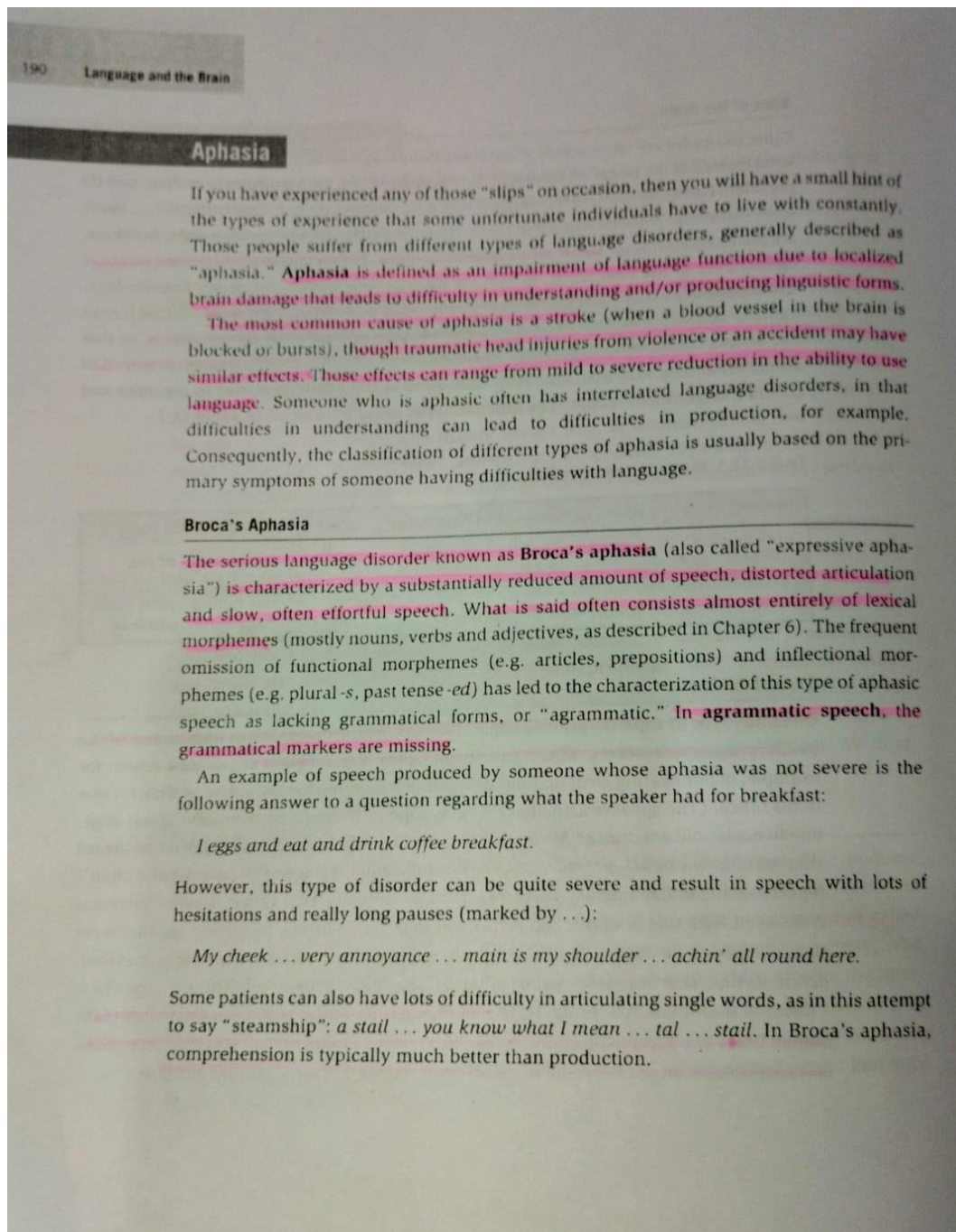
Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

194 INTRO: A Guide to Communication Sciences and Disorders

of instances of **circumlocutions** (i.e., roundabout talking) due to word-finding problems.

Broca's aphasia results from a lesion to Broca's area, which is in the left frontal lobe at Brodmann area 44 (see Figures 8-7 and 8-12). The lesion is accompanied by some sort of one-sided (right-side) body weakness or paralysis (i.e., **hemiparesis**). This particular type of aphasia is characterized primarily by fairly intact language comprehension skills, but nonfluent expressive language. The nature of the expressive language is confined to short utterances of approximately four words or less, and speech articulation is likely to be slow and labored as a result of dysarthria co-occurring. Mixed aphasia and global aphasia are nonfluent forms of aphasia that relate more to the severity of the brain lesion rather than to the distinctive communication disorder. The brain lesion is usually deep and covers portions of both Wernicke's and Broca's areas. In mixed aphasia, the problems with expressive and receptive language are generally no more than moderate in severity. Global aphasia reflects a severe to profound communication disorder due to a massive widespread brain lesion. In mixed and global aphasias, speech dysarthria is likely to be present as well.

Yule, G. (2020). *The Study of Language* (7th Edition). Cambridge University Press.



Dardjowidjojo, S. (2016). *Psikolinguistik: Pengantar pemahaman bahasa manusia*. Yayasan Pustaka Obor Indonesia.

Psikolinguistik: Pengantar Pemahaman Bahasa Manusia

kanan. Sebaliknya, kalau *stroke* itu terjadi pada hemisfir kanan, maka bagian kiri tubuhlah yang akan terganggu.

Akibat penyakit *stroke* juga ditentukan oleh letak kerusakan pada hemisfir yang bersangkutan. Pada umumnya, kerusakan pada hemisfir kiri mengakibatkan munculnya gangguan wicara. Gangguan macam apa yang timbul ditentukan oleh persisnya di mana kerusakan itu terjadi. Gangguan wicara yang disebabkan oleh *stroke* dinamakan afasia (*aphasia*).

5.1 Macam-macam Afasia

Ada berbagai macam afasia, tergantung pada daerah mana di hemisfir kita yang kena *stroke*. Berikut adalah beberapa macam yang umum ditemukan (Kaplan 1994: 1035).

Afasia Broca: Kerusakan (yang umumnya disebut *lesion*) terjadi pada daerah Broca. Karena daerah ini berdekatan dengan jalur korteks motor maka yang sering terjadi adalah bahwa alat-alat ujaran, termasuk bentuk mulut, menjadi terganggu; kadang-kadang mulut bisa mencong. Afasia Broca menyebabkan gangguan pada perencanaan dan pengungkapan ujaran. Kalimat-kalimat yang diproduksi terputah-putah. Karena alat penyuara juga terganggu maka seringkali lafalnya juga tidak jelas. Kata-kata dari kategori sintaktik utama seperti nomina, verba, dan adjektiva tidak terganggu, tetapi pasien kesukaran dengan kata-kata fungsi. Pasien bisa mengingat dan mengucapkan nomina *bee* atau nomina *witch*, tetapi dia kesukaran mengingat dan mengatakan *be* atau *which*. Kalimat-kalimat dia juga banyak yang tanpa infleksi atau afiks. Berikut adalah contoh bahasa yang diucapkan oleh penderita afasia Broca (Dingwall 1998: 56).

Yes ... ah ... Monday ... er ... Dad and Peter H...
and Dad ...er ... hospital ... and eh ... Wednesday,
nine o'clock. Ah doctors ... two ... and doctors
...and er ...teeth ... ya. (Pasien ingin mengatakan
bahwa dia datang ke hospital untuk operasi gigi).

Afasia Wernicke: Letak kerusakan adalah pada daerah Wernicke, yakni, bagian agak ke belakang dari lobe temporal. Korteks-korteks lain yang berdekatan juga bisa ikut kena.

4. Global Aphasia

Robb, M. P. (2020). *Intro: A guide to communication sciences and disorders*. Plural publishing.

194 INTRO: A Guide to Communication Sciences and Disorders

of instances of **circumlocutions** (i.e., roundabout talking) due to word-finding problems.

Broca's aphasia results from a lesion to Broca's area, which is in the left frontal lobe at Brodmann area 44 (see Figures 8-7 and 8-12). The lesion is accompanied by some sort of one-sided (right-side) body weakness or paralysis (i.e., **hemiparesis**). This particular type of aphasia is characterized primarily by fairly intact language comprehension skills, but nonfluent expressive language. The nature of the expressive language is confined to short utterances of approximately four words or less, and speech articulation is likely to be slow and labored as a result of dysarthria co-occurring. **Mixed aphasia and global aphasia are nonfluent forms of aphasia that relate more to the severity of the brain lesion rather than to the distinctive communication disorder. The brain lesion is usually deep and covers portions of both Wernicke's and Broca's areas. In mixed aphasia, the problems with expressive and receptive language are generally no more than moderate in severity. Global aphasia reflects a severe to profound communication disorder due to a massive widespread brain lesion. In mixed and global aphasias, speech dysarthria is likely to be present as well.**

Ardila, A. (2014). *Aphasia Handbook*. Florida International University.

Global aphasia

Global aphasia is an extended aphasia observed in cases of damage involving the complete perisylvian area of the left hemisphere (frontal, temporal and parietal areas). Its most frequent etiology is the occlusion of the major trunk of the middle cerebral artery of the left hemisphere, but it can also be the result of multiple lesions ((Pai et al., 2011). Patients with global aphasia present both, expressive and receptive defects, and as a matter of fact, it could be interpreted as a mixed Broca's, Wernicke's and conduction aphasia. Global aphasia is initially the most common type of aphasia in stroke patients (Vidović, 2011); it is observed in about one third of

Whitaker, H. A. (2010). *Concise Encyclopedia of Brain and Language*
(First edition). Elsevier.

Global Aphasia

In global aphasia, speech output is nonfluent, and comprehension of spoken language is severely impaired. Naming, repetition, reading, and writing are also impaired. This syndrome represents the combined dysfunction of Broca's and Wernicke's areas and usually results from strokes that involve the entire middle cerebral artery distribution in the left hemisphere. Most patients are initially mute or say a few words, such as 'hi' or 'yes.'

Dardjowidjojo, S. (2016). *Psikolinguistik: Pengantar pemahaman bahasa manusia*. Yayasan Pustaka Obor Indonesia.

Landasan Neurologis pada Bahasa

Penderita afasia ini lancar dalam berbicara, dan bentuk sintaksisnya juga cukup baik. Hanya saja, kalimat-kalimatnya sukar dimengerti karena banyak kata yang tidak cocok maknanya dengan kata-kata lain sebelum dan sesudahnya. Hal ini disebabkan karena penderita afasia ini sering keliru dalam memilih kata – kata *fair* bisa digantikan dengan *chair*, *carrot* dengan *cabbage*, dsb. Penderita afasia Wernicke juga mengalami gangguan dalam komprehensi lisan. Dia tidak mudah dapat memahami apa yang kita katakan. Berikut adalah contoh bahasa penderita afasia Wernicke (Dingwall 1998: 56):

Well, this is ... mother is away here working her work out here to get her better, but when she's looking, the two boys looking in the other part. One their small tile into her time here. She's working another time because she's getting, too ... (Penderita sedang menggambarkan peristiwa di mana dua anak sedang mencuri kue sementara ibunya sedang menoleh ke arah lain).

Afasia Anomik: Kerusakan otak terjadi pada bagian depan dari lobe parietal atau pada batas antara lobe parietal dengan lobe temporal. Gangguan wicaranya tampak pada ketidak-mampuan penderita untuk mengaitkan konsep dan bunyi atau kata yang mewakilinya. Jadi, kalau kepada pasien ini diminta untuk mengambil benda yang bernama *gunting*, dia akan bisa melakukannya. Akan tetapi, kalau kepadanya ditunjukkan gunting, dia tidak akan dapat mengatakan nama benda itu.

Afasia Global: Pada afasia ini kerusakan terjadi tidak pada satu atau dua daerah saja tetapi di beberapa daerah yang lain; kerusakan bisa menyebar dari daerah Broca, melewati korteks motor, menuju ke lobe parietal, dan sampai ke daerah Wernicke. Luka yang sangat luas ini tentunya mengakibatkan gangguan fisik dan verbal yang sangat besar. Dari segi fisik, penderita bisa lumpuh di sebelah kanan, mulut bisa mencong, dan lidah bisa menjadi tidak cukup fleksibel. Dari segi verbal, dia bisa kesukaran memahami ujaran orang, ujaran dia tidak

mudah dimengerti orang, dan kata-kata dia tidak diucapkan dengan cukup jelas.

Afasia konduksi (conduction aphasia): Bagian otak yang rusak pada afasia macam ini adalah fiber-fiber yang ada pada fasikulus arkuat yang menghubungkan lobe frontal dengan lobe temporal. Karena hubungan daerah Broca di lobe frontal yang menangani produksi dengan daerah Wernicke di lobe temporal yang menangani komprehensi terputus maka pasien afasia konduksi tidak dapat mengulang kata yang baru saja diberikan kepadanya. Dia dapat memahami apa yang dikatakan orang. Misalnya, dia akan dapat mengambil pena yang terletak di meja, kalau disuruh demikian. Dia juga akan dapat berkata *Pena itu di meja*, tetapi dia tidak akan dapat menjawab secara lisan pertanyaan *Di mana penanya?* Bisa terjadi, dia ditanya tentang A, yang dijawab adalah tentang B, atau C.

Di samping keempat macam afasia di atas, ada pula bentuk-bentuk gangguan wicara yang lain. *Disartria (dysarthria)* adalah gangguan yang berupa lafal yang tidak jelas, tetapi ujarannya utuh. Gangguan seperti ini terjadi karena bagian yang rusak pada otak hanyalah korteks motor saja sehingga mungkin hanya lidah, bibir, atau rahangnya saja yang berubah. *Agnosia* atau *demensia (dementia)* adalah gangguan pada pembuatan ide. Penderita tidak dapat memformulasikan ide yang akan dikatakan dengan baik sehingga isi ujaran bisa loncat-loncat ke sana kemari. *Aleksia (alexia)* adalah hilangnya kemampuan untuk membaca sedangkan *agrafia (agraphia)* adalah hilangnya kemampuan untuk menulis dengan huruf-huruf yang normal. Kedua penyakit ini disebut pula sebagai *disleksia (dyslexia)*. Di halaman berikut diberikan contoh tulisan penderita agrafia dari siswa yang mengambil kursus di Universitas Atma Jaya (14 Oktober 1998).

G. Research of the Relevance

Prastiwi, N. D. (2019). *Communication Disorder of The Autistic Character in the “Fly Away” Movie (Universitas Islam Negeri Maulana Malik Ibrahim Malang)*.

COMMUNICATION DISORDER OF THE AUTISTIC CHARACTER IN THE “FLY AWAY” MOVIE

By :

Nadira Dinda Prastiwi

NIM : 15320052

Advisor :

Dr. Hj. Rohmani Nur Indah, M. Pd

NIP : 197609102003122002

DEPARTMENT OF ENGLISH LITERATURE

FACULTY OF HUMANITIES

UNIVERSITAS ISLAM NEGERI MAULANA MALIK IBRAHIM
MALANG

2019

ABSTRACT

Nadira Dinda Prastiwi. 2019. *Communication Disorder of the Autistic Character in the Fly Away Movie*. Thesis. Malang: English Literature Department, Faculty of Humanities, State Islamic University of Maulana Malik Ibrahim Malang.

Advisor: Dr. Rohmani Nur Indah, M.Pd

Keywords: Communication Disorder, Autisme, Fly Away Movie.

This research aims to identify the type of communication disorder in comprehending speech when communicating on autistic characters in the fly away movie. In addition, the study aims to describe the occurrence of communication disorders in comprehending when communicating in autistic characters in the Fly Away movie. In this study, the researcher used the concept of communication disorder theory in the autistic to analyze the type of communication disorder by Paul (2008).

The study used a descriptive method of qualitative, to analyze the outcome of communication disorder types in the main cast of the autistic Fly Away film. In the findings and analysis, there are forty-three data of the five types of communication disorders namely, repetition of words, minimal response, limitation of communication function, use of unusual words, and low frequency. The results stated that this type of word repetition communication disorder is a type of disorder that often occurs in autistic characters in Fly Away. In addition, the results of the study also proved that the communication disorder was not found on the main character in the Fly Away movie is difficult to focus on. The difficulty to focus is not to occur in the main character.

Hati, D. A. (2018). *Linguistic Disorder of Aphasia in the Main Character of the Movie My Beautiful Broken Brain.*

LINGUISTICS DISORDER OF APHASIA IN THE MAIN CHARACTER OF THE MOVIE *MY BEAUTIFUL BROKEN BRAIN*

A PAPER

Submitte to the School of Foreign Language – JIA as partial fulfillment of requirement for he undergraduate degree in English Literature Programme



DIEN AZIZAH HATI

43131510144041

**ENGLISH LITERATURE PROGRAMME
SCHOOL OF FOREIGN LANGUAGES – JIA
BEKASI
2018**

LINGUISTICS DISORDER OF APHASIA IN THE MAIN CHARACTERS OF THE MOVIE *MY BEAUTIFUL BROKEN BRAIN*

DIEN AZIZAH HATI

ABSTRACT

This study aims to find out and study the analysis of language processing produced by aphasia sufferers through the neurolinguistics linguistic disorder approach in the film My Beautiful Broken Brain. The author conducted this study from March to August 2018. This research method is qualitative research. The main theory used by Ardila and Papathanasiou and supported by Carroll about linguistics disorder. In their books Ardila and Papathanasiou gave six types of aphasia, namely (1) broca aphasia, (2) wenicke aphasia, (3) conduction aphasia, (4) global aphasia, (5) anomic aphasia, and (6) transcortical aphasia. And with the theoretical support of Carroll gave 2 types of linguistics disorder, namely (1) expressive language and (2) receptive language. From the analysis process, the total data collected in this study is 31 data. The results vary in the frequency of the most disorder linguistics types that are 24 data result. The next is followed by a receptive language with 7 data. Then, based on the way the patient produces language, broca aphasia becomes dominated by a percentage of 71%, then anomic aphasia has 16.12%, conduction aphasia and transcortical aphasia have the same percentage of 6.45% that is the result of aphasia based on the characteristics and types of linguistics disorder found in the film My Beautiful Broken Brain.

Keyword : Neurolinguistics, linguistics disorder, aphasia.

Nurnisa, S., & Damanhuri, A. (2022). *Speech and Language Disorder on King George VI in the King's Speech*. *LANGUAGE HORIZON*, 10(2), 40–47.

LANGUAGE HORIZON: Journal of Language Studies
Volume 10 Number 2 (2022)
e-ISSN 2356-2633

SPEECH AND LANGUAGE DISORDER ON KING GEORGE VI IN THE KING'S SPEECH

Sofia Nurnisa

Sastra Inggris, Fakultas Bahasa dan Seni, Universitas Negeri Surabaya
sofianurnisa@fbs.unesa.ac.id

Adam Damanhuri

Sastra Inggris, Fakultas Bahasa dan Seni, Universitas Negeri Surabaya
adamdamanhuri@unesa.ac.id

Abstrak

Penelitian ini bertujuan untuk melihat apa penyebab gangguan berbicara pada masalah komunikasi seperti fungsi motorik mulut dan kecemasan antisipatif yang dialami King George VI dalam film *The King's Speech* serta bagaimana cara ia mengatasinya. Film *King's Speech* mengisahkan Raja George yang menderita kegagapan yang membuatnya mengalami gangguan dalam berbicara dan berbahasa sejak kecil. Penelitian ini menggunakan metode deskriptif kualitatif, yaitu mengamati data-data berupa perilaku dan fenomena yang dipaparkan melalui berupa uraian naratif. Data-data tersebut kemudian dikaji menggunakan teori dari Nathan Lavid dan Wendy Leiner. Nathan Lavid berpendapat bahwa kegagapan dapat dibagi menjadi beberapa jenis, yaitu *developmental stuttering*, kegagapan akibat stroke serta kegagapan sementara akibat lidah keseleo karena terkejut. Leiner menjelaskan bahwa penderita kegagapan dapat menerima beberapa terapi untuk mengurangi bahkan menghilangkan kegagapannya. Hasil penelitian ini menunjukkan bahwa King George VI mengalami *language disorder* karena menderita *developmental stuttering*, *anticipatory anxiety*, dan *brain plasticity*. Untuk mengatasi gangguan berbicara tersebut, King George VI melakukan *auditory masking*, *singing*, dan *speaking alone*. Ditemukan bahwa aliran bicara terputus tanpa disadari oleh pengulangan dan pemanjangan suara, suku kata atau frasa, dan jeda yang tidak disadari sehingga mengakibatkan kegagalan produksi suara. Untuk mengatasi gangguan berbicara tersebut, Raja George VI menjalani terapi wicara dan mendapatkan beberapa perawatan semisal *brain plasticity* dan *manoeuvres*.

Kata Kunci: *Speech, developmental stuttering, anticipatory anxiety, brain plasticity, manoeuvres.*

Abstract

This research aims to locate the causes of King George VI's speech and language disorder in *The King's Speech* and how he copes with it. Speech disorders refer to a communication issue and the related areas such as oral motor function and anticipatory anxiety. The movie depicts the story of King George who suffered from stuttering leaving him with speech disorder since childhood. This study uses a qualitative descriptive method, which observes the data of behaviors and events, and is presented through narrative description. The data is examined using Nathan Lavid's and Wendy Leiner's theories on speech and language disorder. Lavid stated that stuttering comes into a few types: developmental stuttering and stuttering due to diseases such as stroke, and temporary stuttering caused by a sprained tongue due to surprise or panic. Leiner explained that people with stuttering can receive several rare therapies to reduce or even eliminate their stuttering. This research employs a descriptive qualitative method using Nathan Lavid's and Wendy Leiner's theories. The result shows that King George VI had been suffering from developmental stuttering, anticipatory anxiety, and brain plasticity. To overcome these disorders, King George VI underwent auditory masking, singing, and speaking alone. It was found that the flow of speech is unconsciously cut off by repeating and prolonging sounds, syllables, words, or phrases, and the failure to produce sound by an unknowing pause. To fix it, King George VI underwent speech therapy, Brain Plasticity and Manoeuvres treatments.

Keywords: *Speech, developmental stuttering, anticipatory anxiety, brain plasticity, manoeuvres.*

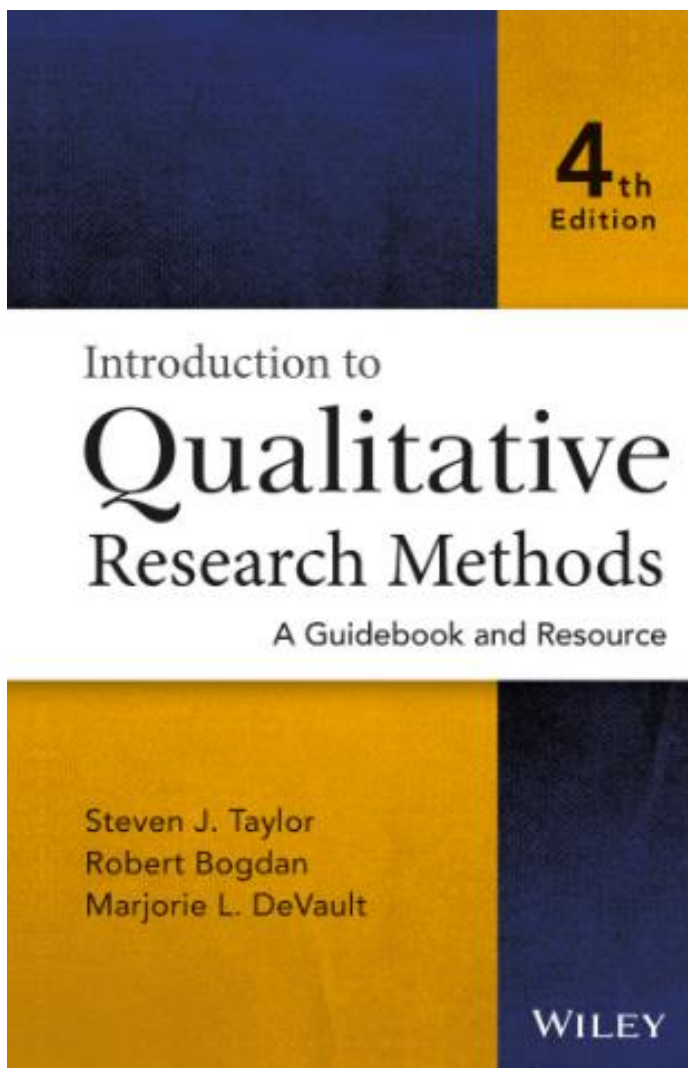
CHAPTER III

METHODOLOGY OF THE RESEARCH

A. Method of the Research

2. Kind of the Research.

Taylor, S. J., Bogdan, R., & Devault, M. L. (2016). *Introduction to Qualitative Research Methods* (4th edition). John Wiley & Sons.



This book is printed on acid-free paper. ♻️

Copyright © 2016 by John Wiley & Sons, Inc. All rights reserved.

Published by John Wiley & Sons, Inc., Hoboken, New Jersey.
Published simultaneously in Canada.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, scanning, or otherwise, except as permitted under Section 107 or 108 of the 1976 United States Copyright Act, without either the prior written permission of the Publisher, or authorization through payment of the appropriate per-copy fee to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400, fax (978) 646-8600, or on the web at www.copyright.com. Requests to the Publisher for permission should be addressed to the Permissions Department, John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, (201) 748-6011, fax (201) 748-6008.

Limit of Liability/Disclaimer of Warranty: While the publisher and author have used their best efforts in preparing this book, they make no representations or warranties with respect to the accuracy or completeness of the contents of this book and specifically disclaim any implied warranties of merchantability or fitness for a particular purpose. No warranty may be created or extended by sales representatives or written sales materials. The advice and strategies contained herein may not be suitable for your situation. You should consult with a professional where appropriate. Neither the publisher nor author shall be liable for any loss of profit or any other commercial damages, including but not limited to special, incidental, consequential, or other damages.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering professional services. If legal, accounting, medical, psychological or any other expert assistance is required, the services of a competent professional person should be sought.

Designations used by companies to distinguish their products are often claimed as trademarks. In all instances where John Wiley & Sons, Inc. is aware of a claim, the product names appear in initial capital or all capital letters. Readers, however, should contact the appropriate companies for more complete information regarding trademarks and registration.

For general information on our other products and services please contact our Customer Care Department within the United States at (800) 762-2974, outside the United States at (317) 572-3993 or fax (317) 572-4002.

Wiley publishes in a variety of print and electronic formats and by print-on-demand. Some material included with standard print versions of this book may not be included in e-books or in print-on-demand. If this book refers to media such as a CD or DVD that is not included in the version you purchased, you may download this material at <http://booksupport.wiley.com>. For more information about Wiley products, visit www.wiley.com.

Library of Congress Cataloging-in-Publication Data

Taylor, Steven J., 1949–

Introduction to qualitative research methods : a guidebook and resource / Steven J. Taylor, Robert Bogdan, Marjorie L. DeVault. — 4th edition.

pages cm

Includes bibliographical references and index.

ISBN 978-1-118-76721-4 (cloth) — ISBN 978-1-118-76730-6 (epub) — ISBN 978-1-118-76729-9 (epub)

1. Social sciences—Research—Methodology. 2. Sociology—Research—Methodology. 3. Qualitative research.

I. Bogdan, Robert. II. DeVault, Marjorie L., 1950– III. Title.

HA1.T385 2016

001.4'2—dc23

2015013707

Cover design: Wiley

Cover image: ©iStock/urbanrow

Printed in the United States of America

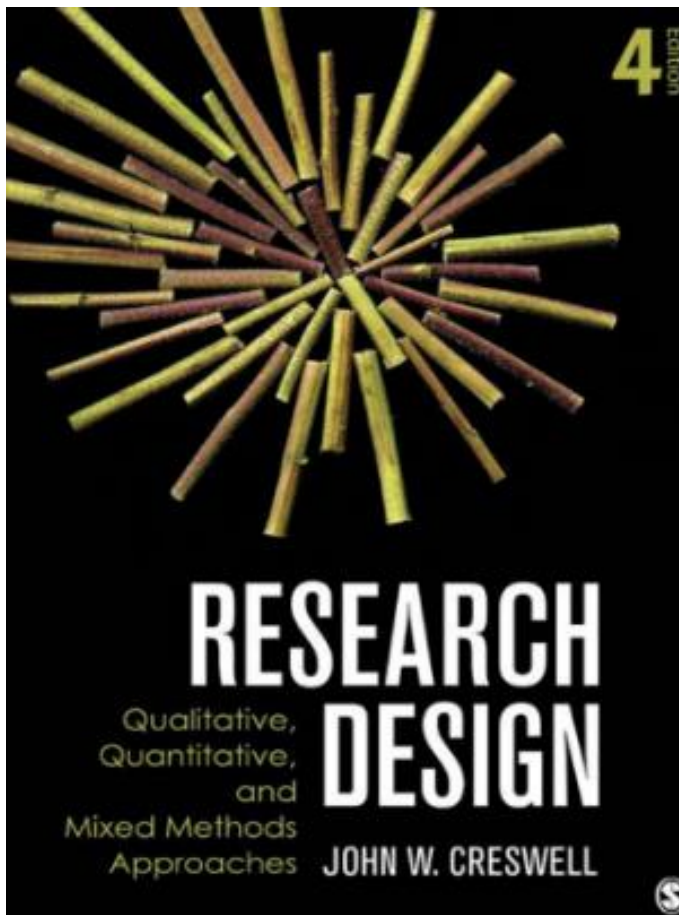
10 9 8 7 6 5 4 3 2 1

QUALITATIVE METHODOLOGY

The phrase *qualitative methodology* refers in the broadest sense to research that produces descriptive data—people’s own written or spoken words and observable behavior. As Ray Rist (1977) pointed out, qualitative methodology, like quantitative methodology, is more than a set of data-gathering techniques. It is a way of approaching the empirical world. In this section we present our notion of qualitative research.

1. *Qualitative researchers are concerned with the meaning people attach to things in their lives.* Central to the phenomenological perspective and hence qualitative research is understanding people from their own frames of reference and

Creswell, J. W. (2014). *Research Design Qualitative Quantitative and Mixed Methods Approaches* (4th Edition). Sage Publications.



SAGE

Los Angeles | London | New Delhi
Singapore | Washington DC

FOR INFORMATION:

SAGE Publications, Inc.
2455 Teller Road
Thousand Oaks, California 91320
E-mail: order@sagepub.com

SAGE Publications Ltd.
1 Oliver's Yard
55 City Road
London EC1Y 1SP
United Kingdom

SAGE Publications India Pvt. Ltd.
B 1/1 Mohan Cooperative Industrial Area
Mathura Road, New Delhi 110 044
India

SAGE Publications Asia-Pacific Pte. Ltd.
3 Church Street
#10-04 Samsung Hub
Singapore 049483

Acquisitions Editor: Vicki Knight
Editorial Assistant: Jessica Young
Assistant Editor: Kalie Koscielo
Production Editor: Brittany Bauhaus
Copy Editor: Megan Markanich
Typesetter: C&M Digital (P) Ltd.
Proofreader: Rae-Ann Goodwin
Indexer: Gloria Tierney
Cover Designer: Michael Dubowe
Marketing Manager: Nicole Elliott
Permissions Editor: Adele Hutchinson

Qualitative Methods

Qualitative methods demonstrate a different approach to scholarly inquiry than methods of quantitative research. Although the processes are similar, qualitative methods rely on text and image data, have unique steps in data analysis, and draw on diverse designs. Writing a methods section for a proposal for qualitative research partly requires educating readers as to the intent of qualitative research, mentioning specific designs, carefully reflecting on the role the researcher plays in the study, drawing from an ever-expanding list of types of data sources, using specific protocols for recording data, analyzing the information through multiple steps of analysis, and mentioning approaches for documenting the accuracy—or validity—of the data collected. This chapter addresses these important components of writing a good qualitative methods section into a proposal. Table 9.1 presents a checklist for reviewing the qualitative methods section of your proposal to determine whether you have addressed important topics.

Table 9.1 A Checklist of Questions for Designing a Qualitative Procedure

	Are the basic characteristics of qualitative studies mentioned?
	Is the specific type of qualitative design to be used in the study mentioned? Is the history of, a definition of, and applications for the design mentioned?
	Does the reader gain an understanding of the researcher's role in the study (past historical, social, cultural experiences, personal connections to sites and people, steps in gaining entry, and sensitive ethical issues) and how they may shape interpretations made in the study?
	Is the purposeful sampling strategy for sites and individuals identified?

C. Technique of the Data Collection

Creswell, J. W. (2014). *Research Design Qualitative Quantitative and Mixed Methods Approaches* (4th Edition). Sage Publications.

The Characteristics of Qualitative Research

For many years, proposal writers had to discuss the characteristics of qualitative research and convince faculty and audiences as to their legitimacy. Now these discussions are less frequently found in the literature and there is some consensus as to what constitutes qualitative inquiry. Thus, my suggestions about this section of a proposal are as follows:

- Review the needs of potential audiences for the proposal. Decide whether audience members are knowledgeable enough about the characteristics of qualitative research that this section is not necessary.

- If there is some question about their knowledge, present the basic characteristics of qualitative research in the proposal and possibly discuss a recent qualitative research journal article (or study) to use as an example to illustrate the characteristics.

- If you present the basic characteristics, what ones should you mention? Fortunately, there is some common agreement today about the core characteristics that define qualitative research. A number of authors of introductory texts convey these characteristics, such as Creswell (2013), Hatch (2002), and Marshall and Rossman (2011).

- *Natural setting*: Qualitative researchers tend to collect data in the field at the site where participants experience the issue or problem under study. They do not bring individuals into a lab (a contrived situation), nor do they typically send out instruments for individuals to complete. This up-close information gathered by actually talking directly to people and seeing them behave and act within their context is a major characteristic of qualitative research. In the natural setting, the researchers have face-to-face interaction, often over time.
- *Researcher as key instrument*: Qualitative researchers collect data themselves through examining documents, observing behavior, or interviewing participants. They may use a protocol—an instrument for collecting data—but the researchers are the ones who actually gather the information. They do not tend to use or rely on questionnaires or instruments developed by other researchers.
- *Multiple sources of data*: Qualitative researchers typically gather multiple forms of data, such as interviews, observations, documents, and audiovisual information rather than rely on a single data source. Then the researchers review all of the data, make sense of it, and organize it into categories or themes that cut across all of the data sources.
- *Inductive and deductive data analysis*: Qualitative researchers build their patterns, categories, and themes from the bottom up by organizing the data into increasingly more abstract units of information. This inductive process illustrates working back and forth between the themes and the database until the researchers have established a comprehensive set of themes. Then deductively, the researchers look back at their data from the themes to determine if more evidence can support each theme or whether they need to gather additional information. Thus, while the process begins inductively, deductive thinking also plays an important role as the analysis moves forward.
- *Participants' meanings*: In the entire qualitative research process, the researcher keeps a focus

D. Technique of Data Analysis

Wertz, F. J., Charmaz, K., McMullen, L. M., Josselson, R., Anderson, R., & McSpadden, E. (2011). *Five Ways of Doing Qualitative Analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*. Guilford Press.

My analytic location for our project is discursive psychology, which involves the application of ideas from discourse analysis to issues in psychology (Potter, 2003). Discourse analysis has been designated a method of analysis; a methodology; a perspective on social life that involves metatheoretical, theoretical, and analytic principles; and a critique of mainstream psychology (Crotty, 1998; Potter, 2003; Willig, 2003; Wood & Kroger, 2000). It is both a way of conceptualizing and analyzing language.

The numerous varieties of discourse analysis reveal its multidisciplinary origins in various branches of philosophy, sociology, linguistics, psychology, and literary theory (Wood & Kroger, 2000). From a focus on how sentences are put together (e.g., linguistics), to how conversation or talk-in-interaction is structured (e.g., conversational analysis), to how sets of statements come to constitute objects and subjects (e.g., Foucauldian discourse analysis), to how discourse can be understood in relation to social problems, structural variables (e.g., race, gender, class), and power (e.g., critical discourse analysis), this approach to thinking about and analyzing language encompasses varied (and often opposing) sets of principles (Potter, 2004; Willig, 2003; Wood & Kroger, 2000). As outlined by Wood and Kroger (2000, p. 18), the many varieties of discourse analysis differ on dimensions such as epistemological position (e.g., constructionist vs. critical realist), nature and role of theory (e.g.,

E. Source of the Primary and Secondary Data

Walliman, N. (2011). *Research Methods: The Basics*. Routledge.

PRIMARY AND SECONDARY DATA

Data come in two main forms, depending on its closeness to the event recorded. Data that has been observed, experienced or recorded close to the event are the nearest one can get to the truth, and are called **primary data**. Written sources that interpret or record primary data are called **secondary sources**, which tend to be less reliable. For example, reading about a fire in your own house in the newspaper a day after will