SSW NEWSLETTER

Vol. 1 No. 2 February 1979

YES

The first issue of the SSW Newsletter asked, "A beginning?...." the SSW Newsletter--"Are you ready?" For the 10 people who met in San Francisco in Nov. 1978, the answer was a rousing, "Yes." Everyone seemed to agree that a newsletter can go a long way to help us remain up-to-date.

The Newsletter will come out quarterly and will present a variety of information submitted by the readership. Your contribution is needed to make this endeavor most worthwhile. We plan the following features: Cases: typical (verified); interesting; rare and strange ones for which you want some HELP! News: jobs; workshops; conferences. Bibliographies & Abstracts: articles and other publications; convention papers. Research: reports; plans; requests for assistance and coinvestigations. We also plan to have some issues devoted to one topic, such as: Children/L.D.; CES; Geriatrics; cochlear; etc. In order to stimulate research and contributions, notification will be made two issues in advance. (SEE pg.5 ON THE SPECIAL ISSUE COMING UP).

It was not my intention to edit the first SSW Newsletter issue-but you know what happens to the best made plans. When the job fell into my lap I had no idea how much I'd enjoy it. So I volunteered to be editor for the 4 1979 issues. In the group of 10 people, protests were sparce, mutterings faint and all of the darts missed the mark. Therefore, I took that for a vote of confidence.

Please think about the work you've done with the SSW or CES tests and submit something that you think would be of interest, help or something you'd like to share or ask. Send it to the editor.

Dear Ackie

Dear Ackie:
The guy I live with got up this morning & threw his pajamas into the toilet instead of the hamper which sits close by. Should I give him an SSW test?

Concerned Audiologist

Dear Concerned:
You were very perceptive to notice this spatial or motoric reversal (unless he's trying to get rid of his P.J.'s or trying to stuff up the toilet). Such reversals have been noted before: Do you recall the kid Bob Lukas tested who stepped out of the car befor it stopped? That was quite a reversal. Don't forget that perfectly normal people will occasionally make a reversal of some sort. It is how often they do it that will tell you if he needs an SSW. Is this his form of a joke? Are you putting me on? Look lady, I'm busy enough without kooks like you sending me crazy letters.

ACKIE

P.S. Don't marry the guy honey, he sounds like imperfect merchandise.

AUDIOLOGY POSITION:
With greater skills in central auditory testing by audiologists there has been an increase in the number of "neuroaudiological" positions. There is an excellent opening at the Cleveland Clinic. It is available immediately. If you are interested please contact:

Dr. Richard Nodar
Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio 44106

Site of lesion -

THE USE AND MISUSE OF THE SSW TEST - II

by Jack Katz

I still hear questions about correcting the SSW for discrimination errors. While no test or correction factor is perfect, all of the studies I've seen support using the C-SSW score. Those who use the raw score instead of the C-SSW do so on a theoretical basis rather than finding the C-SSW wanting.

Most central tests are invalidated by peripheral hearing loss or distortion(12). The SSW is useful in studying central dysfunction whether there is a hearing loss or not. The danger in not correcting the R-SSW is to confuse a peripheral disorder for a central one. In addition, so many people have hearing losses that it would severely reduce the number of patients who could be tested audiometrically for cerebral disorders.

Katz (7) found that C-SSW differentiated normal, cochlear, cerebral auditory reception (AR) and non AR (NAR) cases. These findings were supported by other studies (1, 6,7,8,11).

There seem to be 2 objections to the C-SSW. A. It is not proper to subtract error scores on a monosyllabic word test from a spondaic procedure. B. If cerebral distortion causes errors on the standard discrim test the correction would reduce the central effect.

A. <u>(W-1 - W-22 ≠ R-SSW - W-22)</u>.

There is no argument that monosyllabic (PB) & spondaic words are affected differently by peripheral distortion. However, the SSW is <u>not</u> a standard, simple spondee test. The advantage that spondees have over PB's is offset by the SSW method of presentation. There are at least 2 reasons why the SSW is more challenging than a simple spondee test:

1)The SSW is a complex dichotic procedure using 2 spondees. The words are competing and NC. The listener must spend less time analyzing the competing mono's because he must quickly shift attention to the other side. Thus a person with less than normal clarity for speech will be at a disadvantage in getting the competing word, even if he is able to understand the 1st one. There are many other challenges that are apparent between the SSW task vs. a simple spondee test.

2)Part of the spondee advantage is based on the familiarity of the W-1's and their homogeneous audibility. The SSW words seem less common, have more foils & probably are not as homogeneously audible. In a recent substudy on the SSW(9) a group of college students in speech path. & audiology were asked to guess the 2nd word from the 1st ½ spondee. They correctly anticipated less than 1/3 of the words with even 50% accuracy. 17 of the words were not guessed by any of the 10 judges.

For many reasons SSW items are far more challenging than W-1's. It has become quite clear that spondees are easier than SSW's. Fortuitously the SSW mimics the characteristics of W-22's. Studies corroborate

B. <u>R-SSW = W-22</u>

The foregoing indicates that the SSW is more difficult than spondees. This section will show that it is equivalent to W-22's especially for normal and cochlear S's.

1)Balas & Simon(2) found the PI function for SSW items resembles PI-PB's. This finding was replicated in another study also involving normal listeners(10).

2)In studies with conductive & cochlear cases R-SSW & WDS have been remarkably similar. Means & standard deviations have been almost identical for the 2 tests & the correlations have been between .86 and .93(7,8, 11).

3)Normal S's 11-60 yrs. consistently have normal(<u>N</u>)C-SSW scores. Cochlear cases usually corrected into the <u>N</u> category, but occasionally have <u>O</u> or <u>Mi</u> scores. Dawson(5) tested a large group of cochlear & normal S's. All of the S's within the standard age range scored in the expected categories except for 1 congenital case with a S-N loss. It is quite

USE/MISUSE....CON'T.

possible that even this 1 false positive has a true CNS disorder. Cafarelli & Nodar (4) studied patients with Meniere's disease using the SSW test. Their conclusion was that the C-SSW is the appropriate procedure for analyzing such cases.

The 2nd objection to the C-SSW ignores the use of score categories. The SSW categories were established empirically. The limits were set to maximize 'hits' & minimize 'misses' & false positives. Since the categories are based on C-SSW scores, WDS has been already taken into account.

In order to allay any fears regarding the use of the C-SSW score, 3 points should be made.

A.The SSW test is quite sensitive to various sites of brain lesion (1,3,6,11, 13). This includes the differentiation of AR & NAR disorders.

B.It is quite true that some, brain disorders are associated with depressed WDS. Katz & Pack(11) found their AR cases had mildly depressed WDS and Mo/S C-SSW scores. The 13 AR cases had a mean WDS of 85% in the ear contralateral to the damage. The W-22 score was 89% ipsilaterally. The 17 NAR cases had 96% in each ear.

In AR cases the effect on the SSW is great and on WDS is quite small. Thus the categories work well in identifying the central cases & differentiating them from peripheral cases. NAR cases have small affects on the SSW and almost no affect on W-22's. Thus, there is typically no change in the N or Mi category. Occasionally, the peripheral loss will bring the NAR case into the O category.

C.The acid test of the C-SSW score is to see if it can handle both significant hearing loss and AR disorder. A case was recently reported with a moderate S-N loss and an AR lesion(8,p.111). On the SSW he had a comb. TEC=Mo-O. The Mo score was in the ear opposite the brain lesion & the O was opposite the normal hemisphere. The C-SSW worked out very well in this and many other cases with both types of distortion.

There is a bonus for using the C-SSW. C-SSW helps to differentiate high from low brainstem disorders. This will be covered in a future column.

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3.Berlin,C.,et al., Auditory findings in patients with temporal lobectomies. Presented at ASHA, Chicago, 1965.

4.Caferelli, D.,Nodar,R. et al.,SSW test results by patients with Meniere's Disease. Presented at ASHA, Chicago,1977.

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WYOMING WORKSHOP

Know someone who wants to take a Basic SSW workshop? (At present there are no Advanced ones set up.)

May 24-26, 1979

Write: Ben Koperski
U. of Wyoming
Dept. of Sp.Path. & Aud.
Laramie, Wyoming 82070

A CASE--Submitted by David W. Johnson

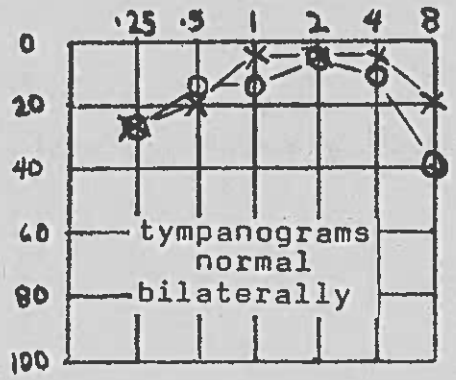
A 32 yr. old woman with a history (hx) of bilateral temporal lobe focal seizures was seen at Dept. of Otolaryngology, Hennepin Co. Med. Ctr. She was referred by her employer who claimed she did not hear well. The pt. said that it was his problem and not hers. She did admit however that she could "hear" but could not always tell what people were saying.

There was no hx of tinnitus, noise exposure nor family hx of hearing loss. At age 6 the pt. had fallen off a seesaw and was unconscious. She had difficulties in school but the seizures were not identified until she was 13. The seizures are not completely controlled by medication. There is an auditory component to these psycho-motor seizures during which the patient is reported to walk or dance. The woman has a history of psychiatric hospitalization and takes many drugs (e.g., Phenobarbital, Valium and Haldol).

The patient's record shows abnormal EEG activity bilaterally in the mid and anterior temporal regions, more so on the left.

Otological evaluation: ears clear and unremarkable, Weber referred to midline and Rinne, negative.

Audiological evaluation:



W-22 discrim at 2 S/N ratios: +10dB R=80%, L=90%; +5dB R=40%, L= 60%. The SSW (list EE) was given at 50 dB above the 3-freq. sp. avg. The test was given REF. The 8 cardinal numbers were: 0 0 0 0 0 2 0 0 , but there were 23 reversals.

Impression: based on the audiometric findings the pt. no doubt has difficulty in communication under noisy conditions, perhaps the right ear more than the left. It is not surprising that the C-SSW score was quite normal as the disorder was in the anterior-mid temporal region sparing Heschl's gyrus. (see USE/MISUSE-I, SSW Newsletter, 1, p.2, 1978). The reversals suggest that the patient has difficulty remembering the sequence of auditory information. On questioning she reported remembering a series of directions but not which ones should be done first.

Disposition: the employer was informed that the pt. had a listening problem in noise. To avoid confusion he should instruct her in the quiet and when backgrouna noise was present he should be sure to face her to provide visual cues. The pt. was instructed to take written notes in order to maintain the proper sequence of her tasks.

Comment: the only SSW sign of CNS disorder & its possible site was the reversals. The S/N test demonstrated a figure/ground disturbance (which is usually associated with brainstem dysfunction). It is not clear how the various medications might have influenced the audiometric results.

[Editor's comment--This is a most interesting case. 1.) It shows that CNS disorders can masquerade as "hearing problems." Without central testing the true problem might not have been identified and subsequent recommendations inappropriate (e.g., the employer might have fired her or sent her to the "shrink" and never instituted the simple, inepensive and appropriate recommendations). 2) EEG is a valuable tool for general localization of cortical dysfunction. I wonder if frontal or parietal leads showed some abnormality too? The anterior temporal lobe is indeed within

CASE(cont.)

the "reversal strip" but 23 reversals is typically supra sylvian. 3)There is the question of the effects of medication. I have tested sedated pts. & found reversals etc. which may have been drug induced. Possibly the medications could have increased her tendency to reverse. 4)It is important to reiterate that posterior temporal disorders are associated with MO/S scores and "posterior bias." Anterior temporal disorders are associated with N/Mi scores and "anterior biases." The latter was the case with this patient. 5)It would have been interesting to see if CES would shed light on the side(s) of dysfunction.

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LETTER TO THE EDITOR

Dear Editor:
Would you believe that I don't know what the peculiar "forgive milkman" response is - which classifies me as a neophyte. My favorite response was "sheepshit bullshit." I also insist that you cannot say "Sunday shoeshine" if you are sober.

B.K.

[Ed. note--B.K.: The response that you got was better than mine. I was talking about "forgive the milkman...ha (chuckle) ha(chuckle)."]

A SPECIAL ISSUE

From time to time we will have a special issue devoted to a topic like: CES, Reversals, and Geriatrics. The first special issue will come out in August and will deal with CHILDREN and LEARNING DISABILITIES. So far we have no material to print but are sure that the readership can come up with an exciting and informative issue.

You Can Help:
1) Have you tested a child or a person with a learning disability that you found interesting, valuable or strange? No doubt others would find it so too. Please communicate with the editor.

2) Have you any published or unpublished data that you would like to share which deals with the SSW and children/learning disabilities. It could be from an article a thesis, a project, a convention paper - or previously unreported results or observations. Please communicate.

3) Everyone/anyone:
ATTENTION PLEASE -
Would you believe that the single most important bit of information that we lack on the SSW is what is normal performance for children? This can be obtained in many ways but the best would be if we could develop a norm together. Would you test 5 normal children who would serve as part of the national sample? If 10 of you can send data on 5 kids we'd have a great start, if 20 of you send data, of course that would give us considerable information. The unique part of such a sample is that it would represent a wide geographic distribution, many different audiometers, tape recorders, test chambers & testers. Another feature is that it would sample children from a variety of settings. If you will help by contributing 5 subjects to the sample in the next few months, please fill out attached form or write to the editor. This would be a very fine contribution. Ed Smith of the St. Paul Public Schools has sent us the first 5 kids to start us off. Now we need 5 more.

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PHILADELPHIA WORKSHOP

July 12-14, 1979
Write: Elizabeth Protti
Hear. & Speech Center
Drexel Hill, PA 19026
(215) 259-3800

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SWAP SHOP

Do you know of individuals with Organic Mercury Poisoning(Minamata Disease)? If you do, any help is appreciated.
Contact:
Floyd Rudmin
350 Prince Arthur
Apt. #D-1904
Montreal, P.Q. H2X 3R4
CANADA

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Do you know of individuals with confirmed cerebellar disease? If so send information to:

Jack Katz

This issue was cut, spliced and typed by members of SASH, SUNY at Buffalo.
Lise Benziger
Deborah Ungerleider
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SSW Newsletter

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SSW NEWSLETTER

Vol. 1 No. 4 CHILDREN and L.D. AUGUST 1979

BUT WHAT DOES HE DO RIGHT?

We frequently become so involved in errors and response biases that we seldom have anything good to say about a child. A learning disabled child has obvious left hemisphere dysfunctions. The testing by the Speech-Language Pathologist and our central auditory testing are sensitive to the child's weaknesses. At least the psychologist can give a performance IQ so the child can succeed for part of the test period.

What tests do we have which highlight the child's strengths? If Witelson (1977) is right, the reading-disabled child has overdeveloped right hemisphere function. That is, he prefers to take in sensory information holistically. Shouldn't we see good or even superior performance on the CES if that is so?

I firmly believe that the CES should be included in the central battery on every child. But, a word of caution about the response mode. If the child points to the picture, we are probably testing only right hemisphere. If, however, we ask the child to name the sound, we are clouding the issue, Would the scores be different in the two response modes for LD children? Let's hear from CES users.

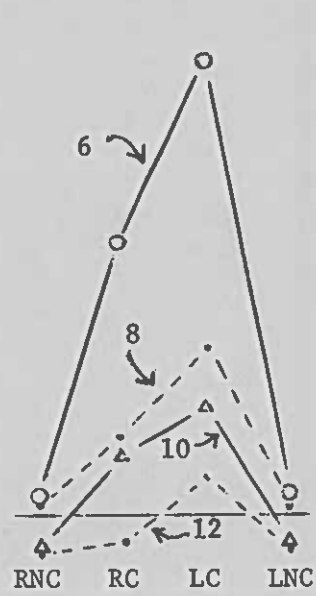
Witelson, S. Developmental dyslexia: two right hemispheres and none left. Science 21: 309-311, 1977.

SSW NATIONAL SAMPLE --- The first peak

So far the data for 86 children have been sent in. They are most encouraging. This report will cover the results for age groups 6, 8, 10 and 12. These data must be considered preliminary, but do give an indication of how the data are going. Please do not be influenced by these data in submitting your cases. It is still too early to know what the "true" norms will look like.

This figure shows the mean C-SSW scores for the 4 Conditions. The results resemble our previous "standards." The present means do not differ by more than 4 points from the C-SSW mean's of Myrick, '65 and Beyer, '77.

Thus far it seems that the SSW scores will be fairly consistent for each of the age groups within the general population. We have less knowledge about response bias (RB). The National Sample can add important data and help us to better understand maturation of the CANS. The work of White, '77; Kushner, et al, '77 and Johnson et al, '78 provide us with an indication of what to expect.



First peak, SSW National Sample C-SSW scores: 6, 8, 10 & 12-yr gr.

It is still too early to say what RB should be expected at the various age levels. We do expect to find RB in many normal children, based on the literature but the extent of the bias should not be so extreme as we find in the LD population. In this sample the major RB has been the reversal with the Type B pattern being the least frequent.

In the cases tested from now on please ascertain the child's handedness. There are some suggestions that there may be some dialect or some racial differences so please indicate race or dialect variations.

WE NEED LOTS MORE NORMAL KIDS --- KEEP SENDING

THE USE AND MISUSE OF THE SSW TEST - IV: THREE NEW SUBTESTS - C. DEMPSEY

Clinicians who erase the "Are You Ready?" from the SSW tape in a desperate attempt to save their sanity may be eliminating a very valuable addition to the central auditory test battery. The structure of the test, in its entirety, has proven to be useful in separating children with auditory learning problems from "normals." Observations of all of the child's responses during the SSW can be predictive of attending behavior in the classroom. In order to record the responses more effectively, I have divided the SSW into three subtests, each of which has one or more response biases.

INSTRUCTION SUBTEST (SSW_I): Children are often referred for testing because they cannot follow directions in the classroom. The SSW begins with 8-stage instructions. Initially, I tried to clarify them for children having trouble, but I found nothing worked with LD children. I finally realized that the instruction section is a good test of sequencing and can be used to confirm the teacher's suspicions. As many of the children we see are good visual processors, they can follow instructions only if they can visualize what they are to do. Note the abstract nature of the instructions for the SSW. In order to follow these directions, the child must be an auditory processor and linguistically intact. I suggest letting the tape run without comment, clarifying only when the child asks questions or is in obvious difficulty. Note whether the child could follow the instructions without help or whether he needed clarification (minor, moderate, constant). If the child spontaneously asks for clarification, he is aware of his problem and has found a method to cope with it. It may be a sign that, with help, he can overcome some of his auditory problems.

PRACTICE SUBTEST (SSW_P): The first four practice items do not test the same listening abilities as do the test items. The practice items cue the child to listen to a group of words, but do not provide practice in dichotic listening. As these are two different tasks, the child must be able to transfer learning. This frequently separates the LD child from the normal. After all, a specific learning disability is one in which a child is able to learn one task very well, but cannot generalize to other similar tasks. The child who succeeds on the practice items and cannot cope with the first few test items may have problems learning in an auditory mode. This is a very useful observation and should be of help to the classroom teacher. Do you then use the first four test items for practice? I think so. As the test scores are sensitive to development of auditory reception areas, they should not be colored by poor auditory generalization behavior, which seems to be an interhemispheric function. Again, it is of interest to note how many actual test items are needed before the child has solved the auditory problem.

ARE YOU READY SUBTEST (SSW_{AYR}): This is perhaps the most interesting and useful of the response biases. As every item is preceded by the carrier phrase, the audiologist has forty chances (if he can stand it) to observe the child's reaction to a rhetorical question. The "normal" child simply ignores the phrase as it is regular and expected and is eventually adapted out of consciousness. Therefore, the child who must deal with the question every time it is asked is behaving inappropriately to an irrelevant stimulus. I think that an LD child tends to show a single mode of coping and frequently does not alter this response during the test. Here are some of the categories of responses. Have you spotted others?

THE MUMBLER: He knows he shouldn't repeat, but can't seem to stop, so he mumbles it.
THE REHEARSER: He not only repeats AYR but says it whenever there's a lull between items.
THE ECHO: Repeats the phrase, mimicking the exact tempo and inflection pattern.
THE ROBOT: Answers all questions, especially those requiring yes/no responses, regardless of how silly they are.

THE USE AND MISUSE OF THE SSW TEST - IV. (CONTINUED)

EMBARRASSED: Gets red in the face when he has inadvertently repeated AYR. Feet begin to shuffle and he squirms in the chair. Has difficulty with the next test item. Child is very hard on himself for making a "mistake."

WHOOPS: Delayed response to error. Claps hand over mouth after responding. This child's papers are usually full of erasures.

OH-THE-HECK-WITH-IT: Gives up sorting it out. Just shrugs shoulders and repeats. Cannot sustain effort.

THE SOPHISTICATE: Does not repeat but smiles secretly to himself each time he hears AYR. May even start to giggle toward end of test. Seems to get pleasure from repeated stimuli. Warn parents about saying, "If I told you once..."

THE ANTICIPATOR: Good sense of rhythm. Says phrase with Jack or mimes it. Refer for drum lessons.

SILLY: Responds "no" to AYR. Seems to need attention constantly.

OH-BOY-THAT'S-DUMB (OR, I'M-NOT-THAT-STUPID): Frowns, knits brows, may even become surly. May believe all tests are tricks by authority figures to show him up.

THE SCREAMER: Gets so frustrated that he yells answer or phrase. No self-control. Eventually stands up and hollers into microphone.

However whimsical some of the categories may seem, these kinds of observations may help the audiologist gain some insight into the child's classroom behavior patterns. Many are associated with attentional disorders and might need further investigation. Certainly, recommendations for control of the auditory environment are more meaningful for parents and teachers if they are individualized for the child. It is important to remember that affective behavior is also a function of cortex and may be disturbed in the children we see.

In summary, if a child can follow 8-stage instructions, generalize from the practice items to the test items, and ignore the carrier phrase, I think he is probably not in trouble, at least as far as primary auditory processing is concerned. Go to tests of auditory integration, if you have any.

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ANYONE FOR AURAL REHABILITATION?
(ABSTRACT)

THE INFLUENCE OF DIFFERENTIAL AUDITORY FEEDBACK UPON THE READING OF DYSLEXIC CHILDREN
J.S. GILLIS AND A.E. SIDLAUSKAS
NEUROPSYCHOLOGIA 16: 483-489, 1978

Ten poor readers, mean age 8.1 years, were asked to read a story aloud once every two weeks for a period of four months. Oral reading was recorded under four conditions:

1. auditory feedback to right ear only, high pass filtered,
2. auditory feedback to right ear only, no frequency modification,
3. auditory feedback to both ears, high pass filtered,
and 4. auditory feedback to both ears, no frequency modification.

Results showed significant increase in reading fluency (number of words read) under condition 2. High pass filtering did not show significance due to poor response from one child.

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1980 ACLD INTERNATIONAL CONFERENCE: MILWAUKEE - FEB. 27 - MAR. 1

ACLD Newsbriefs, 4156 Liberty Rd., Pittsburgh, Pa. 15234 $4.50/yr.

SCHOOL-AGE MALINGERERS - RITA WIECZOREK

SUBJECTS: Ten children (4 males and 6 females) between the ages of 7 and 13 years were found to malinger* during an initial hearing test. After ascertaining that all children had normal hearing, tests of central auditory function were given.

CENTRAL TESTS: SSW, Competing Sentences (CS), Binaural Fusion (BF), Rapidly Alternating Sentence (RAS), and Filtered Speech (FS). Not all children received BF and FS.

RESULTS: SSW: Nine (90%) showed abnormal scores (Type A in LC). The tenth child, who had only a few suspicious errors, showed reversals.

SSW Biases:	
Smush	100%
Reversals	30%
LE Effected	90%

CS: Seven (70%) had abnormally low scores either in one ear correct or double correct (LE).

BF: Seven (100%) had abnormally low scores.

RAS: Six (60%) performed poorly.

FS: Two (40%) showed low scores in the left ear.

DISCUSSION: It is obvious that it is not enough to badger the malingerer into "owning up" to having normal thresholds. The child is trying to tell us something about her hearing. LD children frequently develop malingering behaviors toward school, probably out of sheer frustration and hurt ego. Why pick hearing tests? Any malingerer in his right mind would have backaches or headaches as those can't be diagnosed easily. The hearing test malingerer seems to be smart enough to know where the problem lies. It's interesting that this sample is 60% female, which is the reverse of incidence figures by sex for learning disabilities. Why do females choose this form to call attention to their problems?

CONCLUSIONS: 1. Children who malinger are liable to have central auditory processing disorders. 2. The SSW is the most sensitive test to determine auditory function in this group. 3. Of the Willeford tests, CS and BF are more sensitive than RAS and FS.

* Editors Note: The type of malingering behavior was not recorded for this sample. It has been my experience that the child frequently shows exaggerated thresholds in the non-dominant ear. What have you found?

****

REMEMBER THAT PARENTS LEARN MORE FROM OTHER PARENTS THAN THEY DO FROM PROFESSIONALS. Perceptions is a newsletter by parents for parents. Perceptions, Inc. P.O. Box 142, Millburn, N.J. 07041. $12.00/yr. (8 issues).

*** MORE SMUSH ***

There seem to be two different types of SMUSH errors:

TYPE I:
JAY + BLACK = JACK
SHORE + OUT = SHOUT
SAW + FIRST = SOFT
SPREAD + MUSH = SQUASH
END + WORK = WORD
CAGE + CROWS = CRAY
WALLS + DOG = DOLLS
WHITE + FOOT = FIGHT
GROUND + BAT = BROWN

These occur only in the competing conditions.

TYPE II:
BAND + SAW = SAND
BED + SPREAD = BREAD
FLOOD + FLASH = FLUSH
MEAT + SAUCE = SOFT
SUN + SHOE = SHUN
BACK + PLAY = BLACK

These are some combination of non-competing and competing. They seem to be less related to selective attention skills than to sequencing skills. Are these Spoonerisms?

** PERSEVERATIONS **

Some items seem to encourage repetition. These are common:

GREEN HOUSE GREEN BEAN
RACE HORSE RACE CAR
SHEEP SKIN SHEEP DOG
HAND BALL HAND SHAKE
WOOD WORK WOOD CRAFT
ICE CREAM SWEET CREAM
BLUE JAY BLUE BIRD
SNOW BALL FOOT BALL
SCHOOL BOY SCHOOL BELL
WHITE DOG DOG HOUSE
HOUSE WORK WOOD WORK

At least the child knows there are four test items!

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CASE: EMOTIONAL DISTURBANCE: CHICKEN OR EGG?

Submitted by Liz Protti and Maxine Young

CC: 8 y.o. male referred by neurologist for CAT. Behavior problem in school and placed in class for emotionally disturbed. Has shown aggressive behavior toward teachers, parents and sibs. Family in counseling.
HX: Adopted, normal birth, APGAR 10. Talked at 6 mo. but using only single words at age 3. Talks only when necessary. "Hyper" since birth, colicky, nightmares and enuresis. Given sedative for sleep since birth. Ritalin started at age 7. Does not control behavior now. Motor dev. excel. Frequent nasopharyngitis. EEG normal.
SCHOOL ACHIEVEMENT: Verbal IQ 89, performance 104. Visual-motor integration problems. Short attention span. Poor reader. "Immature."
NEUROLOGICAL: Difficulty balancing on R foot, mixed dominance, rotates Bender figures 90 degrees. Mild choreiform-like movement of outstretched fingers. Impression of mild neurolog. pbm. "Outbursts related to frustration resulting from communic. pbm."
AUDIOGRAM: Mild, bilat. cond. loss (15dB). Imped: Type A rt, C lt. Reflexes reduced rt, absent lt.
CAT: (Tested on meds: 20 mg Ritalin, 70 mg Melaril.)

SSW:

8 CN's =
0 3 7 1 0 14 5 3

Type A - LC

13 Reversals

9 Perseverations

0 Smush

LE Effected

Willeford: CS - 70% rt, 0% lt; FS - 70% rt, 28% lt; BF - 50%; RAS - 90%.

INTERPRETATION: Poor lt. hemisphere function in posterior and anterior temporal lobe areas. Severe auditory sequencing problems. Has nasopharyngitis been associated with subclinical SOM? Pattern typical of children with LD.
DISCUSSION: This child is already diagnosed as ED by school and doesn't qualify as LD under PL 94-142. Note verbal and performance IQs. Are his emotional problems a result of his learning problems as the neurologist believes? Do they coexist? It is obvious that this child is not neurologically "immature." The scattered test results show him working at age level for some tasks and not resembling younger children on those he had trouble with. What type of classroom placement would you recommend?

**** FYI ****

We recently ran into a sad case of a college student who failed practice teaching because she could not produce polysyllabic words. She sounded like Mrs. Malaprop. No one ever noticed that she couldn't spell or read aloud. She had 25 reversals on the SSW. We have now taken to screening our own Speech majors to ward off failures in phonetics and statistics.

*

The older LD student has difficulty taking notes and organizing what he hears or reads. Recommend that he be allowed to use a tape recorder in class. The spoken voice will indicate what is important by stress patterns. He should also be encouraged to read his texts into a recorder as well. Talking Books may have his text already on tape.

*

A tape recorder with a speed control (from .6 to 2.5 X normal rate) is available from Variable Speech Control Co., 185 Berry St., San Francisco, CA. 94107. Two models available. Compact size.

Children with attentional problems may benefit from speeded listening. (More vigilance required?) Some children with sequential problems may need to slow speech down.

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Charlotte Dempsey was the Guest Editor for this issue.

SSW Newsletter

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