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REPORTS

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b. QUESTIONS FROM DANITA ET AL.

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ANSWERING THE MAIL

This has been a busy time for SSW Reports. Communications have been humming. If you have e-mail, we are now on line. Jack and Dear Ackie share an address. It is "JACKKATZ@ UBVMS.CC.BUFFALO.EDU".

This is the second consecutive issue devoted to the mails. The questions we receive, convince me that REHABILITATION is "where it's at". [By the way, we will have a conference here at U.B., September 27 - 28, 1996, titled, CAPD: MOSTLY MANAGEMENT.]

DIANE MANUS' RESPONSE TO CLELLA

I'm replying to Clella Steinke's letter (in the August '95 issue) in which she describes a 7-year-old who has deaf sounding speech, and multiple articulation errors. Despite the appearance of hearing loss, his threshold responses to puretones vary from 10-25dB on one test to 50-80 dB HL on another. He watches every move her mouth makes when speaking, but shows no benefit from a hearing aid or FM auditory trainer. He seems to "prefer" louder sounds.

She wrote, "I believe he has some sort of CAPD, but don't know what to do to help him."

Jack, in my 17 years at the Language Development Program, I've diagnosed moderate hearing loss in children who tested "normal" at another clinic, just weeks before. I've also "missed" hearing losses in children who gave false positive responses, but were later found to have losses of sufficient degree to require amplification.

My first suggestion to Clella is to convince the parents to take their child for another opinion. Here's why.

I worked with a 3-year-old boy, who watched faces intently, had a loud voice with an unusual quality and had articulation errors, especially for sibilant sounds. His constant visual scanning, made him appear anxious, almost hyperactive. His previous audiological report showed low-normal to mild hearing loss, and the test before that (both within the previous 4 months), showed borderline normal hearing.

When I tested him, he gave me one false positive response after another

(trying to "time" my presentations). I re-instructed him, "You are not going to hear any sound for a while. Then when you hear a tiny sound, drop the block in the pot".

I started presenting tones at 0dB and went up in 10dB steps. After several such ascending runs, the child showed a consistent, flat 50dB loss, bilaterally. And yes, he loves his 2 new hearing aids!

Clella's child would certainly make an interesting CAPD case. If so, I would ask, how were the hearing aids and personal FM introduced? Because he does not seem to benefit from amplification, I would wonder what were the pre- and post-fitting criteria? What was the length of the trial period? Three months, 3 days? A sufficient trial period could actually make the child more auditorily aware - enough to become a more responsive auditory test subject.

If the child is asking for constant repetition, an Easy Listener personal FM unit, certainly could not hurt him.

Please don't lose track of Clella's case. I'm dying to find out how he progresses.

And Jack, Ackie doesn't have it "all over" you.

Diane

ANOTHER THOUGHT

Diane's letter above made me realize that Clella did not mention the child's performance on other tests. It is my understanding that the child speaks and attends school. If so, what were his SRTs and WDSs like? You can give false positive responses readily to puretones, but not to speech.

Physiologic measures would be appropriate in this case, starting with tympanometry and acoustic reflexes. If a central problem exists, my guess is that it is at the brainstem level. Therefore, the acoustic reflexes might provide important information. Next, ABR would be most valuable. I like to stimulate one ear at a time, but measure the response on both sides. In this way we can see how the important lower brainstem pathways perform and how one side relates to the other.

The Editor

PARENT'S COMMENT & QUESTION

I recently attended a 2-day workshop that you and Dr. Masters presented. As a parent I learned a great deal about my daughter's CAP disability. She seems to have a Tolerance-Fading Memory problem, which has narrowed my search for ideas.

Could you recommend a program that the speech therapist at school could use to assist my 6 year old daughter to improve her tolerance of background noise? You did describe such a program, but since the therapist was not in attendance, is there a commercially available program?

The program that you and Dr. Masters presented was most informative. It was also therapeutic to meet other parents of children with CAP disorders.

However there was one unexpected bonus. My 8-year-old son (who has a history of otitis media) receives A's and B's on his report cards, but his teacher requested that the child study team evaluate him. Her complaint was the he is disorganized, has poor handwriting, his desk is a mess, exhibits reading comprehension difficulties and in sequencing a story. Now I know what it is, and why it is. Thanks.

D.S.

RESPONSE

Dear D.S.:

We are delighted that you gained so much from the conference. It is also great that you can shed some light on the problems your children have and, of course, it is wonderful that you were able to bring some of this information to the school, and to have a favorable response from them.

However, it is important to keep in mind that symptoms do not constitute a diagnosis. You may be entirely correct about the problem, but you may be mistaken. What is even more possible, is that you may have identified only part of the picture. I would recommend a complete CAP evaluation. This will rule out any hearing factors and will look at the entire central auditory picture. Does your daughter have some Decoding problems, is there evidence of Integration difficulty or, as in the case of her brother, are there signs of Organizational difficulty? Only a test will tell you that.

If your child does well with therapy and management strategies, great. You will probably never remember that she had difficulty, if all is resolved. But, what if it is not resolved, an evaluation at that time could provide a false picture because of the contamination by the therapy. An evaluation might also suggest that your daughter has a short-term memory problem, which you did not pick up from her symptoms, or the symptoms that you noticed.

In answer to your request for a therapy program, Kathryn Barrett, who has been an educational audiologist in the schools often recommends a program from American Guidance Service, "Listening to the World".

A Friend of Ackie

DANITA SULLIVAN IS ON THE LOOKOUT FOR RED FLAGS

Danita is not concerned that the Russians are coming. She wants to know what one should be on the lookout for as possible signs of a lesion in a child being tested for CAPD. What signs would suggest the need for ABR, MRI etc.?

For me the most useful sign has been poor discrimination ability along with normal puretone thresholds. If this is a reliable finding (similar on retest) then the best explanation is a CANS problem (ruling out foreign language speaker etc.). In my limited experience with this finding, I have generally found ABR abnormality. My recollection is

that the III-V interwave difference has been lengthened, on the side of the poor WDS.

My guess is that I have administered ABRs to kids seen for CAPD, about 5% of the time or less. Generally the findings have been positive. Because these were long-standing problems with no apparent symptoms, the parents were made aware of our findings, but no referral was made for neurological examination.

Another red flag is the severity of the finding. If the scores are 5 or 6 SD's poorer than the mean. This is a red flag. We expect those who have "developmental" CAP problems to be further down the continuum than the normal processing child. We do not anticipate such poor results, especially on different aspects of the test or on different tests.

One more red flag is who is sending the case. If referred by the classroom teacher or parent, this in itself does not alert me. But, if sent by the teacher to the nurse, who refers to the family doctor, who in turn refers to a neurologist, then to a psychologist and then to you, this is a great big red (white and purple flag for me). A teacher works with 30 children, so it's not surprising that one or two seem to have more auditory problems than the rest. The nurse sees a small portion of the students and she is aware of medical problems, so her referral is more impressive. The family doctor treats most problems himself. But if it is unusual or difficult, a specialist is called in. If the specialist that was chosen was a neurologist, then obviously a potential CNS problem exists.

After all, how often does a family doctor refer to a neurologist? Not often (unless it's a relative). The psychologist adds further concern because she was not able to diagnose the problem herself (unless she routinely refers to an audiologist all cases of CAPD).

By the time we add all of those probabilities together, we see that this child is very different from our typical cases. When so many professionals needed help to diagnose this child, he's not likely to be just a little bit down on the continuum. The probability fetal alcohol, lead toxicity, brain injury etc. increases considerably, in these cases.

PERSEVERATIONS

Danita also asked about perseverations on the SSW. Does this include the response "upstairs, up town"?

Good question. A perseveration on the SSW refers to an incorrect response that is the same as a previous response on the test. It is more certainly a perseveration if the previous use of the word (whether correct or not) was in the previous item or on one of the previous 5 or 6 items. Of course, if the word or sounds are very unusual (e.g., platches, Boston, or loyalty), it wouldn't matter how many items ago it was said.

My interpretation for most of the perseverations (shown as a "P" circled, in the numbered box), is that the person cannot process any more. They are too fatigued, or perhaps unwilling, to figure out a difficult word, or it simply might be the first word that comes to the person's mind. Fatigue in processing is

most associated with those who have phonemic decoding problems (and those are the ones who generally perseverate on the SSW). This may be quite different from the brain damaged (or other) person who perseverates in conversation (or when he lectures his class). My guess is that the latter problem is more of a memory dysfunction than the SSW perseveration (but that's just a guess).

Repeating a word within the same SSW item, is referred to as "the available word". It has to do with the spondee nature of the test and the fact that there are 3 spondees in each item (not 2). For example, item #1 is "upstairs, downtown". The spondees are "upstairs, down town", and "uptown" (the latter is the combination of the two non competing words).

When a person does not know one or both of the non competing words, he or she can draw from the non competing words to complete the spondee (upstairs, uptown; uptown downtown or just, uptown if both competing words are missed). This seems to be a conscious choice to fill in the known gap. The patient is often hesitant in responding with the available word. However, I usually, pipe in, "fine", or "good", or just nod okay. After that, when they don't know the competing word, they feel free to use the available word (rather than guess the correct answer, by chance).

PARENTS ASK FOR HELP

If you had any doubts where our profession is headed, it seems to me that it is in the direction of remediation and management (but especially remediation). In a managed care system, it seems much more likely that the payer will shell out for a diagnostic if there is therapy to follow.

Two letters arrived from parents, asking where materials can be obtained to remediate CAPD, and where to find people who could do the therapy. Fortunately for us, other professions don't seem to want to do auditory training, so there will not be a fight over territory.

LK's LETTER

I'm writing this letter mostly out of frustration with my public school's inability to teach my son who is diagnosed with a CAPD.

Upon my personal research of the topic, I found your article, "Auditory training for children with processing disorders" (1985). I understood most of it, but I don't have a grasp on exactly how to remediate it. I'm an R.N., and frankly, some of your information is out of my realm.

Do you have any instructional manuals, tapes, etc.? Do you have any colleagues in the New Jersey area, or would you do a consultation? Where can I get the Phonemic Synthesis?

My son is a sweet, frustrated, seven-year-old, whose self esteem is dwindling day be day. I fear that if he doesn't achieve the ability to process, store and blend sounds, that he will be lost educationally.

Any information or resource you could give me would be greatly appreciated.

L.K.

RESPONSE

I gave LK a call and told her that although training herself will help her to find what is needed and who can do it, it is not the best way to help her son in the long run. With the names that I gave her, I feel that they will get the appropriate help that they need.

BLP's LETTER

I read an article in Advance for Speech-Language Pathologists and Audiologists, dated July 10, 1955, about your work. I am writing in the hope that you may give me more information, or help me to obtain more information regarding CAPD.

My daughter, age 9, has been diagnosed as having CAPD, by each of the following: a Psychologist, Audiologist and a Speech-Language Therapist.

She has been in Speech-Language Therapy for 5 years. As stated in the Advance article she presents with academic problems, as well. She attends the third grade, in a parochial school.

It has been difficult to get my hands on any information that will help with remediation. Anything you can provide me, or tell me where to get this information, would be much appreciated.

B.L.P.

RESPONSE

There is much that B.L.P does not say. We don't know the extent of the problem, her daughter has. We can surmise that it is quite severe. I wonder if she paid the three professionals. If they evaluated, found CAPD and expect the parent to research this and figure out what to do, they should refund her money (at least in part) for doing their jobs.

If the Speech-Language Therapist worked for 5 years and did not attend to the CAPD, she was working harder than she needed to and the parents were paying far more than they should have. To my way of thinking, a small amount of work on the child's processing would have facilitated articulation therapy (if it didn't eliminate the problem entirely) and language therapy.

Our experience with CAP habilitation has been that it is a relatively brief form of therapy. One semester is enough for some kiddos, but more likely it would take 1 1/2 or 2 semesters of therapy to produce a major change in CAP skills.

If you have not gotten into this type of therapeutic work, I heartily recommend it. It is fun, it is interesting, it is effective, and it is very much appreciated by the family, the child (usually) and the school. Like the better mousetrap, people will beat a path to your door.

The Editor