

Name: _____

CD 697: MS Comprehensive Examination

Instructions: Fill in the rectangle(s) whose letter(s) corresponds to the correct answer(s). Use a number 2 pencil. This exam has both multiple choice and multiple answer questions. There is **one** correct answer for multiple-choice questions. There is **more than one** correct answer for multiple answer questions. For multiple answer questions, mark **all** the correct answers to receive credit. Multiple answer questions are clearly marked as such.

Use a ruler to hold your place on the answer sheet so that you are filling in the answer rectangle which corresponds to the question you are answering.

Student number _____
(to be assigned anonymously by the office)

SPEECH (HEAD AND NECK ANATOMY AND PHYSIOLOGY)

CTCSLP 1a, 1b

1. The laryngeal muscle responsible for pitch-raising
 - a. is an intrinsic muscle of the larynx
 - b. tilts the thyroid cartilage downward and forward
 - c. is the cricothyroid
 - d. all of the above
 - e. none of the above
2. A muscle that assists with tongue tip elevation, as in articulation of /t/ and /d/ is
 - a. hyoglossus
 - b. styloglossus
 - c. palatoglossus
 - d. all of the above
 - e. none of the above
3. The "pharyngeal recesses" comprise which of the following?
 - a. valleculae and pyriform sinuses
 - b. valleculae and laryngeal vestibule
 - c. pyriform sinuses and lateral channels
 - d. all of the above
 - e. none of the above
4. Cranial nerve VII
 - a. is a pure motor nerve
 - b. supplies motor innervation to the muscles of mastication
 - c. supplies motor innervation to the facial muscles
 - d. all of the above
 - e. none of the above
5. Which of the following statements is **FALSE**?
 - a. cranial nerve XI has bulbar and spinal components
 - b. cranial nerve XII has an important role in the pharyngeal stage of the swallow
 - c. cranial nerve VII has an important role in articulation of bilabials
 - d. all of the above
 - e. none of the above (all are true)

6.	With regard to the angular gyrus (AG) a. it is an association cortical area b. a lesion to AG will result in contralateral sensory loss c. it is Brodmann's area 40 d. all of the above e. none of the above
7.	Cortical association areas important to speech and language are Brodmann's areas a. 44, 17, 18 b. 44, 22, 40 c. 44, 39, 41/42 d. all of the above e. none of the above
8.	Speech praxis is mediated predominantly by a. Brodmann's area 44 b. Brodmann's area 4 c. Brodmann's area 3-1-2 d. all of the above e. none of the above
9.	Lower motor neuron lesions a. give ipsilateral signs b. wipe out reflexive behavior c. cause muscle atrophy d. all of the above e. none of the above
10.	All sensory data from the head, the face and all body areas a. report directly to primary sensory cortex b. report to cortex bilaterally c. travel to cortex via thalamus d. all of the above e. none of the above
11.	In normal swallowing, the airway is protected by a. lowering of epiglottis over the aditus of larynx b. vocal fold closure c. upward and anterior movement of larynx d. all of the above e. none of the above

12.	During the pharyngeal stage of swallowing, the cricopharyngeus muscle
a.	relaxes
b.	contracts
c.	contracts in peristaltic fashion
d.	all of the above
e.	none of the above
13.	Which cranial nerve is responsible for the reflexive cough which may occur during aspiration of food/liquid?
a.	CN VII
b.	CN IX
c.	CN X
d.	all of the above
e.	none of the above
HEARING (ANATOMY, NORMAL PROCESSES, DISORDERS, ASSESSMENT)	
CTCSLP 4g	
14.	What are the two major reasons to measure the auditory brainstem response (ABR)?
a.	To estimate word recognition in noise ability and uncomfortable listening levels
b.	To estimate pure tone thresholds and to determine the presence of a possible retrocochlear site of lesion
c.	To estimate the tympanogram and acoustic reflex thresholds
d.	To estimate air pressure and ear canal volume during tympanometry
e.	None of the above
15.	According to Dr. James Jerger the term “auditory processing disorder”
a.	Has a definition that has been uniformly accepted in the field of audiology since the 1940’s
b.	Represents a disorder that is clearly defined and easily diagnosed
c.	Refers to pure tone thresholds above 110 dB HL
d.	Has more definitions than patients diagnosed with the disorder
e.	A and B
16.	Which set of test results characterize the presence of an auditory neuropathy?
a.	Absent tympanogram and absent external ear canal
b.	Absent or abnormal ABR and present OAEs
c.	Absent outer hair cells and present ossicular chain
d.	Robust ABR and absent OAEs
e.	None of the above

17. ASHA (2004) recommends test protocols for infants and children. What is the primary test protocol recommended for infants? a. Behavioral testing such as BOA b. Physiologic measures such as the ABR, OAEs and acoustic immittance c. Behavioral testing such as CPA d. Behavioral testing such as VRA e. All of the above
18. Absent OAEs and a flat tympanogram are an indication of a. Poorly functioning outer hair cells and a middle ear disorder b. High functioning outer hair cells and a normal middle ear c. A middle ear disorder, nothing will be known about the outer hair cells because the middle ear disorder may interfere with the transmission of the otoacoustic emissions to the external ear canal d. Poorly functioning outer hair cells, nothing will be known about the middle ear because the poor function of the outer hair cells may interfere with the measurement of the tympanogram e. A and D
19. In a hearing aid or cochlear implant, the purpose of a directional microphone is to _____. a. Give location information to the patient while driving b. Improve sound localization ability c. Improve sound perception when the sound is presented from the right or left of the patient d. Improve the signal-to-noise ratio e. All of the above
20. A cochlear implant stimulates: a. the outer ear canal and ossicles b. the inner ear c. the middle ear d. all of the above e. none of the above
21. With a Baha device how is sound conducted to the patient? a. Via air conduction b. Via bone conduction c. Via electrical input through an electrode array placed in the cochlea d. Via electrical input through an electrode array placed in the auditory pathway of the brainstem - None of the above

22.	In tympanometry what is “admittance” a. The flow of sound energy into the cochlea b. The reduction of the electrical activity along the VIIIth nerve c. The flow of sound energy into the middle ear d. The condensation phase of an acoustic waveform e. None of the above
23.	What is the primary purpose of an FM (frequency modulation) system. a. To improve the signal-to-noise ratio for the listener b. To transmit radio programs to the listener c. To transmit television programs to the listener d. Just to make transmission of sounds wireless. e. None of the above
24.	What is otitis media? a. Fixation of the stapes in the oval window b. Disruption of the ossicular chain c. A middle ear infection d. A hole in the tympanic membrane e. None of the above
25.	A normal tympanogram is represented by a pressure peak at approximately a. + 200 daPa b. - 400 daPa c. + 400 daPa d. 0 daPa e. None of the above
PHONETICS AND PHONOLOGY	
CTCSLP 1c	
26.	The formant structure of speech sounds, particularly vowels, is determined by a. the frequency of the ninth harmonic b. the density of the vocal folds c. the length of the vocal folds d. the length and shape of the vocal tract e. none of the above

27.	A speech sound spectrogram a. provides a frequency by intensity over time display b. is comparable to the vowel quadrilateral c. is of little use in clinical management d. all of the above e. none of the above
28.	In speech acoustics, the second formant transition a. gives information on place of articulation b. gives information on manner of articulation c. gives information on voicing d. all of the above e. none of the above
29.	A child's phonetic inventory: a. is difficult to compute because the clinician must determine which sounds are phonemes and which are allophones b. is useful for target selection because it is an indication of the child's phonetic capability c. includes only sounds that are used correctly compared to the adult target d. is not useful because substitution patterns are not indicated in the analysis
AUGMENTATIVE COMMUNICATION	
(CTCPD 6a, 6c CTCSLP 4f, 5f	
30.	When selecting an AT device, in order to balance the degree of technology with the user, we would consider all EXCEPT a. the learning potential b. motivation c. chronological age d. socioeconomic status e. developmental level
31.	For programming an AAC device, what is considered to be part of an individual's fringe vocabulary? a. adjectives b. nouns c. verb conjugations d. most frequently used words e. names

32.	What quality is NOT typically associated with a Low Tech Device? a. it is easy to program b. it is relatively inexpensive c. it has limited storage for voice output d. it has pages or levels e. it has a dynamic display
RESEARCH METHODS	
33.	What is a significant limitation to an A-B type of research design? a. it is difficult to specify the treatment to be used b. it is difficult to assert that any change observed was due to the treatment alone c. it is difficult to find subjects to serve as untreated subjects for the “a” condition d. it is difficult to withhold treatment from the control group subjects
34.	Which of the following characterizes an advantage of single-subject research when compared to group designs? a. low incidence communication disorders may yield too few subjects for meaningful statistical computations b. statistical computations of single subjects may yield more clinically relevant results c. controlling order and sequence effects is simplified by counter-balancing single subjects d. all of the above e. none of the above
35.	If there are three or more independent groups of subjects for an experiment, what is the limitation of using the <i>t</i>-Test for independent means as a measure of any possible difference among the groups in performance? a. the first group to be tested will have a bias for being superior b. it is not possible for the stated probability of error in rejecting the null hypothesis to be accurate when there are more than two pairs of means to be compared c. the small computed <i>t</i> score will always be statistically significant. d. none of the above.

ETHICS AND CULTURAL COMPETENCE

CTCPD 2a, 2b, 3a, 3c, 4b, 5b

CTCSLP 2b, 2c

36. For individuals approaching “end of life,” the role of SLPs typically includes:
- a. evaluating the patient’s level of independence in ADLs as well as the severity of their illness when assessing and treating communication deficits
 - b. relieving patients and their families of the burden of planning medical procedures during the stress of hospitalization
 - c. a focus on improvement of word-retrieval skills
 - d. only assessment and treatment of oropharyngeal structure and function
 - e. only assessment and treatment involving alternative modes for communication
37. Concerning continuing education, ASHA:
- a. highly recommends CEUs for the CCC/SLP because it is a professional responsibility
 - b. mandates CEUs for certificate holders
 - c. requires CEUs for individuals engaging in a new scope of practice
 - d. all of the above
 - e. none of the above
38. Universal Precautions
- a. are specific to hospital and skilled nursing facility settings
 - b. require barrier and face protection with all clients
 - c. are a set of precautions specific to the HIV virus
 - d. all of the above
 - e. none of the above
39. IDEA addresses
- a. continuum of service delivery options
 - b. personnel qualification
 - c. cultural and diverse students
 - d. all of the above
 - e. only b and c
40. Which is true about cultural competence?
- a. competent services must be offered to all populations according to the ASHA code of ethics
 - b. a person should be aware of one’s own culture and the culture one serves
 - c. a barrier to cultural competence may be how speech language pathology services are accepted by minorities
 - d. all of the above
 - e. none of the above

41.	Evidence based practice (EBP) a. allows clinicians to continue using treatments that are known to have little to no efficacy if the clinician feels they are useful b. includes integrating clinical judgment with best available research findings c. is based on the results of large group studies as opposed to individual case studies d. does not include evaluation of assessment procedures e. allows the best available research findings regarding a treatment to override client-specific cultural considerations and views regarding that treatment
42.	Under the recently enacted federal “Health Insurance Portability and Accountability Act” (HIPAA), which of the following statements is/are true? a. electronic transmission of patient data must be encrypted to prevent disclosure b. patient sign-in logs at the front desk of a healthcare provider’s office must not reveal one patient’s name to another patient c. telephone messages left on patient voice mail must not disclose the nature of the healthcare provider’s practice d. all of the above e. none of the above
MULTICULTURAL	
43.	Code switching among languages a. is a sign a child is not acquiring a second language successfully b. is a red flag indicating language disorder c. is a natural process d. is a random occurrence which does not show any patterns
44.	African American English (AAE) is spoken by a. all African Americans b. no person who is not African American c. only African Americans in large cities d. all of the above e. none of the above

	45. Characteristics of Spanish-influenced English include which of the following pragmatic behaviors? a. closer personal distance during conversation than speakers of Standard American English (SAE) b. less direct eye contact than speakers of Standard American English (SAE) c. more touching among conversational partners than speakers of Standard American English (SAE) d. all of the above e. none of the above
46. In Native American cultures, which of the following pragmatic behaviors may be found? a. Silence is a positive functional feature of conversation b. Narratives do not differ from the classic structure found in SAE Standard American English narratives c. The tempo of speech is faster than that found among speakers of Standard American English (SAE) d. all of the above e. none of the above	47. Which of the following factors contribute to dialect differences among speakers? a. Use of specific words or idioms b. Vocal quality, for example, nasality c. stress and intonation d. all of the above e. none of the above
AURAL REHABILITATION CTCSLP 5g	
48. The middle ear implant a. attaches to the incudo-stapedial structures of the middle ear b. is reserved for single-sided deafness c. used in candidates not suited for cochlear implants d. all of the above e. none of the above	49. CONNEXIN 26 refers to a a. phenotype b. a localized gene producing gap junctures, responsible for hearing loss and deafness c. always involved and responsible for complete profound deafness d. all of the above e. none of the above

50. Hereditary hearing loss is categorized into:

- a. syndromic forms
- b. nonsyndromic forms
- c. sex-linked genes
- d. a and b
- e. b and c

CASE STUDIES

CTCPD 3b, 5c, 7c, 8a

CTCSLP 2d, 2e, 3a, 3b, 4a, 4b, 4e, 5a, 5b, 5e

Case Study 1 – Child Language

Mary, age 7-7, was referred to you by an Educational Psychologist for a full speech and language evaluation to rule out receptive and expressive language problems and auditory processing problems. Mary is a native English speaker whose parents have upper middle class socioeconomic status. Mary had begun articulation therapy 6 months prior to your current speech and language evaluation. Mary's peripheral auditory function was evaluated within the past 8 months and pure tone results were within normal limits.

Test Behaviors

Mary's test behaviors included utilizing auditory rehearsal and repeating some test stimuli before responding. She benefited from repetitions of stimulus items. She paid close attention to the examiner's face in some instances.

51. Mary's behaviors suggest that she was using strategies to facilitate which of the following?

- a. auditory processing
- b. hearing
- c. language formulation
- d. figurative language interpretation

Articulation

Mary exhibited variable intelligibility throughout the evaluation because of decreased intensity, fast rate of speech, imprecise articulation and phonemic substitutions and distortions. Her productions of /r/, /l/ and /w/ were variably distorted. Mary had difficulty pronouncing a few multisyllabic words, for example *department* and *vegetable*.

52. Mary's articulatory history and behaviors suggest which of the following?

Choose all that apply.

- a. She may have concurrent problems with her focus of attention.
- b. She may have concurrent problems with intonation.
- c. She may have concurrent problems with reading.
- d. She may have concurrent problems with arithmetic.

Expressive Language

In conversation, Mary exhibited delay in initiating some responses, word repetitions, truncated utterances, the use of general nouns (*stuff, thing*) and the use of discourse markers (*uh, um*).

53. These behaviors suggest which of the following? **Choose all that apply.**

- a. figurative language problems
- b. language formulation problems
- c. semantic category problems
- d. word finding problems

In conversation, Mary produced the word *crab* for *lobster* and *coconut* for *pineapple*. She described clothes hanging on a line as *hooked on a rail*.

54. These errors can be described by which of the following? **Choose all that apply.**

- a. grammatical paraphasia
- b. semantic paraphasia
- c. literal interpretation
- d. word choice problems

Initial Clinical Interpretations

55. Based on your answers to the 4 questions above, choose the domains in which Mary is exhibiting problems. **Choose all that apply.**

- a. phonology
- b. semantics
- c. morphosyntax
- d. pragmatics

Case Study 2 – Child Language

Alley is a 4;0 year old girl referred to you by her teacher because her receptive and expressive language seems characteristic of a much younger child. As part of your language evaluation, you collect a language sample and do an MLU analysis in order to assess Alley's morphology. Alley's MLU in morphemes is 3.36. Her MLU in words is 2.98.

In order to interpret Alley's achieved MLU; you do a distribution analysis of Alley's morphemes per utterance.

56. What would you expect if the language sample results in a typical distribution? **Choose all that apply.**

- a. half the utterances fall above the mean
- b. half the utterances fall below the mean
- c. the majority of utterances fall at the mean
- d. there is variation of utterance length around the mean

57. What do the MLU in morphemes and the MLU in words indicate about inflectional morphology in the language sample?
- There is typical inflectional morphology in the sample for Alley's age
 - There is little inflectional morphology in the sample
 - There is no inflectional morphology in the sample
 - No conclusion can be drawn about inflectional morphology from these numbers.
58. What Brown's stage is predicted by Alley's MLU?
- Stage III
 - Early stage IV
 - Late Stage IV – Early Stage V
 - Late Stage V
59. What MLU is predicted by Alley's chronological age? Use Table 3 below from Miller (1981).
- 3.78
 - 4.09
 - 4.40
 - 4.71

Table 3. Predicted MLUs and MLU ranges within one standard deviation of predicted mean for each age group

Age $\pm$ 1 Month	Predicted MLU ^a	Predicted SD ^b	Predicted MLU $\pm$ 1 SD (middle 68%)
18	1.31	0.325	0.99 – 1.64
21	1.62	0.386	1.23 – 2.01
24	1.92	0.448	1.47 – 2.37
30	2.54	0.571	1.97 – 3.11
33	2.85	0.633	2.22 – 3.48
36	3.16	0.694	2.47 – 3.85
39	3.47	0.756	2.71 – 4.23
42	3.78	0.817	2.96 – 4.60
45	4.09	0.879	3.21 – 4.97
48	4.40	0.940	3.46 – 5.34
51	4.71	1.002	3.71 – 5.71
54	5.02	1.064	3.96 – 6.08
57	5.32	1.125	4.20 – 6.45
60	5.63	1.187	4.44 – 6.82

^a MLU is predicted from the equation $MLU = -0.548 + 0.103 (\text{age})$

^b SD is predicted from the equation $SD_{MLU} = -0.0446 + 0.0805 (\text{age})$

Case Study 3 – Traumatic Brain Injury

Miguel woke up in a hospital bed, unsure of how he got there. He thrashed about trying to get out of his bed, but was unable to due to restraints on his arms and legs. He called for help, but instead of words, he drooled. ‘What the hell is goin’ on,’ he thought. Catherine Mateer has published extensively about the rehabilitative phases of brain injury rehabilitation, attentional deficits in particular. Answer the following questions about attention as related to brain injury recovery.

60. The ability to maintain consistent behavioral responses during continuous and repetitive activity is called:
- a. Selective attention
 - b. Sustained attention
 - c. Focused attention
 - d. Sustained and selective attention
 - e. Any type of attention
61. The capacity to shift focus of attention and move between tasks having different cognitive requirements or behavioral responses is called
- a. Focused attention
 - b. Selective attention
 - c. Alternating attention
 - d. Divided attention
 - e. Focused and sustained attention
62. The ability to maintain behavioral or cognitive set in the face of distracting or competing stimuli. Incorporates concept of “Freedom from distractibility”.
- a. Alternating attention
 - b. Focused attention
 - c. Sustained attention
 - d. Divided attention
 - e. Selective attention
63. Ability to respond discretely to specific, visual, auditory, or tactile stimuli. Does not imply purposefulness of response.
- a. Sustained attention
 - b. Focused attention
 - c. Divided attention
 - d. Selective attention
 - e. Alternating attention

64. Which evaluative tools would you use for a patient specifically with attentional deficits? All EXCEPT:
- a. WAIS-R Digit Span
 - b. Visual Memory Span
 - c. STROOP Test
 - d. WAB
 - e. Wechsler Memory Scale- Revised

Case Study 4 –Traumatic Brain Injury

CTCPD 5a

Patient PD is a 6 year, 11 month old boy who sustained a severe traumatic brain injury following a motor vehicle accident in which he was ejected from the car and was found 20 feet away from the scene lying in supine position in severe distress with decorticate posturing, bleeding from ears, and a Glasgow Coma Scale score of 5. PD was unresponsive, with a blown left pupil, had bleeding with CSF coming from ears and a clenched jaw. He was intubated at the scene and then taken to the hospital where he spent approximately 1½ months and was in a coma for approximately 3 weeks. He was then transferred to Children’s Hospital for rehabilitation services.

PD experienced significant damage to the left frontotemporal lobe as a result of the accident. He had a left parietal frontal skull fracture and extensive facial fractures including fractures of the superior orbital rim and roof, inferior orbital rim and floor and the medial border of the left orbit. A small left frontal parietal extra-axial hemorrhage was noted with small petechial hemorrhage noted within the brain. As a result, PD underwent an emergent left frontotemporal craniectomy with duraplasty, suction of subdural hematoma and partial resection of the temporal lobe for contusion. There were 3 MCA bleeds noted by neurosurgery and PD was intubated for approximately 18 days.

Results of an EEG showed diffuse slowing overall, consistent with diffuse encephalopathy. PD also experienced fractures in his arms. Hearing was tested and found to be within normal limits. PD exhibited a right hemiparesis along with a right hemianopsia with poor fixation and tracking of the left eye. PD also experienced agitation, significant difficulties with self-regulation and attention, and visual/motor deficits.

65. PD suffered which of the following injuries as a result of the accident?
- a. closed head injury with focal damage
 - b. closed head injury with diffuse damage
 - c. closed head injury with focal and diffuse damage
 - d. concussion
66. What is the most likely cause for PD’s coma?
- a. small petechial hemorrhage
 - b. swelling of the brain causing pressure on the brainstem
 - c. contusions
 - d. subdural hematoma

67. Based on the medical information given above, what deficits would you expect to see resulting from PD's injuries?
- Severe motor speech deficits with intact expressive and receptive language skills
 - Moderately impaired word retrieval and auditory comprehension skills
 - Moderate word retrieval deficits with functional auditory comprehension skills
 - Severe deficits in speech and language abilities (expressive and receptive language), including severe motor speech deficits
68. Which of the following statements would not be an acceptable approach in determining a test battery for a child with TBI?
- Integrate the cognitive-communication assessment with those of other professionals whose scope of practice includes cognitive assessment (most notably neuropsychology).
 - Only use published standardized, norm-referenced tests for the evaluation and assessment of persons with TBI.
 - Consider evaluation of the child's pre-injury characteristics, stage of development and recovery, communication-related demands of personally meaningful everyday activities and life and communication contexts.
 - Use standardized tests to assist in identifying the underlying cognitive-communication impairments. Use supplementary, dynamic, non-standardized evaluation procedures and evaluation of the communication context to make decisions about intervention and support.

Case Study 5 – Dysphagia

You are a speech-language pathologist at a metropolitan hospital. You receive an order to evaluate a new patient. The patient has been put on an NPO status until she receives a swallowing evaluation.

69. After you do a chart review, and find out the patient's medical history, you will perform the following other activities listed below **EXCEPT ONE**. Find the one you will not perform.
- Ascertain the patient's respiratory status. Is the patient breathing at an average of 12-16 breaths per minute?
 - Check level of responsiveness. Is the patient able to follow directions?
 - Check patient's diadochokinetic rate. Is the patient coordinated enough to chew?
 - Observe patient's voluntary swallow. Assess patient's ability to perform a dry swallow on command; feel and watch for laryngeal elevation.
 - Other observations. Observe presence of drooling, mouth odors, and abnormal reflexes that may affect feeding.

70. When evaluating a patient, one should always look at the medications a patient is taking. Many medications have side effects that can potentially interfere with the normal swallow. The following are common side effects of medication, **EXCEPT**:
- a. Dry mouth
 - b. Gagging
 - c. Distorted taste
 - d. GERD (Gastroesophageal reflux disease)
 - e. Impaired attention and cognition
71. The most important determination of your swallowing evaluation is the risk of aspiration.
- a. True
 - b. False
 - c. Neither
72. The hospital based speech-language pathologist has several instrumental assessment tools available to use with swallowing patients. One of them is considered the gold standard, meaning it provides the best picture of the swallow. Which is it?
- a. Ultrasoundography
 - b. FEES
 - c. VFSS
 - d. Scintigraphy
 - e. c and d

Case Study 6 – Dysphagia

Mr. D., 77 years old, is referred for an inpatient swallowing evaluation. He was brought to your large medical center for dehydration, fever, and altered state of consciousness by his two daughters, who noted that he recently had received a diagnosis of dementia from his general medical practitioner. He has a history that includes two falls on the job, one of which resulted in loss of consciousness and hospitalization. While in the hospital, he will have tests to determine the cause of his current infection, and he has an IV for hydration. He is reported to be confused, but converses easily, although he does not seem to understand many of the nurse's questions.

The admitting physician would like to determine if he is safe for oral nutrition, and he is currently NPO. Mr. D is bilingual for Spanish and English; completed education at the 10th grade level, and has been employed as lead carpenter in an upscale construction and home remodeling company.

73. What will be the first step in evaluating this patient's ability to tolerate oral nutrition and hydration safely?
- FEES
 - An MBS/videoswallow study
 - Reading the medical chart and talking to family, if possible
 - Educating the patient regarding the normal swallow process
74. What possible role could cognitive deficits play, if any, in this patient's potential swallowing difficulties?
- His current altered cognitive status could make the eating process difficult (e.g. bolus is not carefully prepared and swallowed; patient talks while eating, etc.)
 - Both the accidents and his recent diagnosis of dementia might indicate cognitive deficits which impact eating and swallowing.
 - Attention, executive function, and sensory deficits associated with dementia can negatively affect the oral and early pharyngeal stages of swallowing.
 - All of the above could be important considerations in determining the effect of Mr. D's cognitive status upon his swallowing ability.
75. Which of the following arguments regarding dysphagia assessment are valid in this case?
- A bedside or clinical swallowing evaluation is not indicated here, as there is no reason to suspect bolus formation and management difficulties.
 - An imaging study (videoswallow) is not indicated in this case, as Mr. D is probably only having oral stage difficulties, which can be easily observed.
 - An imaging study (videoswallow) and/or FEES would be helpful, as Mr. D may be experiencing silent aspiration that is not detected by a bedside evaluation.
 - None of the above are valid considerations in determining the appropriate evaluation of Mr. D.
76. If Mr. D is determined to have oral and early pharyngeal stage dysphagia, which of these approaches would be appropriate in managing oral nutrition and hydration?
- He would benefit from muscle strengthening techniques to improve strength in the tongue and lips.
 - He would benefit from having a caregiver manage food presentation, supervising eating, and encouraging oral care after food consumption.
 - At this point, he and his doctor should consider alternative means of hydration and/or nutrition, as he is probably not safe for any PO intake.
 - Oral and pharyngeal stage dysphagia, combined with suspected cognitive deficits, is not likely to cause any safety issues with regard to PO intake.

Case Study 7 – Voice

CTCPD 4a, 4b

Mr. Johnson is a 78 year-old male presenting with bradykinesia, upper and lower extremity rigidity, ataxic gate, and postural instability. It is highly likely that Mr. Johnson suffers from Parkinson's disease, per a neurologist report.

Mr. Johnson's wife indicated that she noticed a change in her husband's voice and speech about 2 years ago. She indicated that the patient has become less verbal and needs to take more breaths to produce longer utterances. She reported that the client's voice is somewhat "hoarse" with very low vocal intensity. She also said that her husband has become somewhat withdrawn socially, and not participating in their weekly bridge games. Mr. Johnson denies any overt communication difficulties, but observes that he feels that others tend to ignore him and leave him out of conversational discourse.

An otolaryngologist performed an endoscopic evaluation of this patient's true vocal folds, and generated a consult for speech pathology services. This specialist observed somewhat limited bilateral movement and mild bowing of the true vocal folds during her evaluation, and some evidence of gastroesophageal reflux disease. The otolaryngologist sent a consult that requested speech pathology services to please further evaluate and if appropriate, to treat vocal fold dysfunction and provide further education regarding proper vocal functioning and hygiene.

77. Mr. Johnson most likely exhibits signs/symptoms of:
- Hypokinetic dysarthria
 - Apraxia of speech
 - Flaccid dysarthria
 - Rhino-laryngeal dystension
 - All of the above
78. Videostroboscopy would likely be performed to:
- Measure aerodynamic performance and provide information about airflow of volume of air per time expelled through the vocal folds during phonation.
 - Further assess microdynamics of mucosal wave motion.
 - Determine amount of pressure generated in the upper esophagus.
 - Measure mean phonation time.
 - None of the above
79. Stimulability tasks most likely to elicit improved vocal quality and intensity as well as speech intelligibility include:
- Attempts to increase volume of air inspired during diaphragmatic breathing
 - Eliciting increased vocal intensity during phonation attempts
 - Encouraging the client to repeat short phrases with increased breath support and greater vocal intensity
 - Attempts to increase volume of air expired during diaphragmatic breathing
 - All of the above

80. Vocal hygiene recommendations should include:
- a. To avoid speaking in a loud voice
 - b. To increase phrase length utterance per each breath
 - c. To avoid heavy, greasy meals right before bedtime
 - d. To increase caffeine intake to improve alertness to increase articulatory precision
 - e. None of the above

Case Study 8 – Voice

Ms. T is a 25 year old untrained rock singer who reports a sudden onset of dysphonia with moderate to severe hoarseness, decreased pitch range, and vocal strain. During the case history interview, you note intermittent diplophonia and frequent phonation breaks, pervasive hard glottal attacks, and the tendency to speak too long on one breath. She reports her voice problem began after a performance in which she states she ‘sang harder than usual.’ Ms. T also reports numerous vocal hygiene issues such as extensive phone use and social talking, untrained singing, frequent alcohol and caffeine intake, as well as the recent onset of heartburn and a burning sensation in her throat almost every morning.

The ENT report states a nasendoscopic exam performed 2 days post injury showed severe vocal fold edema, incomplete glottal closure, and a large unilateral nodule. A 10 week course of voice therapy has been prescribed as well as anti-reflux medication. Your client presents high motivation to regain her singing and speaking voice.

81. Which of the following goals are most appropriate for your client?
- a. Decrease vocal demands by 50%, including limiting phone use, avoiding speaking in noise, and eliminating unnecessary social voice use.
 - b. Decrease alcohol and caffeine intake and increase water intake
 - c. Identify reflux risks and apply appropriate strategies to minimize adverse effects on voice
 - d. All of the above
82. Which of the following voice therapy techniques is most appropriate for your client?
- a. Confidential Voice
 - b. Yawn-Sigh
 - c. Hand press with phonation to increase glottic closure
 - d. Melodic Intonation Therapy

83. You have now seen your client for 4 weeks and she has been 100% compliant with all vocal hygiene and reflux management recommendations, vocal conservation, and with her home program of voice therapy exercises. However, there is little change in your client's voice. In order to verify and clarify your client's diagnosis, you
- a. Request a stroboscopic exam be conducted utilizing an oral (rigid) endoscope
 - b. Suggest she seek a second opinion from a different ENT
 - c. Repeat all instrumental acoustic and aerodynamic test procedures and re-evaluate the results
 - d. Consult with her primary care physician
84. Considering all information presented in the case study as well as the additional information given in question #83, it is likely that the correct diagnosis is
- a. a unilateral nodule
 - b. a vocal fold polyp
 - c. Reinke's edema
 - d. a vocal fold cyst

Case Study 9 – Fluency

An 11 years old girl named Judy comes to the CSUN Speech and Hearing Clinic. The SSI-3 was given and she demonstrated a mild stuttering disorder. She had many filler words (um, like, you know) and phrase repetitions, and some whole word repetitions mainly on the words (and, because, but). Judy demonstrated long pauses before answering questions and her eye contact was good. She has had no speech therapy in the past and her parents reported no relatives that stuttered. No secondary behaviors were noted. However Judy frequently put her hands to her mouth at rest and when talking. Speech was 100% intelligible.

85. The best approach to eliminate filler words is to have Judy:
- a. Tally each time she uses a filler word
 - b. Stand up when she says a filler word
 - c. The use of filler words is a common and need not be addressed
 - d. Read out loud
86. The best approach for therapy at this time is:
- a. Fluency shaping
 - b. Stuttering modification
 - c. Further language testing is needed before therapy can start
 - d. A complete voice evaluation is needed before therapy can begin

87. Judy may have language issues due to what stuttering behaviors:
- a. Frequent phrase repetitions
 - b. Whole word disfluencies
 - c. Long pauses before answering questions
 - d. All of the above
88. Judy has a minimal chance of recovering from stuttering because she:
- a. Is a girl
 - b. Has no history of stuttering in her family
 - c. Has no phonological delay
 - d. None of the above

Case Study 10 – Fluency

A 28 years old male named Joe comes to the CSUN Speech and Hearing Clinic. The SSI-3 was given and he demonstrated a severe stuttering disorder. He demonstrated poor eye contact especially when he was blocking on a word. Secondary behaviors consisted of head movements, eye blinks, and tremors of the lips. Joe demonstrated on the average silent 15 second blocks on plosive sounds. Joe repeated syllables 1 to 10 times on the sounds (d, t, k, g).

89. A standardized test that evaluates feelings and attitudes is the:
- a. Stuttering Severity Instrument, 3 (SSI-3)
 - b. Overall Assessment of the Speaker's experience of Stuttering (OASES)
 - c. Locus of Control of Behavior Scale
 - d. Black Inventory of Stuttering
90. To break up Joe's silent hard blocks on plosive sounds he should try to:
- a. Use a prolongation
 - b. Use a "bounce" technique where he stutters on purpose with a syllable repetition
 - c. Use pullouts
 - d. All of the above
91. Joe has loose syllable repetitions (ta- ta- ta- ta- table). He appears to have trouble transitioning from the vowel to the consonant. The best technique for him to use is a:
- a. Prolongation
 - b. Bounce technique where he stutters on purpose with a syllable repetition
 - c. Pullout
 - d. All of the above

92. To get rid of Joe's secondary behaviors he should:
- a. Use the mirror
 - b. Have him count all the head movements and eye blinks
 - c. Pause after each secondary behavior and close his eyes
 - d. All of the above.

Case Study 11 – Cleft Palate/Craniofacial

As a speech-language pathologist working in a public school in a large metropolitan area, you are referred a six year old boy for speech assessment and treatment recommendations. His 1st grade classroom teacher states his speech is hard to understand and he seems to “talk through his nose. There are no previous speech, hearing or medical records available for this youngster. His facial features appear grossly within normal limits for his age, with no asymmetries or unusual structures noted.

On intraoral exam, there is no visible evidence of repaired or overt cleft palate. The palatine tonsils appear large. His conversational and other connected speech is moderately hypernasal with audible nasal emission and you note nasal consonant substitutions, nasal fricatives, and glottal stops in his speech. Based on this information, respond to the following questions.

93. Which of the following would not be among the possible causes of his VP inadequacy? **Select any that apply.**
- a. He has an unoperated submucous cleft palate
 - b. He has palatopharyngeal disproportion/a deep nasopharynx
 - c. His glottal stops are contributing to his VP closure problem
 - d. He has a mechanical interference to closure
 - e. His nasal emission is phoneme-specific
94. Based on your diagnostic hunches/responses in question 1 above, what single instrumental assessment would be most informative in this case?
- a. An accurate diagnosis can be made without an instrumental assessment
 - b. Videonasendoscopy
 - c. Videofluoroscopy
 - d. b. or c.
95. What referrals, if any, or requests for information would you recommend?
- a. You would refer him to an ENT for evaluation of his tonsils
 - b. You would assume he has never been seen by a CLP/Craniofacial team refer him to a and would refer him to a team assessment and treatment recommendations
 - c. You would initiate a request to the parents for all pertinent history information before recommending any referrals
 - d. None. You would enroll him in speech therapy for correction/elimination of his cleft type speech errors

96. With regard to the clinical description provided above:
- a. You would suspect this child has non-syndromic VP inadequacy
 - b. You would suspect this child has Pierre Robin sequence
 - c. You would suspect this child has velocardiofacial syndrome
 - d. You would suspect this child has a craniosynostosis syndrome
 - e. None of the above

Case Study 12 – Cleft Palate/Craniofacial

You are a speech-language pathologist working in a medical center and have recently begun working in the hospital's craniofacial clinic under the mentorship of a more senior SLP. You both see a 7 year old patient with a repaired cleft lip and palate and a nasolabial fistula for a videonasendoscopy (VNE) study of VP function. Previous clinical speech evaluation has determined that she has compensatory misarticulations (CMAs) including glottal and pharyngeal stops, audible nasal air emission on many pressure consonants, and moderate to severe hypernasality. You want to rule out (or rule in) a persisting VP insufficiency. While CMAs replace or are coproduced with several high pressure consonants, some pressure consonants appear to have good placement but are distorted by the nasal emission. The VNE study is conducted by having the patient repeat syllables, single words, and sentences, and engage briefly in conversational speech. During the study you observe the following: (1) the VP port never fully closes; (2) when closure is approximated, the velum contributes the greatest movement while the lateral pharyngeal walls move slightly and there is negligible posterior wall movement.

97. Based on the VNE findings, which of the following statements is accurate?
- a. Her continuing VP inadequacy is most probably due to her use of CMAs
 - b. She has a sagittal closure pattern
 - c. Her nasal air emission is due to the fistula
 - d. Her continuing VP inadequacy is most probably due to a true physical problem/VP insufficiency
 - e. None of the above
98. Based on the collective perceptual speech and VNE data, which of the following would you recommend? There is only one correct answer.
- a. Physical management, specifically secondary surgery, followed by speech therapy
 - b. Speech therapy that incorporates blowing and muscle training to improve her velopharyngeal closure
 - c. Speech therapy to eliminate her glottal and pharyngeal stops and therefore achieve adequate VP closure without physical management
 - d. No intervention is indicated at this time
 - e. None of the above

99. When you interpret your speech findings to the parents, they ask you why their child developed this speech disorder. What might you discuss and expand upon... with them? **Select all that apply.**
- a. It is caused primarily by the conductive hearing loss associated with cleft palate...
 - b. Before their palates are repaired, some children (about 25% of children who have clefts of the palate) learn to make speech sounds with their vocal folds and in their throat to build air pressure for speech because...
 - c. Probably it's because she has not had any speech therapy to date...
 - d. Initial surgical repair of clefts does not always result in adequate soft palate closure for speech.
100. If and when you enroll this youngster in therapy to eliminate her glottal stops, which of the following procedures and techniques might you use to establish correct target sounds?
- a. You would teach error versus target place contrasts
 - b. You would avoid using whispered speech as an early therapy approach
 - c. You would incorporate oral motor therapy and do "warm-up" drills for tongue and lips at the outset of each session
 - d. Since this is a speech production problem, you would not spend time on auditory discrimination activities
 - e. all of the above

Case Study 13 – Aphasia

Mr. W., an 81 year old man, is referred to your private practice for a "speech evaluation". He is approximately two years post-onset for a left CVA. The radiologist's report indicates that he sustained an occlusion of the middle cerebral artery, sustaining damage to the pars opercularis of the inferior frontal gyrus in the left hemisphere (roughly Broadman's areas 44 – 45). He was a bank manager, and leads a fairly quiet life since his retirement.

101. Which of the following would be an appropriate overall and comprehensive formal assessment tool for evaluating the communication abilities of this patient?
- a. Informal assessment of his ability to follow commands
 - b. The Boston Diagnostic Aphasia Examination
 - c. The Token Test
 - d. Informal assessment of his ability to name objects in the room

102. Based on the type of damage described above, what type of aphasia would you predict he might exhibit?
- Wernicke's
 - Broca's
 - Global
 - It is impossible to predict type of aphasia based on site of neurological damage
103. While talking to the client, you note that he sometimes pauses and seems to search for a name of an object. He compensates by trying to define or describe the item for which he apparently cannot recall the exact name. He is exhibiting:
- anomia
 - word-finding difficulties
 - circumlocution
 - all of the above
104. Which of the following might characterize the comprehension profile of a patient with the type of damage described above?
- Relatively good functional language comprehension skills, although there may be difficulties with more complex sentences
 - No impairment in language comprehension skills associated with the expected aphasia
 - Very poor functional comprehension skills
 - There is no expected profile for language comprehension skills for the predicted aphasia.

Case Study 14 – Motor Speech

Mr. W., a 63-year-old man, is referred for an outpatient speech evaluation at your community medical center. He has noticed increasing speech difficulties over the past 8 - 12 months. When Mr. W. arrives for his speech evaluation, you immediately note that his voice is monopitch, breathy and decreased in loudness. Your evaluation indicates that articulation is imprecise, with the overall effect one of poor understandability/intelligibility. You also notice some gait disturbance, and he reports some "minor" memory deficits. Mr. W has been a pesticide salesman and applicator. He lives with his wife, teaches a gardening class, and is active in several charities in his community.

105. Given the history and symptoms of this patient, what would be the most probable diagnosis for his speech disorder?
- Acquired apraxia of speech
 - Spastic dysarthria
 - Ataxic dysarthria
 - Hypokinetic dysarthria

106. Which of the following etiologies might you suspect as causing his current speech disorder?
- Parkinson's Disease
 - Hemorrhagic stroke
 - Alzheimer's Disease
 - Traumatic Brain Injury (TBI)
107. Which of the following referrals would you make FIRST for this client, and why?
- Clinical social worker, to help him manage life stress
 - His general practitioner, to evaluate him for hypertension
 - A neurologist, to evaluate the medical cause for the acquired speech, cognitive, and motor disorders
 - No referrals are indicated at this time.
108. What therapeutic approach or intervention might be helpful for an individual with the speech deficits noted for this case?
- The PROMPT method (to increase voluntary control of articulators)
 - LSVT (Silverman approach)
 - Melodic Intonation Therapy (MIT)
 - Use of augmentative devices

Case Study 15 – Apraxia of Speech

You have diagnosed your 56 year old patient with Apraxia of Speech. The patient's Primary Care Physician would like to know how you reached that conclusion. The series of questions below are designed for you to walk through a differential diagnosis process, as you would with any of your patients. Please answer each question with this Apraxia of Speech patient in mind.

109. Adult Apraxia of Speech has all of the following characteristics **EXCEPT**:
- Islands of error-free speech
 - Trial and error groping
 - Consistent errors
 - Slow speech
 - Articulation errors include transpositions and perseverations
110. Which of the following neurodiagnostic results is consistent with an expected site of lesion for Adult Apraxia of Speech:
- Evidence of pathology in the left hemisphere
 - Upper motor neuron lesion
 - Bilateral, diffuse brain damage
 - Lesion in the frontal cortex
 - Evidence of pathology in the right hemisphere

111. Adult Apraxia of Speech manifests itself differently from the Dysarthrias in the following ways **EXCEPT**:
- In Dysarthria both vegetative and voluntary movements are affected; in Apraxia of Speech, voluntary movements are affected, not vegetative movements
 - In Dysarthria, performance deteriorates with a faster rate, but in Apraxia of Speech, performance improves with a faster rate
 - In the Dysarthrias, there is a simplification of articulation (distortion and substitution); in Apraxia of Speech, there is a complication of articulation (anticipatory errors, perseverations, paraphasias)
 - A Dysarthria patient displays a disturbance of prosody and stuttering-like struggle reactions; an Apraxia of Speech patient displays a slow rate of speech
112. When testing a patient you suspect of Apraxia of Speech, your test battery should include the following:
- Oral-Motor Evaluation
 - Spontaneous Speech Sample
 - Articulation Test
 - a and b, not c
 - a, b, and c

Case Study 16 – Phonology

Use the following data to answer the questions below:

<u>Child's Production</u>	<u>Adult Target</u>
[du]	"school"
[pI]	"fish"
[doU]	"soap"
[mami]	"mommy"
[du]	"girl"
[da]	"stop"
[pa]	"pop"
[doU]	"go"
[nana]	"banana"
[du]	"shoe"
[hoU]	"house"

113. Based on the limited data above, which of the following describe this child's productions:
- consonant harmony
 - metathesis
 - homonymy
 - all of the above
 - none of the above
114. In this data set, the child's production of "girl" can be described by which of the following phonological processes:
- cluster reduction
 - velar fronting
 - stopping
 - all of the above
 - none of the above
115. Based on the limited data above, the child:
- omits the coda
 - demonstrates an articulation/phonologic delay
 - probably has velopharyngeal inadequacy
 - all of the above
 - none of the above
116. Based on the limited data above, which of the following characterize this child's productions:
- vocalization
 - reduplication
 - cluster reduction
 - all of the above
 - none of the above

Case Study 17 – Aphasia

Medical History

This 50 year-old right-handed male was admitted to the hospital with a 3-5 day history of confusion and speech difficulty following use of crack cocaine. At CT scan showed left temporoparietal infarct with some hemorrhagic transformation. There was no lateralized limb or facial weakness. Past medical history is significant for drug abuse, hypertension, and diabetes. The patient was discharged home with a persisting aphasia (2 weeks post CVA) and is now 3 months post onset. This consult was requested for continued evaluation and treatment of his aphasia.

Social History

The patient is married and has one daughter. He works as a night counselor in a program for delinquent teens.

Speech/Language Evaluation

The pt. was evaluated using the Western Aphasia Battery (WAB). On the WAB the patient achieved an aphasia quotient of 49.9 out of 100. Specific results were as follows:

Language Area	Possible Score	Actual Score
Spontaneous Speech		
▪ Content	10	5
▪ Fluency	10	6
Auditory Comprehension		
▪ Yes/No Questions	60	45
▪ Single Word	60	33
▪ Sequential Commands	80	39
Repetition	100	50
Naming		
▪ Objects	60	25
▪ Word Fluency	20	0
▪ Sentence Completions	10	4
▪ Responsive Speech	10	2
Derived Aphasia Quotient (AQ)	100	49.9

Spontaneous speech is grammatical/paragrammatic with significant word-finding problems characterized by hesitations, related word substitutions, descriptions (circumlocutions), and perseveration. A sample of a description of the 'Cookie Theft' picture was as follows:

“ There's cookies/----/ The kids have the cookies/ and I guess one child--/
that's a child here/could be a child/ ---on this uh chair/he's standing on it
and---I guess it almost fell/ You have the mom, dishes/ She has dishes/
Okay, and the water is spilled, has come over the, uh spilled”

The patient was able to communicate his basic thoughts about 30% of the time during today's evaluation.

- Auditory comprehension: The patient correctly answered 15 of 20 yes/no questions erring on more complex questions. He correctly identified 33 of 60 objects, pictured objects, shapes, letters, numbers, colors, room objects, body parts, fingers, and left-right body parts. He correctly followed simple 1-part and 2-part commands, but had difficulty performing complex and longer commands (3 of 6).
- Repetition: He was able to repeat familiar single words, but had difficulty repeating sentences (e.g., The telephone is ringing/ "The telephone, ridging").
- Naming: The patient correctly named 4 of 20 common objects and an additional 13 of 16 objects were named after phonemic cueing. Examples of errors include 'cob' for a corn cob pipe, 'pen' for paperclip, 'a small ball pen' for a ball peen hammer, and several no responses or perseverative responses. On a one-minute word fluency measure animal naming the patient was unable to list any items. He did correctly perform 2 of 5 sentence completions and gave correct responses to 1 of 5 responsive speech tasks (i.e. 1-2 word answers to short familiar question).
- Reading: The patient correctly matched 6 of 6 printed words to pictured objects. He

correctly performed 3 of 3 simple 1-part printed commands though he was slow to do so. He could not perform any longer or more complex commands. He matched 2 of 4 spoken to printed words. When reading aloud he was noted to read garden as 'tree' in one instance.

- Writing: The patient was able to write his name and 2 of 5 short words to whole word dictation (e.g. errors "now" for no; "aro sp" for nurse; "fome" for home).

117. Which best describes the patient's speech/language disorder:

- a. Moderate, fluent aphasia
- b. Mild, fluent aphasia
- c. Moderate non-fluent aphasia
- d. None of the above

118. Which of the following is/are a part of the patient's aphasia profile:

- a. Dyslexia
- b. Dysgraphia
- c. Apraxia of speech
- d. a and b
- e. All of the above

119. Which of the following is/are true for this patient:

- a. He is still in a period of spontaneous recovery
- b. He has completed spontaneous recovery
- c. Prognosis for further improvement is poor
- d. b and c
- e. a and c

Case Study 18 – Bilingual Assessment

CTCPD 5c

A child is referred for speech-language testing because she is struggling academically. In her teacher's view, she is not learning English with the expected speed and her academic skills are lagging behind those of her monolingual English-speaking classmates.

120. Your primary job is to:

- a. Determine whether the child qualifies for special education services
- b. Determine the child's language proficiency in English
- c. Determine whether the student has a language-learning disability or is merely manifesting the normal process of acquiring a second language
- d. Provide recommendations to the classroom teacher

121. What environmental variables would you need to take into account when developing your assessment plan? Choose all that apply.
- a. Languages spoken in the home and with friends
 - b. Language of instruction
 - c. How long child has been learning the second language
 - d. Student's attendance
 - e. All of the above
122. Assessment may result in all **EXCEPT** which of the following:
- a. Identification of the individual's relative language proficiency
 - b. Diagnosis of a learning disorder
 - c. Clinical description of the individual's speech-language and communication abilities in the individual's first language and in English
 - d. Identification of a communication difference, possibly co-occurring with a language disorder
 - e. Referral for other assessments or services
123. Interference, a normal pattern for acquiring English as a second language, is defined as:
- a. A process in which a communicative behavior from the first language is carried over into the second language.
 - b. Specific second language "errors" that remain entrenched despite good proficiency in the second language
 - c. Alternating between two languages in discourse
 - d. Decreased use of the first language as proficiency is acquired in the second language, which causes the learner to lose skills in the first language
124. Which of the following statements regarding bilingual assessment is **not** accurate?
- a. The performance of bilingual children must be judged in relation to a bilingual rather than a monolingual reference
 - b. Assessment of language proficiency must take both languages into account and expectations as to rate of progress in intervention must consider the amount of input received in each language
 - c. Assessment must adequately consider the structural and pragmatic differences between languages, which result in different sequences of acquisition and different age expectations cross-linguistically in various domains of language
 - d. Bilingualism should be discouraged for children with language impairment

Case Study 19 – Early Intervention

CTCSLP 2a

Ms. W. is a 19 year old single mother who has brought her two and a half-year-old son to your clinic for an evaluation accompanied by the boy's grandmother who believes that Little W is not talking as he should be for his age. Ms. W. is not really concerned, since her pediatrician said there was no cause for worry; some children are simply "late bloomers." The little boy lives at home with his mother and grandmother and has no other siblings. Ms. W speaks primarily English, and the boy's grandmother speaks Spanish. Little W's first words were at approximately 16 months of age. Neither the mother nor the grandmother recalls hearing any extensive babbling.

There is no significant medical history. Little W has been a healthy little boy. His phonemic repertoire consists of /m, b, g, / with some vowels, but they don't recall which ones specifically. Ms. W reports that sometimes he can say a full word such as "mama" or "more," when "he really wants something." Sometimes, Little W is prone to temper tantrums when he is not understood, at other times, he simply points. Little W. appears to have stopped talking recently. Ms. W is not very concerned since she believes her son is merely experiencing "the terrible twos."

125. Given the above information, what would be an appropriate next step as you proceed with your assessment?
 - a. Educating Ms. W. regarding early developmental milestones
 - b. Asking Ms. W if her son has established hand dominance
 - c. Deciding which standardized test to administer
 - d. Asking the mother how Little W plays at home
126. You decide to administer a standardized test to this little boy. Of the following tools, which one is a normed test that will help you determine eligibility for services?
 - a. The Rosetti Infant-Toddler Language Scale
 - b. The Hawaii Early Language Profile
 - c. The Preschool Language Scale
 - d. The Clinical Observations of the Therapist
127. Based on parental interview and your own observations, you determine that this little boy's receptive comprehension of language is intact and at an age-appropriate level. However, now he has stopped cooperating with testing and is ignoring your attempts to engage him in the testing. This would be a good time to:
 - a. Take a break from testing
 - b. Attempt an oral motor examination
 - c. Discuss your findings with the mother
 - d. Discuss treatment options and scheduling

128. During the assessment, the boy tantrums when you put away a toy. This most likely indicates which of the following:
- a. He has poor manners
 - b. His inability to communicate verbally frustrates him
 - c. He does not like musical toys
 - d. All of the above
129. Testing indicates that Little W has a significant speech and language delay. You believe that the most likely diagnosis for this is:
- a. Autism
 - b. Otitis Media
 - c. Language confusion from growing up in a bilingual home
 - d. Apraxia
 - e. Selective Mutism

End of Test

CD 697 Comprehensive Masters Exam in Communication Disorders: Linking Document

CTCPD

Standard 2a – A: pg. 9
Standard 2b – A: pg. 9
Standard 3a – A: pg. 9
Standard 3b – A: pg. 12
Standard 3c – A: pg. 9
Standard 4a – A: pg. 20
Standard 4b – A: pg. 20
Standard 5a – A: pg. 16
Standard 5b – A: pg. 9
Standard 5c – A: pg. 32
Standard 6a – A: pg. 7
Standard 6c – A: pg. 7
Standard 7c – A: pg. 12
Standard 8a – A: pg. 12

CTCSLP

Standard 1a – A: pg. 2
Standard 1b – A: pg. 2
Standard 1c – A: pg. 6
Standard 2a – A: pg. 34
Standard 2b – A: pg. 9
Standard 2c – A: pg. 9
Standard 2d – A: pg. 12
Standard 2e – A: pg. 12
Standard 3a – A: pg. 12
Standard 3b – A: pg. 12
Standard 4a – A: pg. 12
Standard 4b – A: pg. 12
Standard 4e – A: pg. 12
Standard 4f – A: pg. 7
Standard 4g – A: pg. 4
Standard 5a – A: pg. 12
Standard 5e – A: pg. 12
Standard 5f – A: pg. 7
Standard 5g – A: pg. 11