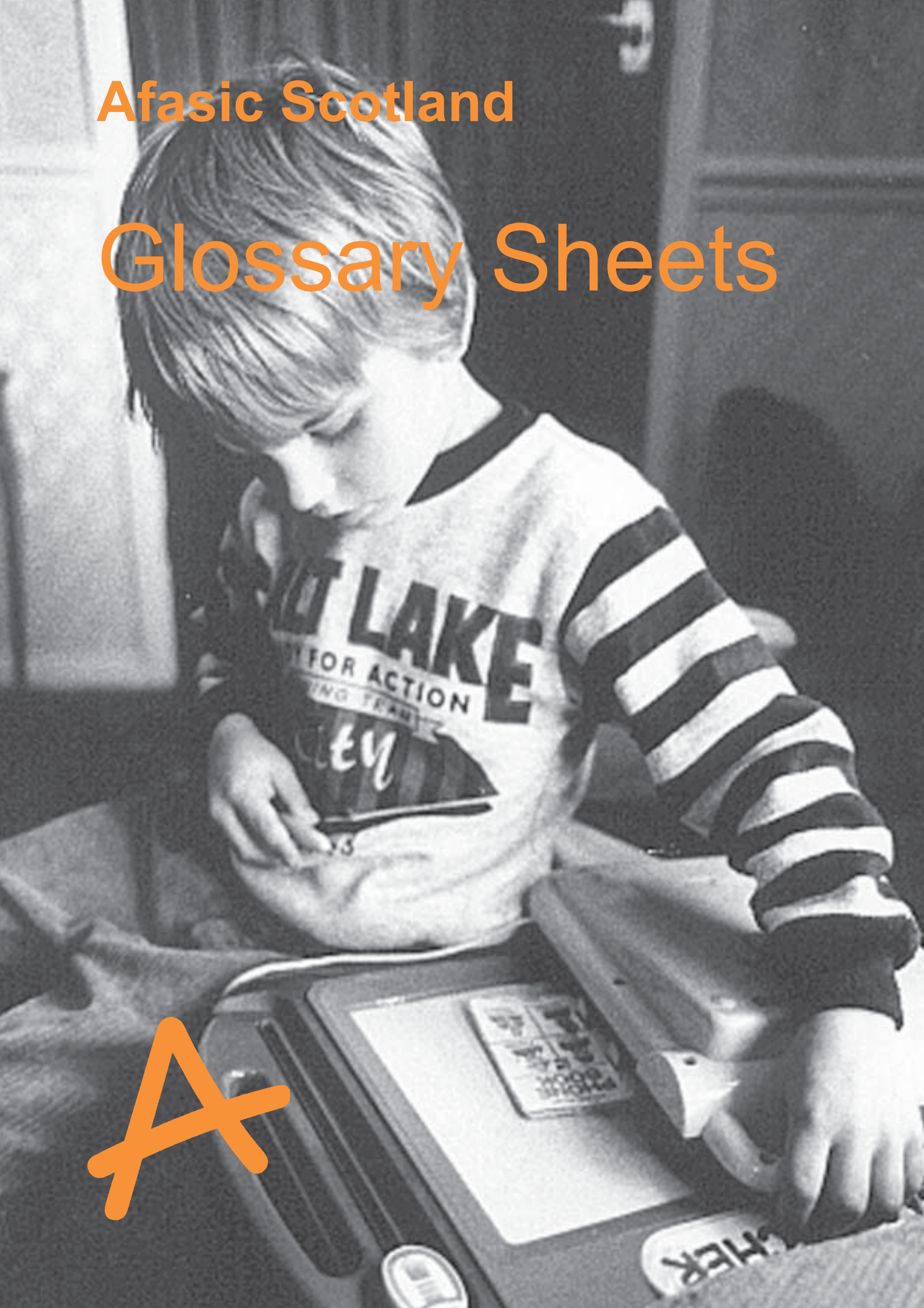


Afasic Scotland

Glossary Sheets



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**The Afasic Glossary Sheets
have been edited for use in
Scotland by Professor Gilbert
MacKay, University of
Strathclyde and sponsored by
The Scottish Executive
Education Department within
the SEN Innovation Grants
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Glossary

Glossary Sheets on Speech, Language and Communication Difficulties

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Glossary

Introduction

Overview

Speech and language impairment is a complex area. The terms used by health and educational professionals in this field can be confusing and even bewildering.

There are some particular areas of confusion or difficulty.

- **The same impairment can be described in different ways.** For instance, “specific language impairment,” “developmental language disorder” and “dysphasia” may be used to describe the same general impairments.
- **There is overlap or shared ground among some impairments.** For instance, the boundaries across autism, Asperger syndrome and semantic-pragmatic disorders are often hard to define confidently.
- **One general term can be used to describe a variety of disorders.** For example, “dysarthria,” “verbal dyspraxia,” “semantic-pragmatic disorders” and “phonological problems” could all be termed “expressive language disorders.”
- **Terminology can develop and change.** “Aphasia” was a common term thirty years ago, but is now very rarely used for developmental difficulties.

Afasic Glossary Sheets

The aim of these glossary sheets is not to give a detailed overview of relevant research and practice. Rather, it is to give a basic explanation of the meaning and use of terminology which is associated with speech and language impairments or disorders.

Cross-references

Afasic’s glossary sheets are fully cross-referenced so that the reader can locate any other relevant glossary sheets. Reasons for a cross-reference might be as follows.

- There is considerable overlap or sharing of symptoms among some impairments.
- Some impairments may be part of a more general group.
- Some impairments may commonly be associated with other problems.
- Some impairments may be otherwise linked.

Review and update

Afasic reviews the glossary sheets on a regular basis to ensure that all recent developments are taken into account.

Specific language impairment

What is specific language impairment?

This is one of three terms often used to mean the same thing. The others are “**developmental language delay**” and “**developmental language disorder**.” These second and third terms refer to different groups of children, but “**specific language impairment**” refers to all children with marked problems in their grasp of spoken language.

“**Specific language impairment**” (SLI) is the term used most widely. It does not include children who do not develop language because of intellectual or physical disability, hearing loss, emotional problems or environmental deprivation. It is used of children whose difficulties are with speech and language only.

Different children are referred to by the term “**specific language impairment**.” Some typical difficulties are listed below.

- The child seems to understand what is said, but people can not understand what she or he is trying to say.
- The child speaks clearly and at length, but often fails to get the point of a conversation, making inappropriate comments and replies.
- The child speaks clearly in single words, but has difficulties linking them together to make sentences, often leaving words out.
- The child understands almost no spoken language and says only a few words.

It is common to distinguish between comprehension (understanding language) and expression (using language). Most children with an SLI will be better at one area though they may have difficulties in both. The areas can be grouped as follows.

- **Speech apparatus** — the mouth, tongue, nose, breathing, and so on, and how they are co-ordinated and operated by muscles. Children with

a difficulty in this area only are usually identified quickly as having a speech and language impairment.

- **Phonology** — the sounds that make up the language.
- **Syntax (grammar and morphology)** — the way that words and parts of words combine in phrases and sentences.
- **Semantics** — the meaning of words, bits of words and phrases and sentences.
- **Pragmatics** — how we use language in different situations and how we convey feelings.
- **Intonation and stress (prosody)** — the rhythm and “music” of the way we speak.

A child can have difficulties with phonology, syntax, semantics or pragmatics which affect comprehension, expression or both. The child may have other difficulties as well as the one which is most obvious. Considerable expertise is needed to assess children with SLIs. A problem in one area of language is likely to affect other areas too. Each child requires skilled assessment and a planned programme of help.

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Other relevant Glossary Sheets

- Developmental language delay/disorder (3)
- Semantic and pragmatic disorders (5)
- Higher level language disorders (13)
- Phonological problems (14)
- Expressive language difficulties (15)
- Dyspraxia (18)
- Comprehension or receptive language difficulties (22)

Other organizations which can help

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Dyslexia/specific learning difficulties

What is meant by dyslexia /specific learning difficulties?

Dyslexia can be described as "an unexpected difficulty with written language". "Unexpected" implies that the child's difficulties can not be attributed to obvious physical, emotional or intellectual problems.

"Dyslexia" is often used interchangeably with "specific learning difficulties" (SpLDs), and indeed the terms mean the same in the case of many children. However, it is possible to make a distinction between them. Children with SpLDs need not be dyslexic. For example, some children have little or no trouble learning to read, write and spell. Yet, they may confuse "left" and "right," have great difficulty noticing the exact details of shapes and directions, and have unusual difficulty with maths or arithmetic. Strictly speaking, these children do not have dyslexia, though they may have a specific learning difficulty. SpLD, then, describes children who have difficulty in one or two aspects of learning but who do well in other areas.

The debate about terminology, especially the use of "dyslexia," has rumbled on for decades. At times, its use has been more popular among therapists, medical practitioners and the general public than among teachers and educational psychologists, though there is no simple polarization of opinion. "Specific learning difficulties" is a more flexible term than "dyslexia." However, many children with SpLDs will also have difficulty with reading, writing and spelling, and so can be described as "dyslexic" also. The debate about the right word to use has often been remote from the fact that pupils need help when they have unexpected difficulties with literacy. The result is that probably more hot air has been generated in this area of educational support than in any other over the years.

Children with SpLDs need skilled assessment and teaching. The assessment begins with teachers but may move to educational psychologists and speech &

language therapists. There is evidence that appropriate teaching can reduce and often overcome the development of a reading and spelling difficulty.

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 Reid, G. (1997). *Dyslexia: A practitioner's handbook*. Chichester: J. Wiley.

Other organizations which can help

Department of Equity Studies & Special Education (Dr Gavin Reid)
 Moray House Institute, University of Edinburgh,
 Charteris Land, Holyrood Road, Edinburgh EH8 8AQ
 Tel 0131 651 6381 Fax 0131 651 6511

The Scottish Dyslexia Association
 Stirling Business Centre, Wellgreen, Stirling FK8 2DZ
 Tel 01786) 446650 Fax (01786) 471235

Dyslexia Scotwest (The Dyslexia Institute)
 74 Victoria Crescent Road, Dowanhill, Glasgow G12 9JN
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Written by Gilbert MacKay, Bob Daines, educational psychologist, with thanks to Elizabeth Auger, specialist language teacher.

Developmental language delay / developmental language disorder

What is developmental language delay/developmental language disorder?

These terms are often used interchangeably to describe the general problems of children who are not developing language as expected for their age, although their development in other areas appears to be appropriate. A third phrase often used as a general term is "specific language impairment."

The important distinction to grasp is that between delay and disorder. As children build their ability to use language, their use of sounds in speech, their sentences, their words and what they choose to say all change. In the early stages they can seem to be making mistakes, when what they are really doing is using their existing ability to the full. These mistakes are part of learning. Some are very common and to be expected from all children. The various aspects of language also develop in an orderly way. Children generally learn certain sounds, words and sentences before others.

The language of children is described as "delayed" when they continue to make the common mistakes and when their language is developing slowly in the usual order of language development. The language of children who make the rare mistakes or whose language is developing in an unusual order is called "disordered." Assessment by a speech & language therapist is required for the distinction to be made reliably.

It is not always possible in the early stages to say whether a child's language is delayed or disordered. Early delay may resolve itself — but it may turn out to be a disorder.

Developmental language delay

This describes a mild or severe delay in the child's development of language, but once the child's language does appear, it develops normally in sequence and pattern.

Developmental language disorder

This refers to language development which is not only severely delayed but also atypical and uneven. The disordered nature of their language makes it hard for these children to continue developing it. In addition, they have great difficulty coping with communication and learning at school and home. Language is part of almost every aspect of life.

These terms are useful, but they can also be misleading as they seem to refer to children with the same kind of problem. However, there is considerable variety in the pattern and severity of abnormal language development.

Language development is made up of a number of different areas, including learning to hear speech sounds, making speech sounds, knowing the meaning of words, using words and knowing how words combine to make different types of sentences. It is usually more helpful to look at the areas where the child is having difficulty and how they affect each other.

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Other relevant Glossary Sheets

- Specific language impairment (1)

Other organizations which can help

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Learning difficulties

What are learning disabilities?

The term "learning disabilities" is currently used by many people to cover a wide and varied range of difficulties. The following features show how children with learning disabilities may appear in the classroom.

- They grasp new skills and knowledge slowly. It is often helpful for their educational activities to be broken down into smaller steps.
- Their ability to speak and understand language is less efficient than that of other children of the same age. They may have difficulty keeping track of a conversation, especially when topics change. Some children with learning disabilities may not develop language at all.
- They have limited ability to plan and organize their work. They may have difficulties in working out what to do, what to attend to and what to remember.
- The children may have difficulty working out which are the important points or bits of information in lessons and conversations. They have difficulty seeing relationships among ideas, events, objects and so on.
- The children may find it hard to concentrate. They may look or move around more than other children spending less time on the tasks and activities.
- They may be socially immature, acting younger than their age. Their play and interests may also be more typical of younger children.

Professionals recognize that it is difficult to subdivide learning disability into categories confidently. Certainly, the effect of the disability is mild in the case of some children (as in the list above), but others are affected much more markedly. For example, people with the most severe learning disabilities may never learn to speak. It is less important to find a label for an individual's category of disability than to make a good match of the child to school placement and educational support.

The *Standards in Scotland's Schools etc. Act 2000* (section 15(3)) states that we should presume that children will attend their local mainstream schools. Yet, the Act also recognizes that some pupils will require the support provided in special schools or units if they are to have access to the "broad and balanced curriculum" which is their entitlement.

Some children with learning disabilities will receive this entitlement satisfactorily in their local schools; others will need special support. The best solution for individual children will be worked out in negotiation among their families, the education authority, the other support agencies and (when possible) the pupils themselves. It is important for teachers and parents to work together, exchange ideas on ways which have worked in helping the child to learn, and support each other's efforts to help the child master new skills.

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Other relevant Glossary Sheets

- Dyslexia/specific learning difficulties (2)
- Developmental language delay/developmental language disorder (3)

Other organizations which can help

Children in Scotland
Princes House, 5 Shandwick Place, Edinburgh. EH2
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Semantic and pragmatic disorders

What are semantic and pragmatic disorders?

Children with semantic and pragmatic disorders are often first identified because of their unusual language characteristics. Children may have difficulty understanding some words, phrases and sentences, and use others oddly or inappropriately. They often show signs of limited social development and play.

“Semantic” refers to the meanings of words and phrases. “Pragmatic” refers to knowing what to say when, and how to say it to other people. These are complex areas of language learning and use. Frequently, professionals refer to “semantic-pragmatic” disorders, combining the two terms into one. This can often make good sense, but we should guard against assuming that the label suits all circumstances (Gagnon, Mottron & Joannette, 1997). That is why the terms on this glossary sheet are split — “semantic and pragmatic.”

Some communication specialists prefer to consider children with pure semantic problems under the headings of “receptive language disorder” and “higher level language disorder.” In combination, semantic and pragmatic problems will often centre on working out the topic of the sentence. The children often know the possible meanings of a word, but can not work out how it is being used on a particular occasion.

Some words which refer to concepts such as feelings (“sad,” “puzzled,” “jealous”) or status (“important,” “official”) can be particularly hard to learn. There may also be difficulty with non-literal use of language such as, “Cut it out!” (for “Stop it”) or “She’s a push-over.”

Children with pragmatic problems have difficulty using language in a social context. They do not seem to understand how we take turns when we talk, they interrupt more than is acceptable and make little effort to keep conversations going by saying little things such as, “Yes,” or “What did you do?” They sometimes seem unaware of what their partner needs to know and can say too much or little about the subject. Their conversation is often felt by the other person to be

inappropriate or irrelevant. Children with pragmatic difficulties may also use their language for a more restricted range of purposes than do the rest of us: asking, directing, recounting experiences, working out puzzles, imagining, predicting, and so on.

Semantic problems often blend into pragmatic difficulties. For example, the children will interpret a message quite literally. In the case of the question, “Can you open the door?” the child might reply, “Yes” without moving a muscle. The child has treated the request to open the door as a question about their ability to do it. This is normal at a certain stage of development, but is something the child should grow out of as they develop.

Rapin and Allen (1987) said that the following characteristics describe children with a semantic-pragmatic disorder:

- fluent, well formed sentences
- verbose with adequate speech articulation
- literal interpretations often alongside a good vocabulary
- use scripts in situations (that is, they say the same thing each time)
- they say more than they are capable of understanding
- problems with turn-taking and knowing what is being talked about
- going round the point, being unclear of what they are saying

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Other relevant Glossary Sheets

- Comprehension or receptive language difficulties (22)
- Higher level language disorder (13)
- Autism (7)
- Asperger's syndrome (11)
- Pervasive developmental disorders (16)

Other organisations which can help

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SCA (Scottish Centre for Autism)
(Consultant psychiatrist: Dr John Shemilt)
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Selective mutism

What is selective mutism?

Selective mutism is a term used when children who are able to talk quite freely in some situations, usually with their families at home, and are persistently silent in other situations, usually outside the home and with less familiar people. The problem commonly shows up in school where children who have not spoken for two terms or more can usefully be described as having selective mutism.

This is not normal shyness nor obstinacy; it is a psychological problem when children seem to freeze and become unable to speak, a sort of fearfulness and social anxiety, together with an excessive sensitivity to the reactions of others.

“Selective mutism” is a more recent term for “elective mutism”; both terms can be used, but “selective mutism” is now favoured by most professionals.

A few facts

- Selective mutism is a relatively rare condition. The best estimate suggests that less than one child per thousand is affected.
- Selective mutism is usually reported between the ages of three and five.
- Girls are affected slightly more frequently than boys.
- Children who come from a bilingual background are slightly more likely to display selective mutism.
- Children with selective mutism are more likely to have other speech and language difficulties than other children.
- The majority of children with selective mutism are of average or above average intelligence, but some show moderate to severe learning difficulties.

What can be done to help?

In most situations referral to both a speech &

language therapist and a psychologist is recommended. Then a full assessment of the child can be carried out over a period of time, including assessment of intelligence and all areas associated with the mutism. Assessment of the child's verbal comprehension (understanding of language) is usually possible, and their expressive language and speech (what they say) can be indirectly assessed using home tapes or the like.

Treatment may involve a graduated programme carried out by a therapist or key worker in school to tackle the mutism — several specific programmes have recently emerged. Parent-child work may help, and support and advice to both school and parents are needed.

The condition is complex and progress is slow. Excessive sensitivity is a personality characteristic, and although the children can make significant progress over the years they are likely to remain somewhat reticent.

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Other relevant Glossary Sheets

- Expressive language difficulties (15)

Other organizations which can help

SMIRA (Selective Mutism Information & Research Association)
13 Humberstone Drive, Leicester, LE5 0RE
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Autism / autistic disorder / childhood autism / infantile autism

What is autism?

People with autism have characteristic ways of behaving, communicating and thinking. Some of the most distinctive are listed below, though it is important to recognize that they vary from individual to individual. Many people are affected to such a mild degree that they need no special support other than normal understanding, tolerance and encouragement. Others have their lives disrupted severely, and will always need special support from others. Some autistic people have learning disabilities; others show high intelligence in learning and problem-solving; still others show isolated areas of high ability. Other difficulties may well accompany the autism: specific learning difficulties, specific language difficulties and dyspraxia are examples. However, the items in the list below are widely agreed to be the distinctive features of autism when they appear in combination.

1 Difficulties interacting socially

Some children with autism enjoy physical and social contact but, generally, they may seem aloof and withdrawn. They are likely to have poor social skills, with little insight into the feelings of others. Special programmes can improve sociability and communication, but the underlying difficulties are likely to persist.

2 Difficulties in communication

Some individuals are delayed in acquiring speech, others never learn to speak. Language grows from our need to communicate with each other. Some of the following features may be characteristic difficulties.

- There may be a weak response when others speak, gesture or make facial expressions. Other non-verbal communication, such as eye contact and body language, may also be affected.
- There is often difficulty in beginning conversations and in following them. This weakness is accentuated when the children are in groups.

- The children may use words and phrases which do not quite fit the situation. Some may repeat phrases inappropriately, or use particular phrases persistently.
- Their speech may show unusual patterns of the “musical” aspects — speed, stress, rhythm, intonation and pitch. These aspects all carry messages and follow social rules.

3 Rigid thinking

Imaginative play is likely to be limited, with interests which are narrow and restricted. Pretend-play with toys such as cars, dolls and dressing-up may be limited, and late to develop. There is a tendency to want to do the same things with objects and people in the same situations. The individual seems rigid, inflexible and stuck in routines, and often becomes distressed by attempts to change things. The following may be evident.

- Repeating movements for no obvious purpose — twiddling an object, flicking the hand, banging the head.
- Persistent preoccupation with parts of objects — watching a washing machine go round, moving a toy car just to look at the wheels.
- Showing obsessive interests — perhaps including remarkable feats of memory, and attention to detail.

It is important to recognize their difficulties, when children show autistic behaviour, communication and thinking. Yet, it is equally important to see the children as individuals whose education, sociability and happiness are not determined entirely by the extent of their autism. The responses of their families, teachers, therapists and other professionals are powerful forces for shaping their future too.

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Jordan, R., & Powell, S. (1995). Understanding and teaching children with autism. *Chichester: John Wiley.*
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Seach, D. (1998). Autistic spectrum disorder: Positive approaches for teaching children with ASD. *Tamworth: National Association for Special Educational Needs.*
Trevarthen, C., Aitken, K., Papoudi, D., & Robarts, J. (1998). Children with autism: Diagnosis and interventions to meet their needs (2nd ed.). *London: Jessica Kingsley.*
Wing, L. (1996). The autistic spectrum. *London: Constable.*

Other relevant Glossary Sheets

- Semantic and pragmatic disorders (5)
- The autistic spectrum (8)
- Asperger syndrome (11)
- Pervasive developmental disorders (16)
- Dyspraxia/apraxia (19)

Other organizations which can help

The Scottish Society for Autism
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The autistic spectrum

What is the autistic spectrum?

The "autistic spectrum" is a blanket expression which many professionals use just now. It covers the characteristics of groups of children who show, in varying degrees, similar styles of behaving, thinking and communicating. This spectrum includes labels such as "autism," "Asperger syndrome" and "semantic-pragmatic disorders." None of these labels is defined with unmistakable certainty, even in the international directories of classifications.

Some children do fit the definition of particular terms quite well. Many others appear on the borderlines. The use of "spectrum" draws attention to the blurring of boundaries across the terms. However, "spectrum" is misleading if it is seen as a simple progression of impairment, with semantic-pragmatic difficulties at one end and the most severe autistic behaviour at the other. The diversity of individuals is more complicated than that. The specific characteristics of each child's difficulties need to be identified and addressed on that basis.

"PDD" and the "autistic spectrum" are, respectively, the American and European expressions for the same range of conditions.

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approaches for teaching children with ASD. Tamworth: National Association for Special Educational Needs.

Trevarthen, C., Aitken, K., Papoudi, D., & Robarts, J. (1998). Children with autism: Diagnosis and interventions to meet their needs (2nd ed.). London: Jessica Kingsley.

Wing, L. (1996). The autistic spectrum. London: Constable.

Other relevant Glossary Sheets

- Semantic-pragmatic disorders (5)
- Autism (7)
- Asperger syndrome (11)
- Pervasive developmental disorders (16)
- Dyspraxia/apraxia (19)

Other organizations which can help

The Scottish Society for Autism
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Alternative/augmentative communication (AAC)

What is alternative/augmentative communication (AAC)?

AAC is a form of communication which supplements spoken communication or substitutes for it. AAC does this either by means of a particular device (assistive communication) or by means of a system — signing or symbols (non-assistive communication). AAC is also broadly divided into high-tech and low-tech communication aids or systems.

High-tech aids are usually typewriter- or computer-based aids using a keyboard and visual display, and may have voice. The voice may be real (an actual recording of a person's voice) or synthetic (an artificial voice).

The keyboard may be QWERTY (as on a normal typewriter), alphabetic or display symbols instead of letters. The latter is used for those who do not have literacy skills — the child or adult does not have to be able to read in order to use a communication aid. Many aids with a scanning device can be operated by a single switch for those with very limited movement such as knee, head or eye movements.

It is also possible to vary the number and complexity of the symbols and to combine these to produce phrases and sentences. Most aids can also store a number of phrases and sentences which can be accessed by a single key press.

It is vital that a specialist assessment is made by a professional experienced in AAC before any device or system is recommended, whether it is high or low-tech.

Low-tech aids usually take the form of pointing boards or frames, or small Filofax or dictionary-type aids, all of which can be personalized to meet the client's needs. Again letters, symbols or pictures can be used.

Symbol systems may use pictorial representations (such as Rebus) or abstract symbols (such as Blissymbolics), which are pointed to or indicated on a

computer screen.

"Magic" slates and notebooks for writing are another low-tech aid.

Signing systems can be simple, with gestural representation of a word, such as Makaton, or complex including grammatical signs, such as Paget-Gorman or British Sign Language. **References** Baumgart, D., Johnson, J., & Helmstetter, E. (1990). *Augmentative and alternative communication systems for persons with moderate and severe disabilities*. Baltimore, MD: Paul H. Brookes. Horwood, W. (1988). *Skallagrigg*. Harmondsworth: Penguin. Nolan, C. (1999). *Under the eye of the clock*. London: Phoenix. Rush, W. (1986). *Journey out of silence*. Lincoln, NE: Media Publishing & Marketing. Southgate, T., & Cochrane, G. (Eds.). (1990). *Communication equipment for disabled people*. Oxford: Oxford Health Authority.

Other relevant Glossary Sheets

- Specific language impairment (1)
- Articulation (10)
- Dyspraxia (18)
- Dysarthria (21)

Other organizations which can help

Scottish Centre of Technology for the Communication Impaired (SCTCI)
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Communication Matters (*for all of UK*)
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Oxford
OX3 7DR
Tel (Edinburgh) 0131 555 3279

Royal National Institute for the Deaf (RNID Scotland)
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Articulation

What is articulation?

Articulation refers to movements of the articulators — tongue, soft palate, jaws, teeth, lips. Problems with any of these lead to an articulation disorder affecting intelligibility to varying degrees.

Problems may be...

- structural — for example, cleft lip and palate
- orthodontic — for example, protruding upper teeth, micrognathia (very small lower jaw), short soft palate
- neurological — for example, dysarthria, where the range of movement in tongue and lips is restricted. This may be specific to the articulators or more usually associated with a general condition such as cerebral palsy or stroke.

Difficulties may also be due to head injury or facial injuries or dyspraxia where movements cannot be organized (see Afasic Glossary Sheets on dysarthria and dyspraxia).

Therapy concentrates on improving the range, rate and accuracy of movement, but severe problems may require alternative or augmentative communication. Orthodontic treatment or corrective surgery may also be necessary.

In any articulation problem it is important to have a comprehensive assessment carried out by a speech & language therapist who can also refer on to an ENT surgeon or orthodontist and can recommend appropriate alternative or augmentative communication.

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Other relevant Glossary Sheets

- Alternative/augmentative communication (9)
- Dysarthria (21)
- Dyspraxia (18)

Other organizations which can help

Royal College of Speech & Language Therapists (RCSLT)
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The speech & language therapy service of your local health board or trust. Details appear in the business section of the telephone directory, under "Health" and the name of the board or trust.

Written by Pat Mobley, speech & language therapist, with thanks to Elizabeth Auger, specialist language teacher.

Asperger's syndrome

What is Asperger syndrome?

This condition was first identified in 1944 by Hans Asperger. He described a group of children with autistic behaviour and thinking, who, generally, had good intellectual and linguistic abilities. They are defined as a discrete group in the classification systems of the World Health Association and the American Psychiatric Association, but there is controversy about whether the distinction can be made reliably. Typically, children with Asperger syndrome acquire speech and linguistic structures, but have difficulty with the social use of language.

Tantam (1988) suggests that the term Asperger syndrome is best reserved as a term to describe those who...

- use language freely, but fail to make adjustments to fit different social contexts or the needs of their listeners
- wish to be sociable even though their peer group tend to avoid them because of their apparently eccentric behaviour
- are conspicuously clumsy
- develop unusual interests in which they become deeply engrossed
- have problems in expressing themselves in ways such as their facial expression, gestures or posture.

These children often have semantic and pragmatic disorders, but not all children with semantic and pragmatic disorders can be classified as having Asperger syndrome (Botting & Conti-Ramsden, 1999). The difficulties persist into adult life and can present particular problems during adolescence because of social isolation and awareness of being different from their peer group.

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Other relevant Glossary Sheets

- Semantic-pragmatic disorders (5)
- Autism (7)

Other organizations which can help

The Scottish Society for Autism
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Cocktail party syndrome

What is cocktail party speech?

In normal development, understanding of spoken language is usually in advance of expressive language development. Very young babies can understand some of what is said to them long before they say their first word.

In some children, however, expressive language is better than their understanding of spoken language. Some of these children acquire a veneer of seemingly quite sophisticated language without really understanding it. They use phrases they have learned, often based on the social interactions of adults. This language may give the impression that they have a better grasp of language than is actually the case. "Hello, how are you today? Are you having a good time? I'm having a wonderful time," and so on. It is from language such as this that the term "cocktail party speech" arises. The difference between the sophistication of the spoken language and its actual functionality make it a pragmatic communicative difficulty.

This type of speech is often associated with specific learning difficulties, general learning disability and hydrocephalus.

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Other relevant Glossary Sheets

- Dyslexia/specific learning difficulties (2)
- Learning disability (4)
- Semantic and pragmatic disorders (5)

Other organizations which can help

Royal College of Speech & Language therapists
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The psychological service of your local council.
Details appear in the business section of the telephone directory, under the council's name and "Education."

The speech & language therapy service of your local health board or trust. Details appear in the business section of the telephone directory, under "Health" and the name of the board or trust.

Written by Pat Mobley, speech & language therapist, and Gilbert MacKay, with thanks to Elizabeth Auger, specialist language teacher.

Higher level language disorder (HLLD)

What is higher level language disorder (HLLD)?

HLLD is a term which has found its way into the literature on communicative difficulties relatively recently. People described as having HLLD develop language which is structurally normal and have some understanding, but have problems with...

- understanding more complex statements, questions and instructions - they often get hold of the wrong end of the stick
- expressing more advanced concepts, such as, "I ought to have ..."
- word-finding
- the more sophisticated aspects of language - for instance, knowing that "Go away home now," is rude, but "You must try these biscuits," is polite
- humour which depends on language
- inference - they have to have things spelled out to them
- literal interpretation - a child told to "Pull your socks up," (meaning, "Try harder") might bend down and pull up her or his socks.

Often there is early language delay or disorder which seems largely to clear up, leaving the difficulties listed above. Many people with HLLD are of normal or above normal intelligence with good attainments in acquiring knowledge, solving problems and literacy. They often learn coping or masking strategies which hide their problems, and HLLD frequently does not show up on conventional language or psychological testing. Close observation and knowledge of the person is necessary for the diagnosis to be made, especially when checklists such as that above show such a degree of overlap with other contentious labels such as semantic-pragmatic disorder and Asperger syndrome. People with HLLD often have difficulty with social skills and forming relationships with others. This, again, makes distinctions with other terms on the autistic "spectrum" hard to maintain confidently.

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Other relevant Glossary Sheets

- Semantic and pragmatic disorders (5)
- Asperger syndrome (11)

Other organizations which can help

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Phonological problems

What are phonological problems?

A child with a phonological problem has a difficulty pronouncing a number of sounds. The sounds which are mispronounced can be grouped according to certain features, such as the place in the mouth where the sound is produced or how it is produced.

There are many phonological processes (sound rules) which a child uses which affect the pronunciation of groups of similar sounds. Examples include...

- fronting, when sounds which should be produced at the back of the mouth are produced further forward in the mouth ("car" becomes "tar" or "par", "gun" becomes "dun" or "pun", "sing" becomes "sin" or "sim");
- backing - the opposite of fronting - when sounds are produced further back in the mouth ("pen" becomes "ten" or "ken", "table" becomes "cable", "bear" becomes "dere" or "gere", "dog" becomes "gog");
- stopping of fricatives, when longer fricative sounds (f, v, s, z, sh, th) are pronounced as short plosive sounds (p, b, t, d, k) ("sun" becomes "tun", "finger" becomes "pinger");
- cluster reduction, when the child omits one of the two or three consonants which occur together ("black" becomes "back", "sweet" becomes "weet", "bread" becomes "bed") - l, r and s are the most commonly-omitted letters.

A child may make use of more than one phonological process, even within one word. The processes may be affected by the position of the sounds in the words. For example, fronting sounds only at the beginning of words, so that "cup" becomes "tup" but "back" is pronounced correctly.

The child may use the processes consistently or inconsistently - every k and s sound at the beginning of words, or only some of them. Because of the number of sounds affected, the child's speech is often unintelligible to strangers and to the family, causing both parties to become frustrated.

A phonological problem may also be referred to as a phonological disorder. A child is seen to have a

phonological delay when using phonological processes which are more typical of a younger child. A child's phonology is disordered when the processes used are inconsistent and not following the normal pattern of phonological development.

Phonological problems may be caused by many factors including...

- general immaturity or learning disability
- recurrent middle ear infections which affect the child's ability to hear differences among similar sounds
- low motivation on the part of the child, because the family understands the child anyway, or does not expect the child to speak more clearly
- poor control of the lip, tongue and palate muscles used for speech.

Phonological problems can also be associated with reading difficulties. A phonological problem cannot be caused by a tongue-tie. A tongue-tie affects the pronunciation of one sound only — r.

References

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Other relevant Glossary Sheets

- Specific language impairment (1)
- Dyslexia / specific learning difficulties (2)
- Articulation (10)

Other organizations which can help

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Expressive language difficulties

What are expressive language difficulties?

One simple classification of language is to split it into its receptive and expressive aspects.

Receptive language refers to meaning, understanding language and “decoding” language. Expressive language refers to production, spoken output and coding - “a process of formulating ideas into words and sentences, in accordance with the set of grammatical and semantic rules of language” (Cantwell & Baker, 1987).

Expressive language can be delayed or disordered. Many elements of delay and disorder overlap, but they are also very different problems. In the early stages, it may be difficult to determine whether the language is delayed or disordered.

A child with expressive language delay is slow to develop spoken language, but this language follows the normal sequence and pattern of acquisition when it does appear. “Expressive language disorder” implies that acquisition is not only slow, but different from normal. The pattern of development is uneven and atypical. The features of expressive language disorder vary greatly, depending on the severity of the disorder and the child’s age.

Language is made up of many areas, including...

- morphology, the way word structures change (such as, “sleep”, “sleeping,” “slept”)
- grammar, rules about combining words in phrases and sentences
- semantics, the representation of meaning in language
- pragmatics, how language is used
- phonology, the sound system of the language.

Expressive language difficulties may affect any or all of these areas. Specialists in communication often consider difficulties in terms of their content, form and use.

Content

Difficulties with content of language relate to its meaning. Children with expressive language difficulties may have a limited vocabulary, word-finding difficulties, and difficulty expressing abstract concepts or categorization problems. Difficulties with language content may occur in the case of visually impaired children (Warren, 1981) or those with restricted mobility.

Form

Some children have difficulty developing the surface aspects of language - its form. This leads to disorders of the sound system, word forms and grammar. Such children may have difficulty with word order, structuring sentences or expressing what they know and understand. They will perform better on non-verbal tests than on language tests. They may have difficulties with word endings, plurals, possessives, verb tenses or prepositions. Such problems may arise because of acquired or developmental dysphasia or to impaired hearing.

Use

A child may have an expressive language disorder if he or she uses language inappropriately or out of context. The term “semantic-pragmatic disorder” may be used to describe these children, who may seem to have very good verbal comprehension and age appropriate sentence structure, but may have difficulty receiving or interpreting conversational cues. Such problems are also typical of children with learning difficulties. In that case, the children often lack verbal fluency, may overuse a limited or concrete vocabulary, and frequently fail to appreciate a need for clarification (Wiig & Semel, 1980).

References

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Wright, J. A., & Kersner, M. (1998). Supporting children with communication problems: Sharing the workload. London: David Fulton.

Other relevant Glossary Sheets

- Specific language impairment (1)
- Dyslexia/specific learning difficulties (2)
- Developmental language delay / disorder (3)
- Semantic and pragmatic disorders (5)
- Aphasia/dysphasia (17)

Other organizations which can help

Royal College of Speech & Language Therapists (RCSLT)

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Pervasive developmental disorders

What are pervasive developmental disorders?

This term was first adopted in 1980 by the American Psychiatric Association. Since then it has been retained and achieved quite widespread acceptance in the Americas. It was chosen to describe both autism and conditions which share similarities with autism. In the UK and continental Europe the term "autistic spectrum disorder" was developed to serve the same purpose. The word "developmental" emphasizes that the problem is present early in the child's life. "Pervasive" implies that many aspects of the child's development are affected.

In the UK and Europe, it is argued that although the disorders are pervasive they are not pervasive of every aspect of development. The term is criticized as uninformative in that it does not describe the nature of the abnormal features associated with the condition. By contrast, many Europeans argue that "autism" has proved to be a relatively viable diagnostic term. It should be retained, they would argue, because it has won wide recognition, describing a difficult condition which requires special help. Also, members of the public are beginning to understand the needs of people with autism. Thus, the term "autistic spectrum disorder" has a certain useful currency.

In America, however, it is believed that the term "pervasive developmental disorders" has an advantage over "autism" because it is free from misconceptions about the condition. The argument is that various conditions included in the class of pervasive developmental disorders share some similarities, but the assumption that they all represent some variant of autism is not proven and may not be useful.

References

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- World Health Organization. (1993). *The ICD-10 classification of mental and behavioural disorders: Diagnostic criteria for research*. Geneva: Author.

Other relevant Glossary Sheets

- Semantic and pragmatic disorders (5)
- Autism (7)
- The autistic spectrum (8)
- Asperger syndrome (11)

Other organizations which can help

The Scottish Society for Autism
Hilton House, Alloa Business Park, Whins Road, Alloa
FK10 3SA
Tel 01259) 720044 Fax 01259 720051
www.autism-in-scotland.org.uk/main.html

National Autistic Society (Scotland)
Central Chambers, 109 Hope Street, Glasgow G2 6LL
Tel 0141 221 8090 Fax 0141 221 8118
Email scotland@nas.org.uk
www.nas.org.uk

SCA (Scottish Centre for Autism)
(Consultant psychiatrist: Dr John Shemilt)
Department of Child & Family Psychiatry, Royal
Hospital for Sick Children, Glasgow G3 8SJ
Tel 0141 201 0000

Department of Educational Support & Guidance
Faculty of Education, University of Strathclyde,
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Aphasia / dysphasia

What is aphasia/dysphasia?

These are the oldest terms used in the field of specific language impairments. Originally they would have described the field completely. They have Greek roots, and describe the conditions of having no speech ("a" = "not" and "pha" = "speak") and having deviant speech ("dys" = "bad") following brain trauma, such as head injury, a stroke or meningitis. Speech here includes language. These terms are still used widely in the adult field in connection with acquired language difficulties. For nearly a century, all research and clinical understanding of speech and language impairments was gathered under these terms.

In the 1950s, professionals began to realize that children could show developmental difficulties that resembled the adult conditions described by the terms aphasia and dysphasia, but without any known brain trauma having occurred. The terms were initially very valuable in identifying the children we would now describe as having specific speech and language impairments. An immediate problem of transfer to children arises from the fact that nearly all children move from an aphasic to a dysphasic state as their development continues and as help is provided. For this reason dysphasia came to be more commonly used for children.

In a further attempt to make the terms applicable to children the word "developmental" was added, leading to the appearance of the terms "developmental aphasia" and "developmental dysphasia." There are other variations that can be encountered with reference to children...

- congenital aphasia/dysphasia — used for those whose difficulty is present from birth
- acquired aphasia/dysphasia — used for those whose speech and language development is affected by, for example, brain injury or meningitis
- receptive aphasia/dysphasia — used for those who have difficulties in understanding speech
- expressive aphasia/dysphasia — used for those who can understand speech but have problems using it.

Broadly speaking, all the above terms can be used

according to their definitions provided of course that they describe the child's circumstances. It is wrong to assume that they correspond to exact medical or psychological conditions, or that they convey a clear picture of the exact problem that the child has. These terms have become less frequently used in recent years, particularly in the UK and USA.

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- Lees, J., & Urwin, S. (1997). Children with language disorders (2nd ed.). London: Whurr.*

Other relevant Glossary Sheets

- Specific language impairment (1)
- Semantic and pragmatic disorders (5)

Other organizations which can help
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Dyspraxia/apraxia

What is dyspraxia/apraxia?

Dyspraxia describes difficulty with controlling and co-ordinating learned patterns of movement, where there is no damage to muscles or nerves. Apraxia describes a loss of the ability to carry out voluntary regulated patterns of movement, although there is no damage or weakness of nerves or muscles. Either of these terms may be used, although "dyspraxia" is heard more commonly in the United Kingdom.

The two terms may be used with the prefix "developmental" when describing the condition in children, as in

- developmental apraxia of speech
- developmental verbal dyspraxia
- developmental articulatory dyspraxia.

Articulatory verbal dyspraxia is a condition where the child has difficulty making and co-ordinating the precise movements which are used in the production of spoken language although there is no damage to muscles or nerves. A child with dyspraxia may have difficulty producing individual sounds as well as in co-ordinating the sequence of sounds necessary for making words, or co-ordinating the increasingly complex sequences used in words, phrases and sentences.

Dyspraxia may be present in varying degrees from mild to severe in different children. Most clinicians agree on the following diagnostic features, and the child may exhibit one or more of them.

1 Difficulty in control of the speech apparatus

The child may have difficulty in making and co-ordinating the precise movements necessary for accurate speech production. The speech apparatus includes

- the lips
- the tongue
- the soft palate (the fleshy continuation of the hard palate — roof of the mouth — which closes off the nasal passages for blowing, sucking, swallowing and speaking)
- the larynx (voice box)
- muscles used to control breath for speech

- muscles used for facial expression. Difficulties with feeding may also be experienced.

2 Difficulty in speech sound production, with limited sounds used and inconsistent production

3 Difficulty in sequencing sounds to make a word

4 Difficulty in regulating breathing and in controlling the speed, rhythm and volume for speech

There may also be difficulty in balancing nasal resonance and in maintaining good voice quality.

Language development

Usually the child's understanding of what is said is relatively normal. The majority of these children however will have been slow to speak, with late development of babbling, first words and word joining. They may continue to show some difficulties with the length and complexity of sentences. Problems with specific forms of grammar (such as auxiliary verbs, verb tenses or pronouns) may persist for a long time.

The speech & language therapist, who is the professional responsible for the assessment and treatment of this condition, will check and monitor all aspects of the child's speech and language development.

The child with dyspraxia requires skilled assessment and a planned programme of therapy. Progress will be slow and depends on appropriate help being given.

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Stackhouse, J. (1992). Developmental verbal dyspraxia I: A review and critique. *European Journal of Disorders of Communication*, 27(1), 19–34.

Other relevant Glossary Sheets

- Specific language impairment (1)
- Articulation (10)

Other organizations which can help

Dyspraxia Foundation
8 West Alley, Hitchin, Hertfordshire SG5 1EG
Tel 01462 454986

Dyspraxia Foundation (Regional Co-ordinator for Scotland)

Graham Robertson
9 Rosebush Crescent, Dunfermline, KY11 4GB
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Fragile X syndrome

What is Fragile X syndrome?

Fragile X is a genetic condition. The gene that causes Fragile X is found at the tip of the X chromosome and shows as a fragile site - hence the name. Both men and women can be carriers of Fragile X and the gene may pass through several generations of carriers before a child affected by the syndrome is seen. Diagnosis is established by a DNA or Chromosome test but a Fragile X test must be specified.

Learning difficulties

Fragile X is the most common inherited cause of learning disability. It affects boys and girls and it is found in all populations and ethnic groups. Learning disabilities vary from subtle educational delays to severe mental impairment. Boys who are affected almost always have some learning difficulty which can range from moderate to severe. Up to half of the girls have learning problems which are occasionally severe.

Behavioural features

The behavioural features include inattentiveness, distractibility and poor impulse control often associated with hyperactivity. Shyness and social withdrawal are striking features in girls with Fragile X syndrome who may experience difficulty in making friendships and feel alienated from peers.

Poor eye contact, difficulty in relating to other people, anxiety in social situations often leading to tantrums, insistence on familiar routines and hand flapping or hand biting may also occur.

Physical features

Physical features may include a largish head and prominent ears but these may not be obvious in young children. Twenty percent of people with Fragile X have epilepsy.

Speech and language delay

Speech and language delay is almost always present but its severity varies considerably. There may be an entire absence of speech through to milder and more

subtle communication difficulties.

The characteristic speech pattern is fast (cluttering) and fluctuating. Generally the speech pattern has a jocular, running-on narrative style with frequent repetitions and swings of pitch described as "litany-like". There is a tendency to stick to one theme in conversation (topic perseveration) and children may repeat words or phrases that are spoken to them (echolalia) or repeat many times words or phrases that they themselves say (verbal perseveration). There may also be a tendency to leave sentences incomplete.

Girls with Fragile X may also have a high-pitched voice with repetitions.

Some children with Fragile X experience articulation difficulties which may be due to a large jaw and high arched palate. Hypotonia (low muscle tone) which occurs in some children with Fragile X may affect their muscles at the back of the mouth, the lips, nose and tongue which may in turn affect their ability to produce speech sounds.

Delay in the development of speech and language or language dysfunction as described above is often an indicator that a child with learning difficulties has Fragile X syndrome.

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Turk, J., & Zwick, L., Autism and the Fragile X syndrome. Communication, 27 (1), 10-11.

Other organizations which can help

The Fragile X Society
53 Winchelsea Lane, Hastings, East Sussex,
TN35 4LG
Tel 01424 813 147

The Fragile X Society (Scottish contacts)
Mr & Mrs H. Muir
26 Orchard Street
Galston
Ayrshire
KA4 8ER
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Down's syndrome

What is Down syndrome?

Down syndrome is a genetic disorder which is associated with some physical, processing and learning difficulties.

Down syndrome and speech and language acquisition

The following is a list of some problems which may be associated with the speech and language of individuals with Down syndrome. Not all of these will be identified in every individual with the syndrome, and their influence will also vary depending on the individual's stage of development, the severity of the problem itself, or both.

- The palate may be high arched and narrow.
- The tongue may be large for the area it occupies, with reduced muscle tone and sometimes fissured. Tongue co-ordination, speed and accuracy of movement may be reduced, which influences sound production, clarity and speed of utterances.
- Intermittent "glue ear" produces hearing loss which is usually more severe during winter months. Some individuals with Down syndrome, just as some people in the general population, may have a sensory-neural hearing impairment.
- Children with Down syndrome find auditory processing difficult. This is the process by which we make sense of what we hear. Children with Down syndrome appear to have problems in listening, retaining what they hear and decoding or translating it. All three processes are needed to learn language and use it appropriately.
- Memory, particularly recalling what they have heard, can be slow to develop and often requires practice to extend.
- Difficulties with receptive language — the recall and the decoding of what we hear — make understanding more difficult. Understanding is made easier if information is related to the individual's immediate situation, rather than about another place or time.
- Hearing and auditory processing problems may also mean that an individual with Down syndrome may not recognize changes made to words which alter meaning (morphology), such as the addition

of "s", "ing", "ed", and so on.

- The sounds of speech (phonology) are often produced less clearly because of the structure of the mouth, lower muscle tone in the tongue, hearing difficulties and slow processing skills.
- It may be very difficult for even adults with Down syndrome to comprehend abstract information, subtle language, or alterations to meaning marked by changes in stress, tone, use of inference, innuendo, sarcasm and so on.
- Expressive language is slower to develop and, as with understanding, is often context bound. Physical and processing problems influence content and clarity. Gestures or signs that have been individually devised or learned may be used. Early attempts at verbal communication may produce partial attempts at words only. These are often followed by clear words mixed with unclear verbalizations which use sentence-like stress, intonation and pauses.
- A number of people with Down syndrome show a degree of dysfluency. This is often intermittent, and varies from the rhythmical, relaxed repetition of words and syllables, to tense blocks on sounds or words.
- Voice quality sometimes appears deeper in tone, and may sound rather less modulated to the listener.
- The visual processing of people with Down syndrome is often an area of strength. This may appear to be a strange area to be discussed in a glossary about speech and language. However, individuals do tend to use their visual processing strength to compensate for their rather weaker auditory channel. This point may be useful in teaching. However, a high proportion of people with Down syndrome require glasses, and so their visual acuity will need checking if the visual channel is to augment auditory input.

This is not a complete list of all the areas in which children and adults with Down syndrome may have difficulties. They will all have some problems with the development of speech and language. The extent and type of problem depends on the individual people, as does the type and extent of intervention to help them.

References

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- O'Kane, J. O., & Goldbart, J. (1998). *Communication before speech (2nd ed.)*. London: David Fulton.

Other organizations which can help

Down's Syndrome Association
153-155 Mitcham Road, London SW17 9PG
Tel 020 8682 4001
www.downs-syndrome.org.uk/

Scottish Down's Syndrome Association
158/160 Balgreen Road, Edinburgh EH11 3AU
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Dysarthria

What is dysarthria?

Dysarthria is a condition affecting speech production. It results in slurred speech because of weak or imprecise movements of the speech organs. These can include the articulatory organs of the lips, tongue and jaw, the larynx, the control of the airstream on which speech is produced through the respiratory tract and the movement of the soft palate and pharynx.

The involvement of these different parts of the speech production and mechanism may vary. Dysarthria occurs in a number of neurological conditions and can be the result of brain dysfunction or injury. This means that it may be part of a developmental speech condition (present from birth) or an acquired condition (as a result of the onset of a particular neurological condition or after brain injury).

Dysarthria can range in severity from mild, through moderate to severe. Speech patterns may have a number of different characteristics depending of the nature of the damage to the brain. The speed of speech production may be affected. Most commonly, speech is slow, but sometimes quick involuntary movements affect speech production. All movements may be slow and limited in range. Those with very severe dysarthrias may have no movement at all in some organs which are required to move in a controlled way for clear speech production.

Where dysarthria is associated with cerebral palsy, or head injury, there may also be difficulties in language understanding or general learning. It is important to understand these as they may influence the approach taken for education or speech & language therapy.

Sometimes, developmental dysarthria is referred to as Worster-Drought syndrome (<http://www.btinternet.com/~w.d.s.p.g/>). This is more appropriate where it is congenital and non-progressive and is associated with mild general motor problems and some general learning problems. The condition may run in families and an early history of poor sucking and swallowing is usual. There may be difficulties in introducing solid food. The usual pattern is of weakness and problems controlling the voluntary

movement of the lip muscles, tongue, soft palate and, when more severe, the pharyngeal and laryngeal muscles. Speech usually sounds very "nasal", slurred and indistinct, but children can be anarthric (that is, unable to develop useful movement for speech).

What to do about dysarthria

Assessment by a speech & language therapist is helpful for a child with dysarthria. Different treatment options may be explored according to the type and severity of the dysarthria. Where dysarthria is accompanied by severe drooling (as in some types of cerebral palsy), drug or surgical management may be recommended, and the therapist may have a role in monitoring these effects. Where speech is unintelligible and likely to remain so for some time, a Communication Aids Centre might be consulted for advice about alternative and augmentative communication. Such centres can also advise less severely dysarthric speakers who want to opt for a communication aid (see Glossary Sheet 9).

Early treatment for developmental dysarthria emphasizes the building up of developmental motor patterns, increasing range and precision of movement through exercise. These build on the child's general developmental and motor progress. Specific treatments in older children with residual dysarthrias may include electropalatography, a computerized visual display system which gives a child feedback about the accuracy of their speech production.

References

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Robertson, S., & Thomson, F. (1986). Working with dysarthrics: A practical guide to therapy for dysarthria. Bicester: Winslow Press.

Other organizations which can help

Capability Scotland
ASCS (Advice Service Capability Scotland)
11 Ellersly Road
Edinburgh EH12 6HY
Tel 0131 313 5510 Fax 0131 346 1681
Textphone 0131 346 2529
Email: ascscapability-scotland.org.uk
<http://www.capability-scotland.org.uk>
Where dysarthria is part of a general motor problem.

Scottish Centre of Technology for the Communication Impaired (SCTCI)
WESTMARC, Southern General Hospital, 1345
Govan Road, Glasgow, G51 4TF
Tel 0141 201 1100
Email sctci@waacis.edex.co.uk
For advice on communication aids.

Communication Matters
22 Claremont Road
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0131 555 3279
For advice on communication aids.

Royal College of Speech & Language Therapists (RCSLT)
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Other relevant Glossary Sheets

- Alternative / augmentative communication (9)
- Dyspraxia (18)

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Comprehension or receptive language difficulties

What are comprehension or receptive language difficulties?

Many children whose development of speech and language gives cause for concern have difficulties understanding what is said to them. That is, their understanding of spoken language falls below the level expected for their age. Difficulties with comprehension are sometimes known as “receptive language difficulties”. For these children it is important to consider listening and speaking skills separately, as the two will not be working together effectively. Unless and until they are, a child’s ability to learn will be seriously impaired, for understanding of language is fundamental to learning and to understanding the world.

Many skills are involved in language comprehension including the following.

- Ability to hear. Some children have intermittent hearing loss which can affect understanding of language.
- Ability to pay attention to speech sounds. Some children have difficulty in establishing and maintaining their attention in certain situations or the control of their attention may be less than expected of a child of their age.
- Ability to distinguish between speech sounds.
- Ability to process language. Some children have difficulty in “taking in” language — it takes them longer to understand what is being said.
- Memory for strings of speech sounds.
- Knowledge of word meanings.
- Knowledge of sentence structure.
- Ability to make sense of language in and out of context.
- Difficulties with sight.

There can be difficulties with any one of these skills — this should be borne in mind during an assessment. Identification of a child’s difficulties may not be straightforward as there are many ways in which a child can understand or even anticipate what is required of them without actually understanding what

has been said. Gestures, facial expression, and contextual clues can all supply vital information.

On the other hand, such children may show behaviour difficulties or apparent lack of interest. This is likely to be more so in situations which make explicit demands on understanding of spoken language.

Research has shown that difficulties in understanding are more widespread than was previously thought. Even children whose difficulties appear to be limited to expressive language may have subtle but significant receptive language difficulties also.

Assessment

Assessment is not easy because difficulties with understanding the spoken word are complex,. Identification of impairments of hearing or sight is essential as these may influence the ability to take in information.

It is also crucial to assess a child’s ability to pay attention, for it may be this that is impaired rather than understanding. On the other hand, some children who do pay attention will not understand what is said to them. A child’s ability to process information may be impaired. Thus, assessment should include considering whether or not the giving of more time makes a difference.

Because of all these factors, observation plays a critical part in any assessment, and it is important that the child is observed in a variety of contexts, with different people.

Particular care is necessary when assessing a child whose first language is not English. Most tests are in English and may well not give an accurate picture because of cultural bias. Ideally the assessment should be done in the child’s mother tongue as well as English.

References

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Other organizations which can help

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Landau Kleffner Syndrome (LKS)

What is Landau-Kleffner Syndrome (LKS)?

Landau Kleffner Syndrome is a rare form of childhood epilepsy which results in a severe language disorder. It is also known as "acquired epileptic aphasia". LKS affects girls and boys almost equally.

The disorder usually starts between 4 and 7 years of age, though it may occur in children as young as 2 or as old as 11. Typically the first indication that something is wrong is that the child's understanding of language deteriorates. In most speech and language disorders in children the child's language will always have lagged behind; but in LKS there is a loss of language skills in a child who was previously developing normally and who was beyond the "first words" stage. This deterioration of language can happen slowly, over a period of weeks or months, or much more quickly, over days.

The language disorder in most children affects understanding of spoken language; the ability to speak is usually seriously affected too. The child may not respond to environmental sounds, like a doorbell, phone or vacuum cleaner.

Children with LKS are often thought to be deaf because of their difficulty in understanding what people say to them. However, hearing tests show that the child can detect sounds: the difficulty lies in interpretation of the sounds.

In some cases a diagnosis of selective mutism may be suspected. Unlike the child with selective mutism, the child with LKS will fail to speak in all situations, not just in some. Furthermore, children with selective mutism do understand what is said to them, whereas this is typically not the case in LKS.

Sometimes it may be difficult to distinguish between LKS and autistic disorder. Children with autism often have severe difficulties understanding spoken language, and they too may lose language skills after a period of normal development. But in autism difficulties begin earlier (usually being apparent to parents by 30–36 months of age) and the child has

difficulties with all aspects of social interaction and communication. Children with LKS, by contrast, will respond socially in a normal way, and will communicate in ways other than spoken language, for instance, through gestures and facial expressions.

This does not mean that the difficulties for a child with LKS are restricted to language. Some children are frustrated or frightened by their inability to communicate: this can cause temper tantrums, withdrawal from the world or other behavioural difficulties. If the epileptic activity affects the frontal regions of the brain, children may be uninhibited and lack restraint in their behaviour.

LKS can be difficult to diagnose because many children do not have obvious epileptic seizures. Abnormal epileptic activity, in one or both temporal lobes of the brain, does show up on an EEG (electroencephalogram). The temporal lobes are important for language comprehension and memory. There is no evidence that the brain is damaged in LKS, but the underlying epileptic activity interferes with the child's ability to learn and understand language.

In some children the communication disorder fluctuates, so that speech and language may improve and then get worse again. Older children, especially those aged 6 and above when the disease starts, will often make a good recovery. For younger children (those less than 4 years at onset) the ability to understand speech may remain seriously impaired, though some younger children do make a good recovery after an initial period of deterioration. As for seizures, the outcome is usually good, and the EEG becomes normal.

As LKS is rare, many paediatricians will never have encountered a case. Thus the reason for the child's communication difficulties can go unrecognized. Any child who develops serious communication difficulties after a period of normal development should be seen by a specialist with expertise in epilepsy, who will investigate any underlying epilepsy and recommend the appropriate treatment.

Medical treatment

Medical treatments are not usually very effective, but it can be of benefit to control the epileptic activity at an early stage. Drugs called corticosteroids can help - but these are powerful and most paediatricians will use them very cautiously. Other anti-epileptic medicines can control epileptic activity, but do not always improve language. Some children have benefited from a specific method of brain surgery - but this is not appropriate for all children with LKS.

Educational implications

Most children benefit from alternative communication methods, especially sign language. Those with persistent language impairment may well need special education with other language-impaired children in a school where sign language is used by teachers and other pupils. Children with LKS are sometimes educated with children who have hearing impairments. Parents of children with LKS may be advised to learn sign language, so that they can communicate more easily with their child.

References

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Other relevant Glossary Sheets

- selective mutism (6)
- epilepsy and speech and language (24)

Other organizations which can help
FOLKS (Friends of Landau Kleffner Syndrome)
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Epilepsy and speech and language

What is epilepsy?

The World Health Organization defines an epileptic seizure as a transient loss of function of all or part of the brain because of excessive electrical activity. Physical, sensory or other functions can be temporarily lost.

Certain types of epilepsy can be linked with learning, behavioural and speech and language difficulties. This is increasingly recognized, and the risks are greater if epilepsy occurs before 2 years of age. Parkinson (1994) found that from a small study of children referred for assessment of their epilepsy, 40% had undiagnosed language impairment of varying degrees of severity.

Epilepsy can cause temporary loss of function in one or more parts of the brain. If these parts are involved with understanding, organization and communication processes, difficulties in using language can result. These difficulties can be severe, causing general delay in language development or a disordered pattern of language abilities.

The following epilepsy syndromes have associated language difficulties.

- Landau Kleffner Syndrome
- ESES or Tassinari's syndrome, now called CSWS (Continuous Spike Waves of Slow Sleep)
- Lennox-Gastaut syndrome
- Temporal lobe epilepsy

Sometimes the disability can be extremely subtle, in the form of a high level language impairment or disorder. They may have pragmatic difficulties and, therefore, will not have a clear understanding of language use. They can appear socially inept and can misread others' intentions. In these cases they may exhibit bizarre or socially unacceptable behaviours or their language may appear to be odd in an inconsistent way. They may have poor turn-taking skills, excessive or restricted topic maintenance, and poor skills in greeting, questioning, seeking the attention of others, describing or commenting.

Some children may have episodes of slurred or

dysfluent speech. These episodes can occur suddenly and be unconnected with stress or other obvious trigger factors. They can be caused by changes in medication and/or as a result of epileptogenic activity, that is, electrical activity in the brain which does not necessarily manifest itself as an obvious epileptic attack.

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Other relevant Glossary Sheets

- Aphasia / dysphasia (17)
- Semantic and pragmatic disorders (5)
- Developmental language delay / developmental language disorder (3)
- Landau Kleffner Syndrome (23)

Other organizations which can help

Epilepsy Action Scotland
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Cluttering

What is cluttering?

Cluttering is speech which is so rapid, muddled and inaccurate that it is nearly unintelligible. It is variously described as a motor disorder and a disorder of fluency. Cluttering was described by Luchsinger and Arnold in 1951, and opinions have varied as to whether it is a type of stammering or a separate disorder.

What is cluttering like?

- Speech is excessively rapid.
- The speaker may start a conversation at normal speed, but gradually speak more and more quickly.
- Sounds, syllables and words may be omitted.
- Syllables may be telescoped, that is, shortened by the omission of some sounds.
- Sounds may be repeated.
- Breathing may be jerky.
- Writing may show similar effects.
- The speaker may be unaware or unconcerned about his or her speech.

What causes it?

Some evidence suggests that there may be an organic cause — in other words that a physical abnormality of some kind is the reason for cluttering. It is also believed that cluttering may, to some extent, be a hereditary condition.

Can it be treated?

Treatment is difficult because of the clutterer's poor awareness, and perhaps because of an organic basis of the disorder. Unlike stammerers, few clutterers seek therapy. If motivated, however, a clutterer can be taught to be more aware of his or her speech, and to modify those features which interfere with communication.

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Rustin, L. (1990). Parents, families and the stuttering child. *London: Whurr.*

Other organizations which can help

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The speech & language therapy service of your local health board or trust. Details appear in the business section of the telephone directory, under "Health" and the name of the board or trust.

Written by Pat Mobley, speech & language therapist

Auditory sequential memory

What is auditory sequential memory?

Auditory sequential memory enables us to remember sequences that have been spoken to us. Examples include telephone numbers, the days of the week, the words of songs, the events of a story, instructions for carrying out a task, and so on. Many children with a history of late-speaking and early speech and language difficulties reach secondary school age with adequate levels of speech and understanding. However, they may have the remnants of earlier problems which perhaps only they, their parents and teachers can detect. It is not uncommon for reading and writing difficulties to persist after the speech problem has resolved, the key factor being a limited auditory memory span.

Memory span is unlikely to improve significantly by the time children reach secondary school. The children and those around them need to accept the problem and look for ways of compensating for it, rather than hope to overcome it.

The practical suggestions below were compiled by staff at Gap House School in Broadstairs, Kent, which specializes in the education of primary-school children with speech and language impairments.

Following instructions

- Say things more than once, and ask for instructions to be repeated back to you to make sure that the child has caught what you have said. This will also show you exactly how much she or he can retain at once, and make you aware of how much to expect.
- Minimize the number of key points that have to be remembered by the child.
- Sequence the items clearly and avoid any excess language which will only confuse the issue.
- Encourage children to repeat instructions silently to themselves while on their way to do them.
- Use visual imagery to aid recall. For example, let's say that you have asked your child to buy washing-up liquid and toothpaste, feed the gerbils and fetch in the washing while you are out. Make it clear there are four things to remember, then get them to

imagine a scene where the gerbils are running up and down the washing line, squirting each other with Fairy Liquid and toothpaste! (This may sound odd advice, but the effects of visual imagery are very strong and continue to aid recall after considerable periods of time.)

- Mnemonics can be used in a variety of ways. For example, a difficult spelling such as "ought" can be memorized as "Oswald Usually Grinds His Teeth." A telephone number, such as "13265," could be split as "my age," "my door number," "the fingers on my hand."

Useful Aids

- Visual aids.
- Digital watch with date.
- Keeping a diary of "things to remember."
- Carrying a notebook and pencil to jot things down as they crop up. Children cannot rely on their listening memory for homework, invitations, and so on. A Junior Filofax serves the purpose well and has street credibility.
- The older child might benefit from a pocket dictaphone, particularly if handwriting is a problem.
- Encourage the child to keep a list of vital information handy — personal addresses, phone numbers, dates of birth. It is amazing how one can go blank on these things just at the wrong moment.
- Use maps/diagrams/lists to explain things, rather than giving instructions verbally.
- Whenever possible, get children to make out lists themselves, either by writing or drawing items. Try to turn a blind eye to spelling mistakes. What's important is training children to be self-reliant, and of course the extra effort put in is a further aid to memory. The end product may look messy to you, but will be more meaningful to the child.

General

- Help the children to understand and accept their problem. Encourage them to say to others, "I'm not very good with words. Could you write it down for me please?"
- Make sure that all involved with the children are aware of their limitations and do not dismiss a poor memory as laziness or inattention (though obviously these factors can play their part too!).

- Encourage the child to ask questions if they are not sure of anything. Check that teaching staff are prepared for this. If the child has plucked up courage to ask for repetition or clarification, then it is important that this effort is rewarded by a patient answer. Similarly, the child will need to understand that the teacher may be busy and can not always drop everything to give an immediate answer. With will and understanding on both sides, a compromise can be reached.

References

Bristow, J., Cowley, P., & Daines, B. (1999). Memory and learning: A practical guide for teachers. London: David Fulton.

Other organizations which can help

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About Afasic

Afasic is the UK charity representing children and young adults with communication impairments, working for their inclusion in society and supporting their parents and carers.

Afasic was founded in 1968 as a parented organisation to help children and young people with speech and language impairments and their families. Today, Afasic is recognised as an authority in its field and works in partnership with other established and respected organisations.

Afasic promotes the interests of children and young people through:

- training and conferences
- information sheets, newsletters and publications
- support through local groups
- a telephone helpline service
- activity weeks and weekends
- supporting the development of children and young people.



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