of pervasive developmental disorder and the necessity for multiple levels of neurobehavioral evaluation with epileptic children.


Neuropsychological Deficits in First-Episode Patients.
Investigations into the neuropsychological functioning of schizophrenic patients are frequently confounded by the effects of medication and duration of illness. Recent studies have attempted to control for these factors by evaluating the neuropsychological functioning of patients who are experiencing their first episode (FE) of psychosis and are essentially neuroleptic-naive. These studies have found FE patients to be generally impaired relative to normal controls, with particular deficits in verbal memory and learning, spatial organization, attention, and motor function. In the present study we used a comprehensive neuropsychological test battery to evaluate the performances of 34 FE patients and 35 age-matched NCs (FE mean age = 26.2(7.4), NC mean age = 26.6(4.8)). FE patients were diagnosed with a structured clinical interview, and subjects with a history of substance abuse or a neurological diagnosis were excluded. Years of education significantly differ between groups (p < .005). Overall, the FE patients’ test performances are lower than those of the NCs on a wide range of tasks. Test results were standardized for the FE patients based on the NC group performance, revealing FE patients’ deficits in psychomotor speed, abstraction ability, mental flexibility, and word list learning and recall relative to NC’s. No differences in visual memory were found. These results suggest that specific regions of cortical processing are affected early in the illness, and are consistent with hypotheses and MR findings of left temporal dysfunction, and frontal/executive dysfunction in schizophrenia. Findings will be discussed in terms of confounding factors such as general intellectual functioning and years of education.

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Accuracy and Utility of the Satz-Mogel Short Form With Patients With Intractable Epilepsy.
Although the Weschler Adult Intelligence Scale-Revised (WAIS-R) is not designed to be a neurodiagnostic instrument, it is routinely employed along with neuropsychological tests to assist in clinical decisions regarding the surgical treatment of patients with intractable epilepsy. The Satz-Mogel (SM), a selected-items short form that estimates WAIS-R IQs, is employed to reduce assessment time for the patient and/or to allow for more time for the administration of specific neuropsychological instruments. The accuracy and utility of the SM was evaluated with 84 pre-surgery and 48 post-surgery standard WAIS-R protocols that were rescoring according to SM decision rules. As in previous work, SM IQs were very highly correlated with the WAIS-R IQs. However, pre- and post-surgically, the SM was significantly different from the WAIS-R FSIQ (pre: t = -3.22, p = .002; post: t = -4.28, p < .001) and PIQ (pre: t = -5.16, p < .001; post: t = -5.64, p < .001). SM VIQ was not significantly different from WAIS-R VIQ (pre: t = 0.49, p = .628; post: t = 1.94, p = .058). Age corrected scaled scores on a number of subtests also were found to be significantly different when employing the SM. According to Weschler’s categories of intellectual functioning, 22.6% of the presurgical patients were misclassified relative to WAIS-R FSIQ (14.3% over-estimated, 8.3% underestimated). Caution should be exercised when interpreting the results of the SM with patients with medically refractory epilepsy.

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Qualitative Block Design Performance in Epilepsy Patients.
Broken configuration errors on the WAIS-R Block Design subtest are thought to be associated with right hemisphere damage. This effect has been reported in patients with right
hemisphere strokes or extensive right hemisphere damage from traumatic brain injuries. Little is known, however, about whether this pattern exists in patients with more subtle lesions. The present study examined whether pre-surgical epilepsy patients with foci restricted to the right hemisphere would make more broken configurations (as a proportion of the total number of designs administered), during design construction, than those with left hemisphere foci. Subjects included 38 patients with unilateral right (six males; 14 females) or left (nine males; nine females) hemisphere localization-related epilepsy of frontal or temporal lobe origin. The left and right hemisphere groups did not differ significantly in age at testing, education, Full Scale IQ, handedness, or age of seizure onset. Those subjects with right hemisphere foci did have a significantly higher proportion of broken configurations than did those with left hemisphere foci. In the right hemisphere group, a higher proportion of broken configurations was associated with a lower Block Design scaled score and a lower Full Scale IQ. The left and right hemisphere groups did not differ on Block Design raw or scaled scores, nor did patients with frontal and temporal foci differ significantly in the number of broken configurations generated. This finding suggests that the observation of broken configurations in the Block Design can assist in lateralizing the seizure focus and highlights the importance of qualitative Block Design analysis.