Test Battery Study #	Study	Speech Tests (listing by committee member)	Subject sample (age, number, groups)	Age effects/speech test	hrg loss effects/speech test	cognitive effects/speech test	possible confounding/speech test	Other observations	
1	Jerger, J., Jerger, S., Oliver, T., & Pirozzolo, F. (1989). Speech understanding in the elderly, Ear and Hearing, 12, 103-109.	PAL-PB 50 word test, SSI test, SPIN test, DSI test; presentation level for PB, SSI, and SPIN were 50 dB SL re: babble threshold of each ear; for SSI, MCR = 0 dB, for SPIN, SBR = +8 dB, and DSI - intensity level to each ear was 50 dB HL. Abnormal result: PB-SSI > 20%; SPIN test abnormal if performance < 2s.d. below mean; DSI: difference between ears > 16%	Tested 130 community-dwelling, nonclinical subjects, ranging in age from 51-91 years.	CAPD defined as abnormal performance on one or more of 3 speech measures; and this was 20%. Tested only elderly subjects so no comparison group. Presumably, positive CAPD results reflect age effects. Of 65 subjects with abnormal speech results, 16 had PB-SSI diff, 5 had abn SPIN, 12 had abn DSI, 6 had abn SPIN + PB-SSI, and 26 had abn DSI + SPIN and/or PB-SSI diff. Age as a co-variate was not explicitly examined; the focus was on CAP and cognitive status	accommodated by presenting signal level at 50 dB SL re: babble threshold and selecting subjects with PTA (.5, 1, 2k Hz) < 50 dB HL in either ear. hearing sensitivity mild-to-moderate sloping sn hearing loss. Thus, results could be confounded by significant high-frequency sensorineural loss.	Neuropsychological battery administered: MMPI, WAIS-R, Wechsler Memory Scale, Boston Naming Test, Spatial Orientation Memory Test, Burschke Selective Reminding Test, Simple Auditory and Simple RT tests, and 4-choice Visual RT test; subjects classified as Normal or Abnormal; In total - 41% classified as Abnormal: of the 65 S's with abnormal CAPD status, 35 S's also had abnormal cognitive status	Of 130 tested, 23% classified as CAPD with normal cognitive status; however, these could have had some confounding due to high frequency hearing loss. Not broken down by test; of 130 tested, 27% classified as CAPD with abnormal cognitive status - clearly had abnormal cognitive findings and also may have had hearing loss.	The largest category of abnormal findings resulting in a classification of CAPD is multiple findings (DSI + SPIN and/or PB-SSI difference).	
2	Stach, B., Spretnjak, M., & Jerger, J. (1990). The prevalence of central presbycusis in a clinical population. Journal of the American Academy of Audiology, 1, 109-115.	SSI and PAL PB-50 word lists; established PI-PB functions in quiet, SSI presented at 0 dB MCR. Central presbycusis defined as : SSI rollover > 20%, PB scores - SSI scores > 20%, or absolute SSI score lower than normative boundary with same degree of hearing loss.	Retrospective analysis of data from 700 clinical patients, aged 50 years +, with 100 subjects/half age decade (5-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80+) and 138 nonclinical subjects (20/age group described above)	Prevalence of central presbycusis increased with age (17%, 50-54 yrs to 95%, 80+ yrs) (not broken down by test measure)	because hearing increased with age, conducted a substudy to control for hearing loss with 20 S's/half-decade, matched for degree of hearing loss based on PTA; even when degree of hearing loss controlled, prevalence of central presbyacusis increased with age. But greater prevalence of CAPD in hearing loss group compared to non-clinical group (suggests confound)	not measured.	hearing loss and cognitive decline. However, authors mention that their methods of identifying CAPD are relatively immune to the effects of hearing loss. Didn't specify if S's were native speakers of English.	Significance of individual measures - unknown.	
3	Cooper, J.C. Jr., & Gates, G.A. (1991). Hearing in the elderly—the Framingham cohort, 1983-1985: Part II. Prevalence of central auditory processing disorders. Ear and Hearing, 12, 304-311.	PI/PB functions for CID W-22, SSI-ICM (SSI presented at 50 dB HL at MCRs of +10, 0, -10, -20 dB; SSW test at 50 dB SL re: PTA. Abnormal results: PB rollover > 20%, PB-SSI > 20%; SSW: moderately and severely abnormal (and over-corrected) categories based on TEC analysis (total, ear, and condition error scores)	n = 1018 from the Framingham cohort who provided sufficient data.	1.4% of subjects failed PI-PB rollover test (CAPD), 18.1% subjects failed PB-SSI difference and were classified as CAPD; 10.7% showed abnormal SSW results. Total prevalence of CAPD in this group: 22.6%; abnormal performance increased with age. Accounted for ~15% of the variance and not considered a dominant factor in etiology of CAPD	not assessed directly, but assumed it was minimal	not assessed	cognitive decline, high frequency hearing loss (not reported). Didn't specify if subjects were native speakers of English.	Prevalence of CAPD in a nonclinical population was 23% among those > 63 yrs	
4	Jerger, J., Jerger, S., & Pirozzolo, F. (1991). Correlational analysis of speech audiometric scores, hearing loss, age, and cognitive abilities in the elderly	Speech tests identical to those described for #1 above (Jerger et al., 1989), but derived five speech scores (PB, SSI, SPIN-high, SPIN-low, DSI) by averaging the individual ear scores	n = 200 subjects, 50-91 yrs (same as subject recruitment in #1)	For SSI, hearing loss and age significantly contributed to performance. For other measures, age was not a significant predictor variable contributing to performance.	Predictor variable of hearing loss was significantly associated with PB (58% variance accounted for, VAF) and SPIN-Low scores 61% VAF), addition of other variables accounted for only 3-6% additional variance. For SSI, hearing loss (42% VAF) and age (another 12% VAF) significantly contributed to performance; for SPIN-high - only hearing loss (54% VAF). For DSI, hearing loss (30% VAF) and digit symbol score (speed of mental processing; accounted for 13% of variance)) accounted for 43% of total variance.	For DSI, hearing loss and digit symbol score (speed of mental processing) accounted for 43% of variance.	Appears that hearing loss was a variable contributing to most of performance among this group.	Considerable variance was not accounted for, for each of the tests. If younger subjects were tested to compare to the older subjects, might have been possible to state that there were age effects (so pure age effects could not really be assessed, because it was an older group of participants). Of data reported, degree of hearing loss was strongest predictor variable for the 4 monotic speech measures, but accounted for less variance for the dichotic speech measure (DSI)	
5	van Rooij, JCGM, & Plomp, R. (1992). Auditive and cognitive factors in speech perception by elderly listeners III. Additional data and final discussion. JASA, 91, 1028-1033.	reduced battery to SRT in Q and N, memory span and processing speed. Tests administered on computer in S's home (NOT in the lab)	85 S's, 53-94 yrs; healthy volunteers, otoscopically inspected	None	Canonical correlations: Thresholds - 63% var, HL slope - 11% var	Canonical correlations: Digit span and memory scanning - 10% var			
6	Humes, L.E., Watson, B.U., Christensen, L.A., Cokely, C.G., Halling, D.C., & Lee, L. (1994). Factors associated with individual differences in clinical measures of speech recognition among the elderly. Journal of Speech and Hearing Research, 37, 465-474.	CUNY NST, CID W-22 in unshaped (W-22U) and spectrally shaped (W-22S) noise, R-SPIN; presentation level for all speech materials 70 and 90 dB SPL; SNR = +7 dB (using speech-shaped noise) [total of 20 mesures of speech recognition: 5 tests x 2 presentation levels x 2 noise conditions (Q & N)	n = 50, 63-83 yrs; air-conduction thresholds show a mild-to-moderately severe hearing loss (on average)	Canonical analyses revealed that age was part of the set of predictor variables to predict speech scores at the lower presentation level (although weight was weak)	Canonical analyses identified hearing loss as the largest predictor variable to account for variation in a set of criterial variables (esp. the first speech variable: Speech scores at lower presentation level) among the elderly subjects. Canonical correlations: HL, 70-75% VAF	Canonical analyses showed that all cognitive variables were part of the set of predictor variables to predict speech scores (especially COG 5 - measures from WAIS-R), but low weights. Little or no additional variance accounted for by cognitive or auditory-processing measures.	accounted for through PCA and Canonical Correlations - to examine contribution of these sources. Didn't specify if subjects were native speakers of English.	PCA's second speech component reflects speech perception in noise at a high signal level that was not accounted for by audibility (accounts for about 7 % of variance); source not identified	
7	Humes, L.E., Coughlin, M., and Talley, L. (1996). Evaluation of the use of a new compact disc for auditory perceptual assessment in the elderly. Journal of the American Academy of Audiology, 7, 419-427.	Dichotic nonsense syllables (simult and 90 ms lag), dichotic digits, DSI, dichotic CV segments (voice in one ear-consonant in the other ear), binaural NU6 with high and low-pass filtering, NU6 with 45 and 65% TC; all presented at 90 dB SPL	n = 38 elderly subjects and 40 young adults; young adults had normal hearing; elderly subjects had hearing ranging from normal to moderate sloping high-frequency sn hearing loss; elderly subjects divided into 2 subgroups: ENH (13) and EHI (25)	Age effects observed on Dichotic CVs (2 levels), vowels in 1 ear- consonants in the other, and NU6 - filtered. NOTE: little association between scores on dichotic digit and DSI with high frequency PTA up to 50 dB HL.; PCA showed that age was associated with dichotic-competition skills and auditory-pattern/temporal sequencing factor.	hearing loss was signif for 5/10 tests: dichotic digits, DSI, NU6 filtered, NU6-45% and 65%TC; no effect of age was observed for Dichotic Digits, DSI, and NU6-45% TCR; NOTE: the 3 measures involving NU6 were strongly correlated with high freq'y PTA; DESPITE presentation level of 90 dB SPL, HFPTA strongly negatively associated with general speech understanding (PCA Factor 1)	not assessed	Didn't specify if subjects were native speakers of English.	Observed questionable test-re-test reliability for dichotic NS and DSI; recommend 2 speech tests for auditory perceptual evaluation of elderly (at 90 dB SPL): VICECITO (vowels in one ear consonants in the other) and dichotic nonsense-syllables with 90 ms lag.	
8a	Divenyi, P., & Haupt, K.M. (1997). Audiological correlates of speech understanding deficits in elderly listeners with mild-to--moderate hearing loss. I. Age and lateral asymmetry effects. Ear and Hearing, 18(1) 42-61.	SRT, CCT at 50 dB SL re PTA with contral white noise masking at + 30 dB SNR, low-pass filtered speech at .75 and 1-kHz, rapid alternating speech (RAS), MRT in reverberation a t = 0, .45, .85, and 1.25 sec reverberation time, SSI-ICM SSW, Competing sentence test at -5 dB SNR - monaural and binaural, NU6 with TC30 and TC60, SPIN at +4 dB SBR - monaural and 3 spatial conditions	n = 45 elderly subjects (60-81 yrs), pure-tone thresholds < 50 dB HL at .5, 1k, 2, and 4kHz; and 16 young normal hearing control subjects.	Following ANCOVA to remove hearing loss effects, continued to see age effects for some tests, incl: RAS, CCT, TC30, RT .45 and .85 sec, and SPIN spatial separation measures	hearing loss effects seen on SSI, Contral competing sentence tests, TC 60, MRT without reverberation and in1.2 sec reverberation and some of the SPIN spatial non-spatial measures. (that is, different scores between young and eld before ANCOVA and differences were not preserved after ANCOVA)	not assessed	Didn't specify if subjects were native speakers of English.	Robust age effects for reverberant speech, SPIN in spatial separation, sentence context-based facilitation of speech intelligibility (HP vs. LP SPIN)	
8b	Divenyi, P., & Haupt, K.M. (1997). Audiological correlates of speech understanding deficits in elderly listeners with mild-to--moderate hearing loss. II. Correlation analysis. Ear and Hearing, 18(2) 100-113.	Same as 8a	same as 8a, without young control group	Age was expressed as the linear combin. of 4 predictor variables: pure tone slope, SPIN 36 mono (SPIN 360 deg High + Low minus SPIN Monaural High + Low), SSI, and bilateral competing sentence test (but only accounted for 31.5% of variance); when hearing loss removed, age predicted by CCT, SPIN SPT H+L and Auditory Filter Width (53.4% VAF)	observed a high canonical r between hearing sensitivity measures and 6 measures of speech understanding in non-optimal conditions (mostly SPIN measures with and without spatial sep) and speech in reverberation; and between hearing sensitivity and 7 measures of speech understanding in distortion or interference	not assessed	Didn't specify if subjects were native speakers of English.	hearing loss accounts for 2/3 of variance in speech measures; believe the remaining variance must be due to central mechanisms (esp. for babble-related and other interference measures and reverb); thus, ability to perceptually segregate one speech signal from another - still a factor in older people when auditory sensitivity is controlled.	
8c	Divenyi, P., & Haupt, K.M. (1997). Audiological correlates of speech understanding deficits in elderly listeners with mild-to--moderate hearing loss. III. Factor representation. Ear and Hearing, 18(3) 189-201.	Same as 8a	same as 8a with control group	PCA extracted 6 factors, with the largest factor intepreted as speech understanding with interference; 2nd factor is hearing sensitivity (didn't really talk about "age effects" per se)	2nd factor extracted was hearing sensitivity in PCA	not assessed	Didn't specify if subjects were native speakers of English.	re-affirmed importance of evaluating perceptual segregation of simultaneous speech stimuli	
9	Dubno, J.R., Lee, F-S., Matthews, L.J. & Mills, J. H. (1997). Age-related and gender-related changes in monaural speech recognition. J Speech Language Hearing Res, 40, 444-452.	NU6, SSI, R-SPIN; generated PI ?ns for NU6 and SSI; for SSI,-ICM, MCR was 0 dB. SPIN presented in standard mode (+8 dB SNR); derived PB and PB-max, SSI-Max, SPIN-PH, SPIN-PL, and SPIN HFS (% hearing for speech)	n = 129 people with sn hearing loss (55-84 yrs); selected people within 10-year age ranges with equivalent thresholds (55-64, 65-74, 75-84); final sample was 125 people; 250 ears)	found no significant age effects on any of the 6 speech measures, across the 3 elderly age groups; after score and age were adjusted for association with PTA, age effects on speech scores observed for males but not females (Pomax, SSI max, SPIN-PH)	co-varied with the speech measures; hearing loss accounted for largest proportion of variance in speech recognition scores	not assessed	Didn't specify if subjects were native speakers of English.	gender differences noted on decline in speech recognition that were not accounted for by hearing sensitivity.	
10	Jerger, J., & Chmiel, R. (1997) Factor analytic structure of auditory impairment in elderly persons. JAAA, 7, 269-276.	PB-50 word lists, SSI, DSI, at 2-3 SPLs (60, 80, 100); DSI with free report (FR) and directed report (DR)	n = 180 elderly S's > 60 hearings with high-frequency sensitivity loss (at 1, 2, and 4kHz) > 15 dB HL; normal score on MMSE (>24)	1 factor was general speech-understanding ability (word recog in both ears - not strongly related to audibility); other factors - separate ear-specific dichotic performance - interpreted as a central processing factor. No effects of age per se.	2 hearing loss factors accounted for 40% variance in the data (low-frequency sensitivity loss and high-frequency sensitivity loss)	assessed measures of cognitive function but not reported in this study	Didn't specify if subjects were native speakers of English.		
11	Humes, L.E. (2005). Do 'Auditory Processing' Tests Measure Auditory Processing in the Elderly? Ear and Hearing, 26, 109-119.	PI functions, to determine PI-PB rollover, dichotic CVs with 90 ms lag, NU6 at 45% TCR	213 elderly subjects, 60-88 yrs (males and females); bilat, symm sensorineural hearing loss (compared performance to young norms)	older listeners performed much poorer on NU6TC and dichotic CVs than comparative norms (not examined directly, though); Dichotic CV identification age was a second signif predictor variable accounting for performance but multiple correlation was low;	NU6 TC speech scores - accounted for by high-frequency hearing loss (nonverbal IQ also identified but n.s.)	IQ was the first signif predictor variable for dichotic CV perf (although VAF was low);for TC speech - with hearing loss partialled out, increases in age and decreases in IQ associated with decreases in TC speech (associations were weak)	Didn't specify if subjects were native speakers of English.	most subjects showed no PI-PB rollover; results indicate that many measures of auditory processing in the elderly may reflect individual differences in cognitive function - but this needs to be verified with parallel tasks in different modalities	
12	Golding, M., Taylor, A., Cupples, L., & Mitchell, P. (2006). Odds of demonstrating auditory processing abnormality in the average older adult: The Blue Mountains hearing study. Ear and Hearing, 27, 129-138.	Macquarie SSI (MSSI), Macquarie DSI (MDSI)PB scores; derived CAP test outcomes that were + for CAPD: poorer than expected perf for Right MSSI max, Left MSSI Max, Right MDSI, Left MDSI, MDSI Diff score, Right PB - MSSI max, Left PB-MSSI max	n = 1192 participants, 54-99 yrs, PTA < 50 dB HL and no ear asymmetry	effects of age seen for all tests except Rt MDSI score	Did not study hearing loss per se but excluded individuals with >50 dB HL at.5, 1, 2 kHz and any asymmetry in PTA > 30 dB. Did not include a measure of hearing as a factor because subsample had good hearing (PTA< 20 dB HL); also think that results from sentence-based CAP materials are resistant to influence of peripheral hearing loss; outcomes were corrected for hearing loss	screened for MMSE - looked for normal performance > 24); odds of demonstrating CAP abnormality increased by 24% with every 1-unit decrease in MMSE score (thus, strong r between cognition and CAP findings)	possible that high frequency hearing loss could have influenced performance on the speech measures; native language/dialect of participants not specified	recommend testing for CAP abnormality and cognitive screening routinely in auditory assessment of older adults; also observed gender differences in dichotic MDSI test (men higher odds of CAPD than women); also observed ear difference with age effects on dichotic measures seen for LE and less for RE	
13	Vaughan, N., Storzbach, D., & Furukawa, I. (2006). Sequencing versus nonsequencing working memory in understanding of rapid speech by older listeners. JAAA, 17, 506-518.	IEEE sentences and anomalous sentences - time compressed at 0, 40, 50, 60, and 65% (TCR); also conducted extensive neuropsychological battery that included working memory tests, speed-of-processing tests, and tests of attention	n = 176 speakers of American English, 50-75 yrs; hearing thesholds in normal, mild, moderate, or mod-sev range; screened for normal cog function for age	Removed effects of age using ANCOVA; hence, age as a variable was not examined in relation to the speech recognition tests	Did an ANCOVA to remove hearing loss effects, so hearing loss wasn't considered a variable that could influence performance	PCA showed that nonsequential WM accounted for 22.4% of variance in speech scores; Processing Speed accounted for 19.5 % of variance, and sequential WM accounted for 19.2% of variance; after partialing out age - sequential WM had most robust assoc with speech recognition followed by nonsequential WM.		Didn't conduct a multiple regression or factor analyses to examine how much of the variance in TC speech is due to hearing sensitivity, age, and cognition.	

14	Cox, L.C., McCoy, S.L., Tun, P.A., & Wingfield, A. (2008). Monotic auditory processing disorder tests in the older adult population. Journal of the American Academy of Audiology, 19, 293-308.	Low-pass filtered speech (LPFS: cutoff 760 Hz), Q-SIN, SSI-ICM at MCRs of +10, 0, -10 and -20 dB, Time-compressed sentences and words - at 40 and 60% time compression; presentation level did not exceed 80 dB HL	n = 45 older adults: 14 older normal, 15 with high frequency hearing loss, 15 with low and high frequency hearing loss (PTA < 50 dB HL through 4000 Hz); 3 groups similar in cognitive measures	Only TC Speech at 60% in the hearing loss group (hi/low) would be considered + for APD (scores < 2 s.d. from norms); age did not emerge as an imp. factor in APD performance	Hearing was a signif ME for TC sentences and words, LPFS.; in Mult Reg analysis - sp. Frequency hearing measures significantly predicted LPFS, SSI (-10 MCR), TC sent and words (60% TCR); high frequency hearing loss NOT a signif predictor	cognitive measures were negligible in analyses; verbal ability was a significant predictor for TC words only		hearing loss in the speech range played an imp. role in APD performance, but age had little effect; the only speech APD test that was not degraded by peripheral hearing loss was Q-SIN; BUT SSI-ICM, LPFS, and TC sp - influenced by peripheral hearing loss (but mostly when there is hearing loss in low + high frequency range in mild to moderate category)	
15	Gates, G.A., Feeney, M.P., & Mills, D. (2008). Cross-sectional age-changes of hearing in the elderly. Ear and Hearing, 29(6), 865-874.	W-22 at 90 dB HL or max comfort level,SSI-ICM (0 dB MCR), DSI - free report, DDT (Dichotic Digits Test) - free report. SSI, DSI, and DDT presented at 50 dB SL re PTA Tested until asymptotic performance	n = 241 subjects with normal cognitive abilities (based on screen), PTA < 47 dB HL, word rec > 70%	SSI-ICM scores adjusted for PTA declined from .85 to 1.6%/yr depending on ear and gender; DDT showed small age effect after adjustment for PTA in men (RE; -.3/yr) and women (LE; -.92/y)	not examined but adjusted age regressions for PTA	not examined, but S's were screened for cognitive function	doesn't indicate if native language was English	concludes that CAPD dysfunction, beyond changes in peripheral input, is a major component in presbycusis in people > 70 yrs. SSI-ICM showed more rapid decline with age than the two dichotic tests; thus, recommend routine clinical assessment of CAP with SSI-ICM test (but need to have adequate memory)	
16	George A. Gates; Melissa L. Anderson; M. Patrick Feeney; Susan M. McCurry; Eric B. Larson. (2008) Central Auditory Dysfunction in Older Persons With Memory Impairment or Alzheimer Dementia. Arch Otolaryngol Head Neck Surg, 134, 771-777.	CID W-22 at 90 dB HL, SSI-ICM (d dB MCR), DSI, DDT (same as study #15 above)	n = 313 volunteers; 3 groups: controls without memory loss, individuals with mild memory loss without dementia; memory-impaired individuals with dementia; otherwise, criteria are same as in study #15 above (Gates et al., 2008)	two memory groups were older than the control group, hence, age was factored out of analyses	two memory groups had poorer hearing than control group; hence, hearing was factored out of analyses	adjustment for pure tone thresholds and age was used in evaluating group scores; DSI test showed largest difference between the 3 groups controls > mild memory > dementia dementia groups; SSI-ICM showed largest difference between mild memory and dementia groups (SSI may be sensitive to progression in memory impairment)	doesn't indicate if native language was English	findings suggest strong association between memory loss and tests of central auditory function. Not a surprising result given DSI stresses memory and uses free report as the mode of response selection; tests of perception should minimize memory and motor components of the task	
17	Vaughan, N., Storzbach, D., & Furukawa, I. (2008). Investigation of potential cognitive tests for use with older adults in audiology clinics. Journal of the American Academy of Audiology, 19, 533-541.	IEEE sentences and anomalous sentences - TC at 0, 40, 50, 60, and 65% TCR; also conducted extensive neuropsychological battery that included working memory tests, speed of proc tests, and tests of attention; presented at 90 dB SPL	n = 225 native speakers of English, 50-75 yrs, pure tone thresholds in mild range (low frequencies) and moderately-severe range (high frequencies); normal performance on cognitive screening tests	PCA results not adjusted for age showed 3 components: nonsequential WM, sequential WM, and Processing Speed (61% VAF); sentence PCA with 2 sentence types at 50% and 60% TC--> 1 component (80% VAF)	hearing loss + age accounted for 28% of variance in compressed sentence performance	sequential WM - significantly correlated with performance on the compressed sentence tasks; highest r's with compressed speech were for LNS, full-scale IQ and verbal IQ (when controlling for age and hearing loss); approximately 13% of total variance in compressed speech was attributable to cognitive variables, especially LNS		total variance accounted for by age, hearing loss, and cognitive measures was 41.6% (< half of sentence score variance).	
18	Gates GA, Gibbons L, McCurry S, Crane P, Feeney MP, Larson E. (2010). Executive Dysfunction and Presbycusis in Older Persons with and without dementia. Cognitive and Behavioral Neurology, 23, 218-23.	SSI-ICM, DSI free mode, DDT (as described in #15 above)	n = 313 volunteers (71-96 yrs); 3 groups: controls without memory loss, individuals with mild memory loss without dementia; memory-impaired individuals with dementia; otherwise, criteria are same as in study #15 above (Gates et al., 2008)	among control group with normal cognitive function, observed abnormal central auditory results in 40--45%. Reported as controlled, but not assessed as a separate factor.		derived an exec function score from neuropsych tests: trail making, clock drawing, Stroop color and word test; Executive function score was associated with PTA after controlling for sex, age, and educ; Executive function score was significantly associated with all 3 CAP speech tests; Executive function explained worse DSI, and 16% variance of worse DDT (lower for better ear). Trails B was most strongly associated with auditory outcomes		confirm an associate between CAPD in aging and cognition (CAP tests require short-term memory, task-shifting, and attention-to-task); recommend that elderly patients with substantial CAPD be referred for neuropsych eval.	