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## MSHA VOICE SUMMER 2010

### MESSAGE FROM THE EDITOR

*By Nancy Telian, MS, CCC-SLP, Editor, MSHA Voice*

As I sit here in my air-conditioned office, taking refuge from the blistering heat, I occasionally gaze out of the window and reminisce about summers from my childhood. Quick jaunts through the backyard sprinkler, picnic lunches under a shady tree, and marathon trips to Nantasket Beach were all I needed to be happy.

All of this reminiscing brings me to a very important question. How can we, as hard working professionals attempting to balance family and work, bring the "fun factor" back into our lives? One way to do this is to invite humor. MSHA is very fortunate to have John Murphy, past president of MSHA and seasoned speech language pathologist, show us the way. John, along with his wife, Ann, tours the United States speaking at national and state conventions. John and Ann are humor consultants who work with adult groups to relieve stress using humor, play and creative problem solving. In February of 2011, John and Ann, of Humor Talks, will be presenting a MSHA-hosted, interactive seminar on humor where participants will learn not only how to utilize humor when working with clients, but also to help cope with the every day stresses of the workplace. John will be MSHA's spotlighted member for our fall edition. I know you will enjoy reading more about this wonderfully entertaining and motivating individual. Stay tuned for announcements about his upcoming workshop.

The other thing that comes to mind when I think of summer is all of those leisurely hours spent reading books. In summer, these are the books you take to the beach, the pool, or outside on the deck with a glass of iced tea. You rush through whatever task you're doing so that you can secretly sneak in a few more pages. Now think: what would it be like if you didn't have these books in your life? Never mind reading for pleasure; what if you were unable to read, period? Today, 38% of US fourth graders are unable to read at a proficient level. With our expertise in language, whether directly or indirectly, SLPs have a great deal to offer in the area of literacy. In recognition of the important relationship between oral and written language, we have an article in this issue, entitled, *Early Identification of "Red Flags" for Reading Acquisition: Differentiating Dyslexia from Specific Language Impairment*, by Pamela E. Hook, Sasha Yampolsky, and Alyson Rodman. In addition, Dr. Pamela Hook, current President of the Massachusetts Branch of the International Dyslexia Association (MABIDA), and Associate Professor at MGH Institute of Health Professions in the Communication Sciences and Disorders Department, is now collaborating with the executive board of MSHA to offer members of both professional organizations an opportunity to learn collaboratively in the area of literacy. MSHA and MABIDA will be co-sponsoring a two-day Reading with TLC seminar April 8-9, 2011. Workshop participants will learn from the program authors how to utilize their clinical expertise to train phonemic awareness, phonics, and sight words. Please stay tuned for more information on this continuing education event.

So, you're outdoors trying to settle in to your book, but something is nagging at you. Perhaps it's the thought of one of your clients who is not responding to traditional treatment approaches. Is it time to try something new, something alternative that has been shown to help treat clients with this type of disorder? MSHA past president, and owner of Pathways to Healing, Suzanne Ducharme, has submitted a great article about an effective alternative treatment approach. Maybe it's not the therapy techniques, but the service delivery model you're struggling with. In this issue, Deborah Kreiger Rosenzweig writes about her unique clinical experience working with students in a full service charter school. In addition, MSHA board member, audiology liaison, and owner of All Ears Hearing Center, Dr. Deb Dempsey, writes about the use of ear plugs for the prevention of hearing loss. Resources, information on action alerts, and updates from ASHA are also included in this issue. You will also find information in this edition about MSHA's next continuing education event. In a full day presentation on October 16, 2010, Karole Howland, Ph.D., CCC-SLP, will provide a lecture that focuses on developmental changes in executive control throughout childhood and adolescence. Specific information on this seminar is included in this issue. By the way, in order to provide multiple continuing education opportunities, as well as support for their professional organization, the presenters of each of the upcoming seminars listed in this edition are donating their services to MSHA (and MABIDA for the literacy event). Please help us to help you. The members of the executive board hope that you will take advantage of these continuing education opportunities to earn ASHA CEUs, add tools to your repertoire of clinical skills, and network with colleagues, while also financially supporting your state organization.

I look forward to seeing you at the MSHA seminars and I wish you a safe and fun summer!



## **MSHA SECRETARY / TREASURER REPORT**

*By Martha H. Testa, MSHA Secretary-Treasurer*

MSHA has been planning continuing education activities for 2010 and details about these events will be forthcoming as plans are finalized. During the planning it has become evident that the primary audience for the planned continuing education events is school-based clinicians. Consequently, the continuing education interests of other MSHA members have not been addressed so an explanation is in order.

First, MSHA has faced significant financial challenges over the past few years due to declining membership and competition with continuing education, among other reasons. One of MSHA's central goals has been to stabilize its financial situation. To reach that goal all expenses, including costly speaker fees and expensive hotel venues, have been drastically reduced so that MSHA can live within its means.

Secondly, on a very positive note, MSHA has had the extreme good fortune to have qualified and dynamic speakers donate their talent to MSHA. These speaker donations have been in the area of literacy and response to intervention, executive control, and use of humor — all topics of interest to school-based clinicians. These offers have truly been too good to refuse!

In addition, MSHA has also been the recipient of donations (or reduced rates) in the form of space for continuing education events. Again, these offers of space have been very welcome because costs for continuing education events are then able to be reduced. MSHA is very grateful for these generous contributions!

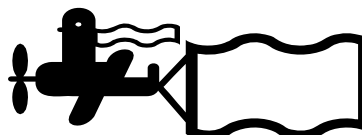
Nevertheless, MSHA strives to represent **all** members -- so where does this leave members who do not work in the schools? Here are some thoughts that come to mind:

- Step forward with speakers who will donate in YOUR area of interest. Contact MSHA at [Education@mshahearsay.org](mailto:Education@mshahearsay.org) if you or someone you know is willing and able to speak on a particular topic.
- Members may also be aware that ASHA is re-organizing the way it manages Special Interest Groups. There are pro's and con's to the proposed revisions, but some members may find that the new MSHA structure complements the Special Interest Group changes. For example, if you choose to opt out of an ASHA group but still maintain an interest in that area you might consider a MSHA task force in that area. Contact MSHA at [Clinicalinfo@mshahearsay.org](mailto:Clinicalinfo@mshahearsay.org) to propose a topic to pursue. Task force involvement can be as short or as long as participants would like it to be. Thank you to former Executive Council members Suzanne Ducharme and Judith Bernier for their efforts to restructure MSHA to allow this type of flexibility.
- Students — What is your area of interest? Have you recently completed research on a particular topic? Feel free to share that information with the membership. Contact MSHA at [msha@camihq.com](mailto:msha@camihq.com) to find out how your article can be published in the VOICE.
- Members outside the greater Boston area--Do you know of any free or reasonably-priced locations that may be suitable for a continuing education event in your area? Contact MSHA at [msha@camihq.com](mailto:msha@camihq.com) to provide details.
- Use technology to our advantage. If you have an interest in a topic it is likely someone else has a similar interest. Use your MSHA membership to connect with others through conference calls or other avenues.

As MSHA tries to re-gain its footing, now is an opportune time to develop a particular interest that can benefit you and your entire state association. Contact MSHA soon to indicate your area of clinical interest and more than likely a way to address that interest can be developed.

**CONTINUING EDUCATION UPDATE**  
By Martha Testa

MSHA is pleased to announce Three Upcoming CEU Events!



**Executive Control**



**Humor in the workplace**



**Literacy**

Save the Date—

**October 16, 2010**

***Developing Executive Control Skills in Children with Language and Learning Disorders***  
*Boston University College of Health and Rehabilitation Sciences at Sargent College*

Karole Howland, Ph.D., CCC-SLP, a Clinical Assistant Professor of Speech, Language and Hearing Sciences at Boston University, will present a lecture that focuses on developmental changes in executive control throughout childhood and adolescence. She will discuss methods to build executive control skills into the regular classroom routine and into speech-language therapy sessions and empower speech-language pathologists to teach an executive skill set that will help children adapt successfully in their learning environments. This lecture is suitable for SLPs, school psychologists, and general and special educators. Please join your colleagues for this informative and relevant event this fall at the Boston University College of Health and Rehabilitation Sciences at Sargent College. Registration information is now available on the MSHA website at [www.mshahearsay.org](http://www.mshahearsay.org). A printable brochure is attached to this newsletter.

**Plans are also underway for two additional MSHA sponsored seminars in early 2011:**

***Humor in the Workplace*** - John Murphy, M.Ed., CCC-SLP, and Ann Murphy will present a workshop in February, 2011 (date and location to be determined) on using humor to cope with daily problems and pressures. They will also provide techniques for utilizing humor, play, and creative problem solving in the workplace with clients.

***Literacy*** - Also, mark your calendars for April 8 and 9, 2011 (location to be determined) when Nancy Telian, MS, CCC-SLP and Penny Castagnozzi, authors of nationally known programs, Lively Letters and Sight Words You Can See, will present a two-day workshop on "Reading with TLC." In this seminar, co-sponsored by MABIDA, participants will learn to simultaneously train phonemic awareness, speech production, and phonics, as well as abstract and irregular sight words, using the RTI model of instruction.

Discounts for MSHA members apply for all seminars so be sure to keep your membership status current.

## FEATURE ARTICLES



### **Early Identification of "Red Flags" for Reading Acquisition: Differentiating Dyslexia from Specific Language Impairment**

*By Pamela E. Hook, Sasha Yampolsky and Alyson Rodman*

Identifying and intervening with young children at risk for reading failure is critical for the development of reading proficiency, particularly reading fluency. While it is sometimes difficult to predict with a high degree of reliability which young children will develop reading difficulties, nearly 75% of poor readers in 2nd grade have an early history of spoken language deficits (Catts, 1999). While parents, teachers, and health professionals can often spot health problems, few are trained to identify the 'red flags' of reading disabilities. This can have far-reaching implications – research indicates that 65% of children at risk for reading difficulties in kindergarten will continue to read with difficulty throughout their school years if they do not receive early and appropriate intervention.

This is not to say of course that older students cannot learn to read accurately with appropriate instruction; however, the lack of early intervention often results in slower, dysfluent reading that continues to hinder efficient reading comprehension in the later grades and as adults.

Some of the most common 'red flags' in young children at risk for reading difficulties are:

- Delays in speaking or understanding language,
- Limited vocabulary,
- Trouble following directions,
- Difficulty with word retrieval,
- Problems sequencing sounds in words,
- Difficulty rhyming words or hearing sounds in words,
- Difficulty learning letter names,
- Recurrent ear infections,
- Family history of reading difficulties.

The reason that all of these are considered to be 'red flags' for reading difficulties lies in the relatively complex relationship between oral language and reading. Although all aspects of oral language influence reading, certain components are more directly related to **word identification** while others are more directly related to **reading comprehension**. Problems related to word identification involve underlying processing disorders such as phonemic awareness, rapid naming and orthographic memory (memory for letter patterns). Those related to reading comprehension involve more general oral language comprehension problems connected to meaning and grammar. These problems can be found in isolation or can overlap creating more complex reading issues. For example, difficulties with word identification will certainly affect comprehension and difficulties with oral language comprehension, such as a limited vocabulary, can affect word identification.

Reading problems primarily related to word identification are often associated with a diagnosis of **dyslexia**. In contrast, reading comprehension issues related to more broadly based language difficulties are often associated with a diagnosis of **specific language impairment (SLI)** in the pre-school years or **language learning disability (LLD)** in the school age years. Although both categories of impairment (dyslexia and

SLI/LLD) involve language processing disorders that affect reading, they should remain distinct because intervention for students with these diagnoses will differ.

Other types of language-related reading difficulties are found in children who have not had environmental opportunities to learn standard English. Children with limited knowledge of standard English may speak a non-standard dialect or speak English as an additional language (English language learners-ELL) or may come from a linguistically impoverished environment and have never been exposed to adequate language input. Although these students would not be considered to have a disability, when confronted with text in school, they may struggle.

Regardless of the cause of the reading difficulties, early identification and intervention is essential. Following are some guidelines for oral language development to help screen for possible 'red flags'. Parents, teachers and health care workers who can recognize the red flags, refer for formal testing, and make arrangements for the necessary intervention are greatly helping young children gain the foundational skills they need to be good readers. Thus, disseminating this information will help to ensure earlier intervention.

Following are milestones that can be used to determine if children are on track for acquisition of phonological awareness and oral language and additionally, therefore, for reading.

**Developmental Milestones for Phonological Awareness Acquisition (more related to word identification and dyslexia)** Adapted from Crumrine (2002)

Pre-school

- o Rhyme: plays with words and nonsense words that rhyme
- o Syllables: implicitly segments words into syllables as in chants and songs, claps to syllables

Kindergarten

- o Rhyme: recognizes, completes, and produces rhyming words
- o Concept of Words: identifies words in a sentence
- o Syllables: blends, segments, counts, and deletes syllables
- o Beginning Sounds: matches and isolates beginning sounds
- o Onset and Rime: blends /t/ + /ake/
- o Phonemes: (2 to 3 sounds) blends and segments

First grade

- o Syllables: deletes final syllable
- o Phonemes: (3 to 5 sounds) blends, segments, deletes initial or final, substitutes phonemes

Second grade

- o Syllables: deletes a medial syllable
- o Phonemes/Blends: (5 to 6 sounds) blends, segments, deletes or substitutes embedded phoneme in a blend

**Developmental Milestones for Oral Language Acquisition (more related to reading comprehension and LLD)** Adapted from Shipley, K. & McAfee, J. (1992).

Ages 2-3

- o Speech is 50% to 75% intelligible
- o Requests items by name
- o Names everyday objects
- o Follows simple directions and answers simple questions
- o Points to pictures in a book when named
- o Asks 1- to 2- word questions
- o Uses 3- to 4- word phrases
- o Understands *why, who, whose, and how many*

Ages 3-4

- o Speech is 80% intelligible
- o Can tell a story

- Engages in long conversations
- Understands differences in meanings (stop-go, in-on)
- Has a sentence length of 4-5 words
- Frequently asks questions
- Begins to follow directions like "put the truck under the table"
- Tells 2 events in chronological order
- Consistently uses regular plurals, possessives, and simple past tense verbs

#### Ages 4-5

- Uses sentences of 4 to 8 words
- Uses grammatically correct sentences
- Pays attention to a story and answers simple questions about it
- Recognizes 1 to 3 colors
- Talks about experiences at school, at friends' homes, etc.
- Accurately relays a long story
- Speech is usually intelligible to strangers
- Answers complex 2-part questions

#### Ages 5-6

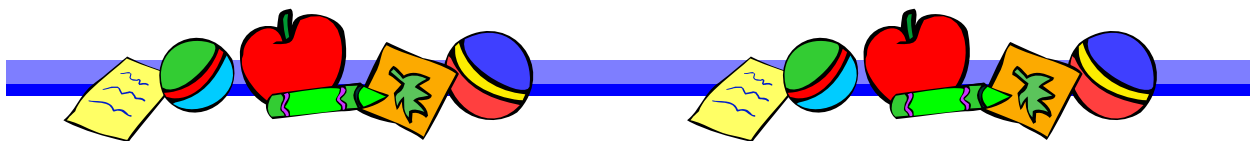
- Names 6 basic colors and 3 basic shapes
- Knows common opposites like "big/little"
- Understands "same" and "different"
- Sequentially names days of the week
- Asks questions for information
- Uses all types of sentences, for example "let's go to the playground *after* we eat"
- Follows 3 part directions
- Uses past and future tense appropriately
- Uses appropriate grammar in most cases
- Accurately relays a story

#### References:

Catts, H. W., & Kahmi, A. G. (Eds.), (1999). *Language and reading disabilities*. Needham Heights, MA: Allyn & Bacon.

Crumrine, L. (2002) Mass. DOE, Baystate Readers Initiative/Phonological Awareness and Phonemic Awareness

Shipley, K. & McAfee, J. (1992). *Assessment in speech-language pathology*. San Diego, CA: Singular Publishing Group, Inc.



#### **Craniosacral Therapy: A New Tool for SLPs**

*by Suzanne M. Ducharme, MS CCC-SLP, MSHA Past President*

As a pediatric SLP in private practice, I work with children who have complex medical issues, and those who have severe speech and language compromise. In many cases, these children are followed by a multitude of medical specialists, and they suffer the ill effects of medications, surgeries and the difficulties of therapy on top of their original illness. Many of these children struggle to participate fully in their treatment because their nervous systems are on high alert, or too sluggish to process information. They are unable to learn new material or retain what they have learned. Many also have challenging behaviors and bodies that betray them.

Most likely, if you are a pediatric clinician, you are familiar with the concepts related to sensory integration. No doubt, you have seen its impact on your treatment, both positively and negatively. I have had the opportunity to work with many wonderful OTs during my career who have taught me a lot about how to parse a child's sensory needs; this information is frequently used to modify treatment, and to navigate a child's changing system moment to moment. However, I needed something more for my kids. I needed to know if there was something that I could do for them, that would actually help them feel better, function better, and get better.

I have found a valuable tool in Craniosacral Therapy, or CST. CST is a gentle, hands-on therapy that works to establish or restore optimal function of the nervous system, and therefore, better function in the body. CST uses force that is equivalent to the weight of a nickel, or about 5 grams. Using this pressure on various parts of the body, "the CST practitioner evaluates the system for ease of motion and the rhythm of the cerebrospinal fluid, or CSF, pulsing within the membranes. Specific treatment techniques are then used to release restrictions in sutures, fascia, membranes and any other tissues that may influence the craniosacral system. The result is an improved internal environment that frees the central nervous system to return to its optimal levels of health and performance." (1)

Beyond this, I have found that one of the biggest benefits to this work is that it quiets the autonomic nervous system (fight or flight) and activates the parasympathetic nervous system (rest and digest.) This alone allows for significant and positive changes to happen. Using the adage that "stressed systems don't strengthen," it makes sense that something that allows us to get to a place of neurological balance would support learning and better cognitive function overall.

As I have gone deeper into this work, and have begun to use it as part of my traditional SLP practice, I have often been asked about the scientific basis of CST. The broad practice of CST was developed by Dr. John Upledger, an osteopath. He expanded the work of those who pioneered cranial osteopathy. A primary focus of Dr. Upledger's work has been to document the scientific basis for what practitioners learn to feel and sense with their hands. He spent many years working with biophysicists and others who could measure physically what was happening in the body as CST was applied. Clinical research is ongoing, and continues to document the many successes of this therapy. Much of his research has been completed with the kinds of patients that we see: children with autism, cerebral palsy and those with strokes, brain injuries and more.

See sidebar for further information.

As a way of illustrating how CST can be helpful to SLPs, I would like to provide a few examples from the literature. Let's take 2 examples of diagnostic groups that we see: children on the autism spectrum, and those with ADHD.

**CST and Autism:** Essentially, medical research has indicated that kids with ASD often show signs of inflammation in the brain and in the body. This inflammation reduces the flexibility of the membrane layers that surround the brain and places a restrictive force on the brain and body. These strains may show up as increased immune response, increased toxicity in the body and endocrine compromise. This cyclical strain reduces the optimal function of the brain and leads to deficits in the autonomic nervous system, reticular activating system and hypothalamus. As we know, these structures play a significant role in the processing of sensory information and in overall arousal and organization. CST enhances the balanced movement of fluids and membranes, and facilitates optimal fluid exchange and waste removal. By cleaning up the nervous system and removing atypical strain patterns, the body functions better. (2) Some positive changes that have been noted include a reduction in self-injurious behaviors, increased control of eye movements, increased vocalization and verbalization, and fewer negative behaviors.

**CST and ADHD:** With ADHD, CST helps to establish and maintain optimal exchange of CSF in the system, which leads to appropriate fluid balance and optimal delivery of nutrients to the brain. For children (or adults) with ADHD, it is thought that they have difficulty in regulating fluid levels and exchange due to structural restrictions in the membrane system or in the cranial base. The cranial base, at the bottom of the occiput, is the location for primary venous drainage of blood, lymph and CSF. If there is restriction in this area, perhaps from birth trauma, it can lead to increased venous pressures and fluid back pressure that compresses the brain. This creates an environment that can result in hypo or hyper functioning of various systems and structures in the brain. CST helps to release restrictions and restore fluid balance; this allows brain activity to normalize and optimize. (3) In my own practice, I have seen that CST helps calm these kids

down, and allows them to focus more easily. In addition, I have seen better processing and expressive output- they have an easier time accessing their language system.

It has taken me several years to integrate this work into my more traditional SLP practice. What I have found is that my kids are getting better, faster. In many cases, they also show positive "side effects" from the treatment, including better sleep, better digestion, fewer ear infections, better attention and better sensory processing. It seems to make them more available for the traditional work that I do, and because their brains are literally functioning better, they also feel better. For anyone reading this with a chronic pain or other condition, you know how much it can distract you during regular activities.

However, CST is not the whole answer. I have found that CST helps set the stage for better processing of all kinds of sensory stimulation. It does not eliminate the need for traditional therapies, nor does it negate the need for medical intervention in some cases. But just as premature infants in the NICU need to be in a quiet alert state to be organized enough to feed, so do our brains need an environment that facilitates rather than interferes with function. CST can provide a more solid foundation on which to place all the effort that goes into traditional SLP treatment, ensuring a better return on that investment.

A few examples from my own practice may help to illustrate how I have been able to use this modality to help a range of kids.

Bob, age 7, is a boy who has been in speech therapy since he was a toddler. He has a history of sensory and speech and language issues, including severe articulation and phonological deficits. He has now improved to the point that he is struggling to master production of /r/. No traditional technique has worked to elicit this sound, despite all efforts. Following discussion with his parents, we decided to try CST before doing our speech work. Evaluation indicated that Bob had compression in the jaw and the vomer bone, as well as imbalances in his maxilla and hyoid muscles. Using gentle hands-on traction and hand placement, these restrictions were released, and Bob was finally able to achieve a correct /r/. It took 3-4 sessions to establish a new motor pattern, and for Bob to retain the new muscle and tissue relationships. He is now working on cleaning up final residual issues and will be discharged from treatment at the end of this month.

Tyler, age 4, has been diagnosed with bilateral vocal polyps. His CST evaluation indicated restrictions in the fascia around his rib cage and significant restriction and strain in his hyoid muscle, jaw and tongue base. Using CST in coordination with voice therapy techniques, he now has better 3D range of motion in his rib cage, resulting in better breath control and less talking on residual air. In addition, he has more balanced hyoid muscle function, which results in less strain, less hoarseness and better modulation of volume and pitch in connected speech.

Amy, age 3, presents with a genetic syndrome and she is nonverbal. She is in constant motion and has a difficult time tolerating stimulation and interaction. She is easily overwhelmed and cries often. She receives a lot of hours of treatment a week, but mom describes them as "hit or miss." When Amy is first brought in, she refuses to get on the table. When she is placed there, she cries and tries to move away. It takes several minutes for her to begin experiencing the light, positive touch of CST. Within 20 minutes or so, she is lying still on the table, getting to a deep state of relaxation. She gets up off the table periodically to move or bounce on a therapy ball. She begins to vocalize more and makes meaningful eye contact. Mom is amazed. As the session progresses, she is able to imitate, engaging in reciprocal babbling. She makes sounds she has never made before. She is interested in play, and connection. This is a whole new place for her to be in.

These are just a few of the examples from the past few years. I have learned that CST has general application to our practice, in that it often addresses the UNDERLYING issues that impact our treatments. It also has specific applications to many areas of our scope of practice, including articulation, feeding/reflux, voice, processing, attention and oral motor issues. CST allows you to directly access cranial nerves, fascial tissue and bones that can directly impinge on the brain and surrounding tissues, degrading function. While research continues to prove the efficacy of this modality, I have SEEN first-hand the benefits. I will continue to integrate this work into my traditional SLP practice when it is indicated.

Suzanne can be reached via e-mail at [SueDucharmeSLP@aol.com](mailto:SueDucharmeSLP@aol.com).

S. S. Speech Pathology Partners and Pathways to Healing  
[www.yourpathwaystohealing.com](http://www.yourpathwaystohealing.com) 781-335-7575

## References:

1. Upledger, J. E. (2008). Craniosacral Therapy: What it is and how it works. North Atlantic Books, Berkeley, CA.
2. Wanveer, T. (2007). "Autism Spectrum Disorders: How CST can help." Massage Today, Volume 7, issue 7.
3. Wanveer, T. (2007). "Helping the Brain Drain: How CST Helps ADD/ADHD." M

## What are some conditions that respond well to CST?

- Headaches/Migraines
- Sinus issues/allergies/Asthma
- Ear infections
- Chronic pain syndromes, and fibromyalgia
- Reproductive system issues
- Reflux and gastric issues
- TMJ disorders
- Depression
- Spinal injuries and back conditions, sacral concussions
- MS
- Autism
- ADHD
- Speech and swallowing disorders
- Thyroid conditions
- Vertigo

## Does ASHA have a position on CST?

ASHA offers CEUs for several of the classes offered through the Upledger Institute, the premier place to get training. Classes are offered throughout the US and the world; they frequently come to MA for beginner level classes.

## Where can I get more information?

You can go to the website for the Upledger Institute, at [www.upledger.com](http://www.upledger.com). On the website, you can find practitioners, search the database of articles and research about CST, and read testimonials from those who have experienced the benefits of CST.

## Do you have to be certified to do CST?

Upledger requires that practitioners have a license that allows them to engage in hands-on work. Certification is offered at both a techniques and diplomate level, but it is not required to do the work.

## Do people have to do CST for a long time to retain the benefits?

No. In many cases, it takes from 1 to several sessions to release the restriction or restore optimal function to the nervous system. Unless something is present that re-creates the original condition, CST is not a long-term therapy. That being said, many people choose to continue receiving it because of its beneficial effects and for its part in stress reduction and pain relief.



## Plugs .....Plugs.....Plugs

### What are we talking about?

By Deborah Dempsey, AuD, CCC-A, FAAA, Doctor of Audiology  
MSHA Audiology Liaison

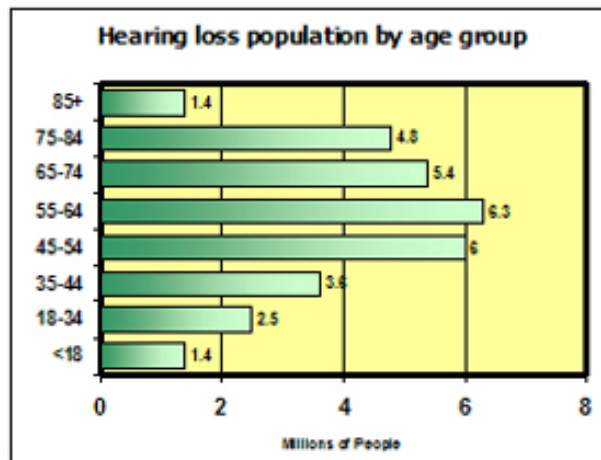
To understand the importance of ear protection we need to know a few facts about hearing loss. A small part of our hearing problems are controlled by our family genetics. BUT there is a large part of hearing loss that is avoidable and YOU can control!

### Prevalence of Hearing Loss

People with hearing loss are often embarrassed because they think that they are different or that they have a rare condition. According to the Better Hearing Institute (Sergei Kochin PhD, Washington DC 2010), estimated that 31.5 million people report a hearing difficulty; that is around 10% of the U.S. population. So if you have a hearing loss, understand that you are not alone. The number of people with hearing loss by age is provided in the graph below.

Here are some general facts regarding the incidence of hearing loss:

- 3 in 10 people over age 60 have hearing loss;
- 1 in 6 baby boomers (ages 41-59), have a hearing problem;
- 1 in 14 Generation Xers (ages 29-40) already have hearing loss;
- 1.4 million children (18 or younger) have hearing problems;
- Hearing loss is the #1 birth defect in the U.S.



### COMMON MYTHS

By Dr. Deborah Dempsey

**Hearing loss affects only "Old People" and is merely a sign of aging.** *Actually it is the reverse of what most people think. The majority (65%) of people with hearing loss are younger than age 65. There are more than six million people in the U.S. between the ages of 18-44 with hearing loss, and nearly one and a half million are school age. Hearing loss affects all age groups.*

**If I had a Hearing Loss my family doctor would have told me.** *Not true! Only 13% of physicians routinely screen for hearing loss during a physical. Since most people with hearing impairment hear well in a quiet environment, like a doctor's office, it can be virtually impossible for your physician to recognize the extent of your problem. Without special training, and an understanding of the nature of hearing loss, it may be difficult for your doctor to even realize that you have a hearing problem.*

### SO WHAT CAN WE DO TO PREVENT HEARING PROBLEMS????

That brings us back to:

**PLUGS ....PLUGS....PLUGS.....!!!**

### What are Decibels???

The average human ear can hear from 0 dBHL (decibels Hearing Level) to 80 dBHL comfortably. Whispered speech is 40dBHL and average speech is 50-65 dBHL. Loud damaging sounds begin at 80dBHL. This level is significant enough to cause hearing loss and destroy the delicate hair cells in the inner ear.



If it "hurts" your ears or you have "ringing" (tinnitus) after noise exposure or you feel "dullness" in your ears after being around loud noise – this is causing damage to your ears! Many sounds around us can exceed this 80dB level. Noises over 80dB include: lawn mowers, leaf blowers, cuisinarts, blenders, loud music from car radios or iPods or MP3 players, target shooting, hunting, chainsaws, any construction equipment.

### WHAT CAN WE DO ABOUT IT?????

**PLUGS....PLUGS.....PLUGS.....**

NOISE EAR PLUGS - block up to 25-30 dB of noise – enough to “protect” your hearing if you are exposed to job related or hobby related noise.

MUSCIAN EAR PLUGS - provide up to 25 dB protection against loud music in bands. These do NOT distort your ability to hear the frequencies and nuances of music.

SWIM PLUGS OR WATER PLUGS – protect against water in the ear canal. People who regularly swim in cold water (such as our Atlantic Ocean waters) develop exostoses of the ear canal. This is a narrowing of the ear canal, which makes it easy for water to be trapped and cause infections (swimmers ear) in the canal.

IMPORTANT TO REMEMBER!!!!

Ear protection is made from soft comfortable plastics. Soft plastics form a better “seal” in the ear (better protection) and are comfortable to wear for long periods of time. HOWEVER, our body chemicals will eventually break down the plastic and the ear protection will be less and less.

If you have any type of ear protection – it’s important to “verify” the fit to your ear – to make sure that you are getting enough protection. This is easily done in 10-15 minutes in the office. This should be done at least every year or two. The more you wear your ear protection the more frequently you need to verify its effectiveness in your ears.

Dr. Deborah Dempsey can be reached at **All Ears Hearing Center**  
[www.allearshearing.net](http://www.allearshearing.net) 508-747-4055 (work) deb@allearshearing.net

### **The Full-Service SLP**

*By Deborah Kreiger Rosenzweig, MS, CCC-SLP*

Neighborhood House Charter School is a full-service charter school in Dorchester, MA for grades K1 (pre-K)-8<sup>th</sup>. I am the speech-language pathologist there. Being a full-service school ensures that our students have the support they need to learn, grow and be successful in school. These services allow me to target speech and language objectives, but also go to doctor appointments with my students, follow-up about hearing screenings done at the school, be in constant contact with the after school program, and have lengthy conversations with our on-site high school placement coordinator about the type of services my students may need moving forward and the type of school that may be a good fit.

My days are not simply strings of services based solely on Individual Education Plans (IEP) objectives. More often, my days also include conversations with all stake holders for every child on my caseload. For the past 3 years I have made it a personal goal of mine to reach out to families and share with them the small triumphs. Quarterly progress notes and annual IEP meetings hardly do justice for a student for whom achieving their goals is a constant, uphill battle.

I often ask my students if they know that there are people in the building who care about them and that they can go to if something is wrong. It warms my heart every time a child answers with a list of four or five staff members at school. It is not everyday that a middle school student feels like they can confide in an adult. NHCS is truly a special place, for it fosters those relationships. It realizes that behavior management, high academic expectations, and homework completion all become easier if there is a strong sense of rapport between the teachers and the students.

Working in this environment has taught me that students tend to make more progress when all stake holders are involved and invested. By reaching out to parents, training teachers and staff, and being honest with the students about their needs I have been able to push students to be there best in speech and language sessions, in the classroom and as citizens. I am a better SLP for this experience and my students have grown more because of this set-up. The full-service model works, and if there is any room for you to adapt some of the principals within your professional environment I would encourage you to do so.

Have a great summer and keep this in mind for next year!



## UPDATES

### **New Information - Parkinson's Disease People with Parkinson's Disease Able to Reclaim Voices** (Reprinted from Northwest Parkinson's Foundation)

Bob Travis opens his mouth and says "aaaaaaaah." His voice sounds normal to him. But his voice as heard on a video recording is slightly more than audible. Travis has Parkinson's disease, and like about 90 percent of those with the condition, he literally has trouble being heard. So he came to the department of speech, language and hearing science at the University of Colorado at Boulder for speech therapy. In jest, he said his wife needed a hearing aid. In truth, he had noticed his vocal power fading.

A month after the initial therapy session, Travis appeared in a post-treatment video. Again asked to say "aaaaaah," his voice veritably booms, loud and robust. Of his wife, he says, "She no longer needs a hearing aid. "Travis has just finished speech therapy developed by Lorraine Ramig, CU professor of speech, language and hearing science.

Like many clients who undergo the four-week program, Travis is better able to participate in everyday activities, like answering the telephone or joining a dinner conversation. As many as 1 million people in the United States have Parkinson's, the Parkinson's Disease Foundation estimates. In addition to problems with movement and stiffness, about 90 percent have voice problems, Ramig says. But only a very few receive vocal therapy that has been proved to be effective.

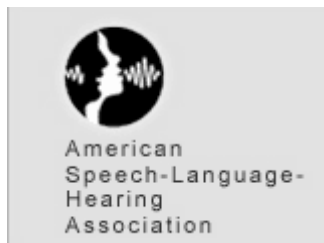
"As a faculty member, it's wonderful, thrilling and all of that to do the science, but what's also exciting is seeing the application of discovery in real patients," Ramig observes. People with Parkinson's have a diminished sense of how loudly they speak. If they think they are attaining a normal volume, they may be hard to hear. But if they think they are shouting, they are probably speaking in conversational tones.

The treatment, called Lee Silverman Voice Treatment, dates to 1983, when a colleague asked Ramig for help crafting speech therapy for Parkinson's patients. She met the family of Silverman, who was living in Arizona. Their wish: "If we could only hear and understand her." Ramig and a student from CU-Boulder set out to develop a treatment protocol, but, "When we began, neurologists said speech therapy doesn't work, and it didn't."

Ramig and her collaborator focused on a high-effort vocal-exercise program -- an hour a day in treatment sessions plus homework -- that proved to be effective. Multiple studies since then have confirmed LSVT LOUD, now a registered trademark of LSVT Global Inc., to be effective. Today LSVT LOUD is being delivered by LSVT-certified clinicians in more than 40 countries.

The essence of the treatment is to get patients to use that "loud" voice as their own voice, and to cue them to know that the voice they think is loud is the right voice.

## UPDATES FROM ASHA



### **ASHA Action Alert: Include SLPs in the LEARN Act Improve Literacy Instruction**

Please ask your members of Congress to include speech-language pathologists as recognized providers of service under any new federal comprehensive literacy legislation. The Literacy Education for All, Results for the Nation (LEARN) Act, H.R. 4037 and S. 2740, was introduced by Congressman John Yarmuth (D-KY) in the House and Senator Patty Murray (D-WA) in the Senate.

These bills have been identified as the starting point for literacy provisions related to the reauthorization of the Elementary and Secondary Education Act (ESEA), however, they do not reflect the integral role that speech-language pathologists play in improving language and literacy skills in children.



For additional information, contact Neil Snyder, ASHA's Director of Federal Advocacy, at 202-624-7750 or [nsnyder@asha.org](mailto:nsnyder@asha.org). Go to this link to obtain the "Take Action" information you need. <http://takeaction.asha.org/asha2/issues/alert/?alertid=14951446>

### **ASHA Action Alert: Temporary Fix Signed Into Law**

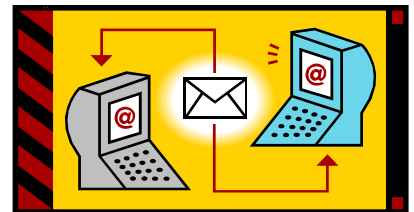
President Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010." This law establishes a 2.2% update to the Medicare Physician Fee Schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010. The legislation was passed in the Senate on June 18 by a unanimous voice vote; House legislation passed by a vote of 417-1.

A 21.2% payment reduction took effect in June, and the Centers for Medicare and Medicaid Services (CMS) has directed its contractors to discontinue processing claims at this rate and to temporarily hold claims for services rendered on or after June 1, 2010 until the new 2.2% update is tested by the contractors. CMS and the contractors are currently working to ensure appropriate implementation of the 2.2% update and it is anticipated that claims will be processed at the new rate no later than July 1.

For additional information regarding congressional action on this issue, please contact Ingrida Lusic, ASHA's director of federal and political affairs, at [ilusic@asha.org](mailto:ilusic@asha.org). For information regarding CMS claims processing, contact [reimbursement@asha.org](mailto:reimbursement@asha.org).

### **New Interprofessional Professionalism Collaborative (IPC) Web site**

ASHA is a member of the Interprofessional Professionalism Collaborative (IPC), a group comprised of representatives from a variety of healthcare professions. The objective of this group is to collaboratively develop a mechanism to measure interprofessional professionalism among students and professionals in the context of interprofessional education and healthcare service delivery. The IPC has compiled key resources and research from the different professions, identified and defined terms associated with professionalism applicable to all involved professions, and identified a series of steps and initiatives that could lead to the collaborative development of a mechanism to measure interprofessional professionalism. A Website was recently developed to further communications about the work achieved to date by the IPC and to provide an opportunity for interested stakeholders to contact this group.



Please visit the Interprofessional Professionalism Collaborative (IPC) Website at <http://interprofessionalprofessionalism.weebly.com/index.html>. To learn more about the group or to contact the group, select the Contact Us tab on the Website menu bar. To speak with an ASHA representative about the work of the IPC, contact Loretta Nunez, ASHA's Director of Academic Affairs, at [lnunez@asha.org](mailto:lnunez@asha.org).

### **ED Launches New Web Site**

The U.S. Department of Education (ED) has launched a new Web site, [www.data.ed.gov](http://www.data.ed.gov), which will increase access to education data. The site will ultimately serve as a one-stop shop where practitioners, researchers, and the public can access information about ED grant programs. Through the Web site and other initiatives, the Department aims to make the grantmaking process more transparent to the public by providing easily accessible data about applications as well as applicants and their partners while protecting applicants' privacy and proprietary information. Data.ed.gov is designed to be more user-friendly than traditional data sites by providing tools that allow users to visualize the data. This is a pilot effort, and the Department welcomes feedback on the site and plans to make improvements over time. For more information visit the site at [the new Web site](http://www.data.ed.gov) or contact Catherine D. Clarke, ASHA's Director of Education and Regulatory Advocacy, via e-mail at [cclarke@asha.org](mailto:cclarke@asha.org) or by phone at 800-498-2071, ext. 5611.

### **From ASHA Website- Section on Multicultural Affairs and Resources**

**Phonemic Inventories Across Languages** "Languages across the world have unique phonemic systems. For individuals learning English as a second language, it is common for the phonemic system of their first language to influence the production of sounds in English. ASHA's policy documents state that SLPs and audiologists must consider the sound systems of all the languages used by a client in order to provide

appropriate assessment and treatment services." ASHA's Office of Multicultural Affairs has compiled information on the phonemic systems for the following languages:

ASHA's Office of Multicultural Affairs has compiled information on the phonemic systems for the following languages.

- [Arabic Phonemic Inventory](#) [PDF]
- [Cantonese Phonemic Inventory](#) [PDF]
- [English Phonemic Inventory](#) [PDF]
- [Korean Phonemic Inventory](#) [PDF]
- [Mandarin Phonemic Inventory](#) [PDF]
- [Spanish Phonemic Inventory](#) [PDF]
- [Vietnamese Phonemic Inventory](#) [PDF]

**Speech-language pathologists** can use this information to:

- Identify sounds in a client's phonological system for languages other than English.
- Determine phonemic influences of a client's native language on English.
- Identify sounds from the client's first language that may not exist in English or identify sounds in English that do not exist in someone's native language.
- Recognize that even if there are similar sounds across two languages, they may not be used the same way. For example, in some languages a sound may only be used at the ends of words and not as a word-initial sound.

**Audiologists** can use this information to:

- Correlate the client's audiogram and the sounds of the client's language(s).
- Recognize and respond to amplification needs.
- Identify the affect of the individual's phonemic system on speech audiometry assessment.
- Modify materials and procedures during speech audiometry assessment.



### **A Free Resource – Therapy Library**

Therapy Library ([www.therapylibrary.com](http://www.therapylibrary.com)) is a website that provides FREE illustrated patient education materials in the fields of occupational therapy, physical therapy, and speech-language pathology. The handouts can be easily printed and given to patients or clients. They can also be used as instructional material in the classroom or clinical setting.

## **IMMEDIATE ATTENTION NEEDED**

### **Regarding Adoption of ANSI/ASA Classroom Acoustics Standards**

The following message was forwarded by: Kym Myer, [Kym\\_Meyer@tlcdeaf.org](mailto:Kym_Meyer@tlcdeaf.org)

"I am forwarding this from the Educational Audiology Association. Please do two things: 1. write a letter as requested below. and 2. pass along to parents of children with hearing loss so they might write their own letter.

*Thank you for supporting students with hearing loss in schools." ...Kym"*

The Architectural and Transportation Barriers Compliance Board (Access Board) received a petition in 1997 from a parent of a child with hearing loss, alleging that poor classroom acoustics constituted an architectural barrier to their child's educational opportunities. The petition further stated that students with learning, developmental, auditory processing, speech, and language disabilities also were at a high risk for learning deficits. After reviewing information and evidence on classroom acoustics provided by many professional organizations and advocates, the Access Board determined that the acoustical environment is a key factor

contributing to student learning and those acoustical barriers should be addressed in the classroom design phase. Under the leadership of the Access Board and the Acoustical Society of America, a Classroom Acoustics Working Group was established to develop a classroom acoustics standard. The standard, ANSI/ASA S12.60-2002, Acoustical Performance Criteria, Design Requirements and Guidelines, was developed by representatives from architectural firms, school facilities personnel, heating- ventilation-air conditioning experts, professional audiology organizations, and other advocacy group stakeholders. The standard was adopted on June 26, 2002.

In order to have greater impact on all students, the Access Board deferred to the Acoustical Society of America to submit the standard to the International Code Council (ICC) for inclusion in the international building codes (IBC). Here the standard would have a focus of creating better listening environments for all students rather than being focused on accessibility for students with hearing disabilities. In May of this year, eight years after completion and 13 years since the petition was received by the Access Board, the ICC voted against adoption of the standard.

Parents and professionals alike are outraged at the amount of time that has passed. We have lost a generation of students who could have benefited from better classroom acoustical conditions. The cost to design and build to the acoustical standard is minimal compared with the cost to retrofit a building after completion. This is a civil rights issue.

Please send a brief letter addressed to David Capozzi, Access Board Executive Director, requesting that the Board undertake rulemaking for classroom acoustics and adopt the ANSI/ASA standards as part of the Americans with Disabilities Act Accessibility Guidelines. Please send your brief letter prior to July 25 to arrive in time for their next meeting. Your brief letter should include the following talking points:

Appropriate classroom acoustics are necessary for children to access instruction and communication in classrooms at school. This means hearing and understanding what the teacher and all students in the classroom are saying.

Current ANSI/ASA Standards for Classroom Acoustics need to be adopted as part of Americans with Disabilities Act Accessibility Guidelines.

Please send your letters to:  
David Capozzi, Executive Director  
U.S. Access Board  
1331 F St. NW, Suite 1000  
Washington, DC 20004

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<a href="http://www.MSHAHearSay.org">www.MSHAHearSay.org</a>		
Continuing Education program information is posted free of charge on the MSHA website at <a href="http://www.mshahearsay.org/upcomingevents.html">http://www.mshahearsay.org/upcomingevents.html</a>  (content may be edited for length)		Free
Web advertisements are offered to members at a reduced cost		\$125.00/month
<b>The VOICE</b>		
Do you have information to share about a program, project, resource or issue that is important to you? Write an article for the VOICE. All submissions are reviewed by The VOICE editor		Free
The VOICE offers advertising opportunities at a reduced cost		
Full page:	1 issue	\$312.50
	4 issues	\$1125.00
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	4 issues	\$675.00
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	4 issues	\$450.00
Business card:	1 issue	\$25.00
	4 issues	\$90.00
<b>Email Flash</b>		
Reach the MSHA members via email. The MSHA office will send your email announcing a continuing education program or other non job posting content.		\$75.00
<b>Labels</b>		
A set of MSHA membership labels is available for one-time use.		\$75.00
<b>Job Postings with Job Target</b>		
Receive discounted rates on all Job Target products and services. For more information, go the MSHA website, <a href="http://www.mshahearsay.org">www.mshahearsay.org</a> , and click on the Job Opportunities button.		

Don't forget...you can use your \$5.00 membership coupon on any of the programs listed above except the job postings.



**MSHA**  
**411 Waverley Oaks Road,**  
**Suite 331B**  
**Waltham, MA 02452**  
**781-647-7031**  
[msha@camihq.com](mailto:msha@camihq.com)



The Massachusetts Speech-Language-Hearing Association is approved by the Continuing Education Board of the American Speech-Language-Hearing Association (ASHA) to provide continuing education activities in speech-language pathology and audiology. See course information for number of ASHA CEUs, instructional level and content area. ASHA CE Provider approval does not imply endorsement of course content, specific products or clinical procedures.

## Developing Executive Control Skills in Children with Language and Learning Disorders

Karole Howland, Ph.D, CCC-SLP

Boston University, Sargent College of Health and Rehabilitation Services

635 Commonwealth Avenue, Boston, MA 02215

Saturday, October 16, 2010

8:30am – 3:00pm

This workshop is offered for .5 CEUs, Intermediate level, professional area

### Presentation Summary

This seminar will focus on developmental changes in ECP throughout childhood and adolescence. The presenter will describe ECP, particularly focusing on developmental stages in acquiring inhibition, planning, working memory, sustained attention, and self regulation abilities. Each of these skills will be related to speech-language development, academic learning and social cognition. The presenter will review evidence that development of ECP is not governed solely by neurocognitive maturation, but also is influenced by experience, environmental expectations, and most importantly for our purposes, specific skill training. Methods to build executive control skills into the regular classroom routine and into speech-language therapy sessions will be presented. A particular emphasis will be placed on re-framing our understanding of “behavior problems”, “attentional problems” and “emotional problems” in children. Rather than focusing on behavior management strategies, the seminar will empower SLPs to teach an executive skill set that will help these children adapt successfully to their current and future learning environments.

### Schedule

8:00am	Registration / Continental Breakfast
8:30-10:00	What are executive control processes and what are all those neuropsychological tests really asking the child to do? What happens when executive control breaks down? ADHD and executive control disorders: What is the overlap and what are the differences between the two?
10:00-10:15	Break
10:15-11:45	Developmental stages in executive control. The relationship of executive control and social information processing in typically developing children and those with ASD. Analyzing language samples to identify vulnerabilities in ECP: Is the problem about language, organization or both?
11:45-1:00	Lunch on your own
1:00-3:00	Developmentally appropriate methods and strategies to improve executive control skills across the grades.

### Learner Outcomes

1. Participants will describe the stages in the development of executive control skills, including: inhibition, planning and working memory.
2. Participants will identify formal and informal methods of assessing executive control skills, particularly in the context of language sample analysis.
3. Participants will explain the relationship between executive control skills, social cognition, and academic success.
4. Participants will build executive control development into their speech-language therapy sessions and their pragmatic groups.
5. Participants will educate classroom teachers about the influence of executive control skills on academic performance.
6. Participants will support classroom teachers in building executive control training into the curriculum at each grade level.



Developing Executive Control Skills in Children with Language and Learning Disorders

Registration

Check one:

- Member registration \$125 \*
Discount Code
Non-member registration \$150
Payment received before September 30
Non-member registration \$160
Payment received after September 30
Student-member registration \$20
Free if you volunteer to help with the program. Call 781-647-7031 for details.

Payment Method:

- Check enclosed
P.O.#
Charge my Visa / Master Card (circle one)

Card Number

Exp. date: CVV Code:

Signature:

Name

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\*Enter the MSHA Member discount code to receive a \$5.00 discount.

Return registration form and payment to: MSHA
411 Waverley Oaks Road, Suite 331B
Waltham, MA 02452
Fax: 781-647-7222
Email: msha@camihq.com

Cancellation policy: cancellations must be received in writing before Friday, October 8, 2010. Cancellations after the cancellation date, or not submitted in writing will be subject to full billing.