

Newsletter

Innovative Therapy Services

**Volume1
Letter 9**

*Expect the Best in Learning Speech,
Language and Social Communication*

May, 2011

MISSION

To teach meaningful, fun and well designed practical speech therapy

BELIEVE

We believe in respecting each child's individuality

RESULTS

We are responsible to our clients and their families in making sure they use the skills we teach in the community

EXPECTATIONS

We provide the best possible experiences to our clients through compassionate teaching



When is it not just speech delays?

In this month's news article I decided to tackle a topic that has began gaining momentum at the national level. Apraxia of Speech, Childhood Apraxia of Speech (CAS), Speech Motor Apraxia. If

the word is confusing to you, please do not be surprised! It is confusing to most people, even in the field of Speech Pathology. I picked this topic, because so many children with "apraxia," are missed or mislabeled. The mislabeling is not because the clinician or therapist does not know what apraxia is, but because children with apraxia symptoms are different, depending on how organized their motor planning system functions from day to day. It is easy to mislabel a child with apraxia, especially if you have only an hour to see and assess the child, more so if the child is verbal. I will begin with some sample cases:

Case 1:Jonah age 9

Jonah came to our clinic at age 9 for simple speech sound errors. His mother stated that he had problems with /s/ and /r/ sounds. Jonah was brought to me, because it was beginning to bother him

ABOUT OUR SUMMER CAMPS

LEVEL 1A



For students ages 3-5. The concept is to pair a child with pragmatic language delays with normal typical age peers, with clearly defined objectives. I find that between ages 3-5 the language style and expectations are similar.



that his friends said he sounded different. I could tell there was more to Jonah's problem, because he was just a little clumsier than other boys his age. When he got excited he talked as if he was swallowing his words. From the parent questionnaire I quickly noted that as an infant Jonah had feeding problems, did not quickly transition to solids and also was a very picky eater. However, the feeding issues went away, and now Jonah will eat almost anything as long as he can add lots of salt or pepper.

*Furthermore, his developmental milestones were significant in the area of acquiring speech. Jonah did not coo or babble. He was generally a very quiet baby. However, by 16 months he started "jargoning" and then using some true words. He eventually used sentences by 3, but few people truly understood him (mom, dad, his older brother). His parents were advised that boys typically are not "great talkers." Jonah finally started sounding clearer by the time he was five, but his parents still had a funny feeling about his speech so they took Jonah to their local school district for an assessment. Jonah passed the assessment as he could say most of the words, on the speech test, even though he sounded a little funny. According to the report he passed the assessment, because he did not meet the criteria for intervention. **Let's look closely at***

Jonah :

History:

- Jonah had a history of feeding issues (**not all CAS will necessary have feeding issues**)
- He did not coo or babble (quiet baby)
- Late speech acquisition
- Problem with /r/ and /s/ sounds
- Poor coordination
- Problem with prosody (*talks as if he is swallowing his words*)

Assessment results:

Oral Motor Test:

- Problems coordination and sequencing of muscle movements for speech
- His **diadochokinetic rate:** In these tasks the child has to repeat strings of sounds (e.g., puh-tuh-kuh) as fast as possible in specified time limit. Then the number of repetition is compared to a normed standard for the age group and sex. In Jonah's case his repetitions were much slower than that of typical boys his age. As a matter of fact, the longer he had to say the different sets and sequence of sounds, the more Jonah began slurping, dropping and switching sounds, and sounding as if he was

LEVEL 1B, 1B+

- Building Friendships: We



exciting time using language playing with our friends and sharing ideas.

- *We also enjoy bringing things from home to share with our friends.*
- *Problem Solving: We learn to use our words and phrases to problem solve conflicts with our friends.*
- *Body Language: We learn to listen to our friends' emotions, personal space, and we learn to tell our friends about our personal space and share our feelings.*
- *Conversations: We learn how to talk about things we like and learn to listen to our friends. Then we ask our friends questions about things they like when they talk to us.*

LEVEL 2

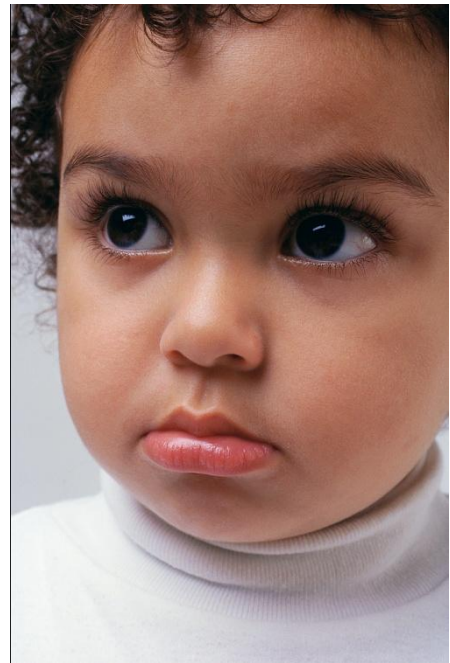
swallowing his words.

Speech Tasks Test:

- He had problems appropriately stressing syllables in words.
- To produce clear sentences, he completely slowed down his speech rate.
- His vowels were distorted at complex sentence level.

Fluency, Pitch and Rate Tasks:

- His fluency was normal (no stuttering)
- Problems with varying his pitch, either high pitch when asking a question or monotone.
- To control his clear speech, Jonah slows down, and often holds his breath between words, making him sound as if he is swallowing his words.



Case 2: Molly age 3 Childhood Apraxia of Speech (CAS)

Molly, age 3, was brought to our clinic because she was not consistently talking. According to her parents, Molly can sometimes say a word and then it appears as if she has forgotten how to say the word. Molly was born 8 weeks premature. Her Apgar score was 7 at 1 minute and 8 at 5 minutes. At the end of delivery, it was noted there was a partial placental abruption. She was in the NICU for two weeks due to respiratory difficulty. At the NICU, Molly was given a bilirubin test, and phototherapy because of jaundice. Following discharge she did not appear to have further medical complications. However, mother reported that Molly had difficulty feeding (latching on). At six months she had difficulty transition to solids. While she continued to gain weight, mother reported continuous feeding difficulties up to date. She was reported as a picky eater and preferred sour (lemon, lime) or very crunchy foods.

Molly did not have problems developing gross motor skills. As a matter of fact she was quite early with those skills. However, mother noted problems not being able to handle loud noises, light touches, teeth brushing. She also reported that as an infant Molly cooed, but would not coo-back and forth, just watched when mother cooed to her. She also reported very limited babbling. However she used lots of gestures and signs early on, since she

- **Friendships:** We discuss social expectations of friendships. We define the different levels of friendships (acquaintances, casual friends, best friends etc).
- **Body Language:** We teach body language through the concept of **non-verbal social cues.** We incorporate activities that encourage active listening and body language.
- **Conversations:** We teach how to show interest in other people's conversation, and how to shift topics.
- **Problem Solving:** We provide the students strategies to effectively get their points across and we also work on applying critical and divergent reasoning in an effective functional way.

LEVEL 3



For students ages 10 to 15

- The students engage in social community activities such as raising money for their fieldtrip.

could not talk. At age 3 Molly had only 11 true words, with significant jargon speech. When asked to imitate lip and tongue movements, her movements were uncoordinated and inconsistent (in terms of number of sequence). Molly was not able to consistently imitate words or sequence sounds. She continuously chewed on her sleeve, especially during the speech motor tasks. When asked to draw a picture, her pencil grip was quite tight and she her tongue protruded one side, as Molly concentrated very hard. Her picture was spectacular, and she is known as a little artist at home. However, I noted as soon as she was done with the art, she became unusually active, jumping on and bumping against my couch, then she seemed to quiet down (appeared fatigued).

Let's now look closely at Molly,

History:

- Molly had complicated birth, which puts her right away at a greater risk for possible neuro-developmental disabilities. The pediatrician may not have referred her for early intervention, as Molly was on track for weight to height ratio.
- She did not develop speech skills in the manner that is expected for all kids.
- Difficulty with imitation of speech tasks (as an infant)
- Feeding issues (not yet resolved)
- Sensory issues (bumping against the couch)

Assessment results:

Oral Motor Test:

- Was able to imitate lip and tongue movements, but groped at times
- During sequencing of the lip and tongue movement tasks, she just watched for about 3 minutes, it almost seemed as if she would not do it, then she got up, paced, came back and sat close to me and performed all of the three movements precisely (***needed time to plan, need gross movement to help her organize***)

Speech Tasks Test:

- Severe vowel and consonant distortions
- Pronounces each sound in different ways (does not have a pattern)
- Sometimes is very clear on imitation tasks, but could not consistently imitate the same tasks for more than two repetitions.
- Intelligibility was judged poor, except on familiar words

Fluency, Pitch and Rate Tasks:

- Does not have enough sentences to look at stuttering
- Problems with varying her pitch,
- To control her speech, stops and thinks, or paces.

According to American Speech-Language-Hearing Association (ASHA)

"Childhood Apraxia of Speech (CAS) is a neurological

Activities could be photography work, car wash, bake sale etc., based on what the students in the group choose as their theme.

- Understanding of the “**Unspoken Social Rules**, para-verbal and non-verbal skills, and increase “**Social Self Monitoring (SSM)**”. We encourage the students to apply **Reflective Reasoning, (RR)**
- **Conversations!** We use strategies to encourage participants to use language to initiate conversations, resolve conflicts, understand teasing behaviors in peer relationships. We encourage the participants to use language to alter their peer’s position about a problem.

Our All For 3’s Club Final Weeks!!

All 3’s Tots Club



Ages: 18 months to 2 ½ years

Club Goals

Tiny Talkers

Gestures, signing, using words, listening

Monkey See Monkey Do

Imitation, joint attention, following directions, facial recognition

Body Actions

Referencing, social play, modeling

Limited to 3 kids

All 3’s Penguins

childhood (pediatric) speech sound disorder in which the precision and consistency of movements underlying speech are impaired in the absence of neuromuscular deficits (e.g., abnormal reflexes, abnormal tone). CAS may occur as a result of known neurological impairment, in association with complex neurobehavioral disorders of known or unknown origin, or as an idiopathic neurogenic speech sound disorder. The core impairment in planning and/or programming spatiotemporal parameters of movement sequences results in errors in speech sound production and prosody.

What do parents need to know?

It is easy to overlook motor planning because of the complexity of how our speech motor system works. Especially if the child can sometimes say the words clearly and repeat some phrases on command. A diagnosis of CAS is the first step for any parent. However, the treatment for CAS is also as complex as just getting the diagnosis. Having worked with children with varying degrees of CAS, I have the greatest respect for the children and their families, as they face the complex tasks of explaining the speech difficulty daily. Imagine having your child say a word to you, and then a minute later, be unable to say the word the same way. Having to deal with this day in and day out can be very frustrating.

Parents must be the child’s number one advocate. The first step is to understand the different treatment options for CAS. I always start with giving the child the basic principal of communication, which is a means to getting your needs and wants met. Augmentative Alternative Communication (AAC) is often a great starting point for kids with very complex motor system deficits. This could mean use of signs, signs and pictures, a communication deviceuntil such a time when your child’s speech becomes fully developed. If your child has few clear words, look at using signs or pictures to communicate. It will reduce frustration and may enhance the motor system, because it will help the child create consistency. The general treatment for CAS includes motor mouth exercises and use of tactile cues to rebuild or maintain consistency of speech production. The therapist may start using some cue cards and as well as speech cues such as: PROMPT, Visual Phonics, Cued Speech, etc.

I always tell parents that this treatment process is like learning to run a marathon. Running a marathon requires multiple levels of training. “In CAS, the planning and/or preprogramming necessary for the speech “routine” is a core deficit, likely resulting in a lack of generalization of repetitive movements to longer utterances.”

For a child like Molly, therapy should start with increasing powerful tools or “Power Words,” Whenever possible, treatment goals should target words that mean something to the child, not random speech card exercises, as the child will not be motivated to use them in everyday



Ages: 3 to 4+

Club Goals

Talking, Taking Turns

Conversations- chipper chatter, sharing, following, transitioning

Playing, Sharing

Imitation, joint attention, social independence, pretend play, problem solving, transitioning

Body Actions

Referencing, following directions, modeling, social cues, body language

Limited to 3 kids

All 3's Sharks



Ages: 4 to 5

Club Goals

Talking, Taking Turns

Conversations- chipper chatter, sharing, following and taking leadership, transitioning

Playing, Sharing

Imitation, joint attention, social independence, pretend play,

situations. Later on in treatment, the therapist should use the speech cards to create precise clear speech.

At home follow the steps below (for younger children or severe CAS):

1. Reduce frustration, by having pictures of things the child knows and want in a book.
2. Allow the child to show you by pointing out things, instead of attempting to get the child to talk.
3. Read simple books that the child likes and have the child watch and clap to the rhythm of how you say the words.

For a child like Jonah: It is best to get ideas and tips from the speech pathologists, as the speech pathologist understands the sensitivity that Jonah may have regarding people correcting his speech. For more information about CAS, visit the following websites: www.asha.org, www.apraxia-kids.org, www.nidcd.nih.gov/health/voice/apraxia.htm

References

American Speech-Language-Hearing Association. (2007a). *Childhood Apraxia of Speech [Position Statement]*. Available from <http://www.asha.org/docs/html/PS2007-00277.html>.

American Speech-Language-Hearing Association. (2007b). *Childhood Apraxia of Speech [Technical Report]*. Available from <http://www.asha.org/docs/html/TR2007-00278.html>.

Up Coming Father's Day Creativity Contest



To celebrate Father's Day we are having a poetry contest. Submit your special child's Father's Day poetry, drawings, or creative art work. Participants must be ages 6 to 8 and diagnosed with a speech or language disorder. One winner will be chosen from each age group. The winner will receive a free speech or language therapy session. The winner's work will be featured in our newsletter next month. Please contact our office for more information on

**imagination, problem solving,
transitioning**

Body Actions

**Referencing, following directions,
modeling, social cues, body
language**

Limited to 3 kids

**~Join Us Again In the Fall,
2011~**

how to enter this contest: ussom@pediatricspeech.com



We invite you to enroll your student at ITS in our 8-week Summer 2011 Social Skills Program. We offer exciting activities for boys and girls that will enhance their ability to build friendships, improve on conversations, and socialize in day to day situations. We make our programs practical, natural, and fun by engaging the children in field trips, and community projects: horseback riding or rock climbing (support body language skills, sensory needs of some of the students), Subway, Safeway (organization and language use in community), Humane Society (classroom skills), park (peer relationships), Car wash, bake sale, photography – for older children (problem solving, perspective, opinions, facts). The students spend four weeks learning social skills in the structured clinical setting and four weeks generalizing the skills in the community. We have only two spaces available. Camp starts: Week of June 20th through the week of August 9th. For more information contact Thao@pediatricspeech.com

**Checkout our Calendar at
www.pediatricspeech.com
for more event dates.**

For more Information on our services:

Contact: Ussom@pediatricspeech.com

(408) 241-2229



“Facilitating inclusive school environments requires ensuring the opportunity for optimal learning and social experiences, and providing a nurturing climate.” *Journal for Exceptional Children*