The Global Bulletin for Speech & Language Therapy & Pathology.

S&world

January 2011

Social skills.
Alex Kelly leads the UK way.

The clinical approach.
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PLUS: Your global news and letters.

Selective mutism.

Is it just an issue of over sensitivity?

S&L world

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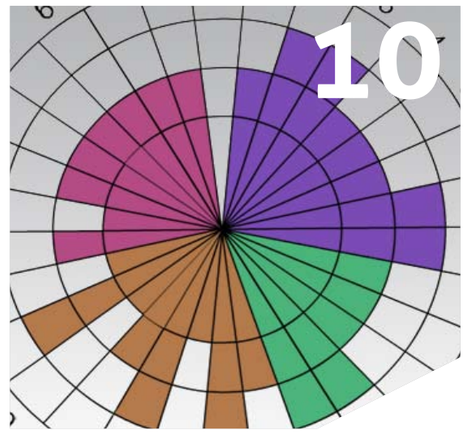

Welcome to the very first issue of S&L world. Sharing ideas and learning from each other is all about communication. S&L world aims to be your platform for communication of the good, the brave and the ingenious methods of achieving our goals. Not just within the walls of your own community, but amongst the global community. In this first issue we are publishing submitted articles from a number of specialists from around the globe. I'm merely here to preside over proceedings and make available the best of the submissions for each quarterly issue. If you log-on you can submit your own too. Letters, comments, news on events past, present and future as well as feature articles. The more we share the greater our collective knowledge. To submit an item, go to www.slworldbulletin.com

Best regards

Libby Hill
Editor

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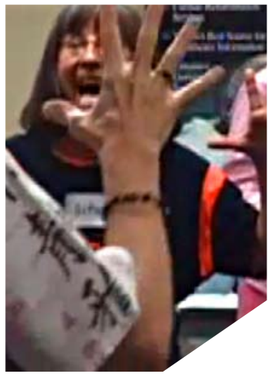
HELLO TO THE NATIONAL YEAR OF COMMUNICATION

Hello is the national year of communication – a campaign to increase understanding of how important it is for children and young people to develop good communication skills. The campaign is run by The Communication Trust, a coalition of over 35 leading voluntary sector organisations; in partnership with Jean Gross, the Government's Communication Champion.
Hello aims to make communication for all children and young people a priority in homes and schools across the UK so that they can live life to the full. The campaign is backed by the Department for Education and supported by BT.
The national year was originally proposed by John Bercow MP – now Speaker of the House of Commons – in his 2008 Review of Services for Children and Young People (0-19) with speech, language and communication needs.
The review identified a"grossly inadequate recognition across society of the importance of communication development."
In the 21st century, the ability to communicate – to say what you want to say and to understand what other people are saying - is fundamental. Speech, language and communication underpins everything we do, though these skills are often taken for granted. Babbling babies do not become talkative toddlers by chance. Communication is a skill that we learn and develop and is something we can all improve. But for some children, their daily struggle to communicate means they are shut out of everyday life.
In the UK today, over 1 million children and young people have some form of speech, language and communication need. This can affect them severely and for life. In areas of poverty, over 50% of children start school with delayed language skills. This puts them at a huge disadvantage to their peers as they struggle to learn and make friends.
A child with a speech, language and communication need may have speech that is difficult to understand. They might struggle to say words or sentences or not understand words that are being used. They may have difficulties knowing how to talk and listen to others in a conversation or simply have a limited vocabulary. Children may have any combination or all of these difficulties. These barriers are often invisible to others, meaning their needs are often misinterpreted, misdiagnosed or missed altogether.
Hello seeks to support you wherever you are – in your school, nursery, health centre, parent and baby group or local authority – to help improve the communication skills of children and young people in your area so that they can fulfil their potential. Hello will provide information and guidance on typical communication development, how to spot if children are struggling and where to go for help and support. There is a series of monthly themes to help you think creatively about how you can link into the campaign and explore in depth some of the key aspects of children's communication development.
We will be using the national year to prompt tangible improvements for children, young people and families affected by speech, language and communication needs. This will include more support for parents and carers, earlier identification of difficulties as well as earlier and more appropriate referral to specialist support.
Visit www.hello.org.uk to get involved and sign up for regular updates.



SAY IT BIG SAY IT LOUD

Research studies from the US National Institute of Health and the Parkinson's Foundation reveal that intense exercise is needed to strengthen the muscles of speech and movement so they developed two highly effective programs: LSVT (Lee Silverman Voice Treatment)Big for motor movements and LSVT Loud for the voice. Sierra Nevada Memorial Hospital's Outpatient Clinic offers intensive LSVT therapy programs tailored to the individual's specific needs. These sessions provide one-to-one sessions four times a week for four weeks with the physical therapist or the speech therapist. Its instructors are licensed professional physical, occupational or speech therapists who then receive further training in LSVT techniques. Sierra Nevada Neurological Rehab team has three clinicians who have completed this training: Katie Garcia, Maggie Edwards, and Kathleen O'Dea. They team teach the Friday classes, bringing humour and high energy to each class. The program is rigorous so it keeps the pace upbeat and fun. Everyone is encouraged to also practice at home and when they start to give reasons why they can't, the motto becomes: No excuses! For more information about the Big & Loud classes, contact SNMH's Neurological Rehabilitation Clinic at (530) 274-617 or http://www.lsvtglobal.com/.
(As reported in The Union News, West Nevada, California, Dec 2010).

SPEECH DIFFICULTY HINDERS ECONOMY

OVER six million Ugandans have speech difficulties, particularly stammering, a problem officials said impacts negatively on the country's economic development.
According to Dr. Patrick Turyaguma, a senior medical officer in the Ministry of Health, "over 20% of the population has some degree of speech and language problems. This excludes the totally dumb, who are also many", he said. Turyaguma was speaking at the December conference on speech intricacies organised by Voluntary Service Overseas (VSO), a UK-based charitable organisation, at Makerere University in December. But he added that only 2% of the six million Ugandans believed to have the problem have access to speech therapy.
This is due to the inadequate number of skilled therapists. There is now a VSO initiated bachelor's degree course in speech and language therapy at Makerere University which began in 2008 and there will be 14 pioneer students who graduate next year. Isla Jones, one of the course coordinators, said they are working on incorporating speech and language therapy specialists in the ministries of health and education to widen advocacy and expand service provision. Closing the conference, the director general of health services, Dr. Kenya Mugisha, applauded VSO and Makerere University for addressing speech problems, an area he said had been neglected. He promised jobs to the speech and language therapy pioneer students once they graduate. Interestingly, Mugisha, also warned health workers against being driven by the desire to make money. "If you are looking for money in the health profession, forget about it, or else you will work day and night and die suffering," he said. *(As reported by New vision News, Uganda 28th Dec 2010).*

SCOTTISH SPEECH THERAPY PILOT FOR STROKE SUFFERERS

A MAJOR project has been launched in the Lothian area of Scotland for stroke victims struggling to recover the power of speech. The three-year pilot, paid for by the Scottish Funding Council, involves sufferers being given intensive speech and language therapy, which uses new software to examine the brain.The work will go ahead at the city's Western General, and it is hoped ultimately it could improve the wellbeing for stroke patients across the world. The people involved in the trial will be able to go through most of the treatment at home. The recruitment process is yet to be launched, with patients being referred from Edinburgh hospitals. PhD student and speech therapist Anna Jones, who is leading the research, said: "Spontaneous recovery occurs in the first three months following a stroke and this is why we are investigating intensive therapy during this period. "The study will look at the effects of long-term computer-assisted speech and language therapy (SLT) and on patient recovery, using a touch-screen tablet computer. "The results will assess the overall effectiveness of SLT and its long-term benefits." *(As reported by The New Scotsman, Dec 2010).*

MORE AWARENESS ABOUT SPEECH THERAPY NEEDED IN INDIA

More awareness about speech therapy needed in India
The medical fraternity in India, especially neurologists and physicians need to realise the importance of speech and language therapy to enable their patients recover better and faster says a new study. Dr. Prema K.S. Rao, Professor of Language Pathology is very concerned about the lack of awareness about the need for speech therapy. The problem is two-fold because of the lack of information stroke patients do not come forwards for therapy. It is especially "difficult to reach out to the patients in rural regions who are reluctant to shift themselves to the city temporarily for therapy. Most of them being farm labourers who hardly need to communicate much with others, they refuse to undergo the therapy during counselling and think that the daily wage they earn through working in the fields is more important for them to eke out a living," Dr. Prema said.

Both Dr. Prema Rao and her colleague Dr. Rangamani are keen to put their knowledge and expertise to practical use. Stroke survivors who know Kannada and/or English and are having difficulties communicating either verbally or through reading and writing, are encouraged to participate in a pilot study at the AIISH. All treatments will be offered free of charge and in Mysore and Bangalore. (Taken from Start of Mysore, Dec 2010).

AUSTRALIAN SPEECH THERAPISTS DRIVEN TO INDUSTRIAL ACTION

The Queensland Public Sector Union (QPSU) is defending its members after around 10,000 health workers walked off the job last month.
Some surgeries and clinic services were cancelled due to the 24-hour strike. Allied health professionals, including physiotherapists, speech therapists, radiographers and theatre technicians, are unhappy with the State Government's offer of a 7.5 per cent pay rise over three years. The dispute is ongoing.
(As reported ABC news, Dec 2010)

Photo: Colin Firth as King George VI in "The King's Speech." Credit: The Weinstein Co.

SPEECH & LANGUAGE PROFESSIONALS APPLAUD NEW FILM

Colin Firth's performance as the stuttering prince who ascended to England's throne in 1936 has generated Academy Awards talk for "The King's Speech." The film which portrays King George VI's relationship with his Australian speech therapist, Lionel Logue (Geoffrey Rush), has also generated unprecedented awareness of stammering/stuttering and the therapists who treat the problem.
"This movie has done in one fell swoop what we've been working on for 64 years," says Jane Fraser, president of The US Stuttering Foundation, founded by her father in 1947. The movie depicts Prince Albert's debilitating stammer and how he overcame it to address the British people on live radio during World War II.Speech therapists are thrilled with the accuracy of Firth's portrayal of the condition. He reportedly spent hours getting the dysfluency right as well as imagining the 'inconsolable despair that those who stutter feel'. Bertie, as Prince Albert was known before he became King George VI, had to face his fears about talking when his older brother abdicated the throne to marry American socialite Wallis Simpson. Early intervention is certainly the key so let's hope that the film will help with awareness and referrals across the globe. *(As seen on smarttalkers.blogspot.com January 2011)*

Letters to the Editor

A letter is the easiest way to let others know about your idea or opinion. They are more effective if they are shorter, so a limit of 250 words is ideal with a focus of one concept or idea. The Editor reserves the right to cut to fit the space available. Please include your name, address, daytime phone number, your occupation and your area. The information (except telephone number and address) will be published unless specifically indicated. Responses to letters published are welcomed too. E-mail: editor@slworldbulletin.com

Libby Hill - Editor **S&L** *World*

MISSING THE RCSLT

I'm delighted to hear that you are doing a global bulletin as I miss the British RCSLT one since I've moved to Hong Kong. There's so much we are all doing similarly and so much more we need to learn from each other.
J Sykes - Happy Valley, Hong Kong

DEAR SPEECH PATHOLOGISTS NATIONWIDE

What discussion forums do people recommend? There seem to be lots but I don't want my email clogged up with junk. I'd welcome suggestions please folks.
Name & Address supplied

FEELING THE SQUEEZE

Dear Editor, I welcome anything which helps me keep up to date with what's going on with the profession. As training budgets are slashed and even time off for local groups & SIGs is squeezed, we need more forums for sharing good practise. I enjoy reading the RCSLT Bulletin especially when they cover international topics so I'm looking forwards to reading S & L World.
F Henderson - London

GOOD LUCK WITH THE NEW BULLETIN

Really looking forwards to hearing about the great work being done over in the UK and the rest of the world.
D Salter - Minnesota, USA

Living and working in the Gulf has its challenges and its rewards.

Gulf ball

An interview with Marie Abou Rjeily Saroufim.

Your name? Marie Abou Rjeily Saroufim
Your Age: 31 (August 6th 1979)

Tell us about your family (partner, children, ages, where you live etc: whatever you feel happy sharing):
I am married to Marc Saroufim (33). He is a Lebanese- American lawyer. We met in Dubai in June 2006, just one week after he left Boston to come and work in the UAE. I had been living in the UAE for 4 years at the time. We've been happily married since August 2008.

Where did you train & when?
I studied speech therapy in Lebanon and had training in France. I graduated in 2001.

Why did you become a Speech & Language Therapist/Pathologist?
In 1997, when I graduated from high school, speech therapy was the newest speciality at the Lebanese University (It started in 1995). I was excited to try this new speciality especially that it involved working with children with special needs.

Tell us a little about how you got to where you are today....
After graduating from university, I immediately started working in the UAE. I never worked in Lebanon. I was recruited by a private hospital in Sharjah, UAE. I worked there for 6 years. After I got married in 2008, I moved to Dubai, UAE, and I had part time jobs at the Rashid Paediatric Therapy Centre and at the Dubai Early Childhood Development Centre (Community development authority of Dubai).
In the summer of 2010, my husband and I left the UAE after he got an offer at a law firm in Riyadh, KSA. We arrived to Riyadh in September 2010. I am currently applying for jobs in some hospitals here.

What do you like best about the job?
What I loved about being a speech therapist in the UAE was the ability to have patients from many different cultural backgrounds. It was a bit challenging but I am blessed to have Arabic as my native language, and to be fluent in French and English. I like the fact that I am able to help people who come from different parts of the world.

What are your least favourite parts?
My least favourite part would be the lack of standardized or published Arabic assessment and therapy material in Arabic. And what makes it worse is the fact that the Arabic language changes a lot between different countries. Lots of work is being done at universities or with personal efforts but it is rarely published or shared. This is challenging for any Arabic speaking speech therapist.

What has worked well in your career?
When I started working at private hospital in Sharjah, I was the only speech therapist. So I had to work with a wide of patients. I was dealing with speech and language disorders, voice and swallowing problems. From early intervention to elderly. Having to know about every aspect of our profession was not easy but it gave me the opportunity to be able to work in any department now.

What has been your biggest challenge so far? How have you dealt with it?
My biggest challenge was my first job when I was fresh graduate and the only speech therapist at the hospital. Technically, I was recruited by the ENT department but I got referrals from all the departments. There was no material related to speech therapy at the hospital so I read a lot, did lots of research and attended many lectures and workshops to be able to get the right assessment and therapy tools.

How do you fit in work with the rest of your life/family?
I do not have children yet so it has been easy to work and still have enough time to spend with my husband. We get minimum 30 days off per year in the gulf area so it is easy to travel and spend time with both our families, in Lebanon and in the USA.

What advice would you give to someone else wanting to work in this area?
Before working in the gulf area, I suggest that you get in touch with professionals working in the country or the city that variety you chose, take their advice and benefit from their personal experience.

Your website link (where appropriate).
Email: mary_speech@yahoo.com
Speech therapy UAE: http://www.facebook.com/group.php?gid=3282635022

Would you like to be interviewed? Contact S&L World via email to editor@slworldbulletin.com

Developing social skills

by Alex Kelly.

The importance of being socially skilled cannot be over estimated. We all need these skills to communicate effectively in order to listen to others, to express ourselves, to be taken seriously, to learn and to make friends. And we know that social competence contributes to quality of life and has been repeatedly demonstrated to be a critical variable in predicting success in future life. As Frea (2006) says: 'even communication skills carry minimal power if social skills are not developed to ensure opportunities to communicate'. However not all children develop social competence naturally. Some children are socially unskilled and require professional intervention. So what can be done to help them? Where do you start and how can it be done?

I thought I would describe some of my work with a young man called Mohammed. (pictured on the left).

Mohammed, or Mo as he prefers to be called, was 15 years old when I first met him. He has Down's syndrome, a moderate learning disability and was just about to start a 3 year life skills course for young adults with a learning disability within a mainstream college. His mother was concerned about his ability to cope within a more adult environment because of his poor social skills. In particular he came across as an over friendly, inappropriately chatty young man who was obsessive in his topics of conversations and showed poor skills in listener awareness.

I started by assessing his social skills and his self awareness. He showed a good basic self and other awareness, for example, he was able to tell me what he looks like and what he is good at and not so good at. I then assessed his social skills using the rating scale assessment in 'Talkabout' (Kelly, 1996). This showed that he had difficulties in all areas of social skills: body language, the way he talks (paralinguistic skills), conversational skills and assertiveness (see figure 1). Skills that need work have been highlighted in bold and underlined.

So where should I start work with Mo? Choosing the right place to start work has to be the most important part of ►

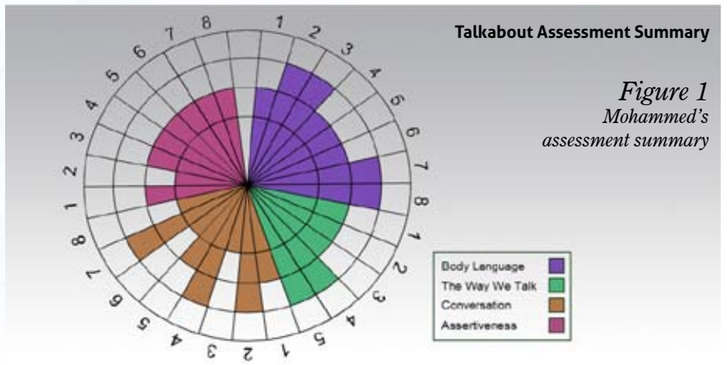


Figure 1
Mohammed's assessment summary

BODY LANGUAGE	THE WAY WE TALK	CONVERSATIONS	ASSERTIVENESS
1. **Eye contact**	1. **Volume**	1. **Listening**	1. **Expressing feelings**
2. Facial expression	2. **Rate**	2. Starting conversations	2. **Standing up for self**
3. Gesture	3. **Clarity**	3. **Taking turns**	3. **Making suggestions**
4. **Distance**	4. Intonation	4. Asking questions	4. **Refusing**
5. **Touch**	5. Fluency	5. **Answering questions**	5. **Disagreeing**
6. **Fidgeting**		6. **Relevance**	6. **Complaining**
7. Posture		7. Repairing	7. **Apologising**
8. Personal appearance		8. **Ending conversations**	8. **Requesting explanations**

intervention as it is the difference between potentially setting a child up to fail or succeed.

Results from social skills work in the early nineties lead to the development of a hierarchy which is the basis of all the Talkabout resources (Kelly, 1996, 2003, 2004, 2006, 2009 & 2010). It was found that the success of intervention increased if non verbal behaviours were taught prior to verbal behaviours, and assertiveness was taught last. In addition, it was found that basic self and other awareness should be taught first if necessary.

The hierarchy of social skills

Awareness of self and others

↓

Non verbal behaviour or foundation skills i.e. body language and paralinguistic skills

↓

Verbal behaviour i.e. conversational skills

↓

Assertive behaviour

This is logical. Think about conversational skills; they are more complex than the non verbal behaviours. For example, consider listening: a good listener uses appropriate eye contact and facial expression to show he is listening. Now consider turn taking: this needs good listening which in turns needs eye contact etc. So choosing the wrong skill to start work on, i.e. a skill that is too complex will potentially set Mo up to fail.

Mo has good self and other awareness, and so using this hierarchical approach, we need to initially work on his body language prior to moving onto his verbal behaviours and assertiveness skills. So my initial goal for Mo was to teach him appropriate touch and distance as it was felt that this would be a huge barrier to college life.

Having decided what skill to teach Mo first, the next step is to decide how to teach the skill and choosing the right type of intervention can be as important as choosing the skill to target.

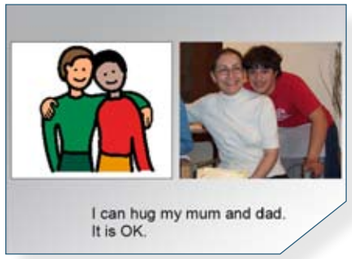


Figure 2: A page from Mo's social story.

There are a number of successful instructional approaches to teaching social skills: social skills groups, social stories, comic strip conversations and video modelling. However, it is also important to consider the child's environment. It is essential that any social skills work is supported by the child's school environment and that skills that are being taught are encouraged throughout the day. Involving parents is also essential if the child is going to generalise skills learnt in school into their everyday life.

In some instances, it may also be important to consider the child's peers, especially if the child spends some time integrated into mainstream. Strategies such as circle of friends or peer mediation can be an excellent addition to any social skills programme.

Mo's therapy centred on writing a social story called 'I'm an adult'. A social story aims to provide the child with the answers to the key questions about a specific situation: what is happening? Who is doing what? Why is it happening? What are the rules? What should they be doing and saying in that situation? (Smith 2003)

So in Mo's story, it explains that touching and hugging is special and is OK in some situations. However it can make people feel embarrassed and uncomfortable if done outside these situations. It also explains that linking arms and holding hands is OK for some people but is not OK in college. The story then tells Mo who he can hug (see figure 2) and who he should high five.

We also used comic strip conversations to help Mo work through some specific situations such as what to do if someone tries to initiate a hug. By using drawings and identifying who did and said what and also what they may be thinking, Mo can see the consequences of his actions and can work out what would be better.

In addition to these two approaches, we also used a number of social skills games and the Talkabout DVD in our sessions to back up what was being taught.

So where is Mo now? Well, 3 years on, he is showing some real improvements. He still sometimes looks at his social story about being an adult and we have added to it on a couple of occasions as specific situations have arisen. He is enjoying college and his tutors continue to remark on the progress he is making. He has also had some part time work experience in a shop which has really boosted his self confidence.

Helping children to develop social skills can be remarkable. You have the ability to make a real difference to a child's quality of life: their ability to make friends, get a job, and be successful. What could be more rewarding? For me, nothing. However, just remember a few key points to maximise the effectiveness of what you do: use a hierarchical approach when planning your intervention; try to use a variety of instructional approaches; and use the child's everyday environment to support what you are trying to develop. Oh, and enjoy – developing social skills should definitely be fun!

Alex Kelly
Speech & language therapist and social skills consultant

Alex is the author of the popular Talkabout resources. She runs her own business offering training and consultancy work to schools in developing social skills, self esteem and relationship skills. Find out more at www.alexkelly.biz or contact her at alex@alexkelly.biz

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Marcus Little is a Canadian Speech Language Pathologist who is passionate about helping kids develop their speech sounds with velocity. He is perpetually tweaking his systematic way of developing speech sounds using high-repetition and speed drills. This method can be easily taught to parents, caregivers and educational assistants. More information and resources available at http://www.thespeechpathway.com/

Automaticity.

The key to acquiring speech sounds rapidly.

by Marcus Little.

When asked to contribute an article to Speech and Language World I readily agreed. I am very passionate about Speech Therapy. More specifically, I'm passionate about developing articulation with velocity. I focus on developing "Automaticity" as it is the cornerstone for the type of therapy I provide.

Ironically, the concept of automaticity was never discussed in the context of Speech Language Pathology in Graduate School, but rather came from a cognitive psychology course I took in my undergraduate degree. Nearly every clinical decision I make is associated with developing automaticity of sound production as an end goal. If you want to drastically improve the speed at which you achieve your speech therapy targets in conversation, you must make developing automaticity of speech your focus.

So what is automaticity? The Wikipedia definition is as good as any. It states:

Automaticity is the ability to do things without occupying the mind with the low-level details required, allowing it to become an automatic response pattern or habit. It is usually the result of learning, repetition, and practice.

Examples of automaticity are common activities such as speaking, bicycle-riding, assembly-line work, and driving a car (see Highway hypnosis). After an activity is sufficiently practiced, it is possible to focus the mind on other activities or thoughts while undertaking an automaticized activity (for example, holding a conversation or planning a speech while driving a car).

Consider that when we speak, we do not think about what is occurring in our mouth. It is an automatic process. Yet every client I work with has to focus on what their articulators are doing in order to say their speech targets accurately. Their target sound production is initially very deliberate and effortful. It is common to hear parents state "My child is lazy - they can say the sound accurately when thinking about it or when they are reminded". The child is not lazy - they are just not to the point where they are saying the sound automatically. Ironically, the child is putting more effort into speaking than the parent is. This is not being lazy! If the child has to focus or think about producing sounds accurately, then the sound production is not automatic.

So how do we develop automaticity? Just as Wikipedia states - automaticity is the result of learning, repetition and practice.

Learning: This starts with developing the child's stimulability for the speech target. Being able to say the sound accurately is the first step. This is followed by being able to say the sound consistently.

Repetition: Having a child perform repetitions is one of the most important tasks performed by a Speech Language Pathologist. Starting out slow and accurate is paramount but the speed of drills need to be increased sooner rather than later. Accurate but slow productions are of little value if they are not a stepping stone to rapid productions. Pushing children to develop their speed, while maintaining accuracy with the sound is critical. In order for a child to go fast with the drills, they need to practice going fast. The end result will be more repetitions in a shorter period of time.

Practice: Due to ever-reducing funding for Speech Therapy, I am seeing clients less frequently that I would like to. Teaching clients and caregivers to effectively practice at home is critical for success. Five minutes of effective high intensity, high rep drill work, performed daily does wonders for speeding up the therapy process. The best way to cultivate this ability is to have parents and caregivers sit in on the sessions to watch what is done during the session. If you are uncomfortable with having parents sit in on sessions you need to get over it. This is the best way to transfer your knowledge. Sending a note home, no matter how clearly written is no substitute for a parent witnessing what we want them to do. From experience I know that if a parent has any doubts about what is required at home, they will not practice.

I borrow much inspiration from music students who develop their skills through drilling musical scales over and over again. This repetitive practice lays down the foundation for developing automaticity of the finger movements involved in playing musical instruments. By practicing sounds and syllables in a highly repetitive manner develops the smoothness and fluidity of the productions laying down a strong foundation for the more complex productions to come.

Speed: Developing speed of productions by doing speed drills is the "secret" ingredient. During normal speech our articulators transition very rapidly to the various points of articulation. As clinicians, we need to facilitate these rapid transitions in the targets we are developing. If we need to go fast when speaking normally then we need to prepare the client for rapid transitioning of the articulators. This occurs by practicing drills quicker.

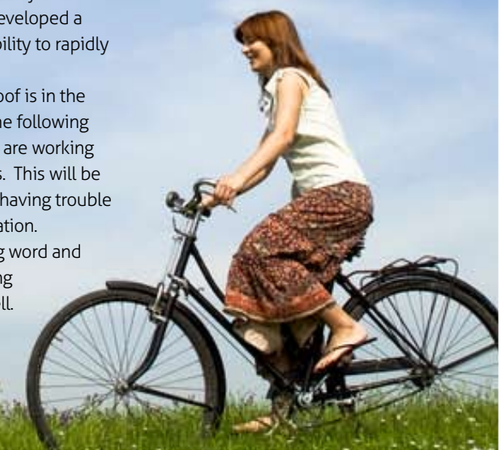
Doing speech drills rapidly is counter to what I remember being taught. In Grad school I remember being taught rate reduction strategies. This technique has its place but not when developing articulation of school aged children. If a child wants to speak fast, then we need to facilitate their articulation skills to accommodate this. Prompting them to slow down is a temporary but unsustainable technique. To me this is like treating a child with ADHD by telling them to "calm down" or "relax".

Graduate school also taught me to try to work at word level (meaningful context) as soon as possible. In my opinion this is the worst thing someone can do when your focus is developing articulation. It ignores developing the foundation skills found in sound, syllable, and especially double syllable level drills. If you spend your time developing a solid foundation grounded in the ability to rapidly transition articulators, the rest falls into place. I no longer have difficulty transferring from sentence level drills into spontaneous conversation. Quite often the child will start carrying over into conversation while I am still working on developing double syllable level drills. Carry over occurs when the child has developed a strong foundation in their ability to rapidly transition their articulators.

Enough talk now. The proof is in the pudding. I want you to try the following with any of your clients who are working on word level or higher drills. This will be especially helpful if you are having trouble with carry over into conversation.

When you are performing word and sentence level drills, try doing them in sets of five (5) as well. Make sure the child is not pausing before his targets or emphasizing his targets. You should notice the productions coming smoother, quicker, and more fluidly with practice. This is the key for speeding up the transfer into conversation.

In conclusion I want you to consider the role "automaticity" plays in developing articulation. Developing automaticity of articulator movements much like a musician develops their finger movements doing musical scales can yield spectacular results. Repetition is the key. Repetition is the key. Repetition is the key.



Sound	10 sets of 5	/k/, /k/, /k/, /k/, /k/, ……../k/, /k/, /k/, /k/, /k/,
Syllable	2 sets of 5	Initial Productions kay kee kye ko koo Final Productions ake eek ike oak ook
Double Syllable	2 sets of 5	Initial Productions kay-key kee-kie kye-ko ko-koo koo-kay Final Productions ake-eek eek-ike ike-oke oak-ook ook-ake

Acute sensitivity in children: is there a link with Selective mutism.

by Michael Jones.

Parents of children with Selective Mutism often describe them as 'highly sensitive'. "Being thin-skinned as opposed to thick skinned", is how one parent sums it up. It was this parent who directed me to the work of Elaine Aaron, and her books 'The Highly Sensitive Child' and 'The Highly Sensitive Person'. Aaron suggests that there are many children and adults who are 'born with a tendency to notice more in their environment and deeply reflect on everything before acting.' She argues that these children are also 'more likely to be overwhelmed by 'high volume' or large quantities of input arriving at once.' They typically try to avoid this by withdrawing into themselves, and thus seem to be shy or timid. When they can't avoid overstimulation they may seem 'easily upset', and are often described as 'too sensitive'.

While the children may notice more about their environment, this does not mean that they have better eyes, ears, and sense of smell or taste buds - although some do report having at least one sense that is very keen. Aaron suggests that their brains process information more thoroughly. They also have faster reflexes, are more affected by pain, medication and stimulants, and possibly having more reactive immune systems and allergies. In a sense, Aaron maintains, their entire body is designed to detect and understand more precisely whatever comes in. However this can lead to being overwhelmed, and feelings of panic, as they may be unable to process all this information.

As one can imagine, being temperamentally disposed to high sensitivity can lead to extreme difficulties in the fast, noisy and busy worlds of pre-school, primary school and secondary school. Here, being orally proficient and making quick responses are not only vital for making friends, but also essential for achievement. Being highly sensitive could be interpreted as being a curse, but it can also be seen, in some circumstances, as a distinct advantage. Aaron observes that highly sensitive children and adults tend to be empathic, intuitive, creative, careful and conscientious. In many professions 'high sensitivity' is essential. Where would we be, after all, without highly sensitive doctors, therapists, animal welfare professionals and artists?

> *"I would get a huge sinking feeling inside and would often feel physically sick."*

Might this definition of high sensitivity help children and adults understand themselves more, and consequently help them as communicators? Laura is an adult who feels that in many ways she was, and continues to be, 'highly sensitive.' I met her on a training course I was leading. We had been discussing selective mutism, and Laura felt that this had been her problem as a child. I remained in contact with her, as she was keen to explore the possibility that what she had regarded all her life as an unexplained 'personality defect' could be something that she has in common with many other people: the temperamental trait of high sensitivity. Both Laura and I were keen to share her feelings about her experiences in school, for the benefit of children with similar reactions, and for the adults who work with them.

In pre-school Laura was always wary of new people and situations. She was worried about being left by her parents, about doing something wrong, or not knowing what to do. "I was very unlikely to ask for help, or say if I didn't like something. I would often get 'stuck' in situations, when I couldn't say I didn't want to do something, or that I wanted to do something else. I probably appeared very quiet, or boring and uninterested. I would have been described as rude at times, I'm sure"

While Laura felt uncomfortable about going to nursery, she hated school. Yet she liked learning. She loved to read and write, and did a lot at home with her parents and grandparents. "I was always very good at school and always tried to do what was asked of me. I panicked at new activities and about getting them right. I used to find any excuse to avoid going to school. My parents got cross with me about this, but I couldn't really find the words to describe how school often made me feel. If I was reprimanded or told off about anything at school I usually felt as if my life had just ended. I would get a huge sinking feeling inside and would often feel physically sick."

Hannah could cope with being asked to do something differently, but being told off ruined the day for her. All she wanted to do was get home and out of that situation- and preferably never ever see the offending adults again, as she was convinced that they must have seen her as a total failure. Sometimes being mildly reprimanded would cause Hannah to be unable to sleep, or she would look worried for days on end. Throughout her school career, Hannah wanted adults to understand how she felt. "I think teachers would have been shocked at just how anxious and frightened I was about things. And I wished they'd taken a moment to think about why this child, who did quite well with her work, and didn't really misbehave, was so unhappy going to school, looked so anxious and often panicked in certain situations."

Secondary school was even more of an ordeal. All teachers judged her as 'shy', and repeatedly reported that she 'didn't speak up enough', despite the fact that she did well in most subjects. Hannah is quite bitter that it was never explained to her why 'speaking up' was so important, and that no one ever offered any help, advice or suggestions for ways to improve her ability to speak and her confidence to do so. "I felt that it was all my fault: that there was something internally wrong with me, and it was something that only I could change – no one else could help. I felt that adults were giving me the message that all I needed to do was to speak more and then I would be more confident. Yet no one expects the dyslexic child to improve just by trying harder to spell, or tells a person with a stammer that if they talk more then they will be OK. It never occurred to me that adults could or should be helping me. "

Yet Hannah was not completely isolated, and she had some very close friends. "My friends all knew I was very quiet, very shy and took a while to get used to new people. They also knew I was very clever, kind to my friends, funny, loyal and creative and, once they got to know me, a great person. I was well liked amongst my friends, and was often the person they came to for advice." Hannah moved to Sixth Form College, but still had difficulty speaking in class or approaching her teachers for help. She found it difficult to grasp practical lessons quickly, and when questioned directly often stuttered or blushed, and found it hard to make eye contact.

Hannah feels that because she was quiet, teachers underestimated her true ability. "I honestly think they thought I was stupid. I sat in the back row in Chemistry with two other girls – both of whom were also very quiet and didn't do well under direct questioning. We all got much higher grades than predicted and our teacher was stunned. In my music A Level I didn't need to speak to pass anything, and the teacher always appreciated my talent and ability. I never panicked about a music lesson."

By the time Hannah got to University she was convinced that she had a 'defective personality'. "I believed that any type of relationship would go badly, and that the tutors wouldn't like me. I wouldn't have many friends, and I wouldn't fit in. People would not be interested in me. I would be forgotten or ignored, or tutors would assume I wasn't clever or talented, and I would miss out on opportunities. Looking back on it, I realise that I was wrong. I made a few really close friends and I was on a really interesting course, which I enjoyed and got a lot from. I worked hard and got a good degree. It didn't matter that not everyone knew my name, or that I felt

uncomfortable at parties or large events (or that I wasn't invited to them). And upon graduating it became apparent that the tutors knew my name, knew my strengths and really respected my clarinet playing abilities! "

Hannah finds the concept of 'high sensitivity' very useful. She recognises that what she grew to perceive in herself as a social deficiency can be interpreted more positively: as having an acute sensitivity to the world around her. She is more aware that she has difficulty with loud noise: especially at large gatherings, and having to respond quickly to what she perceives as a lot of information all at once. And her need to reflect carefully before making decisions is often seen as a distinct advantage.

Does she have any advice for adults dealing with shy or extremely sensitive children? "I think the key thing is to understand just how anxious, nervous and actually scared some sensitive children can be. This is the first step adults need to take. We shouldn't think about curing, fixing or changing children, but about finding a way for their talents and skills to come out."

And what about highly sensitive children; does Hannah have a message for them? "YOU ARE NORMAL. You really, really are. It can feel rubbish, and it can be scary – but it will get better. You will get more confident and you will be capable. And you don't have to become a different person to achieve this. It's not your fault – you can't control how you feel or react to a situation – but you can develop skills and methods to help you deal with things better, and eventually you might feel better or react differently.

I work with children all the time, but (don't tell the loud children!) I usually prefer the quieter ones – you've usually got more interesting things to say. And I don't mind if you don't want to talk to me. I like it if you do, and I might worry if you're ok sometimes, but it's up to me to find that out and make sure that you have the space to tell me, or show me things if you need to. And anyway just because a child is loud and tells me things all the time, doesn't mean that they're always happy."

I have explored these ideas with Maggie Johnson, co-author of 'The Selective Mutism Resource Manual' She regards Hannah's experience as mirroring the experience of many of the adults she has met through the Selective Mutism Information and Research Association (SMIRA) and 'Smiratalk', an online space for sharing ideas about SM and related conditions. "I think that all the children and teenagers with SM that I have worked with are highly sensitive. Though they do not have heightened sensitivity in all areas, they are all super self-conscious, and afraid of making mistakes. Like shy students, they find it painfully difficult to initiate conversation. This includes asking for help, seeking clarification or permission, reporting bullying and false assumptions, and using social greetings and making friends.

Michael Jones is a British Speech & Language Therapist and an educational consultant, trainer and writer.

For more information on the subject of selective mutism and high sensitivity in children visit www.talk4meaning.co.uk

'The Highly Sensitive Child' and 'The Highly Sensitive Person,' by Elaine N Aaron, are both published by Thorsons.

'The Selective Mutism Resource Manual', by Maggie Johnson and Alison Wintgens, is published by Speechmark.

For the Selective Mutism Information and Research Association (SMIRA) visit www.selectivemutism.co.uk

The development of KIDS LANGUAGE RESOURCES

by Linda Hurst.

To help understand the development of Kids Language Resources it is important to outline my clinical style and background. My extensive clinical experience has involved working in private and public, rural and urban areas and with clients from various socio-economic and ethnic backgrounds. The key principle, throughout my work was helping families be involved in therapy for better language success. My client's parents always participate in the sessions and my sessions always involve a discussion on how to teach language disorders outside the clinical setting.

As my client's parents became better at teaching language in the home environment they started to ask me, "Where can I find better resources?" At the time, the resources available to teach specific language items were often black and white photocopied line drawings that were sometimes confusing particularly for children with language disorders. For example, when I was teaching pronouns I asked my clients, "Is that a boy or a girl?" and a number of parents would comment on the picture, "I don't know myself."

So my search began. The resources available on the internet and educational book shops were not quite specific enough for teaching language disordered children or often inaccessible to the families. So I set out to build what was needed. As a result Kids Language Resources was developed.

Kidslanguageresources.com is a website for parents and professionals to use the growing world of technology to access language resources. Kids Language Resources are language therapy programs using photo images. Photo images were used as they are a true and accurate representation of the object, leading to quicker generalisation. The therapy programs can be downloaded and printed by the parents without leaving their home. Kids Language Resources currently focuses on preschool aged children (0-6 years), however a large number of the programs can be used with school aged children with language difficulties. The therapy programs target all areas of syntax, semantics and morphology.

After developing the hardcopy programs the idea of using the photos similar to a slideshow of holiday snaps crossed my mind. As a result Kids Language Program was developed. I have started to use the computer as part of my therapy program and my clients and their parents love it. With the ever growing increase in technology it is not surprising that a three year old can operate a mouse and is highly motivated by the use of a computer in the session. For my clinical work motivation and participation leads to greater, quicker success in therapy. Kids Language Program has enabled me to achieve this with my clients.

Upon reflection there are a number of tips I would give for any clinician looking at moving forward in their business.

1 Get an idea and start brainstorming.

The idea of Kids Language Resources came about to solve a problem for my clinical caseload – the lack of resources available for my clients. Initially the thought was small but with lots of thinking and documenting the ideas grew and grew. A tip I read in a business development book was "think big, think very big – you never know it might happen".

2 Find a mentor.

Immerse yourself with people that are thinking similar to you. Pick their brains. From my experience most people love to share their experiences and knowledge.

3 Take one step at the time.

After each discussion with my mentors I found myself feeling very overwhelmed. After a number of meetings I learnt that recognising and acknowledging these feelings enabled me to move forward one step at the time. I would often say to myself, "Remember when .... was difficult and now it is just 2nd nature".

Moving forward in business, whether in clinical work, research or a new resource is a progression of little steps, involving a lot of time and learning. It is this learning that was so exciting.

www.kidslanguageresources.com

Linda Hurst is an Australian Speech & Language Pathologist

The Global Bulletin for Speech & Language Therapy & Pathology.

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