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PRESIDENT'S MESSAGE

Greetings from the AIC to everyone this spring season! I write this message with a strong sense of empowerment at what our caucus continues to achieve and the knowledge that it is making a slow but steady difference. This alone makes my job worthwhile and I want to extend my foremost gratitude to the executive committee and every member whose support I have received this past year. I am always energized by your input and eager to hear your ideas.

Based on member ideas and feedback, advisory board input, and executive committee decisions, the following goals have been outlined for the year 2003:

- a) Recruiting new leaders to secure leadership needs of the Asian-Indian caucus
- b) Increasing active membership within the AIC
- c) Fundraising campaigns for AIC kicking off in summer 2003
- d) Completing a resource binder on information, issues, and data relevant to understanding communication (typical and disordered) in Asian-Indians
- e) Participating actively in outreach, advocacy, research, and clinical activities relating to ASHA/OMA activities pertaining to the diversity-focused initiatives.
- f) Organizing the AIC meeting at the 2003 ASHA Convention in Chicago
- g) Participating in a booth at the 2003 ASHA convention to increase awareness and information about AIC activities

We have been gratified by your strong presence at the 2002 convention and have appreciated all the support and feedback we received in response to that annual meeting. 2003 has been designated by ASHA as the year of the volunteer and that's precisely where each of you fits in – I ask you to share in the empowerment that comes from volunteering. Step up to the plate this year and share your many skills with AIC and the larger ASHA family. Start with an email to us about something on the 2003 agenda that you could contribute to and do not hesitate to pick something that you enjoy. With your help, I know we can work magic!!

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FROM THE EDITOR'S DESK

We are pleased to present the 1st issue of ASHA KIRAN for the year 2003. In the ASHA Year of the Volunteer I would like say a special word of thanks all our contributors and volunteers for taking time from their busy schedule to write for us as well give us feedback to keep the Asian-Indian Caucus going. The caucus and newsletter depend entirely on you. I would also like to urge current and prospective members, clinicians, students enrolled in graduate programs, academics and interested parents of children with disabilities to help strengthen the Caucus and provide a strong voice for Asian-Indians at ASHA. Both the Caucus as well as the newsletter is young, there is ample room for change, if you have any comments or suggestions, or there is any particular feature or information you would like to see, please feel free to email any of the executive committee members. ASHA KIRAN is proud to be your voice.

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Speech Therapists in Early Intervention in Massachusetts

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When anyone asks me about my job, my stereotypic response is, “I work as a speech therapist for an early intervention program, providing speech therapy for children between the ages of 0 and 3 years.” Most often, I am met with a sense of surprise that speech therapy can be provided to children that young. In the state of Massachusetts, any child between 0 and 3 years, who qualifies for early intervention can receive these services. Qualification for early intervention services is based on delays in development, risk factors at birth or in the family. An assessment provides age levels for different areas of development – fine motor, gross motor, cognition, language, self-care and social/emotional. Risk factors include, but are not limited to, birth weight < 1200 grams, gestational age <32 weeks, NICU admission > 5 days, chronic feeding disorders, hospital stay > 25 days in six months, weight or height under 5th percentile for age. The family characteristics include, maternal age at child’s birth < 17 years, inadequate food, shelter or clothing, substance abuse or domestic violence in the family. In addition, a comprehensive list of diagnoses automatically qualifies a child and family for early intervention services. The two-page list includes cranio-facial abnormalities, syndromes, metabolic disorders, heart defects, sensory abnormalities to name a few. Another important factor in the inclusion of children in the early intervention program is the judgment of the clinician; while the main one is interest of the parent in receiving these services. Referral sources include hospitals, day cares and most often, parents themselves.

The early intervention program that I work for has about 60 employees and is currently servicing about 600 kids in the Greater Lowell area. Due to the size of our program, we are divided into teams by geographical area, which tends to reduce the driving burden on the service providers. Each team includes speech therapists, occupational therapists, physical therapists, educators, social workers, counselors, and nurses. A multidisciplinary team (consisting of two or three different members) visits the child and family for the assessment following the initial screening. The State of Massachusetts has chosen the Developmental Programming for Infants and Young Children checklist (commonly referred to as the Michigan) as one of the qualifying tools. If a child qualifies for early intervention services, we write an Individual Family Service Plan (IFSP) for each family listing the services and goals for the child. More than one provider can be involved with a child/family if the need arises.

These services are often provided by different organizations that work under the auspices of the Department of Public Health (DPH). Insurance companies and DPH bear the burden of the finances for the services provided to each family. Early intervention programs are required by law to provide these services in the natural environment of the child and family – homes, day cares, grocery stores, parks, swimming pools to name a few. Intervention provided to children is based on the philosophy that parents are our partners. The service provider works with the child and shows family ways in which they can aid in the development of the child. The hope is that the family can follow up on these activities different times during the day, consistently. The intervention strategy varies with the strengths of the child and family and their needs and is always play-based. For some children, most intervention is related to language stimulation and providing the children the opportunity to use words. Using of simple signs to augment verbal language, providing the child with choices, waiting for the child to respond – are some techniques that the service provider shows the parent. In addition, for some children (eg. with Down’s syndrome, autism, dyspraxia, cerebral palsy) we start an augmentative system of communication – sign language, picture communication at an early age, so the family’s frustration level is reduced. Kids with low motor tone often benefit from exercises strengthening their oral motor control. Services are always tailored to the needs of the child and family while being respectful to what the family would like and are comfortable with based on their past experiences, culture and a multitude of factors. These services

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terminate when the child turns three. At this time, children who continue to need services are referred to the local public school or other sources of treatment.

My current case load includes PDD/autism, expressive language delays, down's syndrome, stuttering, cranio-facial abnormalities, global delays, articulation and phonological errors, feeding difficulties, and dyspraxia. I always end by telling people that my job is very satisfying and to be present for a child's first word is wonderful. And, of course, maturity is on my side!

A novel approach to treatment of Aphasia: The Semantic Complexity Hypothesis

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Numerous researchers have examined recovery of naming in patients with aphasia when provided with treatment (for a recent review, see Nickels, 2002), although few have focused on patients with fluent aphasia. Several studies have utilized semantically based treatment by means of auditory and written word to picture matching tasks, answering yes/no questions about the target, spoken word categorization, and judging the semantic relatedness of two words. Other studies have compared the effects of semantic and phonological treatment on naming and, in general, have found that a combination of both treatments is most effective.

While most of these studies have reported improvement of trained items, few have found generalization to untrained items and still fewer have examined changes in error patterns resulting from treatment. From a practical perspective, a treatment lacking positive generalization effects has limited carry over potential to an individual's overall communicative abilities and thus, has restricted clinical significance. Treatments based on models of lexical processing, which for example, focus on improving access to semantic representations of target words and their semantic related words (Boyle & Coehlo, 1995; Drew & Thompson, 1999) have been more successful at facilitating generalization.

Generalization also may be enhanced by considering the hierarchical complexity of the stimuli selected for treatment. In a recent experiment (Kiran & Thompson, in press (a)), we applied the notion of complexity to semantic concepts with reference to naming deficits in patients with aphasia. In four individuals with fluent aphasia, we demonstrated that patients receiving treatment on atypical examples (e.g., *ostrich*) demonstrated generalization to naming of intermediate (e.g., *eagle*) and typical examples (e.g., *robin*) within a semantic category (e.g., *bird*). Patients receiving training on typical examples demonstrated no generalization to intermediate or atypical examples. We hypothesized that training features associated with atypical examples emphasizes the variation of features within the category as well as features of the prototype. Therefore, within a category, atypical exemplars are more "complex" than typical ones, since collectively these items convey more diverse information about the category and its semantic features than typical items.

This complexity effect, i.e., training items that are more complex to facilitate generalization to untrained simpler items also has robust evidence from treatment studies for agrammatic aphasia (e.g., Thompson, Shapiro, Kiran, & Sobecks, in press) as well as for children with phonological deficits (Geirut, 2001). Moving beyond language, there is supportive evidence of complexity in motor skill learning by adults, particularly as it relates to the conditions of practice in sports such as golf or tennis (Schmidt & Lee, 1999).

Generalization to untrained structures is an essential outcome to successful treatment, particularly in the current healthcare climate which limits the duration of aphasia treatment to a few sessions. Also, from the perspective of the individual with aphasia, the ability to retrieve novel items (not just those trained) facilitates that individual's return to their normal communicative ability. Therefore, in the context

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of lexical retrieval deficits for individuals with aphasia, the semantic complexity effect provides a promising new approach in facilitating maximal generalization to untrained items.

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SLPs with foreign accents in the clinical arena

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Demographics are changing dramatically in the United States. Minority cultures and immigrants will continue to grow, and as a result the field of Speech-language pathology will also flow with the same tide, embracing more culturally diverse foreign professionals. In order to meet the needs of diverse population, more and more speech-language pathologists (SLP) from diverse background need to be trained before they step into the clinical arena.

Barriers that interfere with service delivery to clients by immigrant SLPs include cultural, linguistic, and communicative differences. The most important barrier relates to communication and to communicate clearly, speech intelligibility is required. Speech intelligibility is compromised in clinical settings when extra efforts are required to understand foreign accents. A “foreign accent” is marked by differences in phonology, timing, rhythm, stress, and intonation patterns (Flege, 1995). Foreign accent often causes the listener to shift focus from the content to the phonological forms, leading to communication breakdowns.

In ethnolinguistic, sociolinguistic, and psycholinguistic domains, much research has taken place to examine foreign accent (Els & Bot, 1987) and understand its impact on clinical speech and language services (Langdon, 1999). An ethnographic interview study (Ray; in preparation), with nonnative professionals indicated that most professionals (occupational therapists, speech therapists, and nurses) had experienced subtle forms of discriminations due to their accents. They felt that effective communication with clients and professional team members is the most powerful tool in clinical service delivery. They reported that accent was used to judge clinical competencies more than 80% of the time.

Employers and supervisors hiring non-native professionals need to see beyond accent and look for communicative competence and performance. They also need to understand that success of nonnative professionals depend not only on their speech intelligibility, but also on their cultural awareness in

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various work settings. Adequate knowledge of the cultures in turn leads to mutual and respectful relationship between all professional team members thus improving unit productivity.

These days, it is difficult to recruit and retain culturally diverse professionals and hence it is extremely important to establish strategies to enhance cross-cultural awareness associated with specific collaborative work skills. Professional developmental programs need to be organized in order to cross the cultural-linguistic barriers. More preservice and inservice programs need to be incorporated in clinical settings. Although many universities offer various courses that deal with assessment and treatment of multicultural population, at the same time it is equally important to prepare non-native SLPs to understand the dominant culture and acceptable communication patterns. SLPs also need to be trained explicitly to gain adequate cross-cultural communicative competence with respect to many subcultures and dialects. Though gaining multicultural awareness requires extensive amount of time and effort, SLPs should assume the responsibility to understand cultural, linguistic, and communicative barriers in order to need to develop clinical strategies for effective service delivery to clinical populations.

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MEMBERSHIP FORM

ASHA KIRAN would like to hear from you. Please provide the information below and mail/fax this page to the address at the back of this letter. Please include your comments and suggestions including issues and concerns that you would like discussed in this forum. Thank you for your involvement.

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