# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who we are: OSLHA and eHearsay</td>
<td>2</td>
</tr>
<tr>
<td>In this Issue</td>
<td>3</td>
</tr>
<tr>
<td>Laurie M. Sheehy</td>
<td></td>
</tr>
<tr>
<td>PART 1: Invited Manuscripts</td>
<td></td>
</tr>
<tr>
<td>Multiple perspectives in counseling for culturally and linguistically diverse populations</td>
<td>4</td>
</tr>
<tr>
<td>Janet Bradshaw &amp; Crystal Randolph</td>
<td></td>
</tr>
<tr>
<td>Increasing self-acceptance of stuttering: the use of art in therapy</td>
<td>16</td>
</tr>
<tr>
<td>Anna E. Lichtenstein &amp; Stephanie Hughes</td>
<td></td>
</tr>
<tr>
<td>Presbyphagia: What we need to know to provide best practice</td>
<td>23</td>
</tr>
<tr>
<td>Luis F. Riquelme, Alexandra Soyfer, &amp; Rebecca Benjamin</td>
<td></td>
</tr>
<tr>
<td>Guidelines for SLPs: Effective implementation of the standards</td>
<td>30</td>
</tr>
<tr>
<td>Kristin Nellebach &amp; Thomas Layton</td>
<td></td>
</tr>
<tr>
<td>Hearing status of children in developing nations: A clinical case study</td>
<td>56</td>
</tr>
<tr>
<td>Samantha Daney, Lauren Lonsway, &amp; Lori Pakulski</td>
<td></td>
</tr>
<tr>
<td>CEU Questions (directions &amp; worksheet for earning on-line CEU’s)</td>
<td>63</td>
</tr>
<tr>
<td>Guidelines for Submission to eHearsay</td>
<td>67</td>
</tr>
<tr>
<td>Open Call for Papers</td>
<td>68</td>
</tr>
<tr>
<td>In the Next Issue</td>
<td>69</td>
</tr>
</tbody>
</table>
MISSION:
Empowering our members by providing opportunities for professional development, advocacy, and leadership development necessary to foster excellence in the services provided to individuals with communication and related disorders.

HISTORY:
Founded in 1945, the Ohio Speech-Language-Hearing Association (OSLHA) is a professional association representing speech-language pathologists and audiologists throughout Ohio. OSLHA is recognized by the national American Speech-Language-Hearing Association (ASHA) as the official professional organization for Ohio. OSLHA members provide services for the evaluation and rehabilitation of communicative disorders. Members work in a variety of settings including: clinics, health care facilities, hospitals, private practice, schools, and universities. Members must abide by the OSLHA Code of Ethics.

eHearsay: Statement of Purpose

eHearsay, the electronic journal of the Ohio Speech-Language-Hearing Association, is designed to address the professional development needs of the state association.

Issues are may be developed around specific themes and can include invited papers, research articles, review, tutorial, research forum, letter to the editor, clinical focus/forum or viewpoints.

eHearsay is published as a web journal annually. Continuing education credits will be available for each issue.
Welcome to the Special Spring edition of eHearsay!

This issue contains five diverse topics that affect our membership who work with school-age children to the aging population. It also covers professional practice domains and service delivery domains.

The first article by Janet Bradshaw and Crystal Randolph discusses the importance of counseling in the field of communication sciences and disorders (CSD). American classrooms (grade school through college) are becoming increasingly diverse. Cultural competence is having an awareness of one’s own cultural identity and views about difference, and the ability to learn and build on the varying cultural and community norms. This article discusses theoretical components that facilitate counseling in culturally and linguistically diverse populations and highlight the triadic relationship that occurs between the client, supervisee, and supervisor within a multicultural context.

The second article, by Anna Lichtenstein and Stephanie Hughes, reports on a single case study of a woman who stutters. They employed the use of Acceptance and Commitment Therapy in conjunction with art to facilitate behavioral and psychosocial therapeutic change.

The article on Presbyphagia, written by Luis Riquelme, Alexandra Soyfer & Rebecca Benjamin, explores age-related changes in the swallowing mechanism. These changes place older adults at risk for swallowing disorders, often temporary. Speech-language pathologists (SLPs) who work with this population need to be knowledgeable in aspects of neurology, gastroenterology, neuropsychology as well as head/neck anatomy and physiology.

The Common Core State Standards (CCSS) Initiative is an educational initiative in the United States that details what K–12 students should know in English language arts and mathematics at the end of each grade. To ensure that today’s students are ready to enter college and be competitive in the workforce, the CCSS establish consistent guidelines as to what every student should know and be able to do in math and English language arts. As authors Kristin Nellebach and Thomas Layton explain, SLPs have extensive knowledge of language (spoken and written). It is important for SLPs to have access and opportunity to collaborate in the effective implementation of Common Core for English language arts/literacy to help our students succeed.

The last article, written by Samantha Daney, Lauren Lonsway & Lori Pakulski examines hearing screening data of children living in an orphanage in a developing country. It is well recognized that hearing is critical to speech and language development, communication, and learning. Hearing loss is a global burden with considerable social and financial ramifications. The development and implementation of hearing conservation programs, the necessity of advocating for policy change, and improved collaboration among professionals is addressed.

Sincerely,

Laurie M. Sheehy M.Ed. CCC-SLP
Laurie.Sheehy@utoledo.edu
Multiple Perspectives in Counseling for Culturally and Linguistically Diverse Populations

Janet L. Bradshaw & Crystal C. Randolph

Abstract
The importance of counseling in the field of communication sciences and disorders (CSD) is recognized in our professional community, but implementation of specific skills, especially for CLD populations, remains vague and at times unknown. Despite counseling being included within the scope of practice (ASHA Scope of Practice for Speech-Language Pathology, 2007), many clinicians may feel inadequately trained to provide counseling in clinical practice (Holland, 2007; Luterman, 2001) and more so for clients considered to be CLD (Stockman, Boul, & Robinson, 2008). When interviewing graduate clinicians (i.e., supervisees) Luterman (2001) found that 82% reported a need for more extensive training with counseling in practicums. In fact, the instruction of counseling is not necessarily a structured component in academic curricula and graduate practicums (Culpepper, Mendel, & McCarthy, 1994; Friehe, Bloedow, & Hesse, 2003; Kaderavek, Laux, & Mills, 2004). This educational oversight may extend to the supervisor and supervisee relationship, especially when considering multicultural issues.

In the 2010 Census, there was a 9.7% increase in the population of the United States with Spanish being the most common spoken language after English (U.S. Bureau of the Census, 2012a). It is projected that by 2050, the Hispanic community will account for 30% of the population (U.S. Bureau of the Census, 2012b). As the demographics in the United States change, so will the needs of the clinical population and the skill set of clinicians. When the cultural perspectives of clients are recognized during clinical practice, clinicians are not only addressing diagnostic or treatment concerns, but also acknowledging the emotional needs of the clients and their families.

The purpose of this paper is to address the need of counseling as a vital role and clinical responsibility for professionals in the CSD field. The authors will identify theoretical components that facilitate counseling and highlight the triadic relationship that occurs between the client, supervisee, and supervisor within a multicultural context. Further, specific counseling techniques to be used during the assessment, treatment, and discharging process will be identified. The authors adapted a presentation from a national conference to formulate the basis of this paper (Bradshaw & Randolph, 2015).

Author Affiliations & Disclosures:
Janet L. Bradshaw Ph.D. CCC-SLP is employed at Armstrong State University in the program of Communication Sciences and Disorders in Savannah, GA
Financial – She is an Assistant Professor at Armstrong State University in the Communication Sciences and Disorders program.
Nonfinancial – She has previously worked as a speech-language pathologist in early intervention and the public school system in New Orleans, LA. Her research interests include social communication skills and social-emotional understanding in children with language-learning differences and counseling in the CSD field.

Crystal C. Randolph Ph.D. CCC-SLP is employed at Valdosta State University in Valdosta GA.
Financial – She is an Assistant Professor and Clinical Supervisor at Valdosta State University.
Nonfinancial - She has 11 years of experience as an SLP, mostly in preschool settings. Her research interests include child language and literacy interventions and pedagogical effectiveness in higher education settings.

What is counseling?
Definitions. The definition of counseling depends on how and what we counsel. In the counseling literature, the definitions are broad-based due to many different theoretical approaches. At the 2010 conference, The American Counseling Association agreed, “Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (www.counseling.org, 2010). For clinicians in the field of CSD, the scope of practice includes counseling as it pertains to a person’s communicative and swallowing abilities (ASHA Scope of Practice, 2007). There are

Learning Objectives
1) Describe how counseling impacts the relationships among the clients, graduate students, and faculty
2) Identify barriers and solutions of counseling in culturally and linguistically diverse populations
3) Identify counseling techniques in culturally and linguistically diverse populations

What is counseling?
Definitions. The definition of counseling depends on how and what we counsel. In the counseling literature, the definitions are broad-based due to many different theoretical approaches. At the 2010 conference, The American Counseling Association agreed, “Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (www.counseling.org, 2010). For clinicians in the field of CSD, the scope of practice includes counseling as it pertains to a person’s communicative and swallowing abilities (ASHA Scope of Practice, 2007). There are
parameters to what clinicians in CSD may counsel and when it is legally necessary to refer to a mental health professional (i.e., psychologist, counselor, or physician). It is not within the scope of practice for clinicians to address concerns regarding mental health issues, such as depression, anxiety or suicidal thoughts, and issues related to life changes (e.g., stress related to divorce, deaths, and job change).

However, speech-language pathologists (SLPs) can counsel clients regarding topics that will improve the quality of life related to communication and swallowing disorders. For example, this includes counseling persons who avoid speaking aloud in public due to their dysfluencies or clients who are too self-conscious to eat in restaurants or helping individuals develop social communication skills at school or in the workplace. During a counseling seminar, ASHA Fellow J. Scott Yaruss, Ph.D. described counseling as “an interactive therapeutic relationship in which the client and clinician work together to find solutions to problems identified by the client” (ASHA Webinar, Counseling Skills for Professionals in Communication Disorders, 2015). As trained professionals, speech-language pathologists and audiologists should address the counseling needs of the clients. The goal is to develop a relationship between the client and clinician that supports a framework of change to address communicative concerns.

The form of counseling can take multiple shapes and can be used in many combinations. For example, counseling can include listening skills, discussing feelings and emotions, providing encouragement, informing persons about the disorder, and providing suggestions for problem solving. Counseling is not a ‘one size fits all’ approach and should be adapted to the person and family, their emotional needs, and goals (Holland, 2007).

**Theoretical background.** Several theoretical frameworks can aid the clinician’s understanding of the emotional needs of the client, which will influence the counseling skills used in the session. This paper will address three models of counseling: Person-Centered Therapy, Cognitive Therapy, and the Egan Model.

Carl Roger developed the Person-Centered Therapy (PCT) in the 1950’s as a response to the behavioral and psychodynamic therapies of that time (McLeod, 2008). It was Roger’s intent to promote a more humanistic approach to therapy in which clinicians and clients are equal partners and not framed as expert and client. PCT purposely focuses on a subjective understanding of the client and not their unconscious motive. Roger (1951, 1961) proposed three arching themes in counseling: (1) the client-clinician relationship can affect treatment outcomes, (2) the role of the clinician is to be warm, genuine and understanding, and (3) the purpose of each session was to increase self-worth, congruence with self-concept, and functionality. Roger termed self-concept as “the organized, consistent set of perceptions and beliefs about one self” (McLeod, 2008). However, a person’s self-concept may not always fit the reality of a situation.

Three core conditions for clinicians are paramount for PCT:

1. Clinician is congruent with client
2. Clinician provides unconditional positive regard.
3. Clinician is empathetic.

Only by being congruent or genuine, with oneself and others, could a person begin to adjust their self-concept. An empathic clinician who accepts the client for whom he is (i.e., unconditional positive regard) will facilitate a level of trust and respect between both clinician and client that will lead to positive changes in behaviors (Roger, 1951, 1961).

Similar to Carl Rogers, Aaron Beck developed Cognitive Therapy (CT) as a response to the current method treatment at that time: psychotherapy (Beck, 1955). Beck proposed that how persons perceive situations would influence how they feel and think about those situations. CT is conceptually based on the idea that a client’s beliefs and attitudes can affect treatment gains (Beck, 1955). If a person’s belief system about a situation could be modified, then behaviors regarding that situation could change. The purpose of CT was to have the client identify distorted thinking, modify beliefs and attitudes, relate to others or situations in different ways, and finally change behaviors. CT emphasizes a client’s problem solving skills on current issues by promoting client-ownership of goals. A key component to CT was to facilitate the client’s ability to become his or her own therapist (Beck, 1955).

The last theoretical framework is by Gerald Egan, A Model for Helping (Egan, 2014). Egan’s model evolved
from the psychology and counseling literature where he primarily focused on how humans solve problems and what can clinicians do to help. In his book *The Skilled Helper*, Egan (2014) stated that learning how to problem-solve issues is managed in three stages. Each stage has specific focus or a question the client must ask himself. In stage 1, “What are the issues in my life that are causing me concern?” For this stage, clinicians help their clients to understand the current reality; what is happening in their life and identify and discuss life-changing events (e.g., dealing with a brain injury from an accident or the inability to make friends and understand social-communicative interactions). The second stage explores the question, “What do I want?” At this stage, clinicians’ help clients identify goals and discuss the commitment needed to address the specified goals. In stage 3, the clinician will prompt an answer for “What do I need to do to get what I want?” Clinicians will help clients identify and develop strategies to achieve their goals; evaluating plans and adapting strategies is part of the process (Egan, McGourty, & Shamshoum, 2006). Stage 4 consists of implementing the treatment plan and helping clients achieve their goals. In the Egan Model, the counseling process must be flexible and adaptive; adjustments are to be made as the client navigates his plan (Egan, McGourty, & Shamshoum, 2006; Egan, 2014).

**Counseling within a multicultural context**

The theoretical concepts mentioned above provide a starting point for SLPs to begin effective counseling, but with the increasing diversity in the United States’ population, SLPs must account for cultural differences when providing counsel. Table 1 shows the increase of the population by race group from 2000 to 2014. This increase in diversity can be seen in individuals diagnosed with and treated for communication and swallowing disorders and in students attending college; thereby increasing the need for counseling strategies that account for a variety of ethnicities and cultural groups. Furthermore, individuals among minority cultural groups have a greater prevalence of communication disorders according to the National Health Interview Survey (Benson & Marano, 1994).

Culturally different clients may exhibit different perspectives of counseling than the SLP. In fact, persons in some non-Western cultures may view support provided by relatives or close friends to be more supportive than support provided through counseling (Battle, 1997). For example, Terrell and Terrell’s (1984) research suggests that African American clients display more distrust for white counselors than they did for non-white counselors. The above ideologies suggest an imminent need for multicultural counseling. Multicultural counseling suggests the idea that differences exist between the counselor and the client and that those differences should be acknowledged without the counselor wanting the client to be like her. The information that exists on multicultural counseling comes mostly from the fields of counseling and psychology, but is applicable to the CSD field.

<table>
<thead>
<tr>
<th>Race</th>
<th>2010</th>
<th>2014</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>75.1</td>
<td>77.4</td>
<td>2.3</td>
</tr>
<tr>
<td>Black or African American</td>
<td>12.3</td>
<td>13.2</td>
<td>0.9</td>
</tr>
<tr>
<td>American Indian &amp; Alaska Native</td>
<td>0.9</td>
<td>1.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Asian</td>
<td>3.6</td>
<td>5.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Two or more races</td>
<td>2.4</td>
<td>2.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>12.5</td>
<td>17.4</td>
<td>4.9</td>
</tr>
</tbody>
</table>

In her account of multicultural counseling, Battle (1997) lists cultural assumptions in counseling that necessitate a multicultural perspective. A few of these assumptions include the definition of “problems” as defined by different cultural groups, defining developmental norms, and meanings of abstract terms such as “good” and “bad.” These assumptions are being highlighted because of the high probability that an SLP may encounter such assumptions when treating a client with a communication disorder. The first assumption that looks at the various perspectives of “problems” has important implications for multicultural counseling. This is because what some cultures may consider a problem may not be considered a problem in another culture. For instance, African American and West African cultures have a high incidence of dysfluency; however, this population does not often seek therapy services because dysfluency is not considered to be a problem (Battle, 1997). Another cultural difference comes from the Japanese culture in which children are not considered late talkers if they are able to talk before entering kindergarten. This cultural difference is different from most native North American cultures in which children are considered to be delayed if they do not speak their first word by 12 months old. Finally, there is use of abstract terms such as “good” and “bad.” One example is polygamy, which is considered “bad” in most Western cultures; however, it is acceptable for Muslims in most non-Western countries.

Due to different cultural assumptions, there may be many barriers to effective counseling including class-bound values, culture-bound values, and language usage and communication style differences (Battle, 1997). Class-bound values can be observed in many clinical situations in which individuals from lower socioeconomic backgrounds may be observed missing more appointments and remaining in treatment for a significantly lesser time than individuals from a higher socioeconomic background can. This pattern in attendance can affect the outcome of treatment for individuals with communication or swallowing disorders. Class-bound values may prevent some individuals from receiving service or may render them to believe treatment may not be as effective as treatments typically administered within their respective culture. Finally, the language use and communication methods of various cultures may be a barrier to effective counseling. SLPs often work with individuals whose disorder may cause communication barriers. As such, dealing with communication barriers is not novel. Nonetheless, communication barriers related to culture may present with some challenges. For example, nonverbal communication varies by cultures; Native Americans and African Americans feel nonverbal language is more trustworthy than words. It is imperative that SLPs providing counseling are familiar with the cultural backgrounds of their clients. This familiarity will enable SLPs to reduce as many barriers to effective counseling as possible.

Counseling helps to enhance the communication skills of clients, which may be ineffective with therapy alone (Reed, 2011). The positive outcomes of counseling such as providing an understanding of communication disorders, assisting the clients with adjusting to their communication disorders, and reducing the emotional impact of communication disorders, have important implications for the CLD population. Acknowledging differences is a crucial component of multicultural counseling. SLPs should be sensitive to the client’s cultural distinctions, which will likely lead to a more trusting relationship. Multicultural counseling allows the SLP to gain more insight into the client’s culture and implement more culturally sensitive interventions. Once a trusting relationship is established, intervention sessions may be more effective (Battle, 1997).

Researchers from the field of counseling have developed the RESPECTFUL counseling model to encourage counselors to think about the multidimensionality of clients using a more comprehensive and integrative approach (D’Andrea & Daniels, 2001). This model includes a variety of cultural groups and other important dimensions of an individual to consider and supports viewing clients as being multidimensional. The descriptors for the RESPECTFUL acronym are included below:

- **R**-religious-spiritual identity  
- **E**-ethnic-cultural-racial background  
- **S**-sexual identity  
- **P**-psychological maturity  
- **E**-economic class background  
- **C**-chronological-developmental challenges  
- **T**-threats to one’s personal well-being  
- **F**-family history and dynamics  
- **U**-unique physical characteristics  
- **L**-location of residence

---

**References**


For example, an SLP may have a Native American client that identifies as an atheist and transgender and lives in one of the richest neighborhoods in the community. The SLP would have to consider the multiple dimensions of this client when providing therapy and counseling.

Because SLPs are delivering services to individuals with disorders from various, cultural backgrounds, it is imperative that multicultural awareness and counseling are a part of the curriculum used to train SLPs. Multicultural and multilingualism is considered to be a fairly new topic of research in the CSD field per http://www.asha.org/practice/multicultural/faculty/metakanalysis/. Consequently, moving towards curricula that requires coursework in multiculturalism and counseling may be imminent. “Knowledge and training in counseling increase your level of empathy and your appreciation for the challenges that the client and caregivers face” (Reed, 2007, p. 11). The current CSD curriculum may include a culture course and a counseling course, a course that combines culture and counseling, one or the other, or neither of the courses. The latter is somewhat concerning given the issues discussed above. Some programs may claim that multicultural awareness and counseling are built into all courses in the curriculum; however, it may be debatable that such integration is sufficient.

**Triadic clinical relationship.** The triadic relationship that exists between the supervisor, graduate student clinician or supervisee, and client is a complex one. Although the American Speech-Language Hearing Association (ASHA) provides a document entailing the knowledge and skills needed by supervisors when providing clinical supervision (http://www.asha.org/policy/KS2008-00294.htm), there is no mention of the supervisor’s role in acknowledging or integrating multicultural awareness. The supervisor serves multiple roles including teaching counseling strategies, while embedding multicultural awareness, to the graduate student clinician and implementing counseling with the client and graduate student clinician as needed. The graduate student clinician’s prominent role is to implement counseling with the client. This creates a dynamic relationship that must have a foundation of multicultural knowledge or awareness. The complexity of the triadic relationship is further confounded by the culture of each individual in this relationship flows (See Figure 1). Multicultural awareness and counseling in this triadic relationship has generally focused on the client rather than the supervisor-supervisee relationship (Victor, 2012) although all of the relationships are equally important and heavily influenced by each individual’s culture. The most essential elements of this triadic relationship ...” is establishing trust and a safe environment, encouraging self-disclosure, identifying transference and countertransference, examining diversity issues, and establishing appropriate boundaries” (Reed, 2011, p.153)

The supervisor and supervisee may not acknowledge different assumptions, beliefs, and values and the effects on clients (Hird, Cavalieri, Dulko, Felice, & Ho, 2001). Not acknowledging differences may pose difficulties and barriers in the supervisor-supervisee relationship. As a result, the relationship may not flourish as it should, causing one party or both parties to be uncomfortable with one another. As so, when faced with cultural conflicts with the client, the supervisee may not feel comfortable presenting this information to the supervisor. Even more devastating is that the clinician may model the same behavior with the client who in turn does not feel comfortable discussing multicultural issues within counseling provided by the supervisee. A previous study found that graduate student clinicians view discussions of culture as a positive aspect of the supervisor-supervisee relationship (Burkhard et al., 2006). Likewise, culture is viewed as negative when it is not discussed or acknowledged.

The supervisor mediates the relationship between the graduate student clinician and the client. The supervisee-client relationship may present with difficulties. The services provided by graduate student clinicians may not always be exact (Chabon, Hale, & Wark, 2008). Consequently, counseling skills may be lacking, which may affect client outcomes. Another difficulty that may be encountered is vast differences in the supervisee and client’s cultures. In some instances, this mismatch may prompt the client to ask for another graduate student clinician. Vice versa, the student may refuse to serve a client due to cultural differences although the refusal may instigate disciplinary actions (e.g., failing grade, expulsion) (Deweber, Harten, Coles-White, & Torres, 2013). There are no “one size fits all” solutions to the above scenario and each case has to be dealt with individually. At a recent conference, Deweber, Harten, Coles-White, and Torres (2013),
outlined the actions of a graduate student clinician, also a conservative Christian, who refused to provide services to a client in a same-sex relationship. The graduate student clinician claimed that the client’s sexual preference violated her religious beliefs and was expelled from school. This case presents a scenario in which client and graduate student’s rights to exercise their cultures were violated (See Deweber, Harten, Coles-White, & Torres, 2013 for complete scenario).

Finally, there is the relationship between the supervisor and client. Although not often, the supervisor may provide direct counsel to a client. This occasion may occur when the graduate student clinician is absent or when the supervisor is providing a model for the graduate student clinician. Unfortunately, there is no research that has explored the supervisor’s role in counseling the client and how culture influences that relationship.

**Figure 1. Directions of cultural influence in the clinical triadic relationship**

![Diagram showing the directions of cultural influence in the clinical triadic relationship.](image)

**Multicultural awareness and counseling training.** The minimal training in counseling and lack of multicultural awareness compounds the ability of supervisors and clinicians to implement effective counseling strategies (Horton-Ikard & Muñoz, 2010). In their recent article, Horton-Ikard and Muñoz, (2010) identified 98 out of 135 CSD programs that did not meet the requirement of integrating multicultural issues in coursework via faculty statements or inclusion in the course syllabi. To increase the effectiveness of or establish multicultural counseling, there must be an increase in cultural awareness in CSD programs and an increase of cultural awareness in individuals involved in CSD programs including students, staff, and faculty. The first step in increasing cultural awareness in a CSD program is performing diagnostics to measure the program’s current level of multicultural awareness. This can be achieved by administering the Multicultural Competency Checklist (MCC) developed by Ponterotto, Alexander, and Grieger (1995). The MCC includes 22 items that make up the following categories: minority representation, curriculum issues, counseling practice and supervision, research considerations, student and faculty competency evaluation, and physical environment. Table 2 includes an example statement from each category. After completing the MCC, measures should be taken to address areas of weakness. Although the MCC is intended for college-level programs, adapting it to suit other businesses or work settings may be useful.

Examining the multicultural competence of individuals (i.e., supervisor, supervisee) is equally important as assessing the competence of a program. Multicultural assessments requiring self-reflection and that can be used include the Multicultural Awareness Knowledge Skills Survey (MAKSS; D’Andrea, Daniels, & Heck, 1991) and the Multicultural Competency Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994). The above assessments are taken from the field of counseling and are thorough in assessing individuals’ multicultural competence and eliciting self-reflections. The Cultural Competence Checklist, which is provided by ASHA, can also be taken and can be found at [http://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Personal-Reflection.pdf](http://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Personal-Reflection.pdf). ASHA also offers an online self-assessment for cultural competence at [http://www.asha.org/practice/multicultural/self.htm](http://www.asha.org/practice/multicultural/self.htm).
Another useful tool is a compilation of assessments and links to access them if applicable. This resource can be found at http://spiritualityandculture.com/uploads/Cultural_Competence_Assessment_Tools.pdf.

<table>
<thead>
<tr>
<th>Minority Representation</th>
<th>• At least 30% of the faculty represent racial/ethnic minority populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum Issues</td>
<td>• Multicultural issues are integrated into all coursework. All program faculty can specify how this is done in their courses. Furthermore, syllabi clearly reflect multicultural inclusion.</td>
</tr>
<tr>
<td>Counseling Practice and Supervision</td>
<td>• Multicultural issues are considered an important component of clinical supervision whether the supervision is conducted by program faculty or on-site supervisors. The program has a mechanism to monitor the quality of field supervision.</td>
</tr>
<tr>
<td>Student and Faculty Competency Evaluation</td>
<td>• One component of students’ yearly (and end of program) evaluations is their sensitivity to and knowledge of multicultural issues. The program has a mechanism for assessing this competency (e.g., relevant questions are included on student evaluation forms).</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>• The physical surroundings of the Program Area reflect an appreciation of cultural diversity. (For example, artwork [posters, paintings] is multicultural in nature and readily visible to students, staff, faculty, and visitors upon entering the Program Area, faculty offices, etc.)</td>
</tr>
</tbody>
</table>

Supervisors at various locations (i.e., university, school, hospital) can encourage supervisees to complete the above assessments and self-reflect about their present levels of multicultural awareness before engaging with clients. Likewise, department chairs, rehabilitation managers, and lead SLPs in school districts can encourage SLPs under their management to complete the multicultural self-reflections as well. Once an individual has completed at least one of the above assessments, further steps should be taken to decrease or address weaknesses related to multicultural awareness. To assess current multicultural knowledge (i.e., specific skills about various cultures), SLPs can refer to the February, 2003 issue of The ASHA Leader.

Counseling techniques in clinical practice
Key principles. Another important perspective in counseling CLD population is counseling techniques used in clinical practice. Audrey Holland (2007) proposed that counseling is not a single event, but an ongoing process with multiple components: understanding, explaining, advising, and translating. Each component is an integrative piece of the puzzle and to focus on one aspect (e.g., explain the test results or advising the next steps) may negate the key principles. First, counseling is a listening process that includes an unbiased perspective to different personal beliefs and cultural practices that will facilitate the second principle, a safe place for communication for both the client and clinician. Third, advising clients encompasses not only the next step in the therapeutic process, but discussing this life-changing event and what goals the client values as important. Finally, translating refers to helping the client transition to an active role in his therapeutic process with encouragement and options to make necessary adaptations to the treatment plan to (Holland, 2007).

Carousel of emotions. Emotions play a significant role in the client’s rehabilitative process. Loss occurs when clients and families experience significant changes in routines, relationships, or expectations (James & Cherry, 1988). Grief is a complex process that develops from the change in daily living, which can involve physical, cognitive, emotional, and spiritual effects (Schneider, 1984). Friehle, Bloedow, and Hesse (2003) described the feelings of families associated with a communication disorder to include shock, denial, anxiety, anger, guilt, depression, and acceptance. In general, movement through a grieving situation is a healthier response than being cemented to a particular stage and feeling.

It is important to note that the grieving process is not always a linear process and that it can be influenced by socio-cultural expectations (Green, 1995; Kubler-Ross & Kessler, 2005). Families from different cultures have different expectations or guidelines in their grieving process. Differences can include the client’s or family’s perception of grief, use of coping strategies, and displaying different behaviors (e.g., avoiding eye contact and touch; being open about the loss or choosing not to discuss the topic of disabilities). According to Rollin (2000), six factors influence how a family addresses grief related to a communicative
disorder: mental health of family, nature of marital relationship, coping strategies, severity of disorder, access to information, and efficacy of treatment.

Treating only the clinical aspect of the symptoms is not counseling the client. Clients experience many emotions as they adjust to their current situation and clinicians can help them to process their feelings of grief, sadness, or culture a resilience to overcome struggles (Bradshaw & Gregory, 2014). To discuss communicative and swallowing behaviors that were once easy and are now experienced with extreme difficulty, frustration, and possibly grief can be an emotionally-charged experience. Holland (2007) suggested that the clinician help clients grieve over skills and experiences that have been lost to better understand the current situation. Once a client has accepted the circumstances of today, he will be more willing to develop strategies and actively participate in the therapy plan.

Speech-language pathologists and audiologists have the unique opportunity to listen and be empathetic toward clients, but also incentivize them in the treatment. However, there may be circumstances when a referral to a mental health professional is the ethical choice during rehabilitation. If a client’s emotional and mental health continues to be a concern or it develops outside the scope of practice for CSD, an immediate referral to a mental health professional should be made.

Types of interactions. There are three primary ways to interact with clients during the rehabilitative process.

David Luterman (2008) described three significant interaction styles: informing, persuading, and value and listening. Informing occurs when clinicians explain the current clinical situation and provide educational information regarding the disorder, whereas persuading involves the clinician convincing the client to think or perform in a specific way. Value and listening allows the client to express feelings, emotions, and ideas during a session (Luterman, 2008). Clinicians who feel unprepared for counseling may utilize only one method for interacting (i.e., informing or sharing knowledge only). According to Simmons-Mackie and Damico (2011), clinicians may purposefully avoid the emotional aspects of counseling by discussing information (e.g., focusing on evaluation results or treatment goals), using humor to deflect emotional situations, and shifting the conversation to treatment tasks. All three approaches have benefits, but some strategies are more effective at different times when counseling clients. The goal is to interact with your client in a way that facilitates meaningful change towards therapy goals.

Counseling skills in sessions. Aspects of counseling should be used during each phase of rehabilitation: assessment, treatment, and discharge. The first opportunity clinicians have to utilize counseling skills is at the first meeting with the client and during assessment. Developing a rapport with clients includes being a skilled interviewer. Shames (2006) proposed specific counseling techniques to be used during assessment: attending behaviors and invitations to talk. Attending behaviors encompass both verbal and nonverbal behaviors such as silent listening, which is complete engagement by the clinician, and verbal following, in which the clinician follows and acknowledges the client’s responses by repeating comments (e.g., It’s frustrating when you get stuck on a sound or word; Shames, 2006). Nonverbal communication is just as communicative as it includes eye contact, posturing, personal space, and body movements (e.g., head nodding during client’s speech). Egan (2014) described attending skills as a foundation for listening because it confirms to the client that the clinician is engaged and invested in the interaction. When discussing sensitive topics, there may be circumstances when a client’s verbal message does not match his nonverbal language (e.g., parents discussing the possibility of an autism spectrum disorder). A mismatch of verbal and nonverbal messages enables the clinician to confirm the client’s intentions, feelings, and perceptions (Egan, 2014). At these opportunities, clinicians can probe for further explanation or clarification regarding an issue or topic (e.g., “Tell me more,” “Can you explain that?” or use gestures with heads and hands; Egan, 2014; Shames, 2006).

During the treatment phase, increasing client awareness of their feelings and commitment to achieving goals is critical. Paraphrasing and summarizing the client’s words promotes the chance for the client to confirm or revise the message and goals for the session (Egan, 2013; Shames, 2006). Paraphrasing and summarizing enables both the client and the clinician to see if they are attuned to each other’s feelings and intentions. Further, clients may benefit from being challenged during the session (Egan, 2014). For a few clients, productivity in a session may be
limited; in such cases, challenging the client's commitment, goals or ability to perform tasks may provide an incentive to overcome an obstacle. Another technique useful for helping clients see the benefits of therapy is to brainstorm (Egan, 2014). Brainstorming by both the client and the clinician allows for a partnership regarding plans for the future and the various tasks clients want to address (e.g., reading aloud during a book club or planning a lunch with family members). The point being that not every session will progress smoothly and that clients may need to be encouraged to continue the rehabilitative process.

The discharge process does not always equate a completion of rehabilitation. Quattlebaum and Stepping (2010) suggest that a productive discharge from services must start at the onset of treatment. It is vital to discuss the requirements of a discharge before and during the rehabilitation process. For some clients, therapy may not end, but be transferred to a different level of intervention (i.e., in-patient rehab to outpatient care). It may be beneficial to help certain clients interpret discharge as transitioning to the next phase of treatment and the opportunity to accomplish goals that are more therapeutic.

**Case Scenario**
The case scenario below is meant to allow the reader to reflect on information presented in the article.

Dr. Smith, an African-American professor serves as a clinical supervisor in her department’s speech, language, and hearing clinic. The clinic has strict rules to follow regarding students’ professional behavior (e.g., attendance, attitude) in the clinic. Dr. Smith is known for her “no nonsense” attitude. Dr. Smith supervises several students, all of which are from different cultural backgrounds than Dr. Smith. Farrah, one of Dr. Smith’s students, is an Arabic female and a practicing Muslim. She wears a veil, which has seemed to perplex her pediatric clients with one of whom attempted to pull it from her head. Parents and children are often seen whispering upon Farrah’s entrance or exit in a room; however, Farrah has a quiet disposition and never reacts or responds. Farrah’s client is a 6-year-old Caucasian male who has a diagnosis of autism. Farrah missed several speech therapy sessions during Ramadan last semester due to an abrupt increase in her blood sugar levels and hospitalization. During the current semester, Farrah has been absent for several therapy sessions. Farrah informed Dr. Smith of her initial absence but not the subsequent absences. Following the clinical and grading policies, Dr. Smith, somewhat furious, proceeds to subtract points from Farrah’s clinical grade. She attempts to contact Farrah via email but has not received a response. Dr. Smith knows that Farrah is attending school on a financial need-based scholarship and would lose this funding if her grades were to drop. Dr. Smith also has to call and speak with the client’s caregiver to inform her of the clinician’s absence and the possibility of a cancellation in sessions for the remainder of the semester. The caregiver previously expressed concerns about the multiple absences and requested another therapist “who wasn’t different.”

Consider the scenario above and using the information presented in this article, respond to the questions below.

1. How would you have responded to the situation with the graduate student clinician?
2. How would you address the client’s caregiver when explaining the excessive number of cancelled therapy sessions?
3. Based on the information from this article, how could this situation have been avoided?
4. What steps should be taken going forward to decrease tension in the supervisor-supervisee relationship?
5. What cultural influences may interact in a bidirectional manner between the supervisor and graduate student clinician? How might these influences affect the client’s therapy sessions?
6. How might the client’s reactions be influenced by the graduate student clinician’s culture?

Although the scenario listed above may be one of many extremes, hopefully the importance of and implications for implementing multicultural counseling in triadic relationships has been illuminated. The questions above are meant to prompt self-reflections, as each individual’s responses will vary according to their levels of counseling knowledge and multicultural awareness. What would you do? The circumstances described in
the scenario above may have been prevented had all parties involved acknowledged their differences and proceeded to discuss the effects of those differences. The scenario above pleads for the use of the RESPECTFUL counseling model and effective multicultural counseling especially in the field of CSD.

Suggestions for implementing effective multicultural counseling:

- Program directors/policy makers: require or include a multicultural counseling class or a culture course in the program curriculum for SLPs
- Expand knowledge of various cultures gradually. Multicultural counseling requires ongoing learning. An individual is not expected to know all characteristics of all cultures.
- Be self-aware of your feelings, stereotypes, and prejudices related to various cultures
- Consider clients’ multidimensionality using the RESPECTFUL counseling model
- Acknowledge cultural differences that may exist in the clinical triadic relationship
- Use the MCC to evaluate multicultural competence in CSD programs
- Utilize a multicultural awareness checklist to measure current level of multicultural awareness; make adjustments as necessary

Conclusion
In conclusion, counseling in the field of CSD has advanced considerably. Even with the latest advancements, SLPs continue to feel lacking in the area of counseling. This may be due to the lack of counseling as required coursework in the field of CSD. Compounding the issue further is the topic of multicultural awareness that has transpired with the rapid increase of diversity in the population. A majority of CSD programs does not require coursework in multiculturalism; thus, putting SLPs at a disadvantage when providing therapy services to an increasingly diverse population. Even with the lack of information provided at the undergraduate or graduate levels, SLPs can still become knowledgeable in the areas of counseling and multiculturalism. Following the suggestions mentioned throughout the article would provide a great start. Attending relevant seminars or workshops would also be helpful. Although not required, advisors within CSD departments can recommend students to take a course in culture, counseling, or both as electives.

Correspondence concerning this article should be addressed to:
Janet Bradshaw
Email: jan.bradshaw@armstrong.edu

References


Increasing Self-Acceptance of Stuttering: The Use of Art in Therapy

Anna E. Lichtenstein & Stephanie Hughes

Abstract
Purpose: This study examined if the therapeutic use of art, in combination with stuttering modification therapy, increased acceptance of stuttering for a client who stutters.

Method: The client, a 46-year-old woman who stutters, attended speech therapy to address stuttering once a week. The use of art as well as stuttering modification approaches such as identification and desensitization were incorporated into therapy. The client was required to collect three pieces of art weekly to be included in an art portfolio. These pieces of art included photographs, words, advertisements, articles, lyrics, and 3-dimentional art. For each art piece she completed a questionnaire that asked her to (a) describe the art pieces she added to her portfolio, (b) write about what the art meant to her and how it represented her speech, and (c) rate her acceptance of stuttering in relation to the piece added to the portfolio. The rating scale ranged from 1=not accepting to 10=very accepting.

Results: Using a BAB single-subject design, results indicated that during the initial B phase, the client’s acceptance of stuttering increased as she continued to build her portfolio. Acceptance decreased during the A (withdrawal) phase but increased again after therapy was reinstated during the final B phase.

Author Affiliations & Disclosures:
Anna E. Lichtenstein M.A. CF-SLP is employed at the Columbus Speech and Hearing Center.
Financial – Employed as a speech-language pathologist at the Columbus Speech and Hearing Center in Columbus, Ohio.
Nonfinancial – As a graduate student at the University of Toledo, she provided services for people who stutter and specifically for the person this article was about.

Stephanie Hughes Ph.D. CCC-SLP is a professor of Speech-Language Pathology at the University of Toledo.
Financial – Associate Professor of Speech-Language Pathology at the University of Toledo
Nonfinancial – Assistant Director of the University of Toledo’s Northwest Ohio Stuttering Clinics. Research interests include psychosocial aspects of stuttering and communication disorders including school-age bullying.

Acceptance of Stuttering and Quality of Life
Stuttering is an involuntary disruption of the smooth execution of a speaker’s intentional speech act (Yairi & Seery, 2011). It is a multifaceted disorder involving primary speech characteristics as well as secondary reactions that can include anxiety as well as negative thoughts, attitudes, and emotions (Yaruss & Quesal, 2004). By the time individuals who stutter reach adolescence, it is unlikely that they will recover or be

Learning Objectives
1) Describe how acceptance of stuttering and quality of life are related
2) Justify the use of art as a therapeutic tool for communication disorders
3) Discuss the effectiveness of art in combination with stuttering therapy for a client who stutters
“cured” from stuttering (Yairi & Seery, 2011). Thus, people who stutter (PWS) must learn to manage their stuttering as a chronic condition.

Quality of life may also be affected for PWS, irrespective of the severity of their stuttering (Beilby, Byrnes, & Yaruss, 2012). Quality of life is a multidimensional concept emphasizing the self-perceptions of an individual’s current state of mind (Bonomi, Patrick, Bushnell, & Martin, 2000). Self-acceptance, including acceptance of stuttering, is one coping mechanism that may lead to better quality of life for PWS. Plexico, Manning, and Levitt (2009) found that PWS may have low self-acceptance because they find themselves lacking compared to their ideal selves; this may cause fear of listener reactions to stuttering. The tendency for PWS to hide or avoid their stuttering due to such negative emotions has been documented in the literature, and therapy approaches that emphasize open and honest stuttering, such as the stuttering modification approach, have been advocated for many years (Van Riper, 1973).

An increasing number of clinicians and researchers are recognizing that promoting acceptance of stuttering can be an important aspect of stuttering therapy (Beilby et al., 2012; Palasik & Hannan, 2013). For example, the use of Acceptance and Commitment Therapy, with its emphasis on awareness, acceptance, and understanding the context of thoughts, may be helpful for PWS (see Palasik and Hannan, 2013, for a more detailed overview). Teaching acceptance is beneficial in treatment because it enables clients to embrace emotional and cognitive events without attempts to change the stuttering disorder itself (Beilby et al., 2012). Similarly, teaching “mindfulness,” i.e., acknowledging thoughts and feelings without judging them, can also promote acceptance of self and stuttering (Plexico & Sandage, 2011). The literature suggests that the inclusion of these concepts into stuttering therapy helps clients to have a better understanding of themselves and their communication abilities, thereby increasing their quality of life and leading to more effective treatment outcomes (Yaruss, 2010).

Acceptance and Art
Art therapy has been used since the mid-20th century as a hybrid between art and psychology (Malchiodi, 2012). It is the symbolic communication of unconscious material in a direct, uncensored, and concrete form that allows clients to use creativity to express, nonverbally, their thoughts and feelings (Malchiodi, 2012). Art therapy for adults can act as a metaphor for conflicts, emotions and situations by tapping the unconscious and helping adults to increase awareness. Art therapy can also create a visible trail of progress and note development and change. Professionals such as counselors, psychologists, psychiatrists, social workers, marriage and family therapists, allied health professionals and speech-language pathologists may use art expression without an art therapy license (Malchiodi, 2012).

The creation of art and interacting with art in creative ways has an uplifting effect on mood in general. De Petrillo and Winner (2005) showed images of tragedy to stimulate negative mood in a group of university students comprised of art and non-art majors. After drawing a picture, both types of students reported improved mood, not just the art majors. This study provides support for the power of art expression to heal among the general population. Other researchers have found similar results for specific clinical populations, including people who have emotional or psychological disturbances (Ball, 2002; Franks & Whitaker, 2007; Saunders & Saunders, 2000) and health conditions such as cancer or chronic diseases (Hamre et al., 2007; Gunter, 2000). Pizarro (2004) reported that the use of art makes participants more likely to continue treatment.

While there do not appear to be any published studies on the benefits of art therapy for people who stutter, there is some evidence to suggest that art therapy is beneficial for people with other types of communication disorders. Pachalska et al. (2001) reported that children and adolescents with severe dysarthria due to cerebral palsy demonstrated improvement in all speech parameters (intelligibility, rate, volume, fluency) when art therapy was combined with speech therapy. Pounsett, Parker, Hawtin, and Collins (2006) found that art therapy improved attention and affect for adults with learning and developmental disorders. Adults with dementia have also been reported to receive benefits from art therapy. Stewart (2011) found that when patients with dementia utilized various art media such as drawing, painting, and graphic design, their engagement in therapy and their expressive language increased. Rusted, Sheppard, and Waller (2006) found similar results, noting that patients...
with dementia demonstrated an increase in mental alertness and willingness to engage socially, physically, and emotionally as a result of art therapy. Thus, the use of art to express oneself when speech and language are impaired may be of interest to SLPs who work with a wide variety of clients, including those who stutter.

The Present Study
The lines of research reviewed here suggest that quality of life and acceptance of stuttering are important considerations for stuttering therapy, and that the use of art in therapy improves mood and is effective for people with speech and language deficits. Although the literature has not reported on the benefits of combining traditional speech therapy for stuttering with art therapy and acceptance in one study, there seems to be evidence to prompt a study of acceptance and art therapy for people who stutter. Thus, data from a single-subject case study was examined to determine if the use of art in therapy, (i.e., “art expression”), in conjunction with stuttering therapy, is useful in terms of increasing acceptance of stuttering for an adult who stutters.

Methods
Participant
The participant was a forty-six-year-old woman named Lola (a pseudonym) who had been diagnosed with a mild-moderate fluency disorder. She worked as a home-health care nurse assistant and lived with her husband and young adult daughter. Lola was a native Ohioan who spoke English as her primary language. Lola had received speech services inconsistently since elementary school. These therapy experiences were not positive; in fact, she had very negative memories of being “pulled” from class. Lola reported negative feelings towards her speech from a young age. As a child, Lola’s parents were constantly trying to find an experimental cure for stuttering that often involved homeopathic remedies, some of which were traumatic for her.

Lola attended a two-week intensive stuttering clinic prior to the current study that focused on improving attitudes toward communication and provided clients with tools to change the way they stuttered. Achieving fluent speech was not emphasized during this intensive clinic. Lola reported that she had benefited from speech therapy for the first time as a result of this intensive therapy. During this time, Lola freely acknowledged a strong and persistent negative attitude towards her stuttering characterized by avoidance, excessive interjections, and overall dislike of the word “stutterer.”

Data for the present study was collected during follow-up therapy after the client’s intensive clinic experience. During follow-up therapy, a stuttering modification approach was continued that consisted of: (a) identification of unhelpful thoughts and feelings related to stuttering, (b) identification and reduction of secondary behaviors, particularly the use of distracting interjections such as “you know,” and (c) desensitization to stuttering in the form of purposeful (voluntary) stuttering. At the beginning of follow-up therapy, Lola was still hopeful of a medical cure to end her stuttering, and she noted that she continued to experience emotional turmoil because of stuttering. The client would engage in lengthy discussions about her emotional distress but was resistant to cognitive-behavioral activities, such as journaling, mood logs, and cost-benefit analysis worksheets that can help clients to cope with stuttering and its emotional effects more productively.

After the first six weeks of follow-up therapy it became apparent that Lola had not maintained the gains she had made in the intensive clinic, and efforts to engage her in traditional forms of stuttering modification therapy (especially identification and desensitization activities) were not effective. The clinician noted that Lola was very interested in art, specifically photography. She enjoyed meditation and art interpretation as hobbies and would often discuss these interests with her clinician. Thus, after several weeks with no forward momentum in progress, the clinician attempted to engage Lola in the therapeutic process by incorporating her interest in art into stuttering therapy.

Research Design
A single-subject experimental (BAB withdrawal) design was implemented to evaluate the effects of the use of art in therapy on the client’s levels of acceptance toward her stuttering. Single-subject designs have the benefit of allowing clinician-researchers to systematically investigate treatment approaches while maintaining flexibility (Kearns, 1986). Single-subject designs also allow the client to serve as his or her own control; accordingly, the functional relationship between independent and dependent variables can be examined without large numbers of participants to
serve in treatment and control conditions (McReynolds & Thompson, 1986).

While there are many types of single-subject experimental designs, a withdrawal design was implemented in this study. More specifically, the BAB design was used, in which “B” represented the use of art in conjunction with the identification and desensitization phases of stuttering modification therapy (specifically identification of thoughts, behaviors, and feelings related to stuttering as well as desensitization to stuttering through voluntary stuttering and trying not to avoid stuttering through use of excessive interjections.) The “A” phase represented the withdrawal of both types of treatments that served as a control mechanism, much as a control group may be implemented in group research designs.

The use of the BAB design is less common than the ABA design, in which a number of data points are gathered until a stable baseline is obtained, followed by the initiation of treatment and the subsequent withdrawal of that treatment in the second A phase. For this study, the BAB design was implemented because after six weeks of stuttering modification therapy focusing on identification and desensitization, the client continued to make statements that indicated she felt negatively about stuttering and had not yet accepted that there was not a cure for stuttering. Accordingly, rather than delay implementation of the art therapy project to formally baseline acceptance of stuttering, the clinician (the first author) decided to integrate art into stuttering modification therapy without delay, prompting the BAB design. Some of the limitations of this design are discussed in the discussion section.

**Data Collection and Materials**

**Instrumentation.** Data were collected through a questionnaire created by the clinician. The questionnaire consisted of the following items:

1. Describe the art piece.
2. What does the art mean to you?
3. How does this art piece represent your speech?
4. Please rate your acceptance of stuttering in relation to the art piece on a scale from 1=not accepting to 10=very accepting.

In the context of this study, experimental control was demonstrated when therapy was withdrawn in the A phase of design.

**Art portfolio.** An art portfolio was used in order to contain all of the pieces that Lola used for the project. The portfolio (see examples in figures 1-2) was in the form of a photo album so that the participant could slide the pictures, quotes, and articles into the clear plastic sleeves. The artwork for the project included both found art and created art, affording the client maximum artistic freedom. Lola brought the portfolio to each session for discussion.

**Procedures**

**Initial Treatment (First B phase).** During this phase the clinician introduced the project and explained the take-home aspect of the assignment. Instructions were dictated as so: “We will be conducting an art therapy project and I will be recording the results for a research purposes if that is okay with you. This project will take place over the span of seven weeks [the remainder of the academic semester]. Each week you will collect three inspirational items in regards to your speech and fill out a data sheet for each item. Please bring your art portfolio and data sheets with you each week for discussion during sessions.” The client was able to ask any questions regarding completion. The clinician kept Lola’s data sheets as she submitted three a week with three new additions to her portfolio. This phase took place over the span of four weeks; no *a priori* decision about the length of this phase was made; instead the trends in the data dictated the length of the treatment before therapy was withdrawn.
Withdrawal (A phase). During this phase, therapy was withdrawn completely. The client and clinician did not meet, and the examiner instructed Lola to stop collecting pieces for her art portfolio but continue to rate her acceptance three times throughout the week.

Final Treatment (B phase). The procedure to collect data for the final B phase of treatment was the same as the initial B phase.

Data Analysis
A line graph was used to plot the client’s self-ratings of her acceptance of stuttering. The three ratings each week were averaged into one data point and plotted on the graph. As this was a single subject design, statistical analysis was not necessary, and determination of the effectiveness of treatment was determined by visual analysis of the graph. The trends in the data as plotted on the graph dictated the length of the treatment and withdrawal phases, as both are influenced by the extent to which changes in the dependent variable, in this case acceptance of stuttering, were observed (as per Balthazar, 2003).

Results
In weeks 1-4 of the study, the client’s self-ratings of her acceptance of stuttering steadily increased from an average rating of 6 to an average rating of 9. At this point, having observed a definite trend and not wanting treatment to generalize before control could be implemented in the A phase, therapy was withdrawn. After one week in which therapy was not provided (this happily coincided with the cancellation of therapy due to the American Speech Language Hearing Association convention), the client’s acceptance ratings decreased to 7. This rating marked a return toward the client’s lowest acceptance ratings at the beginning of the study, and so therapy was reinstated the next week. Weeks 6-7 resulted in another increase in acceptance, and the experimental portion of the study ended after week 7, in which the client’s self-ratings of acceptance averaged 10 on a 10-point rating scale. Participant data is shown in Figure 3.

Discussion
The results indicated that combining identification and desensitization activities with art activities increased self-acceptance of stuttering for one woman who stutters. At the beginning of the treatment period, Lola would mention her dislike for the word stuttering and how her family would avoid the topic. At the end of the treatment period Lola reported having open and honest discussions with her brothers, husband, and daughter about stuttering, particularly with regard to how stuttering had impacted her life and the things she was doing to be a more confident communicator. This was a significant indicator to the clinician that Lola was making an effort to be more aware and accepting of stuttering and that she had an increased understanding of its effects on her daily life and relationships.

At the end of the treatment period, Lola stated that she is on her way to being more accepting of herself and her stuttering and that mindfulness and collecting pieces of art had been very inspiring. Whereas at the beginning of the treatment period Lola seemed uncomfortable and anxious, by the end of treatment she started sessions...
with confidence and immediately shared her progress and her additions to the art portfolio. It was recommended that Lola continue to collect pieces for her portfolio as well as continue with stuttering modification in terms of desensitization and utilizing a mindfulness approach.

Future Research Directions
The results of this study demonstrated an increase in acceptance ratings over a period of seven weeks and show promise for the integration of art into stuttering approaches that involve counseling at their core, such as stuttering modification and Acceptance and Commitment Therapy. Further research, however, is needed to ascertain the extent to which the use of art, by itself as well as in conjunction with traditional therapies, may result in an effective therapeutic tool by which to change attitudes of PWS toward their stuttering.

The lack of carry-over during the A (withdrawal) phase of the study indicated that the art therapy in combination with stuttering modification therapy increased acceptance as opposed to an external factor; however, this does raise the question of whether this type of therapy may need to be ongoing for its effects on acceptance of stuttering to persist. Further, this study did not make an attempt to separate the effects of art therapy from the effects of the identification and desensitization aspects of stuttering modification therapy. To better account for individual components of treatment, an additive design (e.g., BC-B-BC-B) would be more appropriate, in which BC represents a combined art therapy/stuttering modification treatment approach, and B a traditional stuttering modification approach.

Additionally, this was a single-subject design with a woman who stutters, so it is inappropriate to generalize these results to the entire population of PWS, most of whom are male. Further, the age of the client is also a consideration, as she was mature and comfortable enough to share feelings, attitudes, and emotions, whereas the results may have differed if the participant was younger and more immature. To further examine these differences, a group research design utilizing control and comparison groups is warranted. Finally, the difference between the use of “art therapy” and incorporating therapy into art, i.e., “art expression” is unclear at this time. Formal art therapy for people who stutter should be explored in future studies.◆

Correspondence concerning this article should be addressed to:
Anna Lichtenstein
Columbus Speech and Hearing Center
510 E. North Broadway St
Columbus, OH 43214
alichtenstein@columbusspeech.org
614-261-5476

References


Presbyphagia: What Speech-Language Pathologists Need To Know To Provide Best Practice

Luis F. Riquelme, Alexandra Soyfer, & Rebecca D. Benjamin

Abstract
The evaluation, treatment and management of swallowing disorders in older persons require a different skill set of the practicing clinician. Older persons in the United States are living longer and healthier lives. It is not uncommon to see a mostly healthy older adult in our office with a complaint of dysphagia. The question that arises for the clinician/examiner then is: After diagnosis with an instrumental examination, what can I offer? Will exercises be helpful in the aging swallow physiology? Will a modified diet be the manner in which to proceed? Will simply providing a compensatory strategy suffice? These are all questions that arise when working with older adults and trying to understand how an older group of anatomical structures work in the context of another possible etiology, whether neurologic or mechanical. Working with this unique population highlights the need for the speech-language pathologist to be knowledgeable in specific aspects of neurology, gastroenterology, neuropsychology and head/neck anatomy and physiology, aside from our usual training in the field.

Learning Objectives
1) Define presbyphagia and list three associated physiological changes
2) Describe two predictors and two risk factors for aspiration pneumonia
3) Discuss impact of decompensation on the swallow evaluation

Our role, as speech-language pathologists (SLPs), is to help maintain a safe per oral (PO) diet as long as possible and attempt to maintain the pleasure of eating for as long as possible. This should lead to better nutrition, and through good oral hygiene, better pulmonary health. Let us not forget the patient with dementia, or cognitive impairment, who brings to the table another set of challenges. Is the reduced PO intake secondary to a physiological swallowing problem or is it a behavioral issue? This is not always easy to discern. We are only in the beginning stages of trying to understand the unique set of circumstances with this growing population. Again, what is our role as speech-language pathologists? For most, the correct answer is to maintain safe and nutritious PO intake for as long as possible.

Working with older adults may soon be commonplace, as the number of persons over the age of 65 is growing at a fast pace. According to the 2010 U.S. Census Bureau report, this age group is 13% of the total U.S. population, and grew at a faster rate (15.1%) than the total U.S. population (9.7%) since 2000. Experts expect that by the year 2030, the number of Americans over...
age 65 will double, from 33.5 million in 1996 and 40.2 million in 2010, to 69.5 million (Desai, Zhang, & Hennessey, 1999). This change in demographics has brought with it many perceived challenges for current social, educational, and healthcare systems. Many have paid attention to these changes over the past few decades, but change has been gradual and, some believe, slow.

While characteristic changes in the swallowing mechanism of healthy older adults is known as presbyphagia, the influence of other factors cannot be overlooked. Older adults are more vulnerable to disease and with the increased threat of acute illnesses, medications and any number of age-related conditions; they can cross the line from having a healthy older swallow to being a person with oropharyngeal dysphagia.

**Normal Aging Swallow**

Understanding the aging swallow, or presbyphagia, is imperative when working with older adults. Normal physiological changes in an older person may be identified as atypical or even pathological in a younger person, unless the clinician is well-versed in understanding the dynamics of physiological changes in normal aging. Dysphagia is a known result of stroke and Parkinson’s Disease, for example, however new evidence is emerging that correlates dysphagia with more chronic conditions of aging, such as congestive heart failure and diabetes mellitus (Robbins et al., 2005). Sarcopenia, the loss of muscle mass as a natural part of the aging process, is an important factor to also consider when assessing the aging swallow. As mentioned in Robbins et al., 2005, a functional decline in swallowing is a known result of sarcopenia involving the striated musculature of the extremities with negative consequences involving the smaller striated muscle groups, such as those involved in swallowing.

Over the years, we’ve learned about several physiological changes in swallowing that are related to the aging process in healthy individuals. These changes include: increased oral and pharyngeal transit times; increased total swallow duration; increased duration of hyoid movement; increased pharyngeal residue/stasis; higher incidence of multiple hyoid gestures; and increased delay in timing from bolus entry to pharynx to beginning of hyoid ascent (Corbin-Lewis et al., 2004). To further support these changes, Humbert et al., (2009), confirmed temporal changes in healthy aging, including shorter laryngovestibular closure times. She also reported on cerebral activation changes in healthy older adults using fMRI. Results showed that cerebral activation for swallowing became more lateralized to the right hemisphere with healthy aging. Of further interest to many clinicians working with this population is tongue strength, endurance and timing of elicitation of the pharyngeal swallow.

**Tongue strength.** Changes in tongue physiology in older persons have been studied for over a decade now. Robbins et al., (2005), showed that in healthy older participants, lingual resistance exercises served to significantly increase isometric and swallowing pressures. Notably, swallow pressures increased after 8 weeks despite the absence of swallowing tasks in the prescribed exercise protocol. An increase in tongue volume of 5.1% was also noted for those older participants that underwent an MRI. Exercise dosage remains unclear at the present time; however, this study showed gradual increases in isometric pressures consistently up to 6 weeks, indicating these exercises should be performed for at least that amount of time. Several researchers are exploring timing as a factor in studies on other swallow-related structures, such as tongue strength, expiratory muscle strength training and pharyngeal contraction.

**Endurance.** Endurance at mealtime has received some attention, despite its importance in mealtime success and safety. Fatigue at mealtime can negatively affect successful dining in older adults. In 2010, Kays et al., found that young and older adults demonstrated reduced tongue strength and endurance after dining; and that younger subjects showed greater declines in anterior tongue endurance, while healthy older adults exhibited signs of swallowing difficulty (wet voice, throat clear and cough). Older adults took longer to complete their meals than the younger participants. Sense of effort was self-reported by participants, and found that the highest level of effort during mealtimes was reported by the oldest volunteers. This subjective, yet useful, information may be an important tool to utilize during evaluations. Robbins and her colleagues have over time made several key points in this area of research and practice: eating is an endurance activity and therefore endurance may be essential for lifelong successful and enjoyable dining. Understanding these findings is essential to the SLP working with older
adults. It requires the incorporation of mealtime observations and direct questions related to endurance into the overall diagnostic picture. At the present time, clinical and instrumental evaluations do not take endurance into account. Videofluoroscopic swallow studies and FEES are a snapshot of a person’s functional swallow. While many practicing clinicians may conduct these observations, they are rarely documented in the assessment report, and do not always present supporting data for comparison.

**Timing.** The timing for elicitation of the swallow has also received attention in the context of healthy aging. In 2007, Dr. Martin-Harris reported on the variability of locations where the swallow was triggered by different age groups. So, if a person triggers the swallow when the bolus reaches the valleculae, is this abnormal? If it’s an adult over age 65, it certainly is not. Therefore, it is suggested that while the delayed initiation is to be reported, unless symptomatic, there is no reason to focus any treatment or time on attempting to change this normal behavior.

Also influencing the timing of the swallow is the effect of cuing during the instrumental examination. Dr. Daniels (2007), published a paper where she looked at the effects of timing for the elicitation of the swallow when the patient was cued versus not cued. In the cued condition, participants held the liquid bolus in their mouths until instructed to swallow. In the non-cued condition, participants swallowed in their usual manner. This study was completed using videofluoroscopy. She and her colleagues found that verbal cue affected bolus position at onset of timing measures, thereby influencing duration. The bolus was more posterior in the oral cavity at time of onset for the cued swallows than the non-cued.

**Aspiration**

This is of major relevance to the SLP working in the area of dysphagia, as well as the clinician working with the aging population. In the United States, aspiration pneumonia remains the fourth most common cause of death among the elderly (Beers & Berkow, 2000). While the physician can reach the diagnosis of aspiration pneumonia through X-rays, white blood cell counts and/or history of temperature spikes, the SLP needs to explore: why the aspiration event occurs (where is the breakdown in physiology?), when it occurs (before, during or after the swallow?), for what diet consistencies it occurs (maybe for liquids, but not for semi-solids or vice-a-versa) and how can it be prevented from developing into a pneumonia again? It is clear that the challenge of preventing aspiration pneumonia is ours.

In this context, it is imperative that the SLP understand how the upper airway behaves during the swallow as people age. These aspects have to be taken into consideration during the clinical swallow evaluation, as well as during instrumental assessments. The assessment of the respiratory system, as well as protective mechanisms can help determine aspiration risk. We are also just beginning to explore the role of pharyngeal residue and aspiration risk (Molfenter & Steele, 2013). For SLPs the difference between aspiration (sub-glottic) and laryngeal penetration (supra-glottic) is important. **Aspiration** is the misdirection of oropharyngeal contents into the larynx, below the vocal folds. It may occur during oral intake (prandial) or may not be associated with food or fluid consumption (nonprandial). **Laryngeal penetration** is defined as the misdirection of oropharyngeal contents into the laryngeal vestibule, but not below the vocal folds. In the context of best practice, the SLP should be aware that in people under age 50, as reported by Daggett et al. (2006), laryngeal penetration was evident in 7.4% of the swallows; and in persons over age 50, laryngeal penetration was noted in 16.8% of the swallows. This means that we all naturally penetrate food or liquid during our meal. The question is: at what point is it too much? This data should guide the SLP in conducting and interpreting instrumental examinations and thus reduce the over diagnosis of dysphagia or the overuse of modified diets. We also know that during our sleep we aspirate our oral secretions regularly. At what point does this combination become too much for the aging body to handle? We do not know this answer as of yet.

The predictors of aspiration pneumonia remain similar to those reported by Dr. Susan Langmore in 1998. Namely, poor health status, age, prior history of aspiration pneumonia, presence of feeding tubes, presence of tracheostomy tubes, location in the hospital, feeding dependence, immobility/ambulatory status and poor oral hygiene. Predictors of aspiration (the event) also remain similar to those reported in 1998: poor posture, severe dysphonia, wet/gurgly vocal quality, reduced volitional cough, poor hyolaryngeal
excursion. The presence of feeding tubes has always been a bit controversial. When looking at nasogastric tubes (NGT), which are placed transnasally and travel along the posterior pharyngeal wall to the gut, the major concerns voiced by SLPs are its size, the need to sufficiently relax the pharyngo-esophageal segment, and the potential for additional residue adhering to the tube itself. In 2008, Leder & Suiter published a study demonstrating with videofluoroscopy that risk for aspiration did not change in the presence or absence of an NGT. Most recently, in 2015, Pryor and colleagues took a closer look at this issue. They found that NGT presence increases airway penetration-aspiration, pharyngeal residue and prolongs transit through the pharynx in older healthy individuals. Another area that requires further study is the direct impact of feeding dependence to changes in bolus flow, as a result of temporal and other physiological differences in this context.

Many physicians may order “aspiration precautions” for those patients they consider at-risk. The problem in healthcare is that this order is interpreted differently by different healthcare professionals. There is no national standard for the definition of “aspiration precautions.” Healthcare facilities most often employ the term, but do not report on what the definition entails, if they have an agreed-upon definition. This may be part of the reason why we do not have much Level I or Level II evidence for the impact aspiration precautions have on the incidence of aspiration events or aspiration pneumonia. As institutions develop a more cohesive definition for aspiration precautions, it is highly recommended that oral hygiene be included. This is extremely relevant in the context of caring for the elderly.

**Oral hygiene**

The impact of good oral hygiene on the prevention of a myriad of pulmonary infections, including aspiration pneumonia, has finally been receiving attention. In essence, poor oral hygiene increases the risk of aspiration pneumonia. A xerostomic oral cavity (i.e., dry mouth) shows a ten-fold increase in bacteria. Tooth decay shows an increase in streptococcal bacteria, as well as periodontal disease, which also results in increased oral bacteria. When the patient inhales, where does this bacteria travel to? Clearly, to the lungs. This may be one cause of an aspiration pneumonia in a person that is NPO or presents with poor oral hygiene, and not necessarily prandial aspiration of food or liquid.

There are many published articles on how to conduct good oral hygiene, but minimal correlation with pulmonary diseases. Yoneyama et al. (2002) reported that with aggressive oral care the rate of pneumonia was reduced from 19% (in control group) to 11% in the active group over 2 years follow up period. Most recently, in 2014, Quinn and colleagues reported data on the incidence of nonventilator hospital-acquired pneumonia (NV-HAP). They found that after initiating oral care protocols throughout their hospital, the rate of NV-HAP per 100 patient days decreased by 38.8%. This resulted in cost savings for the facility, as well as saved lives.

**Dementia**

When speaking of the normal aging swallow, clinicians must attend to the growing number of persons with dementia, especially in view of the rapid growth of the aging population in the United States. The influence of cognitive status on the swallowing mechanism is unclear. Although there are few studies of the incidence and prevalence of dysphagia in individuals with dementia, it is estimated that 45% of institutionalized persons with dementia present with dysphagia. Overall feeding and oral intake may need to be explored, in addition to the specific physiological components of the swallowing mechanism (Riquelme & Tristani, 2014). While we know that this population presents with changes in oral intake, how much of it is cognitively-based versus an actual breakdown in the physiological components of the swallow? Dementia presents a combination of age-related changes in sensory and motor functions, in addition to other changes that are secondary to neuropathology. It is also important to differentiate Alzheimer’s Dementia from other dementias, such as Vascular or Frontotemporal. The literature does not always differentiate them, and so we must be careful with conclusions reached and their generalization. How the dementias are diagnosed is another complicating factor in this discussion, but not within the scope of this article. Suffice it to say that while best practice dictates that the diagnosis be made by a neurologist, psychiatrist or geriatrician, the truth is anyone with a medical degree (i.e., M.D., D.O.) may label someone with the disease.

In an excellent review of the literature, Easterling & Robbins (2008), reported that dysphagia in Alzheimer’s disease is often caused by anosmia (reduced sense of smell), the impact of memory loss on nutritional status...
and feeding dependence, increasing the risk for pneumonia and malnutrition. They also stated that in frontotemporal dementia dysphagia is most evident in the later stages of the disease. Up to 91% of patients with this diagnosis show changes in food preferences, as well as abnormal oral behaviors (e.g., bite size, chewing). Of significance here is how complex maintaining good nutrition may be in persons with dementing illnesses. Many behavioral approaches have been developed to facilitate oral intake, but the underlying physiology is not clearly understood (Riquelme & Tristani, 2014).

If we follow the premise that cognitive and behavioral changes have a physiological correlate, then it follows that change in the brain areas responsible for swallowing would be seen in this population. There are several cortical areas involved in normal swallowing that have been shown to be affected in Alzheimer’s dementia: insula/inferior frontal gyrus pars operculum, anterior cingulate cortex and the antero-medial temporal lobe. As previously mentioned, in 2009 Humbert and colleagues reported that cortical activation for swallowing changes with varied swallow types (saliva, water, barium) in healthy older adults. They also found that swallowing appeared to become more lateralized to the right with healthy aging and speculated that maybe this was to compensate for greater effort to swallow. It was not known if similar changes are made in early Alzheimer’s disease. So, in 2010 the follow-up study (Humbert et al., 2010) was published. They found that participants with early stage Alzheimer’s disease did not present the natural shift to the right, seen in healthy older adults. In addition, they found that overall cortical activation for the swallow was reduced when compared to healthy older adults. The direct implications of these findings to clinical practice remain unclear, but certainly add to the understanding of the underlying physiological components of behavior and cognition in this growing population.

In 2013, Riquelme and graduate students from New York Medical College conducted a presentation on temporal changes in physiology in persons with dementia, as seen on videofluoroscopy (Deaibes et al., 2013). In this retrospective review, they found that for semi-solids, oral and pharyngeal transit times were longer in persons with dementia, compared to previously reported data on healthy aged participants and persons post-stroke. Oropharyngeal swallow efficiency (OPSE) was also smaller for persons with dementia in this comparison. This lends support to the correlation between behavioral/cognitive and physiologic changes in the swallowing mechanism for persons with cognitive decline due to dementia.

**Dehydration and Decompensation**

Another important factor to not overlook when addressing presbyphagia is the person’s hydration status. Dehydration predisposes the person to infections, skin breakdown, hypotension, confusion and even delirium. All of these may lead to reduced oral intake, which further compromises the person’s overall health status in the acute setting. Dehydration may also cause xerostomia (dry mouth). Multiple medications may cause xerostomia and/or a reduction in appetite.

The SLP about to assess a patient that is dehydrated must pay attention to this probable temporary change in the swallowing mechanism, which is exacerbated by an overall decompensated state. We know little about managing the patient during this temporary stage compared to one in a more chronic state. For example, a patient may present with reduced alertness secondary to malnutrition, UTI or a recent fall. Clinicians in acute care settings may receive consults for a patient admitted with UTI, resulting in dehydration, malnutrition and/or overall decompensation. The first question to ask is why does this person have dysphagia? Is this temporary and acute, or was dysphagia already present, possibly causing the dehydration? The answer to this is unclear. As we evaluate this person, we need to see our role as a progressive one: What does this patient need today to maximize nutrition? It may be a temporary nasogastric tube. These needs may change tomorrow upon follow-up and re-assessment. Maybe the patient will be able to commence limited, but safe, oral intake upon improved alertness and nutritional status, and eventually not need the short-term nasogastric tube. This type of dysphagia management flexibility must be included in our practices as clinicians working in this area. More management models need be explored and incorporated into the SLPs practice in acute care settings.

**Concluding Remarks**

The SLP working with the older adult population faces many challenges. It is of great importance to be able to look at the patient as a whole, and not just at the...
specific swallowing mechanism breakdown. Overall health status greatly impacts amount and efficiency of oral intake. Respiratory status and dental status are also relevant, as well as general alertness and cognitive status. The overall focus should be on the patient’s potential to take adequate amounts of nutrition/hydration safely by mouth and how this impacts their quality of life.

Furthermore, the role of decompensation cannot be overlooked when assessing an older adult. It may be a temporary change that if managed well, will allow for return to their baseline status. For chronic conditions, compensatory strategies and bolus modifications should be considered.

Limitations in access to diagnostic instrumentation for thorough dysphagia work-ups should not be tolerated. It is inappropriate for persons to not have access to videofluoroscopy or endoscopy for full swallowing assessments by SLPs, when necessary. It is up to the clinician to explore options in nearby hospitals and/or with otolaryngology colleagues.

In summary, it should be apparent that new clinical and instrumental approaches to testing and treating older adults are urgently needed. As the general population continues to age, we are faced with the challenge of providing comprehensive care to each individual, while attending to quality of life, personal preferences, cost efficiency and effectiveness and achieving the best outcomes.

Correspondence concerning this article should be addressed to:
Luis F. Riquelme
luis_riquelme@nymc.edu

References


Guidelines for SLPs: Effective Implementation of the Standards

Kristin M. Nellebach & Thomas L. Layton

Abstract
To date, the Common Core State Standards (CCSS) for math and English language arts/literacy (ELA-Literacy) have been adopted by over 40 states. While adoption of the CCSS provides a shared set of guidelines for what knowledge and skills are deemed necessary for 21st century college and career readiness, the responsibility of implementing them lies with individual states. Effective implementation of the CCSS requires collaborative teamwork, but often school-based speech-language pathologists (SLPs) are left out of critical conversations, trainings, and implementation opportunities. Given SLPs’ extensive knowledge and expertise in the language and cognitive skills underlying the expectations of the CCSS, our absence is problematic. This article presents three key ways to ensure that SLPs have access and opportunities to collaborate in the effective implementation of the CCSS ELA-Literacy.

Resources are provided for additional information. Although this article focuses on the CCSS, most of the guidance and resource information can be applied to states that have established their own set of learning standards.

Learning Objectives
1. Identify underlying tenants of the Common Core State Standards for English language arts/literacy (CCSS ELA-Literacy)
2. Describe three key guidelines to ensure that SLPs have access and opportunities to collaborate in the effective implementation of the CCSS ELA-Literacy
3. Understand the importance of identifying the communication skills underlying the expectations of the CCSS ELA-Literacy

In an attempt to increase state-to-state consistency of learning goals and performance comparability, a galvanized state-led effort to develop common learning standards in math and English language arts (ELA) began in 2009, resulting in what has become known as the Common Core State Standards (CCSS). Over 40 states, the District of Columbia, and several United States’ territories have adopted the CCSS (see www.corestandards.org ). While adoption of the CCSS provides a shared set of guidelines for what knowledge and skills are deemed necessary for 21st century college and career readiness, the responsibility of implementing the CCSS lies with individual states. Implementation of the CCSS, therefore, can vary widely at the state, the district, and even at the school level sometimes resulting in ineffective implementation processes/practices.

Effective implementation of the CCSS necessitates that key stakeholders are included in critical conversations, trainings, and opportunities, yet school-based speech-language pathologists (SLPs) are often unintentionally excluded. Such exclusion is problematic given SLPs’ extensive knowledge of the language and cognitive skills that underpin the expectations of the CCSS, particularly for ELA-Literacy. In our work as school-based clinicians/researchers, we frequently encounter discouraged SLPs (and teachers) who struggle to understand CCSS related literature and/or make use of this information in their work with students. To ensure SLPs have access and opportunities to collaborate in the effective implementation of the Standards, we introduce three key guidelines: Know the Ins and Outs of the Standards, Do What You Do Best, and Collaborate to Implement. While SLPs certainly have a role in the implementation of the CCSS ELA-Literacy, the standards for
ELA-Literacy are a strong complement to our profession’s knowledge and expertise base and will be the focus of this article.

Key Guideline #1: Know the Ins and Outs of the Standards
We know that the first guideline may seem obvious, but we cannot underestimate the importance of really getting to know the “ins and outs” of the CCSS ELA. Reading through the CCSS ELA is not an easy task and usually requires several read-throughs to fully understand the graduated expectations of the standards. In order to help you know the Standards, we have included a brief review of the underlying tenants of the CCSS ELA along with a list of recommendations to support further exploration.

Review of the Common Core State Standards
The developers of the standards, spearheaded by the National Governors Association Center for Best Practices (NGAC) and the Council of Chief State School Officers (CCSSO) created “a set of clearly defined, evidence-based expectations that addressed the knowledge, skills, and understandings students need to acquire by the time they graduate from high school in order to be college or career ready” (NGAC & CCSSO, 2010). Although not directly involved with the development of the CCSS, the federal government offered funding opportunities (e.g., Race to the Top program) to states that developed and adopted a common set of career and college ready standards (U.S. Department of Education, 2009). While the effectiveness and fairness of the CCSS continues to be a heated topic of debate, a priority for all SLPs should be to develop a working knowledge of the Standards in order to identify the language and cognitive skills essential to students’ access and engagement with the expectations of the Standards.

Understanding the structure of the Standards. For many professionals, initially navigating the standards can be challenging and requires some background knowledge before being able to effectively implement them. A good starting place is to review how the CCSS ELA are structured (see Appendix A for an outline format). The CCSS ELA are divided into three main sections (see Figure 1). Section 1 contains a set of comprehensive standards for K-5th grade, while Sections 2 and 3 comprise content area-specific standards for students in grades 6-12. Section 2 covers the ELA standards while Section 3 contains the literacy standards in history/social studies, science, math, and technical subjects.

As can be seen in Figure 1, there are communication-based domain strands (or key areas) under each section. Sections 1 and 2 each contain four main domain strands: Reading, Writing, Speaking and Listening, and Language (Speaking and Listening are combined into a single strand). Section 3, however, only contains two strands: Reading and Writing (see Figure 1).

Some of the domain strands are further subdivided into specific areas called sub-strands. For example, in Section 1, the Reading strand has three sub-strands. They are: Foundational Skills, Literature, and Informational Text. In Section 2 there are two Reading sub-strands: Literature and Informational Text. Finally, Section 3 contains two Reading sub-strands: Reading in history/social studies and Reading in science and technical subjects and one Writing sub-strand: Writing in history/social studies, science, and technical subjects (see Figure 1).

The CCSS were designed in a backwards-mapping fashion, starting with the College and Career Readiness “Anchor” standards (CCR/CCRA) representing the global, end-level knowledge, skills, and understandings students need by the time they graduate from high school. Each of the four domain strands are “headed by a strand-specific set of CCR that is identical across all grades and content areas” (NGA & CCSSO, 2010). Corresponding to the Anchor standards are the grade-specific standards, which are the incremental, specific knowledge and skills students are expected to develop by the end of each grade.

In our work we use both sets of standards for complementary, but different purposes. We use the language-based expectations of the CCR Anchor standards as long-term goals that are consistently being spiraled throughout the designs of our interventions (for more on spiraled learning see J.S. Bruner’s (1960), The Process of Education). We use the language-based expectations of the grade-specific standards to develop flexible short-term goals that are appropriately tiered (i.e., parsed, ordered, and timed) relative to students’ current levels of performance.
Commonly, many of the students whom we serve perform well below grade-level expectations.

Most often, this is because students need support in building the foundational language skills needed to access the Standards. In cases such as these, the U.S. Department of Education states, “An IEP Team should determine annual goals that are ambitious, but achievable. In other words, the annual goals need not necessarily result in the child’s reaching grade-level within the year covered by the IEP, but the goals should be sufficiently ambitious to help close the gap” (US Department of Education, 2015, p. 5). For further information on the newly released U.S. Department of Education Guidance document, see http://www2.ed.gov/policy/speced/guid/idea/memods clts/guidance-on-fape-11-17-2015.pdf

**Decoding the Standards.** In addition to an understanding of their basic structure, reading through the standards requires knowledge of how they are coded. Each standard (Anchor or grade-specific) has an accompanying code/identifier. For instance, when reading the Standard, CCSS.ELA-Literacy.RF.K.2.D, the broad category is listed first (i.e., CCSS.ELA-Literacy), followed by the domain strand/sub-strand (i.e., RF-Reading Foundational Skills, then by grade (i.e., K-Kindergarten), and finally by the number/letter assigned to the standard (i.e., 2.D-Standard 2, Part D). Refer to Figure 2 for an example. For a listing of common codes/identifiers associated with each of the domain strands, see Table 1.

While there is no substitute for a thorough reading of the standards, there are several resources available to support and guide SLPs independent navigation of them (see Appendix B for a categorized collection). We also suggest the following general recommendations related to Key Guideline #1:

- Pay attention to the adoption status for your state (watch for any changes)
- Read through ASHA’s guidance documents and policies related to the CCSS
- Read through the CCSS ELA standards
- Read through the CCSS’s supplemental resources (e.g., Application to Students with Disabilities and Application of CCSS for English Language Learners)
Table 1. Decoding the Strands for the Common Core State Standards-English Language Arts

<table>
<thead>
<tr>
<th>Strand</th>
<th>Code/Identifier</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>R</td>
<td>Reading Standards</td>
</tr>
<tr>
<td></td>
<td>RF</td>
<td>Reading Standards: Foundational Skills (Grades K-5)</td>
</tr>
<tr>
<td></td>
<td>RL</td>
<td>Reading Standards: Literature</td>
</tr>
<tr>
<td></td>
<td>RI</td>
<td>Reading Standards: Informational Text</td>
</tr>
<tr>
<td></td>
<td>RH</td>
<td>Reading Standards: Reading in history/social studies (Grades 6-12)</td>
</tr>
<tr>
<td></td>
<td>RST</td>
<td>Reading Standards: Reading in science and technical subjects (Grades 6-12)</td>
</tr>
<tr>
<td>Writing</td>
<td>W</td>
<td>Writing Standards</td>
</tr>
<tr>
<td></td>
<td>WHST</td>
<td>Writing Standards for literacy in history/social studies, science, and technical subjects (Grades 6-12)</td>
</tr>
<tr>
<td>Speaking and Listening</td>
<td>SL</td>
<td>Speaking and Listening Standards.</td>
</tr>
<tr>
<td>Language</td>
<td>L</td>
<td>Language Standards</td>
</tr>
</tbody>
</table>

- Identify the language/cognitive underpinnings (e.g., phonology, vocabulary, semantics, etc.) essential for meeting the expectations of the standards
- Identify local implementation frameworks, practices, and policies

Key Guideline #2: Do What You Do Best

SLPs play an important role in the identification and remediation of literacy differences, deficits, and disorders based on extensive background knowledge of: (1) typical and atypical language development and disorders; (2) basic and advanced language forms that underpin the development of literacy; and (3) remediation techniques for enhancing reading comprehension (ASHA, 2001a; ASHA, 2001b; Ehren & Ehren, 2001). In general, SLPs are also highly skilled at translating evidence-based knowledge into practical applications and using common materials in inventive and accessible ways. The CCSS ELA’s dedicated spotlight on the communication skills essential for students’ access to the standards provides SLPs with a crucial opportunity to engage as equal implementation partners by doing what we do best which is to focus on identifying and targeting the language-based elements underlying the Standards. For information about the roles and responsibilities of school-based SLPs, see Roles and responsibilities of speech-language pathologists in schools (ASHA, 2010), Common Core State Standards: A resource for SLPs (ASHA, http://www.asha.org/SLP/schools/Common-Core-State-Standards/) and ASHA’s Literacy Gateway (http://www.asha.org/topics/literacy/).
Table 2. Examples of speech and language areas located in CCSS-ELA strands.

<table>
<thead>
<tr>
<th>Area</th>
<th>CCSS Identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phonology</td>
<td>CCSS.ELA-Literacy.RF.K.2.D</td>
<td>Isolate and pronounce the initial, medial vowel, and final sounds (phonemes) in three-phoneme (consonant-vowel-consonant or CVC) words.</td>
</tr>
<tr>
<td>Semantics</td>
<td>CCSS.ELA-Literacy.L.4.6</td>
<td>Acquire and use accurately grade-appropriate general academic and domain-specific words and phrases, including those that signal precise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>actions, emotions, or states of being and that are basic to a particular topic.</td>
</tr>
<tr>
<td>Morphology</td>
<td>CCSS.ELA-Literacy.L.8.4.B</td>
<td>Use common, grade-appropriate Greek or Latin affixes and roots as clues to the meaning of a word (e.g., precede, recede, and secede).</td>
</tr>
<tr>
<td>Syntax</td>
<td>CCSS.ELA-Literacy.RH.9-10.5</td>
<td>Analyze how a text uses structure to emphasize key points or advance an explanation or analysis.</td>
</tr>
<tr>
<td>Pragmatics</td>
<td>CCSS.ELA-LITERACY.SL.2.1 &amp; 2.1A</td>
<td>In collaborative conversations with diverse partners about grade 2 topics and texts with peers and adults in small and larger groups students will</td>
</tr>
<tr>
<td></td>
<td></td>
<td>follow agreed-upon rules for discussions (e.g., gaining the floor in respectful ways, listening to others with care, speaking one at a time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>about the topics and texts under discussion).</td>
</tr>
</tbody>
</table>

The CCSS-ELA Dedicated Spotlight on Communication Skills

Central to the CCSS-ELA is an emphasis on an array of communication skills (i.e., reading, writing, speaking and listening, and language) that are essential for learning. The encouraging news is that elements/features of all of the core domains of language (including the Metas: metalinguistics and metacognition) are embedded throughout the CCSS ELA strands and are easy to locate. A few examples have been provided in Table 2.

Identifying and cataloging essential communication skills. In collaboration with fellow SLPs we suggest that you locate, develop, and curate resources that identify the language and cognitive skills underlying the expectations of the CCSS ELA. Readily available resources such as these can assist SLPs in the efficient identification of the essential communications skills linked to any learning task (and standard). SLPs can use this knowledge to assist teachers in determining whether learning difficulties in the classroom are due to the content itself or the language used to convey the content.

Included in these resources should be evidenced-based information about the developmental norms for speech and language (e.g., see ASHA’s resource, Developmental Norms for Speech and Language at http://www.asha.org/slp/schools/prof-consult/norms/). Knowledge of developmental norms is especially critical for determining a student’s current level of language and cognitive functioning in comparison to grade-specific standards. It is often the case for many students with communication differences and/or disorders that there is a significant enough discrepancy between current level of functioning and curricular expectations to prevent them from effectively accessing the curriculum. SLPs can use this knowledge to guide and justify their decisions about developmentally appropriate practices.

Informal, standards-aligned rating scales. There are a number of informal, standards-aligned rating scales created by SLPs that can be used to identify the communication skills underlying the expectations of the CCSS ELA. Many of these informal rating scales are available through open access resources such as ASHA’s, Resources and References: Common Core State Standards (http://www.asha.org) or online marketplaces (e.g., teacherspayteachers). Some of the informal tools we have found useful include: (1) Common Core Checklists (McEldowney & Henry, 2015); (2) Common Core Speaking and Listening Rating Scales (Alcorn, 2014); (3) Georgia Common Core Standards for SLPs (Lozo, 2010); (4) Speech and Language Assessment
Using DA is to glean a diagnostic understanding of the student’s current ability/skill level while promoting new learning through mediated teaching during the assessment (Lantolf & Poehner, 2008; Vygotsky, 1978).

A similar approach to DA is Rubrics for Curriculum-Based Assessment and Intervention (Wiig, Lord Larson, & Olson, 2004). Wiig et al. (2004) call their approach S-MAPS, which stands for “Structured –Multidimensional Assessment Profiles” and focuses on the student’s ability to respond to a performance task or to “perform integrated language and communication tasks within authentic learning and social contexts” (Wiig et al., 2004, p. 4). In essence, DA and S-MAPS are similar approaches in that they encourage in-depth assessments of the student’s actual academic and language skills beyond the static standardized testing scores. The information obtained provides a holistic assessment that is authentic and useful for setting intervention goals for the classroom teacher. (For an example of DA, see Appendix D)

Summative Assessments. To our knowledge, there are no CCSS-aligned summative assessments specifically designed for use by SLPs. Nevertheless, golden standard assessments of language such as the Clinical Evaluation of Language Fundamentals-Fifth Edition (CELF-5) should be educationally relevant and sensitive enough to detect some students’ core areas of strength/need. Conversely, the rise in enrollment of culturally and linguistically diverse students and other special populations necessitates going beyond a “one and done” administration mentality. We recognize that this is a lot easier said than done given the numerous work-related barriers so many school-based clinicians face. To address the full spectrum of language and related cognitive skills underlying the expectations of the CCSS however, it is essential that SLPs use multiple assessment forms as “no one test or battery of tests has been shown to be superior in identifying all types of literacy (difficulties) disabilities” (Lombardino, 2012, p. 71). When appropriate, we suggest a systematic, step-wise assessment approach be used to identify language-based barriers that prevent a student from accessing the curriculum at one level above their current ability (Nellenbach & Erickson, 2011).
Key Guidance #3-Collaborate to Implement the CCSS-ELA

ASHA’s document, the Roles and Responsibilities of SLPs in Schools (2010), provides clear guidance on how SLPs can actively engage in effective implementation of the CCSS that include information on critical roles, range of responsibilities, collaboration, and leadership (see http://www.asha.org/SLP/schools/Key-Issues/). In this article, we have chosen to emphasize collaboration.

Collaborative Frameworks that Support Effective Implementation of the Standards

Collaboration has been defined as “an interactive process in which individuals with diverse areas of expertise address mutually defined goals through the use of creative problem solving” (Idol, Paolucci-Whitcomb, & Nevin, 1986, p. 1). Within a school setting, effective collaboration often requires a “village” of collaborators that may include teachers, SLPs, special educators, faculty/staff, students, and parents. In our experience, for collaboration to be effective collaborators must have protected time and opportunity to (1) build rapport, (2) discover and share unique, but complementary roles, (3) develop and share knowledge (e.g., professional learning communities), and (4) identify and select a common framework(s) to guide collaboration.

The development of the Standards reflects a carefully orchestrated collaborative process, but their implementation has not received the same type of attention. In part, this is because the implementation of the CCSS was intentionally left up to individual states. However, implementation policies, processes, and practices can vary widely. Yet, according to a review of the literature by Durlak and DuPre (2008, p. 334) “there is credible and extensive empirical evidence that the level of implementation affects program outcomes.” Unfortunately, until active forms of implementation processes are widely available, the burden of responsibility for translating the Standards to services lies with district leaders, teachers, SLPs, and others. We believe that collaboration is the linchpin of effective implementation of the Standards.

In the next section, we introduce two collaborative frameworks that have been useful in our implementation efforts and provide general examples of unique, but complementary roles for SLPs and teachers.

Response to Intervention. In many schools, the SLP is directly involved in a Response to Intervention (RTI) approach (Fuchs, Mock, Morgan, & Young, 2003; Justice, 2006). Response to Intervention (RTI) is a multi-tier approach to the early identification and support of students with learning and behavior needs (Bradley, Danielson, & Doolittle, 2005). The RTI process begins with high-quality instruction and universal screening of all children in the general education classroom. Struggling learners are provided with interventions at increasing levels of intensity to accelerate their rate of learning. These services may be provided by a variety of personnel, including general education teachers, special educators, and specialists. Progress is closely monitored to assess both the learning rate and level of performance of individual students. Educational decisions about the intensity and duration of interventions are based on individual student response to instruction. RTI suggests that the teacher and the resource personnel, such as the SLP, collaborate to help the teacher obtain the student’s needs in the classroom before the student receives special services. In order to do this, a RTI team member or the classroom teacher screens the student for specific areas of learning.

Universal Design for Learning. Given the rigorous and uniform expectations of the Standards despite greater diversity in student populations, the need for a flexible framework such as Universal Design for Learning (UDL) is critical to effective implementation. UDL is a framework for guiding curriculum design and application of flexible instructional practices (Meyer, Rose, & Gordon, 2014). A framework such as UDL affords teachers, SLPs, special educators, and others the ability to flexibly implement the Standards using developmentally appropriate and effective methods, materials, and strategies geared towards maximizing access and learning for all students (Center for Applied Technology [CAST], 2011).

A central goal of the UDL framework is to minimize access barriers in order to maximize all aspects of learning for every student (CAST, 2011). This goal can be accomplished by following teaching methods aligned with three UDL principles (Rose & Meyer, 2002). The first guiding principle, representation, is based on the premise that each learner differs in the way they acquire, understand, and retain information. Likewise, the amount of representation required for each student varies. Representation or the “what” of learning should
include multiple and repeated forms to provide open access to learning. The second guiding principle, action and expression, relates to the idea that not all students approach learning in the same way, nor is one means of expression appropriate for all students. In other words, in order for all students to access the “how” of learning they must be provided with a variety of ways for demonstrating what they know. The third principle, engagement, is grounded in the belief that there are affect-based differences (e.g., interests) among all learners that can influence the ways in which students approach and/or sustain learning. Thus, engagement or the “why” of learning should include opportunities that develop and sustain students’ interest and motivation for learning (for more information on UDL, see http://www.udlcenter.org).

SLPs and Teachers: Complementary Roles with Shared Responsibility
According to the NGAC and CCSSO (2010), “The Standards insist that instruction in reading, writing, speaking, listening, and language be a shared responsibility within the school.” The insistence on making literacy instruction a “shared responsibility” within schools indicates that school personnel across disciplines are expected to participate in the literacy development of all students. In essence, the Standards have the potential of facilitating opportunities for each discipline to play unique, but complementary roles.

Collaborative role of the SLP. SLPs are uniquely qualified to provide teachers with information and support for effective implementation of the Standards based on their extensive knowledge of the language forms that underpin the development of literacy (ASHA, 2001; Ehren & Ehren, 2001). In addition, SLPs typically have expertise in modifying linguistically challenging information by employing strategies that appropriately pace and sequence the information based on students’ specific needs. Finally, SLPs can strengthen connections and promote continuity of content that crosses disciplines by engaging in professional learning communities (PLCs) or providing in-services that “jointly build knowledge” (Reed & Groth, 2009, p.15). Engaging in such practices can lead to a collective understanding of how both general and specialized language forms embedded in the texts, materials, and discourse used within content-areas is intricately connected to the academic and literacy achievement potential of all students.

Examples of collaborative roles for SLPs may include:
- Introduce and describe professional roles and responsibilities.
- Provide background information on the connections between language subsystems and reading comprehension.
- Actively engage in Professional Learning Communities (PLCs) with teachers.
- Assist in the identification of potential language-based access barriers to learning the Standards for students with and without identified deficits/disorders.
- Use the Standards and teacher provided reading materials to identify key language-based learning objectives (e.g., compare and contrast) and design or adapt developmentally appropriate strategies that allow for student access and learning.
- Assist teachers in the identification and progress monitoring of students with “possible literacy difficulties affecting their in-classroom participation/performance” (ASHA, 2001a).

Collaborative role of the teacher. Teachers are experts of their disciplines and therefore possess knowledge of the content and the specialized language forms unique to their discipline. Also, the instructional focus and comprehension strategies that content-area teachers expect their students to use to construct meaning from texts, materials, and discourse can significantly differ from generalized comprehension strategies and/or other disciplines (Shanahan & Shanahan, 2012). As a result, SLPs need teachers to explain how and why domain-specific strategies are used within the classroom in order to help students access the content and develop the knowledge and flexible strategies required for learning. Finally, teachers can provide SLPs with information unique to each student including abilities, learning preferences, and motivation/engagement level.

Examples of collaborative roles for teachers may include:
- Introduce and describe professional roles and responsibilities.
- Identify and discuss perceived major obstacles preventing students from comprehending key content-area information.
• Identify and discuss commonly used language registers specific to their content-area texts/materials/discourse.
• Actively engage SLPs in Professional Learning Communities (PLCs).
• Provide a few examples of the primary forms of reading materials used within the classroom including lectures, homework, and tests
• Identify and describe attempted and commonly used comprehension strategies and practices
• Identify students who struggle with comprehending content-area information
• Develop instructional pathways towards meeting curricular demands/standards.

**Case Summary**
A case summary of a high school student identified as being at significant risk for dropping out of school is provided below. While all names are pseudonyms, the context and interprofessional interactions are representative of what occurred in our consultations.

**High School Student-Background**
Nicolás was a 16 year-old student attending an alternative high school when we first met. He had recently transferred from a traditional high school setting. Although technically listed as a sophomore, Nicolás had fallen significantly behind in his coursework across several of his courses, but most notably, struggled with World History. In fact, Nicolás had already taken and failed World History twice and was at risk of dropping out of high school. With only a late history of being identified as a “struggling” student (i.e., middle school-early high school) and no Individualized Education Plan, the history teacher, Mr. Smith, had little information to plan and guide differentiated instruction.

Mr. Smith decided to start Nicolás on an online-learning program that would deliver the core content, while he supplemented instruction and closely monitored his initial progress. After two weeks of participating in the online course, progress monitoring revealed that Nicolás was struggling to meet grade-level proficiency (i.e., course standards). Mr. Smith requested a consultation to develop a deeper understanding as to why Nicolás was struggling to learn the online content (i.e., “is it because of the rigor of the content itself or does he struggle to learn in general?”). Mr. Smith also stated that he was open to any activities that complemented his instruction and that moved Nicolás towards meeting the expectations of the course standards.

**Student-Consult Interactions**
After gaining initial assent, we first encountered Nicolás preparing to engage in a close reading of a 12th century, primary source document. In order to meet the expectations of the course standards (i.e., see the CCSS.ELA-Literacy.RH.9-10) and receive full credit for his response (six points), Nicolás was instructed to read the document (computer-based) and provide a handwritten analysis/commentary on an accompanying worksheet (see Figure 3).

**Supplemental information:** The information gathered during our initial interactions with Nicolás revealed several important cultural, language, and affect-based differences that significantly impacted his ability to readily access the curriculum. For example, Nicolás was placed in and exited from an English as a Second Language Program (ESL) in elementary school, never to be reassessed. Based on our collected information, however, it appeared as though Nicolás did not progress far beyond a basic level of understanding/use of the English Language (i.e., Basic Interpersonal Communication Skills [BICS]). Because the curriculum in the upper grades necessitates the proficient use of sophisticated language forms for learning (i.e., Cognitive Academic Language Proficiency [CALP]), the delay in Nicolás’ second-language progression prevented him from engaging in the curriculum and meeting expectations. Further, while it is typical for students learning a second language to exhibit a “silent period” while focusing on listening and comprehending a new language, Nicolás’ low self-perception as a proficient speaker of English extended this period and limited his social interactions with most teachers and peers. Additionally, Nicolás reported that he was self-conscious about the way his speech sometimes sounded to others. An oral language sample and probe for stimulability revealed that Nicolás presented with a lateral distortion of sibilants that was not the result of a dialectal difference (confirmed by the parent/client). While our time spent with Nicolás indicated that some access barriers were related to language and cultural differences, not disorders, these differences when juxtaposed against a high-stakes, language-laden curriculum had devastating and long-term effects on Nicolás academic potential.

After a two-minute period of silent reading, Nicolás wrote a response (see Figure 3) that clearly fell short in meeting the expectations of the standards (i.e., CCSS.ELA-Literacy.RH.9-10).

This writing sample, along with information obtained during a record review, an informal meeting with the student/family, and two, 40-minute dynamic assessment sessions yielded enough information to guide our initial collaborations with the teacher.
**Figure 3. Primary source excerpt.**

**DIRECTIONS:** Briefly explain what the document says and connect the document to what you have learned in this semester as well as to make specific observations from the text that give basic historical information regarding dates and that show how the text is connected with the time and place that produced it.

The Death of Henry the II of England 1189 AD

“And then the body of the king was carried to Fontevrault, the son attending the funeral procession along the way on foot, sometimes ahead and sometimes behind, when the body was placed in the church, behold Count Richard of Poitou, the oldest of the legitimate sons still living and the heir, at once came in. And when he entered the church and approached the body, the face of his father, having been denuded of the napkin with which it had been covered, was plainly visible. Which, when it appeared to all, just as if colored and with its usual fierceness, the count, not without growling of flesh and horror before the body, dropping to his knees in prayer for a little while, remained for scarcely an hour of Sunday prayer.”

Permission granted for use of the translated excerpt on September 16, 2015.

While a detailed account of the diagnostic sessions is beyond the scope of this article, following is a list of several activities that we engaged in to determine Nicolás’ current areas of strength/need as well as his learning potential in relation to accessing the curriculum:

- Breaking Down the Directions Activity
- Levels/Types of Vocabulary Knowledge Activity
- Thinking Aloud Activity
- Sentence Combing Activity
- Motivation/Engagement Activity/Discussion
- Home Language/Culture Discussion
- Self-Perceptions about Speech Discussion

**Standards-Aligned Screening Tool**

To gather more information about Nicolás’ ability to meet the expectations of the standards, we asked Mr. Smith to complete the N & L Teacher Rating Form shown in Figure 4a. (Copies of the rating form as well as complete directions on how to score it are included in Appendix C).

As can be seen in Figure 4b, Nicolás obtained a raw score of 8 for the first two sections (Key Ideas and Concepts and Craft and Structure) that were converted to an overall score of 1.33 and 1.60 respectfully. On the third section, Integration of Knowledge and Ideas, Nicolás attained a raw score of 6 points that was converted to an overall score of 1.20. (Section 4 was not applicable). Per the scoring directions, converted scores will result in a number between 1.0-4.0. Any score that falls below a 3.0 should be flagged for possible targeted instruction/intervention. Based on Mr. Smith’s observations, Nicolás struggled to meet all areas within the Reading in History/Social Studies Standards for Grades 9-10.

**Teacher-Consult Interactions**

Having gathered information through record review, parent/student discussion, dynamic assessment, and the standards-aligned screening tool, we met with Mr. Smith. We began our discussion by reviewing Nicolás’ sample analysis/commentary. Mr. Smith confirmed that this sample was similar in quality/length to previous work Nicolás had turned in, but remarked that Nicolás’ response was well below what he expected of someone his age and background experience (given that this was Nicolás’ third time taking the course). When we inquired about how many points Nicolás received on his response, Mr. Smith stated that he had given Nicolás a score of 2 points, but that he had been “overly generous” in order not to further discourage Nicolás.
<table>
<thead>
<tr>
<th>Rating Key: 1=Never  2=Sometimes  3=Usually  4=Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH.9-10.1   The student cites specific textual evidence to support their analysis of primary/secondary sources</td>
</tr>
<tr>
<td>RH.9-10.1   The student attends to such features as the date and origin of the information in primary/secondary sources</td>
</tr>
<tr>
<td>RH.9-10.2   The student determines the central ideas or information of a primary or secondary source</td>
</tr>
<tr>
<td>RH.9-10.2   The student provides an accurate summary of how key events or ideas develop over the course of the text</td>
</tr>
<tr>
<td>RH.9-10.3   The student analyzes in detail a series of events described in a text</td>
</tr>
<tr>
<td>RH.9-10.3   The student determines whether earlier events caused later ones or simply preceded them.</td>
</tr>
<tr>
<td>TOTAL = 8</td>
</tr>
<tr>
<td>RH.9-10.4   The student determines the meaning of words/phrases as they are used in a text, including vocabulary describing political, social, or economic aspects of history/social studies.</td>
</tr>
<tr>
<td>RH.9-10.5   The student analyzes how a text uses structure to emphasize key points.</td>
</tr>
<tr>
<td>RH.9-10.5   The student analyzes how a text uses structure to advance an explanation or analysis.</td>
</tr>
<tr>
<td>RH.9-10.6   The student compares the point of view of two or more authors on the same or similar topics.</td>
</tr>
<tr>
<td>RH.9-10.6   The student compares the point of view of two or more authors on the same or similar topics including which details they include and emphasize in their respective accounts.</td>
</tr>
<tr>
<td>TOTAL = 8</td>
</tr>
<tr>
<td>RH.9-10.7   The student integrates (connects) quantitative with qualitative analysis in print or digital text.</td>
</tr>
<tr>
<td>RH.9-10.8   The student assesses the extent to which the reasoning in a text supports the author’s claims.</td>
</tr>
<tr>
<td>RH.9-10.8   The student assesses the extent to which evidence in a text supports the author’s claims.</td>
</tr>
<tr>
<td>RH.9-10.9   The student compares and contrast treatments of the same topic in several primary sources.</td>
</tr>
<tr>
<td>RH.9-10.9   The student compares and contrast treatments of the same topic in several secondary sources.</td>
</tr>
<tr>
<td>TOTAL = 6</td>
</tr>
<tr>
<td>RH.9-10.10  By the end of grade 10, the student reads and comprehends grade-level history/social studies texts independently.</td>
</tr>
<tr>
<td>RH.9-10.10  By the end of grade 10, the student reads and comprehends grade-level history/social studies texts proficiently.</td>
</tr>
<tr>
<td>TOTAL = NA</td>
</tr>
</tbody>
</table>
SCORING FORM FOR THE N & L TEACHER RATING SCALE
CCSS-ELA.LITERACY.RH.9-10
SIDE A

Student Initials: N.H. Date: 04/15/2015 Teacher Initials / Period: Smith / P3

Rating Scale
The rating scale is a Likert-type scale starting from the far left with 1=Never, 2=Sometimes, 3=Usually, and 4=Always.

<table>
<thead>
<tr>
<th>Number</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never-</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes</td>
</tr>
<tr>
<td>3</td>
<td>Usually-</td>
</tr>
<tr>
<td>4</td>
<td>Always-</td>
</tr>
</tbody>
</table>

Subsection Scoring
To determine each subsection score: (1) Calculate the raw score by totaling the circled points ; (2) Divide the raw score by the subsection’s possible maximum points; and (3) Multiple the result of Step 2 by 4. These steps will result in a number from 1.0-4.0. Any score that is below a 3.0 should be reviewed and considered for possible intervention. The total score provides an overall picture of the students’ current level of performance specifically related to each of the subsections within the Reading in History/Social Studies Standards for Grades 9-10.

Example
Standards-CCSS.ELA-RH.9-10.1-3 Subsection (Area)-Key Ideas and Concepts Student’s Raw Score-12 Subsection’s Maximum Points-24
Key Ideas and Concepts Subsection Score [12/24=2; 2 x 4=2; 2.0 is the Subsection score]

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Student’s Raw Score</th>
<th>Subsections’ Maximum Points</th>
<th>Multiply x4</th>
<th>Subsection score</th>
<th>Flagged for Possible Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Ideas &amp; Concepts</td>
<td>8</td>
<td>/24</td>
<td>x 4</td>
<td>1.33</td>
<td>Yes</td>
</tr>
<tr>
<td>Craft &amp; Structure</td>
<td>8</td>
<td>/20</td>
<td>x 4</td>
<td>1.60</td>
<td>Yes</td>
</tr>
<tr>
<td>Integration of Knowledge &amp; Ideas</td>
<td>6</td>
<td>/20</td>
<td>x 4</td>
<td>1.20</td>
<td>Yes</td>
</tr>
<tr>
<td>Range of Reading &amp; Level of Text Complexity</td>
<td>NA</td>
<td>/8</td>
<td>x 4</td>
<td>NA</td>
<td>Yes</td>
</tr>
</tbody>
</table>

We suggested to Mr. Smith that Nicolás would most likely agree with him since Nicolás had assigned his own response a score of “one” during our first diagnostic session. Mr. Smith laughed and asked “so where do we go from here?” We proposed that we take an inventory of the curricular demands associated with the analysis/commentary activity (see Table 3 for our completed inventory).

The Demands Inventory activity located in Table 3 helped us to identify several curriculum-based demands that posed significant barriers to Nicolás’ access and/or full engagement with the task (and curriculum). We then used the information gained from the inventory to create a plan for reducing access barriers and maximizing his learning potential. In addition to creating this plan, we engaged in several other collaborative activities over the course of the year to support Nicolás’ (and other students).

These included:
- Requested an ESL consult/referral
- Reviewed/discussed guidance documents related to shared responsibility for literacy development (see http://www.corestandards.org)
- Reviewed/discussed evidence-based articles related to reading/reading in social studies (e.g., Massey & Heafner, 2004; Shanahan, & Shanahan, 2008)
- Reviewed, modified, and curated discipline-favored literacy strategies
- Identified other students in the classroom who were struggling to access/engage the content because of language-based difficulties.
- Identified text structures that are common to history texts/sources, created a lesson plan for introducing the concepts and developed a plan to reinforce them.
Table 3. Collaborative inventory of curricular demands.

<table>
<thead>
<tr>
<th>Task-Related Demands Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Read, comprehend, and complete multipart directions.</td>
</tr>
<tr>
<td>• Recall and reflect upon prior content-area knowledge to develop deep connections to convey information/knowledge.</td>
</tr>
<tr>
<td>• Comprehend specific task-related concepts (i.e., explain, connect, make specific observations).</td>
</tr>
<tr>
<td>• Attend closely to signal words/phrases/elements in historical documents to make specific observations.</td>
</tr>
<tr>
<td>• Convey information through well-written explanations that include summarizing, paraphrasing, and analysis.</td>
</tr>
<tr>
<td>• Write in expected discipline-specific forms/conventions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Text-Related Demands Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Read (closely/carefully) primary source documents.</td>
</tr>
<tr>
<td>• Read, write, and think like a historian.</td>
</tr>
<tr>
<td>• Attend to signal words/phrases/elements in historical documents (i.e., Boldface, Title, Year, Place) to make specific observations.</td>
</tr>
<tr>
<td>• Draw upon effective reading strategies to support text comprehension (e.g., attend to text structures, reread).</td>
</tr>
<tr>
<td>• Identify and attend closely to important vocabulary and draw upon word learning strategies to determine the meanings for unknown words.</td>
</tr>
<tr>
<td>• Recall and reflect upon prior content-area knowledge to develop deep connections (e.g., text-to-self, text-to-text, text-to-world).</td>
</tr>
<tr>
<td>• Self-monitor/regulate task completion.</td>
</tr>
<tr>
<td>• Shift between digital and traditional learning/material formats.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Materials-Related Demands Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assessment format delivered in one mode-static digital format.</td>
</tr>
<tr>
<td>• Expression format delivered in one mode-handwriting.</td>
</tr>
</tbody>
</table>

**Comments**

We have identified several curricular-based demands related to the written analysis/commentary task. Many of these demands were noted in our review to pose significant barriers to Nicolás’ access and/or full engagement with the task (and curriculum). Our next step is to use the information gathered in the demands inventory to develop a specific plan for reducing access barriers and maximizing learning potential (see example below).

**Standard/Curriculum Demands**

Attend closely to signal words/phrases/elements in historical documents to make specific observations.

**Materials-Related Demands**

Current digital format does not allow for Nicolás’ to engage with the texts in ways that promote identification, understanding, use, and/or expression. Also, primary source documents contain language forms that are either unfamiliar to Nicolás’ or are levels that are outside of his ZPD.

**Reduce Barriers**

Dynamic assessment sessions indicate that Nicolás’ is highly stimulable and motivated to learn. Reducing barriers by engaging in the following should increase Nicolás’ ability to access the curriculum:

1. Start with a description and purpose (Discuss concept and purpose of attending closely to signal words/phrases/elements for both real-word and academic purposes)
2. Provide cross-curricular guides that include text structure/signal words/phrases/elements (e.g., Zwiers, 2014).
3. Curate resources and store in student-chosen formats (e.g., hardcopy or digital notebook)
4. Use a variety of documents (not just historical) to introduce and guide instruction (e.g., newspapers)
5. Use a variety of formats to introduce and guide instruction (e.g., hard copy, video, audio)
6. Use various forms of expression (e.g., written, audio, picture, action, language-Spanish)
• Identified a few alternative technology-based programs/tools that could provide differentiated access to the content (e.g., see Don Johnston’s Snap & Read Universal, Draft Builder, Write Out Loud at http://donjohnston.com) and developed a plan for review/implementation.
• Collaborated with other lead teachers across the disciplines to create a few cross-curricular activities that highlighted key content and communication skills.

Conclusion
The purpose of this article was to provide SLPs with the information and resources they need in order to participate in the effective implementation of the Standards. With this in mind, we explained the three keys for effective implementation:
(1) Know the Ins and Outs of the Standards
(2) Do What You Do Best
(3) Collaborate to Implement

Although the longevity of the CCSS remains to be seen, one can be assured that some form of learning standards will continue to be a staple of each state’s core curriculum. Central to many of the current learning standards (including the CCSS ELA) is the emphasis on communication skills as a vehicle for learning across the disciplines. Such an emphasis provides SLPs with an unprecedented, large-scale opportunity to partner in the effective implementation of learning standards by connecting the language and cognitive-related concepts learned in the therapy room to the classroom. In order to be included as equal partners in the implementation process, SLPs must take steps to: Know the Ins and Outs of the Standards, Do What They Do Best, and Collaborate.

Correspondence concerning this article should be addressed to:
Kristin Nellenbach
krisnellenbach@gmail.com

References


Nellenbach, K. (2010). *Contributions of oral language, problem solving, and reading attitudes to young adolescents’ silent reading comprehension*. University of North Carolina at Chapel Hill, Chapel Hill, NC. Available at https://cdr.lib.unc.edu/indexablecontent/uuid:1338e2e7-84e6-4ab3-b323-9f9be3b3efa1


Appendix A

An Outline of the Common Core State Standards-English Language Arts

I. Section One: Comprehensive Standards for Grades K-5
   a. Reading Strand
      i. Grades K-5 foundational skills
      ii. Literature reading
      iii. Informational reading
   b. Writing Strand
   c. Speaking and Listening Strand
   d. Language Strand

II. Section Two: Grades 6-12-English Language Arts Standards
    a. Reading Strand
       i. Literature reading
       ii. Informational reading
    b. Writing Strand
    c. Speaking and Listening Strand
    d. Language Strand

III. Section Three: Grades 6-12-Literacy Standards for History/Social Studies, Science, and Technical Subjects
     a. Reading Strand
        i. Literature reading
        ii. Informational reading
     b. Writing Strand
        i. Writing in history/social studies, science, and technical subjects
Appendix B

**Common Core State Standards/Learning Standards**


**Collaboration and Coordinated Implementation**


Culturally and Linguistically Diverse


Guiding Frameworks for the CCSS/Learning Standards


Individualized Educational Plan Goals & the CCSS


Informal Standards-Aligned Rating Scales


Nellenbach, K., & Layton, T. (2015). *The N & L Teacher Rating Scale and Scoring Form: Standards in reading in history/social studies: Grades 6-12*. Available upon request from krisnellenbach@gmail.com or tandtcommunication@earthlink.net

Language-Based Components of the CCSS


Appendix C

The N & L TEACHER RATING SCALE

Reading in History/Social Studies Standards – Grades 9-10

Introduction
One of the responsibilities as a Speech-Language Pathologist is to collaborate with teachers to ensure that students have the communication skills (i.e., reading, writing, speaking, listening, language, and thinking) that are essential to meeting the expectations of the CCSS. This includes students with documented communication disorders as well as students who “struggle” or who are identified as being “at risk” of academic failure.

Directions
Attached is rating scale that can be used to informally assess your student’s current level of performance specifically related to the standards for Reading in History/Social Studies Standards for Grades 9-10. The information from this rating scale can be also be used to: identify areas of strength and need, monitor progress, determine level of access to grade-specific standards, and/or document the role communication skills (and disorders) have on educational development.

Based on your interactions, classroom observations, and any other applicable information, please rate your student using the following 1-4 point scale:

| SCALE KEY |
|---|---|
| Number | Meaning |
| 1 | Never | The student never (or rarely) demonstrates the targeted knowledge/skill. |
| 2 | Sometimes | The student sometimes (or occasionally) demonstrates the targeted knowledge/skill. |
| 3 | Usually | The student usually (or typically) demonstrates the targeted knowledge/skill. |
| 4 | Always | The student always (or consistently) demonstrates the targeted knowledge/skill. |

At the end of each area, there is a space to include brief comments or information. You may also use the Additional Comments/Information form if needed. **PLEASE LEAVE THE SCORING BOX BLANK!**

The Speech-Language Pathologist will calculate the scores and provide a summary. When you have completed the form, please return it to: _______________________________________

Thank you for your time!

*Note: There are 10 standards in this sub-strand (see the CCSS References Form), but most of them have been divided into parts for ease of rating and for obtaining detailed information.
COMMON CORE STATE STANDARDS REFERENCES FORM

Reading in History/Social Studies Standards – Grades 9-10

<table>
<thead>
<tr>
<th>COLOR KEY</th>
<th>AREAS (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow</td>
<td>Key Ideas &amp; Details</td>
</tr>
<tr>
<td>Purple</td>
<td>Craft &amp; Structure</td>
</tr>
<tr>
<td>Green</td>
<td>Integration of Knowledge &amp; Ideas</td>
</tr>
<tr>
<td>Pink</td>
<td>Range of Reading &amp; Level of Text Complexity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STRAND STANDARDS (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCSS.ELA-RH.9-10.1</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.2</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.3</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.4</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.5</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.6</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.7</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.8</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.9</strong></td>
</tr>
<tr>
<td><strong>CCSS.ELA-RH.9-10.10</strong></td>
</tr>
<tr>
<td>Rating Key: 1=Never   2=Sometimes  3=Usually  4=Always</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>RH.9-10.1 The student cites specific textual evidence to support their analysis of primary/secondary sources.</td>
</tr>
<tr>
<td>RH.9-10.1 The student attends to such features as the date and origin of the information in primary/secondary sources.</td>
</tr>
<tr>
<td>RH.9-10.2 The student determines the central ideas or information of a primary or secondary source.</td>
</tr>
<tr>
<td>RH.9-10.2 The student provides an accurate summary of how key events or ideas develop over the course of the text.</td>
</tr>
<tr>
<td>RH.9-10.3 The student analyzes in detail a series of events described in a text.</td>
</tr>
<tr>
<td>RH.9-10.3 The student determines whether earlier events caused later ones or simply preceded them.</td>
</tr>
<tr>
<td>RH.9-10.4 The student determines the meaning of words/phrases as they are used in a text, including vocabulary describing political, social, or economic aspects of history/social studies.</td>
</tr>
<tr>
<td>RH.9-10.5 The student analyzes how a text uses structure to emphasize key points.</td>
</tr>
<tr>
<td>RH.9-10.5 The student analyzes how a text uses structure to advance an explanation or analysis.</td>
</tr>
<tr>
<td>RH.9-10.6 The student compares the point of view of two or more authors on the same or similar topics.</td>
</tr>
<tr>
<td>RH.9-10.6 The student compares the point of view of two or more authors on the same or similar topics including which details they include and emphasize in their respective accounts.</td>
</tr>
<tr>
<td>RH.9-10.7 The student integrates (connects) quantitative with qualitative analysis in print or digital text.</td>
</tr>
<tr>
<td>RH.9-10.8 The student assesses the extent to which the reasoning in a text supports the author’s claims.</td>
</tr>
<tr>
<td>RH.9-10.8 The student assesses the extent to which evidence in a text supports the author’s claims.</td>
</tr>
<tr>
<td>RH.9-10.9 The student compares and contrast treatments of the same topic in several primary sources.</td>
</tr>
<tr>
<td>RH.9-10.9 The student compares and contrast treatments of the same topic in several secondary sources.</td>
</tr>
<tr>
<td>RH.9-10.10 By the end of grade 10, the student reads and comprehends grade-level history/social studies texts independently.</td>
</tr>
<tr>
<td>RH.9-10.10 By the end of grade 10, the student reads and comprehends grade-level history/social studies texts proficiently.</td>
</tr>
</tbody>
</table>

Comments: TOTAL =

Comments: TOTAL =

Comments: TOTAL =

Comments: TOTAL =

Comments: TOTAL =
SCORING FORM FOR THE N & L TEACHER RATING SCALE
CCSS-ELA.LITERACY.RH.9-10
SIDE A

Student Initials: __________  Date: __________  Teacher Initials / Period: __________

Rating Scale:
The rating scale is a Likert-type scale starting from the far left with 1=Never, 2=Sometimes, 3=Usually, and 4=Always.

<table>
<thead>
<tr>
<th>Number</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never- The student never (or rarely) demonstrates the targeted knowledge/skill.</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes- The student sometimes (or occasionally) demonstrates the targeted knowledge/skill.</td>
</tr>
<tr>
<td>3</td>
<td>Usually- The student usually (or typically) demonstrates the targeted knowledge/skill.</td>
</tr>
<tr>
<td>4</td>
<td>Always- The student always (or consistently) demonstrates the targeted knowledge/skill.</td>
</tr>
</tbody>
</table>

Subsection Scoring
To determine each subsection score: (1) Calculate the raw score by totaling the circled points; (2) Divide the raw score by the subsection’s possible maximum points; and (3) Multiply the result of Step 2 by 4. These steps will result in a number from 1.0-4.0. Any score that is below a 3.0 should be reviewed and considered for possible intervention. The total score provides an overall picture of the students’ current level of performance specifically related to each of the subsections within the Reading in History/Social Studies Standards for Grades 9-10.

Example
Standards-CCSS.ELA-RH.9-10.1-3  Subsection (Area)-Key Ideas and Concepts
Student’s Raw Score-12  Subsection’s Maximum Points-24
Key Ideas and Concepts Subsection Score [12/24=2; 2 x 4=2; 2.0 is the Subsection score]

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Student’s Raw Score</th>
<th>Subsections’ Maximum Points</th>
<th>Multiply x4</th>
<th>Subsection score</th>
<th>Flagged for Possible Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Ideas &amp; Concepts</td>
<td>/24</td>
<td>x 4</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Craft &amp; Structure</td>
<td>/20</td>
<td>x 4</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Integration of Knowledge &amp; Ideas</td>
<td>/20</td>
<td>x 4</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Range of Reading &amp; Level of Text Complexity</td>
<td>/8</td>
<td>x 4</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
SIDE B (OPTIONAL)

Optional Scoring
In cases where there’s a wide variation of scores within the subsection, but the Subsection Score is a 3 or above, a secondary scoring may be used to identify specific areas of need. For example, a student scoring half 2’s and half 4’s within a subsection, would result in a Subsection Score of 3, which would not get flagged for intervention. This secondary scoring option would capture such cases.

Rating Scale (SAME AS SIDE A)
The rating scale is a Likert-type scale starting from the far left with 1=Never, 2=Usually, 3=Sometimes, and 4=Always.

Areas of Possible Intervention Scoring
To determine which areas may warrant review and consideration for intervention: (1) Calculate the number of responses that were circled as a 1 or 2; (2) Divide the number of student responses (Step 1) by the number of questions in the subsection; and (3) Multiply the result of Step 2 by 100. These steps will result in a percentage from 0-100. The Subsection Percentages provides an indication of the students’ areas of need related to each of the subsections within the Reading in History/Social Studies Standards for Grades 9-10.

Example
Standards-CCSS.ELA-RH.9-10.4-10.6 Subsection (Area)-Craft and Structure
Number of Student Responses at a 2 or Below-4 (Based on receiving a 2, 2, 1, 3, 2) Number of Subsection Questions-5

Craft and Structure Subsection Score [4/5 x 100=80% meaning that 80% of the teacher’s ratings were at a 2 or below.

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Number of Student Responses at a 1 or 2</th>
<th>Number of Subsection Questions</th>
<th>Multiply x100</th>
<th>Need Based Subsection on Percentages</th>
<th>Flagged for Possible Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Ideas &amp; Concepts</td>
<td>/6</td>
<td></td>
<td>x 100</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Craft &amp; Structure</td>
<td>/5</td>
<td></td>
<td>x 100</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Integration of Knowledge &amp; Ideas</td>
<td>/5</td>
<td></td>
<td>x 100</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Range of Reading &amp; Level of Text</td>
<td>/2</td>
<td></td>
<td>x 100</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Complexity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
Table: Answer to Question 7

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key:</strong> N= Nicolás, C=Consultant</td>
<td></td>
</tr>
<tr>
<td><strong>Question 7:</strong></td>
<td>What document did the nobles force King John to sign, giving some power to the people?</td>
</tr>
<tr>
<td>C</td>
<td>Are you familiar with any of these terms?</td>
</tr>
<tr>
<td>N</td>
<td>Yes, some of them.</td>
</tr>
<tr>
<td>C</td>
<td>Okay which ones? Tell me more.</td>
</tr>
<tr>
<td>N</td>
<td>These are important papers.</td>
</tr>
<tr>
<td>C</td>
<td>If you would, please read the terms you’re familiar with aloud.</td>
</tr>
<tr>
<td>N</td>
<td>I’ve heard of the Bill of Rights and the Constitution.</td>
</tr>
<tr>
<td>C</td>
<td>Okay great. You’ve heard of them, do you know what they mean or can you describe them for me?</td>
</tr>
<tr>
<td>N</td>
<td>I’m not really sure, but I know I’ve heard of them.</td>
</tr>
<tr>
<td>C</td>
<td>In what context or situation have you heard of them? In class, on TV, in talks, at home, where?</td>
</tr>
<tr>
<td>N</td>
<td>I’ve heard of them before in social studies class and TV.</td>
</tr>
<tr>
<td>C</td>
<td>Okay so what country do you think the Bill of Rights and the Constitution (i.e., important papers or historical documents) is connected with/linked to?</td>
</tr>
<tr>
<td>N</td>
<td>Here….right, in the US?</td>
</tr>
<tr>
<td>C</td>
<td>Right, they’re really important US historical documents related to the laws and rights of the citizens of this country.</td>
</tr>
<tr>
<td>N</td>
<td>Okay I’m also thinking that I’m pretty sure the pre….how do you say it?</td>
</tr>
<tr>
<td>C</td>
<td>Preamble.</td>
</tr>
<tr>
<td>N</td>
<td>Right the preamble, it looks familiar, but I’ve never seen the Magna Carta before.</td>
</tr>
<tr>
<td>N</td>
<td>I don’t think the answer is the Bill of Rights or the Constitution. So that leaves the preamble or Magna Carta.</td>
</tr>
<tr>
<td>C</td>
<td>Let’s look at the phrase, Magna Carta. You’ve said that you’ve never heard of the word before right?</td>
</tr>
<tr>
<td>N</td>
<td>Right.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>C</td>
<td>Well, just because we haven’t heard of a word before, doesn’t mean we would want to necessarily just skip over it without trying to figure something out about it if we can right? If you’ve never heard of a word before what can you do to try to figure out its meaning.</td>
</tr>
<tr>
<td>N</td>
<td>You told us before we could look at the word in the sentence or con...what was the word?</td>
</tr>
<tr>
<td>C</td>
<td>Context? Right, you could look at the word in the sentence and see if there are any meaning clues from the words/sentences nearby. In this case though the context clues are limited so what else can you do? In fact, I’ve already seen you using this strategy.</td>
</tr>
<tr>
<td>N</td>
<td>Figure out the clues in the word?</td>
</tr>
<tr>
<td>C</td>
<td>Nice memory! So let’s take the words apart here, Magna and Carta. Do you know what either of these word parts mean?</td>
</tr>
<tr>
<td>N</td>
<td>No, not really here except in Spanish Carta means letter or card or maybe a document.</td>
</tr>
<tr>
<td>C</td>
<td>That’s really good word problem solving Nicolás. I’m wondering aloud here...so it could mean a letter, card, or document, or right?</td>
</tr>
<tr>
<td>C</td>
<td>In the context of the question, “What document did the nobles force King John to sign, giving some power to the people” which of the meanings do you think best relates or connects to the question?</td>
</tr>
<tr>
<td>N</td>
<td>A letter or document?</td>
</tr>
<tr>
<td>C</td>
<td>Sounds like a reasonable inference and connection to me.</td>
</tr>
<tr>
<td>C</td>
<td>Again I’m thinking aloud here...at some point it would be good to know if there are other meanings attached to the word chunk Carta. I’ll make a note to myself to check on that later.</td>
</tr>
<tr>
<td>C</td>
<td>What about Magna? What do you think that means?</td>
</tr>
<tr>
<td>N</td>
<td>I’m not sure. (The pre-dismissal bell rings.) Hmmm, I think I’m still going to go with the Magna Carta because maybe of the word clue even though I haven’t heard of it before. (N chooses correct answer, B.)</td>
</tr>
</tbody>
</table>

**Available Choices:**

- A. Preamble
- B. Magna Carta
- C. Bill of Rights
- D. Constitution
Hearing Status of Children in Developing Nations: A Clinical Case Study

Samantha Daney, Lauren Lonsway, & Lori Pakulski

Abstract
This small-scale study examines the hearing screening data of children living in an orphanage in a developing country. Through a review of the literature, it is clear that little is known about hearing and hearing loss among children in developing countries, including those who are institutionalized. Despite the limited data available, the World Health Organization (WHO) has deemed hearing loss to be a global burden with substantial social and economic ramifications (Duthey, 2013). The development and implementation of hearing conservation programs, the necessity of advocating for policy change, and improved collaboration among professionals is addressed.

Author Affiliations & Disclosures:
Samantha Daney B.S., is a graduate student in Speech-Language Pathology at the University of Toledo.
Financial – Receives financial support as part of her participation in the Graduate Studies Consortium for Listening and Spoken Language (GSCLSL) at the University of Toledo.
Nonfinancial – Nothing to disclose.
Lauren Lonsway is a student at the University of Toledo
Financial – Nothing to disclose.
Nonfinancial – President of the University of Toledo National Student Speech-Language-Hearing Association (NSSLHA).
Lori A. Pakulski, Ph.D., CCC-A is employed at The University of Toledo.
Financial – is a Professor in the College of Health Sciences, Department of Rehabilitation Sciences, at the University of Toledo. Developed the Auditory and Language Enriched Program (ALEP) for young children with hearing loss, and was awarded a U.S. Department of Education Professional Training Grant. Developed the Graduate Studies Consortium for Listening and Spoken Language (GSCLSL) in partnership with Dr. Todd Houston (University of Akron) to provide training for graduate speech-language pathology students to work with children with hearing loss who use advanced technology to learn to listen and talk.
Nonfinancial – is a community consultant for families of children with hearing loss in both special education and inclusive environments, and works with educators and other professionals to improve service provision in the classroom.

Learning Objectives
1) Summarize the prevalence of disabling hearing loss in low- and middle-income nations.
2) List possible causes of disabling hearing loss, specific to low- and middle-income nations.
3) List negative consequences of unidentified hearing loss in childhood.

Hearing loss is the most common sensory deficit, and constitutes a public health concern globally, especially among low- and middle-income countries (WHO, 2013a). Despite the high incidence of hearing loss among developing nations, there is limited information available about hearing and hearing loss (Stevens et al., 2013). In an effort to expand the knowledge and database regarding hearing and hearing loss in developing countries and specifically among children in an orphanage, two Speech-Language Pathology (SLP) student clinicians from a Midwestern university traveled to Honduras to perform hearing screenings. The students’ goals were to gather data, investigate the hearing needs of this population, and to raise awareness among professionals in the United States and in developing countries.
The SLP student clinicians participated in a service-based mission trip coordinated by a church affiliated with the university. The trip took place over eight days and was composed of a group of 12 student volunteers. As a group, the university volunteers completed a variety of service projects that included installing two water purification systems, painting the dormitories, delivering donated items, and conducting hearing screenings. Additionally, the university volunteers interacted with the children living in the orphanage in a variety of ways. The children and the volunteers cooked and enjoyed meals together, shared language and culture, and engaged in many meaningful experiences with one another.

Over three days of the visit, the student clinicians completed hearing screenings on 70 children (age three and up) living at the orphanage. Another student volunteer served as a translator to ensure that a language barrier did not hinder the screening results.

The purpose of this article is to share the data, explore hearing and listening options aimed at this group of children, and suggest ways in which other students and professionals can raise awareness and develop programming to support children in developing countries. While this study focuses specifically on children in an orphanage in Honduras, comparative information about hearing loss in Latin American countries is limited, as it is considered a low priority for national health systems (Madriz, 2000).

**Background**

According to the WHO (2013a, 2013b), approximately 32 million children (< 15 years of age) globally live with disabling hearing loss (DHL) of which the majority of cases are preventable or treatable. Among children, the WHO defines DHL as unilateral or bilateral hearing loss greater than 30 decibels (dB) hearing level (HL) (WHO, 2013a). Eighty-nine percent of children with DHL live in low- and middle-income countries, and approximately 2.6 million of those children live in Latin and Caribbean America alone, including Honduras (WHO, 2012). This is significant compared to the 8 million children living with DHL in the United States, a high-income nation (WHO, 2012).

Although the WHO defines DHL in children as greater than 30 dB HL; unilateral, minimal and mild hearing loss (UMMHL) of 15-25 dB HL are also detrimental (Bess, Dodd-Murphy, & Parker, 1998; Kaderavek & Pakulski, 2002). However, much less is known about UMMHL because it often goes undetected. Recent research suggests that as many as 1 in 5 US adolescents aged 12 to 19 years have (unilateral) minimal or mild hearing loss (Shargorodksy, Curhan, Curchang, & Eavey, 2010). Urban minority youth are especially at-risk, and represent an under-reported and under-studied group (Henderson, Testa, & Hartnick, 2011; Mehra, Eavey, & Keamy, 2009). While little is known about children in developing countries, they are most likely at-risk as well.

While the prevalence of UMMHL is not reported in low- and middle-income countries, DHL is nearly double that of high-income nations (WHO 2015b; WHO, 2013b). The high incidence of DHL in these nations is primarily due to insufficient health care (Duthey, 2013). Limited resources in ear and hearing care, a shortage of national attention to assistance programs, few professionals in the field, poor personal hygiene, overcrowding, and a lack of access to medical interventions all contribute to the inadequacy of healthcare available in low- and middle-income nations (Duthey, 2013). According to the WHO, “public health measures” can successfully reduce the incidence and impact of DHL (WHO, 2013a). Along with these factors, minimal and mild hearing loss, in particular, may be a direct result of the “noise-scape,” or ambient noise, many children experience on a daily basis including music, playground and street noise, heating and cooling systems, and common sounds.

Although hearing loss may not be considered a priority in developing countries, it is nevertheless a serious concern for children (Yammah, Mabrouk, Ghorab, Ahmady & Abdulsalam, 2012). Hearing is critical for language learning which impacts education, communication and social skills (ASHA, 2015). Hearing loss can cause a delay in the development of speech and language resulting in negative implications in academic learning and social development. Specifically, delays in spoken language development can limit access to communication and hinder interactions with others, which may cause feelings of isolation and loneliness (ASHA, 2015). These factors impact career choices and may adversely affect quality of life outcomes (ASHA, 2015).

Investigators have also documented that even a UMMHL can place youth at risk for academic learning problems (Daud, Noor, Rahman, Sidek & Mohamad,
2010; Lieu, Tye-Murray, Karzon, & Piccirillo, 2010; Shargorodsky et al., 2010). For example, one study reported that 37% of children with unilateral, mild-moderate hearing loss failed at least one grade in school, and an additional 13% required academic assistance or resource help. This grade failure rate was ten times that of the general school population for that geographic area (Tharpe, 2008). As a result, even more children than those defined by the WHO may be at risk for the negative academic and learning implications of unidentified and/or untreated hearing loss.

In some countries untreated hearing loss is especially significant as it can limit education options. Consequently, limited opportunities for education may have negative implications on employment and the economy at the level of the individual, the local community and the country (WHO, 2013b). Individuals with disabilities, including hearing loss, have a much higher unemployment rate due to limited resources and access to services (WHO, 2013a).

Effective early identification and management of hearing loss can significantly diminish its impact (WHO, 2013a). Although the positive implications of early identification are indisputable, the Center for Disease Control (CDC) (2015) does not have data available regarding early identification in Honduras. Subsequently, limited information exists concerning the prevalence of hearing loss and consequences of early identification in low- and middle-income countries.

Concerns for Orphanages in Developing Nations
Albeit minimal, there is a growing body of research related to hearing and hearing loss among children in developing countries. Yet, studies of hearing loss among children in orphanages in developing countries are essentially nonexistent. There are, however, active mission groups that provide hearing health care and related services. Currently, the student clinicians are working with one such group to organize a follow-up trip with the orphanage in Honduras.

Methods
Subjects
Eighty children resided at the orphanage; 70 of those children served as subjects. Ten children were not screened because of scheduling issues or age (younger than 3 years). The subjects ranged in age from 3 to 18 years, and lived at the orphanage for a varying number of years, and for a multitude of reasons. Personal and medical records were limited.

Instrumentation
Two portable audiometers (Micro Audiometrics Earscan 3) were used to complete the hearing screenings. Each had been calibrated within the past three months and was found to be in good working order each day. Specifically, the student clinicians performed a visual inspection to confirm there was no sign of wear or damage on the instruments including cords and earphones. In addition, a listening check was conducted following the Martin (1997; p.3) protocol, which includes evaluating sounds delivered through the earphones in each ear at each decibel and frequency level used for the screening protocol.

Screening Protocol
Two student clinicians, enrolled in an accredited university program, worked with a faculty advisor (the third author) to develop a hearing screening protocol for children living in an orphanage in a developing country. Both students had successfully completed an introductory audiology course and were familiar with both the hearing screening and basic audiometric techniques. The faculty advisor further trained the students and observed their competency prior to the mission trip.

Children were screened at 25 dB HL, rather than the recommended 20 dB HL due to background noise that could not otherwise be controlled, for each of the recommended frequencies of 1,000 Hertz (Hz), 2,000 Hz, and 4,000 Hz. (ASHA, 1997). Through a translator, each subject was told that the student clinician was putting earphones on his/her ears to check his/her ability to hear soft sounds, and that they would receive a small reward (sticker and chocolate) when they were finished. Subjects were then instructed to raise their hands each time they heard a soft beep, varying in pitch, in either ear. None of the children had been screened prior, thus the directions were repeated or adjusted until the subject demonstrated understanding.
of the expectations. A nurse was available on the campus to provide assistance, and generally oversee the screenings.

Those that failed the hearing screening on the first day were screened on another occasion to ensure accurate results. At that time, an otoscopic examination was also completed to rule out any obvious causes such as cerumen blockage; no abnormalities were noted.

It should be noted that prior to the screening, one additional female in the 11 to 18 years age group had been identified with a congenital hearing loss. She communicated using Spanish Sign Language. She was screened, as she wanted to participate and be included in the program; however, her results were not included in the analysis. She was given the same rewards as the other children.

**Challenges to the Protocol**
The student clinicians identified the most suitable screening environment available on the orphanage campus. While visual distractions were controlled, significant noise was an unavoidable concern. Due to persistent car alarms in the neighborhood and 80 children playing and working on the grounds, finding quiet space was a difficult task. The student clinicians utilized their clinical judgment to locate an environment with minimal ambient noise. As a result, the hearing screenings were conducted in several locations to meet the environmental requirements. Further, fans and air conditioning were turned off to reduce background noise. Even after minimizing the background noise as much as possible, it was determined that a screening level of 25 dB HL was necessary to offset the noise level for each room in which screenings were conducted. This is 5 dB higher than the recommended hearing screening level for children (ASHA, 1997), but a commonly used technique to assure adequacy of the screening protocol. An additional challenge was the fact that tympanometry, common to pediatric screening protocols, was not available. However, otoscopy was completed on those who did not pass the initial screening prior to rescreening.

**Results**
Hearing screenings were conducted on seventy children (3 to 18 years of age) residing in an orphanage; the results (Table 1) were analyzed under the supervision of the third author (a licensed and certified audiologist). Sixty children passed the screening (26 females and 34 males). Of the 10 participants referred for a complete hearing evaluation because they did not pass the screening, eight were female and two were male. The eight female participants, who failed the hearing screening, ranged between 11 to 18 years of age. Of the two male participants, who failed the screening, one was in the 5 to 10 years age group, and the other in the 11 to 18 years age group.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Age (years)</th>
<th>Passed</th>
<th>Referred (Failed)</th>
<th>% Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>3-4</td>
<td>2</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>5-10</td>
<td>8</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>11-18</td>
<td>15</td>
<td>8</td>
<td>65.23%</td>
</tr>
<tr>
<td>Males</td>
<td>3-4</td>
<td>6</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>5-10</td>
<td>10</td>
<td>1</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>11-18</td>
<td>19</td>
<td>1</td>
<td>95%</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>10</td>
<td></td>
<td>83.3%</td>
</tr>
</tbody>
</table>

In this small-scale study, most males, and younger females, passed the hearing screening, which suggests hearing within the normal range. However, a high percentage of females (34.7%) 11 to 18 years of age failed the hearing screening.

**Follow-up & Conclusions**
An important aspect of any screening protocol and one that is challenging in a developing country is follow-up; however, further evaluations are vital for the future of these children. Thus, one of the authors is currently communicating with a nonprofit organization that donates services (including evaluations) and refurbished hearing aids to individuals in need internationally. They are planning for a future trip to evaluate and address the needs of the children that did not pass the screening. With the help from this company, the children that did not pass the initial hearing screenings will be evaluated by an audiologist to identify their needs. If a child is found to have permanent hearing loss, the organization will be able to provide the child with hearing aids. The amplification will, in turn, provide
auditory access to the children with hearing loss, which can lead (with intervention) to improved outcomes in spoken language development, socialization, and academic learning (WHO, 2013a). Those audiologists will also be able to further address prevention education.

While severity or type of hearing loss could not be ascertained in this hearing screening protocol, it should be noted that these subjects, like their counterparts in middle- and high-income countries, are at-risk for both middle ear problems related to general health as well as noise induced hearing loss. In fact, it is estimated that as many as 50% of teenagers and young adults (12 to 35 years of age) in middle- and high-income countries are exposed to hazardous noise levels from personal listening devices (PLDs), such as iPods and MP3 players, which can lead to permanent hearing loss (Shargorodsky et al., 2010; WHO, 2015a). Although much less is known about noise-related hearing loss in low- and middle-income countries, many of these subjects are also at-risk due to use of PLDs. Specifically, it was reported that the females in particular frequently complete their duties at the orphanage while listening to music with earbuds/PLDs. Considering the noise-scape of the orphanage, a higher PLD volume would likely be needed to compete with the background noise while completing daily chores.

Clinical Implications and Future Directions
The aim of this study was to begin the process of identifying children at-risk for hearing loss, or who may have potentially DHL, and to discuss the global burden of hearing loss among children in developing countries, specifically Honduras. Although it was beyond the scope of this study to include tympanometry, otoacoustic emissions, and noise level measurements, findings support the need for further study of hearing status, daily noise-scape and other risk factors, as well as the impact of unidentified and untreated hearing loss among these children. This data may be useful for the collaboration of professionals that have a concern for global hearing loss. Additionally, it has the potential to provide data for the development and implementation of hearing conservation programs in areas where the consequences of hearing loss may not be fully understood. Lastly, this study shows why it is necessary to advocate for policy change.

Limitations of the study
The inability to perform tympanometry or otoacoustic emissions is a major limitation of the screening protocol that could be completed for this study. These tests are critical in identifying the presence of hearing loss as well as the possible causes. Although the most commonly used protocol for hearing screenings is pure-tone hearing screenings at the frequencies of 1,000 Hz, 2,000 Hz, and 4,000 Hz (Meinke & Dice, 2007), utilizing tympanometric measures and, specifically, otoacoustic emissions may improve early identification of possible hearing loss related to middle ear dysfunction as well as noise damage (Helleman, Jansen & Dreschler, 2010; Lapsley Miller, Marshall, Heller & Hughes, 2006).

Future implications and directions include:
- Follow-up the hearing screenings with full audiological evaluations and implement any necessary and appropriate interventions.
- Complete a noise study to better document the daily noise-scape of the children, as well as the environmental noise, and use this data to educate the orphanage administrators and improve the daily exposure of the children as needed.
- Design and implement a hearing conservation program to be utilized in developing nations, specifically geared towards children.

Correspondence concerning this article should be addressed to:
Samantha Daney
The University of Toledo
2801 W. Bancroft, MS 119
Toledo, OH 43606
419-530-4339
Email: Samantha.Daney@rockets.utoledo.edu

References


Continuing Education Questions

Directions: Choose the best answer for each question as you read each article. Then log in at http://www.ohioslha.org/membersonly/index.asp to answer the assessment questions. Follow the online directions to earn free ASHA continuing education units (CEUs), while the opportunity is available.

Counseling in Culturally and Linguistically Diverse Populations

12. Which statement is true?
   a. Speech-language pathologists and audiologists are not legally able to practice counseling techniques during a clinical session
   b. Clinicians are able to counsel on topics related to mental health and issues regarding life changes from divorce, unemployment, and death
   c. Speech-language pathologists and audiologists are able to counsel clients and family members regarding topics that improve quality of life related to communication and swallowing disorders
   d. Clinicians will not be affected by the change in the demographics of the United States population

13. Which strategy may be used to avoid opportunities to counsel in the session?
   a. Paraphrasing and summarizing the client’s words and phrases
   b. Providing humor to distract the client from an emotional response
   c. Brainstorming ideas, topics, and goals to address in the session
   d. Challenging the client to overcome a task or a struggle in the session

14. What is multicultural counseling?
   a. Counseling that acknowledges the counselor and client may have different culture backgrounds
   b. Counseling that acknowledges the cultural background of the client only
   c. Counseling that acknowledges the similarities in the client and counselor
   d. Counseling that acknowledges clients from different cultural backgrounds will not choose to receive treatment

15. Which of the following is not a progressive step to implementing multicultural counseling?
   a. Assessing your multicultural competence and awareness
   b. Suppressing your cultural differences to blend with colleagues
   c. Conversing with supervisees about multicultural awareness
   d. Acknowledging differences between counselor and client

Stuttering and Art Therapy

16. What is the definition of quality of life?
   a. Having a better understanding of communication abilities.
   b. The symbolic communication of unconscious material in a direct, uncensored, and concrete form that allows clients to use creativity to express, nonverbally, their thoughts and feelings.
   c. Enabling clients to embrace emotional and cognitive events without attempts to change.
   d. A multidimensional concept emphasizing the self-perceptions of an individual’s current state of mind.
17. What is TRUE about acceptance of stuttering for people who stutter?
   a. The tendency for people who stutter to hide or avoid their stuttering due to such negative emotions has not been documented in literature.
   b. Acceptance of stuttering is one coping mechanism that may lead to better quality of life for people who stutter.
   c. Acceptance and Commitment Therapy (ACT) has not been beneficial for people who stutter.
   d. Mindfulness has been proven to be unsuccessful for people who stutter in promoting acceptance of self and stuttering.

18. Which of the following is FALSE about art therapy?
   a. Art therapy has been used since the mid-20th century.
   b. Art therapy can create a visible trail of progress and note development and change.
   c. Professionals (such as counselors, psychologists, psychiatrists, social workers, marriage and family therapists, allied health professionals and speech-language pathologists) must obtain an art therapy license.
   d. Art therapy has improved attention and affect for adults with learning and developmental disorders.

19. What are the results of the study?
   a. Treatment was not effective in increasing self-acceptance for the person who stutters in this study.
   b. Art therapy was successful in increasing self-acceptance for the person who stutters in this study.
   c. The data was too inconsistent therefore the results are inconclusive.
   d. There was no fluctuation during the withdrawal (A phase), therefore it is difficult to determine progress.

**Presbyphagia**

20. According to Robbins et al., 2005, the following exercises significantly increase isometric and swallowing pressures in healthy older adults.
   a. Pitch glides.
   b. Lingual resistance exercises.
   c. Lingual range of motion exercises.
   d. Effortful swallow exercises.

21. What changes in timing are consistent with presbyphagia?
   a. Change in location of the bolus when pharyngeal swallow is triggered.
   b. Pharyngeal swallow triggers faster.
   c. Decreased duration of hyoid bone excursion.
   d. Mistimed upper esophageal sphincter relaxation.

22. What was the major finding regarding endurance at mealtime in older adults (Kays et al., 2010)?
   a. Exhibiting signs of swallow difficulty (i.e., wet voice, throat clear and cough).
   b. Reduced anterior tongue strength.
   c. Reduced posterior tongue strength.
   d. Increased lingual residue.

23. What is not considered a normal physiologic change in healthy older adults?
   a. Increased oral and pharyngeal transit times.
   b. Increased pharyngeal residue/stasis.
   c. Shorter laryngovestibular closure times.
   d. Incomplete epiglottic retroflexion.
Guidelines for Speech-Language Pathologists

24. In relation to the Standards, the main priority for all SLPs is to:
   a. Develop a working knowledge of them in order to debate their effectiveness.
   b. Develop a working knowledge of them in order to directly teach content-specific information.
   c. Ignore or defer addressing them in your work with students.
   d. Develop a working knowledge of them in order to identify the underlying language and cognitive skills essential to students’ access and engagement with the curriculum.

25. Which of the following is NOT a key guideline to ensuring that SLPs have access and opportunities to collaborate in the effective implementation of the CCSS ELA-Literacy?
   a. Know the Ins and Outs of the Standards.
   b. Teach the content of the Standards.
   c. Do What You Do Best.
   d. Collaborate.

26. Which of the following domains of language/cognition can be found within the CCSS ELA?
   a. Phonology, Semantics, Morphology, Syntax, Pragmatics, Metas (i.e., metalinguistics metacognition).
   b. Pragmatics, Semantics, Morphology.
   c. Phonology, Semantics, Syntax, Pragmatics.
   d. Phonology, Semantics, Morphology, Metas (i.e., metalinguistics metacognition).

27. Which of the following is NOT an example of an appropriate collaborative role for SLPs?
   a. Use the standards and teacher provided materials to identify key language-based learning objectives and design or adapt developmentally appropriate strategies that allow for student access and learning.
   b. Assist in the identification of potential language-based access barriers to learning the standards for students with and without identified deficits/disorders.
   c. Assist teachers in the identification and progress monitoring of students with “possible literacy difficulties” affecting their access and engagement with the expectations of the Standards.
   d. Teach or co-teach a lesson primarily addressing core content-area information.

Hearing Status of Children in Developing Nations

28. According to the World Health Organization (WHO), what percent of children (<15 years) with disabling hearing loss (>30 dB HL) live in low- and middle-income nations?
   a. 55%
   b. 32%
   c. 95%
   d. 89%

29. Which factor may contribute to the high-incidence of disabling hearing loss in low- and middle-income nations?
   a. Insufficient access to healthcare.
   b. Sedentary lifestyle.
   c. Sufficient access to education.
   d. Sufficient access to medical intervention.

30. Which of the following is the most common sensory deficit?
   a. Inability to smell.
   b. Hearing loss.
   c. Inability to taste.
   d. Visual deficit.
31. According to the American Speech-Language-Hearing Association (ASHA), hearing screenings should be completed at which of the following pure-tone frequencies?
   a. 1,000Hz, 2,000Hz, 4,000Hz, 6,000Hz.
   b. 1,000Hz, 2,000Hz, 4,000Hz.
   c. 2,000Hz, 3,000Hz, 4,000Hz.
   d. 2,000Hz, 3,000Hz, 4,000Hz, 6,000Hz.

SPRING is:
A time to find out where you are, who you are, and move toward where you are going.

~ Penelope Trunk
Guidelines for Submission to eHearsay

eHEARSAY, the electronic journal of the Ohio Speech-Language-Hearing Association, is designed to address the professional development needs of the members of the state association.


**Types of Manuscripts**

Contributed manuscripts may take any of the following forms:

- **Research Article**: Full-length articles presenting important new research results. Research articles include an abstract, introduction, methods and results sections, discussion, and relevant citations. These are typically limited to 40 manuscript pages including citations, tables, and figures. Large data sets and other supplementary materials are welcome for inclusion in the online publication.

- **Review**: A comprehensive overview of an area of speech, language, or hearing sciences and/or disorders (i.e., systematic review or meta-analysis). Reviews should be accessible to knowledgeable readers not expert in the subject area. They should be prepared with the same rigor as a research article reporting specific results. These are typically limited to 40 manuscript pages including citations, tables, and figures.

- **Tutorial**: Educational expositions covering recent literature on topics of interest to clinicians and other scholars. These are typically limited to 40 manuscript pages including citations, tables, and figures.

- **Research Forum**: The purpose of a research forum (RF) is to provide a concentrated focus on a special topic deemed to be of high interest to the readership. An RF contains a series of empirical studies centering on a key aspect of speech, language, hearing, or swallowing science and/or disorders. RFs may also comprise a set of scholarly papers presented at a scientific conference.
  - A proposal for an RF must be approved for consideration by the journal editor prior to forum development. Pre-approval by an editor does not guarantee that any or all manuscripts submitted will be accepted for publication. The proposal should (1) provide a forum summary, (2) outline the probable manuscript titles and author lists, (3) state whether a prologue and/or epilogue is planned, and (4) designate one person, a forum coordinator, as the point of contact and coordinator of communications with forum authors.

- **Letter to the Editor**: Opinions about material previously published in the journal or views on topics of current relevance. A letter relating to work published in the journal will ordinarily be referred to the author(s) of the original item for a response, which may be published along with the letter. Letters are typically limited to 15 manuscript pages, including citations, tables, and figures.

- **Clinical Focus**: Articles that may be of primary clinical interest but may not have a traditional research format. Case studies, descriptions of clinical programs, and innovative clinical services and activities are among the possibilities.

- **Viewpoint**: Scholarly based opinion(s) on an issue of clinical relevance that currently may be neglected, controversial, related to future legislation, or could serve to update the readership on current thinking in an area.
Manuscript Style and Requirements

Style Manual
Authors are expected to follow the style specified in the *Publication Manual of the American Psychological Association* (6th edition).

Language Policies
OSLHA policy requires the use of nonsexist and person-first language in preparing manuscripts.

Page Limit
A guideline of 40 pages (including title page, abstract, text, acknowledgments, references, appendices, tables, and figures) is suggested as an upper limit for manuscript length. Longer manuscripts, particularly for critical reviews and extended data-based reports, will not be excluded from review, but the author(s) should be prepared to justify the length of the manuscript if requested to do so.

Peer Review
All manuscripts are peer reviewed, typically by at least two reviewers with relevant expertise, an issue editor (if applicable), and the journal editor. Correspondence between authors and editors is expected to be professional in tone. If correspondence is not conducted in a professional manner, an editor has the option to bring the matter before the OSLHA Directory of Technology and Publications and/or OSLHA’s Executive Council. After consultation with the Directory of Technology and Publications, the editor may terminate the peer review process for that submission. The author has the right to appeal to the OSLHA Directory of Technology and Publications and/or OSLHA’s Executive Council.

Authorship & Author Disclosures
During manuscript submission, answers to a number of disclosures will be required. The corresponding author:

- Affirms that all of the authors listed in the byline have made contributions appropriate for assumption of authorship, have consented to the byline order, and have agreed to submission of the manuscript in its current form
- Affirms that all applicable research adheres to basic ethical considerations for the protection of human or animal participants in research
- Affirms that there is no copyrighted material in the manuscript or includes a copy of the permission granted to reproduce or adapt any copyrighted material in the paper
- Affirms that the manuscript has not been previously published in the same, or essentially the same, form
- Affirms that the manuscript is not currently under review elsewhere. OSLHA prefers to publish previously unpublished material
- Discloses information about any previous public presentation of the data reported in the submitted manuscript, including at a scientific meeting or in conference proceedings, book chapters, websites, or related media
- Discloses any real or potential conflicts of interest that could be seen as having an influence on the research (e.g., financial interests in a test or procedure, funding by an equipment or materials manufacturer for efficacy research)

CALL FOR PAPERS
Submit your manuscript at any time by sending it to the
Journal Editor: [Laurie.sheehy@utoledo.edu](mailto:Laurie.sheehy@utoledo.edu) or the
Business Office [oslhaoffice@ohioslha.org](mailto:oslhaoffice@ohioslha.org)
The Changing Landscape of Autism Spectrum Disorders

Much has been learned about Autism Spectrum Disorders (ASD) over the decades and much has changed. Today, we have new criteria for the diagnosis of ASD, more refined assessments, and a host of evidence based practice methods available for those with ASD. Hallmark characteristics of ASD include social-communication impairments as well as restricted repetitive behaviors. In the next issue of e-Hearsay, experts review the changes and implications of the new ASD criteria and examine the influence of evidence based practice methods designed on enhancing social-communication while reducing restricted repetitive or aberrant behaviors. Specifically, Schea Fissel reviews research on changes to the DSM criteria. Dr. Diane Williams reviews and integrates findings from the behavioral and the neurodevelopmental literature that can guide our conceptualization of ASD as well as how accommodations and interventions are designed. We then examine ASD intervention from three perspectives. Dr. Andrew Shahriani examines the use of Relationship Development Intervention (RDI) while Dr. Barry Prizant and colleague report on the use of the Social Communication Emotional Regulation Transactional Support (S.C.E.R.T.S.) model to enhance self-regulation and availability for social learning. Dr. Howard Shane and colleagues present results from their research on use of visual supports to enhance language comprehension as well as behavior.

Lisa R. Audet, Guest Editor of Autism Issue

I hope you are looking forward to our next issue! Don’t forget you can earn FREE CEU’s if you are an OSLHA member.

Laurie