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BHSM

BETTER HEARING & SPEECH MONTH

Early Intervention Counts

May 2015 Issue

The Speech Clinic
Speech Voice Language Learning Swallowing
Committed to Results

May is Better Hearing and Speech Month
Early Intervention Counts

From the desk of

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May is Better Hearing and Speech Month. This year's focus is Early Intervention. In children, speech and language development starts from the day they are born. Birth to three years are critical in speech and language development in infants and young children, when their brain is best able to absorb language. If this critical period is allowed to pass without good exposure to language, it will be more difficult for the children to acquire good language skills. By identifying problems early and correcting them, we can capture those early years. Having said that, even beyond the first three years of life, the earlier a problem is identified, the better it is. Early intervention prevents or minimizes many problems from occurring. By addressing the needs preemptively, we can foster progress and assure that the individual is maximizing his or her potential in speech and language development.

Swallowing Therapy

Swallowing disorders occur in all age groups from newborns to the elderly and can result for a variety of medical conditions. They may present themselves acutely; for example, as a result of cerebrovascular accident (CVA) or may worsen slowly over time as in tumors of the pharynx or progressive neurological disorders. Patients with swallowing disorders may be acutely aware of their problem and be able to describe it to their doctor or clinician in detail or may be entirely oblivious to any difficulty with deglutition.

A speech pathologist is trained in treating swallowing problems occurring in the preparatory, oral and pharyngeal stage of the swallow. Swallowing disorders occurring in the esophageal stage of the swallow are outside the training of a speech pathologist and are usually handled by a gastroenterologist. Swallowing therapy includes positioning of food in the mouth with the tongue, chewing a bolus of varying consistencies, recollecting the bolus into a cohesive mass prior to initiation of the swallow and organizing lingual peristalsis to propel the bolus posteriorly. These are the preparatory and oral stages of the swallow.

Techniques for stimulation of the swallowing reflex, improvement of pharyngeal transit time and airway protection are used to improve the pharyngeal phase of the swallow. Once the bolus enters the esophagus through the cricopharyngeal juncture, the expertise of the speech pathologist ends.

Radiographic study of the swallow is essential in planning treatment. A modified barium sallow study is usually done by a speech pathologist in conjunction with a radiologist. If on the modified barium swallow study, a patient is aspirating more than ten percent of each bolus swallowed and therapeutic techniques applied at the time are unable to reduce their aspiration, the patient will function better if therapy focuses on improving the muscle controls required for the swallowing rather than working directly on swallowing by using food or liquid.

Indirect therapy includes exercises to improve oral motor control of the bolus and the voluntary stage of the swallow, stimulation of the swallowing reflex and exercises to increase adduction of tissue at the top of the airway; usually the true vocal folds to improve airway protection during the swallow.

Continued - Swallowing Therapy

When a gastronomy tube or G-tube is inserted, the patient usually gets indirect therapy until he or she is deemed safe to eat orally at which time, food and liquid are introduced for therapeutic feeding and then gradually advanced to three meals. Usually the G-tube is removed with the joint decision of the physician, dietician and speech pathologist. The person's weight is monitored to prevent weight loss.

Swallowing therapy is one of the most rewarding aspects of a speech pathologist's job. That first bite of food and drink for the patient is the ultimate reward for the clinician!

Turn-Taking and Conversation

In children, conversation may begin without words; e.g., a game of rolling a ball back and forth can be a conversation without words. Parent and child take a turn; sometimes a turn will be a nonverbal gesture, indicating, "mine," "go get it". As children develop words to replace much nonverbal communication, taking turns is a basic requirement of conversation. Turn-taking does not happen automatically. It is a skill that children must learn and practice, e.g., during the first games of "peek-a-boo," parents start the game and keep it going. Later the child learns to take a turn. After early experience with these communication games, the child has learned not only about the speaker and listener roles but also that the roles can be reversed. The child has learned that someone always has to take the responsibility for starting an exchange, maintaining it and ending it.

A good way to achieve turn-taking in conversation with your child is to develop a conversational style with your child, e.g., rather than always asking questions, make a comment. This allows the child to make a comment too or comment on your comment. That keeps the communication dyad going; as opposed to if you ask a child a question, he or she answers it and that is the end of the conversation. Being quizzed is not much fun.

Tips for parents:

1. Whenever your child starts a conversation, respond positively.
2. When your child joins the conversation with a remark that is not related to the topic being discussed, gently remind him (after acknowledging the comment) that you will talk about that later.
3. "Tell me about it" or "How did you do it?" is better than "What did you do?"
4. If you ask a question, give the child enough time to talk.
5. Don't put pressure on your child to answer you.
6. Show your child how to end a conversation or change a subject by modeling it.

Otitis Media and Speech and Language Development

Otitis media is fluid in the middle ear caused by an ear infection. It is one of the most common illnesses in children between birth and three years of age. Fluid in the middle ear prevents the ear from conducting sound properly. It can interfere with normal hearing. Even a mild, temporary hearing loss can delay the development of language skills. Therefore, early recognition and treatment of otitis media is important.

What are the symptoms of otitis media?

Some of the common symptoms of otitis media are:

- Earaches or draining of the ears
- Fever
- Partial loss of hearing
- Different response to speech and everyday sounds
- Changes in sleeping or eating habits
- Irritability
- Rubbing or pulling at the ears
- Having difficulty keeping balance, running, or jumping
- Turning the television or radio up much louder than usual
- Frequent need to have directions and information repeated
- Talking less than usual
- Unclear speech
- Using gestures rather than talking
- Delayed speech and language development

The symptoms of otitis media usually appear during or after a cold or respiratory infection, often during the winter months. Since fluid can collect in the middle ear without causing pain, children with otitis media may not complain about it. Parents may even notice before their child does. So if your child has recently had an ear infection, be alert for one or more of these symptoms.

What is recurrent otitis media?

When a child gets otitis media several times during a year, it is called recurrent otitis media. A preschool child with recurrent otitis media frequently experiences a temporary loss of hearing. This loss may continue for up to six weeks after the ear infection has healed. Such a hearing loss is described as "mild and fluctuating," but it may be a major cause of speech and language delay during the preschool years.

Communication development is at its peak from twelve months through four years of age. Fluctuating hearing loss during that time interferes with learning speech and language skills. Many children with otitis media cannot hear clearly. They may "tune out" everyday sounds-even your voice. If your child has otitis media, similar words may sound the same. If you are talking in a noisy room, have the water running, or have your back to your child, hearing becomes even more difficult.

To learn what speech actually sounds like to a child with otitis media, plug your ears with your fingers or ear plugs. Listen to another adult read aloud to you. What happens when the speaker is not facing you? What happens when background noise or other distractions are present? Did you get tired or bored with listening? You probably had some difficulty hearing exactly what was said. Hearing final consonants can be especially difficult in words like bead or beat, bow or boat. Could you distinguish word endings like play or played, cat or cats?

It is not surprising that final consonants, past tense, and plural endings are often left off by children with recurrent otitis media. Since they don't hear these sounds when others talk, they don't learn to say them properly.

What problems can be caused by recurrent otitis media?

Many children who have otitis media three or four times develop speech and language skills normally. But children with recurrent otitis media over several months or year may develop:

- Permanent hearing loss if left untreated
- Speech and language delays
- Problems focusing their attention
- Problems with schoolwork
- Poor self-esteem
- Social problems

What can parents do to help?

Seek professional help: Prompt medical attention is very important for a child with otitis media. If you notice on or more of the symptoms, contact your physician, pediatrician, otolaryngologist (ear, nose, and throat specialist), or an audiologist (specialist in testing hearing).

There are many types of treatment for otitis media. Medical professionals are still debating which treatments are most effective. The two most common methods are the use of antibiotics to control the infection, and the placement of tubes in the ear to drain the fluid. Usually, antibiotics are tried for about three months. Then, if necessary, the placement of tubes is considered.

In addition to medical treatment, young children with recurrent otitis media often need help from a speech and language clinician. Working with the clinician, parents can do a tremendous amount at home to improve their child's speech and language skills.

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