ASHA KIRAN 2009

PUBLICATION OF THE ASIAN INDIAN CAUCUS

ASHA KIRAN

From the President...

Greetings!

The past one year has been eventful for the Asian Indian Caucus in several aspects. There have been changes in the Executive Board. A warm welcome to the new co-editors of Asha Kiran: Suneeti Nathani Iyer and Monica Sampson. Both bring with them immense enthusiasm and commitment for Asian Indian issues. This summer also marked the end of my two-year term as AIC President and Jayanthi Sasisekaran's term as Vice President. The upcoming annual meeting of AIC at the ASHA convention in New Orleans will thus bring fresh faces and ideas to the Executive Board. I urge you to nominate (or self-nominate) current and past Executive Board members and Asian Indian Caucus members for participation in AIC governance. Several of you have expressed a willingness to help with AIC initiatives while being somewhat reticent about participating in governance. While I strongly encourage you to keep up the commitment and enthusiasm, I would like to point out that AIC is a modestly-sized caucus and hence governance is not as time-consuming as it initially appears. To reiterate a message from the previous issue of Asha Kiran: the AIC is *your* organization and needs *your* enthusiasm and vision to fulfill its mission.

Talking about commitment, the level of attendance, participation, and volunteerism at the last AIC meeting (ASHA 2008 Convention in Chicago) was immensely gratifying. I welcome all the new AIC members and thank those of you who volunteered with various AIC initiatives, particularly Arun Biran, Sridhar, Rajashree and Priya James. For those of you who missed the meeting in Chicago, we discussed: (i) how AIC activities relate to the mission of ASHA's Office of Multicultural Affairs (OMA) and the role of ASHA's Multicultural Issues Board (MIB), (ii) the process of formalizing the AIC as an organization, and (iii) expanding our membership and fundraising base. Many of you are aware that the AIC has a representative in the MIB, who serves a three-year term. Dues paying AIC members who have filled out ASHA's volunteer pool form are eligible to be nominated to the MIB (the volunteer form is at http://www.asha.org/practice/multicultural/opportunities/ABC.htm). Other than using funds for regular expenses (website and participation in the Multicultural Constituency Groups Booth at the ASHA convention), we discussed a long-term projected use of funds to support projects with an Asian Indian focus via supplements to existing funding mechanisms such as ASHA's Grant Program for Multicultural Projects. I am happy to share with you that I discussed this with the OMA, which has no objections to this plan. There is a critical need to expand research and services focusing on Asian Indians, as evidenced by a steady stream of email queries the AIC receives about services or materials for Asian Indian clients. However, the AIC has a few hoops to jump through before this long-term objective is brought to fruition.

As I reflect on my four years as a member of the AIC Executive Board (two years as co-editor of Asha Kiran before my current term as President), it has been a rewarding experience to work towards the mission of AIC (albeit in small steps). The bonus has been the opportunity to connect and reconnect with fellow Asian Indians. My best wishes to the next President. Au revoir!

Yasmeen Faroqi-Shah

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From the Editors' Desk...

Welcome to the 2009 issue of Asha Kiran! We are grateful to the Board members – President Yasmeen Faroqi-Shah, Vice-President Jayanthi Sasisekaran, and Secretary Deepa Aier – for giving us the opportunity to serve as co-editors this year. We hope you will enjoy the clinically-focused articles in this issue.

The "Spotlight" section in this issue focuses on Dr. Kalyani Mandke. Dr. Mandke is a renowned audiologist based in Pune, India. She is the first Indian resident on the Council for Clinical Certification in Audiology and Speech-Language Pathology at the American Speech-Language-Hearing Association (ASHA). She also served as the secretary for the recently concluded 2009 Indian Speech-Language-Hearing Association (ISHA) Convention. We are privileged to have this dynamic woman share her unique experiences and perspectives on audiology and the process of ASHA certification for clinicians of Asian Indian origin.

Three clinically relevant articles are also part of this issue of Asha Kiran. The first article by Malathy Venkatesh highlights the challenges faced by speech-language pathologists when evaluating bilingual adults with aphasia, especially those of South Asian origin. Her doctoral dissertation aims to enhance our understanding of the nature of language impairments in Hindi/Urdu–English bilingual speakers with aphasia. Sucheta Kamath outlines the process of cognitive rehabilitation for individuals with brain damage. She advocates for the use of a memory notebook to facilitate cognitive rehabilitation, the need to remediate core cognitive skills such as attention, and the importance of training self-awareness and self-monitoring skills. The third article on telepractice by Manju Jacob provides an introduction to this innovative model of service delivery. She provides both practical advantages and disadvantages of using telepractice and discusses strategies to successfully implement this service delivery model. We thank all of the authors for their contributions to this issue,- it was a pleasure working with them!

If you have ideas for articles or suggestions for improvements to the newsletter, please feel free to contact either one of us (msampson@hesp.umd.edu or snathani@uga.edu). There are several format options (see p. 11) to express your thoughts in Asha Kiran (Voices, Letters, People, Articles, etc.). We look forward to hearing from you

Sincerely,

Suneeti Nathani Iyer and Monica Sampson

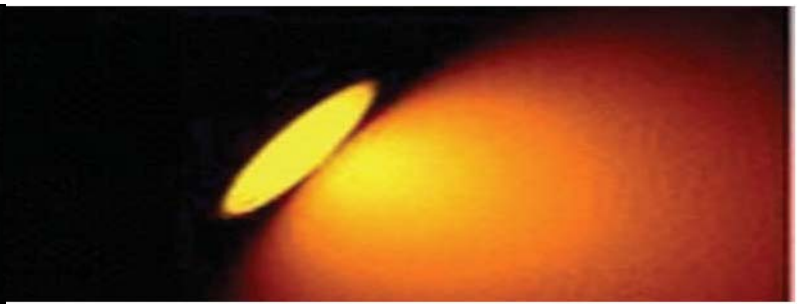
The Editors:

Suneeti Nathani Iyer is an Associate Professor in the Department of Communication Sciences and Special Education at the University of Georgia. Her interests include infant vocalizations, child language disorders, hearing loss, and speech sound disorders. She obtained her doctoral degree from Purdue University and her master's degree from Ohio University.

Monica Sampson is a PhD student at University of Maryland whose primary research interests relate to adult acquired language disorders, particularly, speech monitoring and jargon production in fluent aphasia. She is also a practicing Speech-Language Pathologist focusing on service delivery in sub-acute and long-term care facilities.

Spotlight

Dr. Kalyani Mandke
Mandke Hearing Services
Pune, India



AIC: *Tell us a little bit about yourself: where you are from, your educational history and what brought you to the field of audiology?*

Dr. Mandke: I am from Pune, India. I graduated with my Bachelors from the program at Nair Hospital, Mumbai (Bombay University) and went on to get my Masters in Audiology from Northeastern University at Boston, Massachusetts. I completed my Clinical Fellowship at Milford Audiology Center in Boston and went on to obtain my clinical certification in Audiology in 1983. I returned back to India in 1983 and subsequently obtained my PhD from University of Pune. While continuing to be a guest lecturer and visiting faculty at several institutions in India and abroad, I launched my career in clinical services delivery where I continue to focus until now. I started the first exclusive audiology private clinic in India in 1984 and I continue to run it until today. The focus of the clinic is both diagnostic and rehabilitative audiology. We have also successfully participated in working with 80 cases of cochlear implants and our services include CI intra- operative NRT, Switch on, mapping and AVT programs.

AIC: *You have the distinction of being one of very few audiologists in India who holds the ASHA certificate of clinical competence with an AuD. What prompted you to embark on the journey towards AuD and obtain and maintain your certificate of clinical competence (CCC-audiology)?*

Dr. Mandke: I have continued to maintain my certificate of clinical competence from ASHA since the time I obtained it in '83. The AuD was initiated purely out of an interest in participating in an online curriculum and expanding my horizons. I completed my AuD from Pennsylvania College of Optometry in 2007. ASHA has always provided valuable resources and it also helps me keep in touch with advances in the field here that can be adapted to suit the settings back home. So, it's certainly been worthwhile to keep up my certificate of clinical competence.

AIC: *How has the field of audiology changed in India given the context of rapidly changing technological advances in the western world?*

Dr. Mandke: Indian audiologists have been constantly on top of the state-of-the-art technology thanks to the availability of most resources in India. Students gain good expertise in clinical training and are thus equipped to handle technological innovations as practicing clinicians. The use of cochlear implants is one of the options now open to many children with hearing impairments and their families. State of the art digital hearing aids with their premium product range are also available to all potential customers. All types of electrophysiological tests are available at various hospitals. New born hearing screenings are being implemented in various hospitals and very soon the national program of prevention of deafness will be launched in the country.

AIC: *You are the first Indian resident on the Council For Clinical Certification in Audiology and Speech-Language Pathology at ASHA. What is your role as part of the committee?*

Dr. Mandke: The American Speech-Language-Hearing Association's Council For Clinical Certification (CFCC) develops the standards for clinical certification in audiology and speech pathology and oversees their implementation. I have been a member of this semiautonomous Council since 2008.

AIC: *Based on ASHA's Mutual Recognition of Professional Association Credentials agreement with the Canadian association of Speech-Language Pathologists and Audiologists, the Irish Association of Speech and Language Therapists , the New Zealand Speech- Language Therapists Association (Inc.), the Royal College of Speech and Language Therapists, and the Speech Pathology Association of Australia Ltd. (2008) there is a mutual recognition of professional association credentials. How far away is this prospect for Indian Speech Therapists and Audiologists who are members of their national association?*

Dr. Mandke: All the professional organizations that have entered into the mutual agreement with ASHA are actual clinical credentialing agencies that certify their members after completion of academic course work and clinical practicum. The Indian Speech and Hearing Association (ISHA) has no such credentialing system at the present time and until the standards for clinical certification are nationally established, it is not possible to become a part of the mutual recognition agreement with ASHA (or the other nations' certifying agencies).

(Continued on page 4)

Spotlight

Dr. Kalyani Mandke
Mandke Hearing Services
Pune, India

AIC: *As a member of this Council what advice do you have regarding the process of obtaining clinical certification for graduates from academic programs in India?*

Dr. Mandke: While I cannot offer specific advice as a member of CFCC, I would urge interested individuals to talk to people who have gone through the process before to identify those foreign credential evaluating agencies that can provide the specific information required by ASHA. Also, the Indian curriculum prepares for dual certification in both audiology and speech pathology. While this may serve as an advantage in an effort to obtain dual certification here, it must be recognized that emphasis on both fields would reduce the number of credit hours acquired in either field as a specialty. Also, the Indian curriculum is frequently audiology-heavy in terms of theoretical credits and clinical hours. Furthermore, it is important to recognize that there are some areas in our curriculum (such as dysphagia) that we do not emphasize in India because of the limits of our scope of practice there. Therefore, if it so happens that an evaluation of your degree from India falls short of ASHA's expectations, and you are informed that you need to take additional courses to make up the lacunae, then just go for it. You will be better off receiving that training to develop and to diversify your skills. Look at it as an investment into improvising your clinical skills.

AIC: *You have the unique perspective of being an international member of ASHA. What role do you envision for SLPs and audiologists of Asian-Indian origin, both in India and across the globe?*

Dr. Mandke: I am surprised by the limited representation of both SLPs and Audiologists of Asian-Indian origin at professional organizations in the USA and elsewhere. It takes a sincere contribution of voluntary effort, time and resources to advance the field and champion the cause for recognition of both clinicians and clients of Asian-Indian origin.

AIC: *You have collaborated with many people over the course of your career. Please give us an example of a successful collaboration. Do you have any advice on developing and maintaining research/clinical collaborations?*

Dr. Mandke: I have been actively networking and collaborating on behalf of my clinical practice and the Indian Speech and Hearing Association, both nationally and internationally. The annual meeting of ISHA this year is a testament of the success of international collaboration . The most important thing I have learnt in collaboration is to initiate and ask. It never hurts to attempt.

Dr. Kalyani Mandke is the founder of Mandke Hearing Services in Pune, India and holds many distinguished academic and positions in several academic and clinical organizations in India. She was the general secretary of the Indian Speech and Hearing Association until the end of 2008 and continues to be a pioneer of the field in India. She is also passionate about championing for the rights of the disabled and advancing the profession.

Bi/multilingual aphasia: Do we know enough?

By Malathy Venkatesh

As clinical speech-language pathologists, we come across bi/multilingual adults with aphasia, who are able to speak one language better than the other irrespective of their language abilities prior to stroke. The general impression is that it is the mother tongue of the patient and the language the patient knew very well. Many factors including age of acquisition of the languages and proficiency in the languages prior to stroke have been suggested as possible causes for one language to be available over the other in bilingual patients with aphasia. Another factor gaining popularity as a potential cause for the different languages to be preferentially recovered is the structure of the languages involved. This has been motivated by cross-linguistic studies of aphasia which has focused on language specific and universal nature of the deficits. Different patterns of morphological errors in language production (Bates, Friederici et al. 1987) and different grammatical error patterns have been reported across individuals with aphasia speaking different languages.

Bilinguals present an unusual opportunity to study different linguistic systems within a single brain and, thereby, the effect of brain damage on the different systems. A pattern, however, seems to emerge in terms of structural similarity/dissimilarity between the language combinations known to a bilingual. For languages that are alike (in terms of word order, grammatical morphology and prosody), similar kind of error patterns across the languages have been reported with errors differing only at points where the languages differ (Paradis 1988; Fabbro 2001). Support for this has been provided by structurally similar languages such as Spanish- Catalan, German-Luxembourgish, Fruilian-Italian and structurally less similar languages such as Cantonese-English, Greek- English.

Studying bilingual South Asians with aphasia has been a challenge. Most immigrant South Asians are bilingual or multilingual with their mother tongue as the first language and English or one of the additional languages they know as a second language. This is not only true of South Asian immigrants in English speaking countries but also for people living in countries where English is one of the official languages such as India. Speech-language pathologists continue using assessment tools developed and standardized for monolingual English speakers to assess bilingual speakers with aphasia.

The language in which treatment is given depends on either the language known to the SLP or the language the patient prefers without regard to the nature of the deficit and degree of impairment in each language. Although successful efforts have been made to identify aphasic symptoms in South Asian languages, one such language being Kannada (personal communication, Karanth March 2009), we need to create more awareness about aphasias in other South Asian languages.

Moreover, South Asian languages are not only unique and different in terms of the language structure, the bilingualism patterns too are different from previously studied bilingual populations. Describing aphasic symptoms alone may not be sufficient. We need to recognize the linguistic differences and identify the underlying deficits by developing theories and models of language representation in bilingual and multilingual brains particularly for languages of South Asian origin. With such a large population and a high susceptibility to coronary heart diseases and subsequently to stroke, there is potentially a large clinical population to study. My doctoral study aims to contribute to research into language representation in bilinguals and to shed light on the nature of language disturbance in Hindi/Urdu - English bilinguals with aphasia. The study focuses on domains in which the grammars of the two languages diverge and investigates the grammatical errors in Hindi/Urdu- English bilingual aphasia.

References

Bates, E., Friederici, A., et al. (1987). Grammatical morphology in aphasia: Evidence from three languages. *Cortex*, 23, 545-574.

Fabbro, F. (2001). The bilingual brain: Bilingual aphasia. *Brain and Language*, 79, 201-210.

Paradis, M. (1988). Recent developments in the study of agrammatism: Their import for the assessment of bilingual aphasia. *Journal of Neurolinguistics*, 3(2), 127-160.

Malathy Venkatesh is a PhD student in the School of Psychology and Clinical Language Sciences at the University of Reading. She is studying aphasias in Hindi/Urdu – English speakers within the UK context under the supervision of Professor Susan Edwards and Professor Douglas Saddy.

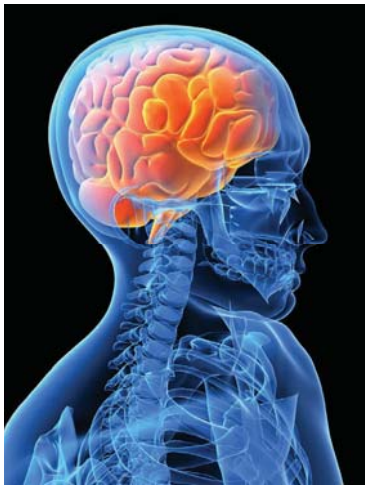
Impaired Cognition and Cognitive Rehabilitation

Attaining Functional Change Using Process Based Training

By Sucheta Kamath

Rehabilitation, in general, is a process whereby people who are disabled by injury or disease work together with professional staff, relatives and members of a wider community to achieve their optimum physical, psychological, social and vocational well-being (McLellan, 1991). From a speech-language pathologist's point of view, the course of rehabilitation needs to address not only the visible or tangible aspects of dysfunction, such as communication and organization of discourse, but underlying invisible components of language and cognition that are a foundation of intellectual functioning, such as attention, memory and executive skills.

Brain injury rehabilitation or cognitive rehabilitation as a result of brain injury requires a two-prong approach to recovery (Ylvisaker, 1998). It requires restoration of functions that can be reconditioned in spite of the damage to the brain. Rehabilitation also calls for relearning of functions that allows carrying out of activities of daily living in a revised manner when functions cannot be returned to pre-injury level. Cognitive rehabilitation is influenced by a variety of factors such as nature of the neurological damage or injury, nature of functional impairment, preexisting psychosocial issues, additional physical impairment or disability, pre-injury education, psychosocial support, and level of motivation.



When developing paradigms for cognitive rehabilitation, one must take into account a broad range of neurofunctional strengths and weaknesses. These neurofunctional abilities need to be thoroughly evaluated using standardized tools as well as using a functional context. In addition, core cognitive skills including sustained focus, divided attention, and working memory, must be strengthened before more complex intellectual skills, such as deductive and inductive reasoning or problem solving can be refined. Recovery of cognitive abilities follows patterns of brain development. Gross or large-scale systems, including attention control systems, must be retrained before finer systems, including executive control. While exercises in various cognitive tasks, such as doing arithmetic problems, solving logic puzzles, enhancing concentration skills, or reading may help cognitive rehabilitation, this is usually not enough. One must also incorporate family education and insight training to minimize maladaptive behaviors and social isolation post injury.

Cognitive training can substantially influence functional performance in patients with cognitive impairments as a result of brain injury (Berrol, 1990). Once properly identified, patients with brain injury are more responsive to cognitive intervention strategies that are hierarchical in nature than nonspecific ones. For example, drills that focus on word retrieval or balancing a checkbook are not the most relevant unless the clinician has worked on visual attention to details. A functional treatment approach must include process-based strategies and elements that allow transfer and generalization of skills into functional and meaningful contexts. It is the clinician's responsibility not only to focus on remediation of individual areas of weakness but to develop awareness for the need for the skills in the first place. Most patients with brain injury experience deficits in the metacognitive areas of insight and judgment making them less appreciative of tedious and involved training. It is very likely that a patient may refuse to either participate or comply with protocols. Metacognitive retraining can address that challenge.

Ylvisaker (1998) states that cognitive prostheses should be explored with the goal of enhancing independence and reducing the risk of escalating behavioral problems. Use of a Memory Notebook as a tool for training is not new. However, using this assistive tool as a way of training executive skills can be a unique application. Zencius, Wesolowski, & Burke (1990) demonstrated that out of four possible training strategies for memory including written rehearsal, verbal rehearsal, acronym formation, and memory notebook logging, only memory notebook logging was proven to be successful in helping patients increase their recall of material acquired in the classroom. Furthermore, Schmitter-Edgecombe et.al (2008) not only noticed the improvement in memory scores because of increased note-taking behavior and more frequent referencing of notes but reduction in anxiety and other behavioral side effects.

The course of cognitive rehabilitation is set in motion in my practice by the clinician introducing a Cognitive Retraining Binder. This binder has five sections: (1) Discussion regarding cognitive abilities and weaknesses; (2) Therapy work; (3) Error Analysis; (4) Specific Strategies & Lessons Learned; (5) Home Assignment

Impaired Cognition and Cognitive Rehabilitation

The therapy work can span over several cognitive subsets including Attention, Memory, Planning and Problem Solving activities. The hierarchy of treatment addresses a variety of components of Attention Control, including divided attention, working memory, and resisting interference. The second crucial element of instructional methodology involves Memory Training that addresses strategic encoding and rehearsal. Finally, the Executive Process Training focuses on skill development in the areas of prospective memory, planning, organization, problem solving, and error analysis. Each patient is expected to complete individualized assignments that require reflection and refining of a skill using drills with and eventually without assistance.

In the Strategies and Lesson Learned section of the cognitive retraining binder, the clinician challenges and prompts the patient regarding relevance of the therapeutic exercises and utility of the underlying process. This approach is based on the work by Malec (1999) on Self-Regulation Skills Interview (SRSI). The SRSI is a tool designed to assess higher levels of self awareness and self-regulation skills. According to Malec, this aspect of training is the primary contributing factor to the maintenance of the gains observed during initial therapeutic sessions.

In conclusion, it takes a village to raise a patient's functional competence in spite of cognitive deficits. The message is that the cognitive retraining can and must be done even though it is time-consuming, tedious, and intricate. A clinician's ability to individualize the process of rehabilitation as well as her creativity and willingness to change the course midstream are the critical pillars of success.

WEB RESOURCES:

For working memory training - http://www.cogmed.com/; Brain Train - www.brain-train.com/; Brain Fitness Pro (http://mindsparkebrainfitnesspro.com/)

REFERENCES:

Berrol, S. (1990). Issues in cognitive rehabilitation. *Archives of Neurology*, *47*, pp. 219-220.

Malec, J. F. (1999). Goal attainment scaling in rehabilitation, 9, 253-275. Evaluation of outcomes in brain injury rehabilitation [Special Issue of *Neuropsychological Rehabilitation*].

McClellan, D. L. (1991). Functional recovery and the principles of disability medicine. In M. Swash & J. Oxbury (Eds), *Clinical Neurology*. Edinburgh: Churchill Livingston.

Schmitter-Edgecombe, M., Howard J. T., Pavawalla, S. P., Howell, L, & Rueda A. (2008). Multi-dyad memory notebook intervention for very mild dementia: A pilot study. *American Journal of Alzheimer's Disease and Other Dementias®, 23*, 477-487.

Ylvisaker, M. (1998). *Traumatic Brain Injury rehabilitation – Children and adolescents* (2nd edition). Butterworth-Heinemann.

Zencius, A., Wesolowski, M.D., & Burke, W.H. (1990). A comparison of four memory strategies with traumatically brain-injured clients. *Brain Injury, 4*, 33-8.

Sucheta A. Kamath has a masters degree in Speech-Language Pathology from Ohio University and a masters degree in Linguistics from the University of Bombay. She is board certified in Neurogenic Communication Disorders. Before moving to Atlanta, she worked at the Massachusetts General Hospital (MGH) in Boston, MA for seven and a half years specializing in cognitive remediation for a variety of disorders. Ms. Kamath is a recipient of the Stephanie Macaluso Expertise in Clinical Practice award (1999) as well as Partners Award of Excellence (2000) from MGH. She has received the Award of Continuing Education (ACE) from ASHA for the past several years. She has developed numerous programs for adults with brain injury and children with executive dysfunction. She has developed an executive curriculum called Organize Your Brain at School and is engaged in gathering data. She is currently pursuing an online doctorate from Walden University.

Language Use Database...Check this out!

Check out this website http://www.plukout.com. It is a unique website that allows anyone to sign up under any number of professions and any number of languages in an attempt to reach out to those that are desperately seeking their skills. One of our AIC members, *Anita N. Rahim* who is an SLP and the CEO of Allied Health Staffing Network found the resource very useful and reported that she has gotten great responses from parents, schools, companies, etc. who can go on this site looking for professionals in their area.

Clinical Innovations

Telespeech Practice: Reaching the Underserved

Manju Sara Jacob

Rebbecca is a 4 year-old with a severe language learning disorder. She lives in a remote area where she has access to speech services twice in six months. In another part of the country or the world, an SLP looks for opportunities with flexible hours, avoid traveling costs and tremendous amounts of paper work. How can both their needs be met? This is where **'Telespeech Practice'** (TSP) comes in. In ASHA's recent position statements (2005), *telepractice* is defined as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation."

Speech-Language Pathologists are increasingly applying tele-health technology to provide training, education, assessment, and intervention. Here is an example of an existing system for a school environment: the student at the school (with the help of teacher's aide) will connect to the SLP at her online office with a secure login. The SLP will work on goal-directed activities established in her lesson plan via the webcam and conclude the session by assigning homework and video messages for later viewing in a Virtual Backpack. The child can login at home or at school and do the assigned homework with a caregiver. Progress notes and reports are generated during and after each session so that the special education team including parents have access to the child's goals, progress, and related activities.

Benefits and Challenges

Increasing need for services, shortage of personnel in rural areas, and the benefit of receiving services in clients' home community makes telepractice critical (Kully, 2008). Besides being cost effective and environment-friendly, all documentation can be stored, completed and sent securely online. Students can also avoid missing school days by not travelling to a distant hospital or practice. A good clinical relationship can easily be achieved with the client (Brick, 2008) and active involvement of teachers and parents also helps with generalization of goals beyond the clinical sessions. School administrators welcome the idea of helping a child whose clinical needs might not be met otherwise. The biggest drawback of telespeech practice is the unavailability of hands-on treatment for clients with issues such as articulatory placement. Technical problems can also pose a glitch at any time. Despite these, telespeech therapy for stuttering, articulation, dysphagia, and stroke have shown reliable results in various programs of telespeech practice across the United States (Mashima, Birkmire-Peters, & Holtel,1999; O'Brien, Packman, & Onslow, 2008).

The children I work with are excited each time they see me on the computer and often have others students vying for this online attention! They achieve goals via fun interactive games and often have to be forced to end the session. I have found that telepractice is a wonderful service delivery model that has the potential to fill the gap in speech-language treatment services.

References:

American Speech-Language-Hearing Association. (2005). *Speech-Language Pathologists Providing Clinical Services via Telepractice: Position Statement* [Position Statement]. Available from www.asha.org/policy.

Brick, M. (2008). Addressing Rural populations and the Speech language Pathologist shortage with Telepractice. Presented for ASHA 2008, Chicago.

Mashima, P., Birkmire-Peters, D., & Holtel, M. (1999). Telehealth applications in speech-language pathology. Journal of Healthcare Information Management, 13(6), 71–78.

O'Brien, S., Packman, A., & Onslow, M. (2008). Telehealth Delivery of the Camperdown Program for Adults Who Stutter: A Phase I Trial. *Journal of Speech, Language, and Hearing Research, 51*(1), 184-195.

Manju Sara Jacob lives in the Netherlands and currently provides services for school age children with speech and language disorders via an online speech therapy telepractice (TinyEye) based in Canada. She also works as an itinerant SLP at the International School in the Netherlands.

Announcements

AIC @ ASHA in New Orleans

AIC Meeting: The Asian Indian Caucus meeting will be held on **November 20, 2009 (Friday)** at **5:00 PM**. at Morial Convention Center, Room 339

Multicultural Constituency Booth: The AIC is proud to be one of the constituent groups participating in the Multicultural Constituency Groups (MCCGs) Exhibit Booth **(Booth # 139).** The AIC Booth Exhibit will include a display about our caucus and resources for professionals interested in working with individuals of Asian Indian origin. Stop by and check it out!

Multicultural Concerns Collective (MC^2): This is the annual reception of ASHA members from the National Black Association for Speech-Language-Hearing (NBASLH), and the Hispanic, Asian Pacific Islander, Asian –Indian, Native American, and L'GASP-GLBT Caucuses, as well as members who serve clients from culturally and linguistically diverse populations. The reception will honor the recipients of the Diversity Champion award. The meeting is on **November 19, 2009** between **8:00 pm and 10:00 pm** at the **New Orleans Hilton Riverside** (Marlborough A & B).

The annual conference of the Indian Speech and Hearing Association (ISHA) will be held from January 22-24, 2010 at the convention center of National Institute of Mental Health and Neurosciences (NIMHANS) with pre-conference seminars on January 21, 2010.

The organizing committee of ISHACON 42 is proud to include among their distinguished speakers many speakers of international repute such as Dr. Laura Ball (East Carolina College of Health University), Dr. Brooke Hallowell (Ohio University), Prof. Anne van Kleeck (University of Texas at Dallas), Prof. Nina Kraus (Northwestern University), Prof. Loraine K. Obler (CUNY Graduate Center), Dr. Patrick Wong (Northwestern University) and Dr. Joan K. Kaderavek (University of Toledo). Another highlight of this conference includes participation of the ISHA overseas caucus where ISHA's alumni from around the world will present their work.

Registration for the conference is now open. All related inquiries may please be emailed to ishacon42@gmail.com. Further information about ISHACON 42 is available at www.ishacon42.org.

About AIC

The ***Asian-Indian Caucus (AIC)*** is one of the six multicultural constituency groups of the American Speech Language and Hearing Association (ASHA). The AIC was established in 1994 to address the professional, clinical and educational needs of persons of Asian Indian origin residing in the United States in the area of communication sciences and disorders. Asian Indians, otherwise known as South Asians, refer to persons who trace their origin to the Indian subcontinent, including, but not limited to the following countries (in alphabetical order): Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. AIC has the following objectives:

- To provide a forum for interaction and collaboration among clinicians, researchers, and students of Asian-Indian origin in the field of communication sciences and disorders.
- To promote initiatives to increase the body of knowledge pertaining to Asian-Indian individuals as it relates to the field of communication sciences and disorders, and to compile and disseminate this body of knowledge.
- To enhance cultural competence among ASHA-certified professionals and increase cultural sensitivity regarding Asian Indians.
- To serve as a networking and mentoring resource for the general ASHA membership serving individuals of Asian-Indian origin with communication disorders
- To work closely with ASHA, it's Office of Multicultural Affairs (OMA), and it's Multicultural Issues Board (MIB) in initiatives pertaining to the above objectives.

Please check AIC's website (**www.asianindiancaucus.org**) for periodic updates, news and events. Please feel free to contact us for any updates or suggestions for information that may be added to the website**.**

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GET INVOLVED WITH AIC !!

Contributions for AshaKiran

Spotlight on an Asian-Indian will profile an Asian-Indian professional in a field affiliated to speech, language, and/or hearing. We welcome suggestions for potential individuals to be interviewed along with their contact information and accomplishments.

People will feature updates on AIC members, including publications, awards, appointments, and other personal achievements. Please send updates about yourself. If you are sending updates about other AIC members, please include a statement that you have the consent of the person you are sending updates about. The write-up should not exceed 100 words.

Voices is your opportunity to express opinions, narrate experiences (at a new job, as an Asian-Indian professional, a trip back to the Asian-Indian sub-continent, etc.), respond to articles published in Asha Kiran, or raise issues that you would like AIC to address. Voices is an open forum for your comments. Contributions to Voices should not exceed 200 words.

Articles provide readers with a broad overview of current developments in research and clinical practice in speech, language, and hearing. The articles should be original work, written with an eye on the diverse readership of Asha Kiran, and should not exceed 500 words, including tables, figures and references.

Please contact Suneeti Nathani Iyer (snathani@uga.edu) or Monica Sampson (msampson@hesp.umd.edu) for more information or to send contributions.

Membership

Get involved with AIC!! You can help AIC meet its mission of professional, clinical and educational collaboration among Asian Indians by enrolling....Membership dues not only help with routine events such as participating in a multicultural booth at ASHA convention and webhosting, but will serve to expand our activities in the future .

To become an AIC member, please send the completed membership form (on page 12) with payment to Deepa Aier. Membership dues are $20 for professionals and $10 for students. Membership can also be renewed with payment of the dues at the ASHA convention during the AIC meeting.

Asian Indian Caucus Membership Form

Date: Place:

Name: _____ _____

(Last) (First)

Type of Membership: ☐Professional ☐Student

(Membership Cost: Professional $ 20 Student $ 10)

Mailing Address

_____ (first line)

_____ (second line)

_____ (City/State/Zip)

Phone: _____(Work) _____(Home)

Email: _____

Professional Title: _____

Employment Setting: ☐ School ☐ University ☐ Hospital ☐ Rehab Agency ☐ Private Practice

Area of Specialty: _____

ASHA Member: ☐ Yes ☐ No NSSHLA Member: ☐ Yes ☐ No
(Professional) (Student)

ASHA Certification: ☐ CCC-SLP ☐ CCC- A ☐ None

If certified, do you consent to be listed as a service provider for individuals with Asian Indian origin in your geographical area in ASHA's database ? ☐ Yes ☐ No

If yes, list your area(s) of clinical expertise and sign below

_____
(Signature)

Please include your dues (Professional: $ 20 Student: $ 10) along with this form and mail it to:

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