



CST CHATTERBOX

Disability Spotlight: Dyspraxia

Dyspraxia is also known as "motor learning disability". Once known as "clumsy child syndrome" Dyspraxia often comes with language problems, and sometimes a degree of difficulty with perception and thought. Dyspraxia does not affect a person's intelligence, but it can cause learning difficulties for children. 4 out of every 5 children with evident dyspraxia are boys. If the average classroom has 30 children, there is probably one child with dyspraxia in almost each classroom.

Children with dyspraxia have problems performing subtle movements, such as tying shoelaces, doing up buttons and zips, using cutlery, and handwriting. Many will have difficulties getting dressed and find it hard on the playground to jump, catch or kick a ball, hop, skip or play hopscotch.

In the classroom, there are problems with using scissors, coloring and drawing, playing jig-saw games and processing thoughts. Children with dyspraxia commonly find it hard to focus on one thing for long and find it difficult to learn new skills. Although dyspraxia is not curable, with time the child can improve. And the earlier a child is diagnosed, the better and faster the

improvement will be.

Occupational therapy will help the child develop skills specific to activities which may be troublesome. Perceptual motor training will improve the child's language, visual, movement, and auditory skills. Tasks are set gradually becoming more advanced to challenge the child so that improvement is gradual without becoming frustrating or stressful. Speech and language therapy can also help a child communicate more effectively as dyspraxia is often associated with apraxia, or speech disorder.

Developmental Apraxia of Speech (DAS) also known as Childhood Apraxia of Speech (CAS) occurs at birth and is more common among boys than girls. Typically a child with CAS understands language better than they are able to express themselves. They may have a range of speech and language problems such as poor grammar, poor vocabulary and difficulty in organizing spoken information, and consequent problems with reading, writing, spelling and math and coordination problems. Apraxia can be so mild that it just affects pronunciation of words with many syllables or so severe that a child cannot communicate effectively at all with speech.

Speech-language professionals

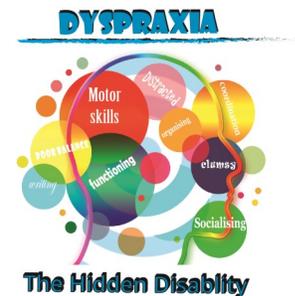
may need to observe a child for some time before reaching a diagnosis and therapy is tailored to the individual. Sometimes frequent and intensive 1:1 therapy is needed and sometimes children make a spontaneous recovery. Children with CAS are at high risk for literacy and language-learning related educational difficulties and create a challenge in the classroom. Teachers will work with speech-language therapists in the school system and provide specific worksheets and resources to help with oral and written language and narrative skills.

Experienced teachers and therapists know that it is essential to understand the child's personality and interests as well as the history of past failures and successes. The home environment offers many opportunities for exercises, games, stories, strategies, and scripts for weaving speech therapy into the time parents spend with their children. A supportive home environment and the active involvement of the child in his or her own intervention programs contribute to successful outcomes for children with apraxia and dyspraxia. Useful online resources for teachers are [The Childhood Apraxia of Speech Association of North America \(CASANA\)](#) and the [Dyspraxia Foundation](#).

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HOT TOPIC IN CHILDHOOD DEVELOPMENT: SCREEN TIME

The effects of screen time on social/emotional development

For babies, toddlers and preschoolers, most of their learning is about picking up the unwritten patterns of social interaction and emotional management that allow them to function in and interact with the world. The problem is, when it comes to screen time, that because of small children's inability yet to transfer the lessons of the screen (assuming there are any) to real-world understanding, this critical social and emotional development doesn't happen, at least not in the amount needed; the time for the parent-child interaction and free play that teach these skills is spent in front of a screen.

This leads to all sorts of social and emotional issues that parents probably only recognize as bad behavior: Studies have associated digital media-watching for toddlers (especially if it's toddler-aimed entertainment) with such effects as more frequent physical aggression, disobeying rules, cheating, stealing, and

destruction. In other words, screen time for toddlers can cause acting out behavior — which can become a self-perpetuating cycle, as often, parents use digital devices as a surefire way to soothe a fussy baby or calm a preschooler's tantrum.

The long-term health effects of screen time for children

Finally, increased screen time for children negatively predicts long-term well-being in general, but particularly undermines two areas critical to kids' long-term healthy growth and development: sleep and physical activity.

Digital media doesn't cause childhood obesity, but studies have found children's exposure is associated with higher risk; a 2014 study found an increase in BMI for every additional hour of screen time for toddlers per week. This occurs two ways: by screen time taking up time that could have been spent in physical activity, and

by digital media distracting children during meals to the point they don't recognize the feeling of fullness. (The inhibited emotional development discussed above may also play a role in increasing risk of childhood obesity.)

And for people of all ages — from babies to adults — the negative effects of screen time on sleep have been clearly documented. For children, this is a particularly high price to pay, considering from babyhood to the teen years, children encode and retain what they've learned throughout the day during their hours unconscious.

Too much screen time for children isn't life-threatening, and parenting is full of all sorts of trade-offs; for your family, more rather than less digital media might be worth it. But the effects of digital media-watching can add up over years and turn into bad habits and behaviors that self-perpetuate beyond what parents can control. That doesn't mean this generation of children are doomed — it just means parents need to learn how to make screen time work for children, rather than against them.

TALK WITH YOUR CHILD ABOUT E-CIGARETTES/VAPING

1. BEFORE THE TALK: KNOW THE FACTS

Get credible information about e-cigarettes (e-cigarettes.surgeongeneral.gov). Be patient and ready to listen. Find the right moment for a discussion so that they are ready to listen.

2. ANSWER THEIR QUESTIONS

Q. Why don't you want me to use e-cigarettes?

A: Right now, your brain is still developing which means you are more vulnerable to addiction. Many E-cigarettes contain nicotine, and using nicotine can change your brain to crave more nicotine. It can also affect your memory and concentration. When people use e-cigarettes, they breathe in fine particles that can harm their lungs. The cloud that people exhale from e-cigarettes can expose you to chemicals that are not safe to breathe.

Q. What's the big deal about nicotine?

A: Your brain is still developing until about age 25. Nicotine is addictive and can harm your brain devel-



NO VAPING

opment. It may make it harder for you to concentrate, learn, or control your impulses. Nicotine can even train your brain to be more easily addicted to other drugs like meth and cocaine.

Q. Aren't e-cigarettes safer than conventional cigarettes?

A: Because your brain is still developing, scientific studies show that it isn't safe for you to use any tobacco product that contains nicotine. Some e-cigarette batteries have even exploded and hurt people.

Q. I thought all e-cigarettes didn't have nicotine- just water and flavoring?

Pod-based systems (like JUUL) and all salt-based e-juice/liquid contain nicotine! 1 JUUL pod contains as much nicotine as one pack/20 cigarettes.

KEEP THE CONVERSATION GOING

Connect and encourage your kids! Remind and repeat! Share facts and resources! Set an example by being tobacco free (1800QUITNOW).

https://e-cigarettes.surgeongeneral.gov/documents/SGR_ECig_ParentTipsheet_508.pdf

Shared Services Child Study Team

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973-361-3010

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973-366-0590

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The Shared Services Child Study Team has made it a goal to increase communication and Special Education knowledge with parents as well as teachers and administration within the three school districts. As part of this goal, you will now be receiving newsletters from the team three times a year filled with information on special education practices/law, community resources, special needs tips, etc. We hope you find this helpful!

Leslie Mozulay, LDTC
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Get to Know Your CST

I have been a Speech-Language Pathologist for more than 30 years. I received my bachelor's degree from Ithaca College, and a Master's degree in Speech-Language Pathology from Northeastern University. The letters after my name stand for "Master of Science" and "Certificate of Clinical Competency - Speech Language Pathology." I love being an SLP and helping children be the best they can be! I'm also a mom - I have 3 kids, two boys and a girl, and they are all in college. I have two dogs named Lacey and Obi. In my free time I love to read - I'm in two book clubs. I like to bake cookies for



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Speech and Language Therapist in
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my kids and treats for my dogs!

