



# **The BEST PRACTICES**

Newsletter  
Of

*The Interdisciplinary Council on  
Developmental & Learning Disorders*

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*The Best Practices Newsletter of the Interdisciplinary Council on Developmental and Learning Disorders, sponsored by the Unicorn Children's Foundation, is written to provide regional updates and networking opportunities to professionals and parents working with young children with communication and relating challenges. We hope to provide information and support and welcome any feedback or contributions that you may have. Please address your comments to Jo Raphael, MSW, Editor at: 3213 Midfield Road Baltimore, MD 21208, E-mail at [JO@ICDL.COM](mailto:JO@ICDL.COM), phone or fax at (410) 486-1251. Thank you.*

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## ***Editor's Note***

Jo Raphael, MSW  
Molly Romer Witten, Ph. D.

The year is moving quickly as we approach the Interdisciplinary Council on Developmental and Learning Disorder's (ICDL) sixth annual international conference on Autism and Disorders of Relating and Communicating. This year's focus is on *Improving Long Term Outcomes of Children with Autistic Spectrum Disorder and Other Disorders of Relating and Communicating*. There are some wonderful panels and speakers and it should be a very informative conference and a great place to learn about what is happening in the field and to network with other professionals, parents and caregivers.

ICDL has been very busy trying to respond to the growing need for more information, education and training opportunities. Please keep posted to our website and newsletter for new upcoming events and opportunities. ([www.icdl.com](http://www.icdl.com)).

In this newsletter we have gathered together some articles about the clinical work including professionals and parents, and new medical and educational ways of weaving all of these important pieces together as we work and live with those who have disorders of relating and communicating.

Your feedback is important to us. Please write to us to post information, to submit an article for consideration or to share your thoughts.

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Best regards,

*Jo and Molly*



## **Medical**

### ***Brain Science and Autism***

Rick Solomon, M.D.

From autopsies to MRI and SPECT scans, from embryological studies to the analysis of the human genome, recent research in brain science is allowing us to literally peer into the developing brains of children with autism. In this article I will review some of the most important findings on the developmental biology, genetics and neurology of autism. I conclude by briefly exploring what these findings mean for intervention especially given the recent recommendations from the National Academy of Sciences

As the embryo forms its nervous system early in the first trimester of pregnancy, any process, whether environmental or genetic, that interferes with the nervous system's development will affect the subsequent development of the brain. The abnormalities seen in the brains of persons with autism indicate that, if a genetic or environmental trigger exists, it must occur EARLY (as early as 20-24 days!) in embryonic development. Various exposures, including thalidomide, retinoids, seizures medications and even excessive alcohol exposure, early in gestation can lead to autistic spectrum disorders (ASD). (Hagerman, 1999) Once the rudimentary anatomy i.e. the neural tube that forms the brain and spinal column, is in place, the microscopic process of nerve development begins. The nerves (neurons) move to their proper locations then branch out by forming dendrites (dendrites are like twigs on a branch and branches of a tree), which in turn form connections (synapses) with each other. In the brains of some children with autism the neurons have been shown to be 'packed' densely; in other children the neurons appear to be poorly organized. Interestingly, for all children, neurons are modified by contact with the outer world. Many neurons that are

reinforced by experience increase their connections and are remodeled, strengthened, or reassigned. Others that are not needed actually whither away. We often refer to this process of modification by experience as 'plasticity'. When we observe neural plasticity, we are observing the brain being 'environmentally influenced' by experience. In autism many of the neural networks in the cerebellum, limbic system and cortex formed during development have been identified as abnormal especially at the microscopic level. Perhaps for children who have autism their cerebellar and limbic system neurons are not sufficiently sensitive to environmental influence.

Genetics also profoundly influences the developing brain. There is a growing consensus that autism is a complex disorder, involving multiple genes. . Identical twins, for instance, have a 60% chance of having autism together and if the research includes milder forms of autism spectrum disorders the finding is a rate of co-occurrence closer to 90%. The risk of having a second child with autism is between 3-7% instead of the 1:250 for the general population. Autism is common in certain genetic conditions including especially Fragile X Syndrome, Tuberous Sclerosis and Neurofibromatosis. Even though over 90% of children with autism have no associated syndromes we still consider their autism to have a genetic influence, although there has been no 'this-is-it' gene discovered. Recent research suggests that between 3-10 (some feel as many as 20) genes are involved. The genes code for proteins that might be abnormal (as in Fragile X) or the genes might control cell function. This control function is being intensely studied because it influences the neuronal growth processes described above



and may explain why the brain cells in autism are either over-produced (packed) and/or disorganized. Chromosome 'hot spots' include the X chromosome, chromosome 6 and chromosome 7. Chromosome 7 is the most promising since very small deletions (when a chromosome loses some of its material) on this chromosome have been implicated in the development of the hindbrain, the control of social behavior in mice and with language development. For instance, the FOXP2 gene that is expressed in fetal brain is necessary for normal embryonic development of neural pathways involved in acquisition of expressive language. In short, autism may be due to a mutation of a control gene that is active during early brain development. A mutation of this gene affects downstream genes that may otherwise be normal but the result is an abnormal brain.

Autopsy research on brain abnormalities shows problems in various areas of the brain that may help to explain many of the difficulties that children with autism have. The disorganization of neurons, for instance, is associated with seizures in up to 30% of children with ASD. Many children with autism have increased head size and brain volume. Abnormalities have been reported in the cerebellum, the limbic system, the brainstem, the basal ganglia and the cerebral cortex. In the cerebellum various researchers have found conflicting results with some reporting increased size and other decreased size. Other studies show abnormalities of various nuclei (i.e. centers of dense neurons) of the cerebellum. The cerebellum is responsible for the mental functions involving shifting attention, auditory processing, motor integration/coordination and regulation of emotion. In the limbic system abnormalities include increased neuronal packing, smaller cells, and decreased complexity of dendritic arborizations (i.e. abnormal branching). The limbic system is responsible for recognizing affect and feelings of others, social orientation, eye gaze, joint attention and

determination of what is pleasurable versus what is distressing. Experimental lesions to limbic structures in experimental animals affect motivation, emotion, learning and memory resulting in purposeless hyperactivity, stereotypic behaviors, decreased social interaction, etc. Abnormalities in the basal ganglia may result in compulsions, rituals and repetitive behaviors.

Rather than rely on autopsy results or experiments on animals, many researchers are turning to non-invasive technologies like auditory evoked potentials which measure auditory brain waves or PET-SPECT and Functional Magnetic Resonance scanning which image biochemical events in the brain. For instance, a recent functional magnetic resonance scan study showed that certain parts of the brain are activated when normal controls look at faces instead of objects whereas autistic subjects' brains were not activated by looking at faces. They preferred to look at objects. These studies are just emerging in the literature and have shown inconsistent results but hold promise for understanding how the brain of the autistic child works.

What are the implications of brain science for understanding the behavioral and psychology of children with autistic spectrum disorders? All the brain structures discussed above, from the anatomy to the brain's neuro-transmitters, influence behavior in some way. Several lines of research into the neuro-psychology of autism that have identified deficits in executive function, impairment of the ability of autistic individuals to interpret other people's nonverbal gestures verbal nuances (called Theory of Mind or ToM) and impaired social referencing. Each of these deficits relates to brain dysfunction. For instance, poor executive function reflects abnormalities in the frontal cortex and is responsible for autistic persons' inability to get humor, jokes, sarcasm and figurative speech. They also have demonstrated that individuals with autism have trouble judging



others peoples' mental states and they have terrible difficulty recognizing the emotional significance of behavior or interaction. For instance, children with autism engage in less imitation of social behaviors when compared to children with Down syndrome. The amygdala and limbic brain structures have been implicated in the inability of children with autism to share attention, play spontaneously and recognize facial emotional expressions.

With all these insights into the brain, there is yet one very important aspect of autism that brain science has not yet addressed sufficiently and that is the clearly evident ability of children with autism to make substantial language and social gains with intervention and sometimes spontaneously. How, from the perspective of brain science is this possible? Clearly young children with autism have a latent potential for development that demonstrates the concept of 'plasticity' of the young autistic brain. In fact there is a newly emerging area of science is called 'neural network theory' that attempts to explain this latent potential. Its main tenet is that while many connections in the brain are 'hard-wired' there are many other connections that are guided by experience. In this view, autism may represent disorders of activity-dependent (experience related) plasticity during brain development occurring at several different levels: gene, synapse, neuron, network and neuronal group.

Taken all together, the emerging picture of the nervous system of the young child with autism is becoming increasingly clear. The world view of children with autism may be a function of their atypical or vulnerable neurology interacting with contextual or environmental triggers. Their 'neurological comfort zone' may be quite different from

the neurology of typically developing children and or children with other clearly diagnosed neurological impairment such as cognitive deficit. What may be the most promising aspect of research into the autistic child's brain is the emerging recognition of the brain's plasticity and concept of experience dependent development. The recent National Academy of Sciences report on educating young children with autism implicitly recognized the importance of experience dependent development in autistic spectrum disorders. They recommended early intervention (ages 18 months-6 years old), with a teacher to student ration of 1:1 or 1:2 and 25 hours per week of engaging intervention that has a strategic direction (e.g. social skills, language, cognition). Further, the NAS report acknowledged that a majority of young children with autism spectrum disorders invariably made developmentally significant gains when intervention met these criteria.

It has been hypothesized that social pragmatic approaches like the DIR (Developmental, Individualized, Relationship-based) model of Stanley Greenspan, which use engagement, humor, play and imagination, may take advantage of the brains' plasticity to integrate various aspects of the brain's functioning by triggering cerebellar, limbic and/or cortical neuronal tracts into activity. The young child with an autistic spectrum disorder may then be 'wooded' out of his unique 'neurological comfort zone' to become more related and functional in his development. Of course, this hypothesis needs to be confirmed by brain science but, at the current rate of research, it won't be long before we know how intervention affects the developing brain of the young child with an autistic spectrum disorder.



## **Clinical Insights**

*.Reflections on the D.I.R. Workshop (July 16 – 20, 2001)*

*Towson, Maryland*

Griff Doyle, Ph. D

*Editor's Note: About 50 clinicians and faculty got together for a workshop on D.I. R. treatment this past summer. Dr. Doyle was a faculty member at this meeting.*

Although I was as overloaded as everyone else when I left Towson, I found myself becoming focused on the theme of affect. I have found previously, that capturing what stirs the child internally fuels progress at all functional stages. Needless to say, I was eager to hear others' perceptions of the role of emotion in producing change. Yet, I never expected to hear so many different, enriching views on affect from every discipline represented.

Sima Gerber, Ph. D., CCC, gave several lectures that illustrated to us the critical role affect plays in driving language. The discussion with Dr. Gerber reminded me of a four year old girl, Kate, whom I treat in parent-child psychotherapy. Kate has a primary attachment disorder and is developmentally delayed in expressive speech, motor development (low tone), and sensory-motor regulation (hyposensitive registration and modulation).

Kate is typically lethargic, under-aroused, monotone, and self absorbed producing mostly 1-3 word utterances. In her play, despite scenes of victims and predators, there was no accompanying emotion and little evident dialogue between characters. Engagement and even brief (3 – 5 circles) reciprocal conversation was achieved only intermittently. In the early sessions, matching Kate's brief utterances and low, whispered tones gradually increased to steadier chains of reciprocal interaction. I remembered this bolstering of lower levels with Kate as I heard Dr. Gerber describe the critical necessity of analyzing and strengthening each stage of pragmatic language used by the child. In hindsight, Dr.

Gerber's advice also helped me realize I subsequently rushed ahead once Kate and I had established a more consistent engagement. When I did this Kate kept conveying to me that my pace and agenda were unwanted and kept cutting me off. The interlacing of more complex language development and affective sharing never seemed clearer.

Dr. Greenspan's address on affective co-regulation explained eloquently what is unfolding now in treatment with Kate. As her mother has patiently matched Kate's 2-3 word, constrained sentences, she received a steadier response. Kate openly struggles to self-correct grammatical and vocabulary errors in an effort to insure that her mother understands her meaning. As Dr. Gerber described, mother's ability to relate to Kate's level of speech and tone allows stronger engagement and early affect sharing. Simultaneously, she has also sensed Kate's subtle new gestures and speech inflections signaling the introduction of meaningful emotion in Kate's communications. Dr. Greenspan explains that this close tracking of Kate's budding affective expression (as well as her level of speech) is caused by mother strengthening affective co-regulation between her and Kate. As this intangible rhythm mounts, more powerful, complex exchanges occur. Dr. Greenspan emphasized also that the achievement of affective co-regulation solidifies other development including attachment, affective regulation, and higher emotional thinking. Indeed, the emotional cueing and sharing begun between Kate and mother is slowly building a more enduring dyadic bond through mother's



measured affective responses to Kate's charged voice tones and more dramatic play. Simultaneously, fragmentation in thinking is reduced as manifested by Kate's increasing desire and success at being able to better organize, express, and understand her basic issues of safety, fear, numbness, and withdrawal.

Several presentations illustrated utilizing the child's affect in all spheres of intervention. Longer, richer periods of interaction, increasingly meaningful, even passionate expressive language, and smoother, more modulated sensory-motor function were all reported to be significantly influenced by mobilizing desire and converting it into more purposeful, organized action. Coming from our separate backgrounds, I found several participants were showing and describing what now is less a unanimous approach but more unique adaptations of DIR based treatment to each child. The "I" (individual) in DIR appears to really be coming alive. This is a concept that has been at the core

of our efforts for some time. However, I had never heard or read before so much interdisciplinary agreement about the critical role of harnessing emotion in moving development.

All this exciting, creative exchange sent me back to Allen Schore's extraordinary work, "Affect Regulation and the Origin of the Self". He posits that "early synaptic development between limbic and orbitofrontal structures depend on modulated affective experience between mother and infant (10-18 months). These original connections (neurological and interpersonal) form the infant's earliest internal organization of caregiver and the foundation of the affective regulatory system for the entire lifespan. Could it be our common work is increasingly demonstrating Schore's contention that affective, higher cognitive, sensory/regulatory, and speech systems are not only neurologically interwoven but mature optimally in affectively regulated relationships?

### *The Start of the School Year, and Beyond*

Molly Romer Witten, Ph. D.

The seventh week of school is always such a relief. During the first six weeks, our children are becoming reacquainted with structured learning after a mostly unstructured summer. It is hard for all children to go back to school. I even saw on television a 'nightmare' commercial in which the parents lured their children into the car with promises of yet another trip to the 'water park', only to 'trick them and lock them in' for a trip to the school. Going back to school presents hard challenges especially for children whose impulses are ineffectively regulated. So, during the first six weeks of school, children with sensory integrative issues routinely 'bottom out'. Even if they don't bottom out, those of us who love them or care for them clinically, (or both) watch with equal parts trepidation,

resignation, and vigilance while they struggle to find a place of equilibrium in school.

If our children with sensory integrative issues are lucky, they are struggling in the appropriate placement. That is to say, they are in an appropriate regular-education or special education classroom, with facilitated support scaffolding interactions with their typical peer friends, and with academic accommodations that allow them to find some pleasure and wonder in the learning process. They are struggling to organize their sensory systems within the context of school being an adventure. Under these conditions, children with sensory integrative issues come home from school wiped out by fatigue, grouchy or moody, needy, and



with their bodies' endurance taxed to the limit.

If however, our children with sensory integrative issues are not in the appropriate placement, they are not finding school an adventure, they are finding it overwhelming. Their bodies' responses include shutting down, becoming overly active, impulsive, avoidant, or oppositional, or any combination of the above, and more. Eating, sleeping, and the other routines that they came to develop with such support and insight as we, the caring adults in their lives could provide, might all go by the wayside. Playing becomes both harder to achieve and more necessary. Maybe the most difficult part of the 'less than appropriate' placement is the realization that we don't know exactly which part of the school day is not right, and which parts are really okay. There begins our quest to fine-tune our child's academic experience.

When we see our child increasingly lose her bearings and regulation during weeks three, four and five, the school personnel with whom we consult often seem calm and dispassionate about the situation. "Give him some more time to get used to things." "It takes getting used to, give your daughter the space to get used to the new routines" "He is in \_\_\_\_ grade now, you'll need to let them take responsibility more." "Let them struggle, eventually she/he will get with the program." Just as we were alarmed when we felt some twinge that something was amiss when our child was 18 months old, or 2 1/2 years old and our pediatrician said, "let's give it some more time, it could be that she'll outgrow this", "maybe it's just a stage", "she is just developing along her own developmental time frame", these first weeks of school we know something is wrong and the school personnel do not share our worry. With 25-35 children in a typical classroom, every teacher has too many children in their care. They don't see what we see; they see only a small fraction of the pattern of discomfort and bewilderment that we witness from the

perspective of our homes and clinics. Since we only have our own child to focus on, we can often see the difficulties more clearly than the teacher can, at first. By the time the teacher recognizes that our child is not "with the program", the situation is often very strained and our child is really suffering.

So, here come the questions.

- 'How do I alert the teacher that what is happening to my child really does need their attention, without sounding like an alarmist?'
- 'How can I know what is going on, and going wrong when my child is just that, a child, and cannot necessarily tell me what is amiss?'
- If things are getting bad, 'how can I advocate for my child, but not keep him out of school? I want him to get the message that everybody goes to school?'
- 'Homework is nothing but a nightmare, how do I get through the homework?'

At each point of recognition that something needs to 'happen', we need to act on our experience. Our role is to foster a partnership with the teacher and bring her on board to our child's therapeutic program. We shouldn't wait for the teachers to approach us with their (anxious) concern, but proactively, and in a low-key manner, request an 'early' parent-teacher conference. If we see that our child is not 'keeping up' without some midcourse correction, we need to go back to the DIR basics.

- Approach your child's teacher with a problem to solve. "My child's/patient's sensory system and individual differences seem to have these characteristics in your classroom. How can we manage these individual differences within the classroom? You may actually have some good, concrete suggestions. However, without defining or creating a common 'focus' that your child's/patient's teacher can share, the possible solutions and suggestions will go unheard or misunderstood. Give the teacher



information that allows him to understand that your child wants to be successful at school, and it is important to create the context that will allow that success to occur.

- Seek out other parents and compare your child's experience with the experiences of other children. The classroom issue is often developmental in scope (for example learning to raise your hand instead of calling out the answer in kindergarten) and other children in the class may be struggling with it too. Or, your child may be the only one struggling with it, but it is developmentally inappropriate for him. Again, search for a focus that your child's teacher can share with you. Together you and other parents, or you and the teacher will be more likely to find the appropriate accommodations.

- Engage in more FloorTime. The DIR approach indicates that when you increase the amount of structure in which a child must function, you also need to increase the amount of FloorTime play. Finding the time to do more FloorTime may seem only a little harder than squeezing water from a rock. However, FloorTime play is the cornerstone of your child's resilience. The more FloorTime you can provide the

more your child will be able to withstand the onslaught on her sensory system. If you are a clinician, encourage your patient's parents to increase their availability for MORE FLOORTIME. It is helpful to actually create a schedule and concretely help parents find an extra 30-60 minutes a day, until the child learns the routines of the classroom. When a child knows what to expect at school, sometimes the internal pressure created by new classroom structure lessens.

As with every other part of your child's development, there is no one 'magic bullet' to help him experience school as fun, a source of success, and appropriately challenging. But, all the small changes that address developmental status, individual differences, and relational strengths can create the scaffold for regulatory balance in the classroom. Somewhat as training wheels provide a sense of safety when you are learning to ride a bike, this regulatory balance will promote a sense of safety for your child. We all need to feel safe in order to learn. By the seventh week of school, we can aim for balance, increasing play to balance out the hard work and sensory impact of learning.

## ***Family Network***

### ***Raising Senor Beezbo***

**Editor's Note:** *The author of the following article has chosen to remain anonymous in order to protect her son's status. However, she and her husband are eager to respond to parents who are facing similar challenges. You can reach Thomas's parents by writing to them c/o our editor: Jo Raphael, ICDL, 3213 Midfield Road, Baltimore, Maryland 21208 or [JO@ICDL.COM](mailto:JO@ICDL.COM). Thank you.*

Our son Thomas was adopted from Paraguay at age 14 months. His challenges are perhaps a result of early deprivation, genetics, or both – we'll never know. Almost immediately, we recognized his pain. The simple task of awakening in our loving home was too much for his senses. Just getting out of bed and coming to the dining room was more than he was able to do. He awoke crying and rocking, with no human connection or eye contact, seemingly unaccustomed or unaware that there was comfort waiting for him. He was

fearful, angry, anxious, defiant, non-compliant and, most alarming, inconsolable to our loving words and touch.

At age 2.5, thoroughly exhausted and frightened for his future, we sought the help of a psychiatrist at a major children's hospital. She branded him with a long list of disorders, told us that he would always be difficult and advised us to stick to a strict regimen, including the number of bedtime stories we promised. Next, we were guided to a behavior modification psychologist who,



through the anointing of empirical studies, taught us to train Thomas like a thoroughbred animal, even introducing 'breakfast dessert' for particularly difficult mornings. It worked for a while – my husband experienced less bruises on his face as a result of Thomas' angry gouging of Bill's facial skin as he whisked Thomas away to pre-school. I remember asking this psychologist, "would it help if I quit my job to spend more time with Thomas?" The answer was "No. I don't think so." During the next two years, we sought the help of another psychiatrist who diagnosed Thomas as being a highly functioning autistic child.

Divine intervention lead us to our current therapist, who, after spending a few hours with our family, diagnosed Thomas with Regulatory Disorder and Sensory Integration Dysfunction, neither of which appear in the empirically anointed DMSIV medical bible. Thus, these diagnoses were not exactly embraced by our other doctors or insurance company. Our therapist simply said, "We can help Thomas, but it will take a lot of work and commitment on your part." The cure was shocking and required a complete reevaluation of our lives and shift in the way we approached our daily schedules and commitments. We had bought into the American Dream of having a child, while still maintaining two full-time careers and now this was being upended. After stepping down from my full-time career, I began following the regimen suggested by our therapist. I worked 3 hours in the morning to balance the family budget. We cut Thomas back to a half day of school from his previous full day plus after school program. At 12:30, after I picked Thomas up, we did two hours of floor time per day, twice per week occupational therapy sessions, and 6 times per day body brushing. When I asked our therapist why we were doing FloorTime, she answered, "It will enhance your relationship with your son". I learned from this therapist and the dozens of books I read that if we truly desired a human, loving connection with our son, that I would need to follow Thomas'

leads during floor time. Almost immediately, I replaced my customary, rigid expectations, of a normally developing 5-year old with what Thomas was in reality – an 18 month old in a 5-year old body. We stopped all participation in other children's birthday parties, all extra curricular activities, and revamped our lives to create an insular existence where Thomas could feel safe, ridding our lives of all the trappings of a typical family with a 5-year old. When he played with other children, especially since he had violent tendencies, I made sure that I was no more than two feet away from him, to help coach him and help him problem-solve. Our lives became, in essence, a scientific experiment. With the exception of our clinician and our occupational therapist, we had no support with our new plan. Our gut instinct told us this plan was right for Thomas. We persevered.

During the first month of floor time, Thomas was unreceptive and uncommunicative, turning his back to me. I used every opportunity for floor time, even while shopping at the grocery store. I brought toys (usually figures of some kind) wherever we went. After two months of unsuccessful floor time, I had the courage to mention to our therapist that nothing much was happening. She suggested that I interrupt his repetitive play with cars by crashing my car into his cars. I did so in our next play session. Even though his back was toward me, I could see a smile on his face when I crashed my car into his cars. Nearly exhausted and feeling hopeless after two months of no response, I thought, "I can do this!" The next time I suggested we play, Thomas said, "Can we play crashing cars?" A connection was made. I was so happy I cried. Not knowing it at the time, Thomas still to this day recognizes my happiness with a smile and lots of tears – undoubtedly from that day and many others like it.

Soon, we were ready for venturing out. I thought it would be a great experience to try a museum together. I picked a holiday from preschool, woke him up slowly, brushed him



for 15 minutes, planned floor time and then left for the museum. Thomas was around 5.5. We waited in line for nearly an hour, a situation that only months ago would have brought me to my knees. We spent the hour with him in my arms, hugging and laughing and planning our time in the museum. We had a grand time and ever since then, museum experiences are high on our list of preferred activities.

Thomas is now 7. He is fully engaged, connected and joyful. He is still anxious, fearful and has an auditory processing disorder which causes him much distress in the classroom. But, I can anticipate his needs now and I know what I need to do to

meet those needs. I need to do a lot less in my life, slow down, do my “Zen” thing with Thomas and be truly available. After a magical summer, two weeks before first grade began, Thomas began regressing. Although I probably could have done better during those two weeks, the day before school began, I spent 5 hours of floor time with Thomas. The benefits were immeasurable. We still have known and unknown challenges ahead of us. And, we look forward to those with hope and a strong foundation. Children tell us what they need. It is our job to decipher their communication and find ways to respond to their needs.



Please e-mail comments or submissions to us at: [jo@icdl.com](mailto:jo@icdl.com) & [besobeso@enteract.com](mailto:besobeso@enteract.com)