The Treatment of Speech Defects in Elementary Schools

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Speech is the tool we use with which to express our thoughts and emotions, and is our chief means of establishing contact with our fellows. If—owing to some disability—we are unable to make full use of this tool, we find ourselves severely handicapped in life.

Defective speech in a child often has one or more of the following results :—

(1) It is likely to give rise to a feeling of inferiority and a reluctance to try to keep pace with his class mates.

(2) It may make him appear to be dull or backward.

(3) It often causes him to worry over the prospects of obtaining employment when he leaves school.

The usual types of speech defects found in school children are :—

(1) Stammering.

(2) Lisping—inability to make the sibilant sounds correctly.

(3) Lalling—" baby-talk "—often found in children of poor mentality.

(4) Cleft palate speech.

(5) Functional nasal speech—post diphtheritic paralysis.

(6) Poor articulation due to general muscular weakness.

Cases of Alexia, Word Deafness, and other less common defects are also treated by the Speech Therapist, as are cases of mutism when this is of a hysterical origin. The correction of *accents* is not undertaken in the Speech Class; this part of the work should be left to the ordinary teacher and does not come within the province of the Speech Therapist whose function is essentially a remedial one.

The importance of early treatment in any form of defective speech has been recognised by Education Authorities for some time past, and most large urban authorities now employ one or two Speech Therapists on their permanent staff.

In smaller areas, or where the schools are very scattered, it is often impossible to make such an appointment, and it was to meet the needs of such areas that in 1931 the Central Association for Mental Welfare appointed on its staff a Travelling Speech Therapist, whose services were placed at the disposal of Local Education Authorities, for periods varying from 8 to 12 weeks at a time, for the purpose of :—

(a) Making a survey of the number of children in need of treatment.

(b) Giving a course of lectures to teachers.

(c) Treating as large a number of children as possible.

Examination of Children

The children, at the outset of my visit, are tested individually, both for speech and hearing, and a case sheet giving family history, medical history, scholastic attainments, etc., is compiled in each case. At the termination of the visit, the case sheets are left at the Education Office for reference purposes should a permanent Speech Therapist be appointed later, or should I return to the area for a further period.

Home and School Visiting

Each school in the area is visited and the Head and Class teachers are interviewed; in this way much valuable information about a child's behaviour and reactions to his defect in so far as it concerns his school work, can be obtained.

In the case of stammerers, I visit the home also, and discuss treatment with the parents, who are asked to co-operate as fully as possible and who are invited to attend the classes at any time. In the treatment of such cases, home conditions play a most important part, and the parents are given a printed list of suggested ways in which they can help the child. If there are other stammerers in the family this creates a formidable additional difficulty and progress is usually then very slow.

Organisation of Work

The children to be treated are grouped according to age and defect, and in order to reduce the amount of travelling to a minimum a room is chosen in five of the most centrally situated schools. Each child attends a class once a week for a lesson lasting from 30 to 40 minutes.

Printed practice sheets are given to all those suffering from articulatory defects, cleft palate speech, etc., and the stammerers are provided with notebooks and pencils so that at every lesson they may take notes.

When possible, a teacher accompanies the children to the class and superintends the daily practices in between classes. (The importance of close co-operation between home, school and Speech Therapist cannot be over-emphasised and is essential if cures are to result.) As it is not always possible to treat all the children examined owing to the limited time available the seniors are given priority except in the case of stammerers, all of whom over the age of 7 are admitted to the classes in view of the severity of their handicap.

Treatment

Very slight cases of "lalling", viz., substitution of F for TH, e.g., "fick" for "thick", can often be treated successfully by the class teacher who is shown the correct method and asked to carry out the treatment in school. This type of defect should be tackled in the Infant School; otherwise the habit of making a wrong muscular movement, thus causing a faulty sound, becomes fixed and is often difficult to eradicate in a child of 12 or 13. Twenty minutes a day should be spent in Speech Training in every Infant School and minor defects of articulation should be treated at the earliest possible moment.

It has been found that stammerers work better in a class, as this tends to lessen self-consciousness and anxiety. The ideal number for such a group is 10 or 12.

An interesting feature in the treatment of stammerers is the marked improvement which follows in general health. Certain nervous habits, such as nail biting, enuresis, etc., clear up completely as the speech becomes normal, and in the case of the "difficult" child, parents and teachers frequently report a marked improvement in behaviour and stability. One stammerer, aged 16, had a pronounced squint which had developed simultaneously with the stammer. The squint began to disappear after 6 months' treatment, and at the end of 9 months it was reported that both the speech and the eye were normal. On leaving school, this boy was offered a job as lift-boy in a London Hotel.

Cases of retarded speech, dyslalia and lisping do not often show physical improvement as they are not living under the same state of physical tension as are stammerers, but in these cases reports have been received stating that improvement in school work is noticeable and that the children are generally brighter and more eager to take part in dramatic work, poetry speaking, etc.

Lispers, lallers, etc., need individual attention, but it is useful to have a group of 3 or 5 in the room at the same time as the competitive element is strong and whilst one child is receiving an individual lesson, the others are encouraged to help each other. Mirrors and other "gadgets" add to the interest of the lesson.

Cases of cleft palate speech are treated individually or in twos.

Incidence

The following figures showing the incidence of speech defects discovered and comparisons between different areas, may be of interest:—

(*See over*)

Area	*School Pop.*	*No. of schools from which children selected*	*No. of children treated*	*Stammerers*
RHONDDA	19,327			
1st Visit, 1934		21 ...	219 ...	175
2nd Visit, 1936		— ...	186 ...	103
3rd Visit, 1937		31* ...	245 ...	118
EBBW VALE, 1935	4,157 ...	11 ...	199 ...	78
DUDLEY†	9,050			
1st Visit, 1936		22 ...	193 ...	54
2nd Visit, 1937		24 ...	231 ...	61
CAMBRIDGE, 1935	7,117 ...	21‡ ...	157 ...	41
STOKE-ON-TRENT, 1935	40,185 ...	66 ...	240 ...	148
SMETHWICK, 1935	10,693 ...	14 ...	129 ...	70
WOLVERHAMPTON, 1936	20,413 ...	43 ...	214 ...	109
		(*also* 15 *cases from Grammar School*)		
PONTYPRIDD, ABERDARE & MOUNTAIN ASH, 1938	17,815 ...	70 ...	230 ...	136

It is interesting to note that certain types of speech defects appear to be more prevalent in some districts than others. In South Wales, stammering was the predominating defect found, and in comparison the number of children suffering from articulatory defects was very small. In certain Midland towns, the number of stammerers was almost equal to the number of lispers and lallers, and in other areas the percentage of stammerers was very low compared with other defects.

It is not possible to account for this difference with any scientific accuracy, although several theories have been advanced. Thus it has been suggested that the high incidence of stammering amongst school children living in South Wales may be due to bi-lingualism and the confusion which may be produced in the mind of a child who, on reaching school age, has to learn to express himself in another language. Bi-lingualism has also been put forward as a reason for the small percentage of articulatory defects in Wales. In the Welsh language there are 27 sounds and every sound in a word is spoken. Articulation is therefore naturally clear and accurate. Out of 300 children under treatment in one area, only 5 were unable to make the trilled R sound. In one large industrial town, on the other hand, it was found that 92 of the 214 children under treatment were unable to make it.

The value of and the need for Speech Therapy amongst school children has been fully recognised by the Education Authorities under whose auspices these surveys have been made, and it is satisfactory to record that in three of the areas, Stoke-on-Trent, Smethwick and Wolverhampton, permanent Speech Therapists were subsequently appointed, whilst in a fourth the matter is being given serious consideration.

* *Including Secondary and Technical Schools.* † *Third visit now in progress.* ‡ *Including Infants' and Nursery Schools.*