XII. THE PLACE OF SPEECH CORRECTION IN PUBLIC HEALTH

Alice Robins

T H E S I S

Spring Term

1 9 4 1

Alice L. Robins

THE PLACE

of

SPEECH CORRECTION

in

PUBLIC HEALTH

BIBLIOGRAPHY

Baldwin, E.T. & Stecher, L., Psychology of the Preschool Child, Appleton,N.Y. 1924
Bateman, W. G., A Child's Progress in Speech, J. EDuc. Psy., 1914 Vol. 5
Bender, James F., PhD, & Kleinfeld, Principles & Practices of Speech Correction, Pitman 1938
De Laguna, G., Speech, Its Function and Development, Yale Univ. Press 1927
Dixon, H.H., M.D., The Present State of the Oregon Child Guidance Extension Program, Commonwealth Review, March 1939
Gesell, A., Infancy and Human Growth, Macmillan, 1928
Gessel, A., Mental Growth of the Preschool Child, Macmillan, N.Y. 1925
Guthrie, Douglas, M.D., & Sether, George, PhD, Speech in Childhood. Its Development & Disorders, Oxford University Press, 1935
Hargis, Donald E., Speech Correction in Oregon, The Commonwealth Review, 1939
Horn, J. L., The Education of the Exceptional Child, p. 198, The Century Co.,1924
Iowa, Child Welfare Research Station, Physical Traits of Young Children, Amer J. Dis Child., 1929 Vol. 38
Kenyon, Elmer L., M.D. Question of Our Ethics & Our Standards, p. 302, Dec. 1939
Martin, Lewis C., PhD., A Speech Survey of Elementary School Children, May 1938 Director of Special Education, Portland, Oregon
Meader, Emma Grant, PhD., Teaching Speech in The Elementary Schools, Teachers' College Columbia University, Contribution to Education No. 317, " " " N.Y., 1928
Milisen, Robert, Introduction of Speech Correction into a New School System, p. 2411, The Journal of Speech Disorders, Sept. 1939
Morris, D. W., PhD., Speech Survey, The Journal of Speech Disorders, Sept. 1939
Putnam, Rex, Speech Course of Study, High Schools, State of Oregon 1937
Ringer, Margaret, The Speech Program of the Traveling Child Guidance Clinic of the University of Oregon Medical School, Commonwealth Review March 1940
Ringer, Margaret, Mental Hygiene News, Oregon Mental Hygiene Society, Oct. 1938
Ringer, Margaret, Survey Lecture Material, Office Adm. Nov. 1940
Sevenaus, Madeline Marie, An Effective Speech Program, Journal of Speech Disorders, p. 358, Dec. 1939
Sterns, Wilhelm, Early Psychology of Childhood
Stinchfield, S.M., The Psychology of Speech, Expression Co., Boston 1928
Stinchfield, S.M., & Young, E.H., Children with Delayed or Defective Speech Stanford Press 1937
Terman, L., The Hygiene of the School Child (Revised Edition)
Van Riper, Charles, PhD., Do You Stutter? Atlantic Monthly Nov. 1939
Van Riper, Charles, PhD., Principles & Methods of Speech Correction, 1939
Wile, Ira E., The Challenge of Childhood
Zeimes, Dorothy J., A Speech Re-education Program in a Small School System, p. 624, Quarterly Journal of Speech, Dec. 1939
Understanding the Child. October 1940, No. 3, Volume IX. Published by the National Committee for Mental Hygiene. Henry B. Elkind, Editor, 3 Joy Street, Boston, Massachusetts

THE PLACE OF SPEECH CORRECTION IN PUBLIC HEALTH

OUTLINE

I. INTRODUCTION

1. Two general methods of speech surveys.
2. Samplings of speech surveys.

II. THE TRADITIONAL METHOD OF SPEECH CORRECTION IN THE OREGON SCHOOLS

1. Colleges and universities.
2. High school curriculum.
3. Grade schools.

III. THE SPEECH CORRECTION PROGRESS OF THE UNIVERSITY OF OREGON MEDICAL SCHOOL, CHILD GUIDANCE EXTENSION

1. Speech correction in the traveling clinic.
2. Public health facilities in connection with the traveling clinics.

IV. THE PUBLIC HEALTH NURSE'S SCHOOL CONTACT WITH THE SPEECH DEFECTIVE CHILD

1. School clinics.
2. Actual school situation.

V. A LOGICAL SOURCE OF DISCOVERY OF THE YOUNG CHILD WITH DELAYED AND DEFECTIVE SPEECH

1. Infant and pre-school clinics.

    a. County program.
    b. Visiting nurses and P.T. program.

2. Responsibility of those in charge of the clinic.

    a. A challenge to public health nurses and doctors.
    b. A small group to train.

VI. CASE STUDIES

1. First case history.
2. Second case history.
3. Third case history.
4. Summary.

VII. GENERAL SUMMARY

THE PLACE OF SPEECH CORRECTION IN PUBLIC HEALTH

Dr. Ira Wile, formerly Commissioner of Education of New York City Schools says,[1] "In the scheme of education, as at present existent, tremendous stress is placed on writing and reading both of which are practical tools in the acquisition of knowledge and in the imparting of ideas. In the work of the world, however, speech itself continues to be the most essential vehicle for the transmitting of ideas, whether for industrial purposes, educational counsel, or spiritual evaluation. The elocutionary phase of education must give way to a more practical scheme of speech improvement."

Many authorities agree with Dr. Wile on a more practical phase but there is little agreement as to how this point is going to be reached. A basis approach would be to find the approximate number of students involved. Surveys of the speech defective students have been made all over the United States. Of these surveys there are two general[2] types. One is the questionaire[3] method and the other is the personal interview method.

---

1. Meader, Emma Grant, PhD., Teachers College, Columbia University, Contribution to Education No. 317
2. Morris, D. W. PhD., Speech Survey. Journal of Speech Disorders, Sept. 1939
3. This type of survey has what might be called a "double purpose." It indicates the number of speech defective children and at a low enough percentage that your school superintendents do not "scare" so badly. Robert Milisen of Indiana University says there is danger in quoting high percentages before getting the cooperation of the school superintendent. He feels that it can be proven 40 to 50% of school children mispronounced common words as "just and get", but do not tell it!

SPEECH SURVEYS

The questionnaire method is easy to make and does not take qualified or extra clinicians to make it, rather the classroom teacher[1] is handed a form and it is on her judgment[2] that the speech defect is determined.

The other general type of survey, or the personal interview method, is done by a speech clinician or specialist who interviews each student for diagnosis. The former method gives general knowledge as to the number of speech defective students, while the latter method is a specific guide to a particular situation. Until speech clinicians have more understanding and methods are stabilized the percentage of the latter method will vary from time to time and place to place. However, as will be seen in the samples of surveys given the percentages of the questionnaire method are all very nearly the same while those of the personal interview vary more but average about the same.

SAMPLINGS OF SPEECH SURVEYS

QUESTIONNAIRE METHOD

1. J. E. Wallin in his report to the Board of Education of St. Louis in 1916 reported an extensive survey of his own and seven other surveys. Wallin found that 2.8% of 89,057 children in elementary and high schools in St. Louis had defects of speech.

2. Lewis C. Martin[3] in his survey of the elementary schools of Portland, Oregon in 1938, found in a city wide survey of 27,882 students 3.62% with defective speech. Dr. Martin says, "This is a greater percentage than is reported in most surveys, the average being under 3%. Dr. De Busk found 2.7% in his survey made in 1927."[3]

---

1. "It is important for us to realize that superior classroom teachers have not been trained to even recognize speech defects." D. W. Morris, PhD. Speech Surveys. The Journal of Speech Disorders Sept. 1939.
2. "It was thus left up to the teacher's judgment to decide whether or not a defect was serious enough to report or needed remedial treatment." Lewis C. Martin. A Speech Survey of Elementary School Children, Portland, Oregon 1938
3. The above reference.

PERSONAL INTERVIEW METHOD

1. In 1916 Smiley Blanton conducted a personal survey[1] of all elementary school children in the public and parochial schools of Madison, Wisconsin. A total of 4862 children from the ages of four to eighteen years were seen with 5.9% reported as having defective speech. Five years later Dr. Blanton reported a survey of 1400 freshmen out of a class of 2240 at the University of Wisconsin as having 18.13% defective in speech.

2. In 1922 Sara Stinchfield, PhD., at Mt. Holyoke College reported that 18% of the entering students had defective speech and that 17% of the sophomore class were required to take speech work. In 1923 the entering class had 16% defective speech and 24% had to take corrective work as sophomores.

3. An intensive study was done at the University of Iowa in 1930 and 1931 of entering students. It revealed that more than half (50.9%) labored with one or more specific handicaps of voice or speech.

4. In the survey at Mankito, Minnesota Public Schools[2] the classroom teachers had reported fourteen cases of defective speech. In September 1937 a speech survey was made by a speech clinician. In this personal interview survey of 1428 students from kindergarten to the ninth grade 17% were found with defective speech and 5.8% with serious defects. This clinician noted the usual facts as well as obtaining a record of the child's hearing, results of physical examinations and the I.Q. of the child.

It has already been pointed out that the questionnaire method of percentage stayed pretty nearly the same, around 3%. The personal interview percentages are within a range of 18 to 20%. These surveys were picked at random and it is interesting to see that an elementary school personal interview survey is in keeping with those of college freshmen.

---

1. Assisted by Erminee Ballard and Margaret Gray Blanton. D. W. Morris, Ph D. Speech Survey, The Journal of Speech Disorders Sept. 1939
2. Dorothy J. Zeimes. A Speech Re-education Program in a Small School System. The Quarterly Journal of Speech, December 1939 P. 624

THE TRADITIONAL METHOD OF SPEECH CORRECTION IN THE OREGON SCHOOLS

In the colleges and universities of the State of Oregon, courses are being offered in speech correction for the prospective teachers. However, quoting from Donald E. Hargis[1], "There is no real training program within the State of Oregon. Some elementary training is given at the State College and at the University, but it is neither intensive nor extensive enough to send sufficient adequately trained workers into the field. Since this time there has been enough demand for speech correction that a course as well as a clinic has been started at the University. The courses as outlined do not equip the student to deal with all types of cases nor will they give him sufficient background for effective work without further training."Insufficnent work is given to develop future clinicians."

In the high schools of Oregon a very elaborate course of study[2] is given as a guide for the Oregon high schools:

I. Objectives of speech training teacher and pupil should keep in mind:
   A. Proper use of English language.
      1. Correct grammar
      2. Enlarged vocabulary.
      3. Improved diction.

   B. Development of mental processes.
      1. Original thinking.
      2. Analysis (for both original composition and interpretation)
      3. Collection of materials (reading and note taking.)
      4. Organization of material.

   C. Adjustment of personality.
      1. Creation of healthy mental attitude
      2. Elimination of inhibitions.

   D. Development of bodily expressions.
      1. Poise
      2. Ease
      3. Purposeful action
      4. Posture
      5. Movement
      6. Gesture
      7. Facial expression

---

1. Donald E. Hargis. Speech Correction in Oregon p. 71. The Commonwealth Review, May 1939
2. Rex Putnam, Speech Course of Study. State of Oregon High Schools 1937 Superintendent of Public Instruction, Salem,Oregon.

E. Development of vocal expression.
   1. Clear articulation
   2. Accurate pronunciation
   3. Correct breathing
   4. Correct placement of tone
   5. Effective resonance
   6. Vocal flexibility

F. Correction of speech defects
   1. Organic defects
   2. Functional defects

II. Debate parlimentary practice.

III. Dramatics - involves the teaching of the arts and sciences of interpreting and producing plays.

General Suggestions for Teachers

A. Theory and practice together

B. Criticism short and to the point adapted to person's emotional status.

C. Private or special attention should be given when possible to students suffering from speech defects or particular emotional disturbance.

In the elementary schools in the state there are a few with teachers that have had some training in speech correction but in Portland, the State's largest city, no program of speech correction has been started.[1] There, of course, have been starts made. One of these was to bring in a Speech Specialist[2] to speak to the primary teachers on preventive measures of defective speech in the spring and fall of 1940.

Special classes have been held for the deaf and hard of hearing since 1917 in Portland. Some training is given there in speech, also some is given at the State Deaf School. Some attempt has been made to work with Portland's students at the Child Guidance Clinic at the Medical School.[3]

---

(1) From the Office of the Dept. of Research-Special Education, Portland, Oregon
(2) Dr. Margaret Ringer gave ten one hour lectures to an auditorium of some 400 to 500 teachers from four to five o'clock once in two weeks.
(3) Dr. Margaret Ringer gives from ten until twelve o'clock each Tuesday for this work. There is no follow-up in the schools.

SPEECH CORRECTION PROGRESS OF THE UNIVERSITY OF OREGON MEDICAL SCHOOL, CHILD GUIDANCE EXTENSION

"A program of child guidance[1] for the state of Oregon outside of Portland, under the direction of the University of Oregon Medical School, was inaugurated in 1937, with funds provided by the Legislature. This program had to be especially planned for the needs of this state because of its comparatively small number of inhabitants (1,000,000) in a relatively large area (95,607 square miles). It was necessary to divide the state into districts, with certain urban areas designated as district centers. Since the Medical School needed local specialists, these centers had to provide a "local staff" consisting of an official of the local medical society (in most cases a public health officer), the public health personnel[2], remedial and clinic case teachers, school mental-hygiene case workers, a school psychologist, and sometimes welfare workers in the child field.

"The Medical School extension staff provided consultation and advice; the local staff was responsible for physical study, psychological study, medical treatments, and remedial teaching and social case-work procedures. Beginning services were limited to children between six and fourteen years of age.

"With the opening of the school year 1938, the Medical School added consultive speech services to the existing Child Guidance Clinic program for Portland and for the state.

"It may be said that the entire field of speech correction has been sadly neglected in Oregon. The first attempt toward correcting this condition was begun by the Department of English of the University of Oregon, Eugene, in 1937. This department, although it has done effective work in a number of cases, has been handicapped by several very serious limitations. Donald E. Hargis, who is in charge of the work at the University, says:

---

(1) Allan East, "Child Guidance Clinics in Small Communities of Oregon," Commonwealth Review, vol. XXL (May 1939), pp. 96-111.

(2) In the districts where there is a Health Department and Health Officer he works with the clinic. In the other districts the Public Health Nurses are clinical workers. In Bend, Medford, Albany, Eugene and Marshfield the school nurses are clinical workers. In the other districts the country school nurses are used.

"First of all, because the staff is small, only a very few patients can be handled at a time; and these are almost entirely University students. Second, no provision is made for boarding patients from the outside. Third, no provision is made for a full-day clinic and this is essential for complete and successful treatment of many patients. Fourth, the physical equipment of the clinic is so limited that only a few of the basic types of cases can be handled and no research can be carried on. Last, inadequate training is offered to develop future clinicians."[1]

"The problem, when the Medical School's speech program for the state of Oregon was inaugurated in 1938, was therefore: how to do effective speech-corrective work in spite of limitations such as those just mentioned and without specially trained and speech-conscious people in the different centers of the extension system.

"A well-trained local staff, mobilized in most of the centers from the public health unit[2] and members of the local school system, was available to provide a physical examination of the child by a local physician, a mental rating (revised Stanford-Binet) by the local psychologist, and the entire social history of the child by the local social workers. Since the Child Guidance Clinic session was held only three times during the school year in any one center, only a few speech-defective children could be seen at a clinic, if the speech consultant was to have time enough to explain the individual problem to the child's parents, the clinic case teacher, and the clinic case social worker. In developing this program, available facilities at each of the climic centers have been realistically evaluated, and the program limited to the possibilities of help in each individual speech case. We have preferred limited individual case study and attention to a "mass clinic." This is in line with the general plan for the Medical School's program of child guidance extension.[3]

---

(1) Donald E. Hargis, "Speech Correction in Oregon" Commonwealth Review May 1939

(2) In each district almost all of the "clinic workers" force is Public Health Nurses.

(3) H.H.Dixon,"The Present Status of the Oregon Child Guidance Extension Program Commonwealth Review, vol. XXI (March 1939) pp. 13-23

"At all clinic sessions, where speech consultation service has been included, special stress has been paid to educating the parents of the individual child in regard to his particular speech defect and to building up in the child's home a feeling of responsibility for cooperation in carrying out clinic recommendations. Diagnostic findings, and short and simple recommendations to the local staff for about three months of follow-up work, have been dictated into the clinic file in presence of the delegated clinic worker. The clinic worker has conducted the child's program at home and at school during the interim between clinic sessions. It has also been her responsibility to see that the good relationship between the child's home and his school, usually established at a clinic, is continued.

"The statistics of the first year of the speech program of the Child Guidance Extension service are as follows:

"During the school year 1938-1939, 102 speech-defective children were seen in the different community centers. A total of 27 clinics were held, during which 51 children were seen once, 34 children twice, 16 three times, and one more than three times.

"A relatively small number of children under 9 years of age (29%), were sent to the Child Guidance Clinic because of speech problems; most of the children were 9 years (35) and older (up to upper age limits of the intake policy). There were no stutterers seen under 9 years of age; only 5 children under 9 years of age were clutterers. The sudden increase of rate and psychoneurotic difficulties appearing with the ninth year shows that the early symptoms of grave difficulties were overlooked during the early school years until they had already developed a definite pattern. The high number of articulation difficulties (with an average age of 9 years 3 months) and the number of children with delayed speech development in the higher grades also shows lack of proper diagnosis and treatment of those children in kindergarten and the first grades.

"With the continuation of the program during the second year, it became more and more evident that only certain types of speech impediments could be much benefited through the extension system. Speech disorders of an organic character were eliminated as far as possible (spastic and cleft-palate children were referred to the State Welfare Bureau, Department for Crippled Children. The second year 95 cases were held over from the previous year, 81 new cases were added, 61 cases were closed and 115 cases are left. Eighty-five per cent showed improvement. The other 15% either had not been treated long enough to show improvement, had moved away or were not suited to the program. Special stress has been paid to diagnosing early symptoms of speech impediments and to proper care of these children before a definite pathological pattern developed. The intake policy has been broadened to those of preschool age. With this development the emphasis of the speech program of the Child Guidance Clinic Extension system shifted from speech correction to speech hygiene and prevention, is based upon the existing knowledge of the physiological and pathological speech development in a child.

"The advantage of a speech service in a psychiatric-clinic extension program is as follows:

1. Opportunity is given for a physical, psychological, and social checkup of each incipient case, before the child appears in the clinic.
2. The home situation of the one child having been studied, the siblings can be aided through the clinics. These sometimes receive as much help, indirectly, as the child who is referred.
3. A whole family readjustment program can be worked out if necessary. Parents with speech defects benefit through the recommendations and explanations given in regard to their children.

4. The cooperation of the local clinic personnel, especially the health officials, makes possible the discovery of speech-defective pre-school children and is helpful in the readjustment of home conditions.

5. The clinic case teacher, who is not supposed to have more than 15 children in her charge, is able to give special attention to speech cases, if needed; she may include speech work in the everyday program of the child without making him too conscious about it.

6. The personal contact of the speech therapist with classroom teachers helps to readjust a child to his own classroom group.

7. A good relationship between home, school, and physician is obtained through the extension procedure.

8. Interest in the early diagnosis of speech cases is emphasized at meetings of the local child guidance clinic advisory committee, usually held after every clinic, to which principals of the schools, teachers, physicians, psychologists, and executives of child-caring youth organizations are invited.

9. Through the concentration on preschool and first graders, early speech difficulties can be diagnosed, and early learning difficulties developed on this basis, leading to school retardation and to severe behavior problems, greatly diminished."

THE PUBLIC HEALTH NURSE'S SCHOOL CONTACT WITH THE SPEECH DEFECTIVE CHILD IN OREGON

Throughout the state Public Health Units have school health programs. According to the facilities available clinics for the examination of the school child are developed. In many communities only the larger centers will have this type of service while in one county[1] the first, third and sixth grades are examined each year. In other Units a system of selective examination is being done.

(1) Jackson County

Few and far between are the Public Health Nurses that cannot name a number of children with defective speech in each community. In school clinics the doctor and nurse have a first hand opportunity of seeing the child and talking with the parent. When rapport has been established with the family the families' worries become the problems of the clinical personnel. An informed staff can greatly enlighten a community. However, an uninformed staff may be able to fool themselves by passifying a worried mother that her child will "outgrow" poor speech habits, but an intelligent parent will ask for more information.

As has been mentioned by many authors a teacher's training does not include speech correction. The following situation occurred in a rural school. A 4-H health examination was being done. The nurse noticed a seventh grade boy with a speech defect. It was called to the attention of the teacher. Her answer was, "This boy doesn't have anything wrong with his speech. I have only one child that has, and he imitates his father who talks "baby talk"! The first boy in question was asked if he liked school. His reply was "Yeth". The astonished teacher said, "And to think I've had that student for seven years and not noticed that." This teacher is doing a good job of teaching the "Three R's", as well as many extra activities. She should not be burdened with more work.

A LOGICAL SOURCE OF DISCOVERING THE YOUNG CHILD WITH DELAYED AND DEFECTIVE SPEECH

For years it has been the work of the visiting nurses' staff[1] to conduct "well baby clinics". This takes the baby from birth to two years of age. During this period the child should show definite signs of speech.[2] Formerly throughout the state the child from two to six was the "forgotten child". As

---

(1) In Portland, Oregon

(2) Norms established by Yale for child's speech-Gessell 1937
Child at 12 months should speak two words
" " 15 " " " four "
" " 18 " " " five "
" " 21 " " join two "
" " 24 " " " words in short sentences.

long as he was classed as a baby there were "Well baby clinics" for him. Also many doctors give post-natal care for that period. At school age the child was again recognized as a possible source of illness. He was put through a pre-school examination whether he needed it or not. The trend now is to include the child from birth, babyhood, the "forgotten"[1] years (2 to 6), and through his school experience as a potentially well person but in need of periodical[2] examinations. With this type of service in the larger cities and in many of the rural areas of the state Public Health personnel is reaching a group in numbers which it can handle. For example, a Mothers' Conference[3] will be held quarterly in a rural area. In this area there is an average of twelve live births a year. This small group could be examined once or twice a year until school age. It would be possible to reach this size of group.

The approach to a medical problem implies prevention, relief and cure.[4] And so it is true with speech. A doctor is expected to know all phases of development for the normal as well as the abnormal child. And so is the Public Health nurse trained to know the normal and recognize deviations from this. Therefore, why do we ignore faulty speech habits and development. Speech is said to be the outward expression of the soul[5]. It is used to awaken response in fellow men.[6] Why, then, do we stand by and try to passify anxious parents that a child will "outgrow" incorrectly learned habits while we give the parent splints, etc. to keep the child from sucking his thumb?[7]

---

(1) Author's terminology.
(2) Well babies are seen from once in two weeks to quarterly, 2 to 6 years are examined quarterly or less often depending on the facilities. School children's examinations vary from yearly to occasionally, again depending on the service, while all adults are advised to have a yearly examination.
(3) This term has been adopted to replace baby clinics, etc.
(4) Those not amenable to relief procure custodial care.
(5) Travis, Lee
(6) DeLaguna
(7) "The relationship between speech impediments and behavior and learning problems is interesting: 69 children, approximately two thirds, had speech problems exclusively. 33 had speech and behavior problems. 48, approx. half, were retarded at schooland had definite learning difficulties."Margaret Ringer Speech Correction Program, Commonwealth Review 1938 p. 48

CASE STUDIES

First Case. This student was referred from high school by the Public Health Nurse to the speech correctionist.

Virginia K. was born March 11, 1920 in the United States of Italian parentage. Both parents spoke Italian in the home and were hesitant about speaking English in front of strangers while the children preferred to speak English in the home.

The family consisted of the mother and father and nine children. The eldest son was married, still lived at home with his wife and child. He was a college graduate. He helped assume responsibilities in the home. One sister was married and lived away from hime. She also graduated from college, later taught school. One sister is away at college and is earning her own way. Her grades are good. There are six other children at home.

The family finances are low but by close economy and pooling of effort they maintain a moderate home. The children come to school neatly dressed but with no spending money. The older brother assumes family responsibilities as well as financial. He feels Virginia's speech has improved during the past few years. A friend of the family who has known Virginia since she was about eight does not remember.

After getting acquainted with this family it was learned that the oldest brother and a sister each had a speech defect. The speech pattern in the family was to speak fast and with the combination of English and Italian poor habits of speech were developed. Virginia's life was built on this insecure foundation which she realized when she entered school. This blocked the normal development of a human creature at the very beginning of school adjustment and fixed the maladjustment from year to year.

The second case study is that of Virgil age eight and one-half years. He has been known to the Medical School Clinic since the third week of his life when his mother brought him to the clinic for advice about feeding and a skin condition. The following month he was started on cod liver oil and the mother given general advice regarding his care. Two years later he was seen again for emergency care of a burn and an infectious mouth condition and bowlegs. He was not seen again for three and one-half years, on his second visit at this time it was noted that he had a speech defect of the "dentals and sibilants". One year later the boy was back with this notation, "Cannot talk plainly, did not pass. Tires quickly, blood count ordered. A prescription was given and Virgil was referred to the Child Guidance Clinic for speech defect and behavior problem. This was in June 1939. During the summer of 1939 Virgil was in and out of the clinic often. He had pertussis and a cough that hung on. He was X-rayed. As a result of the X-ray a two hour daily nap was advised and a tonic. This was in August of 1939, he wasagain eferred to the Child Guidance Clinic because of his speech defect. In September 1939 he was seen in Child Guidance by a pyschiatrist. The psychiatrist felt that Virgil could profit from speech correction. In November 1939 he was examined[1] and diagnosed as having universal stammering.

The social history[2] states that Virgil came to the Child Guidance Clinic because of a speech defect and behavior problems. His mother says she taught him baby talk because she thought it was cute. There are two older and two younger children in the family. Regarding one of the other children that failed in school the mother said he was "lazy - he sits around and reads."[3]

---

(1) Limited facilities.
(2) Taken by visiting teacher
(3) The mother always has three or four library books under her arm.

The financial status of this family is relief or near relief all of the time. There is little marital happiness between the mother and father. Virgil gets along with his parents but is not interested in his brothers and sisters. He is happier away from home than at home.

Virgil was started on as intensive a program of speech correction as was possible with the crowded clinic conditions. It was also advised that he be given cod liver oil and fresh milk in addition to his daily food. The mother showed good cooperation in working with the boy until new exercises were started. It was then felt not advisable to have her work with the boy. Since this time he has shown good cooperation and progress. Because of his listlessness and poor school progress it was recommended by the speech correctionist to have him transferred to Mills Open Air School[1]. Since that time he has made good progress in school and with his speech.

The third case study is that of Henry who was a 17 year old high school boy brought to the clinic because he was a problem in school for many years. The school nurse tells that he stutters in such a way that no one can understand him, and that perhaps there might be an organic (physical basis) background for his speech impediment. In the opinion of most of his teachers he looks dull and stupid, and is carried along with the other children only on account of pity. Hence, the school nurse and another teacher, who observed him for years, cannot help but have the feeling that there might be something "sleeping" in this boy that might be awakened.

Henry was a blond boy, tall, thin, unclean, and self-conscious and dependent on a mother who also has a noticeable speech defect. He lived on a farm of ao prosperous circumstances. He would not talk to anyone if addressed, he answered in a soft voice - emitted through the nose - repeating sounds, syllables and words. One was not able to understand him.

---

(1) The children have regular rest periods in cots, hot lunches.

Examination showed that he suffered a lack of comprehension of the meaning of questions, having no remembrance for words or sounds. Besides this, he had remarkable articulation defects. He was not able to pronounce F, V, L, K, G, Ch, Sh, and S sounds correctly and the muscles of his speech organs of the larynx throat, soft palate and tongue - seemed not to work sufficiently. The repetition of syllables completed this picture of insecurity, occuring through the basid disability for correct speech. Inquiries brought out the fact that Henry suffered from a bad "head-flu" in the early years of life, which probably was really an encephalitis[1] which may have been the cause for the underdevelopment of his speech through injury to certain portions of the brain.

During the treatment it became evident that Henry did not know things that are taught in early school life. He not only pronounced the words incorrectly, but he was also unable to spell them. He did not know that a verb needs an S in the third person singular; she said and wrote, "he drink" instead of "he drinks". He also did not know that a verb usually needs a syllable, "ed" to show the past. He would say and write "he walk" instead of "he walked."

Drills, with his cooperation, deepened his memory span, strengthened his speedh muscles and these in turn improved his personality. He now talks with everyone at the clinic so much that often we have difficulty in getting him to go home. On his own initiative he keeps himself clean. He picked peaches for a neighbor to earn money to buy himself a dark red sweater. He became interested in photography. His neighbors tell him that they are now able to understand him. So, he begins life at the age of 17 - not too late, but with a difficult task ahead, as he lacks ten years of school knowledge.

Moreover, recent developments are very interesting. A teacher in Henry's school has taken an interest and is following up Henry's treatment in her own class-rooms. She invited him to tell of his special exercises and Henry now

(1) Encephalitis-inflammation of the brain resulting in various disfunctions.

takes the leadership in hygenic speech exercises for the whole class. He tells that "everyone is listening and no one sleeps."

Interesting is the change of attitude he shows in his independence. This is brought out in addition to his leadership at school in his comment: "Oh, yes, you see, I come home at a quarter to six. My mother has a nervous speech impediment. I talk slowly as you taught me."

Virginia from babyhood needed help with her timidity, and later speech.

Virgil's mother told the Visiting Teacher that she had taught Virgil "baby talk" because it was cute. How much better for Virgil his mother and the rest of the family, if they had been going regularly to a pre-school clinic that the mother might have been advised in proper habits.

Henry needed help in the understanding of words and his mother needed an understanding of herself and the boy.

These three examples show that speech disorders in young children may develop into serious handicaps, blocking the normal development of the youngsters and increasing and fixing social and mental maladjustment. None of these children would have been able to lead a normal life orearn a living, as they would have become isolated with the years and developed into helpless cripples-probably potential burdens upon society.

In the United States there are many "cure alls" for defective speech. In fact, so many that one doubts the scientific value of many of them. However, there are still scientific people in the field and speech defects are being corrected in the young and older children as well.

One of the first to develop an effective method of teaching the young child was Mrs. Edna Hill-Young. Mrs. Young spent many years developing this method while Dr. Sara Stinchfield collaborated with her to develop the more

scientific phases. Dr. Lee Travis worked with Mrs. Young and Dr. Stinchfield in perfecting the method. The method is being taught at the extension college of the University of Southern California. Mrs. Young feels that at two and one half years a child should be saying some words plainly.[2] Gesell says, however, that if the child is retarded in speaking leave him alone and he'll develop. From the surveys that have been made and the work that is being done in speech correction it is quite evident that, conservatively speaking, three to twenty per cent of our population is still "waiting." Doctors have for too long said to anxious parents, "I wouldn't worry, he'll outgrow it." The facts are in a high percentage of cases he does not outgrow it.

SUMMARY

THE PLACE OF SPEECH CORRECTION IN PUBLIC HEALTH

Public health personnel have the first opportunity to recognize speech defects. In our daily work we are dealing with the developing baby and child. How can we as an intelligent professional group let one of the basic factors of our human development grow slip-shod and incorrectly under our constant care? Is this dealing with the whole child? Obviously not, yet there will be many professional people that will snear at the idea of adding another phase to an already overloaded program. Again, I reiterate, are we dealing with the child as a whole when we ignore one of the most basic factors?

It is my challenge to Public Health personnel to inform themselves to recognize delayed and defective speech, and to prevent its occurrence and secure its treatment insofar as is possible.

---

(1) Dr. Sara M. Stinchfield studied Speech Pathology when the only courses in anatomy offered were with medical students. This she took. Later she married Dr. Hawk, an orthopedic specialist. In taking Dr. Stinchfield's course in speech one has the pleasure of learning the anatomy of the mouth and throat from Hawk, M.D.

(2) Gesell - At two years child should combine words in short sentences.