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ABSTRACT

Described is a projected program involving team teaching for speech clinician and classroom teacher to meet needs of children with communication problems in early childhood education centers. It is explained that the speech clinician will be present in the regular classroom for a given period of time to implement diagnosing and remediation of communication disorders of children. Speech improvement structure is described as modified block or intensive cycle scheduling plan, with speech development and speech modification theory added to regular curriculum. Implementation and advantages of the combined program from viewpoints of training coordinator, teacher, speech clinician, children, and parents are then presented. Advantages for training coordinator discussed are program and curriculum planning, scheduling, equipment and materials, staff training, and parent information. Advantage for classroom teacher is said to be in the team effort to meet children's needs. The speech clinician's main advantage is explained as being a part of the children's everyday experience. The children are thought to benefit from having no separation out of those having communication disorders, while parents are said to benefit by improved speech performance of their children. (CB)

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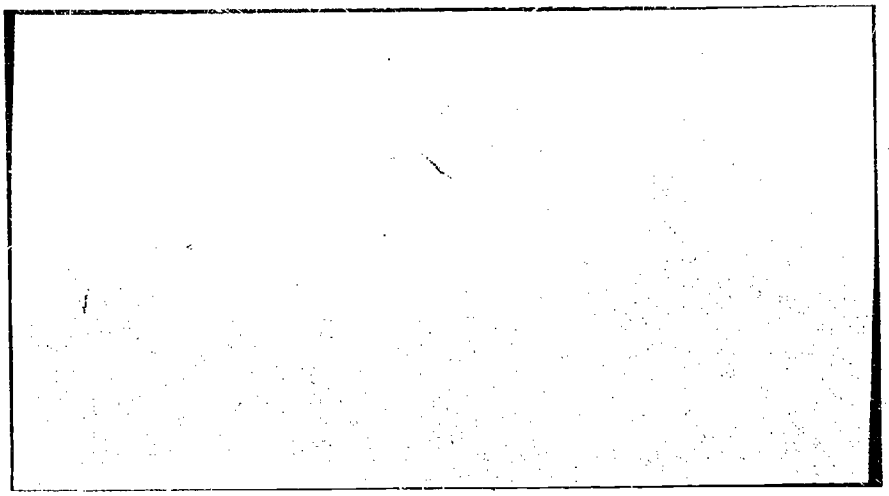
EARLY CHILDHOOD EDUCATION FOR HANDICAPPED CHILDREN

THE DEPARTMENT OF SPECIAL EDUCATION
THE UNIVERSITY OF TEXAS AT AUSTIN

STAFF TRAINING

A MONOGRAPH



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Program for Staff Training of Exemplary Early Childhood Centers for Handicapped Children

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THE DISTINGUISHED STAFF TRAINING MONOGRAPH SERIES

SPEECH AND HEARING SERVICES IN EXEMPLARY EARLY CHILDHOOD EDUCATION CENTERS

By

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Vol. I No. 3

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I. INTRODUCTION

The traditional speech and hearing program in the school setting has been characterized by its separation from the academic program of the classroom. To a great extent this separation has been both philosophical and physical. Although there has been some attempt, probably, by both speech clinicians and classroom teachers to make the kinds of things that go on in speech sessions relevant for the children in their everyday speech environment, actual experience indicates little concerted effort to make the practice a part of the curricular experiences the children are having. True, there have been expressed attempts on the part of speech clinicians to inform teachers of the types of activities the clinicians are engaged in with the children during the therapy sessions, and attempts to find out from the teachers if the children are demonstrating any of their improved or changed speech skills in the classroom. Beyond this type or degree of contact, most persons involved, both teachers and clinicians, would probably admit that there has been little directed effort to coordinate the programs philosophically. If this is a valid description of the traditional speech therapy program, most speech clinicians and teachers would probably attempt to rationalize this separation on the basis of relative levels of preparation for understanding of

roles and procedures and the separatist tradition of specialization.

In the physical sense, the separation has been visible in the process of having the child leave the classroom to go to the speech session and then return to the classroom at the completion of the session. If the clinician drops by the classroom to pick up the children for the speech session, there then may be token interaction between the clinician and teacher, but these doorway conferences may actually be worse than no conferences at all. If the more usual situation exists, however, then the children are made responsible for getting to the speech session and even token teacher and clinician interaction is impossible. This separation is usually explained by the scheduling situation and the amount of valuable time consumed in having the clinician call for the children. In some types of speech improvement activities, the clinician has gone into the classroom and worked with all the children together on some aspect of speech behavior such as general articulation, or phonics activities, or fluency improvement; but these activities are not traditionally considered clinical speech activities. Also, the classroom speech improvement program may serve as an off period for the classroom teacher and she leaves the classroom to go to the office or to the teacher's lounge or to work on lesson plans. In any event, the teacher may not be present to observe or, even if present, may not feel obligated to interact or implement the follow-up of the speech program. Descriptions and explanations

of practices and procedures in school speech and hearing programs are available in several publications (Journal of Speech and Hearing Disorders, Monograph Supplement 8, 1961; Black, 1964; Irwin, 1965; Van Hattum, 1969).

The downward extension of the traditionally structured speech and hearing program into early childhood education centers such as the nursery school or kindergarten has not taken place to any great extent even in the public school supported programs. Admittedly, there are early childhood education facilities which have speech clinicians as consultants or as staff members, and they provide some speech services particularly for the child who has an organically-based problem but this provision of speech services has not been a routine part of private and community sponsored early childhood education programs. This is not to imply that concern with speech acquisition is not an important part of nursery school and kindergarten curricula but that the concern has been with the normal not with the abnormal (Leeper, et al, 1968; Todd and Heffernan, 1964). A subjective judgment of population selection in private early childhood education programs, particularly, would lead to the idea of exclusion of children with various types of handicaps. This exclusion is predicated, probably, on the feeling that the children with problems require such specialized help that the traditionally-trained nursery or kindergarten teacher is not able to cope with the problems.

Also probably as a result of the lack of early education opportunities for handicapped children, segregated programs for special types of handicaps have been developed. Public and private facilities have been established for the young deaf child, for the preschool age child with cerebral palsy, for the young blind child, and the mentally retarded child, but these programs have encouraged the separation of these handicapped children from their non-handicapped peers. This situation of segregation has probably worked to the detriment of both the handicapped and non-handicapped child from the standpoints of social and psychological development. Again the rationalization for this situation comes from the fact of the specialized training needed to help these children with special problems. The young deaf child needs particular approaches to facilitate his development; the young blind child needs specialized equipment and experiences. The usual training for the early childhood education teacher does not include principles of special education; the usual training for the special education teacher does not include in-depth training in the processes of preschool experiences for the handicapped child.

Additionally, there has been little apparent effort to develop any type of preschool experience for children with oral communication problems in general or in particular outside of community and/or university sponsored speech and hearing clinics. The child with delayed speech acquisition without other obvious physical

abnormalities has been excluded, traditionally, from private early childhood education facilities, particularly below the kindergarten level. Even in some public school kindergartens, speech therapy has been reserved for the severely involved usually because of the belief that the upper limits of speech acquisition are at the sixth or seventh year of life and most early speech delays will right themselves by this time and also because of the shortage of competent speech clinicians. Common observations and a growing body of research evidence (Lenneberg, 1967; Hess and Bear, 1968) tend to indicate that the older ideas that children may "grow out" of early speech delays are no longer tenable and the "wait and see" approach may actually be permanently harmful to children experiencing speech delays. The vast majority of children have well developed oral language processes by the ages of five or six and this should point to the importance of the early years for speech acquisition for those children not demonstrating a progression through the expected (normal) stages of speech performance. Children with early speech delays need the experiences of structured early childhood education.

It has been only in the past few years with government-instigated and -sponsored day care centers and head start programs that there has been any concerted effort on the part of early childhood education facilities to look at the problem of children with oral language handicaps. These programs have been designed primarily

for those children who come from socially impoverished homes and in many communities there is still no provision for children with delayed speech acquisition from more advantageous situations.

In this brief statement of background of the problem, there has been an attempt to point up two aspects. One is the segregation aspect which separates the handicapped child from the non-handicapped child in early childhood education facilities. The related aspect stems from the shortage of persons trained in both early childhood education and some phase of special education. The field of special education does educate teachers in both, but the teachers specialize in work with children with cerebral palsy or those with significant hearing losses and once again there is separation because of specialization. Moreover, in the traditional training of speech and hearing clinicians, there has been little effort in the direction of acquainting clinicians with the processes of early childhood education. The clinicians know something about child development, but little about preschool techniques and educational procedures. Therefore, few early childhood education facilities exist for children with significant oral communication problems and because of this lack, there is not a large body of information or prior practice available to direct persons in the program development of early childhood education centers including children with communication disorders. Probably one of the best known of the pre-academic centers for children with communication disorders is that one which is a part of the Houston Speech

and Hearing Center. In this center there has been a very definite program designed for combining a preschool curriculum with speech acquisition practices and directing them to the needs of children with communication disorders (Bangs, 1968).

II. DESCRIPTION OF THE COMBINED PROGRAM

The impetus for designing this particular program comes from the situations which exist in the Exemplary Early Childhood Centers for Handicapped Children and author bias of the need to look again at the types of programs which can be made available to all children, handicapped and non-handicapped, in a preschool setting. The type of program which is being projected is one which would involve close coordination between the speech clinician and the classroom teacher in their attempts to meet the needs of the children with significant communication problems in these early childhood education centers. The teacher and the clinician would work as a teaching team to meet the general and particular needs of the children. In the present instance, there will be little attempt to spell out the details of the therapeutic-educational processes because these processes are well known by competent clinicians and teachers, but there will be an attempt to describe program procedures which would be applicable in a situation where the speech clinician becomes an important member of the early childhood education center staff.

Simply put, the structure of this combined program would involve the physical presence of the speech clinician in the early childhood education facility's classrooms for a significant portion of the time in order to implement all aspects of the educational

process of diagnosing and remediating significant communication disorders of the children within these classrooms. Therefore, in this setting there will be no need to physically remove the child from the classroom for speech therapy because the speech clinician will come into the classroom and be a regular member of the teaching staff in the facility. The major portion of this presentation will deal with the implementation and advantages of the combined program from the standpoints of the training coordinator, the teacher, the speech clinician, the children, and the parents of the children.

STRUCTURE

The physical structuring of the program would necessarily vary from one early education facility to another, but a specific case can be cited for an example. The center has eight rooms with twenty children in each room. It runs nine months of the year with one-half day sessions; there are four classes in the morning and four in the afternoon. The speech program would be structured on a modified block or intensive cycle scheduling plan. There is some evidence to indicate that the block plan is as an effective way of modifying speech behavior as the traditional twice-a-week for thirty minute periods has been (MacLearie & Gross, 1966; Van Hattum, 1969). In the combined program the block plan could have at least two and maybe more variations. Both variations would require the clinician to spend a block of forty hours in each

classroom. In one plan, the clinician would spend approximately a half day in each of two rooms for two months and then move on to two more classes as shown:

	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May
A.M.	1 (room)		3		5		7		
P.M.	2		4		6		8		

The other plan would involve a shorter period of time in each room each day (two hours) but the same total amount of time (forty hours) with each class for the year as shown:

	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May
A.M.	1 3				5 7				
P.M.	2 4				6 8				

Both plans provide for make-up days in May as needed because of holidays and other time-consuming breaks in the routine of the school term. Also if the facility plans on the forty hour time schedule, then the clinician can spend some time in each segment on records and in parent conferences and other responsibilities which come up to interfere with in-class time. The days in May will then provide some needed flexibility.

For a larger facility, it might be possible for the clinician to spend two hours a day in a room on a three month rotation and

that way twelve classrooms could be covered but for only a thirty-hour block. The details as to the scheduling are not so important as the basic premise behind the plan which is that the clinician becomes a part of the classroom for a sufficient period of time to decide what speech program needs to take place and to begin the implementation of the concentrated portion of the speech program. After the concentrated part is over, it is probable that the classroom teacher can maintain the program within the regular activities because she has been present for the complete program. The speech program would be self-sustaining within the regular classroom framework.

There needs to be some consideration of the daily schedule within the classroom. It is difficult to prescribe exactly what speech activities will take place and when they will occur in any particular classroom. These things will depend on the daily schedule which will be set up jointly with the teacher and the clinician with consideration of the curricular needs which must be met. The subsequent section on content indicates how the speech program combines with the curriculum as far as subject matter is concerned. In scheduling however, it is projected that some of the speech activities will be conducted with the group as a whole, especially those things concerned with general theory; some activities will be conducted with subgroups of the classroom population, especially those procedures involving drill and practice for

effective realization. At any one time, there may be some activities being directed by the teacher with one group of children and speech activities being directed by the clinician with another group of children, or the children may be in a total group for instruction or explanation of a procedure directed by either the teacher or the clinician.

Little has been said about the population for which this program has been planned. It is probable that the population in any early childhood education center will need a speech development program of some nature and certainly a center serving children with various types of physically handicapping conditions will profit from a speech program such as the one described.

CONTENT

The content of the combined program would consist of the planned curriculum of the early childhood education program with the application of speech development and speech modification theory to this curriculum. There is little need to elaborate on either curricular considerations or speech theory but a brief reminder of the types of content involved will show how the two processes overlap. Standard early childhood education references (Todd and Heffernan, 1964; Leeper et al. 1968; Hymes, 1968) have included in these the program aims of social, emotional, physical, and intellectual development realized through the specialized areas of language arts, physical development (health and safety), mathematics

(time and space relations, numbers), social studies (environment and culture), music and art, etc.

The major areas of concern in speech acquisition and remediation are such things as intelligibility (strongly related to articulation), vocabulary (both comprehension and expression), grammar (how children put words together), verbal fluency (how facile and rhythmical is the children's use of speech), usefulness of speech for environmental interaction, vocal quality, etc. (Johnson et al. 1967; Irwin, 1965; Van Riper and Butler, 1955; Van Riper, 1963; Byrne, 1965). A brief summation of the procedures of the combined program from the standpoint of content would be that the teacher provides the experiences and the speech clinician provides ways of talking about these experiences.

A specific example of curricular and developmental and remedial speech activities overlapping is included. In the portion of the classroom program concerned with physical development, the speech clinician could work with the children on the use of large and small muscles for speech and lead the children through a series of physical activities designed to improve muscle coordination for speech. Also, here, the clinician could take the children through motor imitation drills designed specifically for the speech mechanism like tongue-tapping or lip-pursing.

For science activities and concepts, it might be possible to fit into the section of the curriculum on body parts and their functions information about the speech mechanism and how it works

and the ear and how it works. Of course, these explanations would have to be simplified but it could make an interesting tie-in to the speech activities. For that part of the curriculum having to do with number concepts and spatial and temporal concepts, the speech clinician could present activities designed to help the children explore the space within the oral cavity and the spatial relationships assumed by the tongue, palate, teeth and lips in producing various sounds. The vocabulary for relating these postures could also be the responsibility of the clinician. Understanding of such phrases as "put you tongue between your teeth; place the tip of your tongue behind your upper teeth; put your upper teeth on your lower lip, etc." would be an essential part of the speech program.

Rhythm as an integral part of speech and speech activities comes naturally out of the music portion of the early childhood curriculum. If rhythm is the organizing principle of speech which has been advocated by Lenneberg (1967) then the recognition and imitation of rhythm patterns in music can be used for speech purposes. Pitch variations related to inflection can be explored for both speech and music. Speech patterns stressing rate, rhythm and inflection can be dealt with in the musical program. The beginnings of auditory discrimination training can begin here with the children learning to differentiate between two sound producing instruments on a basis of sound alone or with the children differentiating between sounds on the basis of pitch differences or

loudness differences, etc. The music program lends itself readily to the process of learning to listen which seems to be integral to speech acquisition and development. The children can be taught to listen to sounds, to classify their sources and categorize them according to likenesses and differences.

Most social studies activities in the early childhood education curriculum seem related to experiences within the child's environment which is the home, school, the neighborhood, community, etc. These activities are excellent for vocabulary building and language usage. The children can play store and realize the importance of knowing names of things one wants and how to go about asking for them. Or he can go to the playground and recognize the help speech is to him in playing with other children or getting them to play with him. Or he goes to the fire station and learns the name of the equipment the fireman uses, etc.

With all of these opportunities to incorporate speech activities into the curriculum of early childhood education, it seems a type of redundancy of effort to have a special period for language development and yet most programs provide for such a special program. It is probably because of a lack of interaction between early childhood education specialists and speech acquisition specialists and speech pathologists that such a division takes place without the realization that speech is a tool which is basic to learning and an integral part of all areas of development, social, emotional, physical, and intellectual. Nevertheless, a

special language program is written into most preschool curricula and it usually includes such things as vocabulary acquisition, articulation, fluency, idea organization, syntax, listening, learning about language, etc. These things cannot be taught out of context and the advantage of the combined program is that the speech program can be integrated into the total program and become a part of the context. The speech clinician in the classroom can effect such a total program and make language relevant.

The above are examples, only, of how the content of the program can be utilized for the speech program. After a period of working together the teacher and the clinician will probably come up with many more ideas and details as to program arrangements.

In the subsequent sections, attention will be directed to the advantages of and responsibilities for the combined program on the part of the various persons involved in the program. Because it is a team approach, coordination and understanding of each person's role is necessary.

III. PERSONNEL

TRAINING COORDINATOR

The major advantages and responsibilities in the combined program for the training coordinator are to be found in program and curriculum planning, scheduling, equipment and materials, staff training, and parent information. The combined program will change the traditional responsibilities of the areas of program management.

In the brief description of the program content, the overlap or coordination of the speech program in the regular classroom program was pointed out. This would certainly work to the advantage of the training coordinator in curriculum and program planning for he will not have to consider a plan for two different activities but can develop one subject matter curriculum which can be multipurpose in use. One field trip experience can serve the purposes of both speech and the regular curriculum. One set of materials can be used because all activities are tied to the central curriculum and the same materials can be used in both programs. The materials may be used in different ways by the two specialists in the classroom but the same basic materials can be used and the different uses of them will only serve to enhance their appeal and will add variety to their use. It will be necessary for the training coordinator to work closely with both

teacher and clinician in designing and implementing the curriculum of the combined program but it will be a coordinated exercise which will lighten the responsibility of each individual involved. The coordinator will have to be rather knowledgeable about the aims and contents of both the early childhood education curriculum and the speech development and remediation program.

An additional advantage in this phase of the combined program would be in expenditures for materials and equipment. There may be some equipment needed for the curriculum implementation that would not be useful to the clinician or the speech clinician may request something special like a tape recorder (which is actually a rather routine piece of classroom equipment in these days) or an audiometer. But even with these special requests, the financial outlay for equipment and materials is considerably less if the two programs are combined.

Another tremendous advantage of the combined program for the training coordinator would be in the area of scheduling. Scheduling, of course, always involves the efficient use of space, personnel, and equipment over a particular unit of time. The program will provide for more effective use of space in utilizing the classroom totally and making unnecessary the use of an additional room for speech activities. In view of the fact that the children will not be going in and out of the room for speech activities, the coordinator will not have to be concerned with overseeing the scheduling problem of determining the best times for the children

to be in and out of the classroom. Some training coordinators might argue that the program does not provide for the most efficient use of personnel because the speech clinician is not spending his time exclusively with the children with speech problems and therefore he is not using his time and talent efficiently. To some extent this is a narrow-minded viewpoint because if the clinician is able to diagnose and remediate those early speech problems then the child's future learning career is going to go easier. By interacting with all the children the clinician is in a better position to observe and pick up those early problems and get started working on them. In the long run then, the combined program may be more economical in that it may prevent later and more firmly established speech problems. So the time spent by the speech clinician in the classroom is profitable scheduling from the standpoint of the coordinator and the long run success of his facility.

An additional advantage from the standpoint of the training coordinator would be in the in-service training program of the center. The needs of the classroom teacher and the speech clinician for background and supplementary information about what each is doing would be obvious and clear-cut if they have shared in experiences in the classroom. The in-service training program would be very practical from the standpoint of true integration of the types of experiences being provided the children by the two disciplines and why each discipline does the thing it does. There

could also be some helpful suggestions for curriculum modifications coming out of the kinds of interactions taking place; procedures that could be changed which would be beneficial to the speech programs, and procedures which could be enhanced or modified to some extent, or in some way which would be beneficial to the total curriculum. In this sharing of knowledge and interaction, these persons would go out from the in-service program with a great deal more information and knowledge about the processes of each discipline and possibly this could work to the benefit of both programs and to the benefit totally of the kinds of experiences that the children are getting in the classroom. A professional advantage to the in-service program would be in the development of a new breed of specialists. The teacher learns about speech and the speech clinician learns about the classroom. At the present time our colleges and universities are not turning out individuals who are expert in both areas. This lack of persons who are expert in both early childhood education and speech and hearing services has probably influenced, to some extent, the way the programs for preschool children have developed and, if, through in-service training and the combined program, it is shown that these programs are beneficial and helpful, then it may eventually influence the appearance of a specialist who is trained in both areas. The need for this type of a teacher-clinician has long been pointed out by Dr. Tina Bangs of the Houston Speech and Hearing Center (Bangs, 1968).

The training coordinator can design in-service training programs which emphasize such things as: 1) recent research in early childhood development, 2) psycholinguistic theory and speech acquisition, 3) curricular modifications for speech processes, 4) team teaching in the early childhood education center, 5) recent research in learning and behavior modification, etc. There will be no attempt to spell out the themes of the in-service training program but these suggested titles serve as examples of the types of topics which should be of concern and interest to the professional personnel of the early childhood education centers.

The training coordinator will also recognize a need to subject this combined program to some types of research to study effectiveness and effects of the program. Research studies could also be a part of the in-service training program and the details and implementation of the studies could be worked out in the in-service program. For example, studies could be designed to measure the attitudes of the professional personnel to the combined program or the attitudes of the parents to the program. Attitude change studies could be designed which would measure the attitudes of teachers to speech therapy at the beginning of the semester and at the end of a period of interaction with the speech clinician. Or studies could be evolved which would measure the speech skills of children involved in the combined program with those of children in a traditional program. A study which would measure the knowledge of speech processes of the classroom teachers at the

beginning of the year and at the end of the period of clinician interaction might reveal something about the instructional aspects of the combined program.

Another kind of advantage for the training coordinator which might come out of the combined program would be in the planning and execution of the parent program. With both programs combined the parent has to become involved in only one program and he gets a sense of a unified approach to his child rather than a compartmentalized approach. The program can be directed to the influences of the total behaviors of the child that the preschool is interested in. The coordinator will need to plan only one set of parent programs to cover all aspects of the program and the parents' responsibilities to the program. Additionally, parent conferences can be joint conferences with parents, teacher and clinician all meeting together to discuss particular aspects of a particular child's behavior and the relationship of this behavior to the child's adjustment and success in the program.

There has been no attempt in this section to enumerate or describe all the responsibilities of the training coordinator in the combined program or to suggest all the possible ways in which the coordinator can implement the program. The intent is to suggest aspects of the combined program that the coordinator may want to consider or plan for as he attempts to administer or execute such a program.

CLASSROOM TEACHER

The advantages of the combined program may not be too obvious from the viewpoint of the classroom teacher. She may feel initially resistant to the idea of having a professional equal in her classroom for a significant portion of time. But this resistance may be overcome rather quickly if the program is well organized and fully supported by the other persons involved. The greatest advantage for the teacher would seem to be in the team effort to meet the needs of the children. It would be a support to the philosophy of dealing with the whole child in a package rather than dividing up his needs and the ways to work through these needs. Instead of a feeling of frustration as to ways of helping the young stutterer or the hard-of-hearing child, the teacher would begin to understand ways of working with these children as she observes the clinician's approach to them. She would learn techniques of teaching these children with communication problems and ways in which they may engage in successful communication.

The team effort would also extend to the work with the parents of the children and the counseling process for them. The teacher and the clinician can work together in designing ways in which the parents can assist in implementing aspects of the education process at home. They can share in the responsibility of recommendations to the parents about how the children should be managed at home and the future educational course for the children.

Another advantage would be in the growth and understanding of the classroom teacher of the speech therapy process which should be of help to them in working with young children who are at critical points in their speech acquisition process. The teacher would have the opportunity to observe and help in the implementation of techniques of speech and language development. Most early childhood educators have not had intensive or extensive training in this area, although they may have had a course or two in it. The combined program would give the teachers a first hand opportunity to see speech therapy or speech development techniques in a day to day situation and to see how the children's communication behaviors do change as a direct result of the kinds of things that happen to them in the applied speech process.

An additional fringe benefit for the teacher would be to have someone present in the classroom with whom to interact and to use for feedback purposes. It would also be helpful to the teacher in fulfilling the obligation to see that the children practice and put into effect some of the things that are happening in speech therapy. In the traditional program, the teacher really has not had this opportunity to interact and be a part of the total development of the children. Perhaps, the teacher has been asked to help the children with their speech problems but this request has not been accompanied, frequently, by the details of how to do it. She has been told to ignore Johnny's stuttering during "show and tell" but she has not been shown how to make the speaking task

easier for him. In the combined program, she will be able to see how the speech clinician handles the situation.

Additionally the classroom teacher can carry on aspects of the speech program after the clinician's time in the classroom is over. In other words, at the conclusion of whatever span of time it is decided the clinician will spend in the classroom, forty hours or thirty hours, the classroom teacher would be equipped to carry on some of the speech processes and continue to aid the children in the development and improvement of their speech behaviors.

The classroom teacher will have major responsibility for the organization of the combined program within her classroom. This is not to say that there will not be some shared responsibility with the clinician but it is the teacher's domain and the clinician will be there for only two months or so and the teacher has the responsibility for seeing that the content needs of the children are met. The teacher may want to organize the program with maximum usefulness for the clinician during the period of time the clinician is in the room. This would mean then that certain aspects of the program would be given more coverage before and after the clinician is in the room. Much of the credit for the success or failure of the combined programs will be the teacher's. They can cooperate and accept the clinician and what she does as a valuable part of the program or they can make the clinician feel that she is an imposition or a disruption to the early childhood education program.

SPEECH CLINICIAN

In view of the fact that this combined program is being advocated by a speech clinician, the advantages of the program to this professional area are going to be most numerous. The responsibilities may also be heaviest for the clinician. As mentioned earlier, the classroom teacher may be the ultimate key to the success of the program because of her acceptance or rejection of it; but whether or not the classroom teacher accepts the program may depend on the effectiveness of the clinician in implementing her portion of the program. If the clinician will assume a responsibility for learning something about early childhood education in an attempt to make the speech program fit in easily and efficiently, if she will assume a responsibility for helping the teacher learn something about the clinical speech process, if she will do a little more than her share in program planning and in-service training and in the parent program, then the clinician will show by actions that she is interested in and concerned about the total program not just her part of it. Because of her willingness to become involved totally she will begin to realize the many advantages of this combined program.

One of the strongest advantages will be found in the fact that the clinician becomes a part of the group and not an outsider with whom the children have no frequent or constant interaction.

The combined program provides, in psychological terms, a common history between the clinician and the occupants of the classroom. This common history will result in a number of advantages for the therapy process. The clinician will know what is going on in the classroom and the kinds of experiences the children are having which will help in vocabulary building and selecting the kinds of speech tools the children need to get along in the classroom as well as out of the classroom. The clinician will have a ready-made content for speech practice. By being a part of the group, the clinician will be able to discuss with the classroom teacher the communication goals that they both want to reach with these children and help each other realize these goals.

The combined program makes the speech work a part of the curriculum and this provides as least two more advantages. The clinician will be able to use the materials and equipment in the classroom which are tied into the curriculum and will not need separate sets for the children from each different classroom. Another advantage of speech in the classroom is that it does not set the speech program apart as something different or unusual. A frequent complaint about the traditional school therapy program is that it makes the children look different because they are removed from the classroom for a period of time. The other children are curious about where they went and what happened to them and the separation from the classroom gets to be a negative point of difference. In the combined program, because the children are all a part of the program, they will be aware of all the things that

happen in the speech program and therefore aware of and more understanding of all kinds of differences in communication behavior and the kinds of remedial devices such as hearing aids and what they do. These will not, then, be points of differences or curiosity but will be commonly experienced things which are known about and understood and accepted.

Another advantage of the combined program is that the clinician gets to know the children and their behaviors as they appear in different settings. The clinician observes them in the classroom, on the playground, on a field trip, rather than in the relatively sterile and isolated setting of the therapy room only. The opportunity to observe the children in their interactions with each other will also be there.

The combined program represents a time saving process in that the children do not have to go in and out of the classroom and spend time getting to the therapy room. The clinician does not have to spend time hunting up the children when they do not show up for therapy. In the classroom there is always someone or some group to work with so the clinician does not find herself without something to do for thirty minutes because a child is absent. This certainly provides for a more efficient use of time. Additionally, in the combined program, there is less distraction and interruption in the on-going classroom activities. The speech program is a part of the classroom activities and when the speech

groups form this is a routine thing and no one asks where the children are going and when they will be back, etc.

Additionally, by being a part of the classroom process, the speech clinician will have to learn about the overall development of young children which is something given lip service in our training programs but frequently not carried out with any fervor. The clinician will also be forced to learn something about pre-school curricula. This forced learning should work to the advantage of the clinician for the present situation and all future work with young children who have communication problems.

The strong advantages of the combined program for the speech clinician will be in the actual evaluation and therapeutic processes. For communication behavior, the evaluation process is two-fold. One aspect consists of the observation of the communication behavior of the person with the speech problem. The other aspect consists of types of formal testing of the communication behavior. The clinician then makes decisions as to the nature and extent of the problem as well as the best probable treatment approach on the basis of the observations and testing. A complete evaluation of the problem is crucial to a good solution of the problem.

The observation aspect of the evaluation process is greatly aided by the clinician being in the classroom. The clinician can observe the children in a relatively relaxed and usual situation in which they are interacting or not interacting with their classmates. Observations can be made of the way the children use or

do not use speech in the classroom and playground experiences. Speech clinicians have long been aware of the inefficiency of the traditional evaluation approach where the child is removed from the classroom and taken to another room by a relative stranger and asked to tell about some pictures or talk into a tape recorder. It is reasonable to assume that the clinician is getting a less than adequate sampling of this child's habitual speech behavior in such an isolated situation. In the combined program, after the period of observation is over the clinician can then decide on the more structured formal testing that needs to be done. When this formal testing is done it may be necessary to move out of the classroom for a short period of time but it should not take as long as when there has been no classroom involvement. The combined program should certainly provide for a more efficient, earlier evaluation so that the clinician is not spending an inordinate amount of time in diagnosis and evaluation rather than in the remedial activities which the children need. With the observation going on in the classroom there will be more opportunity for the clinician and teacher to exchange information and opinions about the significance and meaning of the different types of communication behaviors the children display. In view of the fact that the clinician will be moving on to another classroom after a period of time, the teacher will be able to continue the evaluation process in the absence of the clinician. The classroom teacher will be able to recognize and evaluate the ongoing progress of the speech

patterns of the children after the clinician has ended the relationship with this particular class.

There are also several advantages in the combined program for the therapeutic process. One of the greatest advantages would be the opportunity to work with groups of children. In view of the fact that speech is a social behavior, it seems reasonable to develop ways of practicing it in a social context. Also there will be little advantage to differentiating among the various types of disorders but the groupings can be on a basis of communication needs rather than symptomatology or etiology. The clinician will be challenged by the need to work out general speech procedures which will be applicable to all kinds of communication disorders and needs in the classroom from the standpoint of small group processes. There will be little or no need to develop therapy procedures designed specifically for the one-to-one relationship.

Children of the preschool age are usually unable to attend to any activity for any significant period of time. After a brief exposure to anything which requires attention, they usually become restless and inattentive. Most speech procedures initiated in the traditional program require some attention and concentration because the children are removed from the classroom for thirty or fifty minute speech sessions two or three times a week and there is an urgency to get a lot accomplished in these periodic encounters. With the speech clinician in the classroom, it is possible to structure brief periods of speech related activities and fit

them in periodically throughout the day when appropriate to the ongoing activities. This would not require the sustained attention of the children to something which may seem not a part of the ongoing class activities.

The combined program will provide ample opportunity for the clinician to see how the child uses his improved or improving speech patterns in routine situations. The clinician can provide on the spot help and advice and can also see where things are going wrong or right for speech within the classroom environment. It also provides an opportunity for immediate consultation and interaction with the teacher concerning communication behaviors which are observable in the classroom.

THE CHILDREN

There seems to be little point in the redundant spelling out of the advantages of the combined program for the children involved. A brief enumeration at this point should serve as a reminder.

All of the children are involved in all the programs. There is no separation out of the children who may have special types of communication disorders. Various parts of the speech program may be emphasized for certain of the children; for example some of the children may be exposed a little more frequently to auditory training if this seems to be their area of difficulty, some may have more drill on motor aspects of speech, some may have more

opportunity to practice fluency in structured speech situations, etc. But even with this emphasis it will not constitute a point of difference because all children will be included in all parts of the program, some will just spend a little more time in one activity than in another.

Secondly, the children will be working at all times with someone who is a part of their everyday experiences. The clinician will be another member of the classroom team and not a relative stranger or occasional visitor to the children. Not only will the clinician get to know the children and their ways of doing things and working but also the children will get to know the clinician and her way of doing things and working.

Additionally, with the clinician present in the classroom, the children are helped to implement at all times the speech skills that have been taught during the speech program. Under the traditional program, the children tend to do well in the therapy sessions and feel some success but they may have trouble with the carryover part of the program. It helps to have someone there a significant portion of the time to help the children continue in their successful speech attempts.

There is some uniformity for the children. They are not exposed to one set of materials and subject matter with the teacher and another set with the clinician. There is a unipurpose and singularity of approach which keeps confusion to a minimum. There is a relevancy between one thing and another of the activities and

procedures in which the children are engaged. There is an established routine in which the children are to move and this provides a sense of security for them. They know what is expected of them in most of the classroom and extra-classroom situations.

The children become cognizant of and accepting of individual differences. The mysteries of why some of their peers wear hearing aids and why some of them talk one way and others talk another way become less mysterious as these differences are accepted and not allowed to make a difference by the adults in a classroom. Everyone gets to wear a hearing aid and to hear what happens to sound when it is amplified, they get to find out what happens to what they say when they protrude their tongues between their teeth or speak with a high pitch or try to talk when someone else is talking. Differences then become understandable and therefore not notable in these situations. In conversation with directors of nursery schools and kindergartens when I have attempted to get children with significant communication problems accepted in a preschool program, they frequently imply that it is difficult for the children to come into their programs because the other children will not accept them or will not play with them because of their speech patterns. This situation will not come up frequently in the combined program because the situation minimizes the points of difference.

THE PARENTS

Advantages for the parents of the children in the program

should also probably be obvious by this stage of the discussion. The strongest advantage should be in the improved speech performance of their children and this is what we are all about. An additional advantage is in the package deal and the unified approach. Their children are being treated as wholes and not divided up into parts.

An additional advantage will be in the unified approach to the parent. They will be included as part of the total program and they will not get some advice from the teacher and some advice from the clinician but the conferences will be combined and singular in content. Since the teacher and clinician are interacting they know what each is attempting with the children and their parent conferences reflect this understanding in the types of things they ask the parents to observe and implement at home. At a practical level it will involve only one trip to the school rather than two when it is time for parent conferences. Also there is more opportunity for the clinician and parent to interact daily if necessary when the parent delivers or picks up his child. Under the traditional program, these frequent encounters are less possible because the clinician may not be available at the start of the school day or at its conclusion.

IV. SO WHAT?

So, what has been described here is a new wrinkle in the fabrics of both early childhood education and speech and hearing programs. The attempt has been to explain and argue for a truly combined program, not just the addition of speech therapy or speech development to the early childhood education curriculum, not just the addition of a speech clinician to the already existing staff of the classroom, but an actual combination of the two professional philosophies and procedures. There is no extensive amount of research to guarantee the success of such a program but there is a logic behind it which makes it a good risk for success - success from the standpoint of improved speech skills and socializing experiences for all the children involved.

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V I T A

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EDUCATION

High School -- Thomas Jefferson, San Antonio, Texas -- 1945

Universities --

Trinity University, San Antonio, Texas -- 1945-1946
The University of Texas (at Austin) -- 1946-1949
B.A. in Speech -- 1949
M. Ed. in Educational Psychology -- 1953
Northwestern University -- Summer, 1954
University of Wisconsin (at Madison)
Ph.D. in Speech -- 1958

WORK EXPERIENCE

1949-1953 -- Eloise Japhet School for Cripple Children
San Antonio, Texas -- Speech Clinician

1953-1960 -- North Texas State College, Denton, Texas
Director of Speech and Hearing Clinic

1953-56 -- Instructor of Speech
1957-58 -- Assistant Professor of Speech
1958-60 -- Associate Professor of Speech

1956-1957 -- University of Wisconsin (at Madison)
Graduate Student Clinic Supervisor

1960-present -- The University of Texas (at Austin)
Supervisor of Speech and Hearing Clinic and

1960-66 -- Assistant Professor of Speech
1966-69 -- Associate Professor of Speech
1969 -- Associate Professor of Speech and Education

BASIC AREAS OF PROFESSIONAL INTEREST

Speech Pathology

Supervision and program administration in speech pathology and audiology

Diagnostic methods in speech pathology

PROFESSIONAL ACTIVITIES AND ORGANIZATIONS

American Speech and Hearing Association -- Member
Certificate of Clinical Competence in Speech Pathology
1962 Convention - Paper on "Speech and Hearing Personnel in Hospital Facilities"
1966 - Committee on Internship Year
1966, 1967 - Committee on Clinical Certification

Texas Speech and Hearing Association -- Member
1958-61 - Committee on State Certification
1961 - Treasurer
1962- Vice-President and Convention Program Chairman
1963, 1964 - Chairman of Certification Committee
196e - Business Manager, Texas Communicologist (publication)
1955 - President-Elect
1966 - President
1966 - present - Coordinator, Directors of Training Programs in Speech Pathology and Audiology in Texas

Southern Speech Association -- Member
1962 - Convention paper on "Psychotherapeutic Aspects of Group Work with College Age Stutters"

Texas Speech Association
1961 - Convention paper on "What the Public Speaking Teacher Can Do for Students with Minor Speech Defects"

Sigma Alpha Eta (National Fraternity for students in speech pathology, audiology, and deaf education)
1960-present-Faculty Advisor for Local Chapter
1964 - Chairman of Nominating Committee (National)
1966 - President-Elect (National)
1967 - President (National)

Speech Association of America -- Member

American Association of University Professors -- Member

Texas Association of College Teachers -- Member

The University of Texas at Austin

1966 - Basic Language Skills Committee - Teacher Education - College of Education

1967-68, 69 - Honors Committee - School of Communication

1969 - Conferences Committee - School of Communication

1968, 69 - Students' Use of English Committee - University

1968 - Staff Member - Learning Disabilities Center - College of Education

1967 - present - Advisory Committee - Austin Evaluation Center

Feb. 1968 - Evaluation of the Brain-Injured and Language Development Programs in the Houston Independent School District

EDITORSHIPS

Associate Editor - Southern Speech Journal of the Southern Speech Association, 1969-1972.

Editorial Consultant - Journal of Speech and Hearing Disorders, American Speech and Hearing Association, 1969 ---

AWARDS

1965 -- The University of Texas Students' Association Teaching Excellence Award

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