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ABSTRACT

The paper looks at rules for discourse in the classroom and how they may complement or conflict with each other in facilitating the learning of language disordered children in the classroom or therapy session. Six critical skills are identified which children need for a good teaching-learning interaction. They are: attention, turn taking, coherence, repair (self correction), listener modification, and informativeness. Similarities and differences in styles in clinical discourse compared with classroom exchanges are noted. Problems which speech-language impaired children have in bridging these two styles of teaching-learning discourse is analyzed using an ethnographic study of the underlying rules of the interactions. Problems of the clinician studying the classroom include physical access, psychological access, and overcoming personal biases. Examples of direct (field notes, participant observation) and indirect (interviews, role play) methods of data collection are given. A case study of a 9-year-old communication disordered boy which uses the steps of the ethnographic method is offered. The steps are as follows: identify the child; describe communication problem; interview the child; develop a summary of the problem; observe in the classroom; summarize observations and determine pattern of communication breakdown; and, validate observations. Finally an intervention plan is developed by the clinician, the teacher, and the child. (DB)

Boston University Conference on Language Development

Current Issues in Language Disorders

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Children spend time in school learning on two levels. First, they learn the content of lessons - spelling, science, history. Second, they learn the form that learning exchanges take - social interaction rules. There is a dual or as Bates (1978) terms it "in deutro" learning taking place throughout schooling. The children we see often have trouble with the second level, social interaction and communication level. This causes problems in their ability to access the first level - content and so a poor get poorer phenomenon (Donahue, 1985) occurs.

Understanding the communicative demands placed on children in the classroom and various school contexts enables us to help the child gain access to the content of learning. Given the importance of acquiring a knowledge base through schooling, development of strong classroom communication skills may be the most valuable assistance we can offer many children we see.

Today we will be talking about the rules for discourse in the classroom and the therapy room and how they may complement or conflict with each other in facilitating children's learning. We will begin by briefly discussing classroom discourse competence. A colleague, Fran Spinelli, determined six critical skills children need for good "School Talk,", that is, good teaching-learning interaction. These skills are on your handout. Let's look at these skills required for classroom competence within the context of clinical interaction.

I Attention: There are two issues regarding attention I'd like to talk about.

1. First -- the physical context of therapy

A. A small room - hopefully not next to the music or furnace room - or as in one school I worked in it was in a pantry in the cafeteria. Let's assume a small quiet room.

B. Chairs and a table - shared common space of the table connects the clinician and child. All important business conferences - government conferences - and even family conferences are conducted around a table.

C. The materials placed on the shared space of the table.

D. The clinician and child or in small group work - children seated at the table.

Although the therapy room and the classroom are within the school, differences in physical context are readily apparent.

A. The child or clinician can speak softly and be heard.

B. The clinician is seated not standing at some distance and this face-to-face arrangement makes soliciting attention much easier for both the child and clinician.

C. Infact most studies of clinician child discourse reveal very few instances in which the child <u>needs</u> to solicit attention. The clinician is focused on the child.

Once I was sitting with a group of speech pathologists discussing "my worst experience in therapy." One of my friends said that the worst thing she ever did was to come to school after a big weekend of partying

and try to conduct therapy. She was so exhausted she fell asleep and the next thing she knew the child was tapping her on the arm and saying "Excuse me, do you want me to say these cards one more time?" At least the child had practice soliciting attention in the therapy room.

2. Secondly, studies have shown that good teachers - as judged by student evaluations - use lots of attentionals. These are precursors to a conversational act and serve to hold the listener's attention. "now," "So," "O.K." and Ronald Reagan"s favorite "Well." Clinicians also use a high number of these speech forms. Children in the role-play therapy sessions studied by Ripich show the "clinician child" using 90% of all attentionals in the role-play lessons, so that even by age 6 children recognize that teachers and clinicians use this communication feature to gain attention in teaching.

In summary, two important points are raised with regard to attention.

1. It is easier to maintain and gain attention in the clinical setting.
2. High occurrence of "attentional devices" in therapy assist in framing and focusing child toward the task.

II Turn Taking: There are at least two complexity inconsistencies in classroom and intervention turn-taking, at one level.

1. Turn-taking in intervention can be more complex than in the classroom. This complexity is a result of the clinician's focus on both form and content of children's responses. The Initiation-Reply-Evaluation Sequence becomes more elaborate as shown in this example.

This exchange was taken from a language lesson with a hearing impaired child.

Clinician: What can we walk through to go into a house?	(I)
Child: Winow	(R)
Clinician: Window?	(E)
Child: Window	(R)
Clinician: Can we walk through a window into a house?	Reinitiate- or prompt variation (I)
Child: Sidewalk	(R)
Clinician: Sidewalk?	(E)
Child: Oh, door	(R)
Clinician: OK	(E)

Further study of this clinician's style revealed consistent correction of utterance form before content. In contrast, research by Hulet and Bar show that mothers focus on content before form as so do many classroom teachers.

Rules about what is being focused on need to be made explicit to the child. In transcribing this lesson from the videotape I couldn't understand how the hearing-impaired child seemed to always know whether the correction was for form or content. On further observation we discovered that when the clinician corrected form, there was less than a second delay in the evaluation - for content the evaluation came after at least a one second latency. We speculated the hearing-impaired child somehow had internalized the correction rules of (1) form before content and/or (2) form before one second delay and content after one second delay. The child must have a fairly sophisticated system operating.

2. The second issue is the reduced complexity of turn-taking in the dyad or triad arrangement of intervention. There is a much greater opportunity for taking turns in therapy. In classrooms the student who replies quickly gets the floor, in intervention more processing time is allowed. Research has indicated that monitoring turns in dyads is less demanding than in large groups. The complex monitoring demands of the classroom may affect learning for the child, even though he appears competent at turn-taking in intervention settings.

Turn-taking in clinical discourse, then, is a two level issue.

1. On one hand the instructional sequence turns are more complex because of the shifts in focus between "form" of the reply and the "content" of the reply.

2. On the other hand within the therapy dyad or triad turn-taking and turn-monitoring is far less complex than in the classroom.

III. Coherence

Topic continuation in clinical interaction was documented by Prutting et al. However, in the children's role-play intervention "clinician" topic shifts were noted as being tied to instruction, for example, the introduction of a new language task. "Child" topic shifts were most often tied to conversational topics. "I forgot my sweater," "So, I like your bulletin board." The child acting as clinician immediately reintroduced an instructional topic,"Umhum, let's do these cards now." It appears that the clinician has the role obligation of maintaining instructional topics and children have the right to

attempt to redirect the topic to more conversational areas.

Examination of actual syntax and articulation lessons confirmed the pattern of topic introduction demonstrated in the role-play lessons.

Another cohesion device is the use of nonprositional speech. This is speech that conveys no meaning but serves to connect the flow of discourse. For example:

"Let me see"

"Where am I here"

"Hum, Unhuh, and Mm"

Clinicians produced the far majority of these speech acts. It appears that they have the obligation to maintain a coherent ongoing sense of interaction.

Coherence appears to be effectively maintained in two ways - both of which are similar to classroom interaction:

1. Maintenance of Instructional Topics
2. Use of nonpropositional speech to maintain flow.

IV. Repair

Within most school intervention sessions the child has limited opportunity to request clarification from peers. He is forced to rely on the clinician for instructions.

The child has ample opportunity to repair incorrect responses as demonstrated in the earlier example of the clinician and the hearing-impaired child's revision from winow to window.

Opportunities for self correction occur more frequently in clinical discourse. An error in the classroom usually results in the loss of

the turn and a quick correction by another student.

In therapy two differences emerge: (1) the child has no one to request clarification from but the clinician; children who request clarification from peers are judged smarter by teachers - no chance to "be smart" here; (2) the child has more opportunity to repair and revise errors.

V. Listener Modification

Listener modification is tied to the way the speaker perceives the listener - and the listener's role - These role related characteristics affect clinical discourse. In clinical discourse one aspect of listener modification is also tied to attention as a conversational feature. It is ignoring. In the study of child language intervention sessions by Prutting and her colleagues, she reported clinicians ignoring but no ignoring behavior by children. She speculated that perhaps ignoring is a sophisticated discourse feature that was not present in the repertoire of the children. The subsequent role-play intervention study by Ripich showed the children acting as clinicians frequently ignored requests from the children acting as clients. These findings indicate that ignoring is a role related feature that is seen as being appropriate for clinicians but not for children. The higher status person has more rights and privileges and the lower status person has more obligations, for example - to always answer. Just how these modifications in discourse affect teaching and learning is not well understood.

She helps me talk

She helps me with my sounds

He helps me listen better.

Teachers are typically described as "making" us do things and "giving us work." This difference in perception between the two roles mav influence learning in classroom and clinical settings.

During these same interviews I asked the children what was different about what they did in therapy and what their clinicians did:

Leslie- my favorite

Mrs. Marks makes good "r'."

I make bad "r's."

Don't you ever make good "r's", Leslie

No I supposed to amke the bad "r's."

There is an implied social contract. The child is in therapy because something is wrong - and the clinician role is to be right.

Children may be modifying their speech to fit a "therapy" model of good and bad speech. In summary, we need to be aware that listener m ification may occur as role-related aspects of teacher and learner are interpreted by the child.

VI Informativeness:

This aspect of communication presents one of the most striking contrasts between clinical and classroom discourse. Children have to be succinct when they have the floor in the classroom.

Clinically we attempt to generate the most elaborate and redundant speech.

Where's the pencil? Clinician

Under your book. Child

Tell me the whole thing. Clinician

The pencil is under the book. Child.

We require sentential speech when most spoken discourse is elliptical. We are teaching children to violate the cooperative conversational principle of Informativeness, and teach children an artificial interaction style that doesn't serve them well in the classroom.

In summary -

We have documented aspects of clinical discourse that are consistent with classroom communication. However, we have also discussed clinical discourse features that are inconsistent with classroom exchanges.

In the remaining time this morning we will examine problems encountered by speech-language impaired children in bridging these two styles of teaching-learning discourse.

The role of the speech-language pathologist in the schools appears to be expanding in a variety of ways. One of the most important changes is the development of intervention beyond linguistic rule training in phonology, syntax and semantics to discourse skill development in areas such as topic maintenance, turn taking, and listening. Just as the 1970s saw school clinicians broadening their case loads beyond articulation problems to include children with language disorders, clinicians of the 1980s are opening their case loads to children with pragmatic and discourse problems. The traditional methods of assessment and intervention were amenable to carry over from articulation to language training but don't seem to serve as well in the new area of discourse intervention. This raises the issue of a second major change in school speech-language pathology. The school clinician is leaving therapy room and venturing out into the milieu of the school to conduct intervention. By becoming a more integral part of the school environment the clinician can better understand the linguistic and discourse demands placed on children in their day to day activities.

The following approach is designed to meet the needs of children with discourse problems and to capitalize on the greater mobility of clinicians within the school. It is meant to provide an alternative to traditional assessment and intervention. The approach is based on an established form of description and analysis called ethnography.

What is Ethnography?

Ethnography refers to methods of study of events and persons that enable us to ascertain the underlying rules that operate for the participants. There is increasing interest in the use

of ethnographic techniques, common to anthropology and sociology, to study the unique environment of schools. It is important to note that ethnography has a long tradition in the social sciences but for various reasons has remained outside the mainstream of communication and educational practices (Wilson, 1977; Hymes, 1982). The poverty of ethnographic work in education is a result of both theoretical and methodological limitations. However , we are moving toward a theory of children as participants in the educational process and more comfort with messy naturalistic data -- and so toward more use of ethnography.

According to Wilson (1977), there are two hypotheses that underly the rationale of ethnographic study of education. The first is the naturalistic ecological hypothesis; it is essential to study events in their natural settings because of context influences. Simply stated, if we want to learn about how a child is communicating in the classroom then we need to go into that environment and study the communicative demands of that particular context. Two types of competence will be required of the child; linguistic competence, knowledge of phonological and grammatical rules of language, and communication competence, knowledge of social rules of the classroom context.

The second hypothesis supporting educational ethnographies Wilson terms the qualitative difference hypothesis; it is essential to study behavior within the framework of the ongoing process rather than focusing on the end product.

In following Wilson's hypotheses, study natural events and examine the ongoing process, clinicians encounter the problem of gaining access. Gaining access to the classroom and its processes

is complex. Physical access, entering the classroom or placing recording devices in the context often poses problems. As long as the child is clearly identified as the person who has the problem and is removed from the room to learn to participate better during lessons, schools and teachers are cooperative. This pattern of intervention fits with tradition. An ethnographic approach that includes entering the classroom to study the child and the teacher in the teaching-learning environment challenges the established patterns. Generlaly, clinicians encounter "gatekeepers" (Corsaro, 1979a) in the form of principals, aides and teachers who feel obligated to protect the classroom from intrusion. Even though classroom teachers have referred the child and identified the problem as related to the classroom, they are cautious about allowing someone into this territory. They understand that classrooms are complicated systems and outsiders may fail to appreciate the reasons for certain rules and behaviors within this environment.

This brings us to the second type of accessing that must occur, psychological access. The clinician needs an open attitude from the teacher in order to develop a strong assessment and intervention program. Teachers may inadvertently block important information. They may be fearful of criticism. However, if teachers can see themselves as participants in the assessment and intervention process, they are willing to assist you and the child. If they feel your work is directed toward promoting better communication in the classroom, they are encouraged to cooperate.

Once having gained the cooperaiton of the teacher, the clinician is faced with accessing the child's perspective in the classroom.

Children are also wary of being studied. In addition, they perceive all adults as being aligned together and as having great power and authority. In addition to perceived power and status is the problem of physical size. Bill Corsaro (1981), in an ethnographic study of nursery school classrooms attempted to act as a participant observer. He encountered some resistance to his participation on the part of the children. A conversation, centered around Bill's size, took place early in the school year between Bill and two four-year-old girls, Betty and Jenny. Betty told Bill he couldn't play because he was too big. Bill offered to sit down on a chair but Betty insisted that he was still too big. Bill asked if he might watch and Jenny agreed but cautioned him not to "touch nuthin'." Bill agreed and Betty restated the contract, that he was to just watch. Jenny asked for concurrence by saying "OK, Big Bill?" and Bill said, "OK." Bill was eventually allowed to play and for the remainder of the school year addressed as "Big Bill." In this way the children gave him access to their play but continually noted his difference in status and physical size.

If the clinician is successful in gaining access to the classroom through the teacher and the children, the next obstacle becomes his/her own internal biases and preconceptions. The ethnographer assumes the position of a naive observer who is seeking to uncover the rules of the context. Just as the anthropologist studies many different cultures and seeks to discern the structure of an alien society by suspending prior knowledge and allowing the cultural rules to emerge from observation of daily life. The

clinician studies each classroom as if it operates as a culture within itself and poses the question "If I had never been in a classroom before, what rules would I need to succeed in this particular context?"

If we are successful in gaining access to the classroom, the teacher, and the child - we have the problem of our internal biases. We need to read, study, and become knowledgeable about interaction and then [suspend or bracket] that knowledge and say to ourselves:

If I had never seen a classroom before and I wanted to learn the rules for this culture, how would i go about studying this phenomenon?

Two kinds of data collection approaches are available to us:

Direct and Indirect.

I. Direct

A. Field notes/Charting- Outside Observer

You sit and observe, make notes, and possibly develop a system for charting actions. Tools are paper and pencil.

B. Participant Observation

You participate - not as a teacher, but as a student in the classroom.

C. Audio-videotapes

Recordings are made without any outside person present in the classroom. Cazden has shown that students eventually become acclimated and ignore the microphone and camera.

II. Indirect

A. Interviews

Interviews can be conducted. Open ended questions offer the richest source of information from teachers and students. Putting things "in their own words" adds qualitative information. It may be best to have children do interviewing of other children.

B. Questionnaires

Questionnaires are used but by preselecting questions and ratings you have biased your finding to what you think is important rather than what the teacher or child may think is important.

C. Document Review

Studies have shown that nurses write less and less information on charts of terminally ill patients as if they are disengaging from the patient. Review of teachers' written evaluations in children's school records may offer insight into how the child is perceived by the school faculty - Review of lesson plans give insight into structure of classroom learning.

D. Role-Play

Role-Play is a rich source of information as to the child's perception of a variety of persons and events. Observing role-play and drawing inferences from behavior to underlying knowledge is one method of gaining insight into the child's world.

In summary -

Ethnographic research refers to methods of study of events and persons and enables us to see the underlying rules that operate for the participants.

The purpose of this work is to investigate the nature of

occurrences rather than frequencies. For example - we may tally questions in a classroom - but every question is not really comparable to every other question. By merely equating them we lose the nature, the quality of the query.

Ethnographic Method

Case Study

The following case study follows the steps outlined on your handout.

Background Information

Steven is a nine-year-old fourth grader with a history of communication disorders. He received language and articulation therapy during first, second, and third grades for mild articulation and syntax disorders. At the current time his speech and language appears appropriate except for occasional syntax errors in verb tense. Results of language testing suggest moderate auditory memory difficulties and comprehension and production skils which are slightly below average. He exhibits a slow response to questions but generally answers appropriately. Steven is receiving assistance from a learning disabilities specialist for reading and spelling.

Step One: Identify the Child

Because of the limited language problems, limited probability of continued improvement, and enrollment in a learning disabilities program, Steven's clinician considered dismissing him from therapy. However, when the teacher was informed of the clinician's plan, she protested. Steven's teacher strongly felt that he was an ineffective communicator in the classroom. Steven was a good candidate for an ethnographic approach for two reasons. First,

his primary communication problem was in classroom discourse. Second, his ceacher had identified the areas of breakdown and requested assistance from the speech-language pathologist in developing a plan for assessment and intervention. For these reasons the clinician decided to continue to work with Steven using an ethnographic approach.

Step Two: Describe Communication Problem

The clinician initially obtained a description of Stephen's classroom communication by asking the teacher to describe Steven's problem. The teacher replied that Steven was well behaved, but did not follow instructions well. To assess performance on a variety of discourse behaviors, the clinician and the teacher evaluated Steven's interactions using the Classroom Communication Checklist in your handout. They discussed each of the eight communication areas: (1) participation, (2) soliciting attention, (3) clarification, (4) appropriateness, (5) listening, (6) descriptive ability, and (7) general speech and language skills and assessed Steven's performance relative to his classmates. Steven was reported as being less effective than most children in his class in six of these major areas. Only appropriateness and descriptive ability were judged to be average for the class level.

The areas identified as below the class average were discussed further. A general description of Steven's behavior in each area was recorded. In the area of participation the teacher stated, "Steven almost never raises his hand and when he is called on he gets a look of panic on his face." The clinician probed for specific context information by asking a series of questions.

When does Steven volunteer information? Does he ever respond to questions directed to the entire class? Does he participate in reading group discussions? Is he responsive on a one-to-one basis? The teacher reported that Steven never responds in the general class lessons, seldom participates in reading group work, and, although shy, will interact on a one-to-one basis. The clinician then asked for a description of appropriate classroom behavior in each context. This description guided the clinician in determining the teacher's expectations for Steven. Similar probes were conducted for the remaining areas where he was considered below the class level.

Step 3: Interview with Child

Based on the teacher's report, the clinician interviewed Steven. Each area of communicaiton breakdown was discussed. The interview questions were designed to be generic and to allow Steven to reveal possible motivations for his behavior. The following excerpt from the interview question on participation offers insight into Steven's perspective.

Clinician: Why do children not always answer in class?

Steven: They don't know the answer or they don't think fast enough. My mom says its better to listen

Clinician; So do you try to listen?

Steven: Yeah, that's the best way.

The other areas of communication breakdown were discussed with Steven but always without direct reference to his behavior.

Step Four: Develop a Summary of the Problem

The clinician used the results of the teacher and student

interviews as well as language test information to construct a summary of the problem. She concluded that Steven probably does not participate spontaneously in class. He may participate in a small group setting with prompts and he may have overgeneralized the rule that it is important to listen. Steven exhibits difficulty following classroom instructions. This possibly related to processing variables of memory and attention maintenance.

Step Five: Observe in Classroom

The clinician observed the class for one hour during which Steven participated in an English lesson for the whole class and a reading group for five students. In addition, she asked the teacher to audiotape the reading group lesson for three days. The clinician's four goals for this step of the assessment were (a) to see when Steven participates (b) to see how the teacher responds to him (c) to see how successful Steven is in following instructions (d) to see if the form of the teacher's instructions assist or interfere with Steven's processing of information.

Step Six: Summarize Observations and Determine Pattern of Communication Breakdown

The following information was obtained relating to the four goals of assessment. First, Steven's participation in class is limited. He asks questions only if he is missing a major piece of information. He doesn't volunteer information if anyone else can provide it. He appears tense when asked to answer questions. Second, the teacher seldom calls on Steven with the complete class present and only occasionally in a small group. Third, Steven experienced difficulty in following instructions. Fourth, the

manner of the teacher's instruction may have contributed to Steven's confusion. The following set of instructions were given to Steven's reading group on one fo the days the teacher audio taped the lesson.

Teacher: Look at page four. Read the sentences and the words underneath. Find the best words and put them into the sentences. If you have trouble reading any words, ask Mrs. Jackson (teacher's aide) to help you out. OK now let's see, on the worksheet you did yesterday, I mean the day before, you did real well, Kim. Here it is. Everyone else got their's back yesterday when you were absent. Do the ditto from the workbook first and then the other one, four.

Jimmy: Four?

Teacher: Four. And then the other one. Oh, you haven't got your pencil (to Kim). And page five is just like page four except it's different words. See if you can pronounce them and make sure you know their meaning. One word that was hard is evacuate. The word evacuate, what do you think that means?

Steven; To leave.

Teacher: What?

Steven: To leave.

Teacher: Well, yeah, if a town was evacuated everybody was leaving. Yeah. So find the rest of the words and fill them in. I want your names and dates on all of these please. Okay?

Analysis of these instructions revealed that the children were required to follow nine instructions after the teacher left. Three

of the instructions depended on oral information only (e.g., Do the ditto first then page four). Four of the instructions were aided by worksheet cues (fill in the blanks) and two were routine (give name and date). Steven experienced difficulty on the instruction dependent on verbal information only conpared to instruction utilizing contextual cues. He followed the routine instructions well. On this lesson Steven completed the assignment correctly. He asked the teacher one clarification question and a peer one clarification question. However, he was also reminded by a peer to do the ditto sheet first. Distractions appeared to affect Steven. He took an extra moment to get back to task after the discussion of the previous day's worksheet and he did not appear to attend after the teacher's discussion of "evacuate." The teacher interrupted instruction to discuss materials (Kim's worksheet from yesterday and her pencil) and to introduce new information (definition of evacuate).

In summary, Steven is willing to communicate when highly motivated, that is, if he needs information to complete his work. He is not motivated for social communication. Steven's difficulty in following instructions is probably a result of the teacher's presentation of instructions and Steven's processing difficulties. In larger groups these problems are intensified.

Step Seven: Validate Observations

The clinician, teacher, and Steven met to talk about the information obtained from the interviews and classroom observations. Steven and his teacher listened to the tape of lessons and were shown a transcript of the instructions previously discussed and both agreed that these were representative of what usually occurred

in reading group. They also agreed with the clinician's summary of the problem. Options for a plan of intervention were discussed. The teacher suggested she needed to be more systematic in giving instructions. Steven said he would like to practice "doing his work right and talking more in class." The clinician took responsibility for developing an intervention approach.

Ethnographic Intervention

When the assessment phase is complete, the next step is to develop an intervention plan that includes the teacher, the child, and the clinician. In some cases the focus of the program will be on teaching discourse rules so that children acquire the skills necessary to participate fully in school activities. The goal is to facilitate their "access to learning," a term that has been used to describe the child's ability to interact in teaching-learning exchanges with teachers and peers. Since an emphasis on teaching rules and skills without accounting for differences in context is inappropriate, discourse rules are taught with academically relevant methods. Often children with poor classroom communication have not tuned in to the discourse rules operating in this context at a time when most of their peers are competently managing these rules. For these children a direct, structured and intensive approach to discourse rule acquisition is warranted. This is not necessarily a fixed program, however. The intervention should be dynamic and allow for continuous reassessment and adjustment. There are numerous ways of designing programs that consider discourse rules. A single type of remediation may be used or a combination of several approaches may be developed. There are four main types

of intervention plans to consider: (a) traditional individual berapy, (b) construction of a mini-classroom, (c) entrance to the classroom, (d) consultation with teacher and child in an advisory role.

Based on the information obtained through interviews and observation the following program was designed for Steven. It consisted of a three pronged approach to remediation. First, individual therapy was conducted in the therapy room. The lessons focused on following instructions and asking appropriate questions. The clinician obtained worksheets from Steven's teacher that were at Steven's performance level. These were used to provide practice in following instructions dependent on verbal cues only and on worksheet cues. The clinician deliberately constructed directions that contained these cues. Steven was also given practice in reattending following interruptions. The clinician purposely inserted asides during her instructions so that Steven was forced to shift his attention and then reattend to the task. To give Steven more experience in requesting clarification the clinician gave confusing instructions. Lack of sufficient instruction made Steven request additional information and the clinician encouraged these requests.

In order to facilitate participation the clinician organized an intervention group made up of Steven and four other children who had been identified as reluctant communicators. Given this composition the children in the group were forced to speak or else endure long silences. For the initial part of each session

the clinician took the role of teacher and had students raise their hands to participate. The second part of the session involved peer teaching, in that the children took the role of teacher. They took turns instructing the group on a lesson topic. The child instructor was given information necessary for the performance of the task that was not available to the other children; he/she became the expert. The use of the expert notion to encourage children to interact more freely has been documented recently in classroom research (Cooper, Marquis, & Ayers-Lopez, 1982).

The third aspect of the plan was a discussion with Steven's teacher. The clinician reinforced the teacher for identifying Steven's problem and for her patience and acceptance of Steven's behavior. The teacher asked for suggestions and at this point the clinician discussed her plan for Steven. After explaining the individual therapy goal of improving Steven's ability to follow instructions and [illegible]ns, the clinician suggested that the teacher might want to monitor her instructions to Steven carefully. Presentation of all instructional content together with material related to other academic information being given before or afterwards was recommended. After discussing the goals of the mini-classroom group work, the clinician encouraged the teacher to begin to allow Steven to be the "expert" for his reading group and eventually the entire class. The teacher was enthusiastic about the program and appeared pleased with the suggestions.

Follow up Report

Steven was enrolled in the intervention program for four months. At the conclusion of the program the teacher reported

improvement in all five areas originally identified as being below average for children in Steven's class. She even reported improved speech and language skills although these were not directly worked with during intervention. A follow up conference three months after intervention ended revealed that Steven was continuing to improve in classroom communication skills.

The success story of Steven encourages school speech-langauge pathologists to become more aggressive about identifying and treating children with communication breakdown in the classroom. School is the environment where children spend the majority of their time and poor communication skills can severely impair their ability to develop and learn.

Areas of Conversational Competence

I. Attention - For a listener, the ability to concentrate on appropriate sources of information (e.g., speaker) and to give evidence of this (e.g., acknowledge).
- For a speaker, the ability to obtain and hold the concentration of others.

II. Turn-taking - Knowledge of rules used to initiate and coordinate speakers' participation.

III. Coherence - The ability to relate utterances through the use of topic continuation or structural ties.

IV. Repair - The ability to recognize, indicate and clarify an unsuccessful utterance.

V. Listener Modification - The ability to adjust the form and content of an utterance according to the characteristics of the listener.

VI. Informativeness - The ability to provide information that the speaker believes the listener does not know, but wants or needs to know.

Ethnographic Methods for Studying Interaction

I. Gaining Access

II. Direct Methods
   - A. Field notes/Charting
   - B. Participant observation
   - C. Audio and videotape

III. Indirect Methods
   - A. Interview
   - B. Questionnaire
   - C. Document review
   - D. Role-play

An Ethnographic Approach to Assessment and Intervention

I. Interview with Teacher

II. Interview with Child

III. Develop tentative hypothesis

IV. Observe in classroom

V. Chart communication breakdown
   - A. Breakdown
   - B. Teacher action
   - C. Child action

VI. Identify pattern of breakdown

VII. Validate with teacher, child, and additional observation

VIII. Develop intervention plan for teacher, child and clinician

Guide for Interviewing Teachers about
Students' Classroom Communication Behaviors

1. Description of child's communication problems

2. Questioning of communication skills in specific areas (Include descriptions and examples of student behavior; contexts, such as reading groups, independent study, entire class discussions; and statement of desired behaviors.)
    a. Participation
        1) amount
        2) interruptions
    b. Obtaining teacher attention
        1) manner
        2) frequency
    c. Clarification
        1) Spontaneous
        2) When requested
    d. Appropriateness
        1) Teacher interaction
        2) Peer interaction
        3) Topic
    e. Listening
        1) Attention
        2) Instructions (type)
    f. Questioning
        1) Amount (too much - too little)
        2) Content
    g. Descriptive ability
        1) Organized
        2) Complete
    h. Speech and language

3. Determination of the two or three communication behaviors which are the greatest problems in the classroom.

Butler, K., & Wallach, G. Language Learning Disabilities in School Aged Children. Baltimore: Williams and Wilkins, 1984.

This book discusses a variety of issues related to problems of the speech-language impaired child in the context of school.

Ervin-Tripp, S., & Mitchell-Kernan, C. (Eds.). Child Discourse. New York: Academic Press, 1977.

This book contains 13 chapters about a variety of child discourse topics. The ones by J. Cook-Gumperz and C. Mitchell-Kernan with K. Kernan are especially relevant to language in the classroom.

Gilmore, P., & Glatthorn (Eds.). Ethnography and Education: Children in and out of School. Washington: Center for Applied Linguistics, 1982.

This book highlights the differences between home and school interactions. Various ethnographic approaches are utilized throughout the chapter.

Mehan, H. Learning Lessons. Cambridge: Harvard University Press, 1979.

This book is an ethnographic study of teacher student interaction during elementary classroom lessons.

Ripich, D., & Spinelli, F. School Discourse Problems. San Diego: College Hill PRess, 1985.

This book discusses the development of discourse rules, discourse problems specific to mentally retarded, learning disabled, bilingual, and hearing impaired children, as well as those of speech-language impaired children in the schools.

Sinclair, J.M., & Coulthard, R.M. Toward an Analysis of Discourse. New York: Oxford University Press, 1975.

This book provides a system for hierarchical analysis of discourse during classroom lessons.

Wilkinson, L.C. (Ed.). Communicating in the Classroom. New York: Academic Press, 1982.

This book contains 16 chapters subdivided into the following four areas: theory, individual diversity, contextual diversity, and distributing and directing attention in primary classrooms. The conclusion suggests ways of applying this information to practice.