A STUDY TO DISCOVER HOW THE DEVELOPMENT OF AN INTEGRATING PERSONALITY IS INFLUENCED BY DEFECTIVE SPEECH AND TO OFFER THERAPEUTIC MEASURES FOR THE CHILDREN IN THE ORAN M. ROBERTS SCHOOL, DALLAS, TEXAS

APPROVED:

James H. Dougherty
Major Professor

Bertha A. Harris
Minor Professor

Witt Bean
Dean of the Department of Education

Jack Johnson
Dean of the Graduate School
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THE ORAN M. ROBERTS SCHOOL, DALLAS, TEXAS

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Maurice Rector Sigler, B. S.

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CHAPTER I

INTRODUCTION

Statement of the Problem

This study has been designed to discover how the development of an integrating personality is influenced by defective speech; to ascertain whether or not personal growth is promoted by the correction of said defects, and to discover therapeutic measures if such are warranted.

Purpose of the Study

Through an analysis of the personal development of the abnormal speech this study purposes to help defective personalities by determining the effects of crippled speech upon various individuals. The problem was to determine to what extent such individuals are retarded in personal, emotional, and social growth and to show what influence environment has upon the individual. This study is an attempt to help children who are defective in man's most useful means of communication. Such socially handicapped personalities appear unable to adjust themselves and seem to be unable to face realities.

Source of Data

The data for this study have been obtained from books and magazine articles from the North Texas State College library,
from speech and psychology courses, and tests given the children in the Oran M. Roberts School, Dallas, Texas.

In order to determine deficiencies and emotional instabilities, twenty-five elementary school children having speech defects were observed in the Oran M. Roberts School under the guidance of a speech therapist. Each child was given the Otis Self-Administering Test of Mental Ability, Form, the Stanford Achievement Test, Form, and the California Test of Personality, Form A. A case study was made of each child based upon his personality traits, his school achievement, and his environmental factors. Corrective measures have been administered to some of the children while others have been referred for therapeutic treatment.

Definition of Terms

1. Speech Personality.—The speech personality may be described by such terms as timidity, shyness, negativeness, poise or lack of poise, affectation or sincerity, irony, logicalness of discourse, abstractness of discourse, concreteness of discourse, social indifference, antisocialness, and other similar expressions.¹

2. Emotions.—Emotions are closely related to feelings. They are a departure from a calm state of mind, and are

¹Elwood Murray, The Speech Personality, p. 9.
designated as fear, anger, surprise, grief, joy and happiness.

3. **Speech Defect.**—A defect of speech is an impediment in vocalization which prevents clear or natural flow of speech.

4. **Environment.**—The total situation in which a person lives.

5. **Integrating Personality.**—An integrating personality is one that is continually changing to meet the needs of society.

**Method of Procedure**

This study was first prompted by an extensive survey of all the children of the Oran M. Roberts School, Dallas, Texas, who possess abnormal speech. It includes an analysis of the home environment of the case studies from two sources: first, from case histories obtained from the school records, and, second, from personal visits to the home. Personality tests were given for the purpose of revealing the extent to which each pupil was adjusting to the problems and conditions which confront him. Speech tests were given to each child to determine types of defects. A recording of each child's voice was made at the beginning and at the end of the nine months school term to record improvement and to encourage the child in his progress. In order that the child see the correct lip, tongue, and mouth movement, a mirror was placed in the room. This study was limited in so much as all children do not possess the same intelligence quotient or the same environment.
After such extensive study was completed, certain conclusions and recommendations were drawn.

Good speech is essentially good thinking; in fact, speech many times has been designated as the explicit, and thought as the implicit manifestation of the same process. However, since speech is a social technique, its improvement involves the improvement not only of the intellectual but also of the emotional, evaluational, and physiological sides of man; in short, it involves an improvement of the total personality. Speech and personality grow, develop, differentiate, and become refined together. Speech is a means of conveying ideas.

It is the most instrumental invention yet devised to promote social relationships. Hence, speech training in itself may serve as excellent personality therapy.\(^2\)

The appallingly large number of children who are handicapped by defective speech is evidence of the fact that a vital need is not being met by the speech program of the present. It is estimated that 4,000,000 children in the United States alone are handicapped in the use of speech.\(^3\)

If the maladjusted speech personality is to be correctly trained, it is essential to know what is wrong and to determine

\(^2\)Ibid., pp. 9-10.

\(^3\)Sarah M. Stinchfield, and Edna Hill Young, Children with Delayed or Defective Speech, p. 95.
certain methods of procedure before any treatment can be
given. Cooperation between the teacher and parent is essen-
tial before these desirable habits and skills can be performed.
CHAPTER II

THE INFLUENCE OF SPEECH IMPEDIMENT ON
DEVELOPMENT OF PERSONALITY

Personality is defined differently by many writers. F. B. Knight says:

Every part of the whole child contributes to his personality. By 'personality' is meant the individual's own unique style, or system, or habitual strategy of presenting himself to his world and of interpreting his world to himself. The child's personality grows out of his inherited constitution as the latter matures by its own inner forces and is modified by myriad environmental influences.¹

Personality is the result of an integrating process, continually changing to meet the needs of the individual and of society. Louis P. Thorpe says:

Our modern idea of personality is a definite one. It includes, in addition to one's pattern of social skills, his facilities for meeting the requirements of his own inner nature, as well as for making harmonious adjustments to the many obligations of the practical world around him. In order to fill these personal and social requirements, in a way that makes for harmony and personal happiness, one must find satisfaction of and give expression to the basic motives of life.²


Explanatiaon of California Personality Test

The Nature of the Test.--The California Test of Personality Elementary, Form A, was used to check personal and social adjustment of twenty-five speech defective children. The tests were divided into two parts, self adjustment and social adjustment. The first half indicates how the pupil thinks about himself, his self-reliance, personal worth, his sense of personal freedom, and his feeling of belonging.

Section two is concerned with the composites of social adjustment. The purpose of this section is to reveal the child's relationship with society. This table reveals the child's knowledge of social standards and skills, freedom from antisocial tendencies, family, school and community relationships. The tests are so constructed that the profile of one child may be compared with that of the group, and deviations from the norm determined.

Testing Procedure

Twenty-five speech defective children of the Oran M. Roberts School, Dallas, Texas, were tested at intervals between the months of September, 1949, and March, 1950. Each was given a pencil and test form. The test instructions were used in administering each section of the test. All the children were allowed time to complete the test. Questions were read to one of the children. Each child was told to answer the questions truthfully.
The highest possible score on the elementary form was 144. The lowest score of sixty-five was made by an eleven year old boy. The highest score, which was 129, was made by a thirteen year old boy. The median for the personality test was 100.4. The lowest percentile rank was five; the highest percentile rank was seventy-five; the median was forty-five. The child who made the highest rank had an excellent home environment. His parents, above the average, take part in all school organizations.

The child who made the lowest rank represented the poorest home environment. He does not feel secure or happy in his home and does not have an adequate feeling of belonging or of being accepted in other situations. This condition is reflected by his tendency to withdraw and to report anti-social behavior in his nervous symptoms, and in his less successful school and community relations.

The profile as a whole of this child suggests decided feelings of insecurity and self-concern which are not being adequately met and which might easily lead to more serious difficulties unless help is given him. His mental achievement was seventy-one as revealed by the Stanford Achievement Test.

Data Revealed from the Self-Adjustment Component.--To assist in the analysis of the self-adjustment test section, Table 1 was devised.
TABLE 1
RANGE OF SCORES OF TWENTY-FIVE ELEMENTARY CHILDREN
OF THE SELF-ADJUSTMENT SECTION OF THE
CALIFORNIA PERSONALITY TEST

<table>
<thead>
<tr>
<th>Components</th>
<th>Range of Actual Scores</th>
<th>Range of Scores</th>
<th>Percentile</th>
<th>Possible Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Reliance</td>
<td>5-12</td>
<td>15-99</td>
<td>58.1</td>
<td>99</td>
</tr>
<tr>
<td>Personal Worth</td>
<td>2-12</td>
<td>1-99</td>
<td>63.5</td>
<td>99</td>
</tr>
<tr>
<td>Personal Freedom</td>
<td>3-12</td>
<td>1-90</td>
<td>56.1</td>
<td>99</td>
</tr>
<tr>
<td>Feeling of Belonging</td>
<td>4-12</td>
<td>1-90</td>
<td>43.2</td>
<td>99</td>
</tr>
<tr>
<td>Freedom from Withdrawing Tendencies</td>
<td>1-12</td>
<td>1-95</td>
<td>36.4</td>
<td>99</td>
</tr>
<tr>
<td>Freedom from Nervous Symptoms</td>
<td>1-12</td>
<td>1-95</td>
<td>36.4</td>
<td>99</td>
</tr>
</tbody>
</table>

Nervous symptoms are signs of emotional instability, and seem to be the greatest handicaps to the children tested. Requirements of the inner nature of the children are not being satisfied. Nervous disturbances can cause much unhappiness; worry, pain and fear and may be the result of emotional or physical ills. The group was above the norm in personal worth, personal freedom, and self-reliance. They fell below the norm of fifty in feeling of belonging, withdrawing tendencies, and nervous symptoms.

Table 2 indicates again, that these speech defective children have nervous symptoms as their worst enemy.
TABLE 2

QUESTIONS AND RESPONSES OF SUBJECTS TO SECTIONS I F, OF CALIFORNIA TEST OF PERSONALITY-ELEMENTARY, FORM A

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you often have sneezing spells?</td>
<td>16</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Do you often have bad dreams?</td>
<td>17</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Do you bite your finger nails often?</td>
<td>16</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Does it usually take you a long time to go to sleep at night?</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Does your head ache often?</td>
<td>6</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>Do you often find you are not hungry at meal time?</td>
<td>15</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Do you take cold easily?</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Do you often feel tired in the forenoon?</td>
<td>12</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Do you often tap with your fingers on a table or desk?</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Do you often feel sick at your stomach?</td>
<td>5</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Do you often have dizzy spells?</td>
<td>7</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Do your eyes hurt you often?</td>
<td>8</td>
<td>17</td>
<td>25</td>
</tr>
</tbody>
</table>

Children of this type may suffer from a variety of physical symptoms. Some of these symptoms, such as lack of appetite, eye strain, dizzy spells, headaches, and chronic fatigue may be due to physical disorders of the body and
should be diagnosed by a physician. Many physical symptoms of this kind, however, are caused by feelings of insecurity and by emotional conflicts. Children suffering from these nervous difficulties are usually unhappy in their homes, have few good friends, are lacking in social skills, and are very much inclined to utilize their energy in self-concern and self-pity. Thus these children are maladjusted in both self and the social phases of life.

In reply to question one of the test: "Do you often have sneezing spells?" 3 sixteens answered "yes". Only nine replied with "no"; these suffered from physical pain that could be a result of nervous symptoms.

"Do you often have bad dreams?" 4 seventeen answered "yes". This could be the result of emotional fear. Eight answered negatively.

Question three, "Do you bite your finger nails often?" 5 was answered correctly by nine pupils. Sixteen of the children had the habit of nail biting which could be classified as unsatisfied emotions. "Does it usually take you a long time to go to sleep at night?" 6 was answered "yes" by six of the children. Only nineteen answered "no".

To the question, "Does your head ache often?" 7 nineteen

3Louis P. Thorpe, Willis W. Clark, and Ernest W. Tieg, California Test of Personality, Elementary, Form A, p. 6.
4Ibid.
5Ibid.
6Ibid.
7Ibid.
answered correctly. Fifteen said they were hungry at meal time, ten took cold easily, twelve felt tired in the forenoon and five often felt sick at their stomach. This question, "Do you often feel sick at your stomach?" had the highest number of correct answers.

"Do you often tap with your fingers on the table or desk?" ten answered in the affirmative, fifteen answered in the negative. Seven of the children often felt dizzy and seven complained of their eyes hurting them.

Nervous symptoms and emotional reactions are closely related. Nervous disturbances can cause much unhappiness, worry, pain and fear. They may be the result of emotional or physical ills.

Table 3 illustrates the answers given to the sense of personal freedom component of the self-adjustment section. A pupil enjoys a sense of freedom when he is permitted to have a reasonable share in the determination of his conduct and in setting the general policies that shall govern his life. As long as he can adjust himself within the changing society, he can satisfy his social needs.

The pupil who recognizes desirable social standards is the one who has come to understand the rights of others and who appreciates the necessity of subordinating certain desires to the need of the group.

\[8\text{Ibid.} \quad 9\text{Ibid.}\]
<table>
<thead>
<tr>
<th>Questions</th>
<th>Number Giving Each Response</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>May you usually choose your own friends?</td>
<td>20 5</td>
<td>25</td>
</tr>
<tr>
<td>Are you allowed enough time to play?</td>
<td>16 9</td>
<td>25</td>
</tr>
<tr>
<td>Do others usually decide to which parties you may go?</td>
<td>8 17</td>
<td>25</td>
</tr>
<tr>
<td>May you usually bring your friends home when you want to?</td>
<td>12 13</td>
<td>25</td>
</tr>
<tr>
<td>May you usually do what you want to during your spare time?</td>
<td>20 5</td>
<td>25</td>
</tr>
<tr>
<td>Do you have a chance to see many new things?</td>
<td>17 8</td>
<td>25</td>
</tr>
<tr>
<td>Do your folks often stop you from going around with your friends?</td>
<td>6 19</td>
<td>25</td>
</tr>
<tr>
<td>Are you given some spending money?</td>
<td>5 20</td>
<td>25</td>
</tr>
<tr>
<td>Are you punished for a lot of little things?</td>
<td>18 7</td>
<td>25</td>
</tr>
<tr>
<td>Do you feel that your parents boss you too much?</td>
<td>17 8</td>
<td>25</td>
</tr>
</tbody>
</table>
**Social Adjustment.**—Social standards, social skills, antisocial tendencies, family relations, school relations, and community relations are analyzed in this section of the personality test. Twenty-five and two-thirds per cent of the pupils tested had better social adjustment than self-adjustment.

**Table 4**

**RANGE OF SCORES OF TWENTY-FIVE ELEMENTARY CHILDREN ON THE SOCIAL ADJUSTMENT SECTION OF THE CALIFORNIA PERSONALITY TEST**

<table>
<thead>
<tr>
<th>Components</th>
<th>Range of Actual Scores</th>
<th>Range of Scores</th>
<th>Percentile</th>
<th>Median</th>
<th>Norm</th>
<th>Possible Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Standards</td>
<td>3-12</td>
<td>1-90</td>
<td>42.4</td>
<td>50</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Social Skills</td>
<td>4-12</td>
<td>5-95</td>
<td>34.2</td>
<td>50</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Freedom from Anti-social Tendencies</td>
<td>3-12</td>
<td>1-90</td>
<td>42.4</td>
<td>50</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Family Relations</td>
<td>4-12</td>
<td>1-90</td>
<td>63.4</td>
<td>50</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>School Relations</td>
<td>3-12</td>
<td>1-90</td>
<td>46.8</td>
<td>50</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Community Relations</td>
<td>6-12</td>
<td>1-85</td>
<td>47.7</td>
<td>50</td>
<td>99</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 indicates actual percentile scores. The lowest median score, 34.2, reveals a lack of social skills. The norm for this division was fifty. Some of these children resort to bullying in order to achieve their satisfactions in ways that are damaging and unfair to others. Normal adjustment is characterized by reasonable freedom from these tendencies. Few of these children cause conflict in the classroom, yet they do not get along with others during their social hour. They do not have a sense of values. The highest score was 63.4 on family
relations. The majority of the children examined seem to have desirable family relationships. By means of these tests it was found that forty-eight per cent of the children ranked lower in self-adjustment, thirty-five per cent ranked lower in social adjustment, and seventeen were equally divided.

Table 5 indicates the answers given by the group in social skills.

**TABLE 5**

**QUESTIONS AND ANSWERS OF SUBJECTS TO SECTION 2 B, OF CALIFORNIA TEST OF PERSONALITY ELEMENTARY, FORM A**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Number Giving Each Response</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you like to speak or sing before other people?</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>When people make you angry, do you usually keep it to yourself?</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Do you help new pupils to talk to other children?</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Does it make you feel angry when you lose in games at parties?</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Is it hard for you to talk to people as soon as you meet them?</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Do you usually help other boys and girls to have a good time?</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Do you usually act friendly to people you do not like?</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Do you usually forget the names of people you meet?</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>Do you often say nice things to people when they do well?</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Do you talk to new children at school?</td>
<td>16</td>
<td>25</td>
</tr>
</tbody>
</table>
A child must have the right ideas of social standards in order to develop acceptable social skills. Eighteen of the children gave the desirable answer to the first question, "When people make you angry do you usually keep it to yourself?" appeared to be a serious problem. These children resorted to temper tantrums and emotional disturbances. Twelve children were not accustomed to helping new pupils. Ten pupils did not have the spirit of fair play or good sportsmanship. Twelve children could not talk to new people. Their personalities were handicapped by speech defects. One-half of the group found it easy to talk with strangers.

Nine children displayed selfish interests, since they were not concerned about others not having good times. Five of the group had difficulty conversing with people whom they disliked. One-half of the pupils, who were given the test, usually forgot the names of people whom they met. Five failed to say nice things to others when they did well and nine did not talk to new children at school. This lack of social skills indicates selfish motives.

Social skills are potent factors in the development of an integrating personality. The improvement of personality and social adjustment consists of learning to substitute better responses for unsatisfactory or inadequate reactions.

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10 Ibid.
in the concrete types of situations in which the pupil experiences adjustment difficulties.

Data Collected in the Personality Test

The majority of the children studied were from homes where finance was not a serious problem. Many of the children traveled during the summer vacation. Good books and magazines were found in many of the homes. Three children represented broken homes and seven reported destitute living conditions.

A study of Table 6 will reveal the total scores of all the components. At least two-thirds of the families from which these children came exceeded the average. All of the evidence presented by test results showed inner conflicts of emotional status. Nervous and withdrawing tendencies were the predominating factors.

**TABLE 6**

<table>
<thead>
<tr>
<th>Components</th>
<th>Actual Range</th>
<th>Score Median</th>
<th>Percentile Range</th>
<th>Percentile Median</th>
<th>Percentile Norm</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Adjustment</td>
<td>25-66</td>
<td>52.1</td>
<td>10-90</td>
<td>50.8</td>
<td>50</td>
<td>0.8</td>
</tr>
<tr>
<td>Social Adjustment</td>
<td>34-77</td>
<td>53.0</td>
<td>5-95</td>
<td>54.1</td>
<td>50</td>
<td>4.1</td>
</tr>
<tr>
<td>Total Adjustment</td>
<td>60-135</td>
<td>103.6</td>
<td>10-90</td>
<td>51.0</td>
<td>50</td>
<td>1.0</td>
</tr>
</tbody>
</table>

The social adjustment of these children was more satisfactory than the self-adjustment. Their medians were as
follows: self adjustment, 52.1; social adjustment, 53.0 per cent; total adjustment, 103.6 per cent. No child had a perfect score on either self or social adjustment.

In the training of the child for a more democratic life, the school program must function as a vital part in developing proper social concepts. The home and community also influence the learning experiences of the individual, and these factors affect the social adjustment and personality of each child. William A. Yeager in his book *Home-School-Community Relations*, states:

> Education is definitely related to the democratic purposes of society, to social adjustments, and to individual development. Moreover, the objectives and functions of education vary with time, needs, conditions, and the community. The public school contributes to its more formal aspects. Within the home and the community are many informal influencing situations and conditions contributing to the child's educational pattern. The child is a many sided individual to be developed and adjusted.\(^{11}\)

Through the watchful attention of the classroom teacher who realizes the significance of speech disorders, the child in need of speech correction can be detected. Before any corrective work is started, the child should be given a complete medical and physical examination by a competent physician or clinical staff to determine whether or not there is a serious physical cause for his speech difficulty. A thorough study

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should be made of the individual. Since factors in a child's development or personality frequently are the cause of speech difficulty, it is well to make a detailed case history of the individual. This step requires the co-operation of the patient, the parents, and the physician.

In addition to the physician's examination and the case history examination, it is frequently advisable to use certain special tests. Because of the part played by low intelligence in producing articulatory and voice disorders, intelligence tests should be given to help determine the possible rapidity of remedial work and the general types of techniques to be used. Therefore, the teacher, before beginning the corrective work, should observe the child to familiarize herself with any organic defects.
CHAPTER III

THE EFFECT OF SPEECH ON PERSONALITY DEVELOPMENT

The speech personality is the verbal communication of ideas. Personality depends upon speech as its chief means of social interaction just as speech depends upon the well-integrated personality for its effectiveness. Furthermore, the best speech training in itself may serve as excellent personality therapy.¹

Speech provides means whereby the individual must develop an adequate and precise vehicle for the expression of his ideas, his wants, his aspirations, and his desires and, at the same time, may achieve the greatest possible social efficiency.

Good speech must be the result of clear thinking. Beautiful speech enhances and beautifies the personality. When mental and physical maturation progress smoothly, speech will develop steadily and evenly. Likewise, disturbances are reflected in speech.²

Teachers and parents should do everything in their power to encourage the child with a speech defect to establish himself socially and to adjust himself to his group. It should be unnecessary to say that the teacher should protect the speech defective from the barbarous cruelty of ridicule and should set an example of sympathy and understanding.

¹Elwood Murray, The Speech Personality, p. 9.
Speech Re-education

One of the fundamental principles of first aid is "do no further injury." This might be taken as the slogan of the regular teacher who has in her class a student who suffers with a serious speech defect. A disorder of speech is almost invariably accompanied by serious disturbances of the whole personality. In many cases the speech deviation is merely one of the symptoms in the general picture of personality unbalance. When the vehicle of communication is seriously impaired, the whole social relation is impeded. Speech re-education, then, both diagnosis and therapy, should be in the hands of a specialist in speech correction. In the regular classroom the following information will enable the classroom teacher to understand the basic nature of speech disorders:

Any serious speech defect may be either the cause or the effect of a serious psychological or emotional impairment.

There is no evidence to support the theory that children 'out grow' speech disorders.

Any measure that improves the physical health, the mental and emotional poise, or the social adjustment will assist in improving the speech.

The correction of a serious speech disorder requires time, patience, special information, and the cooperation of the school and home.\(^3\)

\(^3\)Letitia Raubicheck, *How to Teach Good Speech in the Elementary School*, p. 63.
Speech may be considered defective when it is not audible and intelligible to the listener. Speech is defective if it is vocally or visibly unpleasant or labored in production. Finally, speech is defective if it is inappropriate to the individual in regard to his mental and chronological age, sex, and physical development.

In considering speech difficulties there is a need to distinguish between disorders and defects. The former is the more comprehensive; it takes into consideration not only the atypical acoustic end result, but also the underlying condition causing it. Hence all disorders of speech exhibit defects of speech; but not all defects of speech are disorders.

A person may speak English with a lisp because (1) he is a Spaniard, (2) his mother lisps and thus taught him that form of pronunciation, or (3) his lower teeth protrude. The first two cases should be classified as defects of speech, but not as disorders. The last is a defect of speech and may be classified as a disorder as well.

Testing Procedure

The testing procedure was two-fold: observational and conferences, and testing. Individual patients were given sentences on the reading level of the patient. As sentences

4Robert West, The Rehabilitation of Speech, p. 15.
were read, the twenty-seven sounds were checked by the examiner in order to discover an initial, medial, or final mistake. Since many sounds can be made correctly when alone but incorrectly produced when they occur with groups of sounds, patients were observed closely throughout the testing period. Conferences with teachers and parents were held at intervals. The majority of the defects were articulatory cases and remedial treatment was given to these.

A recording of each patient's voice was made in the month of September and another record in March in order to detect improvement and to encourage the child.

The sound test was composed of a check sheet with sounds listed in corresponding order with the sentences in the test. The test contained twenty sentences. Sentences were constructed on the reading level of the children. Each sentence tested one sound which occurred in three different positions in a sentence: initial, at the beginning of the word; medial, in the middle of a word; and final, which occurred at the end of the word.

Analysis of Material

Environment, emotions, and heredity play an important role in molding children's lives. The personality in turn is so constructed that it must depend upon the world of material things and the people therein for satisfaction of its basic needs. Five of the patients lisp. Lisps are frequently
due to malformations of the teeth or jaws. This disorder may be defined as any marked deviation in the pronunciation of any or all of the sibilant sounds "s", "z", "sh", "ch", or "j". These patients were referred for orthodontic treatment. Teachers may assist in the treatment. Exercises for the tongue, lip, and soft palate should be given in order to develop the muscles.

**TABLE 7**

<table>
<thead>
<tr>
<th>Stuttering</th>
<th>Lisping</th>
<th>Tongue-Tied</th>
<th>Lolling</th>
<th>Lazy Speech</th>
<th>Cleft Palate</th>
<th>Nasality</th>
</tr>
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<tbody>
<tr>
<td>3</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Only one patient was tongue-tied. Tongue-tied speech is a specific organic defect. The frenum is too short and prevents the tongue from operating correctly. Every sound will be affected. A surgeon was consulted concerning the tongue-tied child and an operation was scheduled for the month of May. This child was referred to the speech clinic for the coming year for further exercises and treatment.

Seven of the children had nasality. This defect robs the "m", "n", and "ng" sounds of their proper nasal resonance. The back of the tongue blocks sound passages to the nose. Nasality may be the symptom of an organic defect or it may
be functional. Sinus enlarged turbinates, deviated septum, adenoids, asthma, or common colds may be the cause. A physician can determine whether the cause is functional or organic. If there is an organic obstruction, it must be removed before corrective measures can be administered. The voice does not have its proper resonance since these certain sounds do not possess their true quality. Exercises to strengthen the tongue and soft palate should be given. Humming and yawning are exceptionally good exercises.\footnote{Robert West, \textit{Disorders of Speech and Voice}, p. 40.} Three of these cases were mild and were dismissed after three months of training.

Another serious defect is cleft palate. This is an inherited defect. One child with cleft palate has had five unsuccessful operations. Any teacher should cooperate with the physician concerning exercises and time. The patient should never work too long at a period of time.

The remaining eleven cases are functional disorders, three of whom stutter. Stuttering is the most serious defect and the hardest to treat; often the environment of the patient must be changed. There is no definite and known cure; that which causes one child to stutter will not be the reason another stutters. Usually there is something in the emotional life of the patient which upsets him. It is generally conceded that changing a left-handed child to be right-handed may cause stuttering. This is true only when there is an
emotional disturbance. However, if a child who stutters has been changed it is worth time and effort to have him learn to use the other hand. It may cure him, and no harm will be done, unless more emotional fervor develops. A stutterer can sing, act in a play, talk while crawling, can talk in a peculiar voice, can talk in a sing-song manner, and can talk in the presence of some while he cannot in the presence of others. 6

Stuttering so disturbs the emotions that clear thinking is impossible. The extent of cluttered thinking depends upon emotional stability and the severity of stuttering.

The stutterer must be taught a sense of re-evaluation and given confidence by being allowed to achieve. The stutterer must go back to the beginning of his troubles, begin all over with new ideas of speech and social adjustments, and through the application of these in speaking situations, must establish new physical, mental, and emotional habits. Whatever is done, the stutterer must do it himself. Emotional control and constructive thinking must be practiced in those situations where anxiety and tension have prevailed. 7

Introduction to Case Study

Because of the continuous interaction of the individual and his environment, various personality traits cannot be segregated. The causes of maladjustment can be discerned only by information about the child and his environment.


7Conrad F. Wedberg, The Stutterer Speaks, p. 36.
Facts, such as divorce of parents, older brothers and sisters, the lack of or too many outside interests, and physical disabilities, can often reveal the reason a child behaves as he does under given conditions.

Some behavior problems are easily recognized; others are more difficult to detect because the child's overt behavior does not conflict with the ordinary progress of the classroom. Children's difficulties are classified under three main headings: undesirable habit formations, undesirable relations with other people, and unsatisfactory scholastic performances. Some of the most common symptoms are the lack of discipline, social immaturity, and a lack of security or feeling of security. Symptoms are often associated with the child's physical condition and maturation. Poor eyesight, malnutrition, inharmonious growth, and nervous disorders may be discovered by the competent and alert teacher. Most authors agree that the greatest danger of physical handicaps lies in their influence upon the emotional and social reactions of the individual.

Several of the subjects examined have been selected to illustrate the manifold personality difficulties presented by elementary school children.

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8 Dorothy Van Alstyne, The National Elementary Principal, Fifteenth Yearbook, p. 472.
Case A was a boy eleven, who had been in Oran M. Roberts School three years. He had two older brothers who had quit school. When A first entered school he cried every morning. The principal and teacher relieved this situation by giving him early morning tasks to perform. A soon began to make friends.

His home life seemed to be a congenial one. His father was a business man, and his mother has had two years in college. Their economic status was average or above.

A, unfortunately, had the serious defect of cleft palate; a serious defect caused by failure of closure of the hard palate. The mother revealed the fact that he had had five unsuccessful operations. All sounds of speech were affected.

He did not give any trouble in the classroom and had few friends, but he was liked by his classmates. His rank of sense of personal freedom was ten. His total adjustment percentile was thirty, self-adjustment, thirty-five, and social adjustment, fifteen. The only component that was above the norm of fifty was self-reliance.

If work was very difficult, A ceased to try and thought that people were not fair. It was difficult for him to talk to new people. He was over-protected and depended upon the sympathy of other people. This had been slightly overcome by his teachers treating him just as other children were treated; no special privileges were allowed.
It usually took him a long time to go to sleep, he felt hungry in the forenoon, and was often hungry at meal time. The health card revealed no physical defects other than the speech defect and a visual problem. His parents were contacted and told of this defect but nothing was done.

A was very conscious of his defect and became nervous and upset when he was called on to read or recite before a group. Little speech training was given; the organic defect had to be removed.

Remedial Suggestions for Case A

1. The teacher should co-operate with the physician concerning exercises.

2. The patient should never work too long at a period of time.

3. The child should see an ophthalmologist.

4. The teacher should encourage and motivate the child.

5. Very little can be done until the cleft is repaired.

6. Speech re-education should be given by the speech correctionist.

Case B was a boy of twelve who had been once retained in school. He had no brothers or sisters. His mother deserted him when he was five years of age. His father placed him in a home with an elderly couple. The father came to see the boy once a year. B was undernourished and had a serious
sinus infection. This case was classified as a nasality defect. All sounds were blocked, thus cutting off the resonance chambers of the nose.

B's total average on the Stanford Achievement Test was thirty-two. His age equivalent was 8-5 and his grade equivalent was 3-4. When taking the personality test, "Do your friends have better times at home than you do?" his answer was, "I have not been in many people's homes, so I do not know." Withdrawing tendencies and nervous symptom percentile ranks were one, while family relations and school relations were twenty; thirty points below the norm.

B consistently bit his finger nails, took colds easily, and often complained of a headache. It usually took him a long time to go to sleep at night. He did not participate in games or group activity in the schoolroom. Several weeks ago, B wrote a poem about "God." He was so pleased that he made a copy of it for ten of the teachers. He was praised highly for this and his eyes beamed with joy.

The visual survey showed a visual problem. The woman with whom he stayed was visited by the school nurse. When the nurse told the woman of the defect she replied, "We ain't got no money for doctor bills; we do well to get enough to eat on."

B came to school with dirty and untidy clothes. His shoes were always untied and a size too large for him. An outside
school organization was asked to get warm clothes for him, but the clothes were refused by the couple.

In some phases of school work he was efficient. He dramatized parts in plays during auditorium period and made many things with his hands during art class, but was poor in arithmetic and reading. He could not read from the fifth-grade books, so his teacher gave him third grade story readers. He was also given these readers for his speech class period.

Case B improved on the "m" and "n" sound but could not master the "ng" sound.

Remedial Suggestions for Case B

1. The child should see an ophthalmologist.

2. The teacher should help the child feel secure and help him develop a feeling of belongingness and self-confidence.

3. The child should be placed in a better home environment so that he will develop a better understanding of a good home atmosphere of love and affection.

4. He should be given exercises and drills that will improve the nasal consonants, "m", "n", and "ng."

5. The child should be taken to a physician for a physical check-up.

Case C came from a broken home. His father and mother had been divorced five years. His father ran a carnival. The mother took care of an invalid. C's total average on the
Stanford Achievement Test was 40.2. His age equivalent was 9-3 and his grade equivalent was 4.3. His total adjustment rank was seventy-two, a percentile of fifteen. His social adjustment was thirty-four and his self-adjustment was thirty-eight. He ranked lowest on withdrawing and nervous tendencies. He thought people were mean and unfair; he often had bad dreams, dizzy spells, and felt tired. C fought constantly with his classmates and had been caught stealing bicycles, money, and clothing.

Physically, C was below the average child of twelve. His weight charts showed him to be undernourished, weak, and pale. He had a club foot that prevented free action of his foot. His speech defect was not a serious one. He had a lolling tongue and a slight lisp. He took directions easily concerning his defect but disregarded them. The cure of any speech defect rested with the patient.

He gave the impression that he was superior to other children. In reality, his sense of personal worth and freedom from withdrawing tendencies were far below the norm of fifty. Case C often complained of financial troubles in the home.

The child's health card disclosed the following diseases: mumps, chicken pox, pneumonia, whooping cough, and measles. His dental card referred him for orthodontic treatment, but no treatment was given.

When Case C enrolled in the speech class, he could not
pronounce any of the sibilant sounds "s", "z", "sh", or "j", and became very nervous and excited when the speech teacher asked him questions. After a month of training the teacher won his confidence. One day, while he was going through his exercises and drills he said, "You know, I am going to teach my mother how to say these words because she don't talk right either." After that incident, the speech teacher had no further problem with the patient. He improved on most of his sounds, but was referred to speech class the coming year.

Remedial Suggestions for Case C

1. The child's parents should try to improve their economic status.

2. The parents should see that the physical defects are corrected.

3. The teacher should contact the home and try to develop a better understanding, on the part of the mother, of the influence that the homelife has upon the child.

4. A better understanding between the pupil and teacher should be promoted.

5. The teacher should develop within the group a friendly relationship between its members.

6. Exercises and drills should be given that will strengthen the tongue elevation and tongue compression.

Case D was a fifth grade boy whose total average on the
Stanford Achievement Test was 51.7. His age equivalent was 10.6 and his grade equivalent was 5.5. His total adjustment percentile on the California Personality Test was seventy; on social adjustment, forty-four; and on self-adjustment, twenty-six. His percentile rank on all the components was below the norm of 50. D did not have any close friends and felt that he could not do things as well as others. In order to overcome this inferior emotion, his teacher gave him many responsibilities in the classroom. On the playground, he was elected captain of his ball team. At the end of a two-month period, much of this complex was removed.

His home life was not a co-operative one. His parents have always had a hard time financially. His father is a day laborer and does not average over thirty or forty dollars a week. The mother works in a cafe and is never at home when the child comes from school; so he roams the streets. His mother does not show any interest in his school work.

Case D is "messy" in his school work and likes to sit by the window and day dream.

His health card disclosed the following diseases and physical defects: mumps, measles, chicken pox, a bleeder, hearing loss of eighteen per cent in one ear according to the audiometer test, and a speech defect. This speech defect was a slight lisp and substitutions which produce baby talk. Case D was referred to the speech class clinic in September 1949.
During the speech class, Case D made all of his sounds correctly but when he returned to class he did not practice them.

Remedial Suggestions for Case D

1. The parents and teacher should try to develop a feeling of security within the child.

2. The parents should have the hearing defect corrected.

3. The teacher should help the child develop a feeling of self-confidence.

4. The child's parents should provide a better home environment.

5. There should be more co-operation and interest from the parents.

6. The child should be motivated in speech and classroom situations.

7. The child should be given exercises to develop agility and pressure of articulatory muscles.

8. The child should watch the tongue, lip, teeth and jaw activity when the teacher makes the sound.

9. The child should watch his own attempts in the mirror.

10. The speech therapist should make the child aware of the feel of the articulatory organs when pronouncing certain words.

E represented a family where the father accepted full responsibility. He did most of the cooking, washing, and
helped care for the children. He was ten years older than his wife who was timid and bashful. There were two boys older than E. The children spoke only when spoken to. E took piano lessons and had been in recitals. However, if one asked him to play, usually, he sat and grinned and said nothing. Sometimes, if he were in the right mood for playing, he would play. He could not enunciate correctly but spoke baby talk if he spoke at all. The older boys of the family also spoke baby talk.

E's rank on the personality test was high. On no component did he fall below the norm of fifty. Nervous and withdrawing symptoms were lowest.

E's most difficult sounds were the medial "p", medial "g", initial "wh", and initial "r" sounds. The defect was functional. E needed more play and social contacts. He was not allowed as much freedom in choosing his playmates as he needed; he was thrown with grown-ups too frequently. He also needed to share more responsibilities in the home. E had shown little improvement during the testing period.

Remedial Suggestions for Case E

1. The child needs more social contacts outside the home.
2. The child needs to associate with children his own age.
3. The teacher should teach the child voluntary control of articulatory organs.
4. The teacher should try to motivate the child strongly and stimulate in him the desire to enter into speech situations.

5. The parents' co-operation should be obtained.


F was a boy of twelve who had been twice retained in school. He had an older sister, a younger sister, and a younger brother. His family represented the lower middle class. They lived in a "shabby" neighborhood with no modern conveniences. His parents showed very little interest in the child and he received little encouragement at home. He was a poor reader. His percentile rank on the family relations test was one. He answered the test with ten undesirable answers. He thought that the family needed more money, that the family treated him mean, and that someone at home "picked" on him. His percentile rank on feeling of belonging and freedom from antisocial tendencies was seven. F did not like the place where he lived and sometimes wished for other parents. In the schoolroom, he often sat and day-dreamed. He was lazy about school tasks but enjoyed his play activities.

His speech was so defective that to understand him, one had to know him well. His palatal arch was higher than the average and interfered with production of the "k" sound.
This defect is classified as lazy speech. F's lips and teeth remained inactive during enunciation. His tongue was used very little. His speech consisted of sounds instead of words. F's brother and sister had the same defect. Instead of helping and teaching the children to speak, the parents imitated and laughed at their speech pattern. Correct sound production was taught F, but a lack of practice and no encouragement at home prevented progress.

The school health card showed that F had had the following diseases: measles, whooping cough, and mumps; a visual problem which was not corrected, and the dental card disclosed that immediate attention was needed. The child was underweight and showed other signs of malnutrition.

F was allowed to make things with his hands in art classes and enjoyed making them. When the teacher complimented him, he was very pleased. His speech improved little; he learned to make some sounds, but he failed to practice them or adopt them as his own.

Remedial Suggestions for Case F

1. The child needs more encouragement at home.
2. The child needs a better environment.
3. The child needs more social contacts with the right kind of people.
4. The child's parents should try to improve their economic status.
5. The child's parents should have his physical defects corrected.

6. Special exercises, drills, word lists, and sentences for the correction of lazy speech should be provided.

Case G was a boy who has lived in Dallas all of his life. The neighborhood in which he lived was considered average. The homes of the community were, in the majority of cases, owned by the occupants. The home in which Case G lives, was more "run down" than those surrounding it. There were six people living in the six room house.

The step father of Case G was the "bread winner", however, the income was irregular and indefinite, approximately $30 a week. The family managed to maintain financial independence except for medical assistance and even this has not always been entirely charity.

The father was twenty years older than his wife. He has had two previous marriages, two children by the first, who are married, none by the second, and four by the third and present marriage. He seems to like his family and the emotional life of the immediate family seems fairly stable.

According to the nurse's report he was treated for syphilis in 1942, 1943, 1944, 1945, and 1946. His last treatment in 1947 was positive but he did not return for further observation.
The mother attended Oran M. Roberts School but her teachers state that "she occupied a seat but learned little." She seems to realize her responsibilities to her family, but often seeks excuses for not following through with them.

Case G was a slender boy in physique and ahead six months in growth, according to his weight chart. He had never been seriously ill, but had chronic, enlarged tonsils all of his life and a hearing loss of thirteen per cent in the right ear and five per cent in the left ear according to the audiometer test. His appetite had always been good. He stated he seldom had milk to drink other than canned milk.

Case G was in the fourth grade. His reading readiness score was fifty-two. His reports showed very little progress.

In January, 1950, Case G was taken to the Freeman Clinic, Dallas, Texas, for a vision test. The physician found severe and marked reading reversals of the extreme type. This condition is known as "mirror reading." The physician suggested remedial treatment for this case.

Further examination revealed that Case G was tongue-tied. The frenum, which is the muscular tissue that joins the tongue to the middle line of the floor of the mouth, was too short. The physician suggested that he be referred to the speech teacher for a few months treatment to try to stretch the tongue by tongue exercises. He took speech lessons and practiced all the exercises. His speech was improved and many
of the sounds were made correctly. In March, 1950, his tonsils and adenoids were removed. His recovery was normal.

The teachers have noticed a change in his attitude; he is much cleaner, happier, and is beginning to take a greater interest in his association with other children.

Remedial Suggestions for Case G

1. The parents should continue their co-operation.
2. The teachers should give the child reading material on his level.
3. The speech teacher should continue tongue exercises and drills.

Case H was a boy of twelve and the son of a theater operator. His mother was a seamstress. He had twin brothers and three sisters. One sister was married and had two children of her own. These eleven people lived in the same house, which proved to be an unsatisfactory home situation.

He had no physical handicaps but a very serious speech defect, stuttering. Home visitations revealed the same defect from the mother and the twins.

He was a very nervous child and became emotionally upset over insignificant things. He was "messy" in his school work, a very poor reader, and pretended to be sick when asked to recite in class. His percentile rank on self-reliance on the Personality Test was twenty, sense of personal worth, twenty-
five, nervous symptoms, five, and social standards, thirty. His total adjustment was forty-five which was fifty-four points below the norm of ninety-five.

H, unlike many of the children, had a wide range of experiences. He had read many books and magazines, yet he felt insecure, feared group criticism, and did not participate in group activity. The child's health card disclosed the following diseases: measles, mumps, whooping cough. He was underweight, had no energy, and possessed the following visual and emotional traits: frowning, brushing away blurs, closing one eye, losing place when he read, disturbing others, humming, and being inattentive.

The visual survey of the school health department showed a visual problem. Unfortunately, he received no visual training. The skipping of lines, losing place, and repetition of words indicated poor motor control of the eye.

H's average on the Stanford Achievement Test was 51.7. His age equivalent was 10.6 and his grade equivalent was 5.5.

During the month of January, 1950, Case H became very ill. He was taken to the hospital and placed under the care of a special nurse. After a month of treatment and observation, this child was referred to a psychiatrist. No further speech training was given because of the child's condition.

In order for the teacher and parent to help the stutterer, Kathleen Varner, Speech Therapist, Dallas Public Schools,
Dallas, Texas gave the following suggestions regarding the problem of stuttering.

Suggestions Regarding the Problem of Stuttering for the Teacher

I. Remove all speech conflicts:

1. Do not interrupt the child when he is talking.
2. Do not talk for the child whenever he has difficulty in speaking.
3. Do not suggest other methods of talking, as
   a. talking slowly
   b. taking a deep breath before words
   c. thinking what he will say before he starts to talk
   d. substituting another word for the one on which trouble occurs
4. Do not ridicule, penalize, or punish the child when he stutters.
5. Do not require the child to talk when he is fatigued or excited.
6. Do not attempt to make the child hurry when he is talking slowly.

II. React unemotionally to the child's stuttering blocks:

1. Always look the stutterer directly in the eye while he is talking.
2. Do not show signs of impatience.
3. Make no attempt to help him speak.
4. Always wait quietly for the blocks to pass.

III. Cancel all the child's unpleasant memories or experiences of stuttering:

1. When the child does have a block, call his attention to something else immediately. Thus it will not remain in his consciousness.
2. Do not remind the child of previous experiences of stuttering.

IV. Give the child as many ideal speech situations as possible:

1. Encourage the child to tell stories, recite verses, and read aloud when there is no pressure or tension.
2. Never place the stutterer on exhibition, or require him to talk when he is reluctant to do so.

V. Establish favorable speech conditions in the school and on the playground:

1. Always ignore the stuttering and refuse to react to it. Never show impatience or embarrassment.
2. Encourage the child to recite, but never call attention to his stuttering during the recitation.
3. Help his classmates to have an understanding attitude of acceptance and to accept the stuttering unemotionally.

Regarding the Problem of Stuttering for the Parent

I. Observe these points in the home environment:

1. Give the child a feeling of security.
2. Train him in independence and self-reliance by giving him responsibilities and privileges appropriate to his age.
3. Pay attention to what he says.
4. Wait patiently for him to continue when his speech blocks.
5. Let him look to you for understanding.
6. Be consistent in discipline.
7. Encourage his social tendencies.
8. Remove pressures that might cause conflicts.
10. Guard against the development of a feeling of inferiority.
11. Guard against tension and the development of fears in his environment.
12. Have patience.
13. Provide speech situations in which he can be successful.
14. Remember that these things are dangerous to his speech:
   a. Taboos too severely made.
   b. The dual language situation.
   c. Arguments, quarrels.
   d. The broken home.

9Kathleen Varner, Speech Therapist, Dallas Public Schools, Dallas, Texas, (Unpublished).
15. Guard against:
   a. Nagging.
   b. A domineering attitude.
   c. Sarcasm or too much teasing.
   d. Letting him use his handicap to escape participation in normal activities.
16. Don't supply the words when he blocks in the middle of a statement.
17. Don't react emotionally to his difficulty.
18. Don't label him a stutterer.
19. Don't punish him because he has difficulty talking.
20. Don't force him to talk when he doesn't want to do so.
21. Don't talk about his speech unless he wants to talk about it.
22. Don't hurry him when he is talking.

II. Carry out the following suggestions regarding physical well-being with as little fuss as possible:

1. See that the child is given regular physical examinations.
2. Consult a doctor regarding his diet.
3. Watch such things as frequency and severity of colds.
4. Give ample opportunity for play and exercise.
5. Guard against too long and strenuous play periods.
6. Provide for rest time during the day.
7. Provide for a separate bed and a separate room if possible.
8. Let him choose the preferred hand; then help him develop it.

III. Remember:

1. Sometimes "hands off" is the best policy.
2. He needs ammunition to use when he's labeled by his playmates as a stutterer. Answers like this may be used: "Sure, I stutter. What of it?"
3. It is part of the speech development of a child of three to block, to hesitate, and to repeat sounds. Do not call attention in any way to these speech activities.
4. He needs a chance to excel in non-verbal activities.

Ibid.
Speech defects may be either the cause or the symptom of personality maladjustment. Speech is learned by imitation and is the response and reflection of the whole child. A disorder in speech causes a disturbance of the whole personality and necessitates a change in the speech pattern. Full co-operation of the home and school is necessary for speech therapy.
CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Language is a way of behavior that, as soon as it is meaningful, becomes a pattern for future reactions of individuals and contributes to those of the social group. It plays an important role in mental growth and is an important factor in producing mental health or maladjustment.¹

Since speech is the response of the whole child, a profound change in the speech pattern, such as that required to correct speech disorders, must be accompanied by profound changes in the personality.²

Physical, mental, emotional, and social needs should be met in order for an individual to make complete adjustment to life situations. To meet these needs, one's way of thinking, one's interpretations of facts and problems, or simply one's concepts are essentially important to personality. The school teachers, who help mold the character, concepts, and personalities of the children of today, must be prepared fully to

¹Paul A. Witty, Charles E. Skinner, and others, Mental Hygiene and Modern Education, p. 326.

²Letitia Raubichek, How to Teach Good Speech in the Elementary Schools, p. 60.
study and help build strong, clear-thinking, intelligent individuals, who will be future citizens or leaders of our country.

The evidence secured from the health cards, permanent records, informal inventories, consultations with parents, and results from tests seem to justify the following conclusions:

1. The majority of the group tested were from the average home but have had limited ranges of experiences.

2. The economic status of many of the families is very meager.

3. Uncorrected physical defects retard normal growth and social adjustment.

4. Broken homes have caused emotional instability in many of the children.

5. One-third of the children tested were retarded from two to three years. Retardations impede personality development and social development.

6. Visual training definitely improves coordination of the eyes and visual acuity.

7. Children's attitudes can be improved if the teacher really understands the children.

8. The social adjustment of these children is more satisfactory than the self-adjustment.

9. Functional speech defects and personality defects are the result of emotional conflicts and disturbances.
10. Any measure that improves the physical health, the mental health, emotional poise, or social adjustment will aid in the improvement of speech.

11. The best time for treatment of speech defective people is during elementary school age before the time for the emotional conflicts of puberty.

12. Speech defects delay child development.

13. Speech and personality are interrelated.

14. Speech is a means by which the personality has full expression of social relationships.

15. Speech defects usually manifest themselves in the entire life of the individual.

16. A child who has poor speech habits will have a defective personality; beautiful speech enhances the personality.

17. The majority of defects are functional in nature.

18. Stuttering is the most complex defect to treat.

19. Personalities of children vary with each individual. Experiences, opportunities, and environmental conditions are factors which affect personalities and the ability of one to adjust to the social needs.

20. Health and physical fitness provide important assets in personality and adjustment. Many children possess nervous tendencies which should be studied and corrected.
Recommendations

In considering the foregoing conclusions, it is recommended that:

1. There should be a closer contact between homes and school so that social and emotional problems could be minimized.

2. The parents should have the physical defects of their children corrected.

3. The parents should be taught to understand problems of child development.

4. The teacher should guide the pupil in a graduated series (from easy to more difficult) of adjustment activities which challenge but do not defeat him.

5. The teacher should develop the best teacher-pupil relationship possible and convince the pupil of a sympathetic understanding.

6. The teacher should assign responsibilities which the maladjusted pupil can and will carry successfully and which will not be resented by other pupils.

7. The teacher should adjust regular school tasks and activities to the needs and capacities of the pupil.

8. The teacher should provide speech situations in which he can be successful.

9. The teacher should guard against sarcasm or letting the pupil use his speech handicap to escape participation.
10. Favorable speech conditions in the school and on the playground should be established.

11. The teacher should have sound physical and mental health; she should be well-poised and have a usable knowledge of child psychology and speech pathology.

12. Public schools should have a method of collecting data concerning family relationships and home environment.
### APPENDIX

#### Sound Test

<table>
<thead>
<tr>
<th>Word</th>
<th>Word</th>
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<tr>
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<tr>
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<td>cat</td>
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<td>postman</td>
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<td>bath</td>
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<td>girls</td>
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<td>scissors</td>
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<td>train</td>
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<td>chair</td>
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</tr>
<tr>
<td>lion</td>
<td>sleeping</td>
<td>candle</td>
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</table>
Elementary Test

1. On Pleasant Street there was a little white house with a green door.
2. Children did not live there.
3. But children went there every day.
4. They went to buy cookies and candy.
5. They went to buy apples and nuts.
6. They went to buy toys and things for birthdays.
7. They went to buy valentines, too.
8. The little white house was a store.
9. But it was more than a store.
10. It was a home, too. Mrs. Hill lived in the little white house.
11. And one room was her store.
12. One morning Mrs. Hill was busy in the room behind the store.
13. She was making cookies and candy.
14. There was a bell over the green door.
15. All at once it went ting-a-ling!
16. Mrs. Hill looked up from her work.
17. "Dear me!" she thought. "The door is open but no one has come in. Maybe the wind pushed it open."
18. Then she went back to her work.
19. She went on making cookies and candy.
20. This time Dick and Joe walked in.¹

¹William S. Gray and May Hill Arbuthnot, *Friends and Neighbors.*
Check Sheet

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<tr>
<th>Name</th>
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<td>Age: Mo. ___ Day ____ Year ___</td>
<td>Address _____________________</td>
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<table>
<thead>
<tr>
<th>Nationality</th>
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</tbody>
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Case History Outline

I. Family History
   A. Father
   B. Mother
   C. Siblings
      1. Nervousness
      2. Personality traits
      3. Insanity
      4. Speech defects

II. Medical History
   A. Condition at birth
   B. Illness
   C. Operations and accidents
   D. General health

III. Physical Examination
   A. Weight and height
   B. Posture
   C. Condition of mouth, nose, throat
   D. Hearing

IV. Education
   A. Grades completed
   B. Intelligence quotient
   C. Results of achievement tests
   D. Special abilities
   E. Special disabilities

V. Speech History
   A. Language spoken in home
   B. Talking age
   C. Age speech trouble began
   D. Is defect getting worse or better?
   E. Previous help
   F. Patient's attitude toward defect
   G. Does he block?
      1. On a sound
      2. On a word
      3. Sound combinations
H. Does he repeat?
   1. Sound
   2. Words
   3. Phrases
I. Are the sounds incorrectly made, slurred, or incomplete?
J. Does he use correct pitch?
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