

SPEECH THERAPY IN COLOURED SCHOOLS.

by

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Introduction.

The need for a regular speech therapy service has been recognized by the Transvaal Education Department as an essential part of education. This year a speech therapy post was specially created to cater for pupils with speech, voice and hearing defects in Coloured Schools. Apart from facilities at the University of the Witwatersrand Speech, Voice and Hearing Clinic, only meagre amenities existed for coloured speech defective children in the Witwatersrand area.

Working Conditions.

The writer is at present attached to five

The writer is at present attached to five schools. Each school is visited approximately five times in three weeks. In addition a clinical service is run in the afternoons to cater for those children from schools which are not serviced. The clinic has its headquarters at the Rand College of Education for Coloureds in Coronationville. A classroom is used and essential items of furniture have been provided by the college.

Surveys of Speech Defectives.

Surveys were carried out during February and March this year. The following method was used to determine the number of speech, voice and hearing defectives at the schools:

1. Teachers were given lists with the following screening guide.

(a) Stuttering: Excessive repetition and hesitation of words, syllables and phrases.

(b) Voice disorders: e.g. voice too loud, too harsh, too soft, too high, too low, breathy.

(c) Articulation errors varying from com-

plete omission to substitution and distortion of sounds, e.g. lisp ('s' difficulty) and brei ('r' difficulty).

(d) Severe language disturbance involving (d) comprehension and expression.

(e) Cleft lip and palate: Speech usually very nasal.

(f) Hard of Hearing: Teachers were given 7 points to assist them to detect children in this category.

Approximately 60% of the teachers were able to determine the speech disorders in their classes. The remaining 40% felt they were not able to detect these defects immediately and they suggested that they observe their classes more exactly for several weeks in order to establish the cases more thoroughly. In these cases the writer did the surveys herself. During the first terms of the year the Grade I classes were omitted from the surveys; except for the obviously severe cases which had to come to the notice of teachers.

2. Children were asked to count from 1 to 10, and were also asked several questions about their families, friends, hobbies etc. Stutterers, cases of oral inactivity and articulatory errors were detected during these initial speech activities.

Results of Survey.

Results of the survey of speech defectives carried out at 7 primary schools and 2 high schools, revealed the following data:-

Table I. A detailed Analysis of Speech Defectives in 9 Coloured Schools in Johannesburg.

School.	No. of Pupils	No. with Speech Defects.	% per School.
A	389	36	9.3%
B	534	40	7.5%
C	546	75	14.0%
D	593	70	12.0%
E	1012	117	11.0%
F	311	57	18.3%
G	185	35	19.0%
H	992	62	6.2%
I	946	60	6.3%

Table II: Number and percentage of different speech defects per School.

School	No. with speech defects	Dysphemis	/alia	/audia	/phonia	/logia	Cleft palate.
A	36	6 (1.5%)	26 (6.7%)	3 (0.8%)	-	-	1 (0.2%)
B	40	19 (3.7%)	15 (2.8%)	6 (1.1%)	-	-	-
C	75	21 (3.8%)	42 (7.7%)	6 (1.0%)	3 (0.5%)	3 (0.5%)	-
D	70	19 (3.2%)	37 (6.0%)	7 (1.1%)	2 (0.1%)	3 (0.5%)	2 (0.2%)
E	117	33 (3.4%)	61 (6.0%)	8 (0.8%)	6 (1.6%)	9 (0.8%)	1 (0.1%)
F	57	16 (5.0%)	21 (7.0%)	12 (3.8%)	5 (0.6%)	3 (0.9%)	-
G	35	11 (5.0%)	12 (6.4%)	6 (3.2%)	2 (1.0%)	4 (0.2%)	-
H	62	29 (3.0%)	20 (2.0%)	11 (1.1%)	2 (0.2%)	-	-
I	60	16 (1.7%)	27 (2.9%)	13 (1.3%)	3 (0.3%)	-	1 (0.1%)

Table III. Total Percentages of Speech Defects.

Dyslalia	47.1%
Dysphemia	30.8%
Dysaudia	13.0%
Dysphonia	4.0%
Dyslogia	4.0%
Cleft Palate	0.9%

Discussion of Results.

From Table 1 it can be seen that there is a marked tendency for Speech defectives to increase from 7.5% in the Coronationville area (Higher income group) to 19% in the Booyens area, where the socio-economic standards are much lower.

Schools C and D with percentages of 14% and 12% respectively, although situated in a central area in the City, have children on their roll who

live in the area known originally as Western Native Township. Formerly these families lived in the City but have since been evacuated. Many of the children attending these two schools live in Riverlea, Fordsburg, Ferreirastown and Doomfontein. Poor home conditions and very low standards of living in these areas may be contributing factors to the increased incidence of speech, voice and hearing defects in these schools.

The two high schools included in the survey

cater for pupils from Std. 6 to Matric. When compared with the primary schools wide discrepancies may be noticed. The contrast in results suggests that the number of speech defects decreases over the years; either because many of the children have "out grown" their defects, or alternatively, have left the school before completing their education. The high school population is not representative of the population as a whole because children from the lower socio-economic groups leave school earlier as compulsory education does not as yet apply to coloured schools. Therefore, it would seem desirable to study speech defects in a more random sample of the adult population before making any generalizations.

Dysphemia.

The incidence of Dysphemia was found to be disturbingly high. In schools F and G the incidence is 5.1% and 5.9% respectively. In the areas where these schools are situated there is undeniable evidence of unstable or grossly irregular home life with recurrent patterns of illegitimacy, divorce and turbulent familial relationships. In school E 3.3% of the speech defectives were stutterers and a quarter of these children were living at an orphanage. It would therefore appear that a contributory factor would be the unmet emotional needs and unsatisfactory social relationships. In these cases stuttering might perhaps act as a vehicle to attract attention, love and affection. On the other hand it may be seen as a reaction to the strain of gross poverty and neglect.

This higher incidence of stuttering among the lower socio-economic groups would seem to be the converse of the findings of other research workers in the field. From the investigations it could be concluded that stutterers were from

could be concluded that stutterers were from predominantly middle and upper class families.

Dyslalia.

Children with articulatory disorders constitute the bulk of speech defectives. 47% of all the cases in this study were found to have articulatory errors, as seen in Table III. The most common errors are the 's', 'r' and 'th'. Errors varied from complete omission to substitutions of other sounds and distortions of the particular sound.

In many cases it was noted that the tendency to 'brei' (Guttural 'r') was a familial occurrence; usually adopted from parents who invariably came from the Cape Districts where this is an accepted form of speech. In one family, four of the five children used to 'brei'. 'Th' defects were found frequently among the Afrikaans speaking children as this consonant blend is absent in Afrikaans. These children often used 'de' as a substitute.

Dysaudia.

The highest rate of hearing defects was noted in schools F and G. An explanation for this high rate may be that neglected colds lead to ear infections. Because of the lack of medical and surgical treatment, some of the middle ear infections lead to permanent hearing impairment.

Dyslogia.

Mentally defective cases constitute a great problem. Because of the complete lack of special schools, a large percentage of these children are accommodated in schools for normal children. The impression was gained from discussions with a number of teachers that nothing much can be done for these backward children. They make very little progress as the classes are large and overcrowded (approximately 40 to 50 per class) and teachers are unable to give individual attention to these children.

Cleft Palate.

The incidence of Cleft Palate is approximately 1 in 1,000. However, no definite conclusions can be drawn as the sample was far too small. There is however reason to believe that the incidence of Cleft Palate is quite high in the Coloured community.

Possible Etiological Factors.

In addition to the factors named above regarding possible casual factors of speech defects, the writer will venture to present a number of problems which affect the Coloured community in particular, and which might possibly contribute to speech defects.

In many cases speech defects were found to have no organic origin, but were a reflection of a disturbance in the whole emotional growth of the child.

Children who do not talk at school or who stutter have been found to be using various mechanisms of defence to cope with the situation at home or at school. A case in point was that of an 8 year old boy who sometimes spoke to peers in his classroom, but as soon as he was addressed by a member of the staff, he immediately became silent. An examination of conditions at home revealed that the prevailing attitude towards the children was 'children should be seen and not heard'. If the children spoke out of turn they were punished.

The school itself should not be excluded as a possible factor contributing to the problem of stuttering, particularly as so many of the teachers show a complete ignorance of the problem and do not know how to treat a stutterer they may have in their class. The child is often exposed to a teacher who is over-demanding and severe and who may constantly ridicule and correct the child's speech. Such a child may develop additional feelings of inadequacy and so aggravate the existing problem.

A factor which may also promote the high incidence of speech disorders in primary schools is the abrupt plunge into formal learning without any previous preparation. The complete lack of Nursery Schools with trained staff does not give the child an opportunity to develop emotionally, physically and socially at his own pace.

Studies have shown that where the community is not sufficiently integrated there is a greater incidence of social disorganization. Since speech is viewed as an aspect of social behaviour it may be said to be a means of performing social roles. In the writer's experience and general observation there appears to be very little group cohesion among members of the coloured community. There are several reasons which may be advanced for this; one of these being that members of the community have themselves created divisions in terms of class groups. For the most part these class groups are arbitrarily acquired and maintained. The following case related to the writer by a speech therapist illustrates the above point:

A 7 year old boy who had previously coped adequately at school suddenly showed a marked decline in his standard of work. In addition he became very morose and withdrawn and refused to speak. To observers who were unaware of his

previous performance he even seemed retarded. An examination of home conditions revealed that there were two other children in the family who were attending a European school. These children it appeared, were lighter skinned than the boy in question who was unable to pass for white. This family thus had difficulty in having him classified with the others. It was also discovered that the other two children had previously attended the coloured school from which they were later removed. This produced a tremendous emotional disturbance in the child - hence his poor performance at school and his refusal to talk.

Some Case Records.

A few cases have been selected to illustrate etiological factors and some therapeutic aids that have proved to be effective.

Case 1: John, a 17 year old boy, was unable to control the pitch level of his voice. He would begin in a low pitch (suitable for his age and physical development) and then would suddenly become tense and revert to a high, tremulous voice.

Initially, interviews with parents did not reveal anything significant and only after prolonged exploration of the history and self-concept of the case and his environment did the etiology become clear. The boy admitted that he forced himself to use the high pitch long after puberty. He was afraid that his parents would accuse him of smoking with the other teenagers in the district once his lower register became apparent. It was subsequently found that the parents used various harsh disciplinary methods to subdue his emerging personality and were suspicious of every move and sign of independence. Generally his behaviour annoyed and irritated them. In an attempt to ward off these attitudes he experienced increased anxiety and adopted behaviour patterns that were immature, embarrassing and anti-social. It was therefore necessary to give parental guidance and also build up the boy's confidence in himself. As therapy progressed he gradually gained control over his voice and was able to relax. Once he had learnt to use his new pattern consistently another problem arose. He was afraid to use the new voice at home because of the reaction it might evoke from his listeners. Thus further home visits were made in order to gain the

parent's continued co-operation and understanding.

Case 2. Peter, aged 7 years was the youngest of seven children. He was referred for therapy because of his stutter and additional aggressive tendencies. The interview with his guardian disclosed that he had had an extremely unstable emotional life. Until recently he had lived with his parents who were about to be divorced. He had often witnessed their quarrels and violent fights and on these occasions he would become hysterical. Once his parents had separated he lived with his paternal grandmother who gave him very little affection and attention. Inconsistent discipline, scolding, nagging, impatience and occasional indulgence added to his insecurity. His home conditions have considerably improved since he now lives with his maternal grandmother who is understanding and is able to build up a feeling of security. Through psychodrama and participation in a group, he has been able to free himself of much inner tension and internalized hostility. He has since made good progress.

Case 3: Patrick, a 13 year old decondary stutterer who was completely lacking in self-confidence, had acute feelings of inadequacy and suffered increased rejection from his parents, particularly his mother, who had stuttered herself as a child and was violently aggressive towards him. At the onset of therapy he was severely emotionally disturbed and his pattern of stuttering was characterized by frequent and sudden spasms, inspiratory gasps, closing of his eyes, oscillation of the jaw, turning his head to one side and clenching his hands. His whole body was tense and rigid during each block.

Therapy aimed at increasing and supporting his morale by drawing attention of his assets and so changing his self-concept. His fear of stuttering was broken down by providing positive speaking situations in which he experienced success. After a few months he had improved considerably. His teacher reported that his school work had also improved and he showed more self-assertion and initiative in class.

Difficulties Encountered in Therapy.

One of the most urgent problems facing the writer is the lack of professional consultants e.g. psychologists and neurologists, from whom to

obtain additional recommendations and to whom children can be referred for differentiated tests. This is particularly important in cases of dysphasia, dyslexia etc.

The achievement of accurate hearing assessment is also difficult as the only available audiometric facilities are at the Johannesburg General Hospital. Many parents are unable to take their children in for testing as they cannot afford to lose a day's wage, by taking the time off from work. For many even the busfares are too costly and therefore the children are never tested adequately.

An added difficulty is that of working in a newly established clinic where facilities are, as yet, crude. There is a lack of adequate equipment and the atmosphere of stimulation and co-operation from other therapists is lacking.

Need for Educating the Community regarding the role of Speech Therapy.

Greater recognition needs to be given by the community to the value of speech therapy. Here the school can play an important role as it has a recognized status. It is seen as an educational institution and as such its activities are accepted as furthering the aims of education which the community desires.

Many parents are as yet suspicious of the therapist's intentions as they have not previously encountered this aspect of education. Speech therapy is often regarded as 'learning to talk snobbishly' and the significance of the service as a remedial innovation is not clearly understood.

By its inclusion as a free school service and the facilities of parental counselling which it offers, many of these barriers may be broken down. In addition, positive promotion by the school administration and talks to Parent-Teacher Associations will increase the co-operation and recognition which is so urgently needed, if the speech therapist is to fulfill her function to the community.

Conclusions.

The school setting provides opportunities for early detection of speech problems and for work

of a remedial nature. It is often an effective medium for reaching the child who has both speech and emotional problems.

In numerous cases speech problems appeared to be tied up with unfavourable home conditions. Thus it is essential to work with all those factors which have a bearing on the child's development, i.e. the family, school and social milieu.

Although no definite conclusions can be drawn at this stage, the study does seem to point out that a larger percentage of speech defects were found among children from the lower socio-economic groups.

This work has been of an exploratory nature and it is felt that many challenging aspects regarding the Coloured community are open to further research. In this paper only pertinent problems have been briefly outlined.

Summary.

For the first time this year a post for a Speech Therapist was made available to cater for the needs of speech defectives in Coloured schools.

Results of the survey suggest that a large percentage of children require speech therapy. A detailed analysis of the results has been given in tabular form.

The writer has ventured to give a number of possible etiological factors and has also presented some of the problems which appear to affect the Coloured Community in particular.

Opsomming.

Vir die eerste keer, is daar gedurende hierdie jaar 'n pos vir 'n spraakterapeut geskep, sodat aan die behoeftes van die nie-blanke skoolkind voldoen kan word.

Die resultate van die opname dui op 'n hoë persentasie van kinders wat spraakterapie benodig. 'n Uitvoerige ontleding van die resultate is in tabelvorm gegee.

Die skrywer het gepoog om verskeie etiologiese faktore vas te stel en het verder ook gedui op sekere probleme wat blykbaar net betrekking het op die nie-blanke gemeenskap.