1973

New Hope learning center

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INDEPENDENT STUDY PROJECT

done at
The New Hope Learning Center
for profoundly retarded
children

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INDEPENDENT STUDY
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Purpose: To see what the field of Speech Pathology has to offer in helping profoundly retarded children to develop verbal/ functional language skills.

Background Information: New Hope Learning Center began operation in 1966 as a Day Activity Center under a government research grant through the Child Development Center. The grant ran four years and was not renewed at the end of that period. To prevent the closing of the school, a group of parents and interested professionals formed the New Hope Foundation, Inc. as a non-profit organization designed to continue financing the school through private contributions and the profits from the operation of a thrift store.

The purpose of the New Hope Learning Center is to provide a classroom atmosphere for profoundly retarded children who are unable to qualify for any other special education program. In this setting, the children receive training in dressing themselves, personal cleanliness, and other self-help skills. They also participate in language, perceptual stimulation, and socialization activities.

The staff includes two full time,paid teachers and two full time, paid helpers. The remainder of the staff (office workers and aides) is made up of volunteers.

Currently, there are twelve children enrolled in the program ranging in age from 6 to 18 years. The children have

been divided by subjective evaluation of the teachers into two groups; those with some functional speech and language skills and those without. Generally speaking, the older children have more language and are thus separated from the younger.

Testing and Evaluation: In March of 1972, a representative of the New Hope Foundation contacted Central Institute to inquire into the possibility of having members of the speech pathology staff provide language therapy to the children in the school.

In April of 1972, two members of the Speech Clinic staff and six graduate students visited the New Hope Learning Center to evaluate both the speech/language skills of the children and the efficacy of providing services.

Objective testing was attempted with only two children. Those two children were able to attempt the Peabody Picture Vocabulary Test and the Goldman-Fristoe Test of Articulation, but no valid results were obtained. A subjective estimate of the receptive and expressive abilities of each child was arrived at through their responses to spoken commands, gestures, motor imitation tasks, and verbal imitation.

The consensus of opinion after the evaluations was that only four or five of the children had enough rudimentary language skills or social awareness to benefit from language stimulation therapy.

It was decided to provide language services on a trial basis in an effort to see if concentrated language stimulation,

combined with carryover into the classroom and the home, could effect a positive change in the functional communication abilities of these children.

The primary goal of the project was to develop a workable language program that could be adopted by the classroom teachers and parents for incorporation into their daily routines. Because of the very limited time spent in actual therapy with each child, the involvement of the teachers and parents was considered essential for success.

Selection of Subjects: In mid-September, I began making twice weekly visits to the Center. The first six weeks were devoted to observation in the classroom, reevaluation of each child, and experimentation with various therapy activities. My evaluation procedure was almost identical to that used for the initial evaluations. As before, all information about the language abilities of each child was obtained through subjective observation and evaluation of their performance in response to verbal commands, gestures, motor imitation tasks, and verbal imitation tasks.

Due to the severe time limitations and the need for continuity in working with these children, I decided that six was the maximum number of children I could see for therapy. My criteria for selecting the six to receive therapy were as follows: The primary consideration was the amount of language ability each child already had as determined by my evaluation and teacher report. I accepted the children with functional language ability first because they had demonstrated a degree

of natural potential that could be developed. Five children were originally selected on this basis alone, but one was later dropped because of uncontrollable behavior. Since none of the remaining children demonstrated language ability, the selection of the final two children was made on the basis of age. Recent evidence (Lenneberg, 1969) suggests that the innate language learning potential is lost when the brain reaches its adult size at puberty. Therefore, the two youngest children (age 6 and 8) were selected to fill out the caseload.

The six children making up the caseload ~~the caseload~~ were divided into three groups of two in such a way that one child in each group had more language than the other in the hopes of motivating the slower child.

I spent ½ hour twice a week with each of two groups on an alternating schedule:

Groups I and II: Oct. 24, 26, 31, and Nov. 2
Groups II and III: Nov. 7, 9, 14, 16
Groups III and I: Nov. 21, 28, 30, Dec. 5
Groups I and II: Dec. 7, 12, 14, 19

Provision was made to include the other six children in the followup work done by other student clinicians during the Spring semester of 1973.[1]

Therapy Objectives and Procedures: The therapy routine was organized around two goals; to expand verbal comprehension, and to expand functional expressive abilities whether verbal or gestural. Once I established a workable routine, I didn't vary it because I felt that a fixed sequence of activities was very important to give the children a sense of continuity and confidence.[2]

The therapy procedure was as follows:

I. Expanding Verbal Comprehension

A) Picture games were played where T. named and described pictures of common objects. The children then indicated the correct pictures by name or description. The task was extended for the children with more language to include tasks involving comprehension of prepositions and two stage commands. The difficulty of the tasks was adjusted to the level of each child.

B) Same as in A) above but utilizing actual objects (cup, spoon, fork, comb, etc.). The level of abstraction was reduced, and the children received tactual as well as visual stimulation. For the one child with a serious vision problem, this was the only way he could participate.

C) Simple pre-primary picture books were read to the children giving them every opportunity to participate.

II. Expand Verbal/Gestural Expression

A) In the activities outlined in heading(I) above, the children were continuously encouraged to participate either verbally or gesturally.

B) Language experiences were given where the child was made to feel a need to communicate his wishes either verbally or gesturally. The type and complexity of response demanded varied according to the ability of each child.

Teacher Counseling: Teacher counseling and cooperation was one of the primary goals of the project. It was essential that the language activities undertaken in therapy be carried over and expanded upon by the teachers in the classroom. To begin this, the teachers and helpers were asked to observe several therapy sessions. I then discussed the activities with them individually and made suggestions as to how carry over could be accomplished. These suggestions included

splitting the children up into small groups of two or three for language lessons, and concentrating on vocabulary building activities.[3]

Both teachers reported that they had attempted similar activities without much success. They were perfectly willing to let me do whatever I wanted with the children, but they seemed to resist the idea of extending my activities to the classroom. Indeed, they seemed to think that since language activities were now being provided out side the classroom, they could deemphasize language activities in the classroom and devote more time to other things. This attitude seemed to extend up to the policy making levels as well. Shortly before I terminated my services at the end of the semester, I was informed that the "curriculum" was being altered to put much more emphasis on self help activities.

To summarize, despite good intentions on both sides, one of the primary goals of the project, carry over into the classroom, was not accomplished during my semester at New Hope.[4]

Parental Counseling: A second major goal of the project was to encourage the parents to give maximum language stimulation at home and to specifically imitate some of the activities done in the therapy sessions at school. To accomplish this goal, the parents of each child were individually scheduled for an observation and counseling session.

In preparation for these counseling sessions, I prepared

an outline of my objectives and methods to help explain the purpose of the therapy activities and to be used by the parents to guide their activities at home. The outline appears on page 10. It was suggested that a certain period of time be set aside each day to work on the same kinds of activities done in therapy. In addition to the outlined activities, I gave specific examples of things to do at home to provide effective stimulation. Among my suggestions were; waiting until the child attempts to communicate a need before meeting it, and keeping utterances directed toward the child at a simple one or two word level. I also suggested giving the child an opportunity to participate in family activities.

A group session involving all the parents was planned for approximately a week after the last individual counseling session. Unfortunately, this meeting was not arranged before semester end. Provision was made, however, to continue the parental involvement program when therapy was resumed in January 1973 under new clinicians.[5]

Results: The absense of objective information about the language abilities of the children either at the beginning of therapy or at the termination of my services made an objective estimate of progress impossible. Another hindrance to any measurement of progress was the inconsistency of performance exhibited, in varying degrees, by all the children.

Subjectively, the only area in which any of the children

demonstrated gains was vocabulary. Three children achieved small but demonstrable gains in both receptive and expressive vocabulary. The remaining (and youngest) child had no functional language ability at the start of therapy, and I observed no change in that condition.

In the therapy situation, none of the children had ever gone beyong the one word level expressively.[6]

Recommendations: I recommend that CID limit its involvement at New Hope Learning Center. I feel the results obtained from direct language therapy with the children do not justify the continuation of that activity.

The role of a Central Institute clinician should be that of counselor, adviser, and coordinator of classroom and home language activities. I suggest organizing parent group sessions and teacher workshops to demonstrate and discuss ways of presenting general language stimulation, and specific language lessons.

Footnotes:

1) The new clinicians report that they worked with all the children originally. They then counseled the parents of the children they felt wouldn't benefit from therapy and and dropped them from their caseload.

2) Since January, the new student clinicians have focused their therapy on vocabulary building activities. To reduce the level of abstraction, they have stopped using picture stimuli in favor of real objects.

3) Since my departure, the new clinicians have counseled the teachers to use real objects in place of pictures, and to concentrate much more effort toward building receptive abilities. They have also provided the teachers with a vocabulary list for each child, in their caseload. The list is broken down into words the child can use expressively, and words he can understand.

4) An effort has been made by the new clinicians to clear up this misunderstanding. The teachers are now making an effort to carry out their recommendations.

5) Since January, one parent meeting has been held by the student clinicians and plans are made to follow through with individual counseling to focus on a specific and individualized plan of action for each child.

6) Two of the children I worked with are still receiving therapy from the new clinicians. One of these children can now use carrier phrases appropriately in therapy. The other has established enough receptive vocabulary to get a basal on the Peabody.

Language stimulation at home should have two goals. To increase what your child can understand, and to build his or her expressive ability. Imitation is an important tool.

I. Comprehension (understanding what is said)

A. Naming familiar pictures and objects for the child.

B. Having child follow simple commands ("point to cup")
1) If child does not respond, lead him through the task.

C. Talk through simple picture books
1) Name and describe familiar things in the pictures
2) Have child participate by pointing to things

D. Talk to the child about daily activities in very simple sentences.

E. Some good subjects to use for all of the above: body parts, room parts, familiar objects, emotions, colors, numbers.

II. Expression (saying words and phrases)

A. Imitation of body movements

B. Imitation of vocalization (say "ah")

C. Imitation of words

D. Imitation of phrases

E. Responding verbally to simple questions ("What is this?")

BIBLIOGRAPHY

Lenneberg, E., 1969. On explaining language. Science 164: 635-643.