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The Criteria Used in the Selection of Children for Group or Individual Speech Correction in the Public Schools of the State of Washington

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THE CRITERIA USED IN THE SELECTION OF CHILDREN FOR GROUP OR INDIVIDUAL SPEECH CORRECTION IN THE PUBLIC SCHOOLS OF THE STATE OF WASHINGTON

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by

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CHAPTER I

INTRODUCTION

In the profession of public school speech therapy the caseloads for the majority of public school speech clinicians are quite large (Bingham, et. al., 1961). It would seem that therapy groups should be selected with respect to their effectiveness in working together to accomplish their objectives in the time allotted to them.

Statement of the Problem

It was the purpose of the study to determine what criteria are used by public school speech clinicians in the state of Washington to select students for group or individual speech correction.

Importance of the Study

"Approximately nine-tenths of the children who receive speech therapy at least weekly are receiving it in group sessions. National averages indicate that clinicians each week see about 10 children individually and 101 children in groups of four or five" (Bingham, et. al., 1961, p. 38). With such a vast number of children receiving group speech correction it would seem that there would be certain criteria which the speech clinican in the public schools could follow in selecting the members of a group. However, Ginott

(1961, p. 16) writes that "it must be stated that there are few, if any, validated criteria for the selection or rejection of children for group play therapy. The writer knows of no published experimental studies in this area." Through this study it is hoped that tentative criteria can be found which would determine the selection of children for group or individual speech correction in the public schools.

CHAPTER II

REVIEW OF THE LITERATURE

Shames (1953) suggests that the variability of relevant factors operating in a group structure is related to the success that group attains in speech therapy. He says that:

> A group structure should encourage the development of an outgoing sympathetic attitude toward the other clients, and encourage the development of an accepting "speech atmosphere" in which the client need not have fear of negative evaluations and thereby discourage avoidance of the social use of his speech. In addition, it should enable the client to observe the speech and social behavior of the other members of the group so that he can compare his own behavior with theirs and come to recognize and understand his and their behavior. The thinking underlying the...hypothesis of the relationship of group homogeneity to success is that the above mentioned therapeutic processes will be experienced in the group, if the past experiences, attitudes, motivations and needs of the individual clients have common elements. It is suggested that these common elements will have a better opportunity to operate when the clients resemble one another in terms of age, sex, type of speech problem and types of social and psychological difficulties (Shames, 1953, p. 268).

Literature on Selection of Groups

Slavson (1943), Ginott (1961), and Kadis, et. al. (1965) all state that the basic criterion for selection into a group is the person's social hunger, which is defined as the child's desire to be accepted, to be with a group and to be a part of it (Slavson, 1943). Both Slavson and Ginott suggest that children who need group psychotherapy are those

children who are withdrawn, immature, who have phobic reactions, who display habit and conduct disorders, and exhibit other neurotic traits and symptoms. Counter-indications for group therapy are those children who are narcissistic, sadistic, who seek punishment, who steal, are extremely aggressive, who are actively homosexual, who are oral aggressives, and who are homocidal (Slavson, 1943). Ginott (1961) says that children who have intense sibling rivalries, sociopathic children, children with accelerated sexual drives and those who have been exposed to perverse sexual experiences, children who steal, extremely aggressive children, and children who have suffered a gross stress reaction, such as severe trauma or sudden catastrophe, should not be members of group therapy sessions.

Hobbs (1951) comments further on who should be selected into group membership. He says that:

> Two sets of probabilities are involved in the question of who should enter group therapy. One is the liklihood that the individual will gain from the experience; the other is the liklihood that the group will gain from his presence. Both considerations are important, but we do not know how to write an equation that will express their subtle interrelationships, nor can we identify the personality variables that should enter into such a calculation (Hobbs, 1951, p. 312).

Literature on General Grouping Criteria

> It is essential that the members of the group should be chosen for the effect they have upon one another and the possibilities for group equilibrium they offer. This is the ideal toward which one is to strive. In

> practice groupings are seldom perfect...Many characteristics and overt misbehaviours that may affect the group are frequently not known at the time of placement. Another variable to be considered is the personality of the group therapist (Slavson, 1943, p. 119).

Where West and Ansberry (1968) say that consideration before grouping should be given to the type and severity of the defect and the child's age, grade in school and mental level, Slavson (1943) has mentioned other factors which do not totally agree with West and Ansberry to be used in assigning people to groups. The following are his suggestions: (1) the ideal number for therapy sessions is five or six, (2) there should be a two-year span in age distribution, (3) the maturity of the personality must be considered, (4) the composition of the groups must complement each other, (5) membership should be confined to one sex, (6) the intelligence quotient is not an important criterion for grouping, and (7) those in the group should not have had previous contact with each other.

Ginott (1961) says basically the same as Slavson although his views on the chronological age span in the group differs in that Ginott feels there should be no difference of more than twelve months. He also says that the use of a mixed group according to sex depends on the age of the children in the group, and does not say that all groups should be of the same sex. An additional factor mentioned is that the groups should be kept open and allow

new members to be accepted into the groups even after treatment has begun for the group.

Backus (1957) has views on grouping which are different from those of Ginott and Slavson. It is Backus' belief that the same basic principles of group structure apply "regardless of age, type of speech disorder, role of client (i.e., regardless of whether a client's speech is disordered or within normal range)" (Backus, 1957, p. 1039). Any information about the chronological age of the child must be supplemented by information concerning the child's social and intellectual maturity. Backus further believes that it is important for the child to have at least one other member of the group of his same sex, making the groups mixed groups.

The groups should be composed of people who have different speech disorders than the others in the group.

> Where therapy is conceived in terms of the creation of an environment in which a client becomes able to solve his problems, the dynamic property of interdependence among group members has more importance than the similarity of symptoms. Moreover, in the parts of the program which deal with observation of speech production the dissimilarity of clients in respect to speech symptoms can be utilized for therapeutic purposes with a high degree of effectiveness (Backus, 1957, p. 1041).

A previous article by Backus and Beasley (1951) also stresses this same principle.

Literature on Specific Criteria for Group Selection

Concerning the nature of the group, Corbin (1951) states that the group should be as homogeneous as possible, particularly in working with aphasic and/or dysarthric patients. On the other hand, Luchins (1964) has found it valuable to have a mixed or hetereogeneous group. However, he has said that:

> No group is really homogeneous in nature. There are always differences of some kind. It boils down to the criteria one uses. If the therapist says, "I want a group which is homogeneous with regard to age," he is selecting patients only on one criterion; they may still differ in other ways. Moreover, even though the therapist considers patients homogeneous because of his one criterion or pattern of criteria--be it sex, symptomatology, diagnostic categories, attitues, or intelligence--the patients themselves may see that they are different. Homogeneity or heterogeneity is a concept which one uses in looking at the group and selecting patients for it. But in actuality, the group is a unit of differences, the very existence of which helps to make things move (Luchins, 1964, p. 127).

Lebo (1956) points out that the general agreement among psychotherapists is that the child under thirteen years of age has the greatest chance for successful therapy. He adds, however, that in spite of the general agreement of the age level there is nothing much more than personal preference which seems to exist in regard to the age and suitability of the child for therapy. He quoted a study by Gollern who investigated a merger of children in group therapy with children in individual therapy and found that

"for complete success in such group therapy, the child must be under 13 years of age" (Lebo, 1956, p. 232).

Johnson (1963) cited no age limit in group therapy, but did state that in working with adults, he would group together adults of 21 to 50 years of age. However, the age span in working with adolescents he narrowed to three years (for example, 12-14 years, 14-16 years, etc.).

Lebo and Lebo (1957) were interested in determining the types of responses they could obtain in nondirective play therapy in relation to the child's age and level of aggression. A portion of their results showed that aggressive children were more generally aggressive in their speech habits, in addition to being more bullying, assertive, bossy and exclamatory in their speech. Furthermore, it was found that the children were especially aggressive during the fourth and sixth years of age, although the aggression showed up more at age six because of the better speech development. They found also that as the child's age increases, the aggression decreases. This followed their postulate that children would manifest their aggression in verbal behavior and that the aggression would gradually decrease as the child grew older, due to the socialization process. The authors further concluded that "aggression and age exert a marked influence on the amount and variety of

speech produced by normal children in the nondirective play therapy situation" (Lebo and Lebo, 1957, p. 8).

No optimum number for group membership has been determined experimentally; group therapy usually has from six to fifteen members (Backus, 1952). Both Johnson (1963) and West and Ansberry (1968) state that the group should have no more than eight members. According to West and Ansberry (1968), having more than eight would probably cause problems while four would approach the ideal membership. Autman (1964) conducted a study with children who had delayed language. Her group had seven members although she said that the recommended group number was four to six individuals. Slavson (1943) has said the ideal number of members is five or six, while Ginott (1961) has said that the group size should not exceed five.

Sommers, et. al. (1966) were interested in finding out the effectiveness of group and individual therapy using the degree of the speech defect and the grade level of the subject as the basis for establishing group classes. Results showed that anticipated interaction between effectiveness of group and individual therapy and degree of the speech defect did not occur. There was also no significant interactions between therapy and grade level.

Also using the type of defect as a criterion for group selection was Autman (1964). Her study concerned

delayed language children who, it was hypothesized, would also profit from a creative dramatics program. The age span of the children was from six to nine years.

Both Backus (1950) and Beasley (1951) state that the group membership should be composed of children who show various kinds of speech symptoms.

> The goals for these children...are thought of as similar regardless of each one's particular speech symptom. When one child with a cleft palate who omits or distorts numerous sound elements, one who stutters, one who substitutes one sound for another, and one who vocalizes little or none are grouped together, it is possible to focus attention on their abilities rather than confronting them only with their inabilities (Beasley, 1951, p. 105).

In regard to intellectual endowment as a criterion for grouping, Klapman (1947) has said that it is essential in placing in the same group patients of about the same intellectual degree. Autman's (1964) study of creative dramatics with delayed language children was successful although she stated that a possible disadvantage in her method of grouping lay in the fact that some of the children were below the normal intelligence range, and others were slow to comprehend.

However, Mecham, et. al. (1960), in working with cerebral palsied children, is of the opinion that:

> I.Q. and motor involvement have been overused as criteria for placing children together. It should be kept in mind that group therapy should be as nearly like the real life situation as possible. Social maturity and interpersonal stimulation are perhaps the most important aspects to be considered (Mecham, et. al., 1960, pp. 139-140).

Finally, although not suggesting any criteria for grouping, Axline (1947) considers the importance of the therapist in the grouping process.

> An alert therapist, constantly evaluating the behavior of the groups, should be able to spot any factor that seems to be harmful to a particular group and to make the necessary adjustment, either by forming another group to take care of any misfit or by transferring the misfit individual to another group that would be more suitable. ...On the whole, the element of intelligent common sense on the part of the therapist is the important factor in the initial organization of the group (Axline, 1947, p. 270).

CHAPTER III

PROCEDURES

The subjects utilized in this study came from the population of public school speech clinicans in the state of Washington who were also members of the Washington Speech and Hearing Association (WSHA). The data were taken from questionnaires sent to the speech clinicians.[1] Of the 232 clinicians in the state (during the 1968-69 school year), only 197 of them received the form. This discrepancy was due to the fact that one large school district used its supervisor of speech correction as the informant for the entire school district, limiting the amount of information which could be obtained. Of the total number of questionnaires sent out, 103, or approximately 52 per cent, were returned. (See Appendix A)

The questions asked of the clinicians were based on two factors: how the clinicians would ideally select their group members, and how they had selected their group membership in the past. It was anticipated that the answers on the questionnaires would vary according to the clinicians' size of school district, size of caseload, age of the child, and type of speech defect which the child presented.

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[1]Aid in designing the questionnaires was obtained from Mr. Darwin Goodey, Psychology Department, Central Washington State College.

CHAPTER IV

RESULTS

The problem under consideration was to determine what criteria were used by the public school speech clinicians in the state of Washington in selecting children for either group or individual speech correction. Questionnaires were sent out to the clinicians of the state whose names were obtained from the 1968 Washington Speech and Hearing Association Directory (See Appendix A).

During the 1968-69 school year, there were a total of 232 public school speech clinicians in the state of Washington.[1] However, only 197 of the clinicians received the questionnaire. This discrepancy is accounted for by the fact that one school district with a large number of speech clinicians had the supervisor of speech correction fill out the form, thus using the one form as representative of all the clinicians in that district. Of the total 197 questionnaires received by the clinicians, 103, or approximately 52 per cent, were returned, representing 44.4 per cent of the response of the speech clinicians, although 84.9 per cent of them received the form.

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[1]Statement verified by Mr. Claude Kennedy, Statistician in the Office of Education, Division of Administration and Finance.

For the purpose of making comparisons of the data, the forms were divided into four groups on the basis of the population of the school districts: Group I--over 3,000 population; Group II--1,501-3,000 population; Group III--501-1,500 population; and Group IV--1-500 population. In each respective group there were 76, 21, 5, and 1 returns, or approximately 74 per cent, 20 per cent, 4.8 per cent, and .97 per cent of the total returns. Of the 44.4 per cent of the 232 clinicians in the state who returned the questionnaires, 32.8 per cent were from Group I, 9.1 per cent were from Group II, 2.1 per cent were from Group III, and .43 per cent were from Group IV.

Because of the limited returns in Group IV (one), the analysis and interpretation of the data for that group is somewhat misleading as the percentages are either 100 per cent or 0 per cent for each question. Based on one person only, the statistic is insignificant when comparing all the groups. This fact must be taken into consideration by the reader as he continues this study.

Analysis of the Data

The total number of buildings serviced by all speech clinicians was 507.5 or an approximate average of five buildings per clinician. Groups I, II, III, and IV serviced 360.5, 117, 28, and 2 buildings, respectively, with the

respective averages for each group being approximately 5, 6, 6, and 2 buildings.

The total caseload for all the Washington state speech clinicians was 9,549 cases with the average caseload per clinician being approximately 93. Group I, the largest group, had a total caseload of 7,193 and an average of 93, while Group II's total caseload was 1,871 or approximately 89 per clinician. It was found that the remaining two groups had total caseloads of 395 and 90, with the average caseload being 79 and 90, respectively.

The closest overall agreement in answering the question as to which grade levels were serviced (no. 5) was made consistently by Groups I and II. However, all groups appeared to be in close agreement in servicing the K-3 and 4-6 grade levels, while over 60 per cent of Groups I, II, and III service the junior high school (grades 7-9) (See Table I).

TABLE I

PER CENT OF GRADE LEVEL SERVICED BY EACH POPULATION GROUP

Group	Pre-School	K-3	4-6	7-9	High School
I	30.3%	97.3%	94.7%	69.6%	34.2%
II	28.6%	95.2%	95.2%	66.7%	42.9%
III	40.0%	100 %	100 %	60 %	80 %
IV	0.0%	100 %	100 %	0 %	0 %

The total number of years experience for all speech clinicians was 660 years, yielding an average of about 6.4 years for each clinician. Group I had a total years experience of 504.5 and an average of 6.6 years, while Group II's average, 6.3 years, also closely approximated the total average. The experience of Group II was 132.5. Group III and IV fell below the main average, with the third group having a total of 23 years, and an average of 4.6 years while the fourth group had a total of less than one year's experience and an average of the same figure. This latter result is felt not to be significant as the data is based on only one returned form.

When asked the question concerning whether the clinician had adequate information to work with the child (no. 7), Groups I, II, III, and IV had 81.5 per cent, 76.2 per cent, 40 per cent and 100 per cent affirmative answers, respectively, while there were 15.8 per cent, 23.8 per cent, 20 per cent, and 0 per cent answers, respectively in the negative. Only 20 per cent of Group III would give no response to the question as compared with 0 per cent of all the other groups. Some were indecisive and gave both yes and no answers: Group I--2.6 per cent, and Group III--20 per cent. Comments to this question may be found in Appendix B.

In response to question eight, whether the adequacy of information would make any difference in grouping, the results were as follows: 50 per cent, 33 per cent, 40 per cent, and 100 per cent affirmative answers for all four groups, respectively. The negative responses yielded 16 per cent, 19 per cent, 20 per cent, and 0 per cent, respectively. There were more "no response" answers in this section: Group I with 33 per cent, Group II with 48 per cent and Group III with 40 per cent, and a smattering of both yes and no answers (1 per cent in Group I).

The speech clinicians were asked to respond to a question in which they must decide to place a child with a specific speech disorder into a group or individual speech therapy situation. Results of their placement are shown in Tables II, III, IV, and V.

The table shows slight agreement between the various population groups in respect to how they would place the child. The closest agreement is in grouping the child with an articulation disorder and the child working on carryover, while individualizing the disorders of stuttering, cerebral palsy, and multiple problems.

In regard to the question concerning placing children with different disorders into the same group, results showed fair agreement between Groups I, II, and III (yes--53.9 per cent, 47.6 per cent, and 40 per cent, with Group IV 100 per cent yes; no--38.2 per cent, 33.3 per cent, and 20 per cent,

TABLE II

PER CENT OF GROUP-INDIVIDUAL PLACEMENT
OF DISORDERS BY GROUP I

Disorder	G*	I*	NR*	B*
Articulation	77.6%	1.3%	5.3%	15.8%
Delayed Language	43.4%	27.6%	5.3%	23.7%
Stuttering	19.7%	48.6%	5.3%	26.3%
Cleft Palate	18.4%	60.5%	6.6%	14.5%
Hearing Problem	21.0%	46.1%	6.6%	26.3%
Voice Disorders	17.1%	65.8%	6.6%	10.5%
Cerebral Palsy	7.9%	65.8%	9.2%	17.1%
Multiple Disorders	23.7%	50.0%	7.9%	18.4%
Carryover	77.6%	2.6%	6.6%	13.2%

*G = group I = individual NR = no response
B = both yes and no

TABLE III

PER CENT OF GROUP-INDIVIDUAL PLACEMENT
OF DISORDERS BY GROUP II

Disorder	G*	I*	NR*	B*
Articulation	85.7%	0.0%	9.5%	4.8%
Delayed Language	57.1%	19.0%	9.5%	14.3%
Stuttering	33.3%	47.1%	9.5%	9.5%
Cleft Palate	42.9%	42.9%	9.5%	4.7%
Hearing Problem	42.9%	38.1%	9.5%	9.5%
Voice Disorders	28.6%	52.4%	9.5%	9.5%
Cerebral Palsy	23.8%	61.9%	9.5%	4.8%
Multiple Disorders	33.3%	52.4%	9.5%	4.8%
Carryover	80.9%	4.8%	9.5%	4.8%

*G = group I = individual NR = no response
B = both yes and no

TABLE IV

PER CENT OF GROUP-INDIVIDUAL PLACEMENT
OF DISORDERS BY GROUP III

Disorder	G*	I*	NR*	B*
Articulation	80.0%	20.0%	0.0%	0.0%
Delayed Language	80.0%	20.0%	0.0%	0.0%
Stuttering	40.0%	40.0%	0.0%	20.0%
Cleft Palate	0.0%	100.0%	0.0%	0.0%
Hearing Problem	20.0%	60.0%	0.0%	20.0%
Voice Disorders	0.0%	100.0%	0.0%	0.0%
Cerebral Palsy	20.0%	60.0%	0.0%	20.0%
Multiple Disorders	40.0%	60.0%	0.0%	0.0%
Carryover	100.0%	0.0%	0.0%	0.0%

*G = group I = individual NR = no response
B = both yes and no

TABLE V

PER CENT OF GROUP-INDIVIDUAL PLACEMENT OF DISORDERS BY GROUP IV

Disorder	G*	I*	NR*	B*
Articulation	0.0%	100.0%	0.0%	0.0%
Delayed Language	100.0%	0.0%	0.0%	0.0%
Stuttering	0.0%	100.0%	0.0%	0.0%
Cleft Palate	0.0%	100.0%	0.0%	0.0%
Hearing Problem	100.0%	0.0%	0.0%	0.0%
Voice Disorders	0.0%	100.0%	0.0%	0.0%
Cerebral Palsy	0.0%	100.0%	0.0%	0.0%
Multiple Disorders	0.0%	0.0%	0.0%	100.0%
Carryover	100.0%	0.0%	0.0%	0.0%

*G = group I = individual NR = no response
B = both yes and no

respectively). No response and both yes and no categories showed 7.9 per cent in Group I, 19.1 per cent in Group II, 40 per cent in Group III, and 0 per cent in Group IV.

Tables VI, VII, and VIII (pages 23, 24, and 25) show how these clinicians placed children in group or individual therapy situations, according to the overt behavior characteristics which the children displayed. Groups I, II, and III agree to group those children who seem impatient, while Groups I and II agree to group those who appear even-tempered and cooperative. Groups II and III would group the quiet and uncommunicative ones. Individual attention would be given to those who show aggressive traits in Groups I and II. The remaining behavior characteristics listed received mixed responses.

No table is shown for Group IV as the results were 100 per cent no response.

In response to the question (no. 11) concerning placing those children who exhibited the same behavior characteristics into the same group, the affirmative opinion is spread (Group I--22.4 per cent, II-- 38.1 per cent, III--20 per cent, IV--100 per cent) while the negative opinion is also varied (Group I--56.6 per cent, II-- 47.6 per cent, III--80 per cent, IV--0 per cent), although the majority would say no. The "no response" and

TABLE VI

PER CENT OF GROUP-INDIVIDUAL PLACEMENT USING BEHAVIOR CRITERION BY GROUP I

Behavior	G*	I*	NR*	B*
Hyperactive	14.5%	61.8%	18.4%	5.3%
Aggressive	51.3%	19.7%	21.1%	7.9%
Domineering	57.9%	14.5%	23.7%	3.9%
Short Attention Span	22.4%	52.6%	19.7%	5.3%
Impatient	61.8%	11.9%	22.4%	3.9%
Easily Distracted	13.2%	63.2%	21.0%	2.6%
Quiet	68.4%	3.9%	22.3%	5.3%
Even-tempered	75.0%	1.3%	21.1%	2.6%
Uncommunicative	42.1%	30.3%	19.7%	7.9%
Withdrawn	40.8%	32.9%	19.7%	6.6%
Tempermental	59.2%	13.2%	21.0%	6.6%
Cooperative	76.3%	0.0%	19.7%	3.9%
Shy	65.8%	6.6%	21.0%	6.6%
Uncooperative	46.0%	25.0%	23.7%	5.3%
Quick Temper	52.6%	18.4%	25.0%	3.9%
Enthusiastic	75.0%	1.3%	21.1%	2.6%

*G = group I = individual NR = no response B = both

TABLE VII

PER CENT OF GROUP-INDIVIDUAL PLACEMENT USING BEHAVIOR CRITERION BY GROUP II

Behavior	G*	I*	NR*	B*
Hyperactive	47.6%	38.1%	9.5%	4.8%
Aggressive	66.6%	19.0%	9.5%	4.8%
Domineering	66.6%	19.0%	9.5%	4.8%
Short Attention Span	52.4%	28.6%	9.5%	9.5%
Impatient	61.9%	14.3%	14.3%	9.5%
Easily Distracted	42.9%	38.1%	9.5%	9.5%
Quiet	76.2%	4.8%	9.5%	9.5%
Even-tempered	76.2%	4.8%	9.5%	9.5%
Uncommunicative	61.9%	19.0%	9.5%	9.5%
Withdrawn	57.1%	28.6%	9.5%	4.8%
Tempermental	76.2%	4.8%	9.5%	9.5%
Cooperative	80.9%	0.0%	9.5%	9.5%
Shy	71.4%	9.5%	9.5%	9.5%
Uncooperative	57.1%	28.6%	9.5%	4.8%
Quick Temper	71.4%	9.5%	9.5%	9.5%
Enthusiastic	80.9%	0.0%	9.5%	9.5%

*Group = group I = individual NR = no response B = both

TABLE VIII

PER CENT OF GROUP-INDIVIDUAL PLACEMENT
USING BEHAVIOR CRITERION BY GROUP III

Behavior	G*	I*	NR*	B*
Hyperactive	0.0%	80.0%	20.0%	0.0%
Aggressive	60.0%	0.0%	40.0%	0.0%
Domineering	40.0%	40.0%	20.0%	0.0%
Short Attention Span	0.0%	80.0%	20.0%	0.0%
Impatient	60.0%	20.0%	20.0%	0.0%
Easily Distracted	20.0%	40.0%	40.0%	0.0%
Quiet	80.0%	0.0%	20.0%	0.0%
Even-tempered	60.0%	20.0%	20.0%	0.0%
Uncommunicative	60.0%	20.0%	20.0%	0.0%
Withdrawn	60.0%	0.0%	40.0%	0.0%
Tempermental	60.0%	20.0%	20.0%	0.0%
Cooperative	60.0%	20.0%	20.0%	0.0%
Shy	60.0%	20.0%	20.0%	0.0%
Uncooperative	40.0%	40.0%	20.0%	0.0%
Quick Temper	40.0%	40.0%	20.0%	0.0%
Enthusiastic	60.0%	20.0%	20.0%	0.0%

*G = group I = individual NR = no response B = both

"both" categories consist of 21 per cent in Group I, 14.3 per cent in Group II, and 0 per cent in Groups III and IV. Comments in regard to this question may be found in Appendix B.

In the twelfth question, it was found that the majority of all groups would use the age, grade level, and achievement level of the child as criteria for grouping. The criterion of sex of the child showed a split opinion by the groups. Tables IX, X, XI, and XII show these results.

TABLE IX

PER CENT OF POPULATION GROUPS USING SEX AS A CRITERION FOR GROUPING

Group	Yes	No	NR	Both
I	3.9%	90.8%	2.6%	2.6%
II	9.5%	80.9%	9.5%	0.0%
III	60 %	40 %	0 %	0 %
IV	100 %	0 %	0 %	0 %

TABLE X

PER CENT OF POPULATION GROUPS USING AGE AS A CRITERION FOR GROUPING

Group	Yes	No	NR	Both
I	68.4%	23.7%	6.6%	1.3%
II	66.6%	23.8%	9.5%	0 %
III	100 %	0 %	0 %	0 %
IV	100 %	0 %	0 %	0 %

TABLE XI

PER CENT OF POPULATION GROUPS USING GRADE LEVEL AS A CRITERION FOR GROUPING

Group	Yes	No	NR	Both
I	69.7%	23.7%	5.3%	1.3%
II	76.2%	9.5%	14.3%	0 %
III	100 %	0 %	0 %	0 %
IV	100 %	0 %	0 %	0 %

TABLE XII

PER CENT OF POPULATION GROUPS USING ACHIEVEMENT LEVEL AS A CRITERION FOR GROUPING

Group	Yes	No	NR	Both
I	59.2%	28.9%	7.9%	3.9%
II	61.9%	28.6%	9.5%	0 %
III	80 %	20 %	0 %	0 %
IV	100 %	0 %	0 %	0 %

In response to the question (no. 13) of grouping children on a mixed basis, that is, grouping together children of mixed sex, age, grade, and achievement level, the majority of responses were yes (Group I--55.3 per cent, Group II--47.6 per cent, Group III--60 per cent, Group IV--100 per cent). The remaining responses were negative (Group I--40.8 per cent, Group II--42.9 per cent, Group III--

40 per cent) with 13.4 per cent of all groups not responding to the question.

When asked whether the composition of their therapy groups had ever been changed, 96.1 per cent of Group I, 95.2 per cent of Group II, and 100 per cent of Groups III and IV responded affirmatively. There were only 2.6 per cent of Group I and 4.8 per cent of Group II who had not changed the composition of their groups. All population groups changed therapy groups by moving a child in a variety of ways: from individual therapy to group therapy, from group therapy to individual therapy, or moving from one therapy group to another (See Table XIII).

TABLE XIII

HOW THE COMPOSITION OF THERAPY GROUPS HAS BEEN CHANGED ACCORDING TO PER CENT OF POPULATION GROUPS

Group	Individual to Group	Group to Individual	Group to Group
I	92.1%	88.2%	98.7%
II	85.7%	95.2%	95.2%
III	80 %	100 %	80 %
IV	100 %	100 %	100 %

For comments concerning the basis for changing the composition of groups, and also for comments regarding the group-individual selection criteria, refer to Appendix B.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

Because of the vast number of children who receive group speech therapy in the public schools (Bingham, et. al., 1961), it would seem necessary to know what the criteria are in selecting children for these groups. This study was undertaken to determine the criteria used by the public school speech clinicians in the state of Washington. Data for the study were obtained through questionnaires sent to these clinicians.

Of the 197 questionnaires mailed, 103, or approximately 52 per cent, were returned. To facilitate the comparison of the data, the questionnaires were divided into four groups, based on the school districts' population. Group I represented the largest enrollment (over 3,000), while Groups II, III, and IV, respectively, represented these enrollments: 1,501-3,000, 501-1,500, and 1-500 populations. Group I contained 76 or 74 per cent of the returns, Group II contained 21 or 20 per cent of the returns, Group III had 5 or 4.8 per cent, while Group IV had 1 or .97 per cent of the total returns.

For the total 103 clinicians, the average-sized caseload was 93, the average number of years experience was

about 6.4 years, and each clinician serviced five buildings on the average.

Problems in the Interpretation of the Data

After compiling the data from the questionnaire, it was found that problems appeared which had not been considered at the time the questionnaires were designed and mailed. Question three (see Appendix A) asked for the total number of clinicians in the school district. However, the researcher neglected to include anything on the form which would identify the district the clinician was from. Since, in some cases, more than one form was sent to a school district, it was impossible to determine if the figure on the questionnaire was being counted more than one time. This information was needed so that possible comparisons might be made between the average number of clinicians in the population groups and the responses on the questionnaires. Therefore, Mr. Kennedy, a statistician in the Office of Education in Olympia, Washington, was contacted and stated that there were 232 public school speech clinicians in the state during the 1968-69 school year. This figure was then used in the place of the more accurate response to question three.

A further problem appeared which is concerned with the number of returns in the four groups. Although the

total number of returns was 103, this figure included 97 returns in Groups I and II, and only 6 returns in Groups III and IV. This large difference between the two sets of groups resulted in the computation of data which is misleading. None of the total figures which resulted can be said to be completely accurate, as all figures tend to represent the first two groups because of the greater weight occurring there. When the individual groups are compared, it is found that, particularly in Group IV, with a total of only one return in that population group, the statistics shown there are either 100 per cent or 0 per cent response. On the whole, then, the total group statistics actually reflect more closely Group I and Group II (which, incidentally, showed the most agreement between the groups), and when comparing the individual group results to the total group results, this fact must be kept in mind.

Conclusions

As anticipated, the criteria used in group selection seemed to depend on the age and grade level of the child, and the type of speech defect the child had. Furthermore, the time that the clinician has (as related to his size of caseload), and the scheduling with classroom teachers all appeared to be factors in group selection. The results of the questionnaire appeared to show very little agreement

among the groups. The most decisive question was question twelve (see Appendix A) whose results showed that age, grade level, and possibly the achievement level were factors used in grouping.

It is felt also that the type of speech defect which the child has is also a criterion in grouping (refer to Tables II, III, IV, and V, pages 18, 19, 20, and 21). The responses to this question were mixed and it is felt that this occurred mainly for one reason. Most public school speech clinicians have primarily an articulation caseload. According to many of the comments received (see Appendix B), the clinicians group not only on articulation defect, but also group specifically to the type of sound problem the child has. It would seem probable that many of the clinicians have never experienced some of the other disorders, possibly not since their college training, and that when given a list of disorders such as the one in the questionnaire, are uncertain as to how they would place the child.

It appears that behavior characteristics which the child exhibits are not a criterion in group selection or placement. The responses to this question (no. 10--see Appendix A) were interesting, particularly when the large number of "no response" answers were noted (see Tables VI, VII, and VIII, pages 23, 24, and 25). It is felt that this answer appeared often possibly because the clinician failed

to understand the question. However, another reason for this type of response is that the content of this question contains an area of information and/or knowledge which the clinician may not be as conversant with (as compared to the criteria of age, grade, and speech defect), and therefore he did not respond. This last comment deserves further attention.

According to the comments written on the questionnaire (see Appendix B), many of the clinicians felt that behavior characteristics of the child were definitely not a criterion in grouping the child. They stated that other factors, such as those mentioned earlier, formed the criteria. In interpreting the results of this question, and the following one concerning mixing groups with children who had different behavior characteristics, it appeared that the response to both these questions were quite similar. These two questions received more "no response" answers than the others, and it can be concluded that the content of the questions were troublesome to the clinicians.

It appears that the speech clinicians would tend to group as homogeneously as possible according to the type of defect, and to criteria such as age and grade level. The response to questions nine and thirteen showed a split between the groups concerning mixing or not mixing the groups. The chief reasons appeared to be, on the one hand, that the group interaction would be beneficial to the children if the

groups were mixed, while, on the other hand, grouping children of hetereogeneous characteristics would break down the functioning of the group.

In conclusion, it is felt that the criteria for the group placement of children in speech correction is on a homogeneous basis according to age, grade, and type of defect. Scheduling conflicts and the time factor are also considerations in grouping.

It is further felt that many of the therapy groups are formed with the convenience of the clinician in mind, using some of the criteria above. On the whole, behavior characteristics are not used as a criterion, which one might conclude, may tend to bypass the child's individual differences as a factor in grouping.

Implications for further research in this area are many. Studies could and should be conducted in which these criteria could be tested as to their worth in selecting groups. If questionnaire studies were used, they should contain a question asking for a breakdown of the clinician's caseload, which may result in a more accurate interpretation of their actual situation in speech correction. It would also be necessary in a questionnaire study to have the population groups as equal as possible, so that more accurate results could be obtained. Studies centering around the type of therapy conducted in groups would also prove beneficial, particularly in the area of group dynamics.

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APPENDIX A

APPENDIX A

QUESTIONNAIRE

1. Total school population

   1 - 500____ 501 - 1500____ 1501 - 3000____ over 3000____

2. Number of buildings serviced by you_____.

3. Number of speech clinicians (including yourself) in the district_____.

4. Size of caseload_____.

5. Grade level serviced by you

   ___Pre-school ___K-3 ___4-6 ___7-9 ___High School

6. Number of years experience as a speech clinician_____.

7. Do you feel you have adequate information about each child to enable you to work with him? ____yes ____no

   If no, what further information do you feel you should have before you could work with the child?

   _____

8. Does the adequacy, or inadequacy, of information make any difference as to how you would group the child?

   ____yes ____no

9. Assuming you have ideal conditions, place a G(group) or and I(individual) in the blank according to the manner in which you would place children who exhibit the following speech disorders:

   ____Articulation
   ____Delayed language
   ____Stuttering
   ____Cleft Palate
   ____Hearing Problem
   ____Voice Disorders
   ____Cerebral Palsy
   ____Multiple Disorders (example, articulation and voice)
   ____Child working on carryover in any disorder

Would you place children with different disorders into the same group? ___yes ___no

10. Place a G(group) or an I(individual) in the blank according to the manner in which you would place a child who exhibited the following overt characteristics of behavior:

___hyperactive	___uncommunicative
___aggressive	___withdrawn
___domineering	___tempermental
___short attention span	___cooperative
___impatient	___shy
___easily distracted	___uncooperative
___quiet	___quick temper
___even-tempered	___enthusiastic

11. Assuming that the behavior characteristics of a child be used in the decision as to whether that child should be in group or individual therapy, would you place children who exhibited the same characteristics (for example, hyperactivity, aggressiveness, etc.) in the same group? ___yes ___no

Why or why not?_____

_____

12. Assuming ideal conditions, answer yes or no to the following questions:

a. Would you group children according to their sex? ___yes ___no
b. Would you group children according to their age? ___yes ___no
c. Would you group children according to their grade level? ___yes ___no
d. Would you group children according to their achievement level? ___yes ___no

13. Assuming ideal conditions, would you group children on a mixed basis; that is, combining children of various age, sex, grade and achievement into the same group? ___yes ___no

14. Have you even changed the composition of your groups? ___yes ___no

15. If you have changed the composition of your groups, how were they changed?

___Moving child from individual therapy to group therapy
___Moving child from group therapy to individual therapy
___Moving child from one group to another group

16. On what basis do you change the composition of your group and/or individual therapy?

_____

_____

17. In regard to any of the above questions, please comment on any other factors which you feel have an effect on the manner in which you select a child for group or individual therapy sessions.

_____

_____

_____

_____

APPENDIX B

APPENDIX B

COMMENTS TO THE QUESTIONNAIRE

The following comments are representative of those which appeared on the questionnaires.

Comments to Question No. 7:

More interest from others is needed.

Psychological, sociological, and medical reports are needed, in addition to audiograms, case histories, and records of previous speech therapy.

Diagnostic workup is needed, including the ITPA test.

Need adequate time to test and counsel with the parents before beginning therapy.

Excerpts taken directly from questionnaires:

You "never know all there is to know about a child."

"If you don't have adequate information to at least begin work with the child, why waste everyone's time?"

"If child has a speech problem, you have enough information to 'work' with him."

Comments to Question No. 11:

Positive:

Interpersonal relationship with peer groups often add to the effectiveness of the therapy program.

They might see their own behavior in other children and benefit from this.

Group interaction helps child to find his role.

Children would be harder to control and would set a poor example for each other.

Can approach the children and their problems with a common goal in mind.

Guidelines for behavior would be easier to administer if the children had similar traits.

Provides an opportunity for them to adjust.

As a means of control.

Provide competition.

Clinician can control the behavior if the group is small.

Negative:

The children's level of tolerance could not take it, neither could the therapist's.

The influence of the behavior characteristics of others would be operant.

The speech would not change because the children are too hard to control.

Behavior problems are not a general problem in grouping.

Group harmony, environmental awareness and conformity would develop.

Most of the time would be spent working with one characteristic and not doing speech therapy.

There would be too much or not enough competition.

Group interaction.

The fewer the behavior problems, the more time is spent in therapy.

Too much conflict would result.

Counterbalance in groups could be achieved.

Same characteristics would develop more behavior patterns in children.

Excerpts taken directly from questionnaires:

"Group pressures will often change the 'different' child while children of like characteristics often encourage continuance."

"Behavior characteristics are not part of placement criteria."

"I would be more interested in their speech defects."

Comments to Question No. 16:

Change according to the child's individual needs, his progress or regression, and ability.

The type of problem the child has.

Schedule conflicts, classroom teacher needs, physical setup of the building.

Changing of goals.

Group compatibility and interaction affects the change.

The emotion the child is experiencing affects the groups.

Homogeneity of problem, age, and skill.

Some trial and error grouping at first, followed by regrouping, if necessary.

Change when the span of achievement becomes too great.

Need for more extensive therapy (Group to Individual).

Need for better peer association and behavior (Group to Group).

Readiness and individual differences.

Movement toward more effective communication.

The behavior of children.

Achieve the most compatible and emotional setting.

Behavior changes and personalities.

Group to Individual change is based on the problem severity.

Excerpts taken directly from questionnaires:

"The 'whole' child is considered as well as the group interaction desired."

Comments to Question No. 17:

Depends on scheduling with classroom teacher and principals.

Heavy caseload means more groups.

Physical facilities of the school, and availability of room equipment.

Time allotment.

Severity of the problem.

Teacher referrals may increase the load.

Cooperation from the parents, the school, and the child.

The child's needs.

Favorable or negative prognosis.

Number of children needing therapy.

Reading level, comprehension, practicality of materials.

Recommendation of psychologist.

Ability to function within the group.

Sound difficulty, grade level, and age.

Behavior characteristics usually do not have anything to do with placement.

Group out of necessity.

Achievement level a basis in later grades.

Relationship with peers and therapist.

Group on room or classroom basis.

Individual therapy unrealistic due to caseload levels.

Grouping depends on the kind of therapy employed.

The situation is not ideal or stable.

What can the child offer to other children? What are the strong and weak points of each child? What are the behavior characteristics and what is his speech problem?

Each child needs individual therapy whether seen individually or in a group.

Excerpts taken directly from questionnaires:

"Type of speech or language problem is basic to the group or individual therapy scheduled not any of the above mentioned items."

"The decisions as to behavior characteristics has to remain a secondary consideration if scheduling becomes an acute problem."

"Behavior is not the prime consideration for groupings. Other factors play the significant role."

"A single child exhibits a composition of several of the mentioned factors and personality characteristics which together effect group or individual placement."