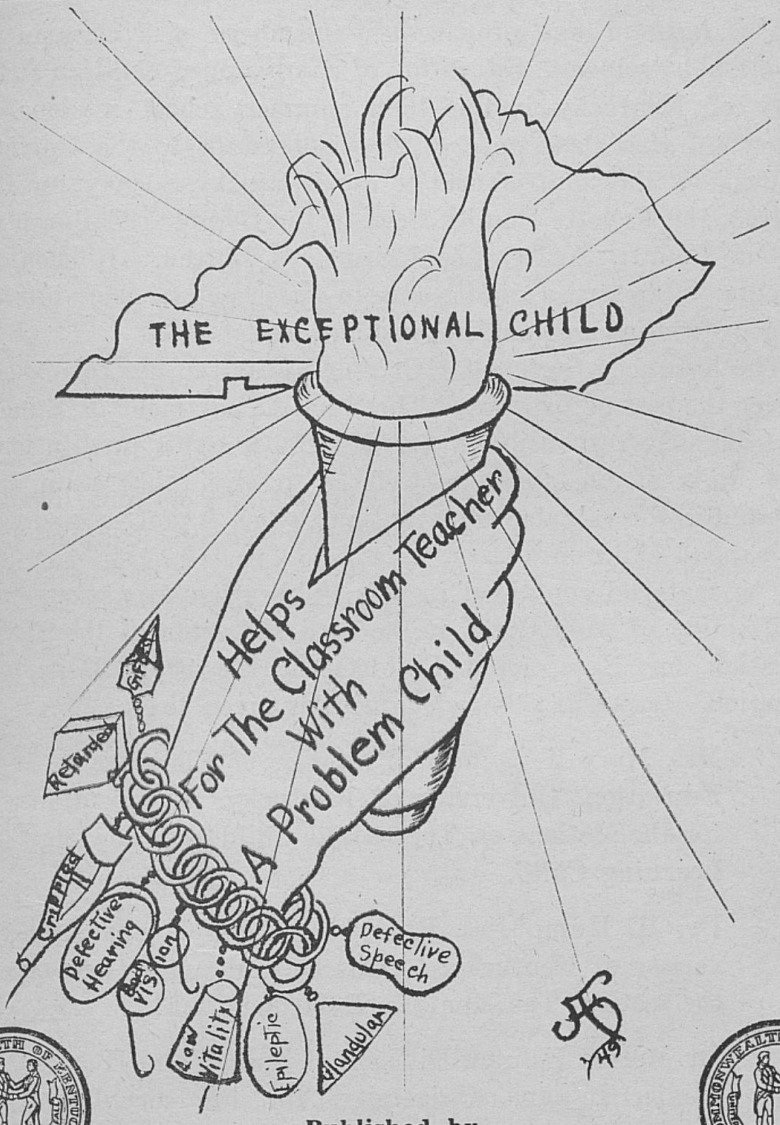
• Commonwealth of Kentucky •

EDUCATIONAL BULLETIN



Published by
DEPARTMENT OF EDUCATION
BOSWELL B. HODGKIN, Superintendent of Public Instruction

ISSUED MONTHLY
Entered as second-class matter March 21, 1933, at the post office at Frankfort, Kentucky, under the Act of August 24, 1912.

Vol. XVII JULY, 1949 No. 5

FOREWORD

This bulletin was prepared by members of a class in Modern Educational Problems: Education of handicapped children at the University of Kentucky in the 1948 summer school sessions. Eight members of this class were given scholarships to the University of Kentucky by the joint efforts of the Kentucky Society for Crippled Children, the Fayette County Society for Crippled Children and the Bourbon County Society for Crippled Children. It should be of particular interest and significance to class room teachers interested in giving instruction for handicapped children.

The Kentucky Society for Crippled Children has furnished funds to cover the cost of printing. The State Department of Education is glad to assume responsibility for distributing this publication to the school units of the state, as well as to any other state or group interested in the valuable contributions which it makes to education of handicapped children.

The material contained in this publication was prepared under the direction of Miss Gwen Retherford, Director of the Division of Education for Exceptional Children of the State Department of Education. Grateful acknowledgment is given to:

Mrs. Mary K. Duncan, Professor of Elementary Education, University of Kentucky, as consultant for the sections on The Gifted Child and The Slow Learning Child.

Dr. H. Humphries, Professor of Psychology, University of Kentucky, for his helpful suggestions on the section, The Mentally Retarded Child.

Dr. Robert Milisen, Division of Speech and Hearing Clinic, Indiana University, for his consultative services on the section pertaining to speech.

BOSWELL B. HODGKIN
Superintendent Public Instruction

TABLE OF CONTENTS

EXCEPTIONAL CHILDREN INCLUDED

A consideration of children should be the foundation of any educational program. Every child is worth educating, has a right to be educated, and the school has an obligation for service to all children.

Every child needs happy parents who love him; a home that provides for his physical needs and where there is respect, harmony and understanding; a social group that inflicts minimum pressure and frustration on him; and a community which assumes responsibility toward its children.

As administrators, supervisors and teachers assume responsibility for *all* children, the education of the exceptional child will be assured. Most teachers realize that every child should be with a group of other children of like ages to develop most normally. Exceptional children should, therefore, be included in regular classrooms, whenever possible.

Since each child in the classroom is planned for as an individual the characteristics and qualities that create the exceptional child can be recognized. In proportion to identification and understanding of the child's needs will the teacher provide for the exceptional child.

Part I

ORTHOPEDICALLY HANDICAPPED CHILDREN

(Reference numbers refer to Bibliography on page 224.)

I DEFINITION

An orthopedic or crippled child is one who has a defect which causes a deformity that interferes with the normal function of bones, muscles and joints. These deformities may be congenital, or caused by accident, injury or disease.[1] They may be aggravated by neglect, disease or ignorance.

II INCIDENCE

In 1945 crippled children in the United States numbered 336,040 of which 112,013 were in need of education. "In Kentucky during the fiscal year of July, 1946 to June, 1947 there were 4,163 crippled children examined."[2] Of this number, according to national figures, about one-third are in need of education.

III STANDARDS

According to House Bill No. 16 the attendance officer of each school district shall ascertain annually all children within his district who are physically handicapped and report same to the Division of Special Education for Exceptional Children.[3]

The classroom teacher through her direct contact with school-age children can give valuable assistance to such a report by fettering out unknown cases. Families are prone to hide their deformed children. "Too many families are ashamed of the child born without an arm or a leg."[4]

For educational purposes crippled children who would profit from normal classroom activity are those:

A. Who have a crippling condition mild enough not to require hospitalization, home-teaching, a convalescent home or special facilities, and

B. Who can attend regular classrooms if special consideration is given transportation, special equipment and materials, and a modified school program.

IV DIAGNOSIS

A school receiving a child as a transfer from a hospital, convalescent home, home-teaching program or special class should request a summary report from the agency; giving a medical diagnosis, description of the case, recommendations relative to wearing appliances, restrictions of activity, and periodic returns to hospital or physician for a check-up. The report should also state that the child may be referred back to the referring agency at any time if a question arises concerning his physical condition.[5]

In the event the child is not an agency transfer, such information should be requested from the physician in charge of the case. If the child received educational instruction during this period an achievement report should also be requested.

Questionable cases relative to profit a child would receive from normal school activity and probable need for special training should be submitted for decision to the Director of Special Education for Exceptional Children. A certified diagnosis of the physical defect by competent professional authorities and a complete general case history are necessary for a final decision about the individual needs.[3]

V CLASSIFICATIONS

CEREBRAL PALSY. This is a type of paralysis that results in lost or impaired muscular control. This impairment more often affects the motor areas of the brain than the intelligence areas. Sometimes both areas are affected. The lost control may be in the arms, legs, tongue, speech mechanism, eyes or hearing. Cerebral palsy may be the result of injury to the brain during or after birth. The majority of cerebral palsy cases are both treatable and educable. About three-fourths of them have normal intelligence.[6] Slow development seems to characterize many of these children but they may later become normal in intelligence.[7] Much emphasis should be placed upon achievement of speech and face control.[8]

POLIOMYELITIS OR INFANTILE PARALYSIS. One of the most common causes of crippling conditions; it is thought to be contagious and caused by a virus. It often reaches epidemic proportions in the latter part of hot, dry summers. Infection spreads rapidly to the spinal cord where an extreme inflammation sets up. Paralysis varies in intensity with different patients. The muscles of the legs are affected more often than those of the arms. The muscles become limp, weak, flabby and helpless.[9]

OSTEOMYELITIS. An acute inflammation of the bone. This may develop from injuries to the bone. Sometimes there is a complete destruction of the bone.

BONE AND JOINT TUBERCULOSIS, A disease of childhood where the germs gain entrance to the growing portions of the bones. The joints may become deformed and large.[9] The joints affected arranged in order of frequency are spine, hip, knee, ankle, elbow and shoulder.[9] The "hunchback" is often the victim of tuberculosis of the spine.

CONGENITAL DEFORMITIES. These are the deformities that exists at birth. Included are clubfoot, harelip, cleft palate, wry neck, and hydrocephalus (very large head).

Other Classifications. Although these are a small percent of the total number of crippling conditions they are, nonetheless, common. MUSCULAR DYSTROPHY (weakness of the muscles), SCOLIOSIS (curvature of the spine), ARTHRITIS (inflammation of the joints), OSTEOMALACIA (brittle bones) and conditions

resulting from injuries (burns, cuts and gun wounds), and accidents (broken bones and loss of arm or leg).

CARDIOPATHICS. Children with heart disease are grouped with the orthopedics because of the weakness of the heart muscles. There are five functional cardiac classifications according to Baker.[10]

A. Organic but able to carry on ordinary physical activity.

B. Organic but not able to carry on ordinary physical activity —may have to omit sports, gym classes and climbing stairs. Transportation will probably have to be provided.

C. Organic but unable to carry on any physical activity— symptoms and signs of heart failure. Should not be in school.

D. Possible heart disease—symptoms evident but not yet diagnosed.

E. Potential heart disease—some illness or factor which might result in a cardiac condition.

Most of the heart conditions develop under ten years of age.

VI **GENERAL SCHOOL ADJUSTMENTS**

The staff should have a well coordinated plan to use in helping any crippled children, the plan to include possible change of classroom location to eliminate step climbing, special supervision during recess, lunch and rest periods, if necessary, and supplemental instruction according to individual needs.

VII **CLASSROOM ADJUSTMENTS**

The teacher of such children should be of sound physical and mental health with a happy outlook on life. She will be called upon to observe, more carefully than in the normal child, the physical and emotional needs of the crippled child. A pillow under a tired arm or leg, a word or two more of encouragement, or the prevention of a social blunder from a normal child.

VIII **THE CLASSROOM**

Classrooms somewhat larger than the average are recommended as being better to care for the needs of crippled children. It is preferrable that the classroom be located on the ground floor. These rooms should be well lighted, decorated with soft colors, orderly arranged with the pleasant, attractive things that help create a happy atmosphere for any normal group.

IX **SPECIAL EQUIPMENT**

A. Cot, pillows and blanket
B. Wheelchair and walker
C. Ramps
D. Adjustable table for standing children
E. Foot rests
F. Adjustable desks or tables
G. Reading racks, easels, lapboards
H. Special transportation

X INSTRUCTIONAL MATERIALS

The teacher will need little in the way of special instructional materials if she has found ways to provide the classroom with applicable special equipment listed above. Unless the crippled child has an additional handicap in another area, such as a hearing or visual defect (necessitating instructional materials for that particular handicap) such adaptations as larger pencils or a pencil inserted through a small rubber ball, and wide-spaced tablet paper are easily supplied and will be conducive to the successful achievement of a child learning the use of a new prosthetic appliance or the one suffering a muscular loss from a severe hand burn. An imaginative teacher can make similar adaptations of materials to fit the individual needs.

XI INSTRUCTIONAL METHODS

The teacher of the crippled child will find that instructional methods suitable to the normal child are quite adequate provided she gives special consideration to the tremendous phychological adjustments which, generally speaking, must be made by crippled children. It is recognized that the attitude of the crippled child or person toward his disability is probably the most important single factor toward making him a normal member of society.

Instructional methods should embrace the following psychological interpretation of the crippled child:

A. "A crippling condition often leads to exaggerated attention from families and in some cases may delay emotional maturity. Others develop compensatory energies or abilities that make them outstanding. Any disabling illness provides the child with the opportunity to gain the center of the stage and to unconsciously utilize the disability to reclaim the golden phase of childhood power, normal in early childhood, but psychologically crippling as the child grows older."[11]

B. Sympathy and understanding but not sentimentalism are needed.

C. With minor exceptions he should expect and receive the same treatment as the normal.

D. It is necessary to make the crippled child realize that he is not alone in his difficulties and that in one way or another all people have handicaps.

E. As life is rarely a segregated one, a crippled child has a great need for social contacts with normals. Classroom teachers can cultivate a sympathetic and cooperative attitude on the part of the normal child to prevent setting the handicapped apart.

F. The child must be guided to a reconciliation of his aspiration level with his performance level.

G. Motivation material can be included in a study unit which reveals world figures who have succeeded despite their handicaps.

H. Due to the limited mobility of the crippled child an enriched program will bring much satisfaction.

I. The development of an incentive in the child for constructive leisure activity is vital.

XII INSTRUCTIONAL ACTIVITIES

A. Units of work:
- The fire station
- Circus
- Store
- Airport
- Farm
- Home
- Science

B. Construction work:
- Kites
- Dolls
- Puppets
- Puzzles
- Soap carving
- Painting
- Weaving
- Sewing
- Hobby collections

C. Physical games:
- Bouncing balls
- Croquet
- Marbles
- Simple rhymes
- Darts
- Blowing balloons

REFERRALS:

Kentucky Legal Agencies:

The Kentucky Crippled Children Commission
301 Heyburn Building
Louisville, Kentucky
(For the assistance and treatment of PHYSICAL conditions of the crippled child.)

The Division of Education for Exceptional Children
Department of Education
Frankfort, Kentucky
(For EDUCATIONAL problems of the crippled child)

Vocational Rehabilitation Division
Department of Education
Frankfort, Kentucky
(For POST-SCHOOL training of the crippled child)

Federal Agency:
The Children's Bureau
Department of Social Security
Washington, D. C.

Private Agencies in Kentucky:
Kentucky Society for Crippled Children
840 South Third Street
Louisville, Kentucky

Kentucky Chapter for the National Foundation
for Infantile Paralysis
Marian E. Taylor Building
Louisville, Kentucky

BIBLIOGRAPHY

1. *Handbook for Teachers of Exceptional Children,* University of Texas, 1947, page 46
2. *Biennial Report of the Kentucky Crippled Children Commission,* 1947, page 20
3. *House Bill No. 16,* Kentucky Legislature, 1948
4. *"Education Is Denied Million Children,"* The Crippled Child, December, 1947
5. *Education of the Handicapped in Detroit Public Schools,* Detroit Board of Education, Detroit, Michigan, 1937
6. *"Gary Grows Up,"* State Department of Education, Sacramento, California, 1948
7. *Psychological Experiments of the Cerebral Palsied,"* Journal of Exceptional Children, March 1948, page 165
8. *"The Medical Aspects of Cerebral Palsy,"* Public Welfare in Indiana, Indianapolis, Indiana, page 13
9. *Special Education for Exceptional Children in Texas,* State Department of Education, Austin, Texas, 1948, page 75
10. Baker, Harry J., *Introduction to Exceptional Children,* pages 191-192
11. Strecker, Dr. Edward A., *"Doctor Says Polio Changes Personality,"* The Courier-Journal, Louisville, Kentucky, July 16, 1948

DEAF AND HARD OF HEARING CHILDREN

Today the deaf and hard of hearing are beginning to come into their own. They have been neglected for years. Now the whole nation is beginning to realize that this group can be made much happier by giving them special training, both educational and vocational, so that they can become economically and socially independent.

I DEFINITION

A. Hard of Hearing—are those in whom the sense of hearing, although defective is functional with or without a hearing aid.

B. Deaf—Those in whom the sense of hearing is nonfunctional for the ordinary purposes of life.

II OCCURRENCE AND STANDARDS

A. The occurrence of hard of hearing is great. It was reported by the American Federation for the Hard of Hearing that 14% of pupils have hearing defects. Out of a class of 35, approximately 5 would have defective hearing.

B. Standards—the deaf have their own schools. The only standard considered for entrance to these schools is being deaf and whether the person considered has learned language usage. Today there are approximately 20,000 deaf pupils and 3,000 teachers.

III FINDING THE HARD OF HEARING AND DEAF CHILD

A. These children should be identified at the earliest possible age. Identification is essential in preventing the hearing loss from becoming more serious or permanent.
The following symptoms may be of help to the teacher in identifying them:
1. Failure to respond—says "what?"
2. Moves closer to the speaker
3. Peculiar posture and tilts head at unusual angle
4. Mouth breathing
5. Running ears and earaches
6. Defective speech and peculiar voice
7. Retarded in school work
8. Appears listless, inattentive, dazed or confused
9. Sensitive, aloof, suspicious, hard to accept as cordial acquaintance

B. Some informal testing can be used in the class room but only as screening device.
1. The whisper test
Whisper numbers softly. Have child stationed so that he is unable to see the speaker's face. The child should be twenty feet away from the person doing the testing. Have child repeat the numbers whispered.
2. 6-A audiometer—gives careful individual screening and is pure tone.
3. 4-A audiometer—a group test designed for finding gross errors.
4. Watch tick test—this test has been used but is now considered obsolete. It is not reliable as different watches have different pitch.

IV DIAGNOSIS

The above tests are are strictly informal methods of raising reasonable doubts about the hearing and must be followed by more formal and exact methods of diagnosis.

Final judgment as to deafness should lie in the hands of a competent physician who has specialized in problems of deafness—known as an Aurist or Otologist.

V EDUCATION

A. What can we do for these children?

The best thing for a teacher to keep in mind is that deaf or hard of hearing is the same as a hearing child except that his hearing is impaired. Treat him as a normal child before and after he has been given special adjustment to enable him to work in a regular class room.

The teacher should see that:

1. Medical attention is given (complete physical check up)
2. Hearing tests are made
3. A remedial education program is provided
4. Proper seating is utilized—i.e., a child with a deaf right ear should be seated to the left of the teacher's desk and vice versa
5. An enriched school program is offered with lots of reading
6. That group activities include the whole group
7. Parents develop a wholesome attitude toward his impairment
8. If doctor advises, a hearing aid should be procured for the child

It is best to adjust the child to the public school if possible. Hard of hearing classes can be set up in the regular school. But these children must not be isolated from the normal school room. They should do as much work as possible in the rooms with children of normal hearing.

For the totally deaf child an entirely different program is necessary. He must first be given an understanding of language, be taught lip reading and speech correction. After years of preparation he can be placed in the regular class room but must still have some supplementary work.

B. STATE AGENCY:

The Kentucky State School for the Deaf, Danville, Kentucky

It is important to recognize the value of an investment in children, who, with special assistance, will become useful and self supporting citizens.

BIBLIOGRAPHY

Baker, Harry J., *Introduction to Exceptional Children.* New York, MacMillan Co., 1943.

Best, Harry, *Deafness and The Deaf in the United States.* New York, MacMillan Co., 1943.

"Helping the Exceptional Child in the Regular Classroom." Michigan Department of Public Instruction, Lansing, 1941.

"The Classroom Teacher Can Help the Handicapped Child," New Jersey State Department of Education.

VISUALLY HANDICAPPED CHILDREN

I CLASSIFICATION AND DEFINITION

A. Children with Impaired Vision:

1. PARTIALLY SEEING: Any child who because of some visual defect or restriction other than blindness and cannot successfully pursue his school work without great fatigue, effort or further injury to his eyes is classified as partially seeing.

2. BLIND: An individual who must learn to live aided by senses other than vision is blind.

   a. He may be totally without sight
   b. He may have object or light perception
   c. His visual acuity is 20/200, or less, after correction. He may be able to read very large type in a limited amount

B. Incidence: 20% of all children have eye defects, i.e., 1 out of every 5 children. 19.75% of all children's defects can be corrected. .25% of remaining are partially seeing or blind. Of this .25%—4/5 are partially seeing and 1/5 are blind.

C. Standards: Standards for eligibility for sight saving classes.

1. Visual acuity of 20/70 to 20/200
2. Serious, progressive eye defects
3. Children suffering from diseases of the eye or diseases of the body that affect vision
4. An unclassified visual defect (under ophthalmological care) which impairs school progress
5. An eye weakness or maladjustment as a result of treatment, operation or convalescence

II ENUMERATION

A. Teacher Observation for the Following Symptoms:

1. CONDITION OF EYES—crusts on lids among lashes, red eyelids, styes, swollen lids, watery eyes, apparent lack of coordination in directing the gaze of the two eyes.

2. BEHAVIOR which may indicate visual difficulties among children:

   a. Attempts to brush away blur
   b. Holds his body tense when looking at distant objects
   c. Inattentive to wall chart, map or blackboard work
   d. Rubs his eyes frequently
   e. Screws up his face when looking at distant objects
   f. Thrusts his head forward to see distant objects
   g. Poor alignment in penmanship

h. When reading: blinks continually, holds book extremely close or far away from face or makes frequent changes in distance; screws up face; shuts or covers one eye, tilts head to one side; tends to look cross-eyed; confuses letters which are similar in appearance such as "O" and "A", "E" and "C", tends to lose the place on the page, complains of dizziness, headaches, nausea as a result of reading.

B. Inspection by screening devices:
   1. Snellen E chart test which is adequate for the function of clearness of vision
   2. Betts' Telebinocular
   3. Massachusetts Vision Test

III DIAGNOSIS

The above screening tests, even though carefully administered, may not discover all children who need attention. Any child exhibiting a visual disturbance should be reported to the parents for competent diagnosis and care by an Ophthalmologist, a medical man who has specialized in eye diseases.

IV EDUCATION AND TRAINING

A. Classroom Adjustments: Get a doctor's recommendation and follow it. If the child is fitted with glasses and remains in the regular classroom the following points should be observed:
   1. Glasses should be worn constantly, if recommended
   2. Glasses should be kept clean and should be properly worn; this means that the child should look through the center of the lens at all times
   3. Light should be good and come from over the left shoulder, except in cases of left-handedness
   4. Children should sit so that all blackboard work, charts, demonstrations, etc., are visible
   5. Permit child to sit or move where he has good light and can see class work; he should not sit facing the light
   6. There should be no glaring surfaces within his line of vision
   7. He should sit erect and bring his work up to the necessary level for seeing

B. General Adjustments:
   1. Encourage adequate rest
   2. Balance diet
   3. Normal outdoor activity
   4. Close cooperation between parent and teacher

C. Instructional Material:
   1. Large size soft chalk to make broad, heavy lines
   2. Pencils with fairly soft, thick, heavy lead making a broad line
   3. Pen with broad writing point
   4. Slightly rough, unglazed, cream manila paper

5. Books printed in large, clear 24-point type with plenty of picture
6. Material for motivated handwork such as clay, finger painting, plasticine

D. Instructional Methods:
1. Avoid excessive or unnecessary reading; employ the services of a reader* whenever possible, especially in the upper grades where assignments are long
2. Plan work so the child's schedule is based on eye work followed by eye rest periods
3. Rest the eyes frequently by closing them or by looking away from the book or work
4. All writing on blackboard should be large manuscript writing

E. Equipment:
1. Use movable, adjustable, tilt-top desks. If the desk top is flat use copy holder for resting working material on eye level
2. Use a bulletin typewriter with upper and lower case letters
3. Radio, record player, the talking book and dictaphone

V GLOSSARY OF TERMS

A. HYPEROPIA (farsightedness), a refractive error in which, because the eyeball is short or the refractive power of the lens weak, the point of focus for rays of light from distant objects (parallel light rays) is behind the retina; thus, accommodation to increase the refractive power of the lens is necessary for distant as well as near vision.

B. MYOPIA (nearsightedness), a refractive error in which, because the eyeball is too long, the point of focus for rays of light from distant objects (parallel light rays) is in front of the retina; thus, to obtain distinct vision the object must be brought nearer to take advantage of divergent light rays (those from objects less than twenty feet away).

C. ASTIGMATISM, refractive error which prevents the light rays from coming to a single focus, because of different degrees of refraction in the various meridians of the eye.

D. STRABISMUS (cross-eyedness), squint; failure of the two eyes to direct their gaze at the same object because of muscle imbalance.

E. ASTHENOPIA, eyestrain caused by fatigue of the internal or external muscles.

F. OPTOMETRIST, one skilled in the measurement of the refraction of the eye for prescription of glasses.

G. OCULIST OR OPHTHALMOLOGIST, terms used interchangeably; a physician who is a specialist in the diseases and defects of the eye.

H. A READER* is a fellow student who has been carefully selected to read materials to the partially seeing child in order to save his vision from further strain when he has an excessive amount of reading to be done.

AGENCIES

1. State Department of Education
2. National Society for Prevention of Blindness
3. State School for the Blind—Louisville, Kentucky

BIBLIOGRAPHY

1. Hathaway, Winifred, *Education and Health of the Partially Seeing Child.*
2. Baker, Harry S., *Introduction to Exceptional Children.*
3. *"The Classroom Teacher Can Help the Handicapped Child,"* New Jersey State Department of Education.
4. *"Helping the Exceptional Child in the Regular Classroom,"* Michigan Department of Public Instruction, Lansing, 1941.
5. *"Suggestions for Classroom Teachers,"* Division for Exceptional Children, Kentucky State Department of Education, 1947.

THE CHILD WITH DEFECTIVE SPEECH

(Reference numbers refer to Bibliography on page 238.)

I **DEFINITION:**

A speech defect may be defined as speech which differs so much from the speech of other people that it attracts the attention of the listener to the difference of speech, and therefore interferes with communication or causes maladjustment.

A. INCIDENCE, OCCURRENCE

Since more than 95% of our communication is through speech, this tool is very important. About 5%* of the population have been found to be defective speakers. The average number of articulatory defects in the first grade is 20% of school population, in second grade 12%, in third grade 6%, and in fourth grade about 4%.

Many teachers and parents in the past have taken poor or defective speech for granted. They have treated the defect with humor, pity, indifference or with other evidences of unconcern. **Now** the good teacher attempts to help the individual attain the maximum of his capacities and abilities. The alert teacher knows that speech defects cause retardation in school (as much as one to three or four years), cause a person to be restricted to a few uninteresting and unimportant jobs, and cause individuals trouble in getting along with other people.

B. STANDARDS

The younger the school child is when given help, the better the chance for success. The teacher must have a standard of measure and should know what is good speech for different ages or developmental groups. She should study her own speech thoroughly. A wire recorder or record machine is a good device for this.

The teacher should familiarize herself with the **true** sounds of letters. A letter does not always sound the same. The teacher should say the words to herself, until she can sense the real sound in the word, regardless of spelling of word. Some examples are: **six** really contains **siks** when the sounds are considered; **his** contains **hiz; scissors—sizers; one—won; can—kan; quiet—kwiet,** etc.

II **ENUMERATION-FINDING:**

A survey by a speech clinician is very desirable, when at all possible. Any survey made by teachers alone, possibly will be inadequate; but any effort is better than no effort at all. Sometimes a very little preventive therapy will avoid further maladjustment.

*From White House Conference (1931).

III **DIAGNOSIS:**

Any child who has speech troubles should be examined by a speech correctionist, if possible. If the teacher has reason to suspect a health factor or an organic disability is involved, then she should suggest to parents an immediate examination by the child's physician, a pediatrician, or any oral surgeon.

If there is no speech correctionist in the area, the teacher must go on her own until the time when speech correctionists are available to all communities.

In the case where there is no correctionist as yet, a simple test for defective articulation might be as follows:

A. Have child count from 1 through 16.

B. List and evaluate sounds. A **mark** could be drawn **under indistinct** sounds; the **letter substituted** written **above** the **sound for which it is substituted** and write letter **"O" above** the **sounds omitted.**

C. Sounds to look for are:
One—**w**on
Two—
Three—**th**ree
Four—**f**our
Five—**f**ive
Six—si**k**s
Seven—**s**even
Eight—
Nine—
Ten—
Eleven—**e**leven
Twelve—**tw**elve
Thirteen—**th**er**t**een
Fourteen—**f**ourteen
Fifteen—
Sixteen—**s**ixteen

D. Ask child if he can say Jack and Jill. If he can, get him to say it; and look for underscored sounds.
"Jack and Jill went up the **h**ill
To **g**et a pail of water
Jack fell down and broke his **c**rown (z and k sounds)
And Jill came tumblin**g** after."

E. Then have child read "**Th**at **sh**oe is by the **r**ed **ch**air." Observe and record sounds missed.

Speech disorders: Functional and Organic.

IV **REEDUCATION:**

Since about 70% of all speech defects are articulatory, it seems wise to consider this phase first. If given sufficient help, about 98% of these defects can be cleared up by the end of the second grade.

A. **"Do's"** for the teacher aiding rehabilitation and adjustment in the classroom.

1. Make the child a happy member of the group
2. Teacher should have a calm, unemotional attitude toward child's speech disorder
3. Help classmates to understand that Johnnie's speech is "more different" than their's. She should stress that all of them have different sounding speech
4. Keep training an educational process
5. Correct only **one** sound at a time
6. Have a specific time, each day if possible, to work with speech
7. Allow and encourage the child to speak

B. **"Don'ts"** for the classroom teacher.
1. Do not call attention to child's defective speech, if he has never noticed it and if the children and parents have nver noticed it
2. Do not correct him every time he articulates a word incorrectly, this is **"nagging"** and will cause resentment
3. Do not exclude him from classroom conversation, talk for him or force him to speak in uncomfortable situations

C. Teacher aids in General Adjustment:
1. Get cooperation of the parents: not always an easy task, to be handled with tact. Help them to understand that:
   a. No one has perfect speech
   b. Defective speakers are not usually retarded mentally
   c. Many speech defects can be corrected
   d. Uncorrected defects frequently retard the child's emotional, educational and vocational growth
   e. The handicapped child must be encouraged in things that he does well

D. Instruction Methods: ARTICULATION DISORDERS.
1. A sound can be produced by a child most easily when it is made alone (in isolation) such as "sssssssss".
2. It is next most easily produced by attaching it to another sound, usually a vowel, and making it a **non-sense syllable** such as: "su", "usu", "es". (Not to become meaningful words).
3. It becomes more difficult when the sound is in a **word,** such as: "see", "saw", "some".
4. It is even more difficult for a child to say a sound correctly when the sound is in words which are a part of a **sentence,** such as: "Did you see my sister?"
5. A careful diagnosis is necessary. A teacher can get some idea by locating the sounds which are defective and by saying those sounds for the child in **"Isolation", "Non-sense Syllables"** and in **"Words."** The sound which can be most easily imitated by the child is usually the one which should be corrected first.
   In "blend words", it may be much more difficult for the child to produce "s" in "slick" where it is followed by a consonant "L", than it would to say the "s" in "sick" where it is followed by a vowel. (Children as a rule do

not have as much trouble with vowels as they do consonants). This should also be kept in mind in the early stages of retraining. Avoid "blends" such as: bl, br, fl, fr, gl, gr, kl, kr, pl, pr, sk, sl, sm, sn, sp, st, sw, tr, tw. In other words, give the child a chance to very nearly master that defective "s" sound in simple words that are in his vocabulary and without blends.

Initial Position	Medial Position	Final Position
sir	pencil	us
soap	mousie	house
side	bicycle	this
soup	Lucy	bus
soon	grocer	face
sign	inside	pass
same	saucer	miss
see	myself	ice

Sounds are produced (1) **normally:** "Did you **s**ee my **s**ister?" (2) Omission: "Did you -ee my -i-ter?" (3) **Substitution:** "Did you **th**ee my **thith**er?" (4) **Indistinct:** The "s" sound distorted, "Did you (s)ee my (s)i(s)ter?"

6. Re-training: Use the **"LOOK, LISTEN AND SAY"** method. The teacher gives Johnnie **Oral** and **Visual** stimulation by **showing** him (**not telling** him) how one looks and letting him **hear** how one sounds when the "s" sound is produced in Isolation. **Avoid calling verbal attention to what the tongue, lips and teeth** are doing. Instead, show him and let him imitate. For example, if working with the "S" sound:

Teacher: "Johhnie, look at me and listen, ssss sssss ssssss, now you say it."
Johnnie: "ssssss sssssss sssss." Work with the sound in Isolation until Johnnie experiences success. (Do not work too long if success doesn't come easily.)
Teacher: "Watch me Johnnie, listen. sa sa sa." (Nonsense syllables, initial position.)
Johnnie: "sa sa sa."
Teacher: "Johnnie watch me, listen, ese, ese," (medial position in non-sense syllable).
Johnnie: "ese, ese, ese."
Teacher: "Listen and watch me Johnnie, es es es" (final position in non-sense syllable).
Johnnie: "es es es."

The teacher must open her mouth and make the sound as **visible** as possible without undue facial distortion. Many sounds can be made much more visible than shown in ordinary speaking and still not disrupt the contour of the entire face. For example: Open the mouth, say "lay" (sustaining the "L" for a second). The movement of the

tongue is readily visible to Johnnie. Likewise in the words ball, Billy, cat, ache, acre, etc."

Stimulation in the re-training process is **oral** and **visual.** The stimulative method of treatment appears to be successful in 95% of articulation cases. Do **not** use artificial breakdown of a sound such as: "Now Johnnie, put your tongue up against the roof of your mouth, now blow." After Johnnie has learned to produce a good "s" sound in isolation and non-sense syllables after **oral** and **visual stimulation,** if he can read, he may be given a few short sentences containing only one "s" sound:

I see you. (Initial position)
I need a pencil. (Medial position)
Will you come with us? (Final position)

Give him sufficient experience with this sort of sentence to realize success. Then have him read a paragraph while the teacher checks the "s" sounds. Then have him talk, again picking out "s" sounds that are incorrect. If Johnnie cannot read, the teacher will have to use pictures which suggest or contain the "s" sound: mouse, house, horse, bus, goose, soap, soup, seat, saucer, etc. In this Johnnie does not have stimulation from the teacher, but is dependent upon his memory.

If he fails to produce an acceptable "s" the teacher may give either oral stimulation, (saying the word, but not let Johnnie see her mouth) or visual stimulation (opening her mouth forming the word but not vocalizing it). If he fails after this, it is best to give him additional training in the non-sense syllables, words, etc., with **both** oral and visual stimulation.

Never drill a child on a sound until he becomes weary. Play games. The teacher may read and have Johnnie listen for the "s" sound. Johnnie may recite memorized material, answer pointed questions, tell stories, etc. If Johnnie is aware of his distortion of the "s", it is wise to get him to **evaluate his own responses as soon as possible.** Have Johnny produce "sa sa sa". Then say, "Johnnie do you think that "s" sound is good, fair, or poor?" The teacher's goal is to get Johnnie to **hear, evaluate** and **correct** his errors. The teacher may repeat a sound as Johnnie says it, then say the sound correctly. This will help him to become aware of how he says it and how he should say it.

E. STUTTERING: "The way to treat a young stutterer in the primary stage is to **let him alone** and treat his parents and teachers."—Van Riper[1]

Treatment consists primarily of prevention:[2]

1. Remove all speech conflicts
   a. Analyze experiences and environment

b. Keep a list of words on which blocks occur, try to determine the pressure that caused the block. It could have been some common conflict such as:
   1) Interrupting the child
   2) Talking for the child
   3) Suggesting other methods of talking, such as: slower, take a deep breath, think before you speak, substitute another word, etc.
   4) Ridiculing child
   5) Too high speech standards for child
   6) Punishment
   7) Asking him to hush
   8) Requiring child to talk when fatigued or excited
   9) Attempting to make him hurry when he is talking slowly
   10) Forcing child to "show off"—speaking pieces for strangers when he is unwilling to

2. Child must be kept in good physical condition
   a. Fatigue increases number of blocks
   b. Well balanced diet
3. Pleasant home situation
   a. Even **implied** attitudes reflect in child's emotional adjustment
   b. The tempo of living in some homes is too fast
   c. Needs calm activity
   d. Rest of the family must accept his stuttering unemotionally as his way of speaking
4. Parents and teachers
   a. Must **not** react emotionally to a child's stuttering blocks
   b. Reaction of parents and teachers help the child to determine his own reactions
   c. Don't appear surprised, embarrassed, impatient
   d. Look stutterer right in eye while talking; do not interrupt
5. Attempt to cancel all child's unpleasant memories of experiences in stuttering
   a. Distract his attention to something else immediately after block occurs
   b. "Fake" a stuttering block occasionally when talking to the child
   c. Manipulate conversation so that child can successfully say words that he previously had trouble with, thus leaving a pleasant memory of that word
   d. If child begins to force words, parents can show child that they too would have trouble if they forced
6. Establish favorable speech condition in school and on the playground
   a. The teacher helps a classroom situation if she ignores stuttering and refuses to react to it. This helps to determine the attitude of the other children

b. Encourage child to recite, but give no comment about abnormality
c. Explain to class that child merely has a different way of talking, only temporary, he just needs plenty of time
d. Handle school ground situations without threats of punishment, help children to see their teasing is harmful to the child

7. Give child many ideal speech situations
   a. Let him tell stories
   b. Let him recite verses
   c. Let him read aloud in situation where there is no pressure or tension
   d. Don't interrupt child
   e. Play speech games which emphasize slow, distinct speaking and rhythmic speech
   f. Do not place child on exhibition
   g. It is unwise to place young primary stutterer in speech correction class
   h. Treatment of primary stuttering is always **indirect**
   i. On days when child has few blocks, have him speak a great deal
   j. On days when child has many blocks, have little speaking
8. Insist on unilaterality in most activities
   a. Let him use hand preferred
   b. Never attempt to change hand preference
   c. When he can write, teach him to write and talk at the same time
   d. Give him many new **one handed** skills, no typing or piano playing
9. Train child to perform temporal patterns with paired musculatures
   a. Parent and teacher can play games in which the child beats out simple rhythms
   b. Use both feet, both hands
10. Increase potential personality assets, give him mastery of new skills and greater social adequacy
11. Try to keep child from being "dubbed" stutterer
    a. Tell him he does have some hesitations and repetitions but he will probably overcome them
    b. Everyone has hesitations and repetitions
    c. Help him to accept comment with, "Sure, I stutter a little, everyone does, what of it?"
    d. Give ringleader the responsibility of preventing any teasig on the playground, he will usually cooperate enthusiastically

F. SECONDARY STUTTERING:

DO'S

1. Treat the child as a normal person who has a special handicap in rhythm of speech

a. Require him to have only as much sleep as he needs
b. Encourage him to take his turn in talking
c. Give him as much time as he needs to finish saying what he has started to say
d. If he stutters **badly** having long interruptions, be sure to call on him early in the class period so he won't have to hurry to finish before the bell rings. (He usually goes slower when he tries to hurry.)
e. Grade the child's oral responses on the basis of information imparted rather than the perfection of the rhythm of speech
f. Observe your own speech such as: ba ba baaaa, an and and annnnd, a a a a, uh uh uh, well etc., this helps you to avoid demanding perfection of the child which you can't offer yourself
g. Encourage the other children to accept the interruptions of the stutterer and realize that his speech isn't really different in kind, but in amount since all people have interruptions in their speech
h. Be calm while the child stutters
i. Talk to the parents about the stuttering but don't make an issue of it in front of the child
j. Give the child a chance to participate in extra curricular activities, both in speaking and non-speaking aspects
k. Urge the child to attempt to say the word and to keep at it **easily** until the word comes out

DON'TS

1. Don't treat it as a habit which can be corrected by telling the child to stop
2. Don't give suggestions of "methods" that will "help" the child "stop" stuttering. They almost always do more harm than good. (Such as take in a deep breath, beat time on the desk with your hand, whistle, swallow, stop and think and hundreds of others equally as bad.)
3. Don't say hard words for the child
4. Don't stop him if he is stuttering
5. Don't ridicule or punish him for his stuttering as if the disorder were his fault
6. Don't talk about his stuttering all the time
7. Don't interfere with his choice of hands, let him make his own choice

BIBLIOGRAPHY

1. Van Riper, C. Speech Correction *Principles and Methods,* Prentice Hall, Inc., New York, 1947.
2. Van Riper, C. Speech Correction *Principles and Methods,* Prentice Hall, Inc., New York, 1947.

Part II

GIFTED CHILDREN

I **DEFINITION**

Dr. Elise Martens has defined the gifted child as that child who has an exceptional intelligence which finds expression in high levels of creative thinking and reasoning.

II **INCIDENCE**

Most educators place the gifted child in that group of children whose I. Q. range is from one hundred thirty and above. The consensus seems to be that there are about one per cent of the children who fall in this range.

III **STANDARDS**

From a medical standpoint, it is advisable to have a thorough physical examination by a reputable pediatrician in order to determine the physical status of the child. It may also be necessary to employ the aid of an otologist, opthalmologist or other specialists in order that the child may function to the maximum of his abilities.

The mental status of the child can be determined by steps given under the topic "Enumeration".

Generally it seems that the child will probably do his best work in a regular school program—adjusting that program to fit his own particular needs.

The size of the group, if the gifted are segregated, should probably not deviate too much from the size of the normal classroom. Educators seem to think that the best number is approximately twenty-five.

IV **ENUMERATION**

There are several steps which are helpful in finding these gifted children. Briefly they may be enumerated in this manner:

A. Previous school marks
B. Achievement tests—example—Standford Achievement Test
C. Intelligence tests—(group or individual) example—California Mental Maturity
D. Interest Scale—example—Kuder Preference Record
E. Factors of health
F. Factors of personality

V **EDUCATION AND TRAINING**

A. **General Adjustment:** One of the major problems of education is to discover and capitalize talents to the maximum. It is sound policy to spend whatever is necessary to make the most of talent for the good of generations.

It is important to remember that the gifted should not be expected to grow socially more rapidly than the average child. There should be emphasis placed upon the importance of a wholesome physical, emotional and social life.

B. **Classroom Adjustment:** Every administrator, supervisor and teacher should be alert to identify the gifted child, study all phases of his development and employ the available facilities for the best interest of the child. It is important that the classroom teacher show an intelligent attitude toward the interests of the child and stimulate his abilities by putting him in contact with gifted people and with as many materials for expression as ingenuity makes possible. Some of the plans which are used to adjusting the classrooms to the needs of gifted children are as follows:

1. **Acceleration**—twenty years ago acceleration was practically the only way the school could meet the demands of the gifted child. This method is now questioned, especially in the elementary school, because generally children seem to prefer and seem to work better with children who are not more than one or two years older.
2. **Enrichment**—if acceleration is not used then the classroom procedure must be modified to meet the demands of the child. This will not necessitate a great change. It is really the same procedure used with the normal child in that the purpose is to challenge the child to the maximum of his abilities. There is a difference in degree and in variety rather than in the kind of method used. It should guide him into an ever widening circle of interests, a higher level of achievement and service, and a greater appreciation of problems which have little or no appeal for less able children in his own age group.[2]
3. **Homogeneous Grouping**—Some instructors feels that the gifted child will realize his potentialities to a greater degree if he associates with children whose abilities are similar to his own. In this grouping there would be a culmination of superior thinking.
4. **Heterogeneous Groupings**—Other educators feel that the advantages outweigh the disadvantages if the gifted child is permitted to associate with a mixed group of children of approximate chronological age. This procedure of grouping seems to be generally accepted as the best one for the development of the whole child to the best of his advantage. He learns to become a member of a group.

There is a possible modification of this plan in that the gifted may be grouped together in the skills and brought with the entire group for activities such as music, art, science, and physical education. Simply stated thus: if a gifted child in your room has acquired the basic skills, he may develop his interests along other lines—such as plan and prepare a play for the group.

It is interesting to note that gifted children do their best work in reading and language. They do their poorest work in handwriting and spelling.

Another very common practice is grouping within the group to meet the needs of the individual. In this way the gifted child may work on units which challenge him.

C. **Instructional Materials and Equipment:** Some of the materials which might be used in the regular classroom with gifted children are slides, motion pictures, microscope, post cards, magazines, radio, and victrolas. Those providing concrete aids include clay, maps and coping saws.

The gifted child should be given every opportunity to pursue different types of enrichment programs as far as he is challenged. They learn very early to use the dictionaries, encyclopedias, visual aids and reference books. They can utilize the group type of discussion in order to share their findings. The library facilities become very important to the gifted child. There he may satisfy his longing for a wide and varied reading program.

The room in which the children work should be attractive. The walls should be painted a soft pleasing color. The desks should be arranged in such a way that maximum lighting is utilized. Interesting books should be arranged in a library corner. All children work better in a pleasant atmosphere and with challenging materials.

D. **Instructional Methods:** The following principles have been formulated by teachers as guideposts in instructing the gifted child:

1. "Organization of subject matter should be centered about material distinctly related to pupil's experience.
2. "Emphasis through subject matter and pupil activities should be placed upon the democratic way of life.
3. "Procedures of the class period should be so adjusted as to minister to individual needs and permit pupils to progress at their own rate of progress.
4. "Pupils should be busy during the class period in thinking through the subject matter and related problems while the teacher should be studying the pupil's approach and method of study.
5. "The teacher should be a daily example of fruitful, logical thinking as he guides the pupils in their activities.
6. "There should be a well-balanced expression of personality on the part of the teacher and pupils in relation to the problems under discussion or the activity in operation."[2-3]

Let us remember that the gifted child needs less drill, less easy reading material, more challenging experience than the average child and that he should be assigned special projects so that he may be prepared to make his contributions to society

E. **Referral to Other Agencies:**

1. Child Guidance Clinics

BIBLIOGRAPHY

1. Baker, Harry J., *Introduction to Exceptional Children,* The MacMillan Company, 1945, pp. 282-295 (1) p. 295.
2. Curriculum Adjustments for Gifted Children, U. S. Office of Education, No. I, 1946, pp. 2-82, (1) p. 9 (2) p. 16.

OTHER REFERENCES

Otto, Henry J., *Elementary School Organization and Administration,* D. Appleton Century Company, 1944, pp. 456-461.
"Classroom Problems in the Education of Gifted Children," National Society for the Study of Education, Nineteenth Yearbook, pp. 1-119.
"Understanding the Child," No. II, Vol. XVII, April 1948, pp. 33-35.

SLOW LEARNING CHILDREN

(Reference numbers refer to Bibliography on pages 246–247.)

I DEFINITION

The slow learner is that child whose I. Q. range is from approximately seventy to ninety. His mental age upon entrance to school is usually from four and one-half to five and one-half. Baker says there are three ways the slow learner differs from the average:

1. Quantitative difference in intelligence
2. Qualitative difference in learning methods and functioning
3. The effects of non-intellectual factors.[1-1]

II INCIDENCE

Studies show that from twenty to twenty-five percent of the children in school are in this particular group.[1-2]

III STANDARDS

It is advisable to have these children checked yearly by a reputable pediatrician, referring to specialists when the need arises. The mental status of the child can be partly discovered by the help of a psychologist and a psychiatrist. It must be remembered however that personality, emotional, and situational factors play so important a part in an individual's social competence that no sharp line can be drawn between the mentally deficient and the so-called "normal" group.[2-1]

Except for remedial work in special classes the slow learner can function well in the regular classroom. The regular classroom teacher still needs to give this special help if other arrangements are not possible.

IV ENUMERATION

No single device should be used in determining mental subnormality. Briefly are listed some of the ways that will help determine the mental status of the child.

1. Group and individual intelligence tests. Examples: Goodenough, Draw a Man (for those who cannot read); California Mental Maturity; Binet Scale.
2. Verbal tests should be supplemented by non-verbal tests.
3. There should be an adequate measure of motor proficiency. Example: Cornell and Coxe's Performance Ability Scale.
4. The possibility of behavior maladjustment as a hindrance to school success should be determined by a psychologist. These behavior problems are often apparent in the child who has difficulty learning because he feels rejected. Example Test: California Tests of Personality.
5. Scores on adequately administered mental and educational achievement tests are considered the basic criteria.

These may be supplemented by medical findings, retardation in school and the judgment of principals and teachers.

Other Tests

Test Reading Example: Gates Diagnostic Reading and Gates Reading Survey.

V GENERAL ADJUSTMENT

In recent years there has been an increase in industrialization which has decreased the number of situations in which the slow learning child can make satisfactory adjustments. This group of individuals are reproducing themselves two to three times faster than the professional groups.[2-2] It is imperative that society realize that slow learners, given time and proper training, can and will become desirable and economically independent citizens.

VI CLASSROOM ADJUSTMENT

Some very practical methods which will help the morale of these children in the classroom are outlined in a book called **Education for All American Children,** prepared by Educational Policies Commission.[5]

A. The child should be wanted and accepted by others.

B. The child should have chances to excel as well as chances to be excelled

C. He should have tasks in which he has reasonable chances for success.

D. He should experience a normal interplay with the group so that there may result wholesome personality and social development.

Different plans that have been followed to answer the needs of these children who have difficulty are listed:

A. Segregated special class. This is the traditional classroom for those children who are mentally handicapped. It is definitely frowned upon by modern thinkers in the field of education.

B. Mixed ungraded room—those children who are more defective may remain with the special teacher all of the time. The slow learner may need to appear just for remedial work in some particular subject.

C. Auxiliary special teacher—this teacher has a regular program of instruction for handicapped children, sometimes for individual instruction or instruction in small groups.

D. Core-curriculum plan—the child may attend regular classes for music, physical education, industrial arts, home economics, auditorium, social studies, but may need special help with the skills. This is the best method for the group unless the teacher can do the necessary remedial work with no segregation even for the skills.

VII INSTRUCTIONAL MATERIAL AND EQUIPMENT

The classroom for any group of children should be cheerful with evidences of activity. The furniture should be movable with desks that are adjustable to meet the needs of each individual. Storage space in the form of shelves and closets are needed and can be provided with very little extra expense. If possible such equipment as sewing machines, cooking equipment, and visual aids materials are highly desirable.

Suggested equipment as outlined in a bulletin sponsored by Ohio State Department of Education are:

Weavit frames—3
Hoops, for hooked rugs
Metal foil
Clay
Paper punch
Waffle weaving frames—3
Leather scraps
Felt scraps
Reed-raffia
Leather punch

Shop

Work benches and vises (2 or 3 in a room)
Bit braces—2
Clamps ("C" clamps)—3
Hammers, 3, 1202
Planes
Bits—one set
Chisels
Files—2 flat 10"
Mallets
Pliers

Saws—1 rip, 22" 7 pt. (1602), 1 cross-cut 22", 9 tooth; 6 back 12", 14 pt., 6 coping, 1 tuming, 1 scroll
Screwdrivers—1 of 4", 1 of 8"
Tin snips—1 pair 3-1

Arts

Finger paints
Poster paints
Water colors
Kindergarten crayons
Poster chalk
Newsprint paper, 24x36"
Charcoal sticks
Brown wrapping paper, 1 roll

Crafts

Remnants of unbleached muslin
Oilcloth
Knitting needles, sizes 4 and 5
Printed cottons
Yarn
Crochet hooks, sizes 5 and 6

This list is a flexible one and should be used merely as an example. It should be changed to meet the needs of the children who are being taught.

Instructional Method

The non-academic phase of the program should stress: special training in personal habits, safety habits, techniques of courtesy with an opportunity to constantly use those techniques and prompt-

ness. The slow learners should be taught simple information regarding the working of the local government. They should be taught cleanliness, homemaking, and the care of children. They should have experiences leading to cultural development. They can participate in sports, music, games, and handwork.

Familiarize the slow learner with vocations that he can do well such as: bus boy, machine operator, waitress and gardener.

In teaching the skills, it may be well to remember that the slow learner will need more drill, more frequent evaluations, testing should cover shorter areas of work. The goals set up for them must be tangible—units of activities should be built around the child's experiences—should be built on the sensory and perceptual foundation rather than on conceptual.

Reading

The reading readiness program should be delayed for the slow learner. It is quite possible that he will not be ready to read at all until the end of the first grade. Most slow learners attain a reading age of about sixth grade. They are able to read and comprehend newspapers, popular magazines and the simpler popular books.

In selecting books for this group it is well to remember that the reading interests of these children, as a group, are about as wide and varied as those of the general run of children. The books must deal with subjects appropriate for a given chronological age and still be simple in style, ideas and vocabulary.

Not more than one or two "new" words should be encountered by pupils in a hundred "running" words.[4-1]

Arithmetic

It is more important to "master" a few simple fundamentals of arithmetic than to be exposed superfically to a variety of things:

1. Learn to count
2. Cost of various common objects
3. Learn the easier addition and subtraction combinations
4. Weight
5. Relative lengths

Language Usage

Both oral and written language should be learned to the point that simple conversation can be carried on and simple letter can be written.

Referrals to Other Agencies

1. Child Guidance Clinics—Lexington and Louisville

BIBLIOGRAPHY

1. Baker, Harry J., *Introduction to Exceptional Children.* MacMillan Co., New York, 1945. pp. 244-255. (1) p. 246.
2. "The Educable Mentally Handicapped Child," Illinois Commission for Handicapped Children, 1946. pp. 7-35. (1) p. 14, (2) p. 8.
3. "Let us Look at Slow Learning Children," Ohio State Department of Education, 1947. pp. 5-34. (1) p. 27.

4. Featherstone, W. B., *Teaching the Slow Learner,* Columbia University, Bureau of Publications, 1914. pp. 1-100. (1) pp. 80-83.
5. "Education for All American Children," N.E.A., Educational Policies Commission, 1948. p. 18.

OTHER REFERENCES

Betts, Emmett A., *Foundation of Reading Instruction,* American Book Company, 1946, pp. 251-305, 373-577.
"A Public School Program for Retarded Children," Department of Public Instruction, Madison, Wisconsin, 1947, Bulletin, pp. 3-33.
"Handbook for Teachers of Exceptional Children," The University of Texas, 1947, Bulletin, pp. 135-137.
"Helping the Exceptional Child in the Regular Classroom," Department of Public Instruction, Lansing, Michigan, 1941, Bulletin 315.
"Meeting the Needs of the Mentally Retarded in the New York City Public Schools," Vol. 3, Bulletin 6.
"Feeble-Mindedness vs. Intellectual Retardation," The Education Digest, November, 1947, pp. 25-26.
Kirk, Samuel A., "Teaching Reading to the Slow Learning Child," Houghton Mifflin Company, 1940.

EDUCABLE MENTALLY HANDICAPPED CHILDREN

(Reference numbers refer to Bibliography on page 249.)

I DEFINITION

Educable mentally handicapped children may be defined as children of school age who, because of mental retardation, are unable to profit from instruction in the regular classroom, without special instruction and/or facilities to meet their educational needs.

II INCIDENCE

About two percent of all children should be enrolled in classes for the mentally retarded, according to Baker. "This number is an estimated total of one-half a million for the entire country," writes Baker. "In 1930 there were 60,000 enrolled in special classes, but by 1935-36 the number had increased to nearly 100,000. Recent enrollment figures are slightly lower than this, so that less than one-fifth have special class provisions. Any city from five to ten thousand general population with 1,000 school children should have enough for a class of from 15 to 20 pupils."[1]

III STANDARDS

A satisfactory criterion of educable mentally handicapped children involves four essential attributes, namely, social inferiority, intelligence, developmental arrest, and constitutional deficiency.[2] No one of these criteria may be omitted without weakening the concept. Thus, low mental ability in itself does not necessarily determine an educable mentally handicapped child according to the above definition.

IV ENUMERATION

According to House Bill No. 16, which was passed during the regular session of the Kentucky State Legislature in 1948, the attendance officer of each school district is required to ascertain annually children in his district who are mentally handicapped, and to report them to the Division of Special Education for Handicapped Children on forms provided for the purpose.[3]

V DIAGNOSIS

Eligibility for special services should be determined in accordance with state standards, and by the proper authorities. In other words, educational, psychological and emotional diagnosis should be made by the teacher and/or the psychologist or other local authorities.[4]

VI EDUCATION

A. General Adjustment:

The major problem of social welfare and that of the teacher in relation to mental deficiency is the care and training of morons. The majority of morons continue to live in the community in their own families and at marginal levels of social success.

They are frequently unrecognized and are held socially accountable for a higher degree of social performance than is consistent with their constitutional aptitudes. The principal problem of the moron is the frustrated maladjustment ensuing from social expectation greater than the ability of the child to meet these demands of society.[5]

The classroom teacher may help the child reach many desired goals by the use of the following methods:

1. By encouraging the child to take part in various social activities for the purpose of helping him become socially adjusted.
2. By finding the child's special aptitudes and by helping him cultivate these aptitudes in order to compensate for his mental deficiency.
3. By treating the child as one would treat other children of the same age and sex in order to prevent feelings of inferiority on the part of the child.

B. Classroom Adjustment:

Many children who come under the heading of educable mentally handicapped are able to make adequate classroom adjustments in the regular classroom, provided that the teacher guides the child in his efforts to make these adjustments. His program should be made a part of the regular school program. In other words, he should receive the same treatment that the other children receive, plus the additional materials and services required in meeting his special needs.

VII EQUIPMENT

Generally speaking, the educable mentally handicapped child needs no special equipment or materials to meet his needs that may not be found in the regular classroom. Sometimes, however, the use of special materials may be required, in which case the school district may receive reimbursement from the Division of Education for Exceptional Children for money spent in excess of the per capita cost for the school district for special books or materials used in the child's educational program.[6]

BIBLIOGRAPHY

1. Baker, H. J., *"Introduction to Exceptional Children,"* Ch. 14.
2. Carmichael, Leonard, *"Manual of Child Psychology,"* p. 847.
3. Commonwealth of Kentucky; General Assembly; Regular Session, 1948; Section 7; *House Bill No. 16.*
4. John S. Hiteman Committee; Pt. 4, Sec. E; from *School Life,* March, 1947.
5. Carmichael, *"Manual of Child Psychology,"* p. 878.
6. Commonwealth of Kentucky; General Assembly; Regular Session, 1948; *House Bill No. 16.*

Part III

SELECTED REFERENCES

The following selected references are available for loan from the Division of Education for Exceptional Children, State Department of Education, Frankfort, Kentucky.

Both the University of Kentucky Library, Lexington, Kentucky, and the Library Extension Division of the Department of Library and Archives, Frankfort, Kentucky, have additional references of value for the administrator and teacher interested in providing for the exceptional child.

BOOKS

Ainsworth, Stanley. *Speech Correction,* Prentiss Hall, 1948.

Baker, Harry J. *Education Exceptional Children,* MacMillan Co., 1947.

Carlson, Earl R. *Born That Way,* John Day Co., 1941.

Hathaway, Winifred. *Easy on the Eyes,* Winston Co., 1947.

Gratke, Juliette McIntosh, *Help Them Help Themselves,* Texas Society for Crippled Children, Dallas, Texas, 1948.

Hathaway, Winifred, *Education and Health of the Partially Seeing Child,* Columbia University Press, 1947.

May, Charles. *Diseases of the Eye,* William Wood and Company, 1941.

Heltman, H. J. *First Aids for Stutterers,* Expression Co., 1943.

Merrill and Oaks. *Your Vision and How to Keep It,* G. P. Putnam's Sons, New York, 1930.

Otto, Henry J. *Elementary School Administration and Supervision,* Appleton-Century Co., 1944. Chapter XII, pp. 437-467.

Van Riper, C. *Speech Correction,* Prentice Hall, Inc., 1947.

Schoolfield-Timberlake, *Sounds the Letters Make,* Little, Brown and Co., 1946.

Wood, Alice L. *Sound Games,* E. P. Dutton and Co., Inc., 1948.

PERIODICALS

General

"Curriculum Planning for Exceptional Children," Kelly, Elizabeth, *Journal of Exceptional Children;* Vol. 14, No. 5, p. 130.

"Exceptional Children and the Four Point Program," Martens, Elise, *Kentucky Parent and Teacher Bulletin;* March, 1948, pp. 12-13.

"Exceptional Children with Multiple Handicaps," Berry, Althea, *Journal of Exceptional Children;* Vol. 14, No. 1, p. 11.

"Failure and Conditional Promotion Among Elementary School Children of Normal Intelligence," Bentall, *Journal of Exceptional Children;* Vol. 14, No. 5, p. 138.

"How Can We Reduce Delinquency," Taylor, Katherine, *Kentucky Parent and Teacher Bulletin;* January 1948, pp. 12-13.

"I Don't Want to be Different," Daniels, Arthur S., *The Crippled Child,* Vol. XXVI, No. 3, p. 20.

"Special Education from the State Level," Retherford, Gwen, *Department of Health Bulletin;* Vol. XIV, No. 11, June 1947, pp. 772-773.

"Toll of Rheumatic Fever," *The Child,* Vol. 13, No. 6, p. 90.

Crippled

"Cerebral Palsied, Psychological Examination of," Bice, Harry V., *Journal of Exceptional Children;* Vol. 14, No. 6, p. 163.

"Feeding and Dressing Techniques for the C. P. Child," Dillingham, Elizabeth, *The Crippled Child,* Vol. XXVI, No. 4. p. 20.

"Hospital Classes and Homebound Instruction in Illinois," Boyles, Iva Field, *Journal for Exceptional Children;* Vol. 14, No. 3, p. 79.

"Parent's Plea for a Kentucky Cerebral Palsy Program, A," Lanahan, Mrs. R. H., *Kentucky Parent and Teacher Bulletin;* March 1948, p. 12.

"Physically Handicapped Children, Special Relationships of," Cruickshank and Medve, *Journal of Exceptional Children;* Vol. 14, No. 4, p. 100.

Epileptic

"Special School Services for Children with Epilepsy," Levinrew, George E., *Journal of Exceptional Children;* Vol. 15, No. 4, p. 66.

Hearing

"Consider the Families," Murphy, Grace E. Barstow, *The Volta Review,* August 1948, p. 353.

"Deaf Children Under Six Go To School," Machie, Romaine, *School Life;* Vol. 30, No. 4, Jan. 1948.

"Hearing and Fatigue," Alexander, A. B., *The Volta Review,* July 1948, p. 308.

Partially Seeing

"Bibliography on Handwork, For Teachers of Partially Seeing Children;" Hittrell, Margaret J., *The Sight Saving Review,* Vol. XVII, No. 4, p. 236.

"Dealing with Visual Problems in the Classroom," Wheeler, Lester R., *The Sight Saving Review;* Vol. XVI, No. 2, p. 92.

"Eyes of Infancy and Childhood, The," Delaney, James H., *The Sight Saving Review;* Vol. XVII, No. 3, p. 159.

"Meeting the Needs of Professionally Prepared Teachers in Sight Conservation," Peck, Olive S., *The Sight Saving Review;* Vol. XVII, No. 2.

Slow Learning

"Changes in Behavior of Originally Feebleminded Children," Schmidt, Bernadine G., *Journal of Exceptional Children;* Vol. 14, No. 3, p. 67.

"Classroom Procedures in a Prolonged Pre-Academic Program for Mentally Retarded Boys," Patterson, Melcher R., *Journal for Exceptional Children,* Vol. 15, No. 1, p. 15.

"Does Special Education Result in Improved Intelligence for Slow Learning Children;" Hill, Arthur S., *Journal of Exceptional Children;* Vol. 14, No. 7, p. 207.

"Early Discovery of the Slow Learner," DeLand, Clara, *Journal of Exceptional Children;* Vol. 14, No. 5, p. 134.

Speech Correction

"How Important is Speech?", Baker, Herbert Koepp, *The Crippled Child,* Vol. XXVI, No. 3, p. 17.

"Parental Assistance for Johnny," Retherford, Gwen, *Kentucky Parent and Teacher Bulletin;* November 1948, p. 6.

"Parent Education for Pre-School Speech Defective Children," Chapin, Amy Bishop, *Journal of Exceptional Children,* Vol. 15, No. 4, p. 75.

"Speech Correction in Illinois," Black, Martha E., *Quarterly Journal of Speech;* April 1948, p. 213.

PAMPHLETS AND REPRINTS

Crippled

*May be secured from the National Society for Crippled Children, 11 S. LaSalle St., Chicago.

"Biennial Report", 1947. Kentucky Crippled Children Commission.

"Cerebral Palsy"—A Discussion of Medical Aspects, Perlstein.*

"Cerebral Palsied Child Goes to School, The", Loviner and Nichols, Ohio Society for Crippled Children, Columbus, Ohio, 1946.

"Cerebral Palsied Grow Up, Help The", Hohman.*

"Crippled Children in School", Mackie, Romaine, Federal Security Agency, Bulletin No. 5, 1948.

"Farthest Corner, The", Phelps, Winthrop.*

"Group-Casework Experiment with Mothers of Children with Cerebral Palsy", Elkes.*

"Handicapped in a Democratic Society, The", Linck.*

"Questions Parents Ask—With Answers", Phelps, Winthrop.*

"Speech Problems of the Cerebral Palsied", Gratke.*

"Starting Him on the Right Road", Bulletin of Department of Health, Louisville, Ky. August 1948, p. 6.

"You Can Help Your Child", Shaw, Detroit Orthopedic Clinic, 1945.*

Epilepsy

*These references may be secured from the American Epilepsy League, Inc., 50 State Street, Boston 9, Mass.

"Building a Future for the Epileptic Child"—A reprint from The Crippled Child.

"Epilepsy and the Public Health Nurse", Abbott, John Adams—M.D.*

"The Epileptic—Who He Is and What He Can Do", Lennox, William G.—M.D.*

"Management of the Convulsive Child", Bradley, Charles—M.D.*

"Treatment of a Convulsive Child in a Children's Psychiatric Hospital", Bradley, Charles—M.D.*

Hard of Hearing

*These references may be secured from the Volta Bureau, 1537 35th Street, Washington, D. C.

"Causes of Deafness, The", Alfara, Victor R., Reprint No. 504.*
"Deaf and the Hard of Hearing, The", Social Work Year Book, 1945.*
"Ears that Hear", Tickle, Thomas, Life Conservation Service of the John Hancock Mutual Life Insurance Company, Boston, Mass.*
"Grade Teacher and the Hard of Hearing Child, The", Reprint No. 75, American Society for the Hard of Hearing, Inc., Washington, D. C.*
"Helping the Hard-of-Hearing Child", Lesser, Arthur J.*
"Higher Goal for the Deaf, A", Tracy, Mrs. Spencer, Reprint No. 579.*
"If Your Child is Hard of Hearing", Volta Review, May 1936.*
"If Your Child or Your Friend's Child is Deaf", Volta Bureau.*
"Letters to the Mother of a Deaf-Born Child", Montague, Harriet Andrews.*
"Normal and Deaf Child in the Preschool Years", Gesell, Arnold.*
"Parents of Little Deaf Children, To", Reprint No. 548.*
"Remedial Reading for Children With Impaired Hearing", The Training School Bulletin, January, 1947.*

PERRY PUBLISHING COMPANY
FRANKFORT, KENTUCKY
PRINTERS TO THE COMMONWEALTH OF KENTUCKY