Reflections On My Early Days in Speech Therapy

Angela Murphy
Learning Assistance Centre*
Saskatoon, SK

As one looks back over a span of years, it is difficult to determine how selective one's memory has become. I remember the sense of satisfaction with the work, the prestige of being *the* speech and hearing therapist, and the elation when change was measurable and lasting; but I also remember the concerns, the feelings of inadequacy, and the isolation.

What were the motivations that brought Canadian pioneer speech students studying in the United States back to Canadian obscurity? How was our identity with this newly emerging profession developed and maintained? Opportunity, then as now, was to the South, but perhaps the desire to contribute to a small but significant aspect of the profession, the uniqueness of the work, and the awareness that there was so much to be discovered and charted about both speech and hearing, were some of the influences. Certainly, the emergence of provincial associations and later the creation of the Canadian association have contributed to our feeling of security, and both have been instrumental in guiding the expansion that our profession has experienced in the last two decades. Although I have been involved in the early formation of these professional bodies, my attempts at recollection will be of the personal aspects of my experience and without the benefit of any written record.

Clinical Practice in the 1950's

My reflections date back to Winnipeg's Children's Hospital in 1952. The hospital's Speech and Hearing Services, as it was then known, had been operating for at least a year and had established itself as an integral part of the Cerebral Palsy Clinic. It also had branched out to serve the more general population through the Out-Patient's Department.

One concern of the administrators at the hospital had been that once the current therapist married, there would be no continuity in the programs, since few females worked for long after marriage in those days. As a condition of employment, I was required to qualify as a speech clinician, and I was provided with an eight hundred dollar loan to do so. The training had to be American as no training programs were yet available in Canada. The profession had become fairly well established in the United States, where a number of training institutions were ready and often eager to welcome Canadian graduates. I attended a university graduate program in Ohio. Since I would be returning to Canada, where it was viewed that I would be very much on my own and without collegial help, I was encouraged to take several ancillary courses beyond those normally assigned in the speech program. The goal, even in those early years, was to qualify for a membership in the American Speech and Hearing Association (ASHA), a process that included not only the successful completion of course work and an internship, but also an on-site observation of one's clinical performance—an expensive out-of pocket proposition for an impoverished Canadian student!

The mistaken idea that a university program is sufficient to enable one to interact on the job successfully with all types of speech and hearing problems was unfortunately not alien to my first professional months. My first employment back at the hospital was with the Cerebral Palsy Clinic, where in addition to handling the speech problems characteristic of cerebral palsy children, requests to teach breathing techniques to post-polio patients who were in respirators (iron lungs), efforts to counsel elderly men slated for laryngectomies, and the daily concerns about the lack of concrete carry-over with the children, soon shattered this illusion. The need for further study was reinforced when, within the year, I became the speech and hearing therapist in a newly formed division of the Out-Patient's Department.

It took time for the services of this division to become well known. Since all patients had to be referred by a doctor, my first few months frequently were characterized by waiting for these referrals to arrive. When eventually they did, I often found myself ill-equipped to answer the most common concern, "Why isn't this child talking?" I was motivated to see if answers were available. My further studies with Myklebust introduced me to the emerging concept of language, the power of making a differential diagnosis based on language, and the importance of the language behaviour brought to the therapy situation by the child. My whole outlook was significantly influenced by this approach, and since that time, children presenting language-based problems have continued to intrigue me.

*Presently on leave of absence

The role of the speech clinician was ill-defined in the early fifties. There were few job descriptions or opportunities for consultation with specialists in the field. The clinician dealt with the cases that were referred or that simply showed up at the clinic door. All the usual types of speech problems were seen but in different numbers from today. Children with repaired (or, more sadly, unrepaired) cleft palates constituted a good proportion of the children in a caseload followed by children exhibiting severe hearing loss due to repeated or continuous otitis media.

The profession wasn't as neatly divided in those days between professionals who practised speech pathology and those who practised audiology. The average speech therapist was expected to test hearing, attempt to measure the suitability of hearing aids, do auditory training, and initiate programs for teaching speech to preschool hearing impaired and deaf children. Testing of neonates was not routine, but infants at risk for hearing problems were often assessed. There were few sound-treated booths, one-way vision mirrors, or calibrated instruments available. We made do with toys which were approximates or, in the case of our institution, we had the Hospital workshop devise a merry-go-round of animals, copied from an article in a current journal. It was the early days of operant conditioning techniques, and in our case, the child was conditioned to operate the switch which illuminated the carnival when the tone was heard. The modern day tester may smile at these amateurish attempts, but they did serve as an important adjunct to testing before modern technology and assisting devices were available.

Although the Speech and Hearing Clinic was in a Children's Hospital, the caseload was not restricted to children. There was no facility which offered speech pathology services to adults in the city. Adults with aphasia, patients with voice problems, and adults who stuttered were the most numerous. A small group of post-operative laryngectomies, who had formed a club, were also a part of a day's schedule. Generally the adults were seen if they could be squeezed in late in the day or, if our resolve was low and they were persuasive, as private patients after hours.

Speech therapy service in our institution in the fifties was patterned on a slightly modified medical model. The emphasis was on diagnosis based on a supposed etiology. This was followed by a prescription for remediation, which in most cases was to be carried out by infrequent sessions with the therapist on a one-to-one basis. The expectation was that the parent would practice with the child until the scheduled follow-up review. We had an assessment package that consisted of a detailed case history (differing little from ones currently used) and the indispensable "artic" cards—a series of cards which contained pictures cut from magazines and catalogues, and mounted on five by eight cards. Usually these cards were arranged so that initial, final, and medial sounds were in loosely ordered groupings, for example, nasals, voice and voiceless plosives, and so on. There were little or no normative guidelines with which to compare the child's performance. We went on accumulated knowledge gained from experience and on Poole's chart for emergence in normal speech development. We had little if any access to published tests that may have been available.

Although it wasn't labelled as "stimulability," we were interested in ascertaining if the children could correctly imitate their error sounds in the various positions in a word. A speech sample, taken on a wire recorder, was elicited by using pictures, imitating sentences, reading, or just talking. Analysis was then made, provided the therapist didn't get wound up with all the wire that tended to cascade from the machine if one was too hasty or careless. It was with great relief that we welcomed the reel-to-reel audio tape recorder and heaven when the cassette could simply be popped in.

Each child had a physical examination for oral abnormalities and a hearing test done by the therapist. Information about social or emotional maturity was obtained from the parents during the case history interview or sometimes from the referral. A measure of developmental maturity depended on informal inventories and observation.

The Development of Professional Associations

Isolation is a term that is probably synonymous with speech therapy in the early days. Part of this isolation was self-imposed by our desire not to be the simple handmaiden of some other professional group; but much of it was due to how few of us there were and the lack of programs in which upgrading was available. Keeping up with the changes that were being reflected in the ASHA journals (most of us were ASHA members) was something we did try to do. As a new profession, we had trouble knowing precisely where we belonged. Was it with Medicine, Physio-Therapy, Occupational Therapy, or Education? Our lack of a clear identity meant we tended to isolate ourselves from other professionals, possibly to guard against dominance or absorption and the consequent loss of the independence and the status which we seemed to want and already had acquired.

We may have regarded ourselves as professionals, but we had very little control over our own time. Since our job consumed most of our time (including Saturdays), meeting with peers or organizing professional upgrading sessions was confined to after work hours. We did find partial solutions—many similar to what happens today in isolated areas: we met, formed a quasi association, and discussed cases or reviewed articles we had read. We argued the pros and cons of heredity

versus environment; we defended or dismissed the broad classification of functional versus organic articulation disorders; we tended to be "oralists" rather than "signers"; and we included any concerns about language as part of the speech process. Language terminology, as we now know it, gradually evolved; but it is impossible to attach this transition to any short time period.

Other ways in which we kept active and learning were more unique to those early times. One of my pleasant memories is of reviewing the material from my courses with Myklebust with two colleagues in twice weekly sessions over several weeks. A similar sharing occurred when one of the clinicians was lucky enough to attend an ASHA Convention. Indeed, clinicians came together to share their expertise and help their colleagues with puzzling cases whenever the physical geography and the weather permitted. With the increase in the number of speech therapists in Manitoba in the late fifties, we were able to get an association on its feet. We also pushed for, though never succeeded, the founding of a training institution connected with the University of Manitoba.

Continuing education opportunities or in-services in either speech pathology or audiology were almost nonexistent in the fifties. As part of a hospital institution, which was early to espouse the concept of the "team approach" to better serve the patient, I was fortunate to be included as a speech therapist in the clinical instruction given to medical students. The opportunities to learn were legion during these clinics in which Dr. Gordon Stephens, a psychiatrist who specialized in pediatrics, and Dr. Wallace Grant, a neurologist and pediatrician, expanded my knowledge and made me look critically at the role that the speech clinician should play on the team. We looked at the "whole child" well before that approach and that phrase became popular.

In a similar cooperative team approach to diagnosis and remediation, the speech therapist was a part of the annual diagnostic clinics provided to rural areas that were sponsored by the Manitoba Society for Crippled Children. We learned a lot, but the expectations were onerous: seeing children continuously for two to three days in each of several rural areas and initiating programs that we taught the parents to use at home. The hope was that parents would continue to teach their children at home through correspondence until our return the following year. Many of the home program clients, of course, fell by the wayside because of the limited contact. The more severely disabled or multiply handicapped were often brought to the city for intensive treatments.

Changing Treatment Strategies

The long time career speech pathologist has witnessed significant changes in what is treated and how treatment is done. This is true for all the different types of speech disorders, but especially so for the changes in the treatment of phonological disorders. That particular terminology is new: We saw children with "disorders of articulation"! Under this general heading were several categories which included: dysarthria, articulatory dyspraxia, dyslalia, and defective articulation due to hearing problems and/or structural abnormalities. Initially, the emphasis was on phonetic placement coupled with "ear-training." The child learned to recognize the target sound and reproduce it, first in isolation, and then in syllables, words, phrases, and sentences in the initial, final, and medial positions. Drill was important, as was the need for practice, to help the child use the new sound in conversation. Our therapy was influenced by intuition and by what seemed to be working; our techniques were influenced by the time available to construct games or motivational material (published programs or materials were not available). However, our goal was the same as it is now—to improve the child's communication efforts.

The era of operant conditioning raised many concerns. Establishing a base line wasn't that difficult, but I found that counting errors, programming stimuli, and recording responses that were controlled by the consequences, was intriguing, exacting, and tedious.

My main recollection of this era is very positive: remediation was becoming much more specific and could be measured. A system was available to analyze the effectiveness of the treatment.

The more linguistically based assessment and treatment of children's phonological patterns places emphasis on the analysis of error patterns that can be compared with norms established for a test or a treatment. As scientific data increases and improves, the time is coming when theoretical bases for intervention strategies will be realized. I am comfortable with this and with the current movement toward more meaning based intervention as espoused by the pragmatists. Children are now being removed from the isolated clinical environment in which context was initiated and controlled by the therapist and treated in environments that are more natural for the child and more meaningful for language learning requirements.

Concluding Thoughts

Thus my thirty-seven years have seen many desirable changes. We have concluded an era of rather informal routines, procedures, and criteria, and must now contend with and be assisted by a proliferation of journals, seminars, and conferences that provide information and guidance that is based on theory and tested in rigorous academic fashion. Rather than isolated instances of sharing information with our counterparts in Psychology, Linguistics, Medicine, and Education, we now have formal and informal access to expertise and to information that

affects the way we treat speech, language, and hearing problems. Our assessment tools have become more standardized, and our intervention techniques are more sophisticated. We have ready access to commercial materials, many of which have been tested to see if they meet the rigorous requirements of a more scientific approach. With our endorsement of alternate means of communication, we no longer frustrate those for whom speech is an overwhelming task. We have become more interested in how adequately the child, as a social being, uses communication to express needs and desires, to make requests and control behaviour. We want the child to interact effectively with the environment.

It has been stimulating to be a member of a profession which has so changed over the years but which has retained its basic commitment to communicative competence for those with speech, language, and hearing problems. We have become an integral part of the total educational experience. I have enjoyed being a part of this evolution, and I look forward to the continuing search for new and better ways to help those who need our assistance.

Address all correspondence to:
Angela Murphy, B.A., M.Ed.
715 3rd Street South
Lethbridge, AB
T1J 1Z4