

Cued Speech for American English

Visually providing the building blocks needed for communication, language development, and literacy.



/d, p, zh/



/ee, ur/



/k, TH, v, z/



/aw, e, ue/



/h, r, s/



/a, i, oo/



/b, n, wh/



consonant alone



/f, m, t/
vowel alone



1/2" - 3/4" down
/uh/



/l, sh, w/



1" forward
/ah, oe/



/g, j, th/



/ay, oi/



/ch, ng, y/



/ie, ou/

Myth: Cued Speech = Speech

Fact: Cued Speech does not require the use of speech or voice to communicate clearly, nor was it developed for the purpose of improving a deaf person's speech skills. While speech therapists and auditory rehabilitation specialists have employed the use of cueing in therapy sessions as a biofeedback tool, it is considered a secondary benefit of the system. In the 1960s, it was believed that phonemes and speech were interrelated and could not be separated, and this is partly why the system was named "Cued Speech."

Myth: Phoneme = Sound

Fact: While hearing individuals do interpret the term "phoneme" to mean the sounds of a language, deaf individuals have different interpretations of the word. For a deaf cuer, a phoneme is a visual representation of a building block of a language. For those who use signed languages, such as American Sign Language, phonemes are based upon the parts of the signs (handshape, palm orientation, location, and movement).

Myth: Cued Speech is now called cued English or cued language.

Fact: Cued Speech is the name for the mode of communication first developed for American English in 1966. The Cued Speech system has since been adapted to more than 60 languages and major dialects (as of December 2006). These languages have some phonemic differences from American English; therefore, the handshape and hand placement groupings in Cued Speech may or may not be the same across languages. Cued American English and cued British English have different vowel groupings, which can make cued communication between users of the two systems difficult.

Myth: You can't cue to babies.

Fact: In fact, infancy is the BEST time to start introducing a child to language. By cueing as soon as possible with a child, you maximize her chances for success in developing strong communication, language, and literacy skills. When encouraged to do so, babies will "cue babble" and make approximations of words using both their hands and mouths.

Myth: Once an individual receives a cochlear implant, cueing is no longer necessary.

Fact: Cueing provides consistent and clear visual access to language and environmental information. Cochlear implant users who cue report that while

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they are better able to interact with non-cuers when their implant is on, cueing clarifies and validates what they hear with the implant. They prefer to have the clear communication that cueing provides to decrease the burden of struggling to understand the message solely through auditory means.

Myth: Children who are deaf can't rhyme.

Fact: Research has demonstrated that cuers who are deaf are able to rhyme in a manner similar to their hearing peers. These cuers were able to generate rhymes based not only on spelling (*fear* and *hear*) but with words where spelling offers no hint at the rhyme (*bird*, *heard*, *word*, and *curd*).

LaSasso, C., Crain, K., & Leybaert, J. (2003). Rhyme generation in deaf students: The effect of exposure to Cued Speech. *Journal of Deaf Studies & Deaf Education*, 8(3), 250-270.

Myth: Facial expression is not important when cueing.

Fact: Facial expression provides a great deal of information about the context and content of the message. The face and body provides details about the cued message that a hearing person would garner from audition alone (the rising and falling of tone, stress on a particular word, emotion, etc.). In other words, facial expression provides answers to questions such as the following: Are you asking a question or making a statement? Are you teasing or serious? Are you providing a definitive answer or being wishy-washy?

Myth: Cued Speech was developed to replace ASL.

Fact: Cued Speech was developed to help raise the literacy levels of deaf individuals. Dr. Cornett, the creator of Cued Speech, envisioned that sign language would always be a part of the deaf community; however, by cueing, children who are deaf would have a way to easily acquire the native home language, read and write proficiently, and more easily communicate with hearing family members who cue.

Myth: Cueing only works for children who have a lot of residual hearing.

Fact: Cued Speech was originally intended for use with children who are profoundly deaf or have no usable residual hearing. These children thrive on the visual access to language that cueing can provide. In addition, cueing has proved to be effective for children who are hard-of-hearing, helping to clarify auditory information in noisy situations. Hearing children with speech, language, and/or auditory processing problems can also gain tremendous benefit from cueing.

Myth: SEE/sign systems provide complete access to English.

Fact: Signed English, Seeing Essential English (SEE 1), Signing Exact English (SEE 2), Conceptually Accurate Signed English (CASE), and Linguistics of Visual English (LOVE) are all types of manually coded English (MCE) systems. None of them are languages. They are all systems that were developed to try to show English through signs. However, they show English at the word and affix (prefixes and suffixes) level, not the phonemic level. For example, the sign for *cat* does not show the English phonemes for the word as /k, a, t/. Results of research by Reid Lyon at NIH indicate that access to the phonemic stream of language and the ability to manipulate that stream are prerequisites to strong reading and writing skills. While these signing systems are adequate for communication between users of two separate languages (ASL and English), they do not provide enough information for native acquisition of English and future development of reading and writing skills.

Lyon, G. Reid. (2003). What principals need to know about reading. *Principal*. 83(2), 14-18.