Involving Parents in Teaching Social Communication Skills to Young Children

Amy L. Weiss and Geraldine Theodore

This article focuses on why and how speech-language pathologists and other professionals can encourage the involvement of parents in teaching social communication skills to their young children. Four main topics are explored: (1) the evidence that many of the children with special needs served by speech-language pathologists and other professionals demonstrate deficits in social communication skill development, (2) the legislated mandate to involve families in the education of their children with special needs, (3) the conclusion reached by many investigators and practitioners that social learning necessitates utilization of natural social learning settings, and (4) the consideration of cultural differences represented by the families served. Suggestions for how speech-language pathologists and other professionals who work with families of young children with social skill deficits can enhance social skill development are included. Key words: autism spectrum disorders, child development, language impairment, parent teaching, social communication skills

Noah (age 2;10) and the first author are playing with Noah’s train set. Noah has been carrying on a lengthy monologue about the trains. When he ends his conversation turn, there are several moments of silence. Then Noah says, “You know, Amy, when I am not talking, you could be talking.”

TO THE OBSERVANT listener, kid talk can provide some insight into what children are thinking, particularly into how they understand their social world. When young children are developing language in typical ways, the mistakes they make with language use and the insights they express are memorable and often humorous. In fact, the first author has used the brief anecdote above for years when teaching a language development class; it never fails to elicit gales of appreciative laughter from the students. Noah has demonstrated that he knows something about how turn taking is supposed to work, given his particular cultural background.

When young children are having a difficult time with language learning, however, the mistakes they make often are not amusing but devastating for caregivers to observe. This is because many caregivers recognize that when a child does not have age-appropriate language skills, future development in both academic and social venues may be compromised. In particular, the goal of becoming a competent language user is likely to be tough when children have difficulties negotiating the social aspects of language use, including competencies as basic as knowing how to get the attention of another person, or recognizing that attention is needed first to establish a communication topic. It is particularly for these children—the ones who are demonstrating deficiencies early on in learning basic social communication skills—that we make the case in this article for promoting partnerships between professionals and caregivers.
We urge speech–language pathologists (SLPs) and other professionals to remain sensitive to variations in the expectations of social appropriateness across cultural groups. This article presents a culture-sensitive perspective for professionals to employ when helping caregivers serve as agents for change in the development of their children’s social skills.

A MODEL OF SOCIAL COMMUNICATION DEVELOPMENT AND DISORDERS

In a recent theoretical paper, Beauchamp and Anderson (2010) presented their conceptualization of a social skills development model. Not coincidentally, the authors dubbed this three-component model, SOCIAL, for the “socio-cognitive integration of abilities.” The authors’ stated purpose was to propose a logical set of relationships that hold between “mediators” (e.g., internal/external factors, infant brain development and integrity), what they refer to as “cognitive functions” (e.g., attention/executive functioning, communication, socioemotional skills), and resulting social competence (i.e., the actual functioning of social skills). In addition, the authors’ purpose was to use the model to explain why and where breakdowns in social skills development may occur. Mediators included internal characteristics, such as personality and temperament that may increase or decrease the likelihood a young child is motivated to communicate with others. External factors relate to features of a child’s environment including the family’s cultural beliefs and values, their socioeconomic status (SES), and qualitative aspects of parent–child interactions. Brain development and integrity was also considered to be a mediator because this critical area of development determines a young child’s readiness for increasingly challenging levels of social interaction. For example, the authors considered diagnoses of autism spectrum disorder (ASD), frank psychiatric disorders such as schizophrenia, and brain injury as indicative of serious disruptions in the adequacy of brain functioning for the development of social competence. Table 1 provides a listing of the specific social competencies that comprise the SOCIAL model’s three cognitive functions and mediators of social skill development delineated by Beauchamp and Anderson (2010).

The SOCIAL model is relevant to this discussion for at least two reasons. First, many professionals work with young children with developmental disabilities who in turn demonstrate difficulties with social skill development and use; therefore, this model helps focus service providers to understand social communication disorders in the context of the whole child beyond the specific behaviors in error. That is, the model highlights other developmental systems that may be necessary to support social skills learning. Second, the model provides a reminder that development of social skills entails a larger skill set than the conversation-based, pragmatic skills and communication competencies familiar to SLPs who work with young, pre-school-age children. In the SOCIAL model, these are housed under the “communication” heading. As children grow and change, the contexts of their activities of daily living also change, necessitating mastery of and participation in a number of different social interaction types and social communication skills.

EXAMPLES OF PRAGMATIC, CONVERSATION-BASED, SOCIAL COMMUNICATION SKILLS

The anecdote that precedes this article demonstrated that even at less than 3 years of age, preschoolers have a rather sophisticated sense of one of the basic rules of conversation that operates in their culture. In this case, Noah was able to express his understanding that conversations require participants to take turns, and if one partner has ceased to talk, then it is appropriate for the other to talk, even if the participants hold different status. Certainly not everyone subscribes to that rule all of the time, and it would violate social communication rules of some cultures. Even if they share the same culture, one conversationalist may be too excited to wait his or her turn or may not recognize that the
Table 1. Three Types of Cognitive Function and Two Types of Mediators Leading to Social Skill Development

<table>
<thead>
<tr>
<th>Cognitive function</th>
<th>Mediators</th>
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<tr>
<td>Communication</td>
<td>Internal/external factors</td>
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<tr>
<td>Joint attention, triadic communication</td>
<td>Personality</td>
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<tr>
<td>Understanding and use of gestures, prosodic cues</td>
<td>Physical attributes</td>
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<tr>
<td>Intentionality</td>
<td>Family function</td>
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<tr>
<td>Receptive and expressive language skills</td>
<td>Culture</td>
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<tr>
<td>Pragmatics use in communication contexts</td>
<td>Socioeconomic status</td>
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<tr>
<td>Attention/executive functioning</td>
<td>Brain development/integrity</td>
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<tr>
<td>Attentional control (e.g., self-regulation)</td>
<td>Autism spectrum disorder</td>
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<tr>
<td>Cognitive flexibility (e.g., working memory)</td>
<td>Schizophrenia</td>
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<tr>
<td>Goal setting (e.g., strategic behavior, planning)</td>
<td>Traumatic brain injury</td>
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<tr>
<td>Socioemotional</td>
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<tr>
<td>Ability to recognize and interpret facial expressions</td>
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<tr>
<td>Theory of Mind/empathy</td>
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<tr>
<td>Attribution of traits and intentions</td>
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<td>Moral reasoning</td>
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other speaker has not actually ended his or her turn, leading to “simultalk” (Kelly & Conture, 1992). All things being equal, however, typically developing pre-school-age children have begun to access and use (and in Noah’s case, to talk about) the underlying rules of their social community’s conversation management system long before they begin kindergarten (Paul, 2007). This acquisition is an important part of a young child’s developmental profile because the competencies gained in using language in a variety of social contexts will have significant ramifications for the child’s success in both social and academic endeavors.

Conversation as the essence of social communication

Conversation provides the essence of social communication skill. Understanding how to manage conversation during the preschool years requires acquisition of a complex set of competencies. One of the features that complicate conversation learning is its inherent unpredictability. For example, topics are not preordained and neither are the lengths of participants’ turns. Another complicating factor is the subtlety of some of the cues that must be read by conversation participants. Take, for example, the fact that not all conversation participants come into a conversation with the same level of expertise about the topics addressed. For a conversation to be successful, accommodations to these differences have to be made, but first a speaker needs to pay attention to the clues (either verbal or nonverbal) indicating that a listener is confused or disinterested. Furthermore, topics can be initiated, maintained, and even shaded; conversational contributions can be relevant, irrelevant, or tangential. Turn taking within a conversation becomes even more difficult to manage when conversation includes multiple partners, as occurs in classroom settings. Signals for appropriate turn-taking can be conveyed linguistically (e.g., "Amy, what do you think?") or nonlinguistically (e.g., a tap on the shoulder or pointing). All of these competencies represent essential, but not exhaustive, aspects of pragmatic language, the area of language learning that deals with how
language is used in context, that is, social communication.

**Examples supporting the interface of language learning and social skills**

Attaining functional, social use of language is critical to achieving age-appropriate academic and social functioning. Consider the following two prototypical examples illustrating social communication skill use by several preschool-age children.

The first example is an exchange between a young child, Maggie, and a teaching assistant, Jenna. Maggie (age 4 years; 3 months) has been seated at a table by herself, working on a drawing for a few minutes and then realizes that she needs more crayons. The crayons in the classroom are kept in a cabinet inaccessible to the children unless they request them from a teacher. Jenna (an assistant in Maggie’s preschool classroom) is the teacher in closest proximity to Maggie, and so Maggie makes her request for assistance to Jenna: “I need more crayons, please.” Jenna (busy putting on Joshua’s shoes and socks and not facing Maggie): “Maggie, I’m in the middle of helping Joshua. I’m glad you asked for help so nicely. If you can hang on for a minute or two, I’ll help you. While you wait for me, think about the crayon colors you need.”

Note that Jenna acknowledged that Maggie had made her request in the “right” way (using “nicely” to refer to Maggie’s incorporation of *please*). Jenna also acknowledged that waiting is hard and gave Maggie something to think about to occupy her until Jenna could be available to help. Jenna may have learned about expectations for politeness in school, but it is also likely that certain rules and regulations for politeness have been presented at home (Nippold, Leonard, & Anastopoulos, 1982). In fact, politeness routines may be one of the few areas of language learning that is actually specifically taught by parents across cultures in any systematic way. The reason for this may be what some parents perceive as the high stakes involved in having your children viewed in the world as appropriately polite, especially with unfamiliar adults.

The second example demonstrates the use of presuppositional skills or perspective taking to increase the likelihood of a successful communication exchange. Abigail (4;8) and Katelyn (2;9) are neighbors whose parents have gotten them together for a play date. Abigail says to Katelyn, “Do you want to play with that dolly? You can play with that dolly. That dolly is a nice dolly. I think you like dollies.”

Not only is Abigail a year older than Katelyn, but her sentences are more complex and she is a better perspective taker. Abigail demonstrates her awareness of the difference in their language competencies as well. To compensate for the difference in their skill levels, Abigail tries three strategies: (1) she uses a speech pattern when she speaks with Katelyn that resembles child-directed speech (e.g., slower rate, smaller number of different words, shorter sentences than she is capable of producing, repetition of important content words), (2) she talks to Katelyn about things that Katelyn is already looking at or activities she is already engaged in (e.g., “following the child’s lead”), and (3) she lengthens the amount of time she allows to transpire before she takes another turn (i.e., Abigail is using increased “response latency” to compensate for Katelyn’s slower language processing time). Abigail’s ability to recognize and accommodate to Katelyn’s different perspective may serve to support the less linguistically sophisticated Katelyn in her conversation attempts. Abigail apparently knows that successful communication is the goal. Given the difference in the two girls’ social communication skills and their general language competencies, the older and more skillful child, Abigail, takes on the role of the accommodator to keep the social interaction going.

In other situations, peers may have to collaborate to decide which game will be played next, or who will take the first turn in that game. Having the social communication abilities to recognize the desires and concerns of others can go a long way to promote and
maintain friendships. Without these types of social communication competencies, children may find both the home and classroom environments difficult to negotiate successfully. Clinical experience indicates that children with poor social interaction skills, such as young children diagnosed with ASD often are not invited to classmates’ birthday parties (Patricia Prelock, personal communication, September 2008), and research has shown that they are rarely picked as friends or favorites by classmates (Babad, 2000; Wu, Hart, Draper, & Olsen, 2001). Marginalization experienced by children with social communication deficits, whether diagnosed with ASD or not, is not only noxious in the short term but also potentially devastating to social development in the longer term.

CHILDREN WITH SOCIAL COMMUNICATION SKILL NEEDS

Who are the children at risk for or already diagnosed with language impairments that can be described as having a social communication component? Statistics would suggest that there is formidable population of actual and potential therapy recipients with social communication needs. Autism spectrum disorders, defined as a set of developmental disabilities characterized by disorders in communication, behavior, and social interaction are currently estimated to occur in 1 in 110 children; specifically 1 in 70 boys is affected, and 1 in 315 girls is affected (Centers for Disease Control and Prevention, 2009).

The problem is not just one of high prevalence rates but the age at which children are first diagnosed and become eligible for intervention. Emphasizing this aspect of the problem, Wetherby and her colleagues (Watt, Wetherby, & Shumway, 2006; Wetherby et al., 2004: Wetherby, Watt, Morgan, & Shumway, 2007) have pointed out that many children with identifiable ASD symptoms go undiagnosed until the later preschool years when therapy will have less chance to be successful. In fact, Wetherby (2007) used data from the U.S. Department of Education to estimate that as high a proportion as 9.4% of infants and toddlers are not receiving the special education services they need. The work of her research group has focused on demonstrating the predictive accuracy of utilizing a checklist of early-emerging language development skills to help identify children with ASD when they are still infants and toddlers. Caregivers are asked to complete the CSBS DP Infant-Toddler Checklist (Wetherby & Prizant, 2002) to evaluate seven types of social communication behaviors that are representative of typical language-learning development between 6 and 24 months of age (e.g., emotion and eye gaze, communication, gestures, sounds, words, understanding, object use). A follow-up protocol both for children who appear to be performing at age-expected levels and those who are not is specified.

Comparisons of the ASHA Schools Survey Reports from 2000 to 2010 (American Speech-Language-Hearing Association, 2010) revealed a fairly consistent percentage of school-based SLPs serving students diagnosed with ASD including pervasive developmental disorder (PDD) and Asperger syndrome (AS), ranging from a low of 80% to a high of 88% reported in 2010. Starting with the 2004 survey, participants were asked to indicate whether there were individuals on their caseloads/workloads for whom they were providing intervention in the area of pragmatics/social communication. This time, the percentages dipped slightly from those reporting above, with a low of 75% and a high of 81%. Although a large proportion of SLPs in the schools are treating individuals with diagnoses of ASD, the survey data presented translate into a relatively small average number (6) of individual clients with the ASD diagnosis on caseloads but a consistently larger average number (8) when the question asked was how many students were served with disorders in the pragmatics/social communication area. This finding apparently indicated that children on the autism spectrum are not the only young clients who are in need of therapy focused on habilitation of pragmatic/social communication competencies.
It is likely that children with diagnoses of specific language impairment (SLI; Leonard, 1998; Tomblin et al., 1997) or pragmatic language impairment (PLI; Bishop, 2000; Conti-Ramsden & Botting, 1999) rather than ASD also are found on the caseloads of SLPs working on pragmatic/social communication competencies. Tomblin et al. estimated the prevalence of SLI in the population of kindergarten children to be 7.4%, but it is not known how often these children present with social communication deficits. By definition, children diagnosed with PLI have difficulties with social aspects of language and, unlike children with SLI, do not appear to have difficulties with syntax and morphology. Although beyond the scope of this article, it is also likely that some older, school-age students accounted for some percentage of the caseloads revealed in the ASHA Schools surveys. Some of those may have been receiving therapy for later-developing social communication competencies, such as executive functioning skills (e.g., organization, prioritization, decision making) and higher-level perspective-taking skills as measured by Theory of Mind tasks (Hewitt, 2010).

Taken together, these data indicate that, not only is there a sizable population of young children (and their families) who are already receiving special services to assist in their acquisition of social communication skills, but there likely are many older children who are not identified early enough to take full advantage of therapy services. This is particularly critical where children with ASD are concerned, given the evidence supporting the efficacy of early intervention (Harris & Handleman, 2000). Continued efforts to address these problems that deserve the support of SLPs and related professionals are focused on the education of families with young children at risk for developing language impairments (including social communication deficits), the inclusion of physicians and other health care personnel in screening and follow-up efforts, and general education of the public regarding the availability of tools to evaluate and monitor early social communication skills.

**SUPPORT FOR PARENT INVOLVEMENT FROM FEDERAL MANDATE**

Perhaps the most obvious way to provide a rationale for parent involvement in the teaching of children’s social communication skills is to consider it as an extension of the widespread adoption of family-centered approaches in the provision of services to young children either at risk for or diagnosed with developmental disabilities. Family-centered approaches, with their focus on the empowerment of families, are considered best practices (Crais, 1991; Dunst & Trivette, 1996). Furthermore, in the United States, family-centered approaches to service delivery are mandated by federal legislation—for example, the Individuals with Disabilities Education Act (IDEA) of 2004 and No Child Left Behind Act of 2001—and they represent a perspective that is consistently reflected in prescriptions for assessment, treatment, and monitoring of the academic and social progress of young children with special needs as exemplified by the Individualized Family Service Plan (IFSP) or the Individualized Education Plan (IEP; Paul, 2007).

Family-centered service delivery presumes that a child’s family is both an inextricable part and a constant feature of the child’s life (as well as their activities of daily living) and that family members must play a role in any therapeutic plans made by professionals for the child. As most readers are well aware, caregivers must be included in all official meetings concerning their children’s IFSPs and IEPs, and the meetings must be conducted in such a way that they are comprehensible to the family members. When language differences are involved, this often means the provision of a translator or interpreter; although not always easy to accomplish, this is not an optional accommodation for caregivers.

What may be even more complicated than a linguistic mismatch between families and professionals is that of a cultural mismatch when perspectives on the roles and responsibilities of families and professionals in the therapeutic process are not aligned. As an
example, consider a family with parents who are concerned about their child’s development, be it in the arena of social communication or not, but who may not have fully expressed their concerns, expecting the professionals to know more than they do. The parents are somewhat surprised when the professional team inquires if the family is in agreement with the team’s recommendations and whether the parents have any suggestions for the professionals regarding prioritizing goals for their child. Rather than interpreting their inclusion in the decision-making process as an attempt on the part of the professionals to partner with the family and show respect for the family members’ valuable input, the parents in this hypothetical case assume that the professional team must be less than competent if it is asking the family for advice. This example illustrates why it is always a good idea to clarify the roles and responsibilities of all of the team members prior to proceeding with an evaluation or treatment.

Trohanis (2008) noted that families not only play a role in their child’s development but also in the “service provision processes” (p. 141). One can interpret Trohanis as indicating that the family, just like the professionals on an IEP or IFSP team, has the responsibility to participate in the child’s therapy. This participation can be interpreted as running much deeper than advising the other team members about a child’s progress in the home environment or providing consent to an updated treatment plan. It is not only an acknowledgement of the full partnership of the caregiver(s) but it also may be a nod to the belief that, in therapeutic contexts, what SLPs and other professionals want to do is to work themselves out of a job. That is, successful therapy means that the clinician’s clients (and family) learn to become their own clinicians. For young children, the initial part of this process is for caregivers to conceptualize themselves as becoming their children’s clinicians. This is the basis for the practice of coaching in early childhood special education (Shelden & Rush, 2001), where professionals provide guidance and demonstration to caregivers regarding the development-enhancing activities to be used with their children. Direct, hands-on therapy by professionals is limited when adopting such an approach so that focus may shift to empowerment of the caregiver.

SOCIAL SKILLS LEARNING REQUIRES NATURAL LEARNING CONTEXTS

To learn social skills, one needs to capitalize on the context where those skills will be most useful. Very young children (ages 0–3) are likely to interact most with their primary caregivers (often parents), who know them best and likely have the most reason to communicate with them. It is a common assumption that the social competencies young children show outside of the home (in a classroom environment if this is part of their young lives) have been built on their knowledge of social skills previously developed in the home environment (Guralnick, 1989, 2001; Guralnick & Neville, 1997; Sheridan, Noche, & Marvin, 2008). The underlying logic of this assumption is that children spend more time in the natural learning context of home than in structured classroom contexts; therefore, the impact of the home environment is not a trivial concern.

Caregivers differ, however, in how responsive they are to their infants, toddlers, or preschoolers, likely due to both individual and cultural differences. Given the positive connection between maternal responsivity and the achievement of first word production, acquisition of 50 words, and syntax development (Tamis-LaMonda, Bornstein, & Baumwell, 2001), caregiver responsiveness is a legitimate focus of caregiver coaching. There is some empirical evidence that responsiveness can be taught. Landry, Smith, & Swank (2006) compared the performance of mothers receiving two different types of responsivity training and found that the mothers who participated in the comprehensive, targeted training demonstrated more frequent and more diverse responsivity behaviors than controls. Their infants also made significantly
greater gains in several developmental areas, including social skills.

**Programmatic approaches to teach caregivers facilitation of social communication**

A number of programs have been developed to teach caregivers and other family members how to enhance the development of their children’s language through social interactions. The following four programs are representative of available evidence-based practices that fit well within the family-centered model. That is, the goal is to provide caregivers with skills that can be adapted for day-to-day use in the home environment.

Developers of the Hanen Programs, such as the original *It Takes Two to Talk—The Hanen Program for Parents* (Manolson, 1992), have promoted the necessity of providing caregivers of young children with special needs with the tools to facilitate language learning in the home since its inception. Following an orientation to the program and a baseline assessment of each child, the parent-based Hanen Program also includes a series of group teaching sessions and a set of three individual feedback sessions with an SLP to discuss parent–child videotaped interactions. Subsequent refinements of the Hanen Programs, such as including a focused stimulation component and teaching parents to follow their children’s lead, have shown that, as parents demonstrate success with their use of responsive strategies, their children are more likely to learn specific vocabulary items taught, as well as to produce communicative attempts more frequently using gestures (Giralometto, Pearce, & Weitzman, 1996a, 1996b, Giralometto & Weitzman, 2006).

Warren et al. (2006) described a program called “Responsivity Education/Prelinguistic Milieu Teaching” (RE/PMT), which, like the Hanen Programs and RT/PMT, focuses on teaching both basic language and social communication competencies to young children who are just beginning to talk. Characterized as a conversation-based and naturalistic method, EMT, according to the authors, “focused on promoting children’s functional use of productive language skills in naturalistic interactions” (p. 203). The EMT program always involves coaching parents to provide prompts to their children to elicit language and then provide feedback to the children contingent on the acceptability of the child’s contribution to the conversation. In addition, parents are taught how to utilize the environment (either at home or in the clinic; coaching sessions can take place in either setting according to family preference).
One notable difference when comparing the EMT program with either the Hanen Programs or the RT/PMT approach is the prerequisite that for a child to be an appropriate candidate for EMT, he or she must already be producing 10 different words, meaning that although the child may still rely on gesture to communicate, one goal of the program is to promote the use of verbal language. This prerequisite certainly does not preclude the teaching of nonverbal social communication skills to children who are becoming verbal but it does disqualify the families of young children who have severely limited expressive output from this choice of treatment strategy.

Another approach that can be used to improve the social communication competencies of young children is the focused stimulation approach. As described by Ellis Weismer and Robertson (2006), focused stimulation is based on the repeated modeling of targeted forms and functions in natural, conversational interactions with parents or SLPs. Fey, Cleave, Long, and Hughes (1993) found that focused stimulation program delivery, whether by parents or SLPs, resulted in gains on the part of children with language disorders. The targeted forms and/or functions are specific targets that are selected for a child depending on the language needs demonstrated. For purposes of this article, if a child were in need of practice with particular types of social communication, a focused stimulation approach could be easily accommodated to target these types of experiences, providing the child with examples of joint action routines for observation and/or participation. Ellis Weismer and Robertson (2006) noted, however, that focused stimulation has been most successful when the language targets have been to increase vocabulary or grammatical complexity. In fact, the authors suggested that the ability of children to exhibit competence with joint attention as well as sustained attention may be prerequisites for the focused stimulation approach. Thus, they would be less appropriate as targets of the approach.

Other considerations for utilizing the least restrictive environment

Just as federal legislation mandates the inclusion of caregivers in the therapeutic process for children receiving therapy for special needs, it also mandates that special services be provided within the least restrictive environment (LRE) for the child. Only in the most unusual of cases is the LRE not considered to be the home environment for children in the 0 to 3 age range. The relationships between caregivers and professionals providing services to young children can become complicated when the contexts for provision of services are altered over the course of preschoolers’ lives.

Early on (birth to age 3 years), the home environment is typically viewed as the required LRE and thus the most appropriate location for service delivery. From a therapeutic point of view, this means that caregivers are at least present and may actually be coached to facilitate their child’s development in the home environment, with the cues and prompts inherent in a family’s activities of daily living.

When children reach 3 years of age, however, service delivery often shifts away from the home environment to a preschool classroom or another location beyond the home where parents may or may not be present at the time treatment is provided. This switch in venue significantly affects the opportunities professionals have to utilize caregivers as information resources and to provide caregivers with information and techniques they can use to facilitate the carryover of therapy goals into the home environment. Thus, the change in venue from home visitation by professionals to provision of professional services when caregivers are not present requires that service providers become creative in figuring out how to monitor the child’s progress in the home environment.

Given the importance of the LRE as a context not just for formal treatment but for day-to-day opportunities for social engagement, it is important to understand the types of activities that make up an individual family’s social
milieu. With this information, it may be possible to individualize suggestions for social skill development activities. To derive a better picture of how families spend their time both at home and in the community, Dunst, Hamby, Trivette, Raab, and Bruder (2000) surveyed more than 3,000 caregivers whose young children were receiving intervention services for developmental disabilities. Their goal was to determine the scope of family life and community life activities beyond the children’s attendance in an early childhood program that potentially could serve as learning opportunities for young children. The authors were careful to include only examples of activity categories that had been deemed culturally neutral. That is, there was evidence suggesting that each item on the survey was incorporated across cultures (e.g., family rituals, family outings), although the specific activities that made up a family ritual, for example, would likely differ among families representing different cultural and ethnic groups.

Understanding the range of activities that make up the worlds shared by families with children with special needs allows professionals to help identify already-occurring activities that may be utilized in new and different ways for learning as well as identifying entirely new, natural learning opportunities. These activities represent both “natural social and nonsocial learning environments” (Dunst, Bruder, Trivette, Raab, & McLean, 2001, p. 19) that are necessary for children to learn about the cultural expectations of their families. The approach used by Dunst et al. would easily allow families to incorporate their own cultural flavor in choosing how to enact the more general learning opportunity categories.

For older pre-school-age children who are no longer receiving therapy at home, there is another potential role for the caregiver, which is to monitor social skill acquisition. SLPs and other professionals recognize that successful therapeutic change cannot be fully measured in a therapy room or preschool classroom. Instead, the most ecologically sound way to assess generalization is in the degree to which the forms and functions taught can be measured in a child’s activities of daily living in multiple environments (Olswang & Bain, 1994). Sometimes caregivers are asked to be part of their children’s therapeutic programs, either in the assessment of generalization, as suggested by Olswang and Bain, or in providing direct intervention. When this occurs, it will be helpful for SLPs to know not only how the child’s caregivers view their role as language facilitators, but also their typical interaction patterns in terms of supporting language learning. Hammer and Weiss (2000) reported, in their analysis of two groups of mothers who differed in SES, that mothers from the low SES group did not view assisting their children’s language development as part of their maternal responsibilities and did not recognize that language learning could be facilitated. The mothers in the mid-SES group differed in that they expressed interest in participating in language-learning activities and also discussed techniques they already had used to that end.

CONSIDERING CULTURAL DIFFERENCES WHEN TEACHING SOCIAL COMMUNICATION SKILLS

Capitalizing on a child’s LRE means that SLPs and other professionals cannot assume a single, predictable characterization of the existing environmental supports that will be available to a language-learning child. Summarizing a review of the literature focused on the means by which social contexts facilitate language acquisition, Hoff (2006) concluded that, given a child without disabilities, language acquisition is just about “inevitable” (p. 55) as long as the child is given the opportunity to participate in communicative interactions within which a language model is available. The implication of Hoff’s conclusion is that regardless of the myriad of cultural differences that have been reported (e.g., children’s access to adult-child communication, the presence of modifications of child-directed speech produced by adults, beliefs on the part of caregivers concerning when a child is producing intentional
communication, vocabulary directed to children by adults, expectations for children’s talk), the language-learning mechanism in typically developing children is robust enough to account for the variability in environmental circumstances so that language acquisition will occur. The data she reviewed, however, led Hoff to conclude further that differences in the environmental supports provided for language learning that may exist across cultures do predict differences in children’s rates of acquisition as well as patterns of acquisition.

As is explained by Beauchamp and Anderson (2010) in the description of their SOCIAL model, environmental supports, although critical, are not sufficient for the acquisition of language. Children also need to be endowed with the underlying cognitive–linguistic abilities to make use of the environmental supports provided. The degree to which those developmental foundations are available also will affect variability of communication acquisition, including social skills development.

Another variable that can influence parent–child interactions is SES, which can be confounded with ethnic differences. In their series of investigations, Hoff et al. (Hoff, 2003; Hoff & Tian, 2005) compared the maternal communication environments provided by mothers of young children, typically less than 3 years of age, from high- and mid-SES families and found several differences. Specifically, mothers from the high SES families talked more to their children, and were more likely to engage their children in conversations than mothers from mid-SES families who speak less often to their children. When they do talk to their children, mothers in low SES groups have a tendency to be more directive. This is consistent with Hammer and Weiss’s (2000) finding that mothers with low SES are less likely to conceptualize language facilitation as part of their maternal role.

Hart and Risley (1995, 1999) studied 42 caregiver–child pairs from families that represented a diverse sample in terms of family size, race, and SES and found that in spontaneous speaking situations caregivers from middle SES households demonstrated a tendency to talk more to their young children than the caregivers in lower SES households. When they conducted further analysis of the ability of these data to predict later outcomes for the 42 children, the authors reported that, regardless of SES, the families with parents who spent more time talking with their children on a daily basis had children with more rapidly growing vocabularies and higher IQ scores at age 3. In a study that compared two groups of African American mother–child dyads, one representing lower SES households and the other mid-SES households, Hammer and Weiss (1999) also found that the African-American mothers in the mid-SES group tended to use a less directive language style with their children and more often attempted to engage their children in conversation. This supports a hypothesis that it is economic status, and even further, maternal education, that influences differences in parent–child interaction styles more than racial/ethnic group membership.

Given Hoff’s data-driven conclusion that young children’s language acquisition will proceed despite great variability in the amount and type of environmental supports provided, it is important for SLPs and other professionals to be open to recognizing alternate forms of richness. That is, social supports may vary among diverse families for socializing their children in the ways of their culture, all of which might be considered “rich” in their own ways. Recognition that different language-learning environments may be found in the homes of young children is critical. When planning for caregivers to participate in therapy, the SLP or other professionals, need to be careful not to make assumptions about how family members typically interact with their children, especially where opportunities for language learning are concerned. Systematic observation of the family may allow professionals to combat the tendency to make assumptions on the basis of stereotypic, group data, but being open to observation is likely influenced by cultural diversity as well. Nevertheless, put simply, it is
the role of the professional to view each family individually. Observations when coupled with “ethnographic interviewing” (Westby, 1990) can afford professionals a more complete and accurate view of the opportunities that actually exist for social communication teaching and practice in the home environment. That is, use of open-ended requests for information such as “Tell me about your child’s day” are more likely to elicit relevant information than questions that make assumptions (and imply judgments) about the family’s life, such as “How many times a week do you read to your child before bedtime?” The latter question makes the assumption that the caregivers can read, that they recognize the usefulness of spending time reading to their children, and that there is some magical frequency that good parents adhere to for this activity. As constructed, the question can be offensive and set an adversarial tone between family members and professional. A more open-ended ethnographic interviewing style would be less likely to start with unfounded assumptions.

van Kleeck (1994), in her review of cross-cultural differences, noted that cultures differ in terms of whether children are viewed as appropriate conversation partners for adults or can properly initiate conversations with them. The use of direct or indirect eye contact, depending on the relative status of the conversation partner, for example, is also governed by cultural values. The cross-cultural differences manifested in conversation management, the most common social communication venue, become essential components in the planning of therapy that will make sense for a family. van Kleeck noted that, when cultural differences exist between a professional and a family, treatment that includes family involvement is more likely to be followed if the differences are understood by both parties and any differences not adhered to are explained so they will make sense to the family. For example, imagine making a recommendation to a family that they practice conversation turn taking daily with their child during “dinner time” when all members of the nuclear family are assembled to partake in the evening meal. This context, although idealized in 1950 family sitcoms and modern-day public service announcements, does not necessarily exist in families where both parents work or attend school or have an extended family unit or have only one parent available for other reasons. Thus, the recommendation may make sense for some but be incomprehensible for others, who could view this suggestion as an indictment of their lifestyle. Knowing how a family’s culture impacts activities of daily living is central to being able to develop home therapy options that are more likely to be followed.

CONCLUSIONS

It is well supported in the existing literature that caregivers of young children who are either at risk or who have already been diagnosed with language disorders can be successfully incorporated into their children’s treatment programs targeting social communication competencies along with other language targets. Beyond the fact that family-centered approaches to intervention for developmental disorders are considered to be best practice, it makes sense that if a child is demonstrating difficulty learning social communication, caregivers, who are the individuals who have the greatest access to the child and greatest opportunity to participate in social interactions with the child, must be involved in that teaching.

The evidence reviewed in this article supports that typically developing children, whether they are learning the prelinguistic, foundational social communication skills or acquiring the more sophisticated pragmatic language development competencies (e.g., communicative intentions, presupposition, conversation management), are assisted by the presence of engaged, responsive caregivers. Although these caregivers are most often parents, they do not have to be. As Hoff (2006) suggested, it is important to explore the environmental supports that exist cross-culturally. Thus, it could
be the case that older siblings provide the environmental supports for social communication exposure, practice, and feedback in some families rather than, or in addition to, the time spent with parents.

The intervention approaches reviewed in this article provide examples of approaches developed to provide efficient and effective treatment for young children with language disorders. These and similar approaches specifically incorporate essential parent training components or allow that parents (or other primary caregivers) could be trained to deliver the therapy program. A variety of methods have been used to teach or guide family members to provide consistent opportunities for their young children to both observe and participate in social interaction. The clinicians and researchers who have developed these parent-focused programs have acknowledged that, to maximize the effectiveness of their programs, any approach must be individualized to meet the abilities and needs of families. This includes understanding the complex manner in which a family’s beliefs and values concerning communication between caregivers and children, language development, and the role family members can play in treatment will likely affect the specific recommendations professionals make.

REFERENCES


Involving Parents in Teaching Social Communication Skills to Young Children


