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ABSTRACT

Suggestions are offered to practitioners on how to consider situational variables in the assessment and remediation of childhood language disorders. Eight sociolinguistic principles, derived from research on normally developing children, are presented. Among the principles are those which state that sociocultural patterns may vary as a function of the ethnic background of the family; the family serves as the first socializing agent and the introducer of language to the child; and traditional assessment involves indirect observation of the environment through careful questioning of the primary caregiver and parental reports. Suggestions are made for incorporating these principles into assessment and a five-step sequence from parent interview to clinician-child interaction is proposed. Remediation techniques involving simulation of frequently occurring situations through play are considered. (CL)

How to Consider the Situation

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Introduction and Background

Changes in theoretical perspectives from which language of the normally developing child can be studied have resulted in concomitant changes in procedures for assessing childhood language disorders. For example, Snow, Midkiff-Borunda, Small and Proctor (1984) used a tabular format to summarize changing theoretical orientations in child language research and discussed subsequent influences on the clinical evaluation process. Similarly, others (cf. Carrow-Woolfolk and Lynch, 1982; Duchand, 1984; Lund and Duchand, 1983; Muma, 1984) treated the historical development of language acquisition as a field of study to demonstrate the effects of various theoretical constructs on the assessment and remediation processes employed in speech-language therapy. The historical trends discussed illustrate the shifts in focus from a solely psycholinguistic orientation to the inclusion of sociolinguistic variables in both assessment and remediation. As a result of the increased attention given language used during interaction, components of situational contexts are currently given more credence than in the past.

A conventional model allocates a limited time for assessment and usually measures language abilities through the administration of formal and/or standardized tests. This means that the assessment of a child suspect of a communication disorder is verified by determining how the child stands relative to others of similar ages and stages of development. Therefore, the child under question is compared with the 'norm.' This procedure primarily reveals a psycholinguistic perspective where the diagnostician's role appears to have clearly defined

boundaries. That is, the diagnostician's role is spelled out in the following manner: (1) determine the child's learning strategies through the administration of a battery of tests; (2) compare the individual child's performance with the normative data from the tests; (3) based on these comparative measures, determine the child's strengths and weaknesses and; (4) plan therapy accordingly. However, this process is limited in that it does not disclose how the child uses what s/he knows or whether that use is appropriate relative to different social situations.

For pragmatic function, it is difficult to compare observed behaviors with established norms, because normative data are not yet available for the different behavioral domains that require assessment. Moreover, communicative norms may not become accessible in the near future due to the range of social and cultural factors influencing speaker-listener behavior at any age. For assessment and remediation of children's communicative abilities then, the practitioner must synthesize results from clinical and experimental research that have the potential for application in different therapeutic settings. To facilitate the practitioner's role in this process, two general types of physical settings may be considered for the subsequent analysis of the child's discourse, small group or classroom settings or one-to-one therapy settings.

Based on the construct that language assessment and remediation should occur in natural contexts, one orientation would suggest procedures useful for classroom or other types of group settings. Here, the diagnostician has the advantage of completing direct observation of the child's interaction. The varying social contexts that take place in the classroom also provide greater opportunity for the child to use newly acquired communicative devices with peers and others. Using a paradigm of assessment, primarily through direct

observations in classroom settings, the clinician is able to move immediately to having the child generalize structure and content in different contexts. For the classroom situation, the primary disadvantages lie in assessment protocols. That is, tools for assessment rely heavily on evaluating communication, e.g., topic maintenance, discourse features, but are limited in determining individual skill levels, e.g., aspects of the conceptual domain.

Alternatively, the traditional one-to-one testing and therapy paradigm offers a means of structuring children with significant attentional difficulties and allows for thorough documentation of individual skills. There is, however, a longer time frame involved in determining an accurate assessment of the child's communicative competence, because measures must be obtained in simulated play situations. The practitioner cannot complete direct observation of the child in different contexts, therefore, clinical judgements are made based on indirect observation, usually parental reports. This not only involves training the parent as an observer, but, unlike the group/classroom situation, does not allow the clinician opportunity for frequent consultation with others in the child's environment (or consultation with significant others in the child's life is sporadic). The subsequent remediation process may also require a longer time frame to move the child through different levels of imitation to the generalization stage (language in context). A high proportion of the therapy is limited to adult-child (often clinician-child) interaction, thereby limiting the practice of newly acquired communicative devices to a single reference person. Finally, when parent and child are asked to interact in the clinic environment, they are both functioning in physically and socially different contexts than those that occur at home or in day care. Acknowledging assets and limitations of group and individual settings allows for the implementation

of assessment of situational variables in traditional therapeutic environments.

Purpose

Given the inherent difficulties in assessing communicative competence when the setting limits the clinician's opportunities to complete direct observations of the child in different types of naturally occurring situations, the purpose of this article is to offer suggestions on how the practitioner can consider situational variables when restricted by the conventional one-to-one paradigm. To achieve the purpose, a set of eight sociolinguistic principles, derived from research on normally developing children (e.g., Oksaar, 1983), are presented first. The discussion is then directed towards application of these same principles with specific suggestions for considering the situation in assessment and remediation of childhood language disorders.

Sociolinguistic Principles to be Considered

Physical and fiscal constraints of the employment setting, time constraints, caseload considerations, few and time consuming communicative assessment tools, lack of protocol to manage the transition from assessment to remediation and lack of opportunity to observe the child in naturally occurring contexts influence clinical decisions to maintain a therapeutic focus on specific linguistic skills, e.g., syntax, versus how language is used, e.g., conversational devices. Since success of any remediation plan is contingent on the diagnostician's ability to observe and make judgements about the behavior under consideration, in this case the child's communicative competence, it is necessary to formulate general principles that serve to direct the clinician's incorporation of sociolinguistic variables in the assessment-remediation process when a one-to-one paradigm must be maintained.

Principle 1: Language acquisition is facilitated by communication, i.e., the practice of social routines in which verbal behavior plays a major role.

Principle 2: To some degree, social routines are determined by cultural behavior patterns of the child's family. In western culture, these sociocultural patterns of behavior are initially practiced in the context of the parent-child dyad where a special language register is often directed to the child.

Principle 3: Sociocultural patterns may vary as a function of the ethnic background of the family, e.g., one culture may be more or less accepting of frequent verbalization from the child.

Principle 4: Concurrent with learning sociocultural patterns of behavior in different situational contexts, the normally developing child is acquiring the form and content of the native language.

Principle 5: As a consequence of principles 1 - 3, the family serves as the first socializing agent and is the first to introduce the child to language.

Principle 6: Children practice social routines and language through play.

Principle 7: The social conditions that strongly influence the amount and quality of the child's language exposure/experience, Principles 1 - 6, must be addressed to determine the nature of language spoken in the immediate environment (family language). In effect, what are the social conditions for stimulating communicatively useful language?

Principle 8: In the traditional clinical setting, assessment involves indirect observation of the environment through careful and extended questioning of the primary caregiver, parental reports.

Application of Principles

To incorporate these principles in assessment, a twofold approach may be employed. For purposes of accountability and to focus the parent on relevant communicative behaviors, the interview may be initiated by using a formal communicative scale such as the Sequenced Inventory of Communication Development (Hedrick, Prather and Tobin, 1975). The interview is expanded by asking questions regarding language produced in the immediate environment and the child's responses to the language. For example, "What are the typical greeting routines of the family?", "How do family members express emotion?" and "How does one request something within the family?" These basic questions provide an index of the child's socializing process and give clues as to the level of verbal stimulation within the child's immediate environment. Since social routines and language are practiced during play, questions regarding type and quality of play with siblings and peers and whether play partners are older or younger are natural extensions of exploring the socialization process.

Since a general therapeutic goal is to 'normalize' the child's ability to communicate effectively (convey messages), there must be an assessment stage that lays the ground work for the treatment plan. In the clinic environment, this is achieved by observing the child in interaction with toys and objects and a single reference person, either clinician or parent or both. Although there are frequent complaints that amount of time to be alloted for direct observation is insufficient, it may be helpful to recall that much of the research reported on parent-child and teacher-child interaction selects no more than 15-20 minute segments for analysis, deeming this to be representative of the overall interaction.

While the clinician directly interacts with the child or observes the parent interacting with the child, remember to observe one behavioral dimension at a time and that length of observation of selected behaviors need last for only a few seconds. For example, when a topic has been established, note facial expression, gaze behavior, gestural expression and proximity to adult when an utterance is produced. Prepared checklists are useful in recording verbal and nonverbal behaviors (cf. Gallagher and Prutting, 1983; Strong, 1983). When the interactive sequence, usually play, is terminated, scan recorded utterances to determine how the child requests objects, actions and information and how the child comments about objects, actions and describes events. Scan recorded utterances also to determine use of conversational devices, e.g., how does the child attend to the speaker, initiate, maintain and change topics, answer questions, ask questions, request clarification and take turns.

Concurrently, notations should be made of adult's behavior. An audio recording can be made of the clinician's own behavior for later analysis and immediate written notations may be made of parental input. Scan adult utterances to determine if language is too controlling or directing. How does the adult initiate, maintain and change topics and what is the rate of change, i.e., is the child being allowed an opportunity (a turn) to respond? Is there sufficient pause time for the child to respond? Is there contingent responding? The clinician should keep in mind that the language delayed child may need more time to respond. What is the nature of the language content directed to the child and is the content appropriate to the situation? What is the utterance length of the child directed language and what are the nonverbal/kinesic behaviors that accompany the verbalization? In essence, measures of the child's communicative competence and performance will include indices of communicative intent and

conversational devices. Measures of the adult's language will include information and affect salient components, i.e., content, length and complexity measures, discourse features and selected suprasegmental features.

Given the previously cited socially oriented principles as well as the need to document individual skill levels, the initial assessment can include a comprehensive language test such as the Reynell Developmental Language Scale (Reynell, 1977) or the Preschool Language Scale (Zimmerman, Steiner and Evatt, 1969). Traditional criteria will be used in selecting the formal measure, e.g., chronological age and suspected stage of development. The clinician should have readily available a conventional grouping of toys and objects such as those recommended for use on play scales (cf. Lowe and Costello, 1976; Nicolich, 1977; Westby, 1980).

The following sequence is suggested for the initial assessment: (1) while child plays nearby, interview parent; (2) interview includes history taking using items from a formal measure and the extended list of questions suggested here; (3) depending on the child's attentional abilities and other behavioral variables, administer all or selected portions of comprehensive, formal language tests; (4) ask parent to play with child and note both partners' verbal and nonverbal behaviors using a checklist of pragmatic protocol (video tape when possible) and; (5) the clinician plays with the child simulating communicatively demanding situations. Creaghead (1983) has validated a pragmatic screening tool that will guide the clinician in setting up communicatively demanding situations and will assist the clinician in making preliminary judgements about pragmatic function in the absence of naturally occurring social contexts. Creaghead's format is highly recommeded since it provides specific suggestions for observing the

child's communicative intent and conversational devices. The format is simple, structures the clinician's observations and can be dealt with effectively considering limited time scheduled for evaluations and extensive caseloads of many practitioners.

Formal tests are selected to measure specific skill levels and for purposes of accountability (pre-post-test paradigm). The parental report, parent-child interaction and clinician-child interaction serve as a baseline measure of the child's communication abilities. Nature of language and sociocultural patterns that occur in the child's immediate environment and the type of language directed to the child are hlepful in providing information regarding the process of socialization used with the child. Overall, the recommended sequence should not take much longer than an hour. Based on results of formal testing and direct observation in the clinic, a clinical judgement is made as to whether the child is having language learning difficulties and which aspect(s) of language and/or communication are most affected. Here, the practitioner must remember to liberally invoke the use of the 'diagnostic therapy' category when writing recommendations and particularly when language differences have been observed in the family.

Assuming the child in question is language delayed, remediation will naturally follow assessment. Since initial assessment has many components of an interactional model, as best as can be obtained given time and caseload constraints, the subsequent therapy will emphasize interaction. This means that the parent is the primary facilitator and remediation will focus on parent-child interchanges.

From initial assessment, language performance data has been obtained through formal testing and cursory interactional data has been obtained through interview and observation of the the parent and the child. However, further identification and clarification of situations that occur frequently in the

child's daily routine are required. This is to say that situational variables strongly influence communicative and linguistic behavior and if not fully accounted for in the course of one-to-one therapy, the process of moving the child to the generalization stage (language in context) will require a much longer period of time than is necessary. (This is also known as a the problem of carry over in traditional speech and language therapy). This is basically an integration of a conventional therapy model. where focus is on specific skills, with an interactive model where varying aspects of the socialization process are emphasized. To substantiate the need for this additional information as projected plans for remediation are begun, the following is an explanation of why context of situation is so important.

During the course of any given day, the child is exposed to and participates in a variety of activities, both planned and unplanned, with people and things inside and outside of the home. The contexts of these situations vary rapidly and are generally affected by a number of setting variables. Setting variables or components include physical features of the environment such as furnishing, light, temperature/humidity, space, noise and so on. The context of a particular situation is dependent on the physical features as well as number and role of people present in the immediate environment.

Specific place, time, person(s) and/or thing constellations have been shown to influence children's functioning because of strong linkages between behavior and environment. Although the individual stands indepedent of the setting, once caste into the setting, this is the place in which the interaction occurs. For example, several researchers have documented that very early in life the same infant-parent dyads behaved quite differently in laboratory and

home settings (Belsky, 1977; Brazelton, Kowsloski and Main, 1974; Feedle and Lewis, 1977; Lamb, 1976; Lewis and Freedle, 1973; Sroufe, 1970). Similarly, situational variables have also been found to influence different aspects of form, structure and use of older children developing normally as well as language impaired children (Hubbell, 1977; Seibert and Hogan, 1983; Siegel and Spradlin, 1982; Spiegel and MacCallum, 1984).

Type and amount of interaction vary as a function of the situation. Different types of situations also have verying degrees of structure and demand different types of social and communicative function from the participants. There are, however, regularities associated with many situations and from the context of regularly occurring situations, the child seems to form scripts or representations of events. In other words, from participation in conventionalized routines, e.g., bathing, feeding, book reading, the child is able to predict what s/he is expected to do. In the context of such routinized activities, joint reference is established and parent and child share knowledge. Some (Bruner, 1978; Nineo and Bruner, 178; Snow, Dubber and deBlauw, 1980; Snow and Goldfield, 1983) suggest that such conventionalized routines establish a framework for emergence of language. Based on the proposal that conventionalized routines establish regularities for communication, and that communication facilitates language, it is extremely important for the clinician to identify and facilitate such routines in the therapy setting.

To achieve this therapeutically, the following suggestions are offered:

1. Ask the parent to provide a schedule of daily activities with the child.
2. Ask the parent and child to pretend it is lunch time, beth time, etc. and demonstrate what they do. Clinician notes the language used by both.
3. Ask the parent to observe and write down for therapy frequently occurring situations in the home.

4. Ask the parent to write down and bring to therapy utterances produced by parent and child in these frequently occurring situations.
5. Ask the parent to bring some of the child's favorite toys to therapy and demonstrate how they interact using these toys.

Requests of parents should be given one at a time with specific explanations of why each is being requested. That is, parents and children participate in regular routines where they practice language. It is important to identify the generalities of these routine situations, because of the apparent importance of conventionalized rituals in language learning. To simulate different contextual situations in therapy, the clinician searches for similarities among situations that can be included during therapy. Play is the primary vehicle employed when working on what is communicatively useful for the child. After determining regularly occurring situations between parent and child then, ask the parent to note frequently occurring contexts between child and siblings, peers and other important people in the child's life.

Remediation then, involves simulating the contexts of frequently occurring situations through play. On many occasions, the clinician may choose to play the role of the significant other to demonstrate how to use certain language structures with the child, e.g., "I'll play grandmother and you tell me about your new doll." Using play as a means of simulating the child's home experiences, the clinician may demonstrate more appropriate language input by modeling how expansions, semantic extensions and partial imitations can be used. Be specific and allow the parent 'practice time' within the therapy context. At times, play may be dyadic (parent-child or clinician-child) or triadic (parent-child-clinician). The child should be given frequent opportunities to initiate activities, however, this will be dependent on attentional and behavioral variables. At other times,

the clinician will select toys and structure the physical setting to elicit selected language forms. This will be contingent on results of formal tests.

In summary, remediation will emphasize interaction, primarily through simulating home experiences during play, with parent(s) intimately involved in the process. Contextual situations from home will be brought to the therapy setting by asking the parents to identify and clarify frequently occurring family routines. When necessary, the clinician will demonstrate more appropriate language input for the parent(s). At still other times, the clinician will take on the role of a significant other in the child's life to allow for practice of conventional routines with those individuals. In the absence of naturally occurring situations then, the clinician attempts to manipulate the therapy setting for the purpose of teaching language through interaction.

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ABSTRACT:

Theoretical and methodological changes in the study of normal language acquisition have resulted in concomitant changes in assessment and remediation of childhood language disorders. Because of the increased emphasis on sociolinguistic factors and their effects on form and content of language, innovative procedures are required to account for measurement of the child's communication abilities when the practitioner is restricted by a traditional one-to-one therapeutic environment. Based on eight general principles of sociolinguistics, this article offers specific procedures for incorporating an analysis of situational variables in the assessment and remediation process.