

SPEECH AND LANGUAGE SKILLS

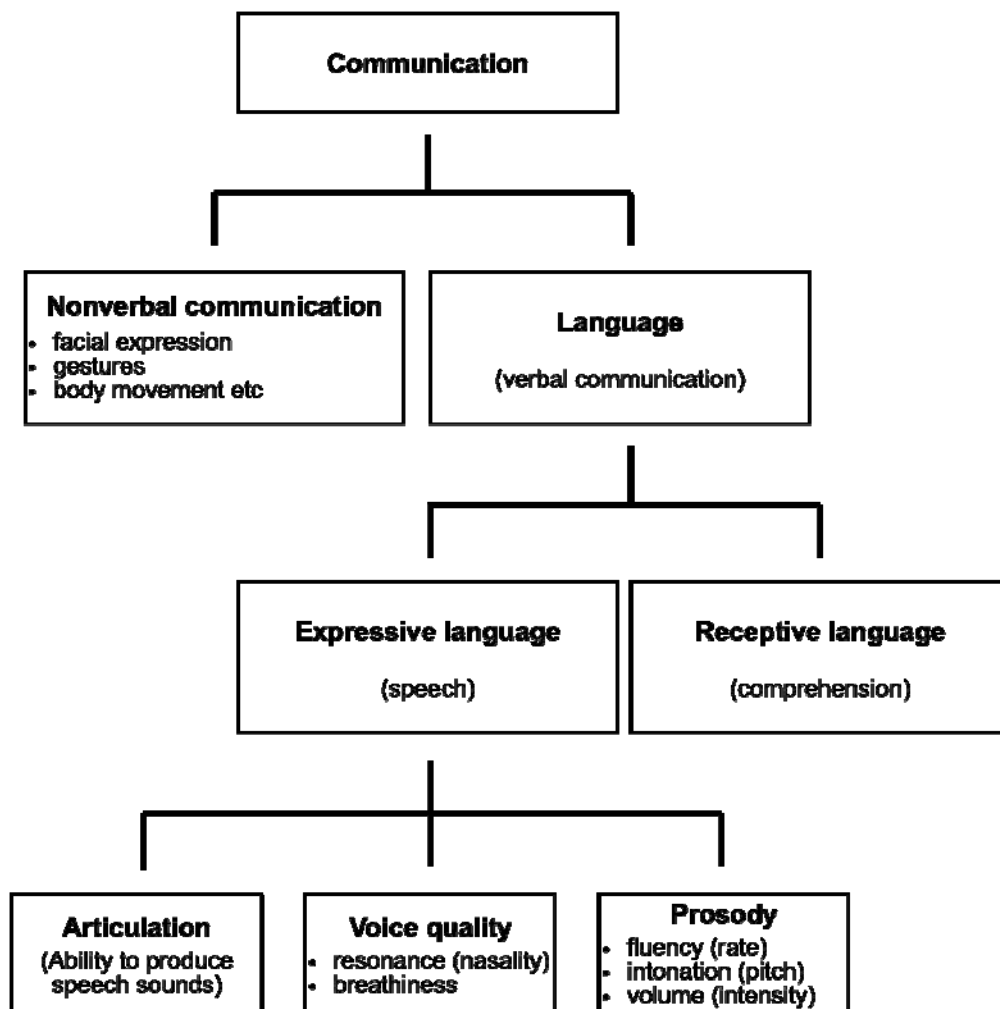
An extract from
Porter, L. (2008). *Young children's behaviour*,
(3rd ed.) Sydney, Elsevier.

As shown in figure 1, there are three main aspects to everyday speech and language: *language* (or *comprehension*) refers to how much children can understand; *speech* refers to the ability to put thoughts into words; and *articulation* refers to how clearly individuals can form speech sounds.

Children can acquire communication skills more slowly than usual, in which case their skills are said to be *delayed*; alternatively, their development might occur out of the usual sequence, when it is said to be 'disordered' or *impaired*. Children with impaired communication skills might understand some complex language and thus seem to be developing at age level, yet they confuse easier concepts. Given that they understand some things but not others, their failure to follow directives can be misconstrued as a deliberate lack of cooperation.

FIGURE 1: THE COMPONENTS OF COMMUNICATION

Source: B. Burnip (2002: 156)



BOX 1 INDICATORS OF SPEECH OR LANGUAGE IMPAIRMENTS

Many of the following characteristics of children's speech or language are normal at young ages; they indicate delays or impairments only when they persist beyond the usual age.

Speech and language use

- delayed vocabulary acquisition
- difficulty finding words to express ideas
- sentences that are ungrammatical beyond the usual age
- prolonged use of immature word endings (e.g. runned-ed)
- difficulty with articulation at an age when unfamiliar adults typically can understand
- echolalic speech (that is, repeating the last word or phrase just spoken by another)
- repetition of questions even when these have been answered
- topic fixation: talking about one topic exclusively, even in the midst of a conversation on an unrelated topic
- repetition of the same comment in the same circumstances
- communication about immediate ('here and now') events only

Attention to language

- inattentive or avoidant during language sessions
- watch other children to know what to do during active songs
- have difficulty following a short sequence of instructions

Learning difficulties

- attention difficulties
- reading delays
- impaired overall academic performance at school
- delays in acquiring self-help skills such as packing away toys, toileting, dressing or grooming, because of deficient self-talk to guide their performance of these tasks

Social skills

- elevated levels of solitary play
- use of physical contact rather than words to greet others
- difficulties initiating friendships
- even greater difficulties maintaining friendships
- problematic interactions with other children e.g. repeated aggression
- inability to use language to solve social conflicts

Emotions

- poor frustration tolerance
- heightened negative emotion
- later in life, higher rates of anxiety disorders, particularly social phobias

Behaviours

- impulsive and risky behaviour, arising perhaps because of an inability to anticipate the consequences of their actions

Sources: Benasich et al. 1993; Beitchman et al. 2001; B. Burnip 2002; Caulfield et al. 1989; Dionne et al. 2003; Doctoroff et al. 2006; McCabe 2005; McClelland et al. 2000; Snowling et al. 2006; Trzesniewski et al. 2006.

Delays or impairments can occur in any one or a combination of the core communication skills, with delays in comprehension (language) being the most significant in three ways. First, the children are less able to understand instructions and therefore can seem to be uncooperative, when in fact they simply have not understood what was being asked of them.

Second, those with expressive difficulties can become frustrated at their inability to communicate their own needs and desires. Their impairments will also interfere with establishing and maintaining supportive peer relationships.

Third and, perhaps even more importantly with respect to their behaviour, children who have difficulty with language *do not talk to themselves*. Self-talk or inner speech is needed to regulate their emotions, direct their task performance (e.g. figuring out where to place puzzle pieces) and to guide their own behaviour. Because they are less able to think through and anticipate the outcomes of their actions, their behaviours can seem impulsive and risky. Their impaired self-talk can also lead to some less obvious problems with the likes of toilet training (as the children cannot talk to themselves about the sensations that signal the need to go to the toilet); and packing away toys, as this has to be planned logically: 'That's a truck, so it goes on the shelf with all the other vehicles'.

Nevertheless, associations between language delays and behaviour problems are modest (Plomin et al. 2002), with only 11 per cent of four-year olds and one-third of eight-year-olds with language impairments also displaying behavioural problems (Benasich et al. 1993). Those least likely to develop behavioural difficulties tend to have higher general cognitive ability and have resolved their language problems by the time they start school (Benasich et al. 1993; Snowling et al. 2006). Language problems that persist into the school years are more detrimental than are severe language difficulties that are resolved early (Snowling et al. 2006).

The range of behavioural and other difficulties displayed by children with delayed or impaired communication skills is listed in Box 1. Together, this cluster of difficulties is often labelled as a behavioural problem, while the underlying language deficit is overlooked.

INTERVENTIONS

All children benefit from language stimulation, although those who are having difficulties comprehending and expressing language will need an assessment from a speech pathologist, who can then guide your interventions.

Language stimulation

Three settings are particularly potent for assisting children to acquire and practise language: during story and song sessions, when children are at play, and during snack and meal times. All require the proximity of teachers and children and all require (as separately advised in earlier chapters) small groups so that adults' conversation does not have to become managerial but instead can entail sophisticated communication. In such settings, you can promote four levels of language:

- *concrete* language that labels and locates events (e.g. 'Where is the crocodile in this picture?');
- *integration of perception* that describes and recalls events (e.g. 'What did we use to make our playdough?');
- *analysing*, summarising, defining, comparing, contrasting and judging events (e.g. 'How do you think Spot felt when he found his mother?');

- *reasoning* about perception: making predictions, solving problems, and explaining events (e.g. 'Why do you think Spot's Mum was worried when she could not find him?') (Massey 2004).

Young children need success with more basic language before they will be capable of the higher-level language skills and, therefore, require adults to use levels one and two in conversation approximately 70 per cent of the time and the last two levels for the other 30 per cent (Massey 2004). Massey recommends recording your story reading session and other conversations so that you can play back your conversations and listen for the quality of the language that you use. This will allow you to embellish your conversation, as its quality – rather than the provision of play objects in the environment – most advances children's language skills (Massey 2004).

Simplify instructions

If your instructions exceed children's comprehension levels, they can appear to be uncooperative, when in fact they simply have not understood what you were asking them to do. To help, you can simplify what you say. For example, if you tell children with language difficulties that there will be cake for afternoon tea, they will hear the word 'cake' and think that you are offering it now. Disappointment and confusion will arise when it does not appear immediately. In the same vein, limit your instructions to one or two parts. Rather than saying, 'I want you to go to your bag, get your teddy and lie down', you could say, 'Time to get teddy and lie down'. If you add extra words into your instruction, children sometimes remember only the first thing you said, so might go to their bag, forget what they were there to retrieve, wander off and then get chastised for not following instructions.

When children's understanding is uncertain, you can ask them to repeat back what you've instructed, keeping in mind that those with echolalia can do this and still not appreciate the actual meaning behind the words.

When children cannot translate what you are saying into an action, help them to get started. Guide them to where they need to be and initiate the physical action, such as picking up a block and dropping it in its container. For repeated lack of cooperation, use the strategies mentioned in Porter (2006, 2008) for helping children get in command of their feelings.

Be alert to otitis media (middle ear infections)

Middle ear infections are the most common childhood illness, particularly in children's first two years of life when their small faces mean that their eustachian tubes are more horizontal than later in life, and therefore do not as readily drain fluid from the middle ear (L. Burnip 2002). Although signs of pain such as pulling at the ears and effusion from the ears can signal an active illness, half of all middle ear infections are not detected because the children show no symptoms (Feagans et al. 1994). Infants with chronic otitis media can have impaired hearing for just over half of their first year of life and just under half in their second year (Paradise et al. 1997; Roberts et al. 1998). The fact that sounds appear only half as loud makes it necessary for the children to concentrate to hear, which will tire them easily.

Even so, this degree and persistence of hearing loss appears not to result in permanent language delays except in unstimulating or low-quality settings. In these settings, because children who do not hear well are less responsive to language, adults and peers to converse with them less – and this lack of language stimulation in turn leads to language and cognitive delays (Roberts et al. 1998; Vernon-Feagans & Manlove 2005). Moreover, disorganised settings pose more distractions that will cause children to be less attentive to language (Feagans et al. 1994).

Model correct articulation

In young children many articulation errors are normal. Many children of preschool age are still not yet accurate with saying the single sounds: th, r, l, sh, ch and s; and have difficulty with blends containing r, l, and s (such as 'tree', 'play' and 'spoon'). Difficulties will also depend on whether the sounds come in the beginning, middle or end of a word. Multi-syllabic words (such as animal, hospital, and ambulance) are often still difficult for children up to school age. Most substitutions for these sounds are developmentally normal; others indicate a speech difficulty.

When young children are learning to talk, do not explicitly correct their articulation errors or force them to say it 'properly'; instead, simply model the correct sound. For example, when a child has called a cat a 'tat', you can respond positively with, 'Yes, that's a cat'. Detecting the difference, they will ultimately learn how to say the word correctly.

Similarly, when they make grammatical mistakes such as using 'runned' instead of 'ran', you might naturally be able to use the correct form yourself without naming the error: 'Yes: he ran across the playground, didn't he? I saw him too'.

Given that articulation delays can impair others' understanding of children's speech and can signal poor awareness of the sounds of language (which is termed phonological awareness), early intervention is wise to prevent social difficulties and later reading problems. If in doubt, therefore, recommend to parents that they seek a speech pathology assessment.

Tolerate baby talk

Four-year-olds often revert to baby talk as they play with their voices. They will also chant, experimenting with rhyme and rhythms. This is necessary for their language development and therefore should not be discouraged. However, if it becomes intrusive, you could use empathic assertion, as in: 'I know that it's fun to play with your voices and with words. But it will be time to find another game soon, because the noise is bothering those of us playing over here'.

Asking repeated questions

Children learn how to make statements before they learn how to ask questions. But once they have mastered the question format, they realise that asking one gets you to speak to them, even if they already know the answer. This is normal and can be responded to by answering them once or twice and then asking them what they think the answer is.

However, asking repeated questions can also be a sign of impaired communication skills. In this case, children can appear to be using language appropriately – such as asking, 'What you doing?' while you are preparing a snack – but they do not absorb the answer or appear to notice that you have answered them. At home, they will ask 'Where we going?' when in the car, not because they are inquiring about their destination, but simply because they have learned that this is what you say when in a vehicle. If this pattern causes you to suspect delayed or impaired language skills, recommend to the parents that they gain a speech pathology assessment.

FURTHER READING

Porter, L. (2006). *Children are people too: A parent's guide to young children's behaviour*. (4th ed.) Adelaide, SA: East Street Publications.

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REFERENCES

- Beitchman, J.H., Wilson, B., Johnson, C.J., Atkinson, L., Young, A., Adlaf, E., Escobar, M. & Douglas, L. (2001). Fourteen-year follow-up of speech/language-impaired and control children: Psychiatric outcome. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40 (1), 75-82.
- Benasich, A.A., Curtiss, S. & Tallal, P. (1993). Language, learning, and behavioral disturbances in childhood: A longitudinal perspective. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32 (3), 585-594.
- Burnip, B. (2002). Communication skills. In L. Porter (Ed.) *Educating young children with additional needs*. Sydney: Allen and Unwin, pp. 154-173.
- Burnip, L. (2002). Hearing. In L. Porter (Ed.) *Educating young children with additional needs*. Sydney: Allen and Unwin, pp. 140-153.
- Caulfield, M.B., Fischel, J.E., DeBaryshe, B.D. & Whitehurst, G.J. (1989). Behavioral correlates of developmental expressive language disorder. *Journal of Abnormal Child Psychology*, 17 (2), 187-201.
- Dionne, G., Tremblay, R., Boivin, M., Laplante, D. & Pérusse, D. (2003). Physical aggression and expressive vocabulary in 19-month-old twins. *Developmental Psychology*, 39 (2), 261-273.
- Doctoroff, G.L., Greer, J.A. & Arnold, D.H. (2006). The relationship between social behavior and emergent literacy among preschool boys and girls. *Journal of Applied Developmental Psychology*, 27 (1), 1-13.
- Feagans, L.V., Kipp, E. & Blood, I. (1994). The effects of otitis media on the attention skills of day-care-attending toddlers. *Developmental Psychology*, 30 (5), 701-708.
- McCabe, P.C. (2005). Social and behavioral correlates of preschoolers with specific language impairment. *Psychology in the Schools*, 42 (4), 373-387.
- McClelland, M.M., Morrison, F.J. & Holmes, D.L. (2000). Children at risk for early academic problems: The role of learning-related social skills. *Early Childhood Research Quarterly*, 15 (3), 307-329.
- Massey, S.L. (2004). Teacher-child conversation in the preschool classroom. *Early Childhood Education Journal*, 31 (4), 227-231.
- Paradise, J.L., Rockette, H.E., Colborn, D.K., Bernard, B.S., Smith, C.G., Kurs-Lasky, M. & Janosky, J.E. (1997). Otitis media in 2253 Pittsburgh-area infants: Prevalence and risk factors during the first two years of life. *Pediatrics*, 99 (3), 318-333.
- Plomin, R., Price, T.S., Eley, T.C., Dale, P.S. & Stevenson, J. (2002). Associations between behavior problems and verbal and nonverbal cognitive abilities and disabilities in early childhood. *Journal of Child Psychology and Psychiatry*, 43 (5), 619-633.
- Porter, L. (2006). *Children are people too: A parent's guide to young children's behaviour*. (4th ed.) Adelaide, SA: East Street Publications.
- Porter, L. (2008). *Young children's behaviour: Practical approaches for caregivers and teachers*. (3rd ed.) Sydney: Elsevier/London: SAGE/Baltimore, MD: Brookes.
- Roberts, J.E., Burchinal, M.R., Zeisel, S.A., Neebe, E.C., Hooper, S.R., Roush, J., Bryant, D., Mundy, M. & Henderson, F.W. (1998). Otitis media, the caregiving environment, and language and cognitive outcomes at 2 years. *Pediatrics*, 102 (2), 346-353.
- Snowling, M.J., Bishop, D.V.M., Stothard, S.E., Chipchase, B. & Kaplan, C. (2006). Psychosocial outcomes at 15 years of children with a preschool history of speech-language impairment. *Journal of Child Psychology and Psychiatry*, 47 (8), 759-765.
- Trzesniewski, K.H., Donnellan, M.B., Moffitt, T.E., Robins, R.W., Poulton, R. & Caspi, A. (2006a). Low self-esteem during adolescence predicts poor health, criminal behavior, and limited economic prospects during adulthood. *Developmental Psychology*, 42 (2), 381-390.
- Vernon-Feagans, L. & Manlove, E.E. (2005). Otitis media, the quality of child care, and the social/communicative behavior of toddlers: A replication and extension. *Early Childhood Research Quarterly*, 20 (3), 306-328.