

ASSIGNMENT No. 2

Q.1 What is the importance of development of language skills and how it is linked with motor skills in children with special needs?

Associations between language and motor skills have frequently been recognized. The developmental pathways within each domain have been described in terms of rapid changes, plateaus, as well as wide variability (Iverson [2010]) and common traits between domains have been found (Hill [1998]). Consequently, it has been difficult to disentangle the associations. Most previous research on this association has focused one-sidedly on motor profiles in children with Specific Language Impairment (SLI) (Iverson and Braddock [2011]). A growing literature investigates the interrelatedness of these developmental domains (Iverson [2010]; Alcock and Krawczyk [2010]). However, previous literature has been dominated by focus on one out of three perspectives, rather than combining them. These three perspectives are; 1) co-occurrence of difficulties, 2) stability of each domain across time, and 3) predictive power from one domain to another across time. Most previous studies are hampered by small sample sizes and are often limited to clinical rather than population based samples, mainly with Specific language impairment (SLI) or Developmental coordination disorder (DCD) (Hill [1998]; Iverson and Braddock [2011]). The purpose of the present study is to gain new knowledge about the developmental relationship between language and motor performance across age by combining the three perspectives described above in one population based longitudinal study.

Several theories suggest links between motor development and specific aspects of language. The development of gestures is the foremost example of this. Motor skills influence the performance of gestures and studies have shown that children with language delays very often have a history of problems with gestures (Iverson and Goldin-Meadow [2005]; Zambrana et al. [2012a]). Further, theories of motor cognition, i.e. the notion that cognition is embedded in actions, suggest that perception and action share common computational codes and underlying neural architectures. This idea has been further developed in the study of mirror-neurons. It has been suggested that the mirror-neuron system is the basic neural mechanism from which language has developed, and that this system represents a strong link between language and action representation. Theories of embodied cognition argue that motor resonance enhances language comprehension. These theories suggest that a broader developmental focus should be employed both in research and in clinical practice when investigating language and motor development.

Lately, researchers have questioned the specificity of several developmental disorders. The frequent overlap in symptoms across domains in developmental disorders as well as co-morbid diagnoses suggests less clear distinction between clinical groups, especially in children, than suggested by the diagnostic systems. When comparing children diagnosed with SLI or DCD to children with no previously suspected disorder but with low standard scores on language or motor skills, researchers found that diagnosed children were more pervasive underachievers on a large set of measures of developmental difficulties additional to those corresponding to

their diagnosis compared to those with low standard scores (Dyck and Piek [2010]). This observation suggests that a broader developmental focus should be employed both in research and in clinical practice.

Arguments have been proposed for grouping neurodevelopmental disorders together, such as language and motor difficulties (Viholainen et al. [2006]; Andrews et al. [2009]). These disorders have several common features (Rutter et al. [2006]). They involve similar neural structures, and the development is characterized by a delay/deviance rather than a remission or relapse (Jancke et al. [2007]). Both of these disorders involve some degree of cognitive impairment and have a marked male preponderance. The genetic influences on individual differences in both domains are quite strong. Language difficulties have been found to be highly hereditary, and children with DCD have been found to have neurological similarities to children with SLI, such as frequent rolandic spikes during sleep, suggesting a genetic component. More research is needed on potential common genetic factors influencing development of both skills. Factors such as socio-economic status, parental history of difficulties or low birth weight are known to influence both language and motor skills. Thus, a child with slow development in one of the domains will also be at risk of developmental delay in the other.

Motor skills are often divided into gross and fine motor skills. These are described as overlapping but different (Hill [2001]). Some studies have found that language skills were associated only with gross and not fine motor skills, but an overall finding in literature concerning children with language delays is that they are characterised by deficits in both gross and fine motor skills.

Studying at risk populations, two literature reviews have concluded that contrary to the definition of SLI, people with SLI may exhibit non-linguistic problems, such as impairments of gross and fine motor skills, and other functional problems. These findings are consistent with the results from a meta-analysis of 14 clinical studies indicating an association between gross and fine motor delay and language delay in children. Comparing language profiles in children with DCD or SLI to controls, results showed that the language profiles of children with either DCD or SLI are similar in the majority of cases (Archibald and Alloway [2008]). Also, research comparing motor profiles in children with SLI or DCD shows that both groups are significantly lower than controls on motor scores (Hill [1998]). Few longitudinal studies have investigated developmental stability of language and motor skills in general populations and results from these are inconsistent. However, the prospective longitudinal study Early Language in Victoria Study (ELVS) (Reilly et al. [2009]) showed that about half of late talkers catch up with their peers, and a Finnish follow up study suggested that about half of children with motor delay also catch up with their peers.

Symptoms of delayed or deviant language development are related to a variety of different developmental outcomes such as ADHD, emotional and behavioural problems. Likewise, impaired motor function early in life has been found to be a precursor of problems with language acquisition later on. Only a few studies have analysed the relationship between language and motor development longitudinally in community samples studied the relationship of early motor development and school age motor and cognitive development in 33 typically developing children. They demonstrated that parent-reported scores on the Ages and Stages

Questionnaire (ASQ), measuring gross motor skills during infancy, predicted later motor and cognitive performance. The same association was not found for fine motor skills (Piek et al. [2008]). These results are consistent with the claims that early locomotor experiences are an essential agent for developmental change. However, the association was limited to working memory and speed of processing only and no association was found between early gross motor skills and later verbal comprehension. Another study of typical language development in 102 children between 9 and 23 months demonstrated large variability in both gross and fine motor skills within each child across age, between the children at each age level and across the developmental domains. Further, one study on 21 month old children, investigated various motor skills, including oral movements, in association with language production, comprehension, and complexity. Results showed no residual associations between gross and fine motor performance and measured aspects of language development when controlling for oral motor movements. These studies do not support a clear predictive power from one domain to the other. Some studies support language and motor skills as separate domains while others suggest that motor skills are a prerequisite for language development (Iverson [2010]) or that language predicts motor performance

Q.2 How the lack of intelligence can have inhibiting or releasing affect on social development of a child?

Socially withdrawn children frequently refrain from social activities in the presence of peers. The lack of social interaction in childhood may result from a variety of causes, including social fear and anxiety or a preference for solitude. From early childhood through to adolescence, socially withdrawn children are concurrently and predictively at risk for a wide range of negative adjustment outcomes, including socio-emotional difficulties (e.g., anxiety, low self-esteem, depressive symptoms, and internalizing problems), peer difficulties (e.g., rejection, victimization, poor friendship quality), and school difficulties (e.g., poor-quality teacher-child relationships, academic difficulties, school avoidance). The goals of the current review are to (a) provide some definitional, theoretical, and methodological clarity to the complex array of terms and constructs previously employed in the study of social withdrawal; (b) examine the predictors, correlates, and consequences of child and early-adolescent social withdrawal; and (c) present a developmental framework describing pathways to and from social withdrawal in childhood. Social withdrawal is not a clinically defined behavioral, social, or emotional disorder in childhood. Indeed, some individuals appear content to spend most of their hours and days removed from others. These individuals include those who spend significant time alone, working, playing, and otherwise acting on their computers. Others may design homes, automobiles, space modules, or may spend their time writing scripts, poems, lyrics, book chapters, and so forth. Often these individuals have a distinct need for solitude. Conversely, there are those individuals who, while in social company, avoid their confreres, or who actively choose lives of solitude to escape the initiation and maintenance of interpersonal relationships. And finally, there are individuals who have little choice in the matter of solitude because they are isolated or rejected by others in their social communities. In the cases of the avoidance of social company and the isolation from

social company, solitude could hardly be construed as psychologically or socially adaptive. It is not the display of solitude per se that may pose a problem; rather, the central issue is that social withdrawal may reflect underlying difficulties of a social or emotional nature.

To some researchers, the expression of social withdrawal represents the developmental outcome of particular temperamental dispositions (e.g., Fox et al. 2005). To others, withdrawal is viewed as a behavioral index of the child's isolation, exclusion, or rejection by the peer group (e.g., Boivin et al. 1995, Gazelle & Ladd 2003). Still others believe that social withdrawal in childhood, depending upon the age at which it is observed, reflects the lack of a social approach motive and a preference for object manipulation and construction over interpersonal exchange (e.g., Coplan et al. 2004). Finally, there are those who believe that social withdrawal is linked to psychological maladaptation as it represents a behavioral expression of internalized thoughts and feelings of social anxiety or depression (Vasa & Pine 2006). As the reader may deduce, social withdrawal is a somewhat fuzzy construct that has defied precise meaning and understanding. In this regard, it becomes immediately apparent why there has not been general agreement among traditionally trained clinical psychologists concerning the relevance and significance of social withdrawal vis-à-vis the development and expression of psychologically abnormal emotions, thoughts, and behaviors in childhood and adolescence.

Given the slippery nature of the phenomenon, one purpose of this review is to provide some definitional clarity for the construct of social withdrawal. Such clarity is particularly important because social withdrawal appears to have many "faces" (e.g., Rubin & Mills 1988), and the multiple forms of social solitude typically expressed in childhood carry with them different psychological functions and meanings (e.g., Asendorpf 1990, Coplan et al. 1994, Harrist et al. 1997). To make matters more confusing, the expression of different forms of solitude appears to have different meanings, not only at different points in childhood, but also within different social contexts (Rubin et al. 2002) and cultures (e.g., Chen et al. 2005). Before defining social withdrawal and associated constructs, we briefly describe the relatively recent history of the study of social withdrawal and relevant developmental and clinical theory. We also review the various ways in which social withdrawal, in its many forms, has been assessed.

A second purpose of this review is to examine factors that may predict social withdrawal during childhood. Third, we consider the correlates and consequences of child and early-adolescent social withdrawal.

Historically, social withdrawal has been considered by clinical psychologists to have limited developmental significance. For example, up until the late 1960s, it was argued that childhood social withdrawal was relatively unstable and not significantly predictive of maladjustment during the adolescent and adult periods (e.g., Kohlberg et al. 1972, Robins 1966). The studies from which these early conclusions were drawn, however, were methodologically and conceptually flawed (Rubin & Coplan 2004). For instance, the samples comprised the exclusive use of clinic or high-risk participants. There was an overreliance on teacher assessments of social withdrawal with unknown validity. And the central focus was on outcomes related to externalizing rather than internalizing disorders. Nevertheless, this view was prevalent until relatively recently

despite the fact that developmental scientists have stressed the importance of peer interaction since the turn of the twentieth century.

Cooley (1902) was among the first to suggest that peer interaction made a significant contribution to children's socialization. And in his early writings, Piaget (e.g., 1932) argued that exposure to instances of peer conflict and opportunities for social negotiation aided children in the acquisition and development of perspective-taking skills, cause-and-effect social reasoning, and an understanding of morality.

Mead (1934) proposed that the ability to self-reflect, to consider the self in relation to others, and to understand the perspectives of others was largely a function of participation in organized, rule-governed activities with peers. He suggested that exchanges among peers, whether experienced in the arenas of cooperation or competition, conflict or friendly discussion, allowed the child to gain an understanding of the self as both a subject and an object. Sullivan (1953) proposed that the experience of peer relationships was essential for the child's development of the concepts of mutual respect, equality, and reciprocity. He emphasized the importance of "chumships," or special best-friendships, for the emergence of these concepts and also for psychological well-being. Theorists in the social learning camp have long suggested (and found) that children learn social behaviors and social norms directly through peer tutelage, reinforcement, and punishment, and indirectly by observing peers "in action" (Bandura & Walters 1963).

Current research on social withdrawal is also guided by the writings of Hinde (1987). From Hinde, social withdrawal can be considered an individual characteristic that influences the quality of a person's social relationships (e.g., friendship) and the individual's reputation and standing in the peer group (e.g., peer rejection). Hinde's conceptual model serves as a useful heuristic to present central lines of inquiry and major research findings regarding children who avoid and withdraw from the peer group.

Building upon the extant theoretical work, strong empirical support has developed for the notion that peer interactions (and the lack thereof) and the relationships that derive from children's interactions or solitude can serve to promote both adaptive and maladaptive social, emotional, and social-cognitive functioning (see Rubin et al. 2006a for a recent review).

The study of children's and adolescents' solitary and withdrawn behavior has been associated with such constructs as shyness, behavioral inhibition, isolation and rejection, social reticence, passivity, and peer neglect. Oft-times, these referents have been used interchangeably, and inconsistencies in definitions and assessments have been pervasive. Recently, however, there has been an attempt to organize these varied constructs in a psychologically meaningful manner (e.g., Rubin & Asendorpf 1993, Rubin & Coplan 2004).

Rubin (1982) originally proposed a distinction between two causal processes that may underlie children's lack of social interaction. "Active isolation" denotes the process whereby some children spend time alone in social company because their peers actively reject and isolate them. Putative causes of active isolation are varied and include the display of such nonnormative, unacceptable behavior as aggression, undercontrolled impulsivity, and social immaturity, as well as such factors as minority group membership and interests and inclinations that

vary from those of the majority of peer group members (e.g., Rubin & Mills 1988, Rubin et al. 2006a). In contrast, “social withdrawal” refers to the child’s isolating himself/herself from the peer group. In this latter regard, social withdrawal is viewed as emanating from such internal factors as anxiety, negative self-esteem, and self-perceived difficulties in social skills and social relationships (Rubin & Asendorpf 1993). The roots of this conceptualization are founded in some of the earliest relevant research, with socially withdrawn children described as “those who are bothering themselves rather than others” (Morris et al. 1954, p. 743). Of course, it may be the case that although some socially withdrawn children initially remove themselves from social interaction, they may also come to be excluded by peers. Thus, over time, it may become increasingly difficult to distinguish between withdrawal and active isolation. Indeed, social withdrawal in childhood may be a catalyst in a transactional model that describes the development of such negative outcomes as negative self-regard, loneliness, peer rejection, victimization, anxiety, and depression (see Figure 1).

In the end, social withdrawal may be best construed as an umbrella term describing a given behavioral prototype (solitude in one form or another) derived from a variety of underlying causes (Rubin & Coplan 2004). Thus, for example, many researchers have focused on fear, wariness, and anxiety as underlying affective contributors to children’s withdrawal from their peers. In this regard, several related constructs have emerged.

Kagan, Fox, and colleagues (e.g., Fox et al. 2005, Kagan et al. 2007) have used the term “behavioral inhibition” (BI) to describe biologically based wariness during exposure to novel people, things, and places. Similarly, “shyness” has been conceptualized as wariness in the face of social novelty and/or self-conscious behavior in situations of perceived social evaluation (Asendorpf 1991, Cheek & Buss 1981, Crozier 1995, Zimbardo 1977). “Social reticence” represents a behavioral construct comprising the watching of others from afar, remaining unoccupied in social company, and hovering near but not engaging others in interaction (Coplan et al. 1994). This behavioral construct putatively reflects internalized feelings of social anxiety as well as conflicted motivations of approach and avoidance. “Anxious-solitude” has been used to denote wariness in familiar peer contexts (e.g., Gazelle & Ladd 2003, Gazelle & Rudolph 2004). These terms share the implication that solitude may result from conflicting emotions and motivations. That is, some children may be motivated to approach others to engage in social interaction; however, their social approach motivation is attenuated by social fear and anxiety, resulting in the simultaneous motivation to avoid others (e.g., Asendorpf 1990, Coplan et al. 2004).

Clearly, there is a conceptual similarity here with social phobia, an internalizing disorder characterized by “a marked and persistent fear of social or performance situations in which embarrassment may occur” (Am. Psychiatr. Assoc. 1994, p. 411). There has been some debate in the literature as to the conceptual nature of the relation between shyness and social phobia (i.e., Does social phobia refer to extreme shyness; Chavira et al. 2002). Indeed, Rapee and colleagues (2005) reported that 90% of “extremely shy” preschool-age children met criteria for an anxiety disorder. Results from a growing number of both retrospective and longitudinal studies have demonstrated empirical links between inhibition in early childhood and the development of anxiety disorders (particularly social phobia) in later childhood, adolescence, and adulthood

Q.3 Discuss the impulsiveness egocentricity, rigidity. How it can be addressed through the curriculum of school?

The aim of this study was to compare the personality traits of adolescents with cochlear implants (CIs) to a reference group (normal-hearing peers). In the past, the personality development of hearing impaired adolescents was severely compromised. Improved speech perception with CI significantly increased their perspectives. In addition, differences between the reference group and CI users were investigated on personality traits according to level of speech perception skills (high/low) and level of language comprehension (adequate/poor). A cohort of 59 adolescents was assessed 10 years after CI implantation. Personality traits were measured using the standardized Dutch Personality Questionnaire, which consists of 5 scales: Inadequacy, Social Inadequacy, Recalcitrance (RE), Perseverance, and Dominance. Speech perception and language comprehension were tested with standardized tests. The distributions of personality scores, in the clinical or non-clinical range, for the CI group were compared to the reference group using the Chi-Square test for Goodness of Fit. Adolescents with CI showed normal or favorable distributions on all personality scales except for the RE scale. There was a significant influence of speech perception and language comprehension on this scale. Consequently, adolescents with CI who demonstrated high speech perception and adequate language comprehension scores showed similar distribution patterns as the reference group on all personality scales. In conclusion; personality traits that reflect social relations, self-conscience, and school- and task orientation in adolescents with CI are similar to those in normal-hearing peers. This holds, despite variations in speech perception ability and language comprehension levels, for the CI group. On the RE scale, the adolescents with CI with low speech perception and poor language comprehension scores are more likely to score in the clinical deviant range and are at risk.

adolescents with CI showed normal or favorable distributions on four of the five investigated personality traits (IN, SI, DO, and PE). Only for the RE trait, the total CI group, the subgroup with low speech perception scores and the subgroup with poor language comprehension scores showed a larger proportion of scores below average as compared to the reference group. Which means that more children with CI especially the CI children with low speech perception scores and poor language comprehension scores show a postponement and avoidance personality trait with little or no responsibility regarding one's own actions. As hypothesized, adolescents with HI implanted with a CI who demonstrate high speech perception scores and adequate language comprehension scores showed similar distributions to normal hearing peers on all personality traits.

Indeed, good speech perception appeared to be a factor in the development of personality among adolescents. This finding is in line with the study by Nasralla et al. (2009). The subjects who obtained low speech perception results in the study by Nasralla et al. (2009), reported difficulties in the area of interpersonal contacts, reacting according to the affective and auditory situations, and did not reach their potential compared to the group with the high speech perception scores.

It is clear that hearing loss itself is not the only risk factor for experiencing social and emotional problems and problems in personality development. It appears that lack of language contributes to these problems (Stevenson et al., 2010; Gentilli and Holwell, 2011). In our study, adolescents with CI attain normal distributions on all personality scales if language comprehension skills were at an average or higher level. Stevenson et al. (2010) endorsed the idea that language is a significant factor in the psychosocial development of adolescents. The authors stated that hearing loss is related to an increased rate of behavior problems because hearing loss is a risk factor for low language competence.

Ketelaar et al. (2015) specifically examined the factor language and reported that emotional language is related to social functioning among children with CI and that language skill levels were related to the frequency of behavioral problems. In hearing children with language disorders, difficulties with social emotional functioning and behavioral adjustment exist not due to the HI. Language is known to support emotional self-regulation and social-cognitive competence. Several studies indicate that young people with specific language impairment are more likely to exhibit abnormal levels of emotional and behavioral difficulties than hearing peers (Toppelberg and Shapiro, 2000; Im-Bolter and Cohen, 2007; Durkin and Conti-Ramsden, 2010; Yew and O’Kearney, 2013). In our study, 66% of the subjects with a CI had high speech perception scores, but nonetheless, 40% had low language comprehension despite good hearing levels. These are children in which language or learning disorders may be present in addition to the hearing loss (Norbury et al., 2001).

In our study, adolescents with low speech perception scores, poor language comprehension scores, or both, frequently had clinical deviant scores on the RE scale. As stated in the Section “Introduction,” the unpredictability of actions based on lack of auditory information or misinterpretations in communication might result in suspicion and lack of trust. Mainly for children with UCI, auditory and language skills remained limited and are expected to have caused more dysfunctional RE traits than in the norm group.

Research of Geers et al. (2013), shows that well-developed social skills are more associated with the ability to discriminate the nuances of talker identity and emotion than with the ability to recognize words and sentences through listening. They found that both abilities were better in BICI children than in UCI children. This could be a secondary benefit of binaural hearing with BICI (Sparreboom et al., 2014). However, due to the small sample size of BICI children in our study, we were not able to perform analyses between these groups.

A positive finding in our study is that the adolescents with CI did not differ from the reference group in terms of the distributions of average or deviancy scores on the scales IN, SI, and DO. In support of this interpretation, other studies reported that children with CI could obtain average social skills and self-esteem in comparison to normal hearing peers. Children with CI showed comparable auditory levels as children with hearing aids, in addition to lower levels of behavioral problems than children with a hearing aid. The CI group showed equal empathy and social competence as normal hearing peers (Ketelaar et al., 2013; Theunissen et al., 2014). No differences in self-esteem and number of friends between children with CI and hearing peers were reported

(Percy-Smith et al., 2008). Bat-Chava et al. (2005) found that children with CI demonstrated a rapid development in socialization with hearing peers after implantation.

Similarly, the level of auditory and language skills of our study group does not hinder them in social interactions, subjectively. Hence, the adolescents' answers to the questionnaire imply that they experience that they are able to comprehend social situations and that they feel secure. This is reflected in a normal personality trait development of (Social) IN.

This social safety also enables them to comply with situations rather than to control them, which is reflected in a normal DO personality trait.

Remarkable results were found on the scale PE. The total group of adolescents with CI as well as both speech perception subgroups and the subgroup with poor language comprehension scores obtained positive deviant scores more frequently compared to the reference group. The subgroup with adequate language comprehension scores did not show this favorable difference on the PE trait. Adolescents with CI with poor language comprehension scores obtained positive deviant scores more frequently compared to the reference group. It might be the case that these children are rewarded for effort rather than for good performance. Percy-Smith et al. (2008) reported that boys with CI were better in managing schoolwork and Wheeler et al. (2007) found that children with CI seek support to achieve mainstream goals.

Profound hearing impairment (HI), from birth or early childhood has a lifelong influence on communication, language development, mental health, and social and emotional wellbeing (Cambra, 1996; de Graaf and Bijl, 2002). Limitations in hearing and (secondary) problems in communication and language development negatively affect the mental health of profoundly HI children with hearing aids (Polat, 2003). The majority (95%) of HI children are born in hearing families with aural communication as the main form of communication (Mitchell and Karchmer, 2004). As a consequence, the social, home, and community environments are mainly oriented toward auditory-based communication. Even with the most powerful hearing aids, children with a profound HI have no auditory access to environmental sounds, speech sounds, and spoken language. Environmental information that is limited or is misinterpreted, results in a world that may seem unpredictable and threatening to a young person. Thus, hearing loss effects the information about social relations, such as cause and consequence. The impact of a combined sensory and communicative impairment, such as profound hearing loss, on social-emotional and psychosocial development therefore, is considerable.

Social and emotional development includes the development of personality traits. A social acceptable development of personality traits and behavior corresponds to expectations of the social environment. These expectations are called developmental tasks and include developing autonomy, achieving emotional independence, developing close relationships with peers, achieving socially responsible behavior, and achieving emotional stability (Sawyer et al., 2012; Piquart and Pfeiffer, 2014). During the transition from childhood to adolescence, one's personality develops and personality traits are defined (Denham et al., 2009). Personality stabilizes in adulthood (Roberts and DelVecchio, 2000). The transition to adolescence is, due to achieving all

the developmental tasks, a challenging period for hearing adolescents. It is expected that development of personality traits in adolescents with a profound HI will pose additional challenges and places this group at risk for developing disordered personality traits.

However, the auditory and communication prospects for most profound HI children have improved since the 1990s. Due to the application of cochlear implants (CIs), which provide auditory input via electrical stimulation of the cochlea, even profoundly HI people can access environmental sounds, hear their own speech and the spoken language of others. Thus, it is to be expected that the application of CI would prevent the development of disordered personality traits.

Q.4 How the cultural differences of students can help each other in the personal development of child?

Cultural background gives children a sense of who they are. The unique cultural influences children respond to from birth, including customs and beliefs around food, artistic expression, language, and religion, affect the way they develop emotionally, socially, physically, and linguistically.

When a child's self-identity is at odds with the social environment due to cultural differences, it can hinder learning. Fortunately, culturally competent educators help children of all cultural backgrounds learn by showing an understanding and acceptance of diverse cultures and how they make each child uniquely valuable.

Because culture is such a powerful indicator of a child's future well-being, those who work with children, including social workers, counselors, and specialists, need to understand the cultural influences on child development and how they impact the way people grow and learn. A degree such as Maryville University's online Bachelor of Arts in Human Development and Family Studies can prepare future professionals for success in these roles, providing them with the background and experience they need to support children and families with their services.

The Importance of Childhood Development

Early childhood is a key period of mental and emotional growth, and what children perceive and experience can shape their future: Our childhood environments and how we respond to them can predict the course for our health and well-being as adults. The Centers for Disease Control and Prevention (CDC) reports, "Although the brain continues to develop and change into adulthood, the first eight years can build a foundation for future learning, health, and life success. ... How the brain grows is strongly affected by the child's experiences with other people and the world."

To understand the environment's impact on a developing child, let's look at the three main ways children process the information around them as they grow.

Classical conditioning. Drawing associations between a stimulus and response. For example, children in religious families might associate bedtime with prayers.

Operant conditioning. Drawing associations between a reward and an action. For example, children might receive dessert after eating their vegetables.

Observational learning. Absorbing and copying what they see from others in real life or in the media. For example, a child might say, “Time to clean up” because a teacher says it in school.

Children learn, therefore, by observing and making associations about their surroundings. Exposure to positive influences can favorably impact a child’s development, while exposure to toxic or stressful influences can negatively impact development.

All else being equal, a child’s cultural influences at birth are neutral. All too often, however, some elements of cultural background may not be accepted or understood by the society in which a child grows up — potentially harming a child’s self-image and development.

In other words, the social cues a young child takes in from others about cultural background can help or hamper development because developing children readily internalize what they see and hear. When a young child’s cultural background differs from the prevailing culture — for example, the child’s family might speak a different language at home, eat different foods, or observe different holidays — it can affect self-image. This is especially the case if peers or even teachers treat the child in a way that reveals bias or casts the child in the role of an outsider.

According to the National Association for the Education of Young Children (NAEYC), childhood exposure to dominant social biases — such as favoring people who are white, Christian, heterosexual, able-bodied, thin, wealthy, fluent in English, natives rather than immigrants — can trigger developing children to judge themselves unfavorably by the same limiting standards. When children do that, their development suffers.

Recognizing Cultural Influences on Child Development

Culture influences development from the moment we’re born, making an impact on us as we grow. For instance, culture can affect how children build values, language, belief systems, and an understanding of themselves as individuals and as members of society.

Children can receive these cultural influences in different ways, such as through their parents, their environment, and the media. How society shows an understanding of diverse cultures can impact a child’s development in many ways, such as how confident in themselves or how comfortable interacting with others they become as adults.

Parental Influences on Child Development

Parents’ culture can influence their children’s development. A 2019 study, for example, found that cultural values often influence the way parents raise their children, including how they discipline and set boundaries. It makes sense that parents raise their children based on cultural influences because they’re preparing them to develop behaviors necessary to operate and thrive in that culture. However, when the social environment and home culture clash, developmental issues can arise.

Collectivist vs. Individualistic Cultures and Parental Discipline

Parents’ cultural influences can impact how they discipline a child’s behavior. This, in turn, can affect a child’s development, particularly if those methods of discipline differ from the dominant cultural tradition.

Before delving into the methods of discipline and culture, what do the terms “collectivist” and “individualistic” mean exactly? Essentially, a collectivist culture values and rewards the prioritization of community needs over individual needs, as well as generous, kind, collaborative behavior. Collectivism is the norm in Asian, Central American, South American, and African cultures.

On the opposite end of the spectrum, an individualistic culture values and rewards assertiveness and independent action, stressing the importance of the individual over the group. Individualism dominates in North American and Western European cultures.

The 2019 study cited earlier found that parents from individualistic cultures discipline differently from parents from collectivist cultures. The former group of parents might discipline their children by taking something away that matters to them personally. On the other hand, parents from collectivist cultures might tell their children to think about how their behavior affects others.

The study found that children raised in individualistic cultures often described themselves based on their unique attributes, such as “I am good at math.” Meanwhile, children raised in collectivist cultures were more likely to describe themselves based on their relationships with others, such as “I am my mother’s daughter.”

Child development can be influenced if parents or teachers discipline children according to the dominant culture — the U.S. has an individualistic culture — rather than the culture of their family of origin. For example, children whose parents have disciplined them to value cooperation over competition might become confused or upset when a teacher urges them to be competitive.

Parental Influences on Children’s Social Behavior Varies by Culture

Children learn how to act by interacting with their parents. For this reason, the parents’ cultural background often influences a child’s behavior.

Communication style is a case in point. Children tend to communicate in a style that resembles their parents’ way of communicating, and diverse cultures converse and explain things in different ways.

Children who communicate based on an individualistic cultural model will often tell long, self-focused stories with themes of autonomy and personal preference. Conversely, children who communicate based on a collectivist cultural model will often tell brief, other-oriented stories with themes of authority and interrelationships.

These cultural influences on children’s language development can help or hinder them on the playground, and later in the workplace. If children’s culture is respected at school, including the way the children interact verbally with others, then they’ll be more likely to experience the acceptance and respect they need to grow and develop. They’re more likely to become adults with a healthy self-image who feel understood and capable of confident, fruitful interactions. If not, however, they may become adults who hesitate to raise their voices and be heard for fear of being ridiculed or misunderstood.

Environmental Influences on Child Development

Environmental influences on child development can include influences from community and culture as well as from environmental health hazards. Pollution from a nearby power plant, contaminated water, or lead in the home, for example, can cause lasting impacts on children's health. As the CDC reports, environmental contaminants can cause greater harm to children than to adults because children's bodies are still developing.

In fact, children take in more air, water, and food per pound of body weight, making them more vulnerable to health issues from environmental hazards. The health issues might not show up until later in life, causing difficulty in school, work, and socialization. A child exposed to polluted air, for example, might develop asthma as a teenager.

Children of low-income communities are most likely to be at risk of exposure to environmental hazards. As the National Environmental Health Association (NEHA) reports, low-income communities may have poor infrastructure, making them more vulnerable to the effects of natural disasters, such as contaminated water and damaged drainage systems. They may also be located closer to factories and highways, both of which contribute to high levels of pollution in the air, soil, and water.

Media Influences on Child Development

Media influences on childhood development include movies, TV shows, video games, and other online content. Research that the American Psychological Association (APA) has shared shows that children's exposure to violent media can result in aggressive behavior; exposure to advertising for non-nutritious foods can increase rates of childhood obesity; and too much screen time can be linked to lower brain development in preschoolers.

A study from the Cognitive Impacts of Digital Media Workgroup found that children begin to learn from TV programs at around 2.5 years old. Educational programs, such as "Sesame Street," can positively influence their knowledge and social skills, preparing them for school. However, after they turn 6 years old, children begin to watch more entertainment programming, which can, in turn, influence their behavior negatively. In addition, while video games can help children develop visual processing skills, they can also yield aggressive behavior. The effects on cognitive skills and behaviors are often specific to the games played.

As a result of these findings, the study suggests that clinicians and early childhood service providers should work with parents to limit TV exposure before children turn 2 years old. As children begin to learn how to read, clinicians and service providers should advise parents to regulate children's media consumption — with a focus on providing educational media content — and encourage reading habits.

The connection with cultural background is clear: Diverse cultures have different attitudes toward TV and other entertainment media, as well as different abilities to afford access to such media. A child from a collectivist culture, for example, may be encouraged to help infant or elderly family members in lieu of watching educational TV after school. Indirectly, culture influences these children's ability to benefit from such experiences.

In addition, to take the example further, children whose culture discourages educational TV and other media may be ridiculed by school peers for missing out on popular pastimes other children engage in.

Another way that media in popular culture can influence child development is by depicting and perpetuating cultural stereotypes. For example, a movie might show women or minorities in a negative light, or not at all. A sitcom might feature only white characters, never those of diverse races or ethnicities.

Clearly, the absence of role models in entertainment media, or the presence of negative stereotypes, can affect children's self-esteem. This can cause media to become a negative cultural influence on a child's development.

A Crucial Understanding of Childhood Development

Educators, parents, caregivers, and social workers need to understand how children's cultural influences affect their development. With this knowledge, adults can better guide students of different cultures and backgrounds through their growth processes and ensure that they're being exposed to healthy influences. They can also provide them with the tools they need to cope with negative influences, such as cultural biases and prejudices against diverse cultures, in schools and in society at large.

According to the Office of Disease Prevention and Health Promotion (ODPHP), for example, early childhood programs can foster children's development — physically, mentally, and socially. Consider the Head Start program, which provides children from low-income families with services to promote their educational and emotional growth. Children who participated in programs such as Head Start grew up healthier and engaged in less harmful activities, such as drinking and smoking, than those who didn't.

Educators and social workers need to be aware of their own implicit biases about cultural differences. As the NAEYC reported, teachers can exhibit biases in their treatment of children according to the child's race, ability, socioeconomic status, and behaviors. The biases can inhibit teachers from effectively helping these students and, therefore, prevent students from developing at the pace that's best for them. By understanding the cultural influences on child development, including their own cultural biases, professionals in these roles can better make an impact on children's lives and deliver the care they need.

Q.5 What are the different aspects of parent's attitude towards their deaf child? Suggest measures to improve the parental perception regarding capabilities of a deaf child.

HL can be a substantial barrier to education and social integration. Early identification and intervention for HL can provide important benefits because hearing is critical for learning oral communication, as well as academic and social participation. The current findings revealed that both fathers and mothers possessed a relatively high level of knowledge in relation to the statement "babies can be born with HL", followed by the statement "head trauma can cause HL", but possessed the least knowledge in relation to the statement "jaundice can cause HL", followed by the statement "low birth weight <1500 g can cause HL." A previous study by Ravi et al. reported that knowledge of risk factors among participants was higher in relation to the statement "prolonged noise can cause HL", while participants possessed poor knowledge regarding the statement "drugs/medication can cause HL." In contrast, a study of knowledge on SNHL by Kaspar and colleagues revealed that participants had better

knowledge about “noise exposure” and “family history”, but poor knowledge regarding the statement “jaundice can cause HL”, followed by “delayed crying at birth can cause HL.” In contrast, Sanju and colleagues reported that, among a sample of surveyed nurses, 70% were aware of the “harmful effect of noise on hearing to infant” while most were not aware of the consequences of “hyperbilirubinemia on infants hearing.” The aspects of knowledge about risk factors of HL highlighted in previous studies differed from the results in the current study. Moreover, the current findings suggest differences in participants’ knowledge regarding HL, compared with previous studies. There are no similar studies done in the region regarding this topic which may contribute to these discrepancies may have also been caused by differences in the culture and believes among the people in Saudi Arabia.

Moreover, questions about the knowledge of parents regarding OM in the current study revealed that both fathers and mothers possessed a relatively high level of knowledge in relation to the statement that “ear discharge and OM can cause HL”, whereas questions about the identification and intervention of HL and revealed a high level of knowledge in relation to the statement “children with HL can attend school.” These findings are consistent with those of previous studies conducted in India and Solomon Island . Moreover, a low level of knowledge in relation to the statement “treatment for hearing loss is available” was also highlighted in both studies.

Regarding the attitudes and practices of parents in relation to childhood audiology services, parents typically expressed positive attitudes in relation to the statement “I would like my child tested at school” followed by “more information about the service.” This finding conflicts with the results of previous studies in India and Solomon island [5, 14], but further confirmed the positive attitudes of parents toward childhood audiology services. In contrast, Sanju and colleagues reported that 40% of surveyed nurses expressed negative attitudes in relation to the statement “HL can be identified soon after birth”, and 88% of nurses were unaware that some children with hearing impairments can still hear and speak

But parents of children with a hearing loss, while striving to do all of the above, also need to:

- Learn communication strategies.
- Develop awareness of deaf culture.
- Acquire and use assistive technology.
- Understand special education regulations.
- Evaluate and choose an educational site.
- Take an active role in the governance of their unique child's special needs.
- Become an unflinching advocate for an education to maximize the child's potential.
- Continuously monitor progress.
- Intervene/Problem-solve when needed.

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Additionally, it is no longer an issue of choosing either a residential school for the deaf or a mainstream deaf education program through the local public school. Deaf/hard of hearing children are being successfully placed in private/parochial schools, and growing numbers are being homeschooled by their parents. Those parents may join a local homeschool association, enroll in a "distance learning" program, an accredited correspondence school, or provide textbooks, oversight and assistance all from home. There are many varied educational philosophies and methods, and parents must weigh the skills and resources of each setting and all key players to find the best match for their child.

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