Edu - Psycatia An International Journal of Education and Psychology
(A Peer-Reviewed Annual Journal) ISSN: 2348-0785

PARENTAL AND FAMILY SUPPORT IN THE EARLY IDENTIFICATION AND INTERVENTION OF DEVELOPMENTAL LANGUAGE DISORDER: A THEORETICAL FRAMEWORK

[1]Falseena Chalil & [2]Dr. Mohammad Akram
[1]Research scholar, Faculty of Education, Desh Bhagat Uuniversity, Mandi Gobindgarh
[2]Assistant Professor, Faculty of Education, Desh Bhagat Uuniversity, Mandi Gobindgarh
Corresponding Author: Falseena Chalil, Corresponding email: falseenac21@gmail.com

Paper Received: 10.12.2025 | Paper Accepted: 20.12.2025 | Paper Published: 2026

Abstract
Developmental Language Disorder (DLD) is a common neurodevelopmental condition associated with significant long-term consequences for academic achievement and socio-emotional functioning. Early identification and intervention are essential; however, traditional models have often underemphasized the role of parents and families. This paper synthesizes evidence from recent reviews and empirical studies to propose a family-centered theoretical framework for DLD. The heterogeneous presentation of DLD and the rationale for adopting the broader diagnostic label are outlined (Rinaldi et al., 2021). Intervention research demonstrating stronger effects for expressive compared to receptive language, alongside emerging attention to narrative and inferential skills, is reviewed. Psychosocial outcomes are examined, highlighting evidence that children with DLD show declining parent-reported quality of life between ages 4 and 9, largely independent of language severity, with early emotional and peer difficulties predicting later quality of life (Eadie et al., 2018). Evidence regarding family involvement is also considered, including the widespread use of indirect, parent-mediated interventions (Law et al., 2019) and findings indicating that targeted parent training can strengthen support for children's emotional regulation (Durgungoz & St Clair, 2024). Drawing on these findings, an integrated model is proposed linking child language and cognitive risk factors, parental beliefs and stress, family clinician interaction (including tiered intervention roles), and child outcomes. The framework emphasizes reciprocal influences between children's language development and the family environment. Clinical and policy implications, including parent-inclusive screening, family-centered therapy, and caregiver support, are discussed, alongside recommendations for future research to empirically evaluate and refine the proposed model.
Keywords: developmental language disorder; family-centered intervention; early identification; parental beliefs; quality of life; theoretical framework

Developmental Language Disorder (DLD) is a common neurodevelopmental condition characterized by persistent difficulty in learning, understanding, or using spoken language that cannot be explained by cognitive, sensory, or neurological deficits (Rinaldi et al., 2021). Research indicates that between 11% and 18% of children aged 18 to 36 months experience slower-than-expected expressive language development. In some cases, these difficulties extend to language comprehension, despite the absence of hearing impairment, intellectual disability, neurological damage, or other identified cognitive conditions (Rescorla, 2011). Although many "late talkers" catch up to their peers, longitudinal data indicate that roughly 5-7% of children continue to experience significant language impairment after age 3 (Rinaldi et al., 2021). In these cases, impairments often persist into school age and adulthood, carrying substantial impacts. For example, children with DLD have a dramatically higher risk of literacy failure, school learning problems, behavioral difficulties, and social-emotional challenges than their typically developing peers (Rinaldi et al., 2021). Language difficulties in DLD frequently co-occur with deficits in procedural memory, phonological working memory, motor coordination, and attention (Rinaldi et al., 2021). The shift from the term "Specific Language Impairment" to "Developmental Language Disorder" reflects growing recognition that language difficulties rarely occur in isolation. The CATALISE (Consensus Approach to Terminology and Assessment for Language Impairments: Synthesizing Evidence) project recommended the term Developmental Language Disorder to acknowledge that these difficulties emerge during development, often lack a single identifiable cause, and frequently co-occur with broader cognitive vulnerabilities (Rinaldi et al., 2021). The breadth and persistence of DLD's effects underscore the need for early detection and intervention. Children with DLD have been found to have 40-50% negative neuropsychological sequelae by early primary school (including difficulties reading and math), and much higher rates of behavioral, emotional, and social problems compared to peers (Rinaldi et al., 2021). Consequently, screening for language delays by ages 2-3 and prompt referral to specialists are widely recommended (He et al., 2022; Sansavini et al., 2021). In practice, parents and caregivers are often the first to notice developmental lags and seek help. Pediatricians' guidelines note that parental concerns about delayed vocabulary, poor intelligibility, or lack of gestures are strong predictors of later language disorders. However, parental beliefs about language development vary greatly. Qualitative research has shown that parents hold

diverse "explanatory models" (ethnotheories) of speech and language delay (Marshall, Harding, & Roulstone, 2017; Marshall, Goldbart, & Phillips, 2007). In one UK study of underserved communities, many parents viewed themselves as competent facilitators of their child's language learning, sometimes attributing delays to factors like shyness or birth order (Marshall et al., 2017). Differences between parents' and therapists' beliefs about causes and remedies can influence how quickly families engage with services (Marshall et al., 2007, 2017). Despite the central role of the family in a child's early development, many clinical models of DLD have remained child-centered. This paper emphasizes that families must be at the heart of effective DLD frameworks. This paper reviews contemporary evidence on DLD's definition, associated deficits, and intervention efficacy, and presents a theoretical model that explicitly integrates parental and family support with early identification and intervention. By synthesizing findings on linguistic heterogeneity (Rinaldi et al., 2021), intervention outcomes (Law et al., 2019; Rinaldi et al., 2021), and psychosocial factors (Eadie et al., 2018), this paper constructs a biopsychosocial framework. This framework conceptualizes child language and cognitive risk factors, family beliefs and dynamics, and tiered service pathways as interacting determinants of children's developmental trajectories. The goal is to provide a conceptual foundation that can guide family-informed practice and policy in DLD.

Literature Review: DLD Heterogeneity and Diagnostic Evolution

The DLD diagnosis encompasses a broad range of language profiles and co-occurring issues. Rinaldi et al. (2021) note that DLD is better seen as a "set of variegated clinical pictures" rather than a single deficit, because language problems rarely occur in isolation. The shift from the term SLI to DLD reflects recognition that underlying causes are often unknown and that affected children may have concomitant deficits. For instance, deficits in memory, motor skills, attention, or social perception frequently accompany DLD (Rinaldi et al., 2021). In practice, DLD includes children with predominantly expressive delays, receptive difficulties, or mixed profiles. Prevalence estimates suggest that up to 11–18% of toddlers have delayed expressive language, but many (≈70%) of these "late talkers" eventually catch up by school age (Rinaldi et al., 2021). Approximately 5-7% of children, however, continue to meet criteria for DLD after age 3. Studies consistently find that children with DLD suffer substantial academic and psychosocial impacts, underscoring the need to reconceptualize the disorder. In about 40-50% of children with DLD, language deficits lead to later learning and behavioral problems, especially as literacy demands emerge in early school (Rinaldi et al., 2021). Indeed, language impairment is associated with up to five times higher risk of school failure and increased risk of attention and conduct problems (Rinaldi et al., 2021). Moreover, many DLD effects persist into adolescence and adulthood, impacting education, employment, and mental health (Rinaldi et al., 2021). Given this, the DLD label emphasizes developmental origin and breadth of impact. The move to a broader DLD definition support considering non-language factors (e.g., memory, executive function) during assessment and intervention, reflecting an inherently multidimensional view of the condition.

Intervention Outcomes for DLD: A key consideration in DLD is which interventions work best for which children. Recent systematic reviews suggest that speech-language interventions yield stronger effects on expressive skills than on receptive skills (Rinaldi et al., 2021; Law et al., 2010). For example, Law et al. (2010) observed clearer treatment gains in expressive phonology and vocabulary than in receptive domains, a pattern echoed by Rinaldi et al. (2021). Rinaldi's 2021 meta-review confirmed that interventions typically produced significant improvements in children's expressive phonology and syntax, whereas evidence for gains in receptive vocabulary and grammar was limited. One implication is that therapies emphasizing production (e.g., modeling, recasting) often outperform those aiming to teach comprehension directly. Notably, narrative and inferential language interventions are an emerging focus. Rinaldi et al. report only a single study to date showing gains in inferential narrative skills, suggesting this is a nascent intervention domain. These patterns are summarized in Table 1. Most evidence supports expressive gains (e.g., articulation, vocabulary) with structured intervention, whereas receptive skills and pragmatic-inferential abilities show mixed or weaker responses (Rinaldi et al., 2021). The table below illustrates this division and the limited evidence base for higher-order skills.

Table:1

Intervention Target	Expressive Gains	Receptive Gains	Source
Phonological skills	Strong evidence of improvement	Moderate evidence	Rinaldi *et al.*(2021)
Vocabulary (lexical)	Some evidence of improvement	*No evidence*	Rinaldi *et al.*(2021)
Morphosyntax	Improvements in production	Minimal to none	Rinaldi *et al.*(2021)
Narrative/Inferential	Emerging evidence (a few studies)	-	Rinaldi *et al.*(2021)

Overall, the current evidence base suggests that intervention effects have been more consistently demonstrated in expressive phonological and morphosyntactic domains. However, the comparatively limited findings for receptive language outcomes likely reflect methodological challenges, including difficulties isolating comprehension skills and measuring change, rather than reduced clinical importance. Given the central role of receptive language in overall communicative competence, further high-quality randomized controlled trials are needed to clarify the effectiveness of interventions targeting receptive and higher-order inferential skills (Rinaldi et al., 2021). The intervention literature also underscores the role of family-based approaches. Rinaldi et al. (2021) noted that newer interventions increasingly involve training parents or educators under professional supervision. This mirrors a tiered intervention model proposed by Ebbels et al. (2019), where the most intensive services (Tier 3) are divided into indirect (Tier 3A: non-specialists or parents implementing the plan) and direct (Tier 3B: specialist-delivered therapy) modes. Evidence suggests that children with milder deficits can make gains under Tier-3A support (when others are well-trained), whereas more severe DLD typically requires direct professional therapy (Tier 3B) (Ebbels et al., 2019). Thus, the effectiveness of an intervention depends not only on the target skill but also on who delivers it and at what intensity.

Parental and Family Perspectives

An emerging body of research highlights the importance of parents and family in the DLD intervention process. Surveys of practitioners show that parent-mediated (indirect) approaches are now standard in early childhood language therapy. In a global survey of over 4,000 professionals, Law et al. (2019) found that indirect therapy delivered via parents was the dominant model in the preschool years, often transitioning to teacher-led or specialist intervention later. Importantly, families across cultures are involved: the survey reported widespread engagement of fathers and other family members in intervention programs (Law et al., 2019). This indicates a broad professional consensus that parents should be partners, not mere bystanders, in therapy. Qualitative studies of parents' own perspectives reveal rich and varied beliefs about language delay. Marshall et al. (2017) explored parental ethnotheories (informal explanatory models) in communities considered underserved by speech-language therapy services. They found that parents held diverse views about the causes of language delay (e.g., genetics, hearing issues, environmental factors) and often saw themselves as primary facilitators of their child's language growth. As one summary notes, many parents viewed themselves as competent in promoting language and expected therapists to support this role (Marshall et al., 2017). Earlier work (Marshall, Goldbart, & Phillips, 2007) also showed that parents might emphasize external factors (such as gender or imitation) in explaining delay, whereas therapists focused on internal or biological causes. These differences in belief can affect engagement: if parents underestimate a child's needs or feel empowered to intervene at home, they may delay seeking formal services. Overall, the literature suggests that effective DLD management must be family-centered. The family's communication environment, parental responsiveness, and cultural attitudes all influence how a child's language develops. For instance, higher maternal education and positive parenting practices correlate with better language gains (Rinaldi et al., 2021). Conversely, parents of children with DLD often report stress and frustration due to communication challenges. Recognizing this, new intervention paradigms explicitly target parent skills: video-modelling, coaching, and home programs are now common. The global trend is toward training parents in language facilitation techniques (e.g. dialogic reading, focused stimulation) and increasing family involvement in therapy (Law et al., 2019; Rinaldi et al., 2021).

Quality of Life and Emotional Outcomes

Beyond core language measures, recent research has examined DLD's broader impact on children's well-being. A key finding is that children with DLD exhibit lower health-related quality of life (QoL) compared to peers, and this gap widens with age (Eadie et al., 2018). In a longitudinal study of children with DLD vs. typically developing controls, parent-reported QoL (covering physical, emotional, social, and school domains) was stable in peers from ages 4 to 9 but declined significantly for the DLD group over the same period (Eadie et al., 2018). By 9 years, the mean QoL score for the DLD group was substantially lower than for controls. Notably, this decline in QoL was independent of language severity: children with mild-to-moderate DLD had similarly poor QoL outcomes as those with severe DLD (Eadie et al., 2018). What predicts this erosion of well-being? Eadie et al. (2018) found that early socio-emotional problems were key. In their cohort, children's emotional symptoms and peer relationship problems at age 4 were stronger predictors of poorer QoL at age 9 than their language scores were. In other words, two children with similar language delays could have very different life trajectories depending on whether one also had anxiety, depression, or peer difficulties in preschool. This implies that emotional resilience and social skills are critical mediators of DLD's impact on quality of life. The linkage between emotion and language in DLD also motivates family interventions. Durgungoz and St. Clair (2024) developed an online program to teach parents of DLD children how to support their child's emotion regulation. After the parent-focused training, caregivers reported significantly greater awareness of the importance of helping their child recognize and express feelings. Parents also increased their use of emotion-focused communication (e.g., discussing feelings after events) and felt more confident in guiding their child's coping strategies. This study illustrates that parents can be equipped to address one of the core determinants of QoL. In

sum, the literature suggests that children's emotional development and family support networks are intertwined with language outcomes: poor emotion skills exacerbate QoL decline, while parental support of emotion potentially protects against it (Eadie et al., 2018; Durgungoz & St. Clair, 2024).

Early Identification Challenges

Early identification of developmental language disorder (DLD) remains clinically challenging due to the substantial overlap between transient language delay and persistent impairment. Rinaldi et al. (2021) reports that 11-18% of children aged 18-36 months exhibit slower-than-expected expressive language development, yet approximately 70% of these "late talkers" spontaneously catch up by school age, leaving only 5-7% with confirmed DLD after age 3. This high natural recovery rate complicates screening specificity, as early expressive delays alone show limited predictive power for persistent disorder (Rinaldi et al., 2021). Parental observation emerges as the first critical detection point. Marshall et al. (2007, 2017) document that caregivers frequently notice developmental lags before professionals, with parental concerns about vocabulary size, gesture use, or intelligibility serving as strong informal predictors. However, parental ethnotheories significantly influence recognition timing: some attribute delays to temperament ("late bloomer"), birth order, or environmental factors, delaying service-seeking until academic impacts become evident (Marshall et al., 2017). In underserved communities, particularly, families may prioritize informal strategies or alternative explanations before consulting specialists (Marshall et al., 2007). **Optimal screening windows cluster between 24 and 36 months. Rinaldi et al. (2021) synthesis identifies gesture production delays, reduced receptive/expressive vocabulary, syntactic comprehension deficits, and absent word combinations by 30 months as the strongest early indicators, though predictive accuracy remains modest without family history consideration. Family history of DLD emerges as the single strongest risk factor, significantly amplifying the predictive value of early language markers (Rinaldi et al., 2021). Low socioeconomic status and reduced environmental language input function as weaker but consistent risk modifiers. Diagnostic confirmation typically occurs around age 4, balancing developmental stability against intervention windows. Ebbels et al. (2019) tiered model positions this period as Tier 1 universal monitoring transitions to Tier 2 targeted assessment, emphasizing joint parent-professional decision-making. The integration of standardized parent-report measures (e.g., MacArthur-Bates inventories) with direct clinician assessment maximizes sensitivity/specificity, though no single tool achieves adequate standalone accuracy (Rinaldi et al., 2021). Family-centered identification pathways thus become essential. Law et al. (2019) international practitioner survey confirms parent-mediated screening as standard preschool practice, with broad family involvement (including fathers) enhancing detection across cultural contexts. This aligns with Eadie et al.'s (2018) QoL findings that early emotional/behavioral concerns often precede or accompany language delays, suggesting holistic parent-clinician screening protocols incorporating socio-emotional observation. These identification challenges underscore the theoretical framework's emphasis on parental agency: families serve as both first detectors and primary mediators between early risk markers and formal service pathways, positioning caregiver education and belief alignment as intervention prerequisites (Marshall et al., 2007, 2017).

Theoretical Framework

To integrate these findings, we propose a biopsychosocial/ecological framework for DLD that places parents and families at its center (see Figure 1). In this framework, child-intrinsic factors (language impairment, cognitive deficits) and family-contextual factors (parent beliefs, stress, and communication patterns) are dynamically interdependent. The model draws on several theoretical strands:

- **Biopsychosocial Model:** DLD is influenced by biological risk (e.g. genetics, neurodevelopment), psychological factors (child temperament, emotion regulation), and social environment (family, education system) in a reciprocal feedback loop.
- **Developmental Niche Theory:** Cultural beliefs and practices (Marshall et al., 2017) shape parents' ethnotheories about language delay, which influence caregiving behaviors (e.g. the amount and type of talk a child hears).
- **Family-Centered Practice:** Parents are viewed as co-therapists. A tiered intervention model (Ebbels et al., 2019) is embedded, where parent-mediated (indirect) therapies function as a key tier of service.
- **Socio-Emotional Integration:** A child's socio-emotional health is interwoven with language development. Parental emotion coaching and family support networks moderate how language deficits translate into participation restrictions.

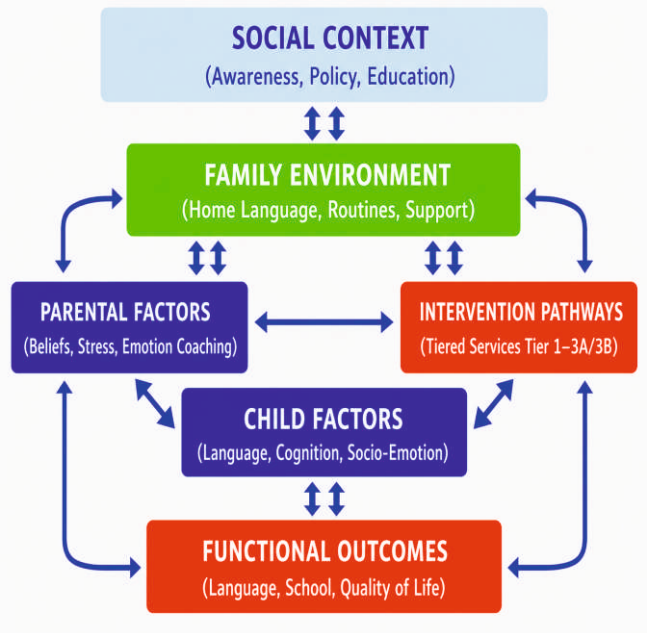
Important elements of the framework include:

- **Child Factors:** The child's core language deficits (expressive and/or receptive), cognitive profile, and any behavioral/emotional issues. Comorbid risk factors (e.g. motor delays) may compound difficulties (Rinaldi et al., 2021).
- **Parental Factors:** Caregivers' beliefs about language and delay, their emotional responsiveness and stress levels, and their engagement in therapy. For instance, a parent who understands the importance of "narrating daily events" may seek more language stimulation (Marshall et al., 2017).

- **Family Environment:** The home language environment (quantity/quality of input), family routines (shared book reading or play), and support systems (fathers, siblings, extended family involvement) shape how language is used and practiced daily (Law et al., 2019).
- **Intervention Pathways:** The timing and mode of service delivery, conceptualized in a tiered model (Ebbels et al., 2019). Tier 1 may include universal monitoring, Tier 2 targeted classroom/group programs, and Tier 3 individualized therapy subdivided into indirect (Tier 3A: parents or teachers deliver clinician-designed activities) and direct (Tier 3B: specialist works one-on-one) approaches. Evidence suggests that milder DLD can improve under Tier 3A support, while more severe DLD often requires Tier 3B (Ebbels et al., 2019).
- **Child Outcomes:** The framework tracks outcomes at multiple levels, including language skill acquisition, school performance, psychosocial adjustment, and quality of life. Parental factors and intervention types jointly influence these outcomes (Eadie et al., 2018).

These components interact dynamically. For example, a child's early behavioral difficulties (e.g. shyness) may influence parents' ethnotheories and communication style, which in turn affects intervention engagement. Similarly, involving parents in therapy can amplify intervention effects: parent-implemented routines can generalize gains beyond the clinic. This framework envisions feedback loops: as children's communication improves, parental stress may decrease, leading to more positive interactions; conversely, parent training can directly bolster child socio-emotional skills, which then support language progress.

Figure: 1. Biopsychosocial/ecological framework for developmental language disorder, positioning parents and families at the center. Child-intrinsic factors interact dynamically with parental beliefs/stress, family communication environment, and tiered intervention pathways to determine language, school, and quality-of-life outcomes. Bidirectional arrows reflect reciprocal feedback loops (adapted from biopsychosocial model, developmental niche theory, family-centered practice, and tiered intervention models).



Methodological/Conceptual Approach: This theoretical paper presents an integrative literature synthesis drawing exclusively from 7 peer-reviewed sources on developmental language disorder (DLD) published between 2007 and 2024. No new empirical data was collected. The synthesis followed a systematic three-stage process: (1) purposive selection of all 7 sources from the author's research library based on their coverage of DLD heterogeneity and intervention outcomes (Rinaldi et al., 2021), quality of life impacts (Eadie et al., 2018), tiered intervention pathways (Ebbels et al., 2019), parent-mediated therapy practices (Law et al., 2019), and parental beliefs/ethnotheories (Marshall et al., 2007, 2017); (2) systematic extraction of family-centered themes using framework analysis organized around five constructs (child factors, parental factors, family environment, intervention pathways, child outcomes); and (3) conceptual integration through iterative mapping to derive a novel biopsych osocial/ecological model. As a theoretical synthesis rather than an empirical review, formal meta-analysis or quality appraisal was not conducted. The resulting framework prioritizes conceptual coherence across high-quality sources and is offered as a heuristic model to guide clinical practice, policy development, and future hypothesis-testing, with all interpretive claims explicitly linked to source evidence and assumptions transparently noted in the Limitations section.

Proposed Integrated Model for Parental and Family Support

Building on the literature synthesis, this paper proposes an integrated, multi-level model in which early identification and intervention are nested within family systems. Key propositions of the model include:

- **Family as Key Agents:** Parents and caregivers are not passive recipients but active change agents. Their beliefs about development, coupled with practical involvement (e.g. at-home language activities, emotional coaching), directly influence the child's developmental trajectory.
- **Ecological Reciprocity:** The child and family reciprocally influence each other. A child's language delays affect parents' stress and behavior (e.g. patience, adaptation of communication), while parental emotional state and interaction style influence how the child's deficits manifest (e.g. in confidence, social participation).
- **Tiered Collaboration:** Intervention is delivered through

coordinated tiers. For example, a child with mild DLD might receive Tier-3A support via a trained parent at home, whereas a child with severe DLD receives Tier-3B therapy from a specialist. Throughout, families are included: progress meetings, home-practice assignments, and parent coaching are integral.

- **Systemic Support:** The model recognizes that broader systems (education, healthcare) provide resources and constraints. Effective early screening programs educate parents, and schools monitor language milestones. Health policies that enable speech therapy funding shape when and how families access services.

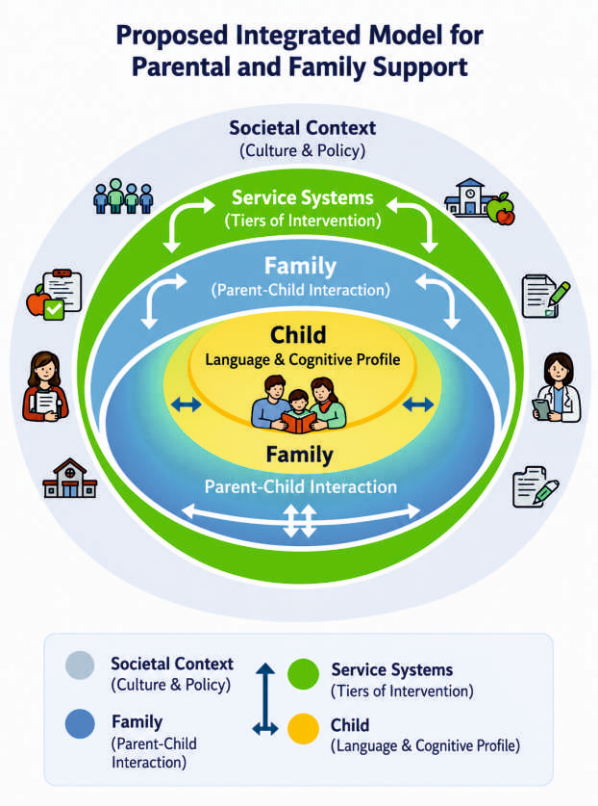


Figure 2: Proposed integrated model for parental and family support in developmental language disorder. The child's language/cognitive profile sit at the core, surrounded by parent-child interaction, family environment, tiered service systems, and societal context (culture/policy). Bidirectional arrows reflect ecological reciprocity and feedback loops where family engagement mediates identification, intervention dosage, and child outcomes.

Model Components

- **Child Developmental Profile:** Language abilities (phonology, vocabulary, syntax, pragmatics) and associated capacities (working memory, attention) form the foundation. Early emotional and behavioral regulation is also part of the profile.
- **Parental Beliefs & Behaviors:** Caregivers' understanding of DLD, expectations for progress, and communication strategies (e.g. recasting vs. directive correction) mediate outcomes. Parents' stress or optimism alters the quantity and quality of language input. For instance, parents who learn to integrate emotion talk may help prevent anxiety in the child (Durgungoz & St. Clair, 2024).

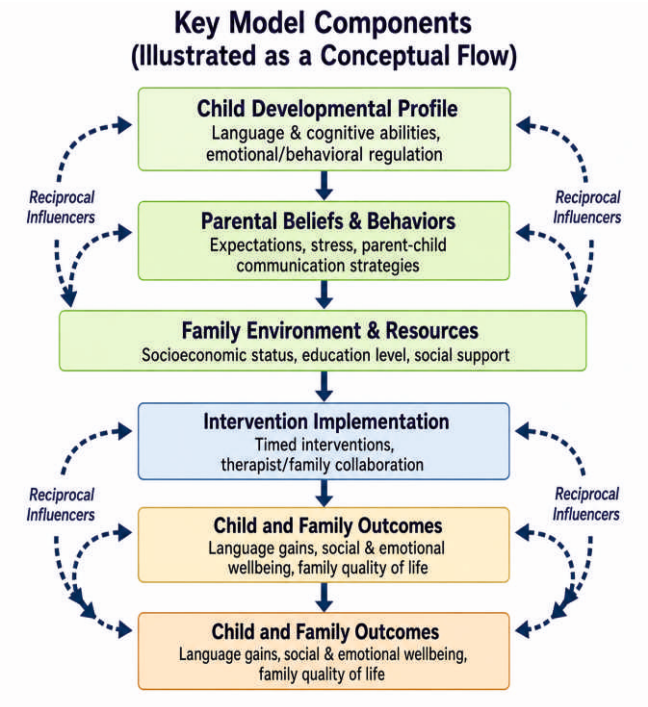
Family Environment & Resources:

- Socioeconomic status, education level, and social support (extended family, community networks) shape intervention engagement. Families with more resources may access early services more readily.
- **Intervention Implementation:** Clinicians assess the child and coach families, determining the appropriate tier. At Tier 2, parents might attend group training sessions; at Tier 3A, they deliver one-on-one language exercises under remote guidance; at Tier 3B, the therapist works directly with the child and models strategies for the parent.
- **Child and Family Outcomes:** The ultimate focus includes the child's language gains, social integration, emotional well-being, and family quality of life. Family outcomes (e.g., reduced parental stress) are equally considered.

This model is recursive: improved child communication reduces family stress, which then improves a more supportive environment, creating a positive feedback loop. Conversely, failure to involve families may weaken intervention effects and leave psychosocial needs unaddressed, perpetuating a negative loop.

Implications for Practice and Policy

This framework yields several concrete implications:



intervention effects and leave psychosocial needs unaddressed, perpetuating a negative loop.

Implications for Practice and Policy

This framework yields several concrete implications:

- **Family-Centered Assessment and Screening:** Clinicians and educators should actively involve parents in early screening. Informational materials should

educate caregivers about language milestones and when to seek referrals. Parent questionnaires (e.g., MacArthur-Bates Communicative Development Inventories) can be routine, empowering families to contribute data.

- **Parent-Mediated Intervention:** Therapy models should routinely train parents in responsive communication techniques. For example, video-feedback or clinician coaching can teach parents how to use rich verbal input and scaffolding in daily routines. Training should explicitly include fathers and siblings, reflecting evidence of broad family involvement (Law et al., 2019).
- **Emotion-Focused Coaching:** Given the role of emotional skills in QoL, speech-language services should incorporate training in emotional literacy. Clinicians can guide parents in recognizing and labeling feelings during interactions and in helping children develop coping strategies. The recent success of online parent programs (Durgungoz & St. Clair, 2024) suggests this is feasible.
- **Interdisciplinary Collaboration:** Policy and practice must break silos. Collaboration between pediatricians, early childhood educators, speech therapists, and psychologists is needed to address the full range of DLD impacts. For instance, a psychologist might help address a DLD child's anxiety while the speech therapist works on language goals.
- **Resource Allocation:** Health and education policy should prioritize funding for early speech-language services and parent education. This could include universal language screening in preschool, funding for family-centered programs, and professional training in indirect therapy methods.

In summary, services should move from a therapist-centered paradigm to one where families are equal partners. Clinicians need training in family-centered practice (e.g. coaching skills) and systems should be structured to support parents (e.g. home-visiting programs, support groups). On a policy level, recognizing DLD's broad impact means investing in preventive and family-oriented approaches, which may reduce long-term costs associated with untreated DLD.

Limitations

This theoretical framework is derived entirely from existing literature and has not been empirically validated. It is constrained by the studies available in our data set, which are predominantly from Western clinical contexts and may not capture cultural variation in family roles. The evidence base is stronger for some links (e.g. parent-mediated therapy improving expressive language) than others (e.g. systematic research on emotion coaching). We have assumed that findings from related fields (e.g. family-centered care in hearing loss) generalize to DLD, which may not always hold. Importantly, while the model highlights associations, it does not specify causal mechanisms. Readers should interpret the proposed links as hypotheses to guide future research and practice refinement.

Future Research Directions

Empirical research is needed to test and refine this conceptual model. Longitudinal studies should measure family factors (parent beliefs, stress, interaction quality) alongside child language and QoL outcomes to quantify reciprocal effects. Randomized trials could compare standard therapy to enhanced family-centered programs (e.g., adding an emotion-coaching component) to evaluate incremental benefits. Also recommend the development and validation of culturally sensitive parent-involvement interventions, as most current data come from English-speaking contexts. Future work should examine how systemic variables (insurance coverage, service delivery models) interact with family engagement. Finally, broader age ranges must be studied; for example, how does family support shape DLD trajectories into adolescence and adulthood?

Conclusion

A comprehensive understanding of DLD requires looking beyond the child to the family system. The evidence reviewed here indicates that parents' roles in noticing delays, in mediating interventions, and in supporting their child's emotional growth are pivotal determinants of DLD outcomes. By framing DLD within a biopsychosocial, family-centered model, we can better align clinical practice with the realities of affected children's lives. In the proposed model, parental and family support operate as catalysts: they enable earlier detection, enrich therapy, and buffer the psychosocial toll of language impairment. Implementation of this framework would involve training professionals in family-engaged approaches, restructuring services around parent-child dyads, and shaping policies that empower caregivers. Ultimately, integrating family support into DLD care holds promise for improving children's communication skills and their quality of life.

Conflict of Interest

The author declares no conflict of interest.

References

- Durgungoz, F. C., & St. Clair, M. C. (2024). Enhancing parental understanding of emotions in children with developmental language disorder: An online parent-led intervention program. Healthcare, 12(16), Article 1571. https://doi.org/ 10.3390/ healthcare12161571
- Eadie, P. A., Conway, L., Hallenstein, B., Mensah, F., McKean, C., & Reilly, S. (2018). Quality of life in children with developmental language disorder. International Journal of Language & Communication Disorders, 53(4), 799-810. https:// doi.org/10.1111/1460-6984.12390
- Ebbels, S. H., McCartney, E., Slonims, V., Dockrell, J. E., & Norbury, C. F. (2019). Evidence-based pathways to intervention for children with language

disorders. International Journal of Language & Communication Disorders, 54(1), 3-19. https:// doi.org 10.1111/1460-6984.12394

- Law, J., Levickis, P., Rodríguez-Ortiz, I. R., Mati?, A., Lyons, R., Messarra, C., Kouba Hreich, E., & Stankova, M. (2019). Working with the parents and families of children with developmental language disorders: An international perspective. Journal of Communication Disorders, 82, Article 105922. https://doi. org/10.10 16/j.jcom dis.2019.105922
- Marshall, J. , Goldbart, J., & Phillips, J. (2007). Parents' and speech and language therapists' explanatory models of language development, language delay and intervention. International Journal of Language & Communication Disorders, 42(5), 533-555. https://do i.org/10.10 80/13 682820600811985
- Marshall, J., Harding, S., & Roulstone, S. (2017). Language development, delay, and intervention: The views of parents from communities that speech and language therapy managers in England consider to be underserved. International Journal of Language & Communication Disorders, 52(4), 489-500. https://doi.org/10.1111/1460-6984 .12289
- Rinaldi, S., Caselli, M. C., Cofelice, V., D'Amico, S., De Cagno, A. G., Della Corte, G., Di Martino, M. V., Loscalzo, C., Sansavini, A., Lanzi, A., Tessier, A., Romeo, D. M., Scala, G., Formisano, S., Sorce, S. D., Pignatelli, E., Molinari, E., Campanili, E., Catapano, S., Chellini, F., … Rossi, S. (2021). Efficacy of the treatment of developmental language disorder: A systematic review. Brain Sciences, 11(3), 407. https://doi.o rg/10.33 90/brainsci11030407.

Author's Disclaimer

The views and conclusions expressed in this paper are those of the author(s). The editorial team bears no responsibility for the content.