Social interaction in Tongan and European families in New Zealand: implications for health care

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Abstract

This paper reports on the findings of a preliminary study which investigated reciprocal social interaction between children aged two to four years and their various social partners at home in three Tongan and three European families in New Zealand. Findings supported the three hypotheses which were derived from Western developmental psychological literature and Western Polynesian ethnography, showing that: 1) Tongan children demonstrated more reciprocal social interactions with siblings than with adults, while the distribution of reciprocal social interactions between adults and siblings was more equal for European children; 2) Tongan children used more nonverbal behaviours in their reciprocal social interactions than verbal ones, while European children used more verbal behaviours; and finally, 3) Tongan children were recipients of social interactions more than they were initiators (particularly with adults), while European children directed more social interactions to other partners than they received, especially adult partners. The clear differences in social interaction demonstrated by the two ethnic groups in this preliminary study suggests that health professionals need to acknowledge a range of patterns of social interaction within the families with whom they work.

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Introduction

Social interaction between the young child and various family members is a fundamental process of social development. The young child develops patterns of social interaction in early relationships, usually within the family niche. Here, the developing infant interacts with primary caregivers and other family members, including siblings and extended family. The early childhood niche[1] describes the immediate social environment of the child who has gained relative independence from a primary caregiver, and has not yet started formal schooling.

Early childhood is an important developmental stage, which is characterised by increasing linguistic competence and refining of sensorimotor skills, which afford the child more autonomy in the selection of activities as well as social partners. The child has access to a wider range of opportunities to extend reciprocal social interactional skills once s/he is independent of a primary caregiver and can move independently. Social interaction is socially and culturally informed in that patterns of interaction reflect goals and expectations of caretakers, which are in turn influenced by the wider community. The concept of the early childhood niche encompasses wider family and community values which inform behaviours, as well as acknowledging factors within the immediate home environment, such as availability of social partners and other resources.

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While many studies have focused on *infant*-mother interaction, social interaction between children aged two to four and their social partners is less well understood. Some of the Western Polynesian literature includes descriptions of social interaction, for example, Morton[2] describes specific types of interactional behaviours demonstrated by young Tongan children and their partners in her ethnography of Tongan childhood. New Zealand studies that specifically address social interaction in two to four year old children have focused on pre-school centres[3,4,5]. The few studies that

Table 1. Social partners for child as actor

Behaviour	*Tongan Adult*	*Tongan Child*	*European Adult*	*European Child*
Verbal				
comment	10	14	42	23
command	0	4	22	2
question	0	0	12	2
response	3	2	12	11
Total verbal	**13**	**20**	**88**	**38**
Non verbal				
approach	17	13	9	7
turn towards	6	11	8	7
fix	1	7	2	7
smile	4	10	6	4
Total non verbal	**28**	**41**	**25**	**25**
Total behaviours	**41**	**61**	**113**	**63**

120 minutes of behavioural observation.

investigate social interaction of young children in the New Zealand home environment focus on the mother[6].

This preliminary study is centred on two to four year old children and their various social partners in three Tongan and three European homes in New Zealand[7]. It investigates reciprocal social interaction, specifically the distribution of social partners, the direction of interactions, and the relative frequencies of different interactional behaviours.

Method

Tongan parents were born in Tonga, and the target child in the family was New Zealand-born. Children in each ethnic group were matched for age and sex; target children were neither first-born nor only children. At least one parent in each family had completed tertiary education. Quantitative data were collected from 120 minutes of videotaped behavioural observations of target children and their families

Table 2. Ranked behaviours

Tongan		*European*	
approach	26	comment	65
comment	24	command	24
turn towards	17	respond	24
smile	16	question	17
visual fix	14	approach	15
leave	14	turn towards	15
turn away	8	leave	11
non–facilitatory verbal	6	smile	10

120 minutes of behavioural observation.

Table 3. Absolute difference between child as actor and receiver for all partners and all behaviours

	T1	*T2*	*T3*	*E1*	*E2*	*E3*
Actor	108	212	220	185	285	263
Receiver	144	155	244	150	262	258
Difference	**–36**	***57**	**–24**	***35**	***23**	***5**

120 minutes of behavioural observation

T = Tongan, E= European
** child is actor more than receiver.*

at home. Qualitative data were collected using semistructured interviews and informal discussion with participants, including target children.

Reciprocal social interaction refers to an interaction where partners, as actors, provide clear verbal and/or nonverbal cues that convey information about their needs to a partner, and as receivers, attend to these cues, contextualise them to determine needs and provide a response within a reasonable time frame. The process of reciprocal social interaction is complex and not well understood; the operational definition used in this study was an actor sending a verbal and/or nonverbal behaviour to a partner who responded with a verbal and/or a nonverbal behaviour within five seconds. This operational definition allowed clear identification of the *reciprocal* nature of dyadic social interaction, specifically that each partner directs behaviours to a potential partner, and subsequently receives a response.

The hypotheses of this study, as derived from the Western psychological literature and Western Polynesian ethnography predicted that:

- Tongan children demonstrate more reciprocal social interactions with siblings than with adults, while in European children the distribution of reciprocal social interactions between adults and siblings is more equal.
- Tongan children use more nonverbal behaviours in their reciprocal social interactions than verbal ones, while European children use more verbal behaviours.
- Tongan children are recipients of more social interactions than they initiate (particularly with adults), while European children initiate more social interactions than they' receive, especially with adults.

Results

Findings supported all three hypotheses above. Firstly, Tongan children in the study interacted more with siblings than adults, whether they were actors or receivers (T able 1). Interactions with older siblings were more freque nt than those with younger siblings, for the two Tongan childr en who were not the youngest in their family. Older siblings were the most frequent social partners of any family member for all Tongan children. In contrast, the three European children in the study interacted more with adults, and sibling interaction was more evenly distributed between older and younger siblings than that of Tongan children. European adults intervened more in sibling-sibling interaction, and European children sought more guidance about social rules from adults. In contrast, Tongan children did not approach parents for guidance as frequently, and neither did Tongan parents intervene in sibling-sibling interaction as often as participating European parents did.

Secondly, the *types* of social interaction also differed markedly between ethnic groups: while all children approach more frequently than any other behaviour (Table 2), two of the Tongan children used more than twice as many nonverbal behaviours as verbal ones. European children used more verbal behaviours than Tongan children did. European children asked more questions and made more demands of adults than their Tongan counterparts. When Tongan children approached adults, they established eye contact and waited for a response, whereas European children often made demands or requests while approaching adults.

Two Tongan children were receivers of social interactions more than they were actors or initiators, while two European children were actors more than they were receivers (Table 3). The youngest children in each ethnic group were recipients more than they were actors.

These patterns of behaviour appeared to reflect parental expectations. While parents in both ethnic groups had similar overall goals for their children, Tongan parents expected sociocentric and respectful behaviours, while European parents expected their children to be verbally competent in order to communicate their individual needs to adults. Overall, European children appeared to be more dependent on adult family members for direction in terms of family social rules, such as gaining permission to eat, or where to play, while Tongan children appeared much more independent in making decisions about these everyday activities.

Discussion

The study is currently being extended to incorporate a larger sample. The preliminary findings reported in this paper showed a marked difference in patterns of social interaction between ethnic groups. While the small sample requires that the findings of this preliminary study be treated with caution, there are implications for the provision of socially and culturally appropriate health care for New Zealand children and their families, and particularly for Polynesian migrants.

The literature shows a clear relationship between Western children's health status and social behaviours.[8] A number of studies which have focused on the preschool child report altered patterns of social interaction in families who have a child with a chronic illness [9,10] or developmental disability.[11,12,13] For example, studies have found that interaction between a child with Cerebral Palsy and his/her older sibling is less reciprocal [14], less co-operative and is sustained for shorter periods of time than in dyads where neither sibling has a developmental disability[12]. Mothers also intrude more in sibling-sibling interaction when one of the partners has a developmental disability.[12,14] The child with a chronic illness may demand, and receive, more attention from parents than other children in the family.[10]

Other studies have shown that mothers and children with a developmental disability or chronic illness have different patterns of interaction than other child-mother dyads. For example, mothers direct more behaviours towards children with a disability than vice versa.[12,13] Children with a developmental disability also provide fewer and less explicit cues than those provided by children without a disability [13]. Some studies have found a negative correlation between the child's level of expressive language and the directiveness of mothers' interactions [14]. The low levels of reciprocal social interaction reported in the Western literature may compromise the social development of family members if reciprocal social interaction is in fact a desirable goal. All of the studies cited are based on Western societies and assume Western middle class values of social competence, where a child is expected to approach adults as well as peers and articulate his/her individual needs. This is the very pattern of interaction that was demonstrated by the European children in the current study, while Tongan participants were recipients of more interactions than they were initiators, interacted more with older siblings than other social partners, and used nonverbal interactions more than verbal ones.

Health professionals often fail to identify the various patterns of social interaction which occur within the early childhood niche, particularly patterns which differ from the dominant group. Moreover, when patterns of reciprocal social interaction are identified, they are often referenced to a middle class European norm; therefore, children who do not initiate and maintain reciprocal *verbal* social interaction with adults may be seen as socially incompetent. This comparative evaluation, whether implicit or explicit, often results in a failure to identify and utilise all of the resources that are available within the family. For example, if older siblings are the most frequent social partners for young Tongan children, it may sometimes be more appropriate for health care providers to draw on older children in the family to work with an ill or disabled child who is required to carry out a home exercise programme.

Optimal family functioning is an important goal, both for families with a child with a chronic illness or disability, and for health professionals with whom these families work. It is not always appropriate for an outsider to determine which patterns of interaction are most important to a family; health care professionals often set goals that are incongruent with the preferred family pattern of interaction. A heightened awareness of different types of social interaction, as well as the family values which inform these behaviours, would allow for the negotiation of health care interventions which reflect family values as well as those of the wider community. Family functioning can only be optimal if it reflects the goals and values of the family, which are in turn influenced by the wider community, which includes health care providers in the case of a child with a chronic illness or disability. For example, it may not be appropriate to encourage a child with an illness or disability to be assertive in his/her demands of adults if this does not fit with family values and expectations. Collaborative decisions between families and various health care providers to facilitate social development of various family members in a socially and culturally appropriate way are more likely to result in behavioural changes that optimise health as well as family functioning.

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Conclusion

In summary, this paper reports on preliminary findings (to be extended) of differential patterns of reciprocal social interaction between young children and their partners in three Tongan and three European families in New Zealand. The clear differences in types of reciprocal social interaction between the two ethnic groups suggest that there are implications for the provision of socially and culturally

appropriate health care that reflects the goals and values of individual families as well as those of health care providers. One of the major aims of health care interventions within the early childhood niche should be to reduce the impact of chronic illness or disability on the child, as well as all other family members, so that social and physical development is optimised. When social development of family members is in fact a desirable outcome of health care interventions, health care professionals need to identify and draw upon patterns of interaction within individual families, including those which differ from the European norm. This can be achieved by: 1) identifying and utilising resources available within individual families, (which may include involving family members who most readily identify with the young child with an illness or disability), and 2) facilitating a style of social interaction which is in congruence with individual family values and expectations.

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To maintain a joyful family requires much from both parents and the children. Each member of the family has to become, in a special way, the servant of others.

Pope John Paul II
In ***Anderson P: Great Quotes from Great Teachers***