The Co-Construction Framework: Seven Forms of Partner Support in AAC

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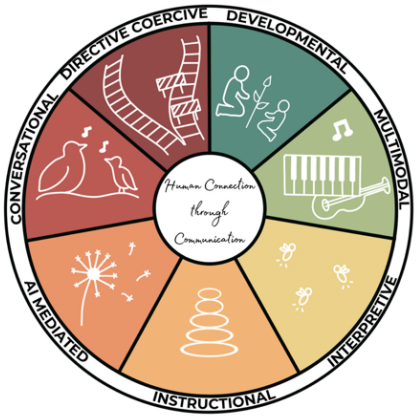
The Forms of Co-Construction

Communication is often described as a co-constructed process in which meaning emerges through interaction between communication partners rather than from either individual alone (Bruner, 1983; Clark, 1996; Vygotsky, 1978). While this broad understanding has significantly influenced contemporary theories of language development, interpersonal communication, and augmentative and alternative communication (AAC), the specific ways in which communication partners contribute to the co-construction of meaning have received less conceptual attention. Different communication situations require different forms of partner support. A communication partner may scaffold learning, interpret incomplete messages, respond to multiple communication modalities, facilitate authentic conversation, or provide access to emerging technologies that expand communicative possibilities. At other times, communication partners may unintentionally constrain participation through overly directive or compliance-based interactions. Distinguishing among these forms of co-construction provides clinicians with a framework for intentionally examining how their own behaviors shape communication opportunities. The purpose of this framework is not to categorize isolated intervention techniques, but to provide complementary lenses through which clinicians can analyze interactions, intentionally adapt their support, and maintain human connection as the central goal of communication.

These forms of co-construction are not mutually exclusive, nor are they intended to represent a hierarchy or sequential stages of intervention. Rather, they function as complementary dimensions of communication that often occur simultaneously within a single interaction. Effective communication partners continually shift their emphasis among these dimensions in response to the communicator, the context, and the purpose of the interaction. The framework therefore serves as a reflective tool, helping clinicians recognize which forms of co-construction are present, which may be underutilized, and how intentionally balancing these dimensions can expand opportunities for authentic participation and human connection. This framework is intended as a conceptual model for clinical reflection rather than a taxonomy of intervention techniques.



Developmental co-construction refers to the way communication abilities emerge and become more complex through meaningful interaction with responsive partners. Within this framework, the communication partner observes what the individual can currently understand and express, joins the interaction at that level, and provides just enough modeling, interpretation, language, time, and support to make a more complex contribution possible without taking over the communicator's message. This understanding is consistent with Vygotsky's concept of the zone of proximal development, in which development is supported through participation with others, and with Bruner's account of language acquisition as occurring within predictable, socially organized interactions that allow adults and children to build meaning together. It also aligns with usage-based accounts of language development, which propose that children learn communicative forms and constructions through repeated participation in purposeful social exchanges rather than through isolated instruction alone (Bruner, 1983; Tomasello, 2003; Vygotsky, 1978). Developmental co-construction therefore does not mean waiting for prerequisite skills before permitting authentic communication, nor does it require the gradual withdrawal of all partner support as the primary measure of success. Instead, the partner adjusts support dynamically so that the communicator can contribute increasingly self-generated, personally meaningful ideas while remaining connected to other people.

Clinical Application

In practice, developmental co-construction begins by considering the communicator's developmental level, life experiences, prior knowledge, and current interests rather than simply their chronological age. Communication partners intentionally select topics, vocabulary, books, activities, and visual supports that are developmentally appropriate while also building upon what the individual already knows. For beginning communicators, this may involve introducing foundational vocabulary and concepts through highly motivating, sensory-rich experiences. For example, many birth-to-three therapists use bubbles to create opportunities for shared attention and early language development. Because the activity is engaging and developmentally appropriate, it naturally supports concepts such as *bubble, blow, more, open, big, little, high,* and *low*. In contrast, presenting the same activity to an adolescent or adult would

likely be perceived as childish and may diminish motivation and authentic engagement. Developmental co-construction instead builds upon interests and accumulated knowledge that are meaningful to the communicator. For example, a discussion following the reading of *Harry Potter* might invite an older student to compare the similarities and differences between their own educational experiences and those at Hogwarts. The vocabulary and language structures may be more sophisticated, but the underlying principle remains the same: meaningful communication occurs when new learning is connected to existing knowledge, experiences, and interests in ways that respect the communicator's developmental stage and identity.

Clinical Caution

Developmental co-construction should not be confused with assigning an individual a fixed "developmental age" or "mental age." Medical and educational records frequently describe individuals as functioning "at the level of a six-month-old" or "with the cognitive abilities of a two-year-old." Although these descriptions are often intended to communicate support needs, they can unintentionally lower expectations for communication, literacy, social participation, and learning. For individuals with complex communication needs, traditional cognitive assessments may not accurately reflect underlying abilities because performance is often influenced by motor, sensory, language, or speech limitations rather than cognition alone. When developmental labels become the primary lens through which a communicator is viewed, clinicians and families may inadvertently limit opportunities for meaningful language, authentic conversation, and academic participation. Donnellan (1984) argued that, in the absence of conclusive evidence, educational decisions should be guided by the **Least Dangerous Assumption**—presuming competence because the consequences of underestimating an individual's potential are far greater than the consequences of expecting more. Likewise, Jorgensen (2005) emphasized that all individuals, regardless of disability, should have access to age-respectful educational experiences, rich language models, literacy, and meaningful participation in inclusive environments. Within the Co-Construction Framework, developmental co-construction encourages clinicians to view development as dynamic rather than fixed, asking not "What developmental age is this person?" but rather, "What is the next meaningful opportunity for this individual to participate, learn, and communicate?"

The goal is not to match activities to chronological age alone, but to create communication experiences that are developmentally appropriate, personally meaningful, and capable of supporting the communicator's next level of participation. Developmental co-construction encourages clinicians to ask not, 'What developmental age is this person?' but rather, 'What is the next meaningful opportunity for this individual to participate, learn, and communicate?'

Multimodal co-construction recognizes that communication is not confined to a single modality but is collaboratively built through whatever combination of speech, vocalizations, facial expressions, gestures, manual signs, eye gaze, body movement, low-tech

communication supports, writing, and speech-generating devices best supports shared understanding. Rather than prioritizing one communication mode over another, communication partners respond to all intentional communicative behaviors, accepting and integrating multiple modalities within the same interaction to facilitate authentic participation. This approach reflects the long-standing AAC principle that aided and unaided communication strategies should complement one another rather than compete, allowing individuals to select the most efficient and effective means of communication for a given context (Beukelman & Light, 2020; Beukelman & Mirenda, 2013; von Tetzchner & Martinsen, 2000). Research further demonstrates that communication competence is strengthened when partners acknowledge and respond to multimodal communication attempts instead of requiring a specific mode of expression before participation can occur (Light & McNaughton, 2014; Romski & Sevcik, 2005). Within this framework, multimodal co-construction positions the communication partner as an active participant who recognizes meaning regardless of modality, supports flexible movement between communication modes, and values successful human connection over the use of any particular communication system.

Clinical Application

Multimodal co-construction recognizes that the goal of communication is the expression of ideas, not the use of a particular communication modality. This can be compared to hearing the same song performed by different instruments. Whether the melody is played on a piano, violin, guitar, or flute, the sound is different, but the song remains the same. Likewise, a communicator may express the same message through speech, American Sign Language (ASL), gestures, facial expressions, eye gaze, picture symbols, a single-message switch, a low-tech communication board, spelling, or icons on a speech-generating device. Although the modality changes, the communicator's intended message does not. Effective communication partners recognize and respond to the message itself rather than requiring it to be expressed in a preferred format. Clinically, this means valuing communication across modalities and supporting individuals in selecting the method that is most efficient, effective, and meaningful for the situation. The focus remains on understanding the communicator rather than evaluating the communication system they used.

Clinical Caution

One common misunderstanding of multimodal communication occurs when clinicians or communication partners require an individual to reproduce a message using a different communication modality after the message has already been successfully communicated. For example, if an individual signs *dog* using American Sign Language, responding with, *"Now find **dog** on your device,"* shifts the interaction from communication to performance. The communicator has already expressed the intended message; asking them to produce it again on a speech-generating device does not enhance communication but instead tests operational skills or symbol knowledge. While there are appropriate times to teach new vocabulary or practice device navigation, these instructional goals should be clearly distinguished from authentic communication.

Multimodal co-construction encourages clinicians to honor the first successful communication attempt, regardless of modality, and to reserve instruction for moments when learning—not message validation—is the primary objective.

Multimodal communication describes the communicator's use of multiple forms of expression. Multimodal co-construction emphasizes the interaction between partners, recognizing that meaning emerges as communication partners perceive, acknowledge, interpret, and respond to those multiple forms of communication. Communication should be judged by the successful exchange of meaning, not by the modality through which that meaning was expressed.

Interpretive co-construction recognizes that communication partners actively construct meaning by drawing upon shared experiences, prior conversations, contextual knowledge, and their understanding of one another. Communication rarely depends on words alone; instead, meaning emerges as listeners combine the speaker's message with accumulated knowledge about the person, the environment, and the interaction itself. Familiar communication partners often understand incomplete utterances, ambiguous references, gestures, or even silence because they possess shared history that allows them to infer intended meaning. Clark (1996) describes this process as establishing *common ground*, in which communication is built upon mutual knowledge accumulated through previous interactions. Similarly, Grice (1975) proposed that conversational partners routinely infer intended meaning beyond the literal words spoken by relying on shared assumptions and cooperative conversational principles, while Bruner (1983) emphasized that language develops within recurring social interactions where partners jointly negotiate meaning. Within the Co-Construction Framework, interpretive co-construction highlights the communication partner's responsibility to thoughtfully interpret communicative attempts without replacing the communicator's intended message. Effective partners use contextual knowledge to support understanding while remaining open to clarification, recognizing that interpretation should facilitate authentic expression rather than impose assumptions. This perspective explains why familiar partners can often understand highly abbreviated or unconventional messages, while unfamiliar partners require additional context to arrive at the same shared understanding.

Clinical Application

Interpretive co-construction is readily observed when working with individuals who have dysarthria or other motor speech disorders. During an initial evaluation, an unfamiliar clinician may judge a person's speech to be less than 50% intelligible, while a spouse, family member, or close friend accurately understands much of what the individual is attempting to say. Rather than simply "hearing better," familiar communication partners draw upon years of shared experiences, knowledge of the individual's vocabulary, routines, interests, and conversational patterns to interpret incomplete or distorted speech. As clinicians continue working with the individual over time, they often notice that the person's speech appears to become more intelligible. While improvements in

speech production may certainly occur, another important change has taken place: the clinician has become a more skilled interpretive communication partner. Through repeated interactions, the clinician develops common ground with the communicator, allowing increasingly accurate interpretation of messages that may have been unintelligible during the initial evaluation. Interpretive co-construction reminds clinicians that successful communication depends not only on the speaker's abilities but also on the listener's growing capacity to understand the individual within the context of their shared experiences.

Clinical Caution

Interpretive co-construction should never be confused with assuming what a communicator intended to say. While familiarity often improves interpretation, effective communication partners recognize that their inferences remain hypotheses until confirmed by the communicator. Respectful listeners verify their understanding before responding, allowing the communicator to affirm, reject, or clarify the interpreted message. Confirmation protects the communicator's authorship by ensuring that the partner's knowledge supports understanding rather than replacing the individual's intended meaning. The role of the communication partner is not to complete another person's thoughts, but to collaboratively construct understanding while preserving the communicator's voice.

Interpretive co-construction depends upon common ground between communication partners. As communication partners become less familiar with one another—including interactions with artificial intelligence systems—communicators must often provide additional contextual information to establish the shared understanding that familiar partners have developed over time. Interpretation should reduce uncertainty, not replace authorship. Interpretation is a hypothesis, not the message

Instructional co-construction recognizes that communication competence develops through intentional teaching embedded within meaningful interactions. Rather than relying solely on direct instruction or expecting individuals to discover communication strategies independently, instructional co-construction emphasizes modeling, guided practice, responsive feedback, and graduated support that enables communicators to actively participate while learning new skills. Communication partners intentionally create opportunities for success by demonstrating language, AAC use, conversational strategies, and problem-solving within authentic contexts, gradually adjusting support as the learner gains confidence and competence. This approach is consistent with sociocultural theories of learning, which emphasize that knowledge is constructed through guided participation with more experienced partners (Vygotsky, 1978), Bruner's (1983) concept of scaffolding, and contemporary educational research demonstrating that modeling and supported practice promote deeper learning than passive instruction alone (Rosenshine, 2012). Within AAC intervention, instructional co-construction extends beyond teaching operational skills by embedding communication learning within purposeful, socially meaningful interactions. The communication partner

intentionally balances instruction with authentic conversation so that teaching serves participation rather than replacing it. As support is gradually adjusted in response to the communicator's changing abilities, instructional co-construction promotes increasing independence while preserving opportunities for shared meaning and authentic human connection.

Clinical Application

Instructional co-construction is perhaps the most familiar form of co-construction for speech-language pathologists and educators because it intentionally focuses on facilitating learning. In practice, this includes explicitly teaching core vocabulary, alphabet knowledge, literacy skills, motor plans for locating vocabulary on a speech-generating device, operational competencies such as adjusting volume or charging a device, and even programming personalized vocabulary. These concepts are most effectively taught through meaningful, engaging experiences such as shared book reading, play, music, art, daily routines, and naturally occurring conversations rather than isolated drills. Within instructional co-construction, communication partners intentionally model language, provide guided practice, and scaffold participation while ensuring that learning remains embedded within authentic communication. The goal is not simply to teach a word or a device feature, but to provide the communicator with skills that expand future opportunities for participation, self-expression, and meaningful interaction.

Clinical Caution

Instructional co-construction becomes less effective when instruction is separated from authentic communication. A communicator may successfully "pass" a lesson on using the core word *more* within a highly structured activity yet fail to recognize its broader communicative applications in everyday life. Conversely, beginning communicators may overgeneralize a newly learned sign or symbol, using *more* to express a wide range of intentions because it is the only communicative tool they have available. Neither situation necessarily reflects a failure to learn; rather, it highlights the importance of providing repeated opportunities to use language across varied contexts and communicative purposes. When instruction resembles a test with predetermined answers, repeated prompting, or isolated practice divorced from meaningful interaction, clinicians may measure performance rather than communication. Instructional co-construction should therefore be embedded within authentic experiences in which new language is immediately used to express genuine thoughts, make requests, comment, ask questions, solve problems, and participate in real conversations. Generalization is not an outcome that follows instruction; it is developed through repeated participation in meaningful communication across people, settings, and contexts.

AI-mediated co-construction recognizes artificial intelligence as an additional communication partner that can support message generation while preserving the AAC user's authorship and communicative intent. Traditionally, unfamiliar communication partners often assist by suggesting words, asking yes/no questions, or offering limited response choices based on their own understanding of the situation. Although well-intentioned, these supports may unintentionally constrain communication by restricting language to the partner's expectations rather than the communicator's intended meaning (Kent-Walsh & McNaughton, 2005; Light & McNaughton, 2014). Building upon established principles of communication partner support and communicative competence, generative AI offers a novel opportunity to expand the range of linguistic options available to communicators while preserving their authorship through active selection, rejection, and revision of AI-generated language. Rather than relying solely on the communication partner's vocabulary or assumptions, large language models can offer diverse language options that the AAC user may accept, reject, revise, or regenerate until the message reflects their intended meaning. In this framework, artificial intelligence does not replace human interaction or assume authorship; instead, it expands the range of linguistic possibilities available to the communicator while preserving the individual's control over the final message. AI-mediated co-construction therefore positions artificial intelligence as a collaborative communication support that complements, not replaces, the interpretive and conversational roles of human partners, increasing opportunities for authentic self-expression, participation, and autonomy (Beukelman & Light, 2020; Gajos et al., 2022; Light & McNaughton, 2014).

Clinical Application

AI-mediated co-construction recognizes artificial intelligence as a collaborative communication support that expands, not replaces, the communicator's ability to express self-generated ideas. Effective use of AI depends upon thoughtful prompting and active decision-making by the communicator. Rather than asking AI to think for the individual, AI is used to broaden communicative possibilities by generating multiple ideas, expanding vocabulary, or offering varied sentence structures that the communicator may accept, reject, revise, or regenerate. This process is particularly valuable for many AAC users whose communication has historically been limited by the vocabulary programmed into their device or by the ideas suggested by familiar communication partners. Although modern AAC systems contain research-informed vocabularies, they inevitably reflect decisions made by programmers, clinicians, or family members regarding which words should be available. Likewise, communication partners often offer language based upon their own experiences, assumptions, and expectations. AI expands this process by providing a wider range of linguistic possibilities, allowing communicators to select expressions that more closely reflect their intended message. For some individuals, AI may also introduce ideas, vocabulary, or perspectives beyond their previous experiences, creating opportunities for new learning while preserving the communicator's authorship through active selection and revision.

Clinical Caution

AI-mediated co-construction should never replace the communicator's intent or decision-making. The value of generative AI lies not in producing the "correct" response but in offering multiple possibilities from which the communicator remains the final decision-maker. Communication partners should avoid accepting AI-generated language without confirming that it accurately reflects the communicator's intended meaning. Likewise, unfamiliar vocabulary or complex sentence structures should not be assumed to represent understanding simply because they were selected. Instead, novel language provides valuable opportunities for discussion, clarification, and vocabulary learning. Concerns have also been raised that AI-generated language may inadvertently reflect biases or produce responses that do not align with the communicator's personality, experiences, or communicative intent. The communication partner's role is therefore not to validate AI's response but to support the communicator in evaluating whether the generated language authentically represents what they wish to say. Authorship is preserved when the communicator directs the prompting process, evaluates the generated options, and determines the final message.

For some communicators, AI may introduce vocabulary, perspectives, or ways of expressing ideas that extend beyond the language available on their device or the language typically modeled by familiar communication partners. Unlike human communication partners, who necessarily generate language from their own experiences and assumptions, generative AI offers a broader linguistic search space from which the communicator…not the partner…determines what best represents their intended meaning. Authorship is therefore preserved not by who generated the first draft, but by who directs the selection, rejection, revision, and final expression of the message.

Although empirical research examining generative AI within AAC is still emerging, recent educational research suggests that large language models have the potential to function as collaborative tools that support idea generation, language production, and learning while requiring thoughtful human oversight (Kasneci et al., 2023). Within the Co-Construction Framework, generative AI is proposed as an additional communication partner that expands linguistic possibilities while preserving authorship through the communicator's active selection, rejection, and revision of AI-generated language. Future research is needed to evaluate this proposed role.

Conversational co-construction recognizes that conversation is a dynamic process through which communication partners jointly create meaning, explore ideas, negotiate understanding, and influence one another over time. Unlike scripted exchanges in which one individual directs the interaction toward a predetermined outcome, authentic conversations evolve in response to the contributions of all participants. The same topic may unfold in countless different ways depending on the experiences, questions, perspectives, and emotional responses that each communication partner brings to the interaction. Clark (1996) describes

conversation as the collaborative establishment of *common ground*, while Bakhtin (1981) argued that meaning is inherently dialogic, emerging through the interaction of multiple voices rather than residing within any single speaker. Similarly, Grice (1975) demonstrated that conversational partners continuously infer, negotiate, and revise meaning through shared assumptions and cooperative interaction. Within the Co-Construction Framework, conversational co-construction extends beyond exchanging information; it acknowledges that genuine dialogue has the capacity to broaden perspectives, strengthen relationships, deepen empathy, promote collaborative problem solving, and increase commitment to shared decisions. Because each participant contributes to the direction and outcome of the interaction, conversation itself becomes a living, evolving process that shapes both the relationship and the individuals within it. For individuals who use AAC, conversational co-construction emphasizes participation in authentic dialogue rather than simply producing correct responses, recognizing that the opportunity to influence others, tell stories, joke, disagree, and collaboratively construct meaning is fundamental to human connection and belonging.

Clinical Application

Conversational co-construction differs from other forms of co-construction because the communication partner is no longer solely supporting the communicator's expression but they are actively participating in the conversation. Skilled AAC clinicians are often taught to avoid influencing a communicator's message by serving as a neutral facilitator. While this is essential during assessment and when establishing communicative intent, authentic conversation requires both partners to contribute their own ideas, opinions, experiences, and perspectives. Communication is not merely the exchange of information but the reciprocal sharing of thoughts that allows people to discover common interests, appreciate differing viewpoints, negotiate understanding, and strengthen relationships. For example, if an AAC user states that *Moana* is their favorite movie, the communication partner might respond, "My favorite movie is *Harry Potter*. What do you like best about *Moana*…the songs, the characters, the humor, or the message?" The clinician might then explain, "I like *Harry Potter* because I enjoy fantasy stories that stretch my imagination." Neither response is intended to persuade the communicator to change their opinion. Rather, each partner contributes authentic thoughts that allow the conversation to develop in unpredictable ways, creating opportunities for curiosity, perspective taking, humor, disagreement, and deeper human connection. The goal is not simply to help the AAC user express themselves, but to participate in a conversation in which both people contribute and both people learn.

Clinical Caution

Conversational co-construction should not be confused with directing the conversation toward the communication partner's agenda. Because clinicians, educators, and family members often possess greater conversational experience or professional expertise, they may unintentionally dominate interactions by asking a series of questions, correcting responses, teaching throughout the conversation, or steering the discussion toward predetermined goals. This same dynamic can occur during team meetings,

family coaching, and professional consultations. When an AAC specialist enters a meeting with a predetermined solution and primarily tells others what should be done, the interaction becomes instructional or directive rather than collaboratively conversational. Families and team members are more likely to develop meaningful, sustainable intervention plans when they are invited to share their own priorities, concerns, experiences, and ideas as equal participants in the discussion. Likewise, conversations with AAC users should preserve opportunities for genuine reciprocity, allowing both partners to influence the direction of the interaction while respecting the communicator's authorship. Conversational co-construction is most effective when communication partners contribute authentically without dominating, persuade through dialogue rather than authority, and remain genuinely open to having their own thinking changed through the interaction.

The purpose of conversation is not simply to reveal what one person thinks, but to discover what neither person would have thought alone. Ultimately, conversational co-construction reflects one of the defining characteristics of human communication: our capacity not only to exchange information, but to shape one another's understanding, relationships, and sense of belonging through shared dialogue.

Directive/coercive co-construction describes communication interactions in which one communication partner largely determines the purpose, content, and expected outcome of the exchange, leaving limited opportunity for the communicator to contribute self-generated ideas. Although these interactions are often well intentioned and designed to teach vocabulary, operational competence, or language concepts, they frequently emphasize identifying predetermined "correct" responses rather than fostering authentic communication. Activities such as "Find the apple," "Show me the dog," or repeated labeling tasks primarily evaluate comprehension or compliance rather than invite the communicator to share thoughts, preferences, experiences, or opinions. Similarly, physically directing an individual's hand to activate specific vocabulary (e.g., hand-over-hand prompting) or restricting communication to partner-selected choices may unintentionally replace the communicator's agency with the communication partner's intentions. Research across communication partner instruction emphasizes the importance of creating opportunities for autonomous participation, self-generated communication, and authentic interaction rather than relying on directive prompting alone (Kent-Walsh & McNaughton, 2005; Light & McNaughton, 2014; Soto & Zangari, 2009). Within the Co-Construction Framework, directive/coercive interactions are not viewed as inherently inappropriate—there are legitimate contexts for teaching operational skills, introducing vocabulary, or ensuring safety. However, when directive interactions become the primary means of AAC intervention, they risk shifting the goal from understanding the communicator to obtaining the expected response. Communication is fundamentally different from performance on a task. Its purpose is to discover what another person thinks, feels, notices, remembers, wonders, or wishes to share. When every interaction has a predetermined correct answer, the communication partner learns very little about the communicator, and the communicator has few

opportunities to influence the interaction through authentic, self-generated communication.

Clinical Recognition

Directive/coercive co-construction is often unintentionally embedded within AAC intervention because clinicians, educators, and family members naturally assume the role of teacher. As a result, communication opportunities may become structured around demonstrating knowledge rather than expressing ideas. Questions such as *"Find the apple," "Show me red," or "Where is the dog?"* have predetermined correct answers and therefore function primarily as assessments of vocabulary knowledge, operational competence, or compliance. These activities have legitimate roles when the purpose is explicit instruction or assessment; however, they should not be mistaken for authentic communication. Clinicians can recognize directive/coercive co-construction by asking a simple question: "Do I already know the answer?" If the communication partner already knows the expected response, the interaction is likely measuring performance rather than inviting communication. Recognizing these moments allows clinicians to intentionally shift toward interactions that encourage self-generated thoughts, questions, opinions, observations, and experiences.

Clinical Caution

Directive/coercive co-construction becomes problematic when performance is mistaken for communication. For example, a clinician may ask a student to *"Find red"* on a communication display. If the student activates every color except *red*, the interaction is often interpreted as evidence that the student does not understand the concept of *red*. An alternative interpretation, however, is that the student understands the vocabulary perfectly but is choosing not to produce the communication partner's predetermined response. When the assumption becomes, *"The field is too difficult; let's reduce the number of choices,"* intervention may unintentionally restrict future communication opportunities rather than expand them. In attempting to simplify the task, clinicians may actually reduce opportunities for authentic expression by limiting vocabulary, narrowing communicative options, and reinforcing compliance over participation.

Human communication is fundamentally different from testing. The purpose of communication is to discover what another person thinks, notices, remembers, wonders, fears, believes, or prefers which is information that the communication partner does not already possess. Authentic communication requires opportunities for self-generated expression in which the communicator contributes something new to the interaction. When intervention consistently emphasizes predetermined correct answers, clinicians may inadvertently learn very little about the communicator while simultaneously limiting the individual's opportunity to influence others through genuine communication. The goal of AAC intervention is not simply to produce correct responses but to foster human connection through conversations in which every participant has the opportunity to contribute ideas that were previously unknown to their communication partner.

Performance demonstrates what the communication partner already knows. Communication reveals what only the communicator knows.

Reflection Tool: Examining Co-Construction in Clinical Practice

The seven forms of co-construction are not intended to be used as a checklist during intervention, nor does every interaction require equal emphasis on each form. Rather, they provide reflective lenses through which clinicians can examine how their own behaviors influence communication. Following a therapy session, classroom activity, family interaction, or team meeting, consider the following questions:

Developmental Co-Construction

Did I meet this communicator where they are developmentally while providing opportunities for the next meaningful level of participation?

- Did I build upon their prior knowledge and experiences?
- Were my activities, vocabulary, and expectations respectful of their age, interests, and identity?
- Did I presume competence while providing appropriate support?

Multimodal Co-Construction

Did I value the communicator's message regardless of how it was expressed?

- Did I respond to the first successful communication attempt?
- Did I accept speech, gestures, signs, eye gaze, facial expressions, pictures, spelling, and AAC equally as communication?
- Did I focus on meaning rather than the communication modality?

Interpretive Co-Construction

Did I use my knowledge of this communicator to support understanding without replacing their intended message?

- Did I thoughtfully interpret incomplete communication?
- Did I confirm my interpretation before responding?
- Did I preserve the communicator's authorship?

Instructional Co-Construction

Did my teaching occur within meaningful communication rather than isolated performance?

- Was I teaching skills that would expand future participation?
- Did learning occur through authentic activities and conversations?
- Was I teaching communication rather than simply testing knowledge?

AI-Mediated Co-Construction

Could AI expand this communicator's expressive possibilities while preserving their authorship?

- Could AI offer additional ideas, vocabulary, or sentence structures?
- Did the communicator remain the decision-maker?
- Was AI used to expand options rather than determine the message?

Conversational Co-Construction

Did I genuinely participate in the conversation?

- Did I contribute my own authentic thoughts, experiences, or opinions?
- Was I open to learning something new from the communicator?
- Did the conversation change both of us in some way?

Directive/Coercive Co-Construction

Was I inviting communication or simply measuring performance?

- Did I already know the expected answer?
- Was I asking the communicator to tell me something I didn't already know?
- Did I unintentionally limit opportunities for self-generated communication?

The Ultimate Reflection

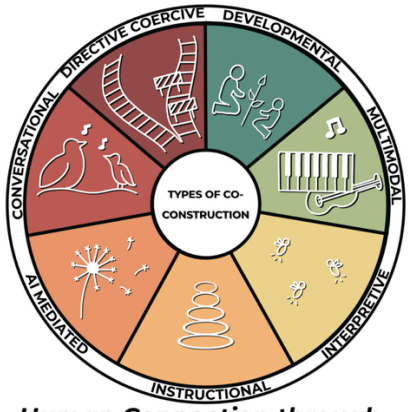
Perhaps the most important question is not which form of co-construction occurred, but whether the interaction expanded authentic participation and strengthened human connection.

After each interaction, ask yourself:

- What did I learn about this communicator today that I did not know before?
- What did the communicator learn that will help them participate more fully in future interactions?
- Did this interaction strengthen our relationship?
- Did this interaction increase the communicator's ability to influence another person's thoughts, understanding, or actions?
- If someone observed this interaction, would they describe it as communication or as instruction, assessment, or compliance?

The seven forms of co-construction are not intended to prescribe therapy. They are intended to cultivate intentionality. Effective communication partners move fluidly among these dimensions, continually asking not only, *"What am I teaching?"* but also, *"What am I learning about this person?"* The ultimate measure of successful co-construction is not how accurately the communicator reproduced what the partner already knew, but whether both participants left the interaction with a deeper understanding of one another.

Co-Construction is not a technique. It is a way of thinking about communication. Every interaction shapes meaning. Every communication partner influences participation. The question is not whether we are co-constructing communication, but whether we are doing so intentionally, respectfully, and in ways that expand the communicator's opportunity to express what only they can contribute.



Human Connection through Co-Construction

Conclusion

Communication has long been understood as a co-constructed process in which meaning emerges through interaction rather than from either communication partner alone. The purpose of distinguishing developmental, multimodal, interpretive, instructional, AI-mediated, conversational, and directive/coercive co-construction is not to create separate intervention approaches or a hierarchy of clinical priorities. Rather, these forms represent complementary lenses through which clinicians can examine

their own interactions and intentionally consider how their behaviors influence communication.

No single interaction relies exclusively on one form of co-construction. Effective communication partners continually move among these dimensions as they respond to the communicator, the context, and the purpose of the interaction. A clinician may scaffold learning, interpret an incomplete message, respond to multiple communication modalities, engage in authentic conversation, utilize AI to expand communicative possibilities, and intentionally teach new skills—all within a single therapy session. The framework is therefore intended not as a prescription, but as a reflective tool that encourages clinicians to ask whether their interactions are expanding opportunities for authentic participation or unintentionally limiting them.

Ultimately, the purpose of AAC intervention is not simply to teach vocabulary, improve operational competence, or produce correct responses. It is to increase meaningful participation in human relationships. Communication is fundamentally different from performance because its purpose is to reveal something another person does not already know. When communication partners intentionally create opportunities for self-generated expression, they do more than teach language—they discover the individual's thoughts, ideas, preferences, humor, memories, fears, and dreams. In doing so, they strengthen not only communication, but the human connections that communication was meant to create. The success of AAC intervention should not be measured by how accurately individuals reproduce what we already know, but by how often they teach us something we could not have known without them.

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