UNIVERSITY OF BELGRADE - FACULTY OF SPECIAL EDUCATION AND REHABILITATION

THE EUROPEAN ASSOCIATION ON EARLY CHILDHOOD INTERVENTION

EUROPEAN ASSOCIATION OF SERVICE PROVIDERS FOR PERSONS WITH DISABILITIES

Eurlyaid Conference 2017

Early Childhood Intervention: For meeting sustainable development goals of the new millennium

PROCEEDINGS

Belgrade, Serbia
October, 6 - 8th 2017

Eurlyaid
THE EUROPEAN ASSOCIATION ON EARLY CHILDHOOD INTERVENTION

EASPD
IMPROVING SERVICES
IMPROVING LIVES

UNIVERSITY OF BELGRADE – FACULTY OF SPECIAL EDUCATION AND REHABILITATION

THE EUROPEAN ASSOCIATION ON EARLY CHILDHOOD INTERVENTION

EUROPEAN ASSOCIATION OF SERVICE PROVIDERS FOR PERSONS WITH DISABILITIES

Eurlyaid Conference 2017

Early Childhood Intervention: For meeting sustainable development goals of the new millennium

PROCEEDINGS

Belgrade, Serbia
October, 6 – 8th 2017

PROCEEDINGS

PUBLISHER / IZDAVAČ
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia /
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju

FOR PUBLISHER / ZA IZDAVAČA
Prof. dr Snežana Nikolić
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia /
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju

EDITORS / UREDNICI
Prof. dr Mirko Filipović
Prof. dr Branislav Brojčin
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia /
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju

REVIEWER / RECENZENTI
Prof. dr Zorica Matejić-Đuričić
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia /
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju
PhD Jean Jacques Detraux
University of Liège, Liège – Department of Psychology: Cognition and Behavior, Special Education
Jürgen Kühl
University of Applied Sciences, Emden, Germany

PROOFREADING AND CORRECTION / LEKTURA I KOREKTURA
Maja Ivančević-Otanjac

DESIGN AND PROCESSING / DIZAJN I PRIPREMA
Biljana Krasić
Zoran Jovanković
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia /
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju

Proceedings will be published in electronic format CD.

Circulation: 200

ISBN 978-86-6203-101-3

Eurlyaid Conference 2017

Early Childhood Intervention: For meeting sustainable development goals of the new millennium

Konferencija Evropske asocijacije za ranu intervenciju 2017

Intervencije u ranom detinjstvu: u susret ispunjavanju ciljeva održivog razvoja novog milenijuma

Belgrade, October 6 – 8, 2017

ORGANIZERS / ORGANIZATORI

University of Belgrade, Faculty of Special Education and rehabilitation / Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju

European Association on Early Childhood Intervention – EURLYAID / Evropska asocijacija za ranu intervenciju

European Association of Service Providers for Persons with Disabilities – EASPD / Evropsko udruženje servisa podrške za osobe sa invaliditetom

PRESIDENT / PREDSEDNIK

Snežana Nikolić, PhD, Dean,
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia / Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju

Scientific Committee

Naučni odbor Konferencije

- Ana Maria Serrano,
  University of Minho, Portugal
- Carolyn Blackburn,
  Birmingham University, UK
- Britta Gebhard,
  Nordhausen University, Germany
- Margarita Cañadas Pérez,
  Catholic University of Valencia, Spain
- Snežana Nikolić,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Aleksandar Jugović,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Gordana Odović,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Vesna Vučinić,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Vera Ilanković,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Sanja Đoković,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Mile Vuković,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Zorica Matejić-Đuričić,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia
- Nenad Glumbić,
  Faculty of Special Education and Rehabilitation, University of Belgrade, Serbia

Organizing Committee

Organizacioni odbor Konferencije

- Noor Van Loen,
  Siegfried Holzschulster from SHFI,
  Austria
- Monica Ingemarsson,
  from IAKM Norge, Norway
- Snežana Nikolić,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Gordana Odović,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Aleksandar Jugović,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Danijela Ilić-Stošović,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Snežana Ilić,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Irena Stojković,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Aleksandra Đurić-Zdravković,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Jasmina Maksić,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Marija Anđelković,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia
- Tamara Kovačević,
  Faculty of Special Education and
  Rehabilitation, University of
  Belgrade, Serbia

TABLE OF CONTENTS

PLENARY LECTURES / PLENARNA PREDAVANJA

PRESENTATION OF GOOD PRACTICE IN DIFFERENT COUNTRIES
PREZENTACIJA DOBRE PRAKSE U RAZLIČITIM ZEMLJAMA

PARALLEL SESSIONS I
ASSESSMENT AND INTERVENTION FOR CHILDREN WITH DISABILITIES
PARALELNA SESIJA I
PROCENA I INTERVENCIJE ZA DECU SA SMETNJAMA U RAZVOJU

PARALLEL SESSIONS II
STATEGIES AND CHALLENGES IN EARLY INTERVENTION SYSTEM
PARALELNA SESIJA II
STRATEGIJE I IZAZOVI U SISTEMU RANE INTERVENCIJE

PARALLEL SESSIONS III
TEAM AROUND A CHILD AND FAMILY IN EARLY CHILDHOOD INTERVENTION
PARALELNA SESIJA III
TIM OKO DETETA I PORODICE U SISTEMU RANE INTERVENCIJE

POSTER PRESENTATION / POSTER PREZENTACIJA

PLENARY LECTURES

PLENARNA PREDAVANJA

udc 316.356.2
37.018.1
613.95-053.2

What Science Tells Us about Our Work with Families in Early Childhood Intervention

Marilyn Espe-Sherwindt
Director, Family Child Learning Center
Akron Children's Hospital, Akron, OH, USA

Relationships matter in early childhood intervention. "Children learn and develop in the context of relationships with others. When children experience warm, responsive, and secure relationships it builds their confidence, sense of identity and trust in the world" (Kids Matter, Australian Early Childhood Mental Health Initiative, www.kidsmatter.edu.au). Science has demonstrated that responsive, "serve and return" relationships between a child and caregivers promote the healthy development of the child's brain architecture. But families also learn and develop in the context of relationships with others. If we define early childhood intervention as "the different types of parenting supports provided by early childhood practitioners and other social network members that provide parents the time and energy, and knowledge and skills, to engage their children in everyday child learning opportunities that promote and enhance both child and parent confidence and competence" (Dunst & Espe-Sherwindt, 2017, p. 831), it is not only the child-caregiver relationship that matters, but also the relationship between families and early childhood intervention professionals. Multiples studies from the field of early childhood intervention, together with research from the field of social neuroscience, have identified evidence-based strategies for working with families that can build their brain architecture, i.e., strategies that can build the family's feelings of competence and self-efficacy, their sense of identity and quality of life, and their confidence about the future.

Key words: *relationships, families, early childhood intervention, evidence-based strategies, social neuroscience*

What is early childhood intervention (ECI)? Shortly after the passage of the first early intervention legislation in the United States, early [childhood] intervention was defined as "educational, health and social services designed to support the development of very young children who, in minor or major ways, have been identified as 'different.' They are also designed to support and strengthen the families that are the primary influences on these children" (Healey, Keesee & Smith, 1989, p. 1). Almost thirty years later, we now define ECI as "the different types of parenting supports provided by early childhood practitioners and other social network members that provide parents the time and energy, and knowledge and skills, to engage their children in everyday child learning opportunities that promote and enhance both child and parent confidence and competence" (Dunst & Espe-Sherwindt, 2017, p. 831). The evolution in the definition of ECI demonstrates that the emphasis has shifted from services targeted at the child to supports targeted at the family.

Relationships matter in ECI. We are all familiar with the research in child development that has demonstrated the centrality of relationships: all learning takes place within relationships (Norman-Murch, 1996), and those relationships are "the building blocks" of human development (National Research Council, 2000). "When children experience warm, responsive, and secure relationships it builds their confidence, sense of identity and trust in the world" (Kids Matter, Australian Early Childhood Mental Health Initiative, www.kidsmatter.edu.au). These principles apply not only to the developing child and his/her relationships with caregivers, but also to the relationships that parents have with us during their time in ECI. The authors of *From Neurons to Neighborhoods* (2000) stress that the outcomes of our ECI intervention are impacted by the quality of the *relationship* established between the service provider and each family. In other words, when **a family** experiences "warm, responsive, and secure relationships," those relationships build the family's "confidence, sense of identify and trust in the world." In their 2014 qualitative study, Blue-Banning, Summers, Frankland, Nelson and Beagle talked extensively with parents and professionals about relationships. Their analysis identified six dimensions of supportive parent-professional relationships: 1) Communication (quantity + quality); 2) Commitment (valuing the relationship); 3) Equality (sense of harmony & ease in the relationship); 4) Skills (knowledgeable, high expectations, individualization); 5) Trust (reliability, safety, discretion); and 6) Respect (caring, nonjudgmental, courteous, acknowledging strengths).

One of our biggest challenges is that families often enter the world of ECI struggling with stressors: the initial stressor that comes with being told that their child may be "different" in need of services, as well as the chronic stressors that can come with caring for a child with chronic illness or disability (Seligman & Darling, 2009). In addition, families in ECI may be faced with the same stressors faced by any family, e.g., poverty, divorce, single parenting, mental or physical illness, addiction, and/or political turmoil. Some families are overcome by these stressors, while others "bounce back," stronger than ever (Singer, Maul, Wang & Ethridge, 2017). Those families would be called "resilient."

What do resilient families look like? Resilient families of children with disabilities . . .

- Use cooperative processes: effective communication and problem-solving, conflict resolution, flexibility;

- Are able to create positive meanings about their child and their life experiences;
- Are successful in accessing and utilizing both community and disability-specific services;
- Enjoy one another yet can acknowledge the feelings that go with more painful experiences;
- Can keep from being overwhelmed by sadness or anger, and do not let those negative feelings take over the family system;
- Can balance the needs of their child with those of other family members;
- Are able to work out accommodations to family routines – can adapt to their child's needs (Gallimore, Bernheimer & Weisner, 1999; Olsson & Hwang, 2008; Patterson, 1991; Singer et al., 2017).

Woodman (2014) examined the longitudinal stress trajectories of parents of children with disabilities: "Child-related stressors and family resources at the time families were receiving early intervention services (age 3) had lasting impacts on parental well-being" (p. 50). If we define ECI as the ways in which we support families so that they have time, energy, knowledge and skills to support their child's development, and if their time in ECI has lasting impacts on family well-being, then one of our highest intervention priorities indeed may be to promote family resilience. In the words of one parent, "Families need our support to help them grow the roots of their tree deep and wide so that their branches can withstand storms that may come even after their time with us in early [childhood] intervention" (R. Bowyer, personal communication, 2017).

How do we help families "grow their roots" deep and wide during their time with us in ECI? The extensive work of Carl Dunst and his colleagues has pinpointed (1) specific capacity-building and family-systems intervention practices, and (2) the pathways through which those practices impact family and child outcomes (c.f., Dunst, 2017; Trivette, Dunst & Hamby, 2010). The use of relational and participatory practices (capacity-building) and the use of family-systems intervention practices (identify needs, build on strengths, and enhance supports) directly impact the parent's self-efficacy and sense of well-being; the parent's sense of well-being in turn impacts parent-child interactions and child development outcomes (Trivette, Dunst & Hamby, 2010).

Recently, the field of social neuroscience has provided additional insights into the power of parent-professional relationships (e.g., Cozolino, 2013; Cozolino, 2014; Ito & Kubota, 2017; Szalavita & Perry, 2010):

- Social neuroscience is the intersection between social psychology and neuroscience, i.e., the using neuroscience theories and methods to understand how people influence one another's thoughts, feelings and behavior.

- When we interact with another person (e.g., with a family), we are sending and receiving signals that can affect not only our own brain function and structure and but also the brain function and structure of the other.
- Even as adults, our brains are "plastic" and can still be "rewired" (the concept of "neuroplasticity").
- However, when stressed, brains can have difficulty learning and "bouncing back." Stressed brains are less plastic. (And, as described earlier, many families in ECI are stressed.)
- Certain aspects of relationships can optimize neuroplasticity:
    - Trust and feeling safe;
    - Moderate levels of arousal;
    - Activating both cognition and emotion; and
    - Co-constructing positive narratives.
- We can use these concepts in our work with families to build strong, supportive relationships and enhance the family's feelings of self-efficacy and well-being.

In the words of Tim Moore (2009), "Relationships change brains neurologically and chemically." In other words, our relationships with families have power – for better (and for worse). What an amazing opportunity for ECI – but what an amazing challenge as well!

In closing, Blue-Banning et al. (2004) posed two challenging questions at the end of their article for us to ponder: (1) Is the quality of parent-professional relationships a prerequisite for successful child and family outcomes? (2) Should programs be held accountable for the quality of parent-professional relationships? The science suggests that the answer to both questions should be YES. Relationships do matter in ECI.

REFERENCES

1. Blue-Banning, M., Summers, J.A., Frankland, C., Nelson, L.L., & Beegle, G. (2004). Dimensions of family and professional partnerships: Constructive guidelines for collaboration. *Exceptional Children, 70*, 167-184.
2. Cozolino, L. (2013). *The social neuroscience of education: Optimizing attachment and learning in the classroom*. New York: W.W. Norton.
3. Cozolino, L. (2014). *The neuroscience of human relationships*. New York: W.W. Norton.
4. Dunst, C. J. (2017). Family systems early childhood intervention. In H. Sukkar, C. J. Dunst, & J. Kirkby (Eds.), *Early childhood intervention: Working with families of young children with special needs* (pp. 38-60). Abingdon, Oxfordshire: Routledge.

5. Dunst, C.J., & Espe-Sherwindt, M. (2017). Contemporary early intervention models, research and practice for infants and toddlers with disabilities and delays. In J. M. Kauffman, D. P. Hallahan, & P. C. Pullen (Eds.). *Handbook of special education (2nd ed.)* (pp. 831-849). New York: Taylor & Francis.
6. Gallimore, R., Bernheimer, L.P., & Weisner, T.S. (1999). Family life is more than managing crisis: Broadening the agenda of research on families adapting to childhood disability. In R. Gallimore, L.P. Bernheimer, D.L. MacMillan, D.L. Speece, & S. Vaughn (Eds.), *Developmental perspectives on children with high-incidence disabilities* (pp. 55-80). Mahwah, NJ: Erlbaum.
7. Healy, A., Keesee, P.D., & Smith, B.S. (1989). *Early services for children with special needs: Transactions for family support*. Baltimore, MD: Brookes.
8. Ito, T. A., & Kubota, J. T. (2017). Social neuroscience. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. DOI:nobaproject.com. Retrieved from http://nobaproject.com/modules/social-neuroscience
9. Moore, T.G. (2009). The nature and significance of relationships in the lives of children with and without developmental disabilities. Keynote presentation at National Conference of the Early Intervention Association of Aotearoa, New Zealand ~ *Quality Practices: New Practices* ~ Auckland, 1st April.
10. Olsson, M.B., & Hwang, C. (2008). Socioeconomic and psychological variables as risk and protective factors for parental well-being in families of children with intellectual disabilities. *Journal of Intellectual Disability Research, 52*, 1102-1113.
11. Patterson, J.M. (1991). Family resilience to the challenge of a child's diability. *Pediatric Annals, 20,* 491-499.
12. Seligman, M., & Darling, R.B. (2009). *Ordinary families, special children (3rd ed.).* New York: Guildford Press.
13. Singer, G.H.S., Maul, C., Wang, M., & Ethridge, B.L. (2017). Resilience in families of children with disabilities. In J.M. Kauffman, D.P. Hallahan, & P.C. Pullen (Eds.), *Handbook of special education (2nd Ed.)* (pp. 793-810). New York: Routledge.
14. Szalavita, M., & Perry, B.D. (2010). *Born for love: Why empathy is essential – and endangered*. New York: HarperCollins.
15. Trivette, C. M., Dunst, C. J., & Hamby, D. W. (2010). Influences of family-systems intervention practices on parent-child interactions and child development. *Topics in Early Childhood Special Education*, 30, 3-19. doi:10.1177/0271121410364250

udc 616-053.32
613.95-053.32

Family Experiences of Early Care and Education for Young Children Born Prematurely

Carolyn Blackburn
School of Education and Social Work,
Birmingham City University, United Kingdom

This presentation discusses a study that explored family experiences of having a child born prematurely. The study involved an online survey to which 209 parents responded. Thirteen parents also participated in a semi-structured interview. Analysis of the online survey data suggests that parents would like the early childhood workforce to know more about the emotional and developmental impact of premature birth, especially in relation to developmental norms and expectations. This includes the health professionals working in hospitals and organisers of parent and toddler groups and other parents that visit them in order to reduce pressure on parents for their child to conform. In particular, they would like more training for health professionals such as Health Visitors about the socio-emotional needs of children and families when children are born prematurely so that parents do not feel pressured. Findings from interviews with parents (including 12 mothers and 1 father) will be presented in this paper for the first time.

Key words: *premature birth, families, children, special educational needs, training*

INTRODUCTION

Globally, 15 million babies are born prematurely (preterm) each year, representing 11% of all live births. In the UK, around 7% of children are born preterm each year. This means that, on average, one in 14 babies is born preterm, and two children in an average sized primary school class are born preterm (Wolke *et al*, 2015). Each year in England, around 10,000 children are born very preterm (at less than 32 weeks gestation) and a further 60,000 are born moderately preterm (at 32-36 weeks gestation). The number of preterm births has increased in the last two decades, and more preterm children are surviving due to improved neonatal care (National Neonatal Audit Programme, 2015). Children born prematurely may also be born with low birth weight (less than 2,500 g), very low birth weight (less than 1,500 g) or extremely low birth weight (less than 1,000 g).

Children born prematurely and/or with low birth weight have a history of biological vulnerability and a greater risk of developmental problems. In particular, children born very preterm have been found to experience specific learning problems including difficulties with mathematics, visual-spatial skills, memory and attention. The most common adverse outcomes following preterm birth are cognitive problems (for example, lower IQ, poor executive function and working memory), learning difficulties, social difficulties (for example, autism spectrum disorders, difficulties interacting and forming relationships with peers), behavioural problems (for example, attention problems, attention deficit/hyperactivity disorders), emotional problems (for example, anxiety disorders, phobias), and poor motor coordination (for example, cerebral palsy and clumsiness). These kinds of difficulties can impact on a child's inclusion in early years settings and later on at school.

There is still much we do not know about the nature and spectrum of these learning difficulties, their long term consequences, and how to deal with them. In particular, there is controversy about whether moderately preterm children experience similar but milder learning problems than children born very preterm. Little research has been conducted on the emotional impact of preterm birth on parents.

Teachers and educational psychologists receive little formal training about preterm birth and are often not aware of appropriate strategies to support preterm children in the classroom. Informing teachers about the special constellation of problems following preterm birth is crucial in preparing them to support the growing number of preterms entering schools in the coming years (Campbell, 2015). Studies have explored parents' experiences of having a child born prematurely. However, these studies have generally focused on the months immediately following the birth and have taken a health and social care perspective (Harvey *et al*, 2013; Garfield *et al*, 2014; Gray *et al,* 2013). Quantitative studies have also examined the development of children who were born prematurely and have identified the learning difficulties that they face during early childhood (Marlow, 2004; Johnson *et al*, 2010; Costeloe 2012). Parents' experiences of early years education is an under-researched area.

This paper aims to report on a study that explored the early care and education experiences of children born prematurely through reports from parents in order to identify best practice in early care and education and provide advice and guidance for policy-makers and early educators.

METHOD

The study involved an online survey which included both open and closed questions. A sample of respondents to the survey participated in a semi-structured telephone interview. 209 responses to the survey were received and 13 interviews conducted with parents including 12 mothers and 1 father. The data were analysed thematically to address the research questions. Closed questions allowed for descriptive statistics.

Findings

Findings from the online survey suggest that professionals across the early childhood workforce need more information and training about how to support families when a child is born prematurely as well as how to support children born prematurely in social settings (Blackburn, 2017). Parents reported that their experience of hospital was often 'traumatic', 'frightening' 'lonely' and 'stressful'. Although some parents said that health professionals in hospital had provided high levels of support and care, many parents said that there was a lack of understanding about the emotional aspects of having a child born prematurely. Often parents said that these earliest experiences had impacted negatively on their relationship with their newborn infant and had resulted in the need for long-term counselling for mothers for post-traumatic stress disorder (PTSD).

> *It was incredibly stressful and the most traumatic experience I have ever had. I have been diagnosed with PTSD.*
>
> *I still get upset about my time in hospital I felt like everything was medicalised to the point where any baby bonding time I had to ask for. Most of the time, I felt like I was visiting someone else's baby. I had to ask permission to feed, change or get my baby out for a cuddle. I know this was for safety of baby as she was fragile but it just made me think I wasn't capable of being a mother.*

On leaving hospital many parents said that they had been provided with insufficient information about their infant's long-term health, care and developmental trajectory. This left them feeling anxious about how to care for their infant and about the future. Some parents were unsure at that stage whether their child would survive. The emphasis from professionals seemed to be on the immediate care for infants. Whilst this may the most effective way to support children and families, it raises questions about how a balance can be found so that parents' anxiety about the future can be reduced.

Many parents reported that they could not attend parent and toddler groups. Often this was associated with their child's ongoing health conditions and care needs. For example where infants were dependent upon oxygen and / or susceptible to infection, parents were advised by health professionals not to take their child to social groups.

> *We were told to avoid mixing with groups of people particularly children as my daughter has chronic lung disease and needed to avoid RSV. This was necessary advice as when she caught RSV as an older baby she was very unwell. It did however contribution to the isolation associated with having a premature and unwell baby.*

Whilst this may be in the best interests of children and families, it isolated parents and impacted upon their emotional well-being. Some parents said that they did not attend these groups due to cost or time restraints especially where multiple births were involved. Others said that they didn't attend these groups as they were cautious about other parents judging their child who often was smaller than their peers and at a different developmental stage.

Some parents had altered their choice of pre-school education for their child following pre-term birth, preferring smaller settings with more specially trained staff and/or specialist equipment. They also said that transition to school had been difficult for their child due to the lack of training for the teaching workforce.

CONCLUSION

The findings from this study indicate that parents would like professionals across the early childhood workforce to have more knowledge about the bio-psycho-social consequences of premature birth for children and families. In relation to early care and education, parents have stressed the need for early years professionals to be trained specifically about the needs of children born prematurely and their families, especially in relation to developmental norms and expectations. This includes the organisers of parent and toddler groups and other parents that visit them in order to reduce pressure on parents for their child to conform. In particular, they would like more training for health professionals such as Health Visitors about the socio-emotional needs of children and families when children are born prematurely so that parents do not feel pressured. The interview data will be analysed shortly and will be presented as part of this presentation for the first time.

REFERENCES

1. Blackburn, C. (2017). Developmental risk for children born prematurely. *Early Years Educator, 18*(12), *32-34.*
2. Campbell, D. (2105). Premature babies more likely to end up in lower- paid jobs. *The Guardian* 1st September 2015
3. Costeloe, K.L, Hennessy, EM., Haider, S., Stacey, F., Marlow, N., Draper, ES. (2012). Short term outcomes after extreme preterm birth in England: comparison of two birth cohorts in 1995 and 2006 (the EPICure studies). *BMJ*; 345:e7976
4. Garfield, C. F., Lee, Y., & Kim, H. N. (2014). Paternal and Maternal Concerns for their very low-birth-weight infants transitioning from the NICU to home. The *Journal of perinatal & neonatal nursing, 28*(4), 305-312.
5. Gray, PH., Edwards, DM., O'Callaghan, MJ., Cuskelly, M., Gibbons, K. (2013). Parenting stress in mothers of very preterm infants – influence of development, temperament and maternal depression. *Early Human Development, 89*(9), 625-629.

6. Harvey, M.E., Nongena, P., Gonzalez-Cinca, N., Edwards, A.D. and Redshaw, M.E. (2013). Parents' experiences of information and communication in the neonatal unit about brain imaging and neurological prognosis: a qualitative study, *Acta Paediatrica, 102*(4), 360-365.
7. Johnson, S., Hollis, C., Kochhar, P., Hennessy, EM., Wolke, D., Marlow, N. (2010). Autism spectrum disorders in extremely preterm children. *J Pediatrics;* 156:525-31
8. Marlow, N. (2004). Neurocognitive outcome after very preterm birth. Arch Dis Child Fetal Neonatal Ed, 89*(3), F224-F228.*
9. National Neonatal Audit Programme (2015). Annual Report on 2014 data. http://www.rcpch.ac.uk/improving-child-health/qualityimprovement-and-clinical-audit/national-neonatal-audit-programme-nnap (accessed 11/04/2016).
10. Wolke, D., Johnson, S., Jakel, J., and Gilmore, C. (2015). The impact of preterm birth on mathematics achievement and schooling: briefing notes and recommendations Nuffield Foundation

udc 364.4-056.26/.36-053.2
364-785.14-056.26/.36-053.2

Participation as Ultimate Goal for Early Intervention Services

Britta Gebhard
Professor for Early Intervention University of Applied Sciences, Nordhausen, Germany

The introduction of the International Classification of Functioning, Disabilities and Health (ICF) of the World Health Organization (WHO) in 2001 made social participation as a major rehabilitation outcome and the ultimate goal of early intervention services. A shift from traditional functional impairment measures such as strength measures or assessments of walking distance occurred, since they do not necessarily represent participation in activities of daily life. Goal definition on the basis of daily activities, individual interests and capacities of the child and its family are central for early intervention services. In our days, there is a lack of participation measurements for young children and the context conditions in which they develop. The aim of the presentation is to illustrate the underlying theoretical concept of participation from an international discursive perspective and its implication for goal setting and diagnostic processes in early intervention services. Basic considerations for early interventions services will be developed.

Key words: *participation, early intervention, goal-setting, ICF-CY, measurement*

Social participation in leisure activities is important for the development of skills, friendships and a sense of belonging in society. It is also important for self-concept and for the emotional, physical and mental health of children and youth (Dijkers, 2010; Law, 2002). Participation (defined as ‘a person’s involvement in a life situation’) is a core concept of the International Classification of Functioning, Disability and Health (ICF World Health Organization, 2001). In the ICF participation is understood as a result of the interaction of an individual with his or her social and physical environment. Bendixen et al. (2014) describe participation as a measurable outcome of health. Especially for children participation includes a number of activity functions for example personal care, mobility, education, recreation, which are of intrinsic social and personal importance (Tuffrey, Bateman & Colver, 2013). Together with participation, activities are classified in the same way in the ICF – the individual user must decide the apportion to sub domains. However, activities should be understood as "the execution of a task or action" (World Health Organziation, 2001), regarding activities as simpler elements of functioning at body level whereas participation includes the attendance in everyday situations and contains an involvement/part taking component as well as an emotional atmosphere e.g. enjoyment and the individual experience of involvement (Granlund, 2013).

The importance of social participation, its meaningfulness and theoretical foundation have been discussed internationally (Granlund, 2013; Heinemann, 2010; Raghavendra, 2013), and questions have arisen over the definition of participation, its dimensions, its theoretical construct and the distinction between activity and participation (Coster & Khetani, 2008; Gebhard & Fink, 2015; Whiteneck & Dijkers, 2009).

Another important issue is the consideration of qualifiers for assessing participation (Granlund et al., 2012; Granlund, 2013). Participation is considered to be a key outcome of rehabilitation programs and (early) intervention services for children with disabilities and their families (e.g. Law et al., 2006). It is a meaningful measure because traditional functional impairment measures such as strength measures or assessments of walking distances do not necessarily represent participation in activities of daily life (Bendixen et al., 2014). A good example for explaining the difference between activity and participation is given by Chien et al. (2014): putting a toothpaste on a toothbrush and brushing the teeth can be categorized as a simple or short sequence of functional actions. From an activity-focused point of view, it can be assessed for example by hand assessments. But in the meaning of a lager goal of participation, the series of activities that require hand use can be seen as oral hygiene which is important for a child, for example when he or she will stay overnight at a friend's home – so the child can fulfill the role of self-care.

Thus – when focusing on participation as an outcome measure, the way of diagnostic and looking on children and their family during early intervention services must be change. The individual perspective and preference must be in focus. Therefor we need participation measures with a good conceptual foundation and psychometric properties. Different researchers and clinicians recommend that participation outcomes should not be assessed and estimated from other levels of assessments (e.g. activity performance assessments) (Bendixen et al., 2014; Chien et al., 2014). Specific participation measurements are required.

Current participation instruments for children and youth were analyzed and compared in three systematic reviews according to their theoretical construct, quality criteria and the reproduction of the nine domains of the International Classification of Functioning, Disabilities and Health for Children and Youth (ICF-CY) (Chien et al., 2014; Phillips, Olds, Boshoff & Lane, 2013; Rainey, van Nispen, van der Zee, C, & van Rens, 2014).

In the first review (Phillips et al., 2013), 20 instruments to measure activity and participation in children (age range 0-18 years) with disabilities where identified to meet the inclusion criteria for research purpose. Reliability and validity of the instruments are described, further the extent of involvement, satisfaction and difficulty with task performance, as well as consideration of activity and participation in the nine ICF life areas. From the 20 examined instruments, no single instrument measured all of the dimension of life areas mentioned in the ICF. Some measurements only rated the frequency of activities, others additionally quantified the difficulty of performing activities or the satisfaction and enjoyment. This aspect allows to better-individualized view on not only the amount of activities but further more on the significance of activities and participation. Following, the concept of participation measurements as well as the qualifier of measuring participation seem to be very different.

In the second review (Chien et al., 2014) the focus lies on the content analysis of children's participation measurements. The aim was to show to what extent the items of the measurements can be classified as activity or participation according to the ICF. Fourteen instruments for children aged between two and 12 years were included in the analysis. The results show, that only one instrument showed 100% participation items (but consist only of six items at all), three instruments had between 88%-75%. Six instrument had more than 50% participation items. This results show the ongoing debate on how to capture "participation" and how to differentiate from activity.

In the third review (Rainey et al., 2014) the aim was to identify measures of participation for children with disabilities in the age between o and 18 years. The second aim was to critically appraise the measurement properties using a standardized approach (Consensus-based Standards for the selection of health status Measurement Instruments (COSMIN)). Eight participation measurements where selected and described. The psychometric quality of the instruments showed mixed results. It is important to notice, that some questionnaires were very poorly assessed due to their psychometric quality. Another important fact is that the definition of the construct "participation" seemed to be very different and imprecise.

In Germany as in many other countries, social laws for people with disabilities focus on enhancing social participation (e.g. Sozialgesetzbuch IX (SGB IX) (social law book IX)), and participation is becoming more important than ever for clinical practice and goal setting in rehabilitation and early intervention services. According to current research, it is important to assess youth's preference for activities in order to support their participation (Dahan-Oliel et al., 2012; Imms et al., 2016).

In respect to these developments, it seems to be a current aim to implement participation as an outcome in early intervention services. Goal setting and treatment planning should be based on the focus of participation. No longer only activities and the quality and quantity of performing activities or a task are primarily should be given priority. Rather the detection of individual meaningful participation whishes and necessary activites and skills for the performance should be in focus always in regard to the context, individual meaningfulness and the situation of the family. For that reason, the theoretical debate on the definition and the theoretical construct of participation must go on. These results should be implemented in the development and construction of future participation measurements. By examining participation as an outcome in early intervention services rather than (or additional to) skills or developmental milestones we can try to capture a more meaningful context and society oriented service for the child and its family.

REFERENCES

1. Bendixen, R. M., Lott, D. J., Senesac, C., Mathur, S., & Vandenborne, K. (2014). Participation in daily life activities and its relationship to strength and functional measures in boys with Duchenne muscular dystrophy. *Disability and rehabilitation*, *36*(22), 1918–1923. https://doi.org/10.3109/09638288.2014.883444
2. Chien, C.-W., Rodger, S., Copley, J., & Skorka, K. (2014). Comparative content review of children's participation measures using the International Classification of Functioning, Disability and Health-Children and Youth. *Arch Phys Med Rehabil*, *95*(1), 141–152. https://doi.org/10.1016/j.apmr.2013.06.027
3. Coster, W., & Khetani, M. A. (2008). Measuring participation of children with disabilities: issues and challenges. *Disabil Rehabil*, *30*(8), 639–648. https://doi.org/10.1080/09638280701400375
4. Dijkers, M. P. (2010). Issues in the conceptualization and measurement of participation: an overview. *Arch Phys Med Rehabil*, *91*(9 Suppl), 16. https://doi.org/10.1016/j.apmr.2009.10.036
5. Gebhard, B., & Fink, A. (2015). Partizipation – theoretische Grundlagen und aktuelle Messinstrumente im Kindes- und Jugendalter [Measuring Participation – Discussion of the Theoretical Foundations of Current Assessment Instruments]. *Klinische Padiatrie*. Advance online publication. https://doi.org/10.1055/s-0035-1554701
6. Granlund, M. (2013). Participation--challenges in conceptualization, measurement and intervention. *Child Care Health Dev*, *39*(4), 470–473. https://doi.org/10.1111/cch.12080
7. Granlund, M., Arvidsson, P., Niia, A., Bjorck-Akesson, E., Simeonsson, R., Maxwell, G., ... Pless, M. (2012). Differentiating activity and participation of children and youth with disability in Sweden: a third qualifier in the International Classification of Functioning, Disability, and Health for Children and Youth? *Arch Phys Med Rehabil*, *91*(13 Suppl 1), 96. https://doi.org/10.1097/PHM.0b013e31823d5376

8. Heinemann, A. W. (2010). Measurement of participation in rehabilitation research. *Arch Phys Med Rehabil*, *91*(9 Suppl), 4. https://doi.org/10.1016/j.apmr.2009.08.155
9. Law, M. (2002). Participation in the Occupations of Everyday Life. *American Journal of Occupational Therapy*, *56*(6), 640–649. https://doi.org/10.5014/ajot.56.6.640
10. Phillips, R. L., Olds, T., Boshoff, K., & Lane, A. E. (2013). Measuring activity and participation in children and adolescents with disabilities: a literature review of available instruments. *Aust Occup Ther J*, *60*(4), 288–300. https://doi.org/10.1111/1440-1630.12055
11. Raghavendra, P. (2013). Participation of children with disabilities: measuring subjective and objective outcomes. *Child Care Health Dev*, *39*(4), 461–465. https://doi.org/10.1111/cch.12084
12. Rainey, L., van Nispen, R., van der Zee, C, & van Rens, G. (2014). Measurement properties of questionnaires assessing participation in children and adolescents with a disability: a systematic review. *Qual Life Res*, *23*(10), 2793–2808. https://doi.org/10.1007/s11136-014-0743-3
13. Tuffrey, C., Bateman, B. J., & Colver, A. C. (2013). The Questionnaire of Young People's Participation (QYPP): a new measure of participation frequency for disabled young people. *Child Care Health Dev*, *39*(4), 500–511. https://doi.org/10.1111/cch.12060
14. Whiteneck, G., & Dijkers, M. P. (2009). Difficult to measure constructs: conceptual and methodological issues concerning participation and environmental factors. *Arch Phys Med Rehabil*, *90*(11 Suppl), 35. https://doi.org/10.1016/j.apmr.2009.06.009
15. World Health Organziation. (2001). *International classification of functioning, disability and health: ICF*. Geneva.

PRESENTATION OF GOOD PRACTICE IN DIFFERENT COUNTRIES

PREZENTACIJA DOBRE PRAKSE U RAZLIČITIM ZEMLJAMA

udc 376.1-056.26/.36-053.2(497.11)
364.4-056.26/.36-053.2(497.11)

Situation Analysis of Early Intervention in Republic of Serbia[1]

Hollie Hix-Small
Portland State University, Graduate School of Education, USA
Snežana Ilić
University of Belgrade – Faculty of Special Education and Rehabilitation, Serbia

Early Childhood Intervention (ECI) services help ensure fulfilment of internationally mandated rights, strengthen inclusive societies, and support children and families. This situation analysis, jointly supported by the Early Childhood Program of Open Society Foundations and UNICEF Serbia, examined the status of ECI services in Serbia. The analysis was part of a project to identify opportunities for the development of ECI in the country. A primarily quantitative, mixed-method approach documented existing ECI infrastructure and service provision. Data were collected from a focus group with parents, field observations, and interviews with key stakeholders belonging to Health, Education, and Social Welfare sectors, advisory board meetings, and a survey completed by professionals serving children with disabilities (e.g., teachers, medical professionals, therapists) and a survey completed by parents of children with disabilities. 184 parents and 416 professionals participated. Professionals and parents agreed parents are often the first to suspect the child has developmental needs. Over half of parents and professionals indicated pediatricians should screen children for delays. There was less agreement on who should assess and serve children. Systemic barriers include lack of time, high caseloads, insufficient human resources, cost, and attitudes toward children with disabilities. Existing infrastructure and disciplines, university programs and emerging training on ECI, patronage nursing, pediatric, and developmental counseling unit services, preschool institutions, and amenable policies and legislation may facilitate the development of ECI services. A shift from a medical to a social and interdisciplinary or transdisciplinary service delivery approach through the Routines-Based Intervention (RBI) model; cross-sector alignment and agreements with program standards and quality indictors; and clear protocols and standardized practices will improve existing services. Piloting ECI services delivered through home visits, at centers, and within inclusive preschools will guide subsequent service development. A financial and efficiency analysis will inform caseloads and service intensity and duration.

---

[1] The opinions expressed in this Situation Analysis are those of the authors and do not necessarily reflect the policies or views of the Open Society Foundations or UNICEF.

Parents and professionals need opportunities to learn about contemporary, evidence-based ECI practices.

Key words: *early intervention, situation analysis, children with disability*

Although Serbia has made gains over the last decade for children with developmental delays and disabilities and their families, there is a growing need within the country to develop an equitable system of Early Childhood Intervention (ECI) services. With support from UNICEF Serbia and Open Society Foundations (OSF), this situation analysis explored key areas of relevancy for the development of a national ECI system. Areas explored included policy, program regulations, personnel preparation, accessibility and service reach, standards, financial support, and accountability mechanisms.

Families in Serbia have access to a number of preventative and support services during a child's early years including prenatal care, patronage nurse home visits, well-child pediatric care, nurseries, and preschool education. Specialized services for children with delays and disabilities are also available through Developmental Counseling Units (DCU) and secondary and tertiary health care. Education services include developmental groups within preschools. Inclusive preschool services continue to develop. Additionally, Roma health mediators provide support for Romani communities. UNICEF Serbia is actively working with the Government to increase access to high quality, inclusive preschool education by strengthening legal and institutional frameworks and develop diversified funding streams and programs to facilitate inclusion of Serbia's most vulnerable children.

Country pilot projects,in collaboration with nongovernmental organizations and university partners, have focused on inclusive preschool education and preventing family separation. While not fully developed, components necessary for ECI are in place or emerging. For example, some pediatricians are implementing standardized developmental screening; a number of professionals have significant expertise in assessment; and existing professionals from various disciplines have a wealth of knowledge that may serve as a solid foundation to develop ECI services.Demand and access, quality, and parent and provider attitude towards services and children with disabilities, however, needs documented.

Since there is no ECI system in place within Serbia, the analysis focused on opportunities and barriers to implementation and sought to identify and analyze pockets of emerging best practice within the country. An international and national consultant planned and carried out the analysis and Open Society Foundations Early Childhood Program and UNICEF Serbia provided guidance.

METHOD

Data included qualitative field-based observations and interviews with key stakeholders including ministry officials, health, education, and social welfare professionals, and university faculty. Six parents of children with disabilities provided information during a two-hour semi-structured interview. A brief document review was completed. A multidisciplinary advisory board representing the fields of pediatrics, psychology, pedagogy, rehabilitation, neuropsychology, special education, and public health along with a parent association representative provided guidance on the methodology as well as insight on the situation of children with disabilities in the country.

Professionals from a range of disciplines as well as parents of children with disabilities completed an online survey in Serbian. Recruitment included invitations sent through existing parent and professional associations through social media and individual emails. Professionals belonging to different sectors were included if they provided services to children with disabilities below the age of six years. A professional translated the original English surveys into Serbian. The second author and multiple Serbian early childhood, education, and health experts familiar with Serbia and highly proficient in Serbian and English reviewed and approved the translation.

Survey respondents included 184 parents and 416 professionals. Forty-three percent of the professionals were medical providers with pediatricians making up 10.6%. Thirty-one percent were defectologists, 14.9% speech therapists, and 12.7% psychologists. Preschool teachers made up 7.9% and pedagogues 6.0%. Forty-four percent of professional respondents had more than 15 years of experience working with young children with disabilities. Half of parents reported living jointly in a relationship (53.8%) and 38% reported no financial problems. Most respondents were from urban communities (86.5% professionals, 68.8% parents).

RESULTS

Many parents reported they or a relative were first to suspect their child's delays (46%) and 36% of professional respondents agreed. This was followed by preschool teacher (14.7%) and pediatrician (13.5%) as first detectors according to professional respondents. Medical respondents were more likely to endorse pediatricians and non-medical respondents were more likely to endorse preschool teacher.

Early identification and referral barriers included pediatric caseloads and the need for mandated, clearly documented referral pathways and follow-up requirements. Parents lack awareness of system navigation and their rights. Case coordination across primary, secondary, and tertiary institutions is lacking. Parents and professionals agreed pediatricians should implement developmental screening. There was less agreement around assessment. Most parents agreed their child's pediatrician is within walking distance and time spent in the waiting room is reasonable; more than half (52.4%) said the hours of operation are difficult.

Overall, professionals identified the defectologist to carry out the assessment following a positive screen (55.8%). Medical professionals were more likely to select pediatrician or psychologist; whereas 62.2% of non-medical professionals indicated defectologist followed by psychologist and speech therapist.

The attitude towards services differed between medical and non-medical respondents. Medical professionals were more likely to indicate routine screening is important (80.6% vs. 59.9% non-medical) even though there was near universal endorsement of the effectiveness of ECI services. Non-medical professionals indicated less knowledge on how to screen (66.5% vs 80.8% medical) and a desire to receive training (92.1% vs 87.6% medical). Failure to screen universally will result in under-detection of up to 60% of children with developmental delays and as many as 80% of children with social emotional challenges (Lavigne, Binns, Christoffel, Rosenbaum, Arend, Smith, et al., 1993; Sheldrick, Merchant & Perrin, 2011; Squires, Nickel & Eisert, 1996; Sturner, 1991). Although parents suspected the delay before the first year (73.2%) and a high percentage of professionals also noticed their child's delay (63.2%), only 43.4% had a diagnosis within this period. Forty-five percent of children received a diagnosis between 12-36 months. Thirty-two percent of parents reported their child's disability established at the secondary or tertiary level (32.1% and 12.4%). Medical providers were more likely to report the tertiary (33.1%), secondary (22.8%) or DCU (21.3%) established the disability.

In general, medical professionals noted a need for professional development. The survey included a series of questions for medical professionals to report the proportion of pediatricians at their Primary Health Care Center who can carry out specific tasks (e.g., identify suspected child abuse or neglect (15.4), provide anticipatory guidance (14.6%); or use a validated screening tool (5.7%). Response options included most (100-75%), many (74-50%) and so forth. Very few respondents reported most of their colleagues as proficient (100-75%). The most highly endorsed area was the identification of biological risk such as low birth weight. Only 9% endorsed use of interview and observational skills to assess aspects of a child's development, and 5.7% use of a valid screening tool. Surprisingly, 14.6% indicated 100-75% of their colleagues could counsel parents how to enhance their child's development; 17.6% indicated their colleagues know how to access ECI or rehabilitation services; and 18% reported 100-75% of their colleagues could manage special health care needs of children with developmental difficulties.

Over half of parents reported receiving Republic or municipal intervention services for less than 30 minutes per session (55%) with 41% of parents receiving services less than once per week. Twenty-two percent of parents use private services more than twice per week. The majority of Republic and municipal services are center-based (94.3) or clinic-based (83.3%) although 60.9% of parents indicated preschool-based services. Parent preferred service location was the home (38.6%) followed by rehabilitation center (32.6%) for children birth to three. Professionals preferred the home (51.4%) followed by inclusive classroom (46.2%). Parents of children 3-6 years preferred the rehabilitation center followed by home-based services. Professionals preferred inclusive classrooms followed by developmental groups for children 3-6 years. Although professionals prefer home-based services, only 6% indicated this is a current service delivery option.

Parents indicated their role in service provision as being in the room watching the specialist (33.3%) whereas medical professionals expect them to be in the room and trying the techniques they observe (45.5%). Non-medical professionals prefer to have the parent in and out of the room depending on what the specialist advises (56.5%).

Overall, parents and professionals most frequently endorsed a lack of knowledge about available services as a barrier for children 0-6 years. Limited or no financing and a lack of trained providers followedaccording to parents.Professionals agreed financing was a barrier (45.2%) and coordination among sectors (43%). A small percentage of parents knew what services were available for their child (42.4%) and how to access them (39.7%).

The role of professional and parent associations can be instrumental in knowledge building. Fifty-eight percent of non-medical professionals belong to a professional association and 50% of medical professionals claimed membership. Forty-seven percent of parents belong to an association; however, this was significantly lower for rural respondents (14%).

Educators need training and support according to parents. Thirty-percent indicated inadequate training for preschool teachers and 35.9% said there are not enough specialists to support teachers and too many children in the preschool group (28.3%). Physical access may remain a barrier at many preschools. Twenty-two percent of parents endorsed this area as a barrier.

Finally, although three-fourths of parents and professionals agreed every child has the right to mainstream education and over 80% said preschool should be universally accessible, there is a lack of consensus on which ministry should lead. This is perhaps due to the recognition that ECI crosses sectors. The overwhelming majority (90% of parents and 91% of professionals) indicated access to education for children with disabilities is the responsibility of education, health, and social welfare.

DISCUSSION

Serbia has many of the necessary components needed for the development of a national ECI system. However, no specific legislation regulates existing components, including financing. A financial assessment is needed to determine adequate caseloads and service intensity and duration. A shift from a medical to a social and interdisciplinary or transdisciplinary delivery approach through the Routines-Based Intervention (RBI) model is recommended. The RBI model, based on understanding family ecology and a functional, family-centered needs assessment; functional goal development and integrated service delivery; and service delivery through a consultative approach, is rooted in the child's daily routine interactions with the environment and individuals. Cross-sector alignment and agreements with program standards and quality indicators as well as clear protocols and standardized practices will improve existing services. ECI program standards and quality indicators need to be developed, agreed, and monitored at the national level. Piloting ECI services delivered through home visits, at centers, and within inclusive preschools will guide subsequent service development. There are few opportunities for professional development and parent and professional awareness raising. Available opportunities are not accessible to all due to cost and free time. Although some data is recorded on the types of disability, data systems need improved. Evidence-based, contemporary pilot services need developed and trialed.

While this situation analysis informs future ECI developments, interpretive caution is warranted. Although 63.6% of the population has a personal computer and completion of the survey with a smartphone was possible, a limitation of the situation analysis is the generalizability to the wider population. Underrepresentation from rural areas and families facing financial difficulties further limit the generalizability of the findings.

REFERENCES

1. Lavigne, J., Binns, H., Christoffel, K., Rosenbaum, D., Arend, R., Smith, K., et al. (1993). Behavior and emotional problems among preschool children in pediatric primary care: Prevalence and pediatricians' recognition. *Pediatrics*, *91*, 649-655.
2. Sheldrick, R. C., Merchant, S., & Perrin, E. C. (2011). Identification of developmental-behavioral problems in primary care: a systematic review. *Pediatrics, 128*(2), 356-363.
3. Squires, J., Nickel, R.E., &Eisert, D. (1996). Early detection of developmental problems: Strategies for monitoring young children in the practice setting. *Journal of Developmental and Behavioral Pediatrics, 17*(6), 410-427.

PARALLEL SESSIONS I
ASSESSMENT AND INTERVENTION FOR CHILDREN WITH DISABILITIES

PARALELNA SESIJA I
PROCENA I INTERVENCIJE ZA DECU SA SMETNJAMA U RAZVOJU

udc 613.95-056.26/.36-053.2
364.4-056.26/.36-053.2

Video-Supported Assessment as a Method of Bridging Together Families and Caregivers with Professionals

Ena Caterina Heimdahl

Department of Complex Learning Difficulties, Statped Southwest, Oslo, Norway

Ana Maria Serrano

Institute of Education, Center of Research on Education, University of Minho, Portugal

Research subject: *Many professionals use video. Many parents take video of their child with mobile and other devices.Video-supported assessment is an instrument that may contribute to real participation, decision-making and empowerment of parents and caregivers for children with a low level of functioning.*

Method: *The aim of the study was to: (a) underline the importance of full participation of caregivers in the assessment process, and (b) evaluate an assessment instrument that facilitates parents to participate in the assessment of their child. We are concerned about bringing the parents and the professionals together in a way that they can understand how they can use the clips in order to develop a deeper understanding of their child behavior. All this is in their own pace and in their own language. We believe that.*

Results: *We described a three-step analysis of a video taken of a parent interacting with a child: 1) to chart what is observed in the video, such as the facial expressions of both parent and child; 2) to reflect on the parent-child interaction seen in the video; and 3) to intervene by creating an intervention tool based on the combined information gathered in the first two steps. We tried to stay on a clip long enough and analyze it. We tried to put maximum energy into meeting the child in more activities than just the recorded activity.*

Conclusion: *Parent participation in the child assessment process works to improve parent-child interaction while building a sense of competence, self-efficacy and empowerment in the parents, who often feel that they have lost control of their child to the health or pedagogical care system.*

Key words: *parents participation, professionals' engagement, video analysis*

In our oral presentation we describe a very small group of children on the lowest level of functioning. The scarcity of reliable data on the prevalence of certain disorders in Europe does not allow us to draw precise conclusions concerning the prevalence of this group of children (Mendez et al., 2011). However, the World Report on Disability (2011) does mention that these children represent 0.8 percent of children in Europe. These are children whose communicative signals are very small, have many health problems and therefore must endure many hospitalizations. The children also experience pain, causing them to persistently readjust their body position, which leads to a loss of focus. This implies that, in order for them to regain their focus, they must reposition their body – an impossible task without external help. The children do not reach the symbolic level in their language development, or remain at a very low level of expression, uttering perhaps only a few sounds or vowels (Horgen, 2006 and Horgen, Slåtta and Gjermestad, 2010). They express themselves essentially through body language. They are very dependent on technology and their caregivers, caregivers who must make every effort to understand what they are trying to convey. We choose to apply the term *Profound and Multiple Learning Disabilities* (PMLD) to these children, because PMLD focuses on learning. Children with PMLD do have the capacity to learn; the question, however, is what and how much they learn.

Our experience has been that children with PMLD are often completely taken over by the public health system. Having to endure multiple hospitalizations, these children are quickly labeled by their pathology. It is often difficult for parents to see their child being viewed through the lens of pathology by the health care system.

We have learned through many years of counselling how difficult it is to assess children with PMLD. The question arises as to which field is it meaningful to do assessment based on questionnaires. Checklists can of course be helpful if they are seen as a basis for starting a discussion during a working session, for instance. Yet we have also experienced that even the best checklists do not help the efforts of those who work closely with a child on a daily basis. Checklists can also be useful for drawing a portrait of the child and labelling the phenomena, but they have to be translated into the daily language of the caregivers if they are to be effective in designing a tailored intervention for the child and his or her caregivers. Often the checklist does not give us much more information than the fact that the child is an early communicator. They reveal all the things the child cannot do or learn.

The question we would like to raise is, which type of assessment is needed so that *the dignity of the parent is preserved?*

We most certainly have to differentiate between *assessment for service planning* and *assessment for intervention*. Assessment for service planning is a reality for many parents, since they already know they have a child at the lowest stage of development. Assessment for intervention is the kind of approach that can give parents their dignity back. Video-supported assessment is one of the methods for assessment that can support the ideology of partnership and family centeredness.

Stern (2007) compares the introduction of video recording in the psycho-pedagogical world to the discovery of the microscope in the scientific world: we could suddenly see more and adjust the movement of time by slowing down or even stopping the lapse of time so that we could share the same image with many others and, most importantly, have the time to reflect on the image together.

In our presentation we describe a three-step analysis of a video taken of the parent interacting with the child: 1) to chart what is observed in the video, such as the facial expressions of both parent and child; 2) to reflect on the parent-child interaction seen in the video; and 3) to intervene by creating an intervention tool based on the combined information gathered in the first two steps. We try to stay long enough in a clip and analyze it. We try to get the max energy out to meet the child in more activities than just the recorded activity.

The three-step video-supported assessment method is designed to allow parents to talk openly about their child, to help them understand the tiny communicative signals given by their child, and allow them to see in video form the way they are personally coping with the challenges they face with their child. The method also helps to build a sense of competence in parents by enhancing their self-efficacy, and to improve the wellbeing and quality of life of families with children with PMLD.

We wish to (a) underline the importance of full participation of the caregivers in the assessment process, and (b) evaluate an assessment instrument that facilitates parents to participate in the assessment of their child. We are concerned about bringing the parents and the professionals together in a way that they can understand how they can use the clips in order to develop a deeper understanding of their child behavior. All this are in their own pace and with their own language.

From a video clip, the caregivers can receive the impression of their own daily interaction with the child. A range of video clips is used to show what the child does, what the caregivers do and what their potential is. At the beginning of the assessment we can look at some photos that help to describe their problems and challenges with their child. Often it is enough simply to choose a picture that describes what the caregivers find difficult to handle and understand about their child. Through this the caregivers are comforted by the fact that somebody else knows how tough it is to be a parent of a child with PMLD. Nevertheless, images of successful interactions should be used more frequently when working with this group of children, as they give the caregivers the opportunity to be affirmed, to feel enabled and to want to learn more.

After we show the assessment video to the caregivers, we give them time to express what they are thinking and feeling. They share with us in non-academic language what they reacted to in the video, and how it made them feel. They begin wondering about what might be possible to achieve in their child – we begin wondering together. We as professionals edited the video footage and chose the best clips and pictures to present to the caregivers. It is our task to make the child attractive, competent and participative. Children with PMLD are very fragile, and their caregivers often feel fragile, too. They can be very unsure of their parenting skills and abilities. They are faced with so many difficult medical conditions, challenging things to learn, unusual body language to decode. Because of this both the child and the parents need to be *charged* by empowering professionals. Video recording is a helpful method in doing this. In this way, time watching an assessment video becomes a time for reflection that not only empowers the caregivers but that creates opportunities for the caregivers to enrich the child's communicative environment.

The contribution of the professionals primarily consists in holding the different levels of video analysis (steps one to three) separate from each other and then linking the observations and comments together so that specific and focused interventions may be generated.

Parent participation in the child assessment process works to improve parent-child interaction while building a sense of competence, self-efficacy and empowerment in the parents, who often feel that they have lost control of their child to the health or pedagogical care system.

REFERENCES

1. Heimdahl, E., Serrano A. (2017). Video supported assessment as a method of bridging families and caregivers with professionals. Manuscript submitted for publication
2. Horgen, T. (2006). *Det nære språket*. Oslo: Universitetsforlaget.
3. Horgen, T., Slåtta K. and Gjermestad, A. (red.) (2010). *Multifunksjonshemming.* Oslo: Universitetsforlag.
4. Mendez, K., et al. (2011). Cross Cultural Variation in the Neurodevelopmental
5. Assessment of Children – The Cultural and Neurological to 2nd Language Acquisition and Children with Autism'. In Mohammadi, M.R. (Ed.) *A Comprehensive Book on Autism Spectrum Disorders*, InTech. Available from: http://www.zums.ac.ir/files/research/site/medical/Mental%20and%20Behavioural%20Disorders%20and%20Diseases%20of%20the%20Nervous%20System/A_Comprehensive_Book_on_Autism_Spectrum_Disorders.pdf#page=157
6. Stern, D. (2007). *Her og nå: Øyeblikkets betydning I psykoterapi og hverdagsliv.* Oslo:Abstrakt forlag.
7. World Health Organization. (2011). World report on disability 2011 (p.30). Available from: file:///C:/Users/ana/Downloads/9789240685215_eng%20(1).pdf

udc 613.95-056.26/.36-053.2(469)
364.4-056.26/.36-053.2 (469)

Perceptions of Early Intervention Professionals and Parents About the Use of Ages and Stages Questionnaires in Portugal

Rita Laranjeira, Ana Maria Serrano

Institute of Education, Center of Research on Education,
University of Minho, Portugal

Research subject: *Developmental screening instruments must allow identifying children in need of a more specific assessment, those who need no support and those who need to be monitored through periodic monitoring. ASQ is a screening tool that promotes family involvement, in conjunction with health and education professionals, to identify developmental problems in children and, at the same time, create opportunities for the promotion of new skills. In Portugal, this instrument was standardized and adapted for children population and is called ASQ-PT.*

Method: *The study uses a qualitative methodology with the aim of understanding the perceptions on the instrument use of parents and professionals working at the Portuguese Early Intervention Local teams.*

Results: *We intend to carry out a qualitative study in Portugal to understand the perceptions of Early Intervention, Health and Education professionals and parents about the use of the ASQ-PT for screening and collaboration of parents in this process, to sensitize professionals to use the instrument, collaborate with families in the screening, and understand the impact of ASQ-PT filling by parents in the knowledge about their child and collaboration with the professionals.Participants in the study will be professionals from three Early Intervention Local Teams, health and education professionals and parents of children screened with ASQ-PT.*

Conclusion: *We will introduce the ASQ-PT to the professionals and families in the Local Early Intervention Teams in order to understand the perception of its use intending the future adoption of the instrument for screening by our National Early Intervention System, focusing on the advantages and disadvantages of its use and its power to empower parents, actively involving them and giving them new knowledge to promote their children development. We will also present the instrument to health and education professionals, since these professionals have responsibility in the process of early detection/identification of children for the Early Intervention System.*

Key words: *early intervention, development screening, eligibility, family's empowerment*

INTRODUCTION

Child development is a complex and dynamic area and the acquisition of competencies by the child varies according to her age (American Academy of Pediatrics, 2001; Castelo & Fernandes, 2009). A delay in a developmental area becomes apparent at specific ages when is expected that the child acquires a certain competence, so recognizing developmental delays requires a knowledge of skills acquisition age being early detection seen as a challenge.

According to studies conducted in the area, the earlier the Early Intervention (EI) is initiated with the child and her family, more effective it will be and the child is more likely to overcome or reduce the difficulties that result from their risky situation (Shonkoff & Philips, 2000; Bairrão & Almeida, 2003; Brassard & Boehm, 2007). The gains from EI can be significant, as the development of the child is promoted, optimizing her evolutionary potential and with an involvement and empowerment of families to contribute to the acquisition of their children's skills.

For children and their families benefit from EI as early as possible, there should be early identification to prevent developmental difficulties from occurring or to reduce the impact of difficulties that children already have or may present due to biological or environmental conditions.

For this early identification to occur, it is necessary and fundamental to routinely screen children in child health or pediatric care and day care centers and kindergartens. It is crucial that each country has an adequate developmental screening system to an early detection of children with special needs or at risk of developmental problems. In order to achieve a screening system, a local and regional network should be promoted where institutions and professionals collaborate and where all children can be screened.

Developmental screening allows, through the use of briefly tests, to determine if children are developing as expected for their age. This procedure is expected to be carried out quickly and to detect and/or identify children with developmental problems, those who are at risk of developmental delays, requiring a formal evaluation, and those who have an age appropriate development (American Academy of Pediatrics, 2001; Glascoe, 2005; Meisels, 1989). Its importance is related to developmental malleability and to manifestations occuring over time and only detected at specific ages (Glascoe, 2005).

The instruments based on parents' reports present positive results in the economically and culturally diverse populations, being given precise information about the child development (American Academy of Pediatrics, 2001). Parental involvement is essential in the screening process as parents are the major source of information about the child, they are also the child's first educators and those who know their child best. They provide valid and essential information that would otherwise not be known. Studies have corroborated that the information provided by parents is a predictor of developmental delays and can effectively identify these delays (Bricker, Squires & Potter, 1997; Glascoe, 2000; American Academy of Pediatrics, 2001; Bricker et al., 2008).

The use of screening instruments is rare in Portugal and most children is identified through observation of professionals, mostly from health and education areas. This leads us to a potential failure to identify children with developmental problems. It is considered that a screening network for all children is essential to identify as soon as possible developmental problems and for all children have the same opportunity to maximize their potential.

After the referral to EI, at the eligibility moment, the process should be faster so that professionals can respond more effectively to identified needs. In addition, parents, as people who know their children best and play a leading role in their development, must have an active role throughout the process, while at the same time learn about development.

We consider that the Ages & Stages Questionnaires 3rd Edition (ASQ-3) is a screening tool that meets the requirements for early identification by health and education professionals and is aligned with the criteria of the child's eligibility for EI and is expected to be completed by parents and caregivers with the collaboration of professionals to interpret the results obtained.

ASQ-3 has been developed since the late 1970s by Diane Bricker and Jane Squires, as well as their collaborators. It emerged in the United States of America to involve parents and families of children in identification screening and intervention with children with special needs or at risk of developmental delay. This instrument is easy to administrate and easy to understand and is expected to be completed by parents and caregivers with the collaboration of professionals to interpret the results obtained (Squires, Twombly, Bricker & Potter, 2009).

ASQ-3 is composed of 21 questionnaires distributed over well-defined age ranges: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54 and 60 months. The questionnaires screen the areas of communication, gross motor, fine motor, problem solving and personal-social. Each questionnaire has 30 items and also has an overall section for general parental concerns. Its completion takes about 15 minutes and is quickly quoted by professionals who will present the results to parents. The ASQ-3 has already been standardized and adapted for the Portuguese child population and is denominated ASQ-PT (Lopes, Graça, Teixeira, Serrano & Squires, 2015).

METHODOLOGY

The objectives of the research that we intend to carry out are:

- know the perceptions of Local Early Intervention (LEI), Health and Education professionals about the use of ASQ-PT for screening;

- know the perceptions of LEI, Health and Education professionals about the parental collaboration in the screening process;
- know parents' perceptions about the use of ASQ-PT for developmental screening;
- know parents' perceptions of their collaboration in the screening process;
- sensitize EI, health and education professionals to the use of ASQ-PT.

The participants of our study will be professionals who belong to 3 LEI (one in the north zone of Portugal, one in the central zone and one in the Lisbon and Vale of Tejo zone), family physicians, pediatricians, child educators and families. We intend to include professionals who have the function of carrying out primary prevention in early identification of children with developmental delays or who are at risk of developing delays, as well as families whose children will be screened with ASQ-PT.

This study is being developed in a serial of steps:

Request of authorizations:

To be able of using the developmental screening instrument ASQ-PT, we obtained authorization from Brookes Publishing and the authors of the Portuguese version. We have already authorization from the Ethics Committee of the University of Minho and the Regional Subcommittees of the National Early Intervention System (NEIS).

We have also requested authorization from Health Center Groupings, Hospitals Directions, School Institutions and Private Social Solidarity Institution Directions to present the ASQ-PT in health centers, hospitals, day cares and kindergartens from the geographical areas of LEI that will participate in our study.

Authorization will be requested for all professionals and families that will participate in the research, following the ethical procedures of informed consent and guarantee of anonymity of the participants.

2 – Study and screening instrument presentation:

We will meet with each LEI to present the study, the ASQ-PT screening tool and do an initial group interview. With this, we intend to know the LEI's procedure when a referral is received: who contacts the family, if the family can choose the place and time, who meets with the family, who evaluates the child, what evaluation instruments are used, how much time this process takes and what's the involvement of parents in the process, using as reference the ASQ-PT. In this way we will be able to understand the functioning of each LEI and the similarities or differences between LEI during this initial phase.

The study and the ASQ-PT screening tool will also be presented to health and education professionals so they use the instrument as primary prevention with children.

3 – Data collecting:

We will monitor with the professionals how ASQ-PT is being used and the acceptance of families to participate in the study.

To collect data, we will conduct interviews with LEI, health and education professionals and families whose children have been screened with ASQ-PT. For the interview with LEI, health and education professionals, after the use of ASQ-PT, we have the following objectives:

- know the advantages and disadvantages of using ASQ-PT;
- understand the collaboration of families during the use of ASQ-PT;
- understand how ASQ-PT helps professionals to value parental involvement.

We will try to understand how screening has been prepared, including the role of professionals and parents; the parents' involvement on filling the questionnaire; what was the parents' interest and understanding about ASQ-PT.

With the interview with the families, we want to have a perspective of their perception of: how the screening process took place, what were their feelings about the process and what was their involvement during their child's screening and their knowledge and empowerment during the use of ASQ-PT. This interview objectives are:

- know the perception of families about the use of the instrument;
- understand the type of collaboration of families during the child's screening with ASQ-PT;
- understand interest and understanding of families about their child's development.

Stage 4 – Data analysis:

After the interviews, they will be transcribed so that we can do a content analysis of the data obtained that will allow us to reach themes and categories.

We intend to understand if the perception of LEI professionals and the Portuguese parents is similar with the research carried out in other countries where the ASQ instrument is also validated, so the future use of this instrument in Portugal can be an added value in the identification/screening of children with developmental problems. The use of ASQ-PT will facilitate the NEIS' developmental screening, while ensuring greater involvement of parents in this process as well as their empowerment. It will also allow health and education professionals to do an early detection/identification of children with developmental problems. At the same time ASQ-3 was developed thinking of its use within a system for early detection and Portugal with the NEIS has ideal pre-requisites for its use.

REFERENCES

1. American Academy of Pediatrics. (2001). Committee on Children with Disabilities. Policy Statement: Developmental Surveillance and Screening of Infants and Young Children. *Pediatrics*, 108, 192-196.
2. Bairrão, J., & Almeida, I.C. (2003). Questões actuais em intervenção precoce. *Psicologia*, *17*(1), 15-29.
3. Brassard, M.R., & Boehm, A.E. (2007). *Preschool Assessment: Principles and Practices*. New York: Guilford Press.
4. Bricker, D., Squires, J., & Potter, L. (1997). Revision of a parent-completed development screening tool: Ages and Stages Questionnaires. *Journal of Pediatric Psychology*, 22, 313-328.
5. Bricker, D., Allen, D., Clifford, J., Pretti-Frontczak, K., Slentz, K., & Squires, J. (2008). The Relationship Between the Ages & Stages Questionnaires (ASQ) and the Assessment, Evaluation, and Programming System for Infants and Children (AEPS). *Early Intervention Management and Research Group*, White Paper nº1.
6. Castelo, T.M., & Fernandes, B. (2009). Sinais de alarme em desenvolvimento. *Saúde Infantil*, *31*(1), 12-17.
7. Glascoe, F.P. (2000). Evidence-based approach to developmental and behavioral surveillance using parents' concerns. *Child Care Health Development*, *26*(2), 137-49.
8. Glascoe, F.P. (2005). Screening for Developmental and Behavioral Problems. *Mental Retardation and Developmental Disabilities Research Reviews*, 11, 173-179.
9. Lopes, S., Graça P., Teixeira, S., Serrano, A.M., & Squires, J. (2015). Psychometric properties and validation of Portuguese version of Ages & Stages Questionnaires (3rd edition): 9, 18 and 30 Questionnaires. *Early Human Development* 91, 527–533.
10. Meisels, S.J. (1989). Can Developmental Screening Tests Identify Children Who Are Developmentally at Risk? *Pediatrics*, *83*(4), 578-585.
11. Shonkoff, J.P., & Philips, (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
12. Squires, J., Twombly, E., Bricker, D., & Potter, L. (2009). *ASQ-3 User's Guide*. Baltimore, Maryland: Paul H. Brookes Publishing Co.

udc 376.1-056.26/.36-053.2
373.2.022
316.614-056.26/.36-053.2

Responding to Disabilities in Young Children while Teaching Societal Norms and Requirements

Matthew Griffiths
Somerset College of Arts and Technology,
School of Social Sciences, England, UK

Research subject: *Early education begins the process of preparing all children for their adult lives and the whole range of their future roles as adults through the inculcation of social norms. This paper explores: the tensions between the recognition and valuing of difference and disability and the requirements for beginning the teaching of compliance with the social norms; how these tensions are manifested in early education systems; suggestions as to how these tensions can be addressed to achieve the best outcomes for all our children.*

Method: *The research aims to discuss the modern inclusive education theory in early age education that promotes the concepts of differentiated teaching and learning to respond to individual differences.*

Results: *The main results refer to: reasonable exemption from the norms of age appropriate behaviour; How much latitude is helpful for the child with a disability; what can, and should, teachers and other children tolerate, and what not; approaches for children whose behaviour is outside reasonable expectations.*

Conclusion: *In preschool provision, we learn many of the social norms of our society and the social norms for school and behaviour with peers. The adult world will be the same for all our children. There is no 'special' section for most people with a disability or any other difference and so learning and growing up with other children is the best preparation for the future, including the acquisition of a range of social norms.* *So how far, and in what ways, should children with special educational needs, including those caused by a disability or social or emotional difficulties, be required to comply with the behaviour expected of all the other children and frameworks of conformity to social norms?*

Key words: *disability, social norms, expectations*

INTRODUCTION

Early years education begins the process of preparing children for their adult lives through the inculcation of social norms. Ifchildren with a disability are to have a full role in the adult world, they also need to comply with their society's social norms.

A social norm according to McLeod 20081, is the accepted behaviour that an individual is expected to conform to in a particular group, community, or culture. They are the unwritten usually unconscious, rules about how to behave. They vary between community and community, society and society, culture and culture. Social norms are most noticeable when they are not followed. Very young children learn the expected norms within their family and immediate community, but it is when they enter the education service that they begin to learn the wider social norms that they will be expected to observe as they grow up. Norms provide order in society to the extent that is difficult to see how human society could operate without social norms. Human beings need norms to guide and direct their behaviour, to provide order and predictability in social relationships and to make sense of and understanding of each other's actions. Early years teachers are instrumental in teaching these norms, although in many cases they are not aware of this. Children learn the rules of being part of a group, of obeying instructions, following routines and showing respect, as well as a myriad of rues which are specific to their society or culture. The inculcation of young children into the social rules and social norms of society is one of the most important roles of early childhood education.

Most of what I really need
To know about how to live
And what to do and how to be
I learned in kindergarten[2]

AIM OF THE PAPER

The aim of this paper is to explore: the tensions between the recognition and valuing of difference and disability and the requirements for beginning the teaching of compliance with the social norms;how these tensions are manifested in early education systems;suggestions as to how these tensions can be addressed to achieve the best outcomes for all our children.

METHOD

The research aimed to explore how the modern inclusive education theory in early age education that promotes the concepts of differentiated teaching and

---

[1] McLeod S. Social Roles. Simply Psychology. 2008

[2] All I Really Need to Know I Learned in Kindergarten by Robert Fulghum

learning can respond to the difficulties which some children with disabilities experience in learning and adapting to social norms. Interviews were carried out with the teachers of four children whose disabilities mean that they experience such difficulties. Teachers were asked in semi-structured interviews to give their views on reasonable exemption from the norms of age appropriate behaviour; How much latitude is helpful for the child with a disability; what can, and should, teachers and other children tolerate, and what not; approaches for children whose behaviour is outside reasonable expectations.

The children were:

Jake, aged five years, three months. Jake has Down's syndrome, severe epilepsy which is moderately well controlled by medication. He attends mainstream provision, where he is much smaller and very much less able than his classmates. He has a full-time support assistant. He finds it difficult to comply with general classroom instructions and his behaviour is more typical of a 2 –3-year-old. His teacher does not know how much she should make him comply with the social norms of the classroom (with the help of his support assistant) and how much he should just be allowed to behave differently,

Rachel aged six years and five months. Rachel has cerebral palsy, resulting in spastic hemiplegia so that the muscles on the right side of her body are in a constant state of contraction. This means she has an awkward gait and writes with her left hand. Rachel has above average intelligence but at home she is allowed to behave in any way that she chooses, is never corrected and so she often refuses to carry out activities in the classroom, interrupts the teacher and other children and becomes aggressive if she does not win in competitive games.Her teacher does not know how much she should make her comply with the social norms of the classroom and how many allowances she should make because of Rachel's disability.

Edward is six years and one month old. He is hyperactive, runs everywhere, sometimes over furniture and is unwilling to comply with the teacher's instructions to the class. He sometimes destroys other children's work. He has a full-time support assistant.His teacher does not know how much she should make him comply with the social norms of the classroom (with the help of his support assistant) and how much he should be allowed to behave differently.

Bobby is six years, 11 months old. He has been diagnosed with Asperger's syndrome. He is of average intellectual ability. Bobby dislikes any changes in routines; appears to lack empathy; talks incessantly about dinosaurs (about whom he is may be very knowledgeable); stares at other children; and often avoids taking part in classroom activities.His teacher does not know how much she should make him comply with the social norms of the classroom and how much he should be allowed to behave differently.

RESULTS

The teachers interviewed were all uncertain as to how much they should acknowledge that the children are unlike the others in their class and therefore allow them to be different and not teach them to comply with the behaviour required of all the other children. All those interviewed erred on the side of making far more allowances than they would for other children and none had thought about the long-term impact of the behaviour of children with a disability on their later life opportunities.

DISCUSSION

Even when early years' teachers are not explicitly aware that they have a major role in teaching social norms, they have an implicit understanding of this major element of their role and are concerned to ensure that all the children in their charge:

- How many allowances should be made for Rachel's behaviour?
- Should Bobby be stopped from talking about dinosaurs?
- Should Bobby have to take part in activities with other children, even when he resists this?

The two support assistants also had to make decisions about how far they should make Jake and Edward do the things that the other children are required to do:

- Should Jake hang up his coat, even though it is difficult for him and takes longer?
- Should Jake queue up with the other children for lunch and carry his own lunch to the table?
- Should Edward be punished for destroying another child's drawing or can he not help it?

CONCLUSION

Far more thought needs to be give in both pre-service and in-service training for early years teachers to the particular requirements for the teaching of social norms to children with disabilities, as the inclusive model of education becomes more and more accepted, particularly in early years education. Discussions should include: reasonable exemption from the norms of age appropriate behaviour, particularly for children like Jake, for whom some form of exemption from a range of social norms will always be necessary, throughout his life.; how much latitude is helpful for children such as Rachel, Edward and Bobby, who have the possibility of leading normal adult lives, if they are not handicapped by inappropriate behaviour; what can, and should, teachers and other children tolerate, and what not; and what approaches should be taken with for children whose behaviour is outside reasonable expectations, so that they can learn to comply with the social norms that will enable them to live happier and more successful lives.

REFERENCES

1. Robert Fulghum. All I Really Need to Know I Learned in Kindergarten
2. McLeod, S. (2008). Social Roles. Simply Psychology.

udc 81'234-056.26/.36-053.2
616.22-008.5-056.26/.36-053.2
373.2-056.264-053.2

Identifikacija govorno-jezičkog poremećaja kao simptoma psihomotorne zaostalosti – preduslov za rane intervencije u vrtićima

Mirjana Nikolić, Gordana Mijailović
Visoka škola strukovnih studija za vaspitače i poslovne informatičare – Sirmium, Sremska Mitrovica, Srbija
Veronika Katrina-Mitrović
Opšta bolnica, odeljenje psihijatrije, Loznica, Srbija

Rana identifikacija dece sa odloženim usvajanjem govora, uz procenu etiologije poremećaja i njegovog odnosa sa relevantnim aspektima razvoja: kognitivnim, motornim i socio-emocionalnim je od izuzetnog značaja za rane intervencije. Iako je poremećaj receptivnih i ekspresivnih jezičkih veština često jedini simptom koji roditelji i vaspitači prepoznaju u periodu ranog razvoja, mnoga deca sa kašnjenjem u jezičkom razvoju imaju istovremeno kašnjenje i u drugim aspektima razvoja, što se, sve zajedno prenosi na bihejvioralni plan. U radu se prikazuje studija slučaja deteta kod koga je prilikom upisa u vrtić, na uzrastu od tri godine identifikovano kašnjenje u govorno-jezičkom razvoju. Cilj rada je dvostruk: 1) da se prikažu tehnike prikupljanja podataka u procesu identifikacije poremećaja; 2) da se prikaže sistemski pristup u identifikaciji poremećaja i ranoj intervenciji. Primenom polustrukturisanog intervjua i upitnika sa majkom, opservacije deteta od strane psihologa i defektologa, uz sistematsko posmatranje u vaspitnoj grupi koje je vršio vaspitač, utvrđeno je sledeće: prisutne su teškoće u razumevanju, verbalizaciji i komunikaciji, ograničen je kapacitet pažnje, kontrole impulsa, samokontrole i modulacije emocija, postoje poteškoće u praćenju i pridržavanju pravilima, kao i značajan motorni i kognitivni deficit. Govorno-jezički poremećaj predstavlja, dakle, samo jedan od simptoma usporenog psihomotornog razvoja, te je intervencija u predškolskoj ustanovi zahtevala dodatnu podršku u svim relevantnim aspektima razvoja, uz angažovanje nadležnih stručnjaka i saradnju sa majkom. Holistički pristup razvoju deteta i sistemski prustup u procesu identifikacije govorno-jezičkog poremećaja i rane intervencije predstavljaju značajan preduslov napredovanja deteta.

Ključe reči: *govorno-jezički poremećaj, usporen psihomotorni razvoj, rana intervencija, timski pristup*

UVOD

Govorno-jezičke poteškoće u artikulaciji, fluentnosti i glasu, kao i upotrebi znakova i funkciji jezika, česte su u detinjstvu i pogađaju između 5% i 8% dece predškolskog uzrasta (Prelock, Hutchins, Glascoe, 2008). Mnoga deca sa kašnjenjem u jezičkom razvoju imaju istovremeno kašnjenje u drugim aspektima razvoja (Markowitz, 2006, prema Prelock, Hutchins, Glascoe, 2008).

Studije koje se bave poremećajima u razvoju govora pretpostavljaju da su *kognitivni i jezički procesi* povezani (Daal, Verhoeven & Balkom, 2009). Deca sa kašnjenjem u razvoju jezika postižu niže skorove na merama kognitivnog razvoja u poređenju sa ostalom decom, na klasifikaciji i prepoznavanju sličnosti (Dumtschin, 1988, prema Carson et al., 1998; Johnston, 1994, prema Carson et al., 1998). Kasnije usvajanje govora dobar je prediktor i bihejvioralnih i socijalnih poremećaja (Carson, Klee, Perry, Muskina & Donaghy, 1998). Deca koja ne umeju na adekvatan način da verbalizuju misli, mogu osetiti nemir, frustriranost ili odbačenost (Baker & Cantwell, 1982, prema Carson et al., 1998). Ali, i bihejvioralne poteškoće mogu pogoršati jezički status (Rutter & Lord, 1987, prema Carson et al., 1998). Takođe, moguće je da socio-afektivno kašnjenje vodi ili je povezano sa kašnjenjem u razvoju jezika, ili da činioci kognitivnog procesuiranja doprinose kašnjenju u oba domena (Voinea & Damian, 2014). Deficiti pažnje su često prisutni kod osoba sa jezičkim oštećenjima. Više dosadašnjih istraživanja pokazalo je da je ovladavanje motornim veštinama povezano sa uzrastom i sazrevanjem (Iverson, 2010). Procesuiranje govornog jezika može uticati na razvoj veština fine motorike (Horn, Pisoni & Miyamoto, 2006, prema Petersen et al., 2013), a ovladavanje hodanjem povezano je sa značajnim povećanjem receptivnog i ekspresivnog jezika (Walle & Campos, 2014). Govorna i jezička oštećenja mogu perzistirati izolovano, ali se pojavljuju i u sklopu razvojnih poremećaja: ADHD (hiperkinetičkog poremećaja), pervazivnog razvojnog poremećaja, ili mentalne zaostalosti.

Često se prvi znaci odstupanja u govorno-jezičkom statusu identifikuju polaskom deteta u vrtić. Vaspitači su, pored roditelja, prve osobe koje mogu da prepoznaju ove poteškoće, ali ih najčešće vide jedine i izolovane od drugih aspekata razvoja, u kojima takođe može postojati odstupanje. Zato je važno da se identifikaciji poteškoća, a zatim i ranoj intervenciji pristupi sistemski, po teoriji Bronfenbrenera (Bronfenbrener, 1997). Cilj ovog rada je da se kroz prikaz studije slučaja deteta sa govorno-jezičkim poteškoćama koje dominiraju polaskom u vrtić prikažu: 1) tehnike prikupljanja podataka u procesu identifikacije poremećaja; 2) sistemski pristup u identifikaciji poremećaja i ranoj intervenciji.

Studija slučaja deteta ranog uzrasta

Dečak A.M. upisuje se u vrtić na uzrastu od tri godine. Majka saopštava da dečak zaostaje u govorno-jezičkom razvoju, što opservira i vaspitač prilikom prvog kontakta sa detetom. U nastupajućem periodu vaspitač prikuplja podatke o prethodnom razvoju deteta i snima aktuelno stanje i funkcionisanje deteta u grupi, sarađuje sa majkom i uspostavlja saradnju sa drugim stručnjacima unutar ustanove i na lokalnom nivou, u cilju identifikacije govorno-jezičkog poremećaja.

Načini prikupljanja podataka

Upitnik i polustrukturisani intervju sa majkom: prikupljeni su demografski i podaci o pre/postnatalnom periodu, trudnoći, porođaju, prethodnom razvoju deteta i aktuelnom funkcionisanju.

Sistematsko posmatranje: vršio je vaspitač, koristeći namenski konstruisane ček liste i skale procene za više aspekata razvoja: fizički, socio-emocionalni, kognitivni i razvoj govora i jezika. Vaspitač je koristio i protokole posmatranja vremenskih uzoraka sa ciljem da opservira određena ponašanja deteta.

Fenomenološko posmatranje: o relevatnim aspektima razvoja deteta vaspitač je vodio narativne zabeleške.

Defektološka procena: defektolog-oligofrenolog u vrtiću izvršio je opservaciju deteta i preporučio da se konsultativno izvrši i psihološka procena razvojnog statusa deteta.

Psihološka procena: izvršio je klinički psiholog Zdravstvenog centra, opservacijom deteta i intervjuom sa majkom. Korišćena je Vinelandova skala adaptivnog ponašanja koja obuhvata sledeće domene: komunikaciju, veštine svakodnevnog funkcionisanja, socijalizaciju, motorne veštine, i maladaptivna ponašanja (Sparrow & Cicchetti, 1985).

Rani razvoj deteta (do tri godine)

Na osnovu prikupljenih podataka vaspitač je u portfolio pribeležio izveštaj o prethodnom razvoju deteta i aktuelnom statusu prilikom upisa u vrtić*; na uzrastu od 18 meseci dečak ne govori, ne gestikulira, ne reaguje na govor odraslih; hoda uz podršku odraslog, ima burne emocionalne reakcije na nepoznate osobe i situacije; nije regulisao higijenske navike. Do uzrasta od 36 meseci najizraženije je kašnjenje u razvoju govora – dečak nije progovio, niti razvio razumevanje osnovnih reči. Kognitivne sposobnosti su tek u začetku, sposobnost klasifikacije i kvantifikacije nije na očekivanom nivou. Pažnja je slaba, prisutne su poteškoće u razumevanju i prihvatanju socijalnih pravila i otežana regulacija emocija. Prisutne su teškoće u oblasti grube i fine motorike.* Zaključak: govorno-jezički poremećaj predstavlja samo jedan od simptoma usporenog psihomotornog razvoja deteta, potrebno ga je posmatrati holistički, u sklopu svih aspekata razvoja deteta, i na osnovu toga planirati ranu intervenciju.

Plan rane intervencije

Tim za dodatnu podršku u predškolskoj ustanovi utvrdio je da vaspitač treba da primeni mere individualizacije vaspitno obrazovnog rada, a defektolog u vrtiću da sprovodi tretman reedukacije psihomotorike, individualno. Predložen je i logopedski tretman u cilju stimulacije govorno-jezičkog razvoja, i tretman kliničkog psihologa sa detetom, uz suportativni tretman sa majkom. Pedagoški profil i plan individualizacije vaspitno-obrazovnog rada izradio je vaspitač uz podršku pedagoga i defektologa. Definisani su i koraci u saradnji između vaspitača, pedagoga i defektologa u predškolskoj ustanovi i stručnjaka iz Zdravstvenog centra (logopeda i kliničkog psihologa), u cilju praćenja napredovanja deteta i evaluacije tretmana.

Praćenje napredovanja deteta: efekti rane intervencije

Praćenje napredovanja deteta vršeno je u periodu kada je dete imalo 3,6 godina i 4 godine. Vaspitač je na osnovu opservacija u grupi i izveštaja stručnjaka priložio u portfolio sledeći izveštaj:

Fizički razvoj: *3g7m – samoinicijativno se uključuje u motoričke aktivnosti, ali kretni zadatak izvodi samo uz individualizovan pristup; 3g9m uspeva samostalno da izvede kretni zadatak; 3g11m prepoznaje i imenuje delove tela, a ne razume njihovu funkciju; 4g1m primetne su i dalje poteškoće u oblasti grube i fine motorike, poteškoće u koordinaciji, tokom hodanja i kontroli pokreta olovkom.*

Socio-emocionalni razvoj: *3g6m počeo rado da ulazi u kolektiv i učestvuje u većini aktivnosti, verbalno komunicira sa vršnjacima i vaspitačem; 3g7m emotivno se vezao za jednu devojčicu, često sedi ili stoji pored nje, grli je; 3g9m počeo da ispoljava agresivne oblike ponašanja prema vršnjacima (gura ih, šutira, udara); emotivno nesiguran, verbalnom negacijom reaguje na instrukcije i uputstva vaspitača.*

Kognitivni razvoj: *3g7m ume da sastavi crtež od dva i tri dela i da prepozna koji od dva predmeta je veći, a koji manji; 3g9m uz podršku klasifikuje predmete na osnovu samo jedne osobine (boja, oblik, veličina); 3g11m prepoznaje i imenuje osnovna prevozna sredstva, biljke i životinje; 4g1m dugotrajnost i kvalitet pažnje i dalje zaostaju u odnosu na uzrast, kao i fond znanja*;

Razvoj komunikacija i stvaralaštva*: 3g6m – izgovora jednostavne dvosložne reči; rečenični izraz je i dalje jednoličan; počinje da shvata i razume jednostavne instrukcije i uputstva vaspitača; na podsticaj vaspitača uspeva da otpeva neke jednostavnije delove teksta pesama; 3g11m počeo da usvaja tekstove pesama i brojalica i da ih samostalno interpretira; rečenični izraz bogatiji (do 3 člana); 4g – uspeva pravilno da izgovori trosložne reči; 4g2m – shvata složenija uputstva vaspitača i reaguje na njih.*

ZAVRŠNA RAZMATRANJA

Holistički pristup razvoju deteta ilustrovan u radu predstavlja dobar način identifikacije govorno-jezičkog poremećaja koji je, kao što je utvrđeno, predstavljao samo jedan od simptoma usporenog psihomotornog razvoja. Primena tehnika i instrumenata sistematskog posmatranja doprineli su temeljenoj opservaciji koju je vršio vaspitač za sve aspekte razvoja u periodu identifikacije poremećaja, planiranja intervencije i utvrđivanja efekata, pa je značajno da vaspitači, kao neposredni organizatori vaspitno-obrazovnog rada razviju kompetencije za izradu i primenu ovih tehnika u radu sa decom koja imaju poteškoće u razvoju (kao i sa drugom decom). Angažovanje svih relevantnih stručnjaka unutar predškolske ustanove i lokalne zajednice, takođe je povoljno uticalo na tretman. Od posebnog značaja je i motivisanost vaspitača i roditelja roditelja da, kao članovi tima, *in vivo* sprovode svakodnevne intervencije i sugestije stručnjaka i prate razvoj i napredovanje deteta. Proces identifikacije poremećaja i rane intervencije može se analizirati i u kontekstu sistemske teorije (Bronfenbrenner, 1997). U središtu su dete i majka, najbliža porodica (mikrosistem). Vaspitač, defektolog, pedagog, logoped i klinički psiholog deluju u okviru mezosistema i ostvaruju komunikaciju sa mikrosistemom, čiji ishodi direktno utiču na dete (i kroz podršku i asistenciju porodici). Podrška na nivou egzosistema i makrosistema (društvena podrška) nije opservirana u ovoj studiji, ali je jasno da predstavljaju jedan od značajnih preduslova ostvarivanja sistemskog pristupa, uz prethodno umrežavanje svih aktera (sistema), pa je preporuka da se ovakav model primeni u identifikaciji i tretmanu i drugih razvojnih poteškoća u istom ili sličnom kontekstu. Iako je rana intervencija, uz proces sazrevanja deteta, dala određene rezultate (poboljšanje govorno-jezičkog statusa i socijalnih veština), potrebno je dalje praćenje razvoja i ponašanja deteta i nastavak timske intervencije.

LITERATURA

1. Bronfenbrener, J. (1997). Ekologija ljudskog razvoja – prirodni i dizajnirani eksperimenti. Beograd: Zavod za udžbenike i nastavna sredstva.
2. Carson, D.K., Klee, T., Perry, C.K., Muskina, G. i Donaghy, T. (1998). Comparisons of children with delayed and normal language at 24 months of age on measures of behavioral difficulties, social and cognitive development. *Infant Mental Health Journal, 19*(1), 59-75.
3. Daal, J., Verhoeven, L., i Balkom, H. (2009). Cognitive predictors of language development in children with specific language impairment (SLI). *International Journal of Language i Communication Disorders, 44*(5), 639–655.
4. Iverson, J. M. (2010). Developing language in a developing body: The relationship between motor development and language development. *Journal of Child Language, 37,* 229-261.

5. Petersen, I. T., Bates, J. E., D'Onofrio, B. M., Coyne C. A., Lansford, J. E., Dodge, K. A., Pettit, G. S., Van Hulle, C. A. (2013). Language ability predicts the development of behavior problems in children, *Journal of Abnormal Psychology, 122*(2), 542–557.
6. Prelock, P. A., Hutchins, T., i Glascoe, F. P. (2008). Speech-language impairment: How to identify the most common and least diagnosed disability of childhood. Pristupljeno 12.04.2017. na http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2491683/#R1.
7. Sarrow, S., Chicchetti, D. (1985). Diagnostic Uses of the Vineland Adaptive Behavior Scales, *Journal Pediatric Psychologist*, *10*(2), 215-225.
8. Voinea, M., Damian, M. (2014). The role of socio-emotional development in early childhood. *Journal Plus Education,* pp. 388-392.
9. Walle, E. A. i Campos, J. J. (2014). Infant language development is related to the acquisition of walking. *Developmental Psychology, 50*(2), 336–348.

IDENTIFICATION OF SPEECH-LANGUAGE DISORDER AS SYMPTOM OF PSYCHOMOTOR RETARDATION: PRECONDITION FOR EARLY KINDERGARTEN INTERVENTION

Mirjana Nikolić*, Gordana Mijailović*, Veronika Katrina-Mitrović**
*Preschool Teacher Training and Business Informatics College of Applied Studies, Sirmium, Sremska Mitrovica, Serbia
**General Hospital, Department of Psychiatry, Loznica, Serbia

Research subject: Early identification of children with speech impairment, with the estimation of the etiology of the disorder and its relationship to other relevant aspects of development: cognitive, motor and socio-emotional, is of utmost importance within early intervention. Although the disorder of receptive and expressive language skills is often the only symptom that parents and preschool teachers recognize in the early stages of development, many children with delays in language development have simultaneous delays in other aspects of development, which is transferred into a behavioral plan. However, the relationships between different aspects of development and speech development are very complex, and their measurement and observation are extremely demanding.

Method: This paper presents a case study of a child whose delay in speech-language development was identified when the child enrolled the kindergarten. The aim of the paper is twofold: 1) to present data collection techniques in the process of identifying the disorder; 2) to present a team approach in early intervention.

Results: By applying a semi-structured interview and a questionnaire with a mother, the observation of a child by a psychologist, a physician and a special educator with the systematic observation in a teaching group conducted by the preschool teacher, the following facts were stated: difficulties in understanding, verbalization and communication, limited attention capacity, impulse control, self-control and emotional modulation. There were difficulties in following and adhering to the rules, as well as a significant motor and cognitive deficit. Speech-language disorder is therefore only one of the symptoms of delayed psychomotor development, and intervention in the preschool institution required additional support in all relevant aspects of development, with the involvement of competent experts and co-operation with the mother.

Conclusion: Holistic approach to child development in the process of identifying speech-language disorder is a significant precondition for adequate early intervention.

Key words: speech-language disorder, delayed psychomotor development, early intervention, team approach

udc 373.2-056.262-053.2(497.11)
378.382:159.9-056.262(497.11)
159.922.7-056.262-053.2(497.11)

Procena stepena razvoja igre i podsticanje igre kod male dece oštećenog vida

Zorica Vladisavljević
Škola za učenike oštećenog vida „Veljko Ramadanović” Zemun, Srbija

Predmet istraživanja: *Tokom petogodišnje implementacije projekta „Prvi koraci” u saradnji sa VISIO, tiflolozi iz Škole za učenike oštećenog vida „Veljko Ramadanović” obučeni su za rad sa decom oštećenog vida od rođenja do šeste godine. Primenom savremenih metoda stručnjaci vrše neophodne procene potreba za podrškom dece i roditelja, kao i evaluaciju tretmana.*

Metod: *Cilj rada je da predstavi primere procene nivoa igre kod slepe i slabovide dece predškolskog uzrasta primenom instrumenta PDS – Bl Skala.*

Rezultati: *Korišćenjem interaktivne video analize razvoj igre se procenjuje kroz četiri nivoa i nekoliko podnivoa. Skala izdvaja dve uzastopne faze tokom igre.*

Zaključak: *Na osnovu procene zaključuje se da je moguće podstaći razvoj dečje igre, uz potrebna prilagođavanja. Podražavanje aktivnosti igre treba da bude povezano sa svim aspektima igara.*

Ključne reči: *VI / MDVI deca ranih godina, Skala za procenu razvoja igre, VIG, tiflolozi u ranoj intervenciji, podražavanje igre*

Tokom petogodišnjeg projekta “The First Steps”, u saradnji sa holandskom organizacijom Royal Dutch VISIO, tiflolozi naše škole obučavani su za rad sa VO/VOVO decom od rođenja do navršene šeste godine. Obučeni smo da primenjujemo savremene metode i postupke, kako u procenama potrebe za podrškom, tretmanima deteta i porodice, tako i u evaluaciji svih naših procedura. Ovo je značajno unapredilo naše profesionalne kompetencije, podižući i kvalitet rada u tiflološkoj ranoj intervenciji.

Jedan od instrumenta procene (koji su svi učesnici projekta visoko rangirali, posebno po primenljivosti u praksi) je **Skala za procenu nivoa razvoja igre kod slepe i slabovide dece** (*Play Development Scale for Blind and visually impaired children (P.D.S.-Bl.),* Van den Broek, Moleman & Hellendoorn, 2010). Skala P.D.S.-Bl. je na holandskom jeziku objavljena 2005. godine, a na engleskom 2010. Radi se o unapređenoj Helendornovoj skali koja je bila namenjena deci i odraslima sa poremećajem u razvoju. Autorke, Jolanda Moleman i Elen van den Brok (klinički psiholozi i psihoterapeuti za decu i adolescente sa dugogodišnjim iskustvom proučavanja razvoja igre dece sa vizuelnim oštećenjem) su u saradnji sa Helendornom adaptirale originalnu verziju u P.D.S.-Bl., koju smo mi, tiflolozi u ranoj intervenciji, preveli i koristimo je u praksi. Adaptirana verzija sadrži i originalne delove Helendornove skale (tekst je pisan crnim slovima) i može se primeniti i na videću decu i na decu sa oštećenjem vida (tekst pisan plavim slovima), kao i višestruko ometenu decu. Lako je upoređivati dostignute nivoe razvoja i izvoditi potrebne zaključke.

Zašto je Skala P.D.S.-Bl toliko pozitivno ocenjena od strane tiflologa koji rade u ranoj intervenciji, kao i od ostalih tiflologa praktičara u našoj školi?

Svi mi, koji se bavimo razvojem, vaspitanjem i obrazovanjem dece, poznajemo, u određenoj meri, brojne teorije vezane za dečju igru. Igra jeste kompleksan fenomen.

Teorije definišu objašnjavaju, analiziraju, kategorizuju dečju igru, ukazuju na njen značaj za razvoj deteta u celini, ili po razvojnim područjima. Neminovno u nekom trenutku postaju jednostrane, uglavnom ističući onaj aspekt igre kojim se bave. Tako čitamo o uticaju igre na učenje, na socijalni razvoj, na fizički, moralni itd.

Jedna od teorija je Grosova „teorija treninga”, tj samovaspitanja koja se bavi značajem igre za psihički razvoj, ne tumačeći njenu prirodu (Spasojević, 2010).

Vigotski (1996) naglašava da igra predstavlja zonu narednog razvitka deteta.

»Igra predstavlja školu morala, ali ne morala u predstavi, već morala u akciji.« (Eljkonjin, 1990).

Za Frojda je igra terapeutsko sredstvo protiv razvijanja neuroza; dete ponavljanjem proživljava traumatske događaje, kojima detinjstvo obiluje (Spasojević, 2010).

Pijaže igru i njen uticaj na psihički razvoj posmatra izolovano, kao proces u kome se, sa jedne strane, u igri odražava struktura mišljenja, a sa druge, kroz igru se mišljenje formira (Pijaže, Inhelder, 1990).

Kamenov ističe značaj intelektualnog vaspitanja kroz igru (Kamenov, 1997).

Ima i teoretičara koji su osporavali značaj igre u obrazovnom smislu, kao Vinsle, Leša, Kroj, smatrajući da je igra besciljna aktivnost (Kamenov, 1989).

Teoretičari su u okviru svojih teorija definisali igru. Definicije igre takođe ističu pojedine aspekte, ima ih i kompleksnih i teško je izabrati pravu.

Dobro je poznavati različite teorije igre i njihove definicije, ali ostaje pitanje kako to znanje pretočiti u praksu? Kako u svakodnevnom radu proceniti na kom razvojnom nivou je igra VO/VOVO deteta, zbog čega je tako, kako realno unaprediti igru, kako obezbediti njen razvoj prema mogućnostima deteta?

Skala P.D.S.-Bl je instrument kojim to možemo da sprovedemo sa svakim detetom koje nam dolazi na ranu intervenciju. Primenili smo je i na VOVO deci, u razrednoj nastavi, u našoj školi i zadovoljni smo rezultatima. Svaki praktičar koji je prošao obuku u okviru projekta “The First Steps” reći će vam da prvi put ima koristan, logičan, praktičan, savremen instrument za procenu dečje igre, praćen jasnim i preciznim uputstvima, sa mnoštvom karakterističnih primera iz prakse. Rezultati procene nedvosmisleno upućuju na moguće načine delovanja. Prateći obrasci su jasni, racionalni, pokrivaju sve aspekte planiranja i fascilitacije.

Pored uvodnog dela, sa bližim uputstvima, P.D.S.-Bl opisuje nivoe razvoja igre –manipulativna igra, relaciona, funkcionalna, simbolička igra.

Posebno se procenjuje senzopatička igra. Senzopatička igra se sastoji od igrovnih aktivnosti koje uključuju dodir ali na mnogo dubljem nivou osetljivosti. Ova vrsta igre se ne odnosi na oblikovanje i pravljenje nečega, već samo na senzornu osetljivost i eksperimentisanje sa materijalima. Senzorni kvaliteti materijala bude kod deteta posebnu pažnju ili zadovoljstvo, što prevazilazi prosto taktilno eksperimentisanje.

Pogledajmo prvi i drugi nivo igre onako kako izgledaju u skali P.D.S.-Bl:

Manipulativna igra

Dete stvara kontakt sa igrovnim materijalom bez odnošenja prema tom predmetu kao takvom ili pridavanja simboličkog značenja tom predmetu. Aktivnost se ne odnosi na funkcionalne mogućnosti predmeta. *(dete manipuliše igračkom na primer ”automobilom”bez obraćanja pažnje na njegovu funkciju i simbolički značaj).*

M-O Posmatranje, kretanje prema predmetu

Ovo je privremeni kontakt sa distance. Predmet sada počinje da ima svoju postojanost za dete. Dete pravi pokret direktno prema predmetu, ali ga ne dodiruje.

Slepo dete sluša, ili okreće svoje uho ili lice prema originalnom zvuku predmeta. Ponekad se ono pri tom potpuno umiri. Slepo dete neće napraviti nikakav pokret ili zvuk, da bi slušalo što pažljivije.

M-1 Jednostavan fizički kontakt

Ovo je opšti ili jednostavan kontakt sa jednim objektom, bez ikakve akcije.

Na primer:
- dodirivanje igračke psa
- dohvatanje lutke

Slepo dete često koristi svoje ruke, stopala, usta, glavu ili celo telo.

Na primer:

- *dodirivanje zvučne igračke sa ustima ili stopalima*
- *prevrtanje preko kockica koristeći celo telo*

M-2 Kratka aktivnost sa jednim predmetom

Dete manipuliše sa jednim predmetom što ima za posledicu više diferenciranu i obimniju akciju sa njim. Postoji više od jedne aktivnosti sa predmetom (kao što je to bilo u slučaju M-1).

Na primer:

- okretanje, trešenje, bacanje ili ujedanje malih kocaka, mekih igračaka ili flašice.

Slepo dete koristi delove svog tela da bi učinilo nešto sa igračkom i cilju taktilnog istraživanja. Dete se angažuje na kratko sa predmetom koji slučajno proizvodi zvuk.

Na primer:

- *guranje, okretanje, bacanje, trešenje*
- *taktilno istraživanje predmeta rukama, ustima, jezikom, stopalima, ili celim telom da bi osetilo, trljalo, udaralo, tapkalo, guralo ili dodirivalo*
- *bacanje predmeta i osluškivanje zvuka koji on proizvodi pri padu (bacanje zvučne igračke i osluškivanje udarca od pada na pod)*

M-3 Istraživanje predmeta tako što se opažaju uzastopno njegovi delovi (istraživanje deo-celina)

Ovde dete istražuje sastavne delove predmeta jedan za drugim. Ovo je stvaranje osnove budućeg istraživanja predmeta.

Primeri:

- dodirivanje kose, stopala, očiju lutke uzastopno
- dodirivanje točkova a nakon toga krova autića

Slepo dete će ponekad istraživati predmet tako što će ga dovoditi u kontakt sa različitim delovima tela da bi pronašlo sastavne delove tog predmeta.

Primeri:

- *Dete će pomerati zadnjicu preko površine stolice, opipavajući naslone za ruke svojim šakama, naslon stolice leđima, i noge stolice svojim stopalima.*
- *Dete postavlja noge lutke između svojih stopala a za to vreme dodiruje kosu lutke šakama i dodiruje lice lutke jezikom.*

M-4 Akcija koja vodi ka pokretu

Dete manipuliše delovim predmeta što dovodi do pokreta.

Primeri:

- dodirivanje točkova igračke automobila
- otvaranje poklopca kutije
- pomeranje lutkinih nogu

Ova vrsta pokreta uključuje različite delove tela. Otvaranje i zatvaranje kutija ili ormara/vrata je omiljena aktivnost slepe dece. Slepo dete ne samo da uživa u pokretima tog predmeta već takođe ima nameru da pri tom proizvede zvuk.

Primeri:

- *otvaranje i zatvaranje kutija*

- *povlačenje žice da bi zvonce zvonilo*
- *udaranje predmeta i nakon toga dodirivanje predmeta da bi osetilo rezonancu*
- *otvaranje i zatvaranje vrata*

M-5 Držanje dva predmeta istovremeno

Dete drži po jedan predmet u svakoj ruci ali pri tom ne čini pokret da se ta dva predmeta dodiruju, niti čini bilo šta sa njima.

Primer:

- držanje igračke automobila u jednoj ruci a male kutije u drugoj

Slepo dete često koristi stopala kao što koristi ruke.

Primer:

- *držanje igračke automobila u jednoj ruci dok sa oba stopala drži zvonce*

M-6 Namerno dovođenje dva predmeta u kontakt jedan sa drugim

Predmeti koje dete drži se dodiruju. Ovaj kontakt je skučajan, prouzrokovan tako što dete svoje ruke drži zajedno, ili dodaje drugi predmet drugom rukom, dok jedan već ima u jednoj ruci.

Primeri:

- držanje po jednog predmeta u svakoj ruci i lupkanje njima jedno o drugo
- drži autić u jednoj ruci, a nakon toga uzima saobraćajni znak drugom rukom
- držanje kocke i dodirivanje predmeta koji leži na podu tom kockom

Slepo dete koristi obe ruke i stopala.

Primer:

- *dodirivanje predmeta koje drži među stopalima sa predmetom u ruci*

Relaciona igra (sa predmetima ili zvukovima)

Stvara se odnos između dva ili više objekata koji nije potpuno slučajan. Odnos je pre svega uzrokovan fizičkom blizinom, mada izvesne osobine matrijala igraju ulogu u tome. Predmeti se ne koriste prema svojoj nameni; može biti korišćen bilo koji predmet.

Slepo dete se igra sa zvukovima i glasovima bez da dovodi u dodir bilo koji predmet sa tim. Glasovi i zvukovi su u međusobnom odnosu prema svom kvalitetu i visini. Jedan zvuk sledi drugi proizvodeći eho sa strane deteta ili osobe koja učestvuje u igri.

Linija razdvajanja: Igra se sastoji od zvukova koji imaju funkcionalni odnos prema predmetu, i koji jasno pripadaju sledećem funkcionalnom stadijumu.

C-0 Uzimanje predmeta iz drugog predmeta

Uzimanje jednog predmeta iz drugog

Primer:

- *Uzimanje predmeta iz ormana*

C-1 Uticaj jednog predmeta na drugi

Dete izvodi aktivnost sa predmetom na taj način što utiče na drugi predmet. Kontakt između predmeta više nije potpuno slučajan (kao u M-6).

Primeri:

- stavljanje jednog predmeta u drugi (stavljanje autića u kofu)
- postavljanje dva predmeta jednog pored drugog tako da se dodiruju
- tapkanje jednog predmeta drugim
- slaganje različitih materijala jedno na drugo (bez namere da se nešto sagradi)
- slaganje kocaka od drveta koristeći češalj

Udar predmeta o predmet često proizvodi zvuk. Slepo dete često pokušava da proizvodi zvučne efekte za vreme igre odnosa.

Primeri:

- *proizvođenje zvučnog efekta pomeranjem jednog predmeta predmeta preko površine drugog (dete pomera drvenu kocku preko radijatora)*
- *namerno postavljanje predmeta iznad, ispod ili pored nečega*

C-2 Razvrstavanje

Dve ili više igračaka je postavljeno zajedno prema njihovim karakteristikama za opažanje kao što su tip, oblik, boja i veličina.

Primeri:

- postavljanje delova konstruktivnog materijala na gomilu
- postavljanje tri crvena predmeta zajedno
- postavljanje tri okrugla predmeta zajedno: lopta, disk, točak
- grupisanje lutaka zajedno
- postavljanje bočica u niz

Slepo dete razvrstava predmete koji imaju slične taktilne i auditivne kvalitete. Ono aktivno istražuje osobine dva predmeta i upoređuje ih prema obliku, mirisu, zvuku, strukturi, težini i veličini. Dete je zadovoljno zato što je sposobno da razlikuje suptilne nijanse i koristi različite kvalitete predmeta dok se igra.

Primeri:

- *sortiranje „Duplo” građevinskog materijala – kocaka, prema broju opipljivih čvorova*
- *postavljanje kocaka zajedno, tako da proizvode isti zvuk*
- *tapkanje po različitim igračkama, upoređujući zvukove koji se proizvode*
- *upoređivanje igračaka po mirisu*
- *upoređivanje igračaka po teksturi*

C-3 Konfiguracija

Dva ili više predmeta se koriste da bi se stvorila spacijalna konfiguracija. Postoji sigurna kohezija (slaganje) u zapaženim svojstvima predmeta.

Primeri:

- umetanje oblika koji ne ogovaraju, u otvore na tabli („pogrešan" oblik)
- slaganje kocaka bez namere da se nešto konkretno napravi

Slepe dete teško da može da napravi prostornu konfiguraciju od objekata. Pre možemo govoriti o konfiguraciji u vremenu a ne u prostoru.

Primeri:

- *tapkanje u ritmu*
- *ponavljanje besmislenih reči*
- *ponavljanje vokala*

C-4 Niz akcionih sekvenci

Dete koristi iste igračke u sekvencama, kod izvesnog broja aktivnosti koje su u međusobnom odnosu, pri čemu sama igra nema konkretno značenje.

Primeri:

- stavljanje kockica u šolju za čaj, a nakon toga se isprazni šolja
- stavljanje pazli u kolica, a nakon toga izbacivanje iz njih
- stavljanje štapića u kutiju, a nakon toga se prevrne kutija

Slepa deca se ponekad igraju jedno sa drugim proizvodeći zvukove. Oni će započeti svoj dijalog frazama bez značenja, rečima ili zvukovima, zato što im se sviđa način na koji proizvode zvuk. Ovo je privremena sekvenca. Zvuk je rezultat njihovog zajedničkog delovanja, a prozvođenje tih zvukova je igra sama po sebi. To nema nikakve veze sa manipulisanjem objektima.

Akcione sekvence su u nizu, uključuju korišćenje više čula.

Primeri:

- proizvođenje reči glasovima koji se kotrljaju ili poskakuju
- tapkanje štapom po malim kockama a zatim slaganje kocaka
- mirisanje lutaka a zatim se one stavljaju u korpu

Slično su predstavljeni i ostali nivoi, naravno, opširnije, zbog složenosti. Senzopatička igra procenjuje se kroz dva podnivoa Spa 1 (sa čvrstim materijalima) i Spa 2 (sa nestrukturisanim materijalima).

U praksi sa malom VO/VOVO decom najčešće se susrećemo sa ova dva nivoa razvijenosti igre. To se posebno odnosi na slepu i teže višestruko ometenu decu, dok kod smo kod slabovidih viđali i funkcionalnu i simboličku igru. Kod školske dece, slepe i višestruko ometene, koju smo procenjivali, rezultati su isti.

Čak i kada slepo dete dostigne funkcionalni ili simbolički nivo, manipulativna igra je zastupljena,dok se kod videće dece tada već gubi. Slepa deca skoro uvek učestvuju u manipulativnoj igri pre prelaska na sledeću fazu igre, jer prvo moraju da shvate sa čime se igraju.

Teže VOVO deca učestvuju u manipulativnoj i povremeno u relacionoj igri, ali ne dostižu fazu funkcionalne ili simboličke igre. Važno je praviti razliku između VOVO i teže VOVO dece zato što se primenjuju različite tehnike u podsticanju razvoja igre.

Deca sa teškim višestrukim oštećenjima nemaju samo usporen razvoj igre. Njihovo ponašanje u igri često ima različit kvalitet. Ne deluje kao da se dete igra pa se to i ne prepozna. Ovo otežava fascilitiranje i stimulisanje njihove igre. Mnoga deca sa teškim višestrukim ostećenjima deluju pasivno jer ne pokazuju tipično aktivno, eksplorativno ponašanje tokom igre kao prosečna deca. Zato je teško razlikovati ponašanje koje je deo igre, od stereotipnog ponašanja kao takvog (Vlaskamp & van der Putten, 2009).

Na kapacitet za igru, ove dece, utiču: pažnja, zainteresovanost za igru, očuvanost senzora, osetljivost na draži, komunikacione, motoričke sposobnosti. Igra sa teže višestruko ometenim detetom zahteva otvoren, izuzetno osetljiv pristup eksperta za igru i mnogo vremena i strpljenja. Stručnjak mora da bude usmeren na dečje reakcije. Ako pristup nije takav, ceo proces biće samo niz aktivnosti koje dete izvodi, bez uvida kada i kako dete pokazuje inicijativu i šta mu privlači pažnju. Često je dete oštećeno toliko da su mu mogućnosti da pokaže reakciju, izuzetno male.

Procenu nivoa igre kod VO/VOVO dece vršimo uz primenu video analize (VIG). Analiziramo petominutni video snimak, po određenoj proceduri i rezultate beležimo u odgovarajućem obrascu. Na osnovu dobijenih podataka određujemo, najpreciznije moguće, nivo /podnivo razvijenosti igre.

Sledeći korak je analiza kvaliteta opservirane igre. Kvalitativni aspekti koje razmatramo su: varijacije u igri – u sadržaju i materijalu, fizičko angažovanje, korišćenje prostora, raspon pažnje, stepen uživanja i drugi.

Na osnovu analize dobijenih podataka, utvrđujemo kako da obezbedimo optimalne preduslove za stimulaciju i fascilitaciju igre.

U okviru vidimo deo obrasca koji se odnosi na dodatno planiranje kada su u pitanju VOVO deca.

Opšti uslovi za višestruko ometenu decu
• postura • doba dana u kojem se odvija igra • pristup • premalo ili previše stimulacije • pozornost

Posebno se planira upotreba igračaka, ogovarajućih nivou igre, podsticajnih za dete, u dovoljnom broju, itd.

Tada se pristupa izradi **Plana intervencije u razvoju igre** (Moleman, Van den Broek, Van Eijden, 2009).

Kao i svi prethodni obrasci i ovaj je praktičan, pregledan i jednostavan. Sadrži opšte podatke o detetu, o utvrđenom nivou igre, kvalitetu igre, potrebnim adaptacijama, materijalima koji će se koristiti, tehnikama fascilitacije koje su predviđene (SMART) i učestalost i trajanje relizacije.

Iz svega navedenog, očigledno je da je proces analize razvojnog nivoa igre dobro osmišljen, da je proces planiranja racionalan, što obezbeđuje kvalitetnu intervenciju u razvoju igre kod VO/VOVO deteta. Kroz praksu smo se uverili da lakše postižemo napredak kod dece, ali treba istaći i da smo uspeli da roditelji ozbiljno shvate koliko je igra značajna i potrebna njihovom detetu. Roditelji su skloni da igru zanemare, kao nevažnu aktivnost i gubljenje vremena. Njima je „učenje" prioritet i kada shvate koliko toga dete uči kroz igru, spremnije se uključuju u planirane aktivnosti.

Intervencija u razvoju igre odnosi se na stimulaciju i fascilitaciju igre, u celini ili pojedinim aspektima, prema potrebama određenog deteta. Igru možemo da stimulišemo/facilitiramo na svakom nivou razvoja igre. Od posebnog je značaja što ovim tehnikama posredujemo u zajedničkoj igri, u grupi sa slepim, slabovidim ili videćim vršnjacima. U praksi smo uspevali da podstaknemo zajedničku igru, održimo tempo i unapredimo je, kada su učesnici bili slepa, slabovida i višestruko ometena deca. U tako heterogenoj grupi, svako se igrao kako ume, koliko može i isto tako uživao. Primeri uspešne fascilitacije zajedničke igre biće predmet drugog izlaganja.

Svrha ovog izlaganja je upoznavanje stručnjaka koji rade sa VO/VOVO decom, u specijalnim školama, vrtićima, u razvojnim grupama, ili u redovnim vrtićima, sa savremenim pristupom u proceni i tretmanu igre VO/VOVO dece. Tiflolozi u ranoj intervenciji, naše škole mogu da pomognu u ovoj oblasti, svakom kome je potrebno.

LITERATURA

1. Van den Broek, Moleman & Hellendoorn (2010). *The Play Development Scale for Blind and visually impaired children* (P.D.S.-Bl.)
2. Playing is Growing by Yolanda Molenan, Ellen van den Broek, Ans van Eijden, (2010) Huizen, Royal Dutch Visio
3. Копас-Вукашиновић, Е. (2006). Улога игре у развоју деце предшколског и млађег школског узраста. *Зборник Института за педагошка истраживања*, 1, 174-189.
4. Kamenov, E. (1989). *Intelektualno vaspitanje kroz igru*. Beograd: Zavod za udžbenike i nastavna sredstva.
5. Eljkonin, D.B. (1990). *Psihologija dečje igre*. Beograd: Zavod za udžbenike i nastavna sredstva.
6. Pijaže, Ž., & Inhelder, B. (1978). *Intelektualni razvoj deteta*, Zavod za izdavanje udžbenika i nastavnih sredstava, Beeograd: Zavod za izdavanje udžbenika i nastavnih sredstava.
7. Bjorklund, D. F. (2009). *Why youth is not wasted on the young: Immaturity in human development*. John Wiley & Sons.
8. Vigotski, L. S. (1996). *Dečja psihologija*, četvrti tom sabranih dela. Beograd: Zavod za udžbenike i nastavna sredstva.

ASSESSMENT OF THE LEVEL OF PLAY DEVELOPMENT AND PLAY FACILITATION IN BLIND AND VISUALLY IMPAIRED YOUNG CHILDREN

Zorica Vladisavljević
The School for Students with Impaired Vision "Veljko Ramadanović",
Zemun, Serbia

Research subject: Within five years of the First Steps project implementation, in co-operation with VISIO, specialists in typhlology from the School for Students with Impaired Vision "Veljko Ramadanović" have been trained to work with visually impaired children (VI / MDVI) from birth to 6 years of age. By applying modern methods, the specialists perform the necessary assessments, both of the child's and parental needs, as well as, the evaluation of the treatment procedure.

Method: The paper aims to present the examples of assessment of the play level in blind and visually impaired pre-school children by applying a special instrument: PDS – Bl Scale.

Results: Using the Video Interactive Guidance analysis, play is assessed at four levels and several sub-levels of play development. The scale distinguishes two consecutive stages in senzopathicplay.

Conclusion: On the basis of the assessment, we are able to encourage the development of children's play, providing the necessary adjustments. Facilitation of play activities should be related to all aspects of games.

Key words: VI / MDVI children of early age, Scale to assess play development, VIG, typhlology specialists in early intervention, facilitation of play

udc 616.831-001-085-053.2
159.937.24-056.34-053.2

Visual Stimulation Methods for Children with Prenatal Brain Damage

Sonja Alimović
University of Zagreb, Faculty of Education and Rehabilitation Sciences, Croatia

Research subject: *Children with prenatal brain damage often have difficulties in visual functioning caused by damage of posterior visual pathway. Knowing the sensitive periods and the possibility of visual function recovery during the first years of life, we carried out the visual stimulation program with 90 children with prenatal brain damage. Goal and method of visual stimulation were designed according to the results of functional vision assessment for each child.*

Method: *The aim of this study was to analyze the methods of visual stimulation for habilitation of visual functions in children with prenatal brain damage. The methods we used for one year were described through four categories; regarding the stimulus we used (bright lights, materials under the UV light, specially designed visual targets and everyday materials). We used descriptive statistics to describe the prevalence of visual stimulation methods we used. Further, we analyzed the correlation (Spearman's rank correlation) of the method we used with the diagnosis of the brain damage, age and prematurity.*

Result: *Results have shown that most of children were stimulated with objects from everyday activities used to improve specific visual functions and that method of visual stimulation correlate significantly to the diagnosis of prenatal brain damage (p=0.001).*

Conclusion: *On the base of the obtained findings, we can conclude that the most common stimuli we used were materials from everyday activities, and that visual stimulation method depends on diagnosis of prenatal brain damage.*

Key words: *visual stimulation, prenatal brain damage, early intervention, sensitive periods*

INTRODUCTION

Brain damage during pre-, peri- and post-natal period is the most often cause of neurodevelopmental impairments in children (Mejaški Bošnjak, 2007). The severity of impairment is determined by the localization and the size of brain lesion (Presečki, Benjak & Barišić, 2009). The localization of brain lesion depends on gestational age of a newborn. In premature children, born before 35th week of gestation, the lesion will be in deep periventricular area, and in newborn with gestational age higher than 35 weeks brain lesion will most often be located in cerebral cortex and subcortical white matter (Presečki et al., 2009). The most often diagnosis of perinatal brain damage are intracranial hemorrhage (IVH), hypoxic ischemic encephalopathy (HIE) and periventricular leukomalacia (PVL) (Mejaški Bošnjak, 2007).

IVH is the most often lesion in immature brain of a newborn (Jensen, Garnier, Middelanis & Berger, 2003). The incidence of IVH depends on gestational age, and it is between 2 and 30% (Presečki et al., 2009; Mejaški Bošnjak, Đuranović, Gojmerac, Krakar, 2005). Furthermore, HIE is caused by problems in blood and oxygen supply of the newborn brain (Presečki et al., 2009). This acute hypoxic ischemic damage leads to brain tissue necrosis and severe impairment in child's development (Presečki et al., 2009). This perinatal brain damage is also more often in premature babies (7 to 26%), than in full-term babies where it is very rare (1 to 5‰) (Mejaški Bošnjak et al., 2005) PVL is the most often type of HIE characterized by necrosis of white matter of the brain (Presečki et al., 2009; Mejaški Bošnjak et al., 2005). Most children with PVL develop cerebral palsy with different severity of visual problems.

Vision problems in children with perinatal brain damage are mostly caused by damage of posterior visual pathway, known as cerebral visual impairment. Severity of problems in visual functioning is again determined by localization and size of lesion. Also, according to localization, children with optic radiation injury have more problems in visual functioning than children with visual cortex injury (Malkowicz, Myers & Leisman, 2006; Guzzetta, Cioni, Cowan & Mercuri, 2001). Therefore, the level of visual impairment is different in children with cerebral visual impairment and different visual functions can be affected due to selective damage of the brain (Malkowicz, Myers & Leisman, 2006; Dutton & Jackobson, 2001).

Stimulation of vision in children with cerebral visual impairment leads to improvement of visual functioning (Mejaški Bošnjak et al., 2005; Celesia, 2005). The immature brain responds to injury with a remarkable re-routing of neuronal pathways from undamaged areas to re-innervate denervated areas and this lesion-induced plasticity occurs in all systems studied so far, including the visual system (Katušić, 2011).

Since visual problems caused by cerebral visual impairment effect the multisensory, motor, cognitive and social functioning of a child (Vučinić, Anđelković, Jablan & Žigić, 2014), it is necessary to provide timely intervention for children with cerebral visual impairment (Brémond-Gignac Copin, Lapillonne & Milazzo, 2011).

AIM OF THE PAPER

The aim of this study was to analyze the methods of visual stimulation used in children with prenatal brain damage regarding the incidents of method using and correlation with type of perinatal brain damage, prematurity and corrected age.

METHOD

We analyzed the methods of visual stimulation used with 90 children with different types of perinatal brain damage, mostly IVH (46.7%), HIE (12.2%) and PVL (41.1%). Children were included in visual stimulation from birth to 27 months of age, with mean age, corrected for prematurity, 9.27 months (Me 8; SD 6.13 months). We had 55.6% of male and 44.4% of female babies. More children from the sample were full-term babies (57.8%) than premature babies (42.2%).

Before including a child in early intervention program in Mali dom Zagreb and in visual stimulation program, functional vision assessment was done by expert in assessment and rehabilitation of vision. After the assessment, methods of visual stimulation were suggested and described to parents and to home visitor following child's development and giving support to family.

Through home visits, home visitor (trained for visual stimulations) observed child's visual behavior and supported parent in doing visual stimulations. Home visits occurred once a week, but parents did visual stimulation, as instructed, every day during all activities.

Methods of visual stimulation were described through four categories, regarding the stimulus we used and presented in Table 1.

Table 1 – Description of visual stimulation methods

Category of visual stimulation method	Description of visual stimulation method
Bright lights	For visual stimulation of children with the most severe visual impairment, with perception of light only, we used materials producing lights (flashlights, light snake, touch button light, toys with lighting effects, light box) in dark room. We also adapted the materials from everyday activities to have bright light on them (small flashlight applied on drinking bottle, LED lights applied on diapers etc.)

Materials under the UV light	For visual stimulation of children with severe visual impairment, able to see bright colors presented under the UV light we used visual targets with fluorescent colors which reflects light and intensify the contrast and brightness of colors
Specially designed visual targets	For visual stimulation of children with moderate visual impairment we used visual targets with very high contrast and bright colors. We also adapted materials from everyday activities by applying high contrast and bright colors on them (wide black stripes on diapers, cardboard case or a sock with high contrast to put the drinking bottle inside etc.)
Everyday materials	For visual stimulation of children with specific problems in visual functions we used materials from everyday activities, specific size and contrast to encourage using of vision and exercising the specific visual function during all activities. We used toys and other functional objects of different size (from 40 cm size to 1 mm size), contrast (from very high contrast to low contrast) and color.

We used descriptive statistics from SPSS program to describe the prevalence of visual stimulation methods, and we analyzed correlation (Spearman's rank correlation) of methods we used with diagnosis of child's brain damage, age and prematurity.

RESULTS AND DISCUSSION

Results have shown that most children were stimulated with objects from everyday activities used to improve specific visual functions and that method of visual stimulation correlate significantly only to diagnosis of perinatal brain damage (p=0.001).

We expected that most children will need additional adaptation of materials we use in activities to encourage development of vision but results have shown different. Therefore, we analyzed results of functional vision assessment. Most children had problems in specific visual functions (oculomotor functions, visual acuity, contrast sensitivity, problems in keeping visual attention on stimuli) and only some of them had severe visual impairment and needed very intensive visual stimuli. Hence, 48.9% children were stimulated with materials from everyday activities, 31.1% with specially designed visual targets, 17.8% with materials presented under the UV light and only 2.2% of children needed stimulation with bright light in dark room.

Method of visual stimulation correlated significantly to type of perinatal brain damage (S_r=0.342; p=0.001). Analyzing the results presented in Table 2, we can see that more children with HIE and PVL needed more intensive stimuli than children with IVH.

Table 2 – Percentage of children using specific category of stimulation method regarding type of perinatal brain damage

Category of visual stimulation method	Type of perinatal brain damage		
	Intracranial hemorrhage (IVH)	Hypoxic ischemic encephalopathy (HIE)	Periventricular leukomalacia (PVL)
Bright lights	59.5%	54.5%	35.1%
Materials under the UV light	14%	18.2%	32.4%
Specially designed visual targets	4.8%	27.3%	29.7%
Everyday materials	2.4%	0	2.7%

Children with HIE and PVL from our study had more severe visual problems than children with IVH. This was also expected, since, according to previous studies those brain injuries cause severe impairments (Presečki et al., 2009).

We found no significant correlation between the categories of visual stimulation method and corrected age (S_r=-0.137; p=0.198). After the analysis of functional vision assessment results, we found no difference in severity of problems in any visual function regarding corrected age.

We found no statistically significant correlation between the categories of visual stimulation method and prematurity (S_r=-0.190; p=0.073) either. But according to results of our study prematurity is significantly correlated only to visual acuity (S_r=0.243; p=0.028) from all other visual functions. Therefore, corrected age and prematurity does not influence on visual stimulation method needed for stimulating vision.

CONCLUSION

The results of our study have shown that most children with perinatal brain damage can be stimulated with objects from every day activities. We can also conclude that the stimuli we should use in visual stimulation program depends on diagnosis of prenatal brain damage, where children with HIE and PVL more often need more intensive visual stimuli than children with IVH.

REFERENCES

1. Brémond-Gignac, D., Copin, H., Lapillonne, A., & Milazzo, S. (2011). Visual development in infants: physiological and pathological mechanisms. *Curr Opin Ophthalmol*, 22, S1–S8.
2. Celesia, G.G. (2005). Visual plasticity and its clinical applications. *J Physiol Anthropol Appl Human Sci,* 24, 23-27.
3. Dutton, G.N., & Jacobson, L.K. (2001). Cerebral visual impairment in children. *Semin Neonatol*, 6(6), 477–85.
4. Guzzetta, A., Cioni, G., Cowan, F., & Mercuri, E. (2001). Visual disorders in children with brain lesions: 1. Maturation of visual functionin infants with neonatal brain lesions: correlation with neuroimaging, *European Journal of Paediatric Neurology,* 5(3), 107-114.
5. Jensen, A., Garnier, Y., Middelanis, J., & Berger, R. (2003) Perinatal brain damage-from pathophysiology to prevention, *Eur J Obstet Gyn R B,* 110, S70-9.
6. Katušić, A. (2011). *Early brain injury and plasticity: Reorganization and functional Recovery Translational Neuroscience, 2*(1), 1-9. DOI: 10.2478/s13380-011-0006-5
7. Malkowicz, D.E., Myers, G., & Leisman, G. (2006) Rehabilitation of Cortical Visual Impairment in Children, *Int J Neurosci*, 116, 1015-33.
8. Mejaški-Bošnjak, V. (2007). Dijagnostički pristup ranom otkrivanju neurorazvojnih odstupanja. *Peadiatria Croatica*, 51(1), 105-110.
9. Mejaški-Bošnjak, V., Đuranović, V., Gojmerac, T., & Krakar, G. (2005). Intrakranijska ultrasonografija u dijanostici perinatalnog oštećenja mozga, *Medicina,* 42(41), 49-55.
10. Presečki, Ž., Benjak, V., & Barišić, N. (2009). Neurološke bolesti novorođenačke dobi: Krvarenja i hipoksično-ishemična encefalopatija. In: Barišić, N. (Ed.), *Pedijatrijska neurologija* (170-95). Zagreb: Medicinska naklada
11. Vučinić, V., Anđelković, M., Jablan, B., & Žigić, V. (2014). Kortikalno oštećenje vida – karakteristike i tretman, *Special Education and Rehabilitation*, 13(3), 313-331.

METODE VIZUELNE STIMULACIJE ZA DJECU S PRENATALNIM OŠTEĆENJEM MOZGA

Sonja Alimović
Sveučilište u Zagrebu, Edukacijsko – rehabilitacijski fakultet, Hrvatska

Uvod: Djeca s perinatalnim oštećenjem mozga često imaju poteškoća u vizualnom funkcioniranju uzrokovano oštećenjem posteriornog dijela vidnog puta. Vođeni spoznajama o osjetljivim periodima i mogućnost oporavka vidne funkcije unutar prve godine života, proveli smo vidne stimulacije sa 90 djece s perinatalnim oštećenjem mozga. Cilj i metode vidnih stimulacija osmišljeni su na osnovu rezultata procjene funkcionalnog vida svakog pojedinog djeteta.

Metode: Cilj ovog istraživanja bio je analizirati metode vidnih stimulacija u habilitaciji vidnih funkcija djece s perinatalnim oštećenjem mozga. Metode vidnih stimulacija koje smo koristili tijekom te godine opisane su kroz četiri kategorije u odnosu na vidni podražaj koji je korišten (žarka svjetla, vidne mete pod UV svjetlom, posebno dizajnirane vidne mete te material iz svakodnevne upotrebe). Deskriptivnom statistikom koliko je često korištena koja metoda vidnih stimulacija. Dalje smo analizirali povezanost (Spearman rank correlation) metode vidnih stimulacija sa vrstom perinatalnog oštećenja mozga, dobi i nedonošenosti.

Rezultati: Rezultati su pokazali da je većina djece stimulirana s predmetima iz svakodnevnih aktivnosti u svrhu poboljšanja specifičnih vidnih funkcija te da je metoda vidne stimulacije značajno povezana s vrstom perinatalnog oštećenja vida (p=0,001)

Zaključak: Metode vidnih stimulacija su opisane kroz četiri grupe u odnosu na korišteni vidni podražaj. Na osnovu dobivenih rezultata možemo zaključiti da vrsta metode vidnih stimulacija koju ćemo koristiti s pojedinim djetetom ovisi o vrsti perinatalnog oštećenja mozga.

Ključne riječi: vidne stimulacije, perinatalno oštećenje mozga, rana intervencija, osjetljivi periodi

udc 159.943-053.2
796.012.1-053.2

Instrumenti za procenu motoričkog razvoja u ranom detinjstvu

Ivana Sretenović, Goran Nedović, Dragan Rapaić, Vesna Radovanović
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Predmet istraživanja: *Iako se motorički razvoj odvija određenim i predvidljivim redosledom, svako dete se razvija brzinom koja mu je svojstvena. Detinjstvo je period ubrzanog motoričkog razvoja, te je važno da se deca koja su u riziku za nastanak motoričkog poremećaja na vreme identifikuju. Rana identifikacija i odgovarajuće intervencije mogu dovesti do poboljšanja detetovog opšteg razvoja i mogu uticati na bolje dugoročne funkcionalne ishode.*

Metod: *Cilj ovog rada je da se pregledom dostupne literature, izdvoje i prikažu instrumenti za procenu motoričkog razvoja koji se obično koriste kod dece koja imaju kašnjenje ili zastoj u razvoju motorike. Pregled literature je izvršen pretragom elektronskih baza podataka dostupnih preko Konzorcijuma biblioteka Srbije za objedinjenu nabavku. Za potrebe ovog rada prikazano je šest instrumenata za procenu motoričkog razvoja. Najveći broj testova se smatra observacionim skalama, ali većina uključuje interakciju sa detetom kako bi se pomoću standardizovanog pristupa dobio adekvatan rezultat. Preporuka je da se procena dece sa motoričkim poremećajima fokusira na korišćenje funkcionalnih testova kako bi se akcenat stavio na programe tretmana od kojih će koristi imati i dete i njegova porodica. Prikazani instrumenti procene motoričkog razvoja mogu biti korisni u određivanju ciljeva tretmana i planiranju tretmana.*

Zaključak: *Za decu sa motoričkim poremećajima postoje dva osnovna tipa funkcionalne procene. Prvi je procena motoričkog razvoja, koja uključuje i kvalitativnu i kvantitativnu procenu motoričkog funkcionisanja i motoričkog izvođenja. Drugi tip je procena opšteg adaptivnog ili nezavisnog funkcionisanja, odnosno merenje sposobnosti deteta da funkcioniše u aktivnostima svakodnevnog života. U zavisnosti od svrhe u upotrebi su prediktivni, diskriminativni i evaluativni testovi.*

Ključne reči: *funkcionalna procena, motorički razvoj, instrumenti procene*

UVOD

Motorički razvoj je složen proces koji zavisi od uspešne integracije određenog broja međusobno povezanih razvojnih procesa. Ako se posmatra kao deo šireg razvojnog procesa, motorički razvoj uključuje: neuromotoriku (tonus, posturalne reflekse i kvalitativne aspekte pokreta), razvojnu motoriku (gruba, fina i oralna motorika), i senzomotoriku (kognitivno/perceptualne motoričke funkcije) (Malina, Bouchard & Bar – Or, 2004).

Iako se motorički razvoj odvija određenim i predvidljivim redosledom, svako dete se razvija brzinom koja mu je svojstvena. Detinjstvo je period ubrazanog motoričkog razvoja, te je važno da se deca koja su u riziku za nastanak motoričkog poremećaja na vreme identifikuju. Rana identifikacija i odgovarajuće intervencije mogu dovesti do poboljšanja detetovog opšteg razvoja i mogu uticati na bolje dugoročne funkcionalne ishode (Blauw-Hospers & Hadders-Algra, 2005).

Ljutić, Joković-Oreb i Nikolić (2012) navode da tipičan motorički razvoj obično teče svojim određenim i predvidljivim redosledom, bez obzira što tempo i godine usvajanja određenih motoričkih veština zavise od deteta do deteta. To znači da su sekvence u razvoju slične, iako se deca razvijaju svojim određenim tempom. Odnosno, može da postoji određena varijabilnost u redosledu motoričkog razvoja, ali je redosled tipičnog razvoja konzistentan. Recimo, deca tipičnog motoričkog razvoja pre nego što prohodaju samostalno sede. Miljokazi u razvoju motorike predstavljaju događaje koji donekle prate predvidljivu sekvencu pomoću koje se može utvrditi detetov opšti razvojni napredak. Kašnjenja koja se javljaju, kod dece sa motoričkim ili drugim poremećajima u razvoju, u doba pojavljivanja određenih motoričkih miljokaza predstavljaju prvi znak ili brigu koja se javlja kod roditelja ili zdravstvenih radnika (Šalaj, 2012).

Za ispitivanje motorike koriste se određeni instrumenti (testovi) koji služe za identifikaciju ili procenu dece sa motoričkim poremećajima. Metode procene uključuju i standardizovane i nestandardizovane testove, kao i korišćenje sofisticirane tehnologije (Payne, & Isaccs, 1998). Preporuke ili opšta razmatranja za procenu podrazumevaju: značaj rane identifikacije i intervencije; identifikovanje početne zabrinutosti o mogućnosti postojanja motoričkih problema; proces procene. Pored navedenih opštih preporuka, za stručnjake koji se bave ovom problematikom neophodno je da znaju i razumeju prirodu motoričkih poremećaja, zatim da prilikom procene imaju kolaborativnu, kooperativnu i integrativnu ulogu, kao i da razmotre kulturološki i porodični kontekst u kojem dete živi. Do rane identifikacije dece sa motoričkim poremećajima moguće je doći na različite načine (Nelson & Ellenberg, 1982).

CILJ RADA

Cilj istraživanja je da se pregledom dostupne literature, izdvoje i prikažu instrumenti za procenu motoričkog razvoja koji se obično koriste kod dece koja imaju kašnjenje ili zastoj u razvoju motorike.

METOD

Za potrebe ovog rada izvršene je pregled literature pretragom elektronskih baza podataka (Science Direct, Wiley Interscience, Springer/Kluwer, SAGE Publisihing i EBSCO) dostupnih preko Konzorcijuma biblioteka Srbije za objedinjenu nabavku. Prilikom pretrage korišćene su sledeće ključne reči: motorički razvoj, procena, instrumenti procene, deca sa kašnjenjem u razvoju, rano detinjstvo. U obzir su uzimani radovi objavljeni u periodu od 1980. do 2016. godine, dostupni u celosti, čiji je istraživački fokus bio usmeren na karakteristike i namene instrumenata za procenu motorike.

PRIKAZ REZULTATA ISTRAŽIVANJA

Grupa autora ističe značaj upotrebe različitih instrumenta u proceni deteta (Provost, Heimerl, McClain, Kim, Lopez, & Kodituwakku, 2004; prema Nedović et al., 2016), pri čemu instrumenti koji se koriste prilikom procene deteta treba da budu pouzdani i značajni, da budu precizni pri identifikaciji dece, i da uključuju članove porodice kao jednake partnere u stručnom timu za procenu. U ovom radu dajemo prikaz šest instrumenata za koje smatramo da su značajni za specijalnu edukaciju i rehabilitaciju i da su našli primenu u proceni dečijeg motoričkog funkcionisanja, odnosno u proceni motoričkog razvoja kod odojčadi i male dece sa motoričkim poremećajima.

Procena motoričkog razvoja

Autori (Dubowitz et al., 1984; Majnemer, Rosenblatt, & Riley, 1994; Majnemer & Rosenblatt, 1995; Majnemer & Snider 2005; Molteno, Grosz, Wallace, & Jones, 1995) smatraju da su instrumenti o kojima sledi kratak prikaz, pre svega observacione skale, ali da većina ovih instrumenata uključuje i interakciju sa detetom kako bi se korišćenjem standardizovanog pristupa dobio potreban odgovor o motoričkom razvoju.

1. Alberta skala motorike odojčeta (*Alberta Infant Motor Scale (AIMS*); Piper & Darrah, 1994) je observaciona skala koja se koristi za identifikaciju odojčeta sa kašnjenjem u motoričkom razvoju na uzrastu od rođenja do 18 meseci. Fokus ove procene je na posturalnoj kontroli koja se posmatra u odnosu na četiri pozicije (supinacija, pronacija, sedenje i stajanje). Ova skala ima diskriminativni karakter, i meri motorički razvoj i sa kvalitativnog i sa kvantitativnog aspekta. Međutim, pregledom literature nije pronađeno da skala ima

i evaluativni karakter (Campbell, Kolobe, Wright & Linacre, 2002; Darrah, Piper & Watt, 1998).

2. Merenje grube motoričke funkcije (*Gross Motor Function Measure 2nd (GMFM-66 and GMFM-88);* Russell, Rosenbaum, Wright, Avery, 2013) predstavlja najbolju evaluativnu meru motoričkih funkcija kreiranu za kvantifikovane promene u grubim motoričkim sposobnostima kod dece sa cerebralnom paralizom različitog uzrasta. Ajtemi u okviru ovog instrumenta su grupisani u pet razvojnih sekvenci (ležanje i valjanje; sedenje; puzanje i klečanje; stajanje; hodanje, skakanje i trčanje) (Avery, Russell, Raina, Walter, & Rosenbaum, 2003). Nasuprot GMFM, sistem merenja motoričkog izvođenja (Gross Motor Performance Measure (GMPM)) je osmišljen da meri kvalitativne promene u razvoju kod dece sa cerebralnom paralizom (Boyce et al., 1995).
3. Pibodijeva skala motoričkog razvoja (*Peabody Developmental Motor Scales (PDMS);* Folio, Fewell, 2000) *namenjena je deci uzrasta od rođenja do* 5 godina. Ovo je kvantitativna mera koja se koristi za identifikaciju dece sa motoričkim kašnjenjem. Sadrži skalu za procenu fine motorike i skalu za procenu grube motorike. Ima i diskriminativan i evaluativan karakter, a brojne studije govore o pouzdanosti i validnosti testa (Van Hartingsveldt, Cup & Oostendorp, 2005; Wang, Liao & Hsieh, 2006).
4. Bruininks-Oseretsky test motoričke spretnosti (*The Bruininks-Oseretsky Test of Motor Proficiency (BOT-2);* Bruininks & Bruininks, 2005) je instrument koji se koristi za procenu motoričkog razvoja, odnosno širokog spektra motoričkih sposobnosti. Namenjen je deci uzrasta 4 – 21 godine. Preporučuje se za dijagnostikovanje motoričkih oštećenja, skrining i ranu detekciju motoričkih poremećaja, planiranje tretmana, razvoj i evaluaciju efekata motoričkog treninga, kao i u istraživačke svrhe. Kao instrument za skrining i brzu procenu opšte motoričke spretnosti može se primeniti i kraća verzija Bruininks-Oseretsky testa motoričke spretnosti iz 2005. godine (*The Bruininks-Oseretsky Test of Motor Proficiency Short Form – BOTMP-SF*; Bruininks & Bruininks, 2005), međutim autori (Venetsanou, Kambas, Aggeloussis, Serbezis & Taxildaris 2007) zaključuju da validnost BOTMP-SF testa nije potvrđena pri identifikovanju motoričkih poremećaja kod dece uzrasta pet godina.

Procena opšteg adaptivnog i nezavisnog funkcionisanja

Procene koje se fokusiraju na opšte funkcionisanje pružaju informacije o detetovom nezavisnom i adaptivnom funkcionisanju u svakodnevnom životu. Ove procene se uglavnom oslanjaju na prosuđivanje koje donose profesionalci ili na osnovu intervjua sa osobom koja najbolje poznaje dete. Instrumenti procene koji se najčešće koriste su:

1. Pedijatrijska skala balansa (*Pediatric Berg Balance Test (PBS);* Franjoine, Gunther & Taylor, 2003) predstavlja modifikaciju *Berg Balance skale* (BSS). Pedijatrijska skala balansa se koristi za procenu sposobnost ravnoteže, dece uzrasta od 5 do 15 godina sa blagim do umerenim oštećenjem motorike (Franjoine et al., 2003), kao i kod dece sa cerebralnom paralizom (Gan, Tung, Tang, & Wang, 2008). Instrumentom se ocenjuju funkcionalne aktivnosti koje dete treba bezbedno i nezavisno da obavlja kod kuće, u školi ili u društvenoj zajednici, i može se koristiti u svrhu skrininga ili evaluacije.
2. Pedijatrijska evaluacija inventara invalidnosti (*Pediatric Evaluation of Disability Inventory (PEDI)*; Haley, Coster, Ludlow, Haltiwanger, Andrellos, 1994) je konstruisana da proceni decu sa smetnjama u razvoju od šest meseci do 7,5 godina života. To je kontrolna lista koju popunjava kvalifikovani stručnjak ili se sprovodi intervju sa roditeljem, odnosno starateljem deteta. Ovaj instrument je napravljen tako da identifikuje deficite u funkcionalnim performansama, tačnije u domenima samozbrinjavanja, mobilnosti i socijalnom funkcionisanju, što govori o njegovom diskriminativnom karakteru. Evaluativna svrha ovog instrumenta ogleda se u mogućnosti merenja promene tokom vremena (Nichols & Case-Smith, 1996; Vos-Vromans, Ketelaar & Gorter, 2005).

ZAKLJUČAK

Na osnovu prikaza odabranih instrumenata, možemo reći da najveći broj pripada observacionim skalama, ali i da većina uključuje interakciju sa detetom kako bi se pomoću standardizovanog pristupa dobio adekvatan rezultat. Procena dece sa motoričkim poremećajima treba da se fokusira na korišćenje funkcionalnih testova kako bi se akcenat stavio na programe tretmana od kojih će koristi imati i dete i njegova porodica. Prikazani instrumenti procene motoričkog razvoja mogu biti korisni u određivanju ciljeva tretmana i planiranju tretmana.

Za decu sa motoričkim poremećajima postoje dva osnovna tipa funkcionalne procene. Prvi je procena motoričkog razvoja, koja uključuje i kvalitativnu i kvantitativnu procenu motoričkog funkcionisanja i motoričkog izvođenja. Motoričko funkcionisanje se odnosi na kvantitativnu procenu dečijih finih i grubih motoričkih sposbnosti, dok je motoričko funkcionisanje usmereno na kvalitativnu analizu dečije motoričke aktivnosti. Drugi tip je procena opšteg adaptivnog ili nezavisnog funkcionisanja, odnosno merenje sposobnosti deteta da funkcioniše u aktivnostima svakodnevnog života, poput brige o sebi, socijalne interakcije, komunikacije, itd. U zavisnosti od svrhe u upotrebi su prediktivni, diskriminativni i evaluativni testovi. Određene metode procene su kreirane za jednu namenu/svrhu, dok se ostale mogu koristiti na više načina. Nisu sve metode procene adekvatne za svaku oblast razvoja. Na primer, metoda procene koja se koristi za predikciju motoričkog statusa, možda neće biti korisna za merenje promene u motoričkom razvoju i ponašanju tokom vremena, odnosno neće biti korisna za evaluaciju. Prilikom odabira instrumenta za procenu potrebno je poznavati njegove karakteristike, način upotrebe, kao i njegovu namenu kako bi odgovarao karakteristikama ciljne grupe i cilju procene. Rana identifikacija dece sa kašnjenjima u motoričkom razvoju omogućava da se deca na vreme uključe u odgovarajuće programe rane intervencije što dovodi do optimizacije njihovog funkcionalnog potencijala.

LITERATURA

1. Avery, L. M., Russell, D. J., Raina, P. S., Walter, S. D., & Rosenbaum, P. L. (2003). Rasch analysis of the Gross Motor Function Measure: validating the assumptions of the Rasch model to create an interval-level measure. *Archives of Physical Medicine and Rehabilitation*, *84*(5), 697-705.
2. Blauw-Hospers, C. H., & Hadders-Algra, M. (2005). A systematic review of the effects of early intervention on motor development. *Developmental Medicine and Child Neurology,* 47(6), 421-432.
3. Boyce, W. F., Gowland, C., Rosenbaum, P. L., Lane, M., Plews, N., Goldsmith, C. H., ... & Harding, D. (1995). The Gross Motor Performance Measure: validity and responsiveness of a measure of quality of movement. *Physical therapy*, *75*(7), 603-613.
4. Bruininks, R., & Bruininks, B. (2005). *Bruininks-Oseretsky Test of Motor Proficiency, second edition (BOT-2).* Minneapolis, MN: Pearson Assessment.
5. Campbell, S. K., Kolobe, T. H., Wright, B. D., & Linacre, J. M. (2002). Validity of the Test of Infant Motor Performance for prediction of 6-, 9-and 12-month scores on the Alberta Infant Motor Scale. *Developmental Medicine and Child Neurology*, *44*(4), 263-272.
1. Darrah, J., Piper, M., & Watt, M. J. (1998). Assessment of gross motor skills of at-risk infants: predictive validity of the Alberta Infant Motor Scale. *Developmental Medicine and Child Neurology, 40*(7), 485-491.
2. Dubowitz, L.M., Dubowitz, V., Palmer, P., Miller, G., Fawer, C.L.,& Levene, M.I. (1984). Correlation of neurologic assessment in the preterm newborn infant with outcome at 1 year. *Journal of Pediatrics,* 105(3), 452-456.
3. Folio, M. R., & Fewell, R. R. (2000). *Peabody Developmental Motor Scales, Second Edition (PDMS-2).* Austin, TX:Proed.
4. Franjoine, M. R., Gunther, J. S., & Taylor, M., J. (2003). Pediatric Balance Scale: A Modified Version of the Berg Balance Scale for the School-Age Child with Mild to Moderate Motor Impairment. *Pediatric Physical Therapy*, *15*(2), 114-128.
5. Gan, S.M., Tung, L.C., Tang, Y.H., & Wang, C.H. (2008). Psychometric Properties of Functional Balance Assessment in Children With Cerebral Palsy. *Neurorehabilitation and Neural Repair, 22*(6), 745-753.
6. Haley, S. M., Coster, W. J., Ludlow, L. H., Haltiwanger, J. T., & Andrellos, P. J. (1994). Pediatric Evaluation of Disability Inventory. *Pediatric Physical Therapy, 6*(1), 42-43.

7. Ljutić, T., Joković-Oreb, I., & Nikolić, B. (2012). Učinak ranog integracijskog programa na motorički razvoj djeteta s neurorazvojnim rizikom. *Hrvatska revija za rehabilitacijska istraživanja*, *48*(2), 55-65.
8. Majnemer, A., Rosenblatt, B., & Riley, P. (1994). Predicting outcome in highrisk newborns with a neonatal neurobehavioral assessment. *American Journal of Occupational Therapy*, *48*(8), 723-732.
9. Majnemer, A., & Rosenblatt, B. (1995). Prediction of outcome at school entry in neonatal intensive care unit survivors, with use of clinical and electrophysiologic techniques. *Journal of Pediatrics*, *127*(5), 823-830.
10. Majnemer, A., & Snider, L. (2005). A comparison of developmental assessments of the newborn and young infant. *Developmental Disabilities Research Reviews*, *11*(1), 68-73.
11. Malina, R. M., Bouchard, C., Bar-Or, O. (2004). *Growth, Maturation, and Physical Activity*. Champaign: Human Kinetics.
12. Molteno, C., Grosz, P., Wallace, P., & Jones, M. (1995). Neurologic exam of the preterm and full-term infant at risk for developmental disabilities using the Dubowitz Neurological Assessment. *Early Human Development,* 41, 167-176.
13. Nedović, G., Sretenović, I., Potić, S., & Arsić, R. (2016). Early Intervention in the World: Implications for Improvement in Serbia. In S. Nikolić, R. Nikić & V. Ilanković (Eds.), *Early Intervention in Special Education and Rehabilitation* (pp. 25-41). University of Belgrade – Faculty of Special Education and Rehabilitation, Thematic Collection of International Importance.
14. Nelson, K.B., & Ellenberg, J.H. (1982). Children who "outgrew" cerebral palsy. *Pediatrics, 69*(5), 529-536.
15. Nichols, D. S., & Case-Smith, J. (1996). Reliability and validity of the Pediatric Evaluation of Disability Inventory. *Pediatric Physical Therapy*, *8*(1), 15-24.
16. Payne, V.G., & Isaccs, L.D. (1998). *Human Motor Development: A Lifespan Approach (4th ed.)*. Mayfield Publishing Company.
17. Piper, M.C., & Darrah, J. (1994). *Motor Assessment of the Developing Infant*. Philadelphia, PA: Saunders.
18. Russell, D. J., Rosenbaum, P.L., Wright, M., & Avery, L.M. (2013). *Gross Motor Function Measure (GMFM-66 and GMFM-88) User's Manual, 2nd Edition*. UK: Mac Keith Press.
19. Šalaj, S. (2012). Osnove ranog motoričkog razvoja. *Kondicijski trening*, *10*(2), 54-59.
20. Van Hartingsveldt, M. J., Cup, E. H., & Oostendorp, R. A. (2005). Reliability and validity of the fine motor scale of the Peabody Developmental Motor Scales–2. *Occupational Therapy International*, *12*(1), 1-13.
21. Venetsanou, F., Kambas, A., Aggeloussis, N., Serbezis, V., & Taxildaris, K. (2007). Use of the Bruininks-Osetetsky Test of Motor Proficiency for identifying children with motor impairment. *Developmental Medicine and Child Neurology, 49,* 846-848.

22. Vos-Vromans, D. C. W. M., Ketelaar, M., & Gorter, J. W. (2005). Responsiveness of evaluative measures for children with cerebral palsy: the Gross Motor Function Measure and the Pediatric Evaluation of Disability Inventory. *Disability and Rehabilitation, 27*(20), 1245-1252.
23. Wang, H. H., Liao, H. F., & Hsieh, C. L. (2006). Reliability, sensitivity to change, and responsiveness of the Peabody Developmental Motor Scales–second edition for children with cerebral palsy. *Physical Therapy*, *86*(10), 1351-1359

INSTRUMENTS FOR MOTOR DEVELOPMENT ASSESSMENT IN EARLY CHILDHOOD

Ivana Sretenović, Goran Nedović, Dragan Rapaić, Vesna Radovanović
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: Although motor development takes place in a certain and predictable order, each child develops at a rate that is characteristic of him. Childhood is a period of intense motor development, so it is important to identify children who are at risk for motor disorders, on time. Early identification and appropriate intervention can lead to an improvement of the child's overall development and can lead to better long-term functional outcomes.

Method: The aim of this paper was to review the available literature, to extract and display instruments for the assessment of motor development that are commonly used in children who have developmental motor delay. The literature review was conducted by searching electronic databases available through the Serbian Library Consortium for Coordinated Acquisition. For the purpose of this paper, six instruments for assessing motor development are presented. The largest number of instruments are considered as observational scales, but most of them involve interaction with the child in order to use the standardized approach so an adequate result can be received. It is recommended that the assessment of children with motor disorders focuses on the use of functional tests in order to put the emphasis on treatment programs from which both the child and his family will benefit. Featured instruments of motor development assessment may be useful in determining the goals of treatment and planning a therapy.

Conclusion: For children with motor disorders there are two basic types of functional assessment. The first is the assessment of motor development, which includes qualitative and quantitative assessment of motor function and motor performance. The second type is the assessment of general adaptive or independent functioning, i.e. measuring the ability of a child to function in activities of daily living. Depending on the purpose of their use, there are predictive, discriminative and evaluative tests.

Key words: functional assessment, motor development, instruments of assessment

udc 159.922.76-056.34/.36
616.89-008.48-053.2

Intellectual Functioning in Autism Spectrum Disorder: Cognitive Profile and Assessment Recommendations[1]

Zorana Jolić Marjanović
University of Belgrade, Faculty of Philosophy, Serbia

Research subject: *A number of studies show that cognitive profile of children with autism spectrum disorder (ASD) is characterized by strengths in nonverbal and weaknesses in verbal intelligence. However, verbal-nonverbal IQ split is not present in all children with ASD, implying that their cognitive profile is more heterogeneous than traditionally assumed.*

Method: *The paper aims to critically analyze and discuss the main questions on assessing intellectual functioning in children with autism spectrum disorder, as well as, their cognitive profile.*

Results: *Recent findings, established under the Cattell-Horn-Carroll (CHC) ability framework, suggest that children with ASD display consistent weaknesses in processing speed and working memory, and strengths in visualization and quantitative reasoning, while the performance on fluid and crystallized tests depends on the task content presentation (verbal/nonverbal) and the current level of child's language development. These uneven cognitive profiles, along with typically present difficulties with attention, social interactions, and language understanding, pose serious challenges for common practices in cognitive assessment.*

Conclusion: *Thus, when assessing intellectual functioning of children with ASD, practitioners need to turn to individualized assessment approach that will account for possible ASD related delays in cognitive, language, and social skills development.*

Key words: *autism spectrum disorder, intellectual functioning, cognitive profile, cognitive assessment*

Children with autism spectrum disorder (ASD) frequently experience delays in cognitive development. However, it is equally often that they exhibit certain peaks in their abilities. This uneven profile, marked by a combination of strengths and weaknesses in cognitive capacities, puts common practices in assessment of intellectual functioning to the test.

---

[1] Preparation of this article was supported by the Ministry of Education, Science, and Technological Development of the Republic of Serbia (Program of Basic Research, Project No. 179018).

The purpose of IQ testing in children with ASD

Several different reasons for evaluation of cognitive abilities in ASD are listed in the literature (Grofer Klinger, O'Kelley, Mussey, Goldstein & De Vries, 2012; Mecca, Orsati & Macedo, 2014). Firstly, intelligence tests are often included as a part of diagnostic battery that is used to determine ASD's presence – cognitive ability tests serve to determine the child's actual developmental level which is then used as a reference point in evaluation of social and communicational delays. Only if these delays are greater than expected from the determined developmental level can the child be diagnosed with ASD. Secondly, cognitive ability test are regularly used in educational evaluations of current strengths and weaknesses that interventions and education should be focused on. Thirdly, they are used to evaluate efficiency of the proposed treatment or intervention in follow up practices. Finally, IQ tests are helpful in predicting long-term outcomes such as educational attainment, communication skills, and independent living skills in individuals with ASD (Seltzer, Shattuck, Abbeduto & Greenberg, 2004, Magiati, Tay & Howlin, 2014).

Cognitive profile in ASD: Verbal-nonverbal discrepancy and beyond

As traditionally assumed, the cognitive profile of ASD is marked by a significant discrepancy between verbal and nonverbal IQ. According to Siegel, Minshew, & Goldstein (1996), the difference between the two IQs is nearly one standard deviation (12 IQ points). Indeed, some studies show that individuals with ASD perform better on nonverbal visual-spatial tasks as opposed to tasks that rely on verbal skills, abstract reasoning, and understanding of social rules/relations (e.g., Happé & Firth, 1996; Goldstein et al., 2008; Mayes & Calhoun, 2008; Ankenman, Elgin, Sullivan, Vincent & Bernier, 2014). However, verbal-nonverbal IQ discrepancy has not received uniform support in the literature (Grofer Klinger et al., 2012). For example, when cognitive abilities were examined across a wide range of intellectual ability and chronological age (Mayes & Calhoun, 2003), higher nonverbal IQ was present only in the preschool sample, and remained such during early school-age years in children with IQs below 80; in children with IQs higher than 80 this discrepancy disappeared by 6-7 years of age. A more recent study confirmed that a significant verbal-nonverbal IQ difference is more common in younger children (Ankeman et al., 2014). The fact that this discrepancy is not typically present in all children with ASD is corroborated by findings on latent classes of IQs in this group (Munson et al., 2008): a large discrepancy between verbal and nonverbal abilities was present only in one out of four identified IQ groups, comprising 12.5% of the sample. In a study by Ankenman et al. (2014) 28% of children with ASD showed a cognitive split favouring nonverbal abilities. Thus, as Grofer Klinger et al. (2012) conclude, there is no single verbal-nonverbal

IQ pattern that can be indicative of ASD diagnosis. The question is then, should we dig deeper and go beyond verbal and nonverbal IQ?

Now that the standard verbal-nonverbal dichotomy is generally abandoned in contemporary intellectual assessment and interpretation, most modern cognitive tests are designed to cover disparate capacities defined by the Cattell-Horn-Carroll (CHC) model of cognitive abilities (Schneider & McGrew, 2012). The CHC model postulates that cognitive abilities are hierarchically organized into three ability levels, with narrow abilities at level I, broad abilities at level II, and general ability at level III. This model implies that meaningful individual differences are to be traced at the broad and narrow cognitive abilities level. Thus, the modern assessment paradigm enables a subtest-level analysis in identification of CHC defined profile of cognitive strengths and weaknesses in ASD. This opportunity is considered beneficial for decisions related to instruction, as well as accommodations and modifications of curricula (Kroncke, Willard & Huckabee, 2016).

To begin with, ASD cognitive strengths are regularly revealed on nonverbal fluid reasoning tasks such as Matrix Reasoning and Picture Concepts (Mayes and Calhoun, 2008); this is further corroborated by findings that scores of children with ASD on the Raven's Matrices fall in the average range (Dawson, Soulières, Gernsbacher & Mottron, 2007). Children with ASD also show stronger skills on (untimed) visual-spatial tasks (Coolican, Bryson & Zwaigenbaum, 2007; Kuschner, Benetto & Yost, 2007) and quantitative reasoning tasks (Coolican et al., 2007; Dawson et al., 2007). In contrast, ASD cognitive weaknesses are exhibited on verbal fluid reasoning tasks such as Absurdities (Harris, Handleman & Burton, 1991), crystallized ability tasks that encompass understanding of social situations and rules, e.g., Comprehension (Siegel et al., 1996; Dawson et al., 2007), processing speed as presented in the Coding task, and working memory (McGrew, Schrank, & Woodcock, 2007; Mayes & Calhoun, 2008); deficits in the latter two are often attributed to impaired executive functions (Kroncke et al., 2016). To sum, while the strengths are consistently related to broad cognitive abilities of visualization (Gv) and quantitative reasoning (Gq), and weakness to processing speed (Gs) and working memory (Gm), both fluid (Gf) and crystallized (Gc) abilities present neither a strength nor a weakness. Performance on measures of Gf is low when the task is presented verbally and high when the presentation is nonverbal. On the other hand, not all verbal tasks appear unsolvable to individuals with ASD, and their performance on these tasks largely depends on their level of language development.

Recommendations for cognitive assessment in ASD

Children with ASD often experience difficulties with attention, social interactions, and language understanding, which is why a traditional assessment set-up is often challenging for both the examinee and the examiner. Awareness of these difficulties is *sine qua non* of successful ability assessment. Likewise, there is no "gold standard" for assessment of intellectual abilities in ASD, since uneven cognitive profile makes an individualized assessment approach not only favoured, but inevitable. Thus, Grofer Klinger et al. (2012) encourage practitioners to take into account following considerations when selecting the most appropriate measure: 1) as mentioned, poor receptive and expressive language skills are an obstacle for administration of most verbally-loaded ability measures. Thus, practitioners are advised to determine the level of both prior to test selection. Even when the scale includes nonverbal tasks, these often require at least some receptive skills in order to understand verbally presented test instructions; 2) the examiner should consider both chronological and mental age when choosing a test. If developmental delay in cognitive functions is high, the examinee might be unable to achieve a basal score that would allow comparison with normative samples (Bishop, Farmer & Thurm, 2015). If that is the case, it becomes impossible to convert its score into a meaningful description of his current abilities. Therefore, if delays are great, the examiner should aim for the test with a wide age range, especially downwards. To add, whenever possible child's performance should be stated in terms of mental age equivalents, instead of standard IQ scores; 3) some children with ASD exhibit behavioural difficulties (e.g., short attention span, heightened motor activity), which is why they can hardly endure a lengthy evaluation of cognitive skills; in such cases practitioner should opt for the least time consuming measure; 5) some tasks typical for cognitive ability tests require skills that interfere with the core symptoms of ASD. For example, tasks that involve social and communication skills (imitation, pointing) could be particularly challenging for children with ASD, which is something that examiners should bear in mind when testing children with recorded deficits in these skill areas; 6) finally, selection of appropriate measure is largely determined by the initial purpose of assessment, which is something that must not be overlooked.

REFERENCES

1. Ankenman, K., Elgin, J., Sullivan, K., Vincent, L., & Bernier, R. (2014). Nonverbal and verbal cognitive discrepancy profiles in autism spectrum disorders: Influence of age and gender. *American Journal on Intellectual and Developmental Disabilities, 119*(1), 84–89. doi:10.1352/1944-7558-119.1.*84*.
2. Bishop, S. L., Farmer, C., & Thurm, A. (2015). Measurement of nonverbal IQ in autism spectrum disorder: Scores in young adulthood compared to early childhood. *Journal of Autism and Developmental Disorders, 45*(4), 966–974. doi:10.1007/s10803-014-2250-3.
3. Coolican, J., Bryson, S. E., & Zwaigenbaum, L. (2008). Brief report: Data on the Stanford-Binet intelligence scales (5th ed.) in children with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 38*(1), 190–197. doi: 10.1007/s10803-007-0368-2.

4. Dawson, M., Soulières, I., Gernsbacher, M. A., & Mottron, L. (2007). The level and nature of autistic intelligence. *Psychological Science, 18*(8), 657–662. doi:10.1111/j.1467-9280.2007.01954.x.
5. Goldstein, G., Allen, D. N., Minshew, N. J., Williams, D. L., Volkmar, F., Klin, A., & Schultz, R. T. (2008). The structure of intelligence in children and adults with high functioning autism. *Neuropsychology, 22*(3), 301–312. doi: 10.1037/0894-4105.22.3.301.
6. Grofer Klinger, L., O'Kelley, S. E., Mussey, J. L., Goldstein, S., & De Vries, M. (2012). Assessment of intellectual functioning in autism spectrum disorder. In D. Flanagan, & P. Harrison (2012), *Contemporary intellectual assessment: Theories, tests, and issues* (3rd ed.) (pp. 670–686). New York: Guilford.
7. Happé, F., & Frith, U. (1996). The neuropsychology of autism. *Brain, 119*(4), 1377–1400. doi:10.1093/brain/119.4.1377.
8. Harris, S. L., Handleman, J. S., & Burton, J. L. (1991). The Stanford-Binet profiles of young children with autism. *Special Services in the Schools, 6*(1–2), 135–143.
9. Kroncke, A. P, Willard, M., & Huckabee, H. (2016). *Assessment of autism spectrum disorder: Critical issues in clinical, forensic and school settings.* New York: Springer.
10. Kuschner, E. S., Bennetto, L., & Yost, K. (2007). Patterns of nonverbal cognitive functioning in young children with autism spectrum disorders. *Journal of Autism and Developmental Disorders,* 37, 795–807. doi:10.1007/s10803-006-0209-8.
11. Magiati, I., Tay, X. W., & Howlin, P. (2014). Cognitive, language, social and behavioural outcomes in adults with autism spectrum disorders: a systematic review of longitudinal follow-up studies in adulthood. *Clinical Psychology Review, 34*(1), 73–86. doi:10.1016/j.cpr.2013.11.002.
12. Mayes, S. D., & Calhoun, S. L. (2003). Ability profiles in children with autism: Influence of age and IQ. *Autism, 7*(1), 65–80. doi:10.1177/1362361303007001006.
13. Mayes, S. S., & Calhoun, S. L. (2008). WISC-IV and WIAT-II profiles in children with high functioning autism. *Journal of Autism and Developmental Disorders, 38*(3), 428–439. doi: 10.1007/s10803-007-0410-4.
14. Mecca, T., Orsati, F., & Macedo, E. (2014). Non-verbal cognitive profile of young children with autism spectrum disorders. *Psychology,* 5, 1404-1417. doi:10.4236/psych.2014.511151.
15. Munson, J., Dawson, G., Sterling, L., Beauchaine, T., Zhou, A., Koehler, E. et al. (2008). Evidence for latent classes of IQ in young children with autism spectrum disorder. *American Journal on Mental Retardation, 113*(6), 439-452. doi:10.1352/2008.113:439-452
16. Schneider, W. J., & McGrew, K. (2012). The Cattell-Horn-Carroll model of intelligence. In D. Flanagan & P. Harrison (Eds.), *Contemporary Intellectual Assessment: Theories, Tests, and Issues* (3rd ed.) (pp. 99-144). New York: Guilford.
17. Woodcock, R. W., Schrank, F. A., Mather, N., & McGrew, K. S. (2007). *Woodcock-Johnson III Tests of Achievement, Form C/Brief Battery*. Rolling Meadows, IL: Riverside

18. Seltzer, M. M., Shattuck, P., Abbeduto, L., Greenberg, J. S. (2004). The trajectory of development in adolescents and adults with autism. *Mental Retardation Developmental Disabilities Research Reviews, 10*(4), 234–247. doi:10.1002/mrdd.20038.
19. Siegel, D. J., Minshew, N. J., & Goldstein, G. (1996). Wechsler IQ profiles in diagnosis of high-functioning Autism. *Journal of Autism and Developmental Disorders, 26*(4), 389-406. doi: 10.1007/BF02172825

udc 159.922.72.072(497.11)
159.953.5-053.4(497.11)

Verbalna kratkoročna i radna memorija kod dece predškolskog uzrasta[1]

Nataša Buha, Milica Gligorović
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija
Jelena Obradović
Osnovna škola „Vuk Karadžić”, Ćuprija, Srbija

S obzirom na to da kratkoročno pamćenje i radna memorija predstavljaju važne prediktore razvoja sposobnosti rešavanja problema, vokabulara, kao i razvoja veštine računanja, čitanja i razumevanja pročitanog, cilj ovog istraživanja je da se utvrdi dinamika razvoja verbalne kratkoročne i radne memorije kod dece predškolskog uzrasta.

Uzorak je činilo sedamdeset petoro dece tipičnog razvoja, uzrasta 4-6,11 godina (AS=5,052; SD=0,814), podeljenih u tri jednake uzrasne grupe. Obuhvaćeno je 39 (52%) dečaka i 36 (48%) devojčica.

Za procenu verbalne kratkoročne i radne memorije korišćeni su zadaci raspona. Kratkoročna memorija procenjena je zadatkom raspona brojeva unapred, a radna memorija zadatkom raspona brojeva unazad. Beležen je broj tačnih odgovora i dostignuti nivo/raspon memorije.

Analizom rezultata utvrđeno je da uzrast statistički značajno korelira sa rasponom verbalne kratkoročne memorije (r=0,503) i rasponom radne memorije (r=0,639). Rezultati analize varijanse su pokazali da je uzrast značajan činilac skora (p≤0,000; parcijalni $\eta^2=0{,}251$*) i nivoa (p≤0,000; parcijalni* $\eta^2=0{,}250$*) kratkoročne verbalne memorije, kao i skora (p≤0,000; parcijalni* $\eta^2=0{,}451$*) i nivoa (p≤0,000; parcijalni* $\eta^2=0{,}403$*) verbalne radne memorije.*

Post hoc analizom utvrđeno je da se značajan napredak u domenu kratkoročnog verbalnog pamćenja odigrava nakon šeste godine (p=0,028), a u oblasti verbalne radne memorije značajne razlike su prisutne među svim procenjenim uzrasnim kategorijama (p=0,004-0,000).

Poznavanje dinamike razvoja verbalne kratkoročne i radne memorije na zadacima raspona moglo bi omogućiti rano detektovanje dece čiji razvoj odstupa od očekivanog i blagovremenu primenu programa stimulacije.

Ključne reči: *kratkoročna verbalna memorija, verbalna radna memorija, zadaci raspona, predškolski uzrast*

---

[1] Rad je proistekao iz projekta „Kreiranje protokola za procenu edukativnih potencijala dece sa smetnjama u razvoju kao kriterijuma za izradu individualnih obrazovnih programa”, broj 179025 (2011-2017), čiju realizaciju finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

UVOD

Kratkoročna i radna memorija predstavljaju privremene sisteme pamćenja koji igraju važnu ulogu u kognitivnom razvoju, učenju i usvajanju veština. Rezultati velikog broja istraživanja upućuju na to da su verbalno kratkoročno pamćenje i radna memorija usko povezane sa sposobnošću rešavanja problema (Murray & Byrne, 2005), jezičkim razvojem (Gligorović, 2012), usvajanjem matematičkih veština (Buha & Gligorović, 2016), kao i usvajanjem veštine čitanja i razumevanja pročitanog (Carretti, Borella, Cornoldi & De Beni, 2009).

Veza između verbalnog pamćenja i profila kognitivnih sposobnosti uočena je i proučavanjem karakteristika kliničke populacije: osoba sa Daunovim (Næss, Lyster, Hulme & Melby-Lervåg, 2011) i Vilijamsovim sindromom (Robinson, Mervis & Robinson, 2003). Pored toga, teškoće u domenu sistema verbalne radne memorije su primećene i kod dece sa specifičnim jezičkim poremećajem (Archibald & Gathercole, 2006), poremećajem pažnje sa hiperaktivnošću (Martinussen, Hayden, Hogg-Johnson & Tannock, 2005), diskalkulijom (Attout & Majerus, 2015), kao i kod dece sa disleksijom (Landerl et al., 2013).

Imajući u vidu značaj verbalne kratkoročne i radne memorije, rana detekcija dece čiji razvoj odstupa od očekivanog bi omogućila blagovremenu primenu programa stimulacije. Iz tih razloga, cilj ovog istraživanja je da se utvrdi dinamika razvoja verbalne kratkoročne i radne memorije kod dece predškolskog uzrasta primenom zadataka raspona koji omogućavaju brzu i jednostavnu procenu.

METOD ISTRAŽIVANJA

Uzorak

Uzorkom je obuhvaćeno 75 ispitanika tipične populacije predškolskog uzrasta, po 25 ispitanika uzrasta četiri, pet i šest godina (AS=5,05; SD=0,81). Uzorak čini 52% dečaka i 48% devojčica. Broj dečaka i devojčica je relativno ujednačen u svakoj uzrasnoj grupi (χ^2=0,321, df=2, p=0,852).

Instrumenti i procedura

Za procenu kratkoročne i radne memorije upotrebljen je zadatak raspona brojeva (*Digit span).* Ovi zadaci se sastoje od rastućeg niza brojeva (od dva do sedam) koje ispitanik treba za zapamti i reprodukuje (Gligorović, 2013). Za procenu kratkoročnog pamćenja od ispitanika se traži da upamćeni niz reprodukuje istim redosledom, dok se za procenu radne memorije očekuje reprodukucija niza brojeva obrnutim redosledom od onog koje je ispitivač izgovorio.

Oba zadatka se sastoje od ukupno 12 ajtema, po dva ajtema za svaki rastući niz brojeva. Ispitivanje se prekida posle pogrešno reprodukovana oba ajtema iz jednog niza, a beleži se ukupan broj tačnih reprodukcija i maksimalni raspon (niz) koji ispitanik uspešno ponavlja.

U statističkoj obradi podataka korišćeni su χ^2 test, Pirsonov koeficijent korelacije, jednofaktorska i dvofaktorska analiza varijanse i Šefeov post hoc test.

REZULTATI ISTRAŽIVANJA SA DISKUSIJOM

Na zadatku kratkoročne memorije, deca predškolskog uzrasta uspešno ponavljaju oko šest, od ukupno 12 ajtema, odnosno mogu tačnim redosledom da ponove raspon od četiri elementa. U domenu radne memorije, ispitanici adekvatno ponavljaju oko dva ajtema, odnosno u sistemu radne memorije mogu da manipulišu samo sa jednom do dve informacije (Tabela 1).

Tabela 1 – Osnovni statistički parametri na zadatku kratkoročne i radne memorije

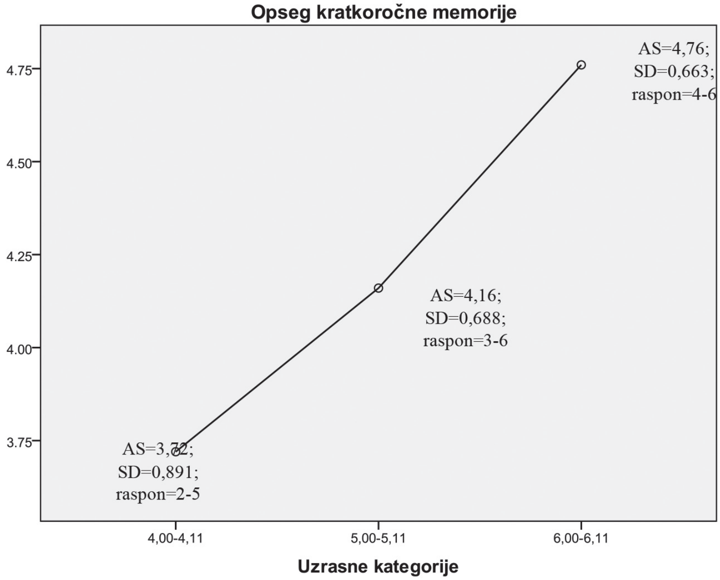
	Min	Max	AS	SD
KP-raspon	2	6	4,21	0,859
KP-ukupan broj tačnih	2	10	6,45	1,757
RM-raspon	0	3	1,60	1,139
RM-ukupan broj tačnih	0	4	1,81	1,440

Legenda: KP= zadatak kratkoročnog pamćenja; RM= zadatak radne memorije

Proverom prisustva polnih razlika u opsegu kratkoročne ($F_{(1)}$=3,333; p=0,079) i radne memorije ($F_{(1)}$=0,276; p=0,601), utvrđeno je da nema značajnih razlika između dečaka i devojčica. Iako dobijeni nalaz ima svoju potvrdu u rezultatima nekih istraživanja (npr. Espy & Bull, 2005), postoje i podaci koji ukazuju na prisustvo boljih rezultata kod devojčica (Gligorović, 2012). Metaanalitičkom studijom je utvrđeno da su na ranom dečjem i adolescentskom uzrastu osobe ženskog pola obično nešto bolje od muškaraca na zadacima raspona, i da se razlika u domenu verbalne memorije s godinama smanjuje i, uglavnom, gubi u odraslom dobu (Lynn & Irwing, 2008). Primenom dvofaktorske analize varijanse nije utvrđena značajna interakcija između uzrasta i pola, ni kada je u pitanju raspon kratkoročne memorije ($F_{(2;69)}$=0,862; p=0,427), ni kada je u pitanju raspon radne memorije ($F_{(2;69)}$=0,253; p=0,778).

Uzrast statistički značajno ($p\leq0,000$), umereno do visoko, korelira sa verbalnom kratkoročnom (broj tačnih: r=0,511; nivo: r=0,503) i radnom memorijom (broj tačnih: r=0,668; nivo: r=0,639).

Značajan skok u broju tačnih odgovora na zadatku kratkoročne memorije se odigrava oko šeste godine života ($F_{(2)}$=12,521; $p\leq0,000$; parcijalni η^2= 0,251). Ispitanici uzrasta od četiri ($p\leq0,000$) i pet godina (p=0,011) su značajno lošiji od šestogodišnjaka. Isti razvojni obrazac se uočava i kod opsega kratkoročne memorije ($F_{(2)}$=11,977; $p\leq0,000$; parcijalni η^2= 0,250) (Grafikon 1).



Grafikon 1 – Uzrast i nivo kratkoročne memorije

Iako se opseg kratkoročne memorije povećava s uzrastom (Grafikon 1), značajniji pomak se viđa tek kod šestogodišnjaka koji su značajno bolji u odnosu na četverogodišnjake (p=0,023) i petogodišnjake (p≤0,000). Petogodišnjaci uspevaju da zapamte nešto više informacija nego četvorogodišnjaci, ali ta razlika nije statistički značajna (p=0,127).

Najveći broj četvorogodišnjaka (40%) uspeva da ponovi niz od četiri informacije (broja), dok petina njih (20%) uspeva da ponovi i niz od pet elemenata.

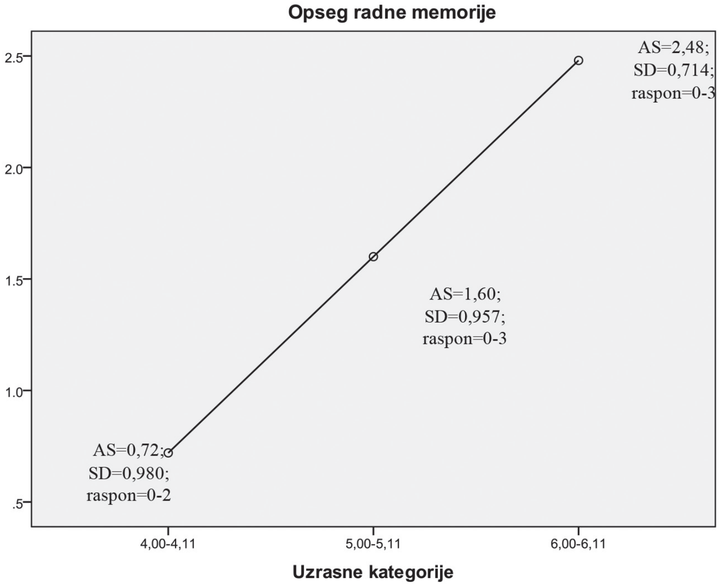
Petogodišnjaci već s lakoćom pamte četiri informacije u nizu (64%). Broj dece koja su u stanju da ponove niz od pet informacija je isti kao i kod četvorogodišnjaka (20%). Na ovom uzrastu se smanjuje broj ispitanika koji nisu u mogućnosti da zadrže više od tri verbalne informacije u sistemu kratkoročne memorije (12%), dok nivo od dve informacije sva deca prevazilaze.

Na uzrastu između šest i sedam godina, opseg kratkoročne memorije u proseku iznosi oko pet informacija. Polovina ispitanika (52%) može da reprodukuje niz od pet brojeva, ali se nešto više od trećine ispitanika (36%) i dalje zadržava na nivou od četiri informacije. Broj dece koja mogu da zapamte i tačno reprodukuju šest brojeva postepeno raste (sa 4% na uzrastu od pet godina na 12% kod šestogodišnjaka).

Slični rezultati dobijeni su i u istraživanjima drugih autora (Chen & Stevenson, 1988; Visu-Petra, Miclea, Cheie & Benga, 2009).

Uzrast je značajan činilac i postignuća na zadatku radne memorije, što se manifestuje povećanjem broja tačnih odgovora ($F_{(2)}$=28,629; p≤0,000; parcijalni η^2= 0,451), i uvećavanjem opsega radne memorije ($F_{(2)}$=24,335; p≤0,000; parcijalni η^2= 0,403).

Detaljnijom analizom je utvrđeno da je razvoj kapaciteta radne memorije intenzivniji: svaka uzrasna grupa je značajno bolja od prethodne; deca na uzrastu od četiri godine su statistički značajno lošija od petogodišnjaka (p=0,004) i šestogodišnjaka (p≤0,000), kao i petogodišnjaci od dece uzrasta od šest do sedam godina (p=0,004) (Grafikon 2).



Grafikon 2 – Uzrast i nivo radne memorije

Deca na uzrastu od četiri godine, u većini slučajeva (64%), nisu u stanju da reprodukuju niz od dva broja obrnutim redosledom, što je u skladu sa rezultatima drugih istraživanja (Bull, Espy & Wiebe, 2008). Sa uzrastom, opseg radne memorije se uvećava, te većina petogodišnjaka (68%) uspeva da zadrži i istovremeno obrađuje dve informacije, dok šestogodišnjaci, uglavnom (56%), uspevaju da zadrže i obrade informaciju koja se sastoji od tri elementa.

Postignuće ispitanika na zadacima raspona u celini potvrđuju ranija saznanja o tome da na predškolskom uzrastu dolazi do značajnijeg povećanja memorijskog kapaciteta dece: do četiri/pet informacije u okviru kratkoročnog pamćenja i oko dve do tri informacije u okviru sistema verbalne radne memorije (Chen & Stevenson, 1988; Bull, Espy & Senn, 2004).

Dobijeni nalaz o opsegu i dinamici razvoja kratkoročne i radne memorije primenom zadataka raspona brojeva, posredno ukazuje na to da se performansa naše dece ne razlikuje od one koja se viđa kod dece drugih zapadnjačkih kultura. Prema rezultatima nekih istraživanja, zadaci raspona, bazirani na brojevima, su kulturološki specifični. Postoje izvesne razlike u performansi između pripadnika istočnih i zapadnih kultura, koje su verovatno (i) lingvistički ustrojene (Chen & Stevenson, 1988; Hedden et al., 2002).

ZAKLJUČAK

Rezultati istraživanja ukazuju na to da se u periodu između četvrte i sedme godine života odigravaju značajne promene u kapacitetu verbalne kratkoročne i radne memorije ($p \leq 0{,}000$). U ovom uzrasnom periodu, raspon kratkoročne memorije se kreće od dve do šest informacija u nizu, dok kapacitet radne memorije omogućava manipulisanje sa dve do tri informacije istovremeno. Značajan napredak u domenu kratkoročnog verbalnog pamćenja se odigrava nakon šeste godine ($p=0{,}028$), a u oblasti verbalne radne memorije značajne razlike su prisutne među svim uzrasnim grupama ($p=0{,}004$-$0{,}000$).

Na uzrastu od četiri godine, najduži niz koji ispitanici uspevaju da reprodukuju istim redosledom iznosi četiri elementa (20%), odnosno dve informacije obrnutim redosledom (36%). Ipak, u okviru kratkoročne memorije najveći broj četverogodišnjaka (40%) zadržava tri informacije, dok sistem radne memorije kod većine (64%) još nije u dovoljnoj meri operativan da podrži istovremenu obradu više od jedne informacije.

Na uzrastu od pet godina, kapacitet kratkoročne memorije i dalje dominantno iznosi tri informacije kod većine ispitanika (64%), dok se u domenu radne memorije uočava značajniji pomak ($p<0{,}01$), te većina petogodišnjaka (68%) uspeva da manipuliše informacijom od dva ključna elementa. Na ovom uzrastu uočava se začetak povećavanja kapaciteta kratkoročne i radne memorije za jedan element više. Kod 4% dece opseg kratkoročnog pamćenja je pet, dok se kod 8% dece kapacitet radne memorije povećava na tri elementa.

Raspon kratkoročne i radne memorije kod šestogodišnjaka ostaje u istim okvirima, ali se povećava broj dece koja dostižu postojeći raspon. U domenu kratkoročnog pamćenja većina dece (52%) uspeva da zadrži četiri elementa, odnosno tri informacije u sistemu radne memorije (56%).

LITERATURA

1. Archibald, L. M., & Gathercole, S. E. (2006). Short-term and working memory in specific language impairment. *International Journal of Language & Communication Disorders, 41*(6), 675-693.
2. Attout, L., & Majerus, S. (2015). Working memory deficits in developmental dyscalculia: The importance of serial order. *Child Neuropsychology, 21*(4), 432-450.
3. Buha, N., & Gligorović, M. (2016). Preconditions of mathematics knowledge and skills. In S. Nikolić, R. Nikić & V. Ilanković (Eds.), *Early Intervention in Special Education and Rehabilitation* (pp. 375-396). Beograd: University of Belgrade – Faculty of Special Education and Rehabilitation.
4. Bull, R., Espy, K. A., & Senn, T. E. (2004). A comparison of performance on the Towers of London and Hanoi in young children. *Journal of Child Psychology and Psychiatry, 45*(4), 743-754.

5. Bull, R., Espy, K. A., & Wiebe, S. A. (2008). Short-term memory, working memory, and executive functioning in preschoolers: Longitudinal predictors of mathematical achievement at age 7 years. *Developmental Neuropsychology, 33*(3), 205-228.
6. Carretti, B., Borella, E., Cornoldi, C., & De Beni, R. (2009). Role of working memory in explaining the performance of individuals with specific reading comprehension difficulties: A meta-analysis. *Learning and Individual Differences, 19*(2), 246-251.
7. Chen, C., & Stevenson, H. W. (1988). Cross-linguistic differences in digit span of preschool children. *Journal of Experimental Child Psychology, 46*(1), 150-158.
8. Espy, K. A., & Bull, R. (2005). Inhibitory processes in young children and individual variation in short-term memory. *Developmental Neuropsychology, 28*(2), 669-688.
9. Gligorović, M. (2013). Klinička procena i tretman teškoća u mentalnom razvoju. Beograd: Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju.
10. Gligorović, M. (2012). Auditivno pamćenje i jezička kompetencija dece mlađeg školskog uzrasta. *Nastava i vaspitanje*, *4*, 565-577.
11. Hedden, T., Park, D. C., Nisbett, R., Ji, L. J., Jing, Q., & Jiao, S. (2002). Cultural variation in verbal versus spatial neuropsychological function across the life span. *Neuropsychology, 16*(1), 65-73.
12. Landerl, K., Ramus, F., Moll, K., Lyytinen, H., Leppänen, P. H., Lohvansuu, K., ... & Kunze, S. (2013). Predictors of developmental dyslexia in European orthographies with varying complexity. *Journal of Child Psychology and Psychiatry, 54*(6), 686-694.
13. Lynn, R., & Irwing, P. (2008). Sex differences in mental arithmetic, digit span, and g defined as working memory capacity. *Intelligence, 36*(3), 226-235.
14. Martinussen, R., Hayden, J., Hogg-Johnson, S., & Tannock, R. (2005). A meta-analysis of working memory impairments in children with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(4), 377-384.
15. Murray, M. A., & Byrne, R. M. (2005). Attention and working memory in insight problem-solving. In B. G. Bars, L. Barsalou, & M. Bucciarelli (Eds.), *Proceedings of the XXVII Annual Conference of the Cognitive Science Society* (pp. 1571-1575). Mahwah, NJ: Erlbaum.
16. Næss, K. A. B., Lyster, S. A. H., Hulme, C., & Melby-Lervåg, M. (2011). Language and verbal short-term memory skills in children with Down syndrome: A meta-analytic review. *Research in Developmental Disabilities, 32*(6), 2225-2234.
17. Robinson, B. F., Mervis, C. B., & Robinson, B. W. (2003). The roles of verbal short-term memory and working memory in the acquisition of grammar by children with Williams syndrome. *Developmental Neuropsychology, 23*(1-2), 13-31.
18. Visu-Petra, L., Miclea, M., Cheie, L., & Benga, O. (2009). Processing efficiency in preschoolers' memory span: Individual differences related to age and anxiety. *Journal of Experimental Child Psychology, 103*(1), 30-48.

VERBAL SHORT-TERM AND WORKING MEMORY IN PRESCHOOL CHILDREN

Nataša Buha*, Milica Gligorović*, Jelena Obradović**
*University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia
**Primary school “Vuk Karadžić”, Ćuprija, Serbia

Research subject: Having in mind that short-term and working memory are strong predictors of development of problem-solving skills, vocabulary, as well as calculation skills, reading and comprehension, the aim of this research is to determine developmental trend of verbal short-term and working memory in preschool children.

Method: The sample consisted of 75 children with typical development, between 4 and 6.11 years of age (M=5.052, SD=0.814), distributed into three equal age groups. There were 39 (52%) boys and 36 (48%) girls. Verbal short-term memory and working memory were assessed by span tasks. Short-term memory was assessed by Digit span forward, while working memory was assessed by Digit span backward. The number of correct responses and the achieved level-span were recorded.

Results: Analysis of the results revealed a statistically significant correlation between age and verbal short-term (r=0.503) and working memory span (r=0.639). The results of analysis of variance showed that age was a significant factor of short-term memory score ($p \leq 0.000$; partial $\eta^2=0.251$) and span ($p \leq 0.000$; partial $\eta^2=0.250$), as well as working memory score ($p \leq 0.000$; partial $\eta^2=0.451$) and span ($p \leq 0.000$; partial $\eta^2=0.403$). Post hoc analysis revealed that significant developmental progress in short-term memory occurred after sixth year of age (p=0.028). In the domain of verbal working memory, developmental changes were more pronounced, and they were present in every age group (p=0.004-0.000). *Conclusion*: Knowing the developmental trend of verbal short-term and working memory on span tasks can enable early detection of children with developmental delay and timely implementation of the stimulation program.

Key words*:* verbal short-term memory, verbal working memory, span tasks, preschool children

udc 616.22-008.5-056.34/.36-053.2
81'234-056.34/.36-053.2

Karakteristike jezičkih poremećaja i oporavak jezičkih sposobnosti kod dece sa traumatskom povredom mozga[1]

Mile Vuković
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Traumatska povreda je najčešći tip stečene povrede mozga kod dece. Trauma mozga često uzrokuje trajna i kompleksna oštećenja kognitivnih funkcija, uključujući i hronične poremećaje jezika. Traumatskom povredom mozga mogu biti pogođene sve lingvističke oblasti: fonologija, leksika, sintaksa, morfologija i semantika. Pored toga, ovaj tip povrede mozga dovodi i do oštećenja viših nivoa jezičke reprezentacije, kao što su diskurs i razumevanje metaforičkih značenja reči. S obzirom na različita i često široko rasprostranjena oštećenja bele mase hemisfera, neuralni korelati jezičkih poremećaja uglavnom ostaju nejasni. U ovom radu je razmatrano prisustvo hroničnih poremećaja jezika uzrokovanih traumatskom povredom mozga u detinjstvu. Rezultati su pokazali oštećenja formalnih lingvističkih oblasti, kao i oštećenje diskursa. Hronični jezički deficiti su evidentirani kod dece koja su pretrpela tešku i umerenu povredu mozga. Utvrđen je komorbiditet između jezičkih deficita i dizartrije, kao i između jezičkih deficita i oštećenja egzekutivnih funkcija. Zaključeno je da prisustvo dizartrije i oštećenje egzekutivnih funkcija kod dece sa jezičkim poremećajima uzrokovanim traumatskom povredom mozga predstavlja povećan rizik za loš oporavak jezičkih sposobnosti.

Ključne reči: *deca, stečeni jezički poremećaj, traumatska povreda mozga, oporavak*

UVOD

Traumatske povrede (TP) predstavljaju najčešći uzrok stečenih oštećenja mozga kod dece. Mogu uzrokovati difuzne i fokalne lezije nervnih struktura (Gaetz, 2004), s tim što su difuzne aksonalne lezije tipične za ovaj tip moždane poverde (Vuković, 2012). Težina TP zavisi od niza faktora, ukjučujuci tip povrede (difuzna ili fokalna), rasprostranjenost i mesto lezije, varijabilnost obrasca oštećenja. Težina povrede se uglavnom određuje na osnovu glazgovske skale kome – Glasgow Coma Scale: GCS (Teasdale & Jannett, 1974), čijom primenom se dobija glazgovski koma skor. Skor između 3 i 8 ukazuje na tešku povredu, skor između 9 i 12 na umerenu povredu, a skor između 13 i 15 na blagu povredu mozga.

---

[1] Ovaj rad je proistekao iz projekta „Evaluacija tretmana stečenih poremećaja govora i jezika" (br. 179068) koji finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

TP u detinjstvu često uzrokuju trajna i kompleksna oštećenja kognicije, uključujući i hronične poremećaje jezika. Empirijski podaci pokazuju da se jezički poremećaji mogu manifestovati u formalnim lingivističkim oblastima: fonologiji, morfologiji, sintaksi, vokabularu i semantici, i na višim nivoima jezičke organizacije kao što je diskurs. Mada poremećaji govora i jezika često predstavljaju hronične sekvele moždane povrede kod dece, njima se još uvek ne poklanja dovoljno pažnje, pa je literatura relativno oskudna podacima iz ove oblasti.

U ovom radu smo nastojali da doprinesemo bližem određivanju prirode i karakteristika stečenih pormećeja jezika uzrokovanih stečenom poverdom mozga u detinjstvu. Istovremeno smo želeli da doprinesemo razmatranju oporavka jezičkih sposobnosti sa aspekta težine povrede i komorbiditeta.

METOD

S obzirom na malu zastupljenost povreda mozga u opštoj populaciji dece, ovaj rad je baziran na studiji slučajeva. Odabrana su tri ispitanika sa posledicama moždane povrede stečene u detinjstvu. Demografske i kliničke karakteristike prikazne su u Tabeli 1.

Tabela 1 – Demografske i kliničke karakteristike ispitanika

Ispitanik	Uzrast u vreme povrede (godine)	Uzrast u vreme ispitivanja (godine)	Težina povrede (GCS)	Mesto lezije	Komorbiditet
M. K	8	12	Umerena (9)	Fronto-parijetalno levo	Poremećaj EF
D. S.	9	13	Teška (5)	Difuzna povreda leve hemisfere	Dizartrija, Poremećaj EF
B. V.	8,5	12,5	Teška (3)	Difuzna povreda leve hemisfere	Dizartrija, Poremećaj EF

Legenda: poremećaj EF – poremećaj egzekutivnih funkcija

Instrumenti i procedura

Podaci o nastanku i prirodi moždane povrede uzeti su iz medicinske dokumentacije ispitanika. Na osnovu uvida u dokumentaciju i anamnestičkih podatka, utvrđeno je da su dva ispitanika u akutnom i subakutnom periodu imala teško oštećenje svih aspekata jezičkih sposobnosti, dok je jedan ispitanik ispoljavao značajno veći stepen oštećenja produkcije nego razumevanja jezika. Sa ciljem da ispitamo dugoročne posledice povrede na lingvističke sposobnosti, izvršena je procena određenih jezičkih funkcija nekoliko godina nakon povrede mozga. Primenjeni su sledeći test-merni instrumenti:

1. Bostonski test imenovanja – BNT (Kaplan, Goodglass, and Weintraub, 1983), za procenu ekspresivnog vokabulara;
2. Tokne test –TT (De Renzi and Vignolo, 1962), za procenu razumevanja;
3. Semantički test (Vladisavljević, 1983), za procenu leksičko-semantičkih sposobnosti;
4. Subtest «Krađa kolača» iz Bostonskog dijagnostičkog testa za afazije (Goodglass i Kaplan, 1983), za procenu narativnog diskursa;
5. Test za apraksiju govora i dizartriju (Wertz, La Pointe, Rosenbek, 1984), za detekciju dizartrije;
6. Test kontrolisanih usmenih asocijacija – Test fonemske fluentnosti (Strauss, Sherman & Spreen, 2006), za procenu egzekutivnih funkcija. Kao test zadaci korišćeni su glasovi "K", "M", "S".

REZULTATI ISTRAŽIVANJA

Rezultati istraživanju prikazani su u tabelama. Performase na primenjenim testovima date su u apsolutnim vrednostima u odnosu na očekivani/mogući broj poena, za svakog ispitanika ponaosob.

Tabela 2 – Rezultati BNT

Ispitanici	Postignuće/mogući skor
M.K.	40/60
D.S.	36/60
B.V.	34/60

Podaci u Tabeli 2 pokazuju da svi ispitanici imaju smanjen opseg ekpresivnog vokabulara. Ostvaren broj bodova je značajno ispod prosečnih vrednosti očekivanih za ispitivani uzrast (Spreen i Strauss, 1991).

Tabela 3 – Rezultati TT

Ispitanici	Subtestovi					
	I	II	III	IV	V	ukupno
	Postignuća/ mogući skor					
M.K.	10/10	10/10	10/10	10/10	16/22	56/62
D.S.	10/10	10/10	10/10	9/10	14/22	53/62
B.V.	10/10	10/10	10/10	9/10	12/22	51/62

Iz Tabele 3 se vidi da su ispitanici uglavnom ispoljili teškoće u izvršavanju verbalnih naloga na petom delu testa, tj. kod naloga koji su formulisani složenim sintaksičkim konstrukcijama.

Tabela 4 – Postignuća na Semantičkom testu

Ispitanici	Homonimi P/M	Antonimi P/M	Sinonimi P/M	Metonimi P/M	Ukupno P/M
M.K.	15/23	9/10	6/20	6/10	36/63
D.S.	13/23	7/10	6/20	3/10	29/63
B.V.	12/23	8/10	6/20	2/10	34/63

Legenda: P/M – postignuće/očekivani skor

Tabela 4 pokazuje da su ispitanici ostvarili veoma loš rezultat na Semantičkom testu, budući da je ukupan skor znatno ispod prosečnih vrednosti dece uzrasta između 9,5 do 10,5 godina (Povše Ivkić i Govedarica, 2000). Ispitanici su bili najuspešniji u kategoriji „antonimi", dok su najveće teškoće pokazali u kategoriji „metonimi".

Tabela 5 – Distribucija postignuća u narativnom diskursu i testu fonemske fluentnosti

Ispitanici	Ocena diskursa	Fonemska fluentnost (K+M+S)
M.K.	2	15
D.S.	2	12
B.V.	2	10

Legenda: K+M+S – ukupan broj produkovanih reči
koje počinju glasovima "K", "M", "S"

Ocena diskursa izvršena je prema sledećoj proceduri: 1 poen – produkcija dve ili više rečenica, koje nisu povezane tako da izražavaju jasno ideju; 2 poena – povezanost ideja, smanjena količina informacija i slaba organizacija kazivanja; 3 poena – organizovano i povezano kazivanje.

Rezultati u Tabeli 5 pokazuju da su sva tri ispitanika ispoljila teškoće u organizaciji diskursa. Istovremeno se može uočiti da su ispitanici produkovali mali broj reči na testu fonemske verbalne fluentnosti. Ostvareni rezultati su značajno ispod rezultata koje postižu deca uzrasta između osme i jedanaeste godine života (Kavé, 2006; Levin et al., 1991).

DISKUSIJA

Ciljevi ove studije su bliže određivanje karakteristika jezičkih poremećaja i razmatranje oporavka jezičkih sposobnosti kod dece sa traumatskom povredom mozga (TPM).

Analiza dobijenih rezultata pokazala je da TPM kod dece ostavlja dugoročne posledice na planu jezičkih funkcija. Evidentirani su deficiti u oblasti vokabulara, razumevanja gramatike i leksičke-semantike. Pored toga, dobijeni podaci ukazuju na hronične deficite u oblasti diskursa, koji se manifestuju smanjenom količinom produkovanih informacija i teškoćama u organizaciji naracije. Prema tome, naši rezultati govore u prilog prisustvu hroničnih deficita jezika kod dece sa traumatskom povredom mozga. Deficiti se ispoljavaju u formalnim lingvističkim oblastima i na višim nivoima jezičke reprezentacije.

Daljom anlizom rezultata ispitivanja pokazano je da težina jezičkih poremećaja koreliše sa težinom povrede mozga. Teži deficiti uočeni su kod dece sa teškom nego sa umerenom moždanom povredom.

U našem istraživanju, dizratrija je identifikovana kod ispitanika sa teškom povredom mozga. Dizartrija je motorički poremećaj govora koji se klinički manifestuje smanjenom razumljivošću govora. Često se javlja kod traumatske povrede mozga, u izolovanom obliku ili u komorbiditetu sa jezičkim deficitima (Morgan, Mageandran & Mei, 2010; Vuković, 2012).

Rezultati testa fonemske verbalne fluentnosti ukazuju na deficite egzekutivnih funkcija kod ispitanika obuhvaćenih ovim istraživanjem. Naime, svi ispitanici su ispoljili značajno snižene sposobnosti brzog pretraživanja mentalnog leksikona. Prema tome, naši nalazi ukazuju na pojavu komorbiditeta između oštećenja jezičkih i egzekutivnih funkcija kod dece sa TPM. O deficitima egzekutivnih funkcija kod dece sa TPM govore i podaci iz literature (Jonsson, 2010), ali se malo zna o komorbidnom ispoljavanju ovih deficita i oštećenja jezika.

ZAKLJUČAK

Na osnovu analize dobijenih rezultata, može se zaključiti da traumatska povreda mozga kod dece dovodi do hroničnih oštećenja jezika, koja se javljaju u komorbiditetu sa dizartrijom i deficitima egzekutivnih funkcija. Ostaje otvoreno pitanje prirode komorbidnog ispoljavanja ovih poremećaja. Moguće je da prisustvo dizartrije i/ili egzekutivnih funkcija predstavlja povećan rizik za loš ishod jezičkih sposobnosti kod dece sa jezičkim poremećajima traumatske etiologije.

LITERATURA

1. De Renzi, E & Vignolo, L.A. (1962). The Token test: a sesnitive test to detect rceptive disturbances in aphasics. *Brain, 85*, 665-678.
2. Gaetz, M. (2004). The neurophysiology of brain injury. Clinical Neurophysiology: Official Journal of the International *Federation of Clinical Neurophysiology, 115*(1),4–18.
3. Strauss, E., Sherman, E. M. S., & Spreen, O. (2006). *A copmendium of Neuropsychological Tests: Administration, Norms, and Commentary*. New York: Oxford University Press.
4. Jonsson, C.A (2010). *Long-term cognitive outcome of childhood traumatic brain injury*. Stockholm: Stockholm University.

5. Kavé, G. (2005). Phonemic fluency, semantic fluency, and difference scores: Normative data for adult hebrew speakers. *Journal of Clinical and Experimental Neuropsychology*, *27*, 690-699.
6. Kaplan, E., Goodglass, H., & Weintraub, S. (1983). *The Boston Naming Test*. Philadelphia: Lea & Febiger.
7. Levin, H. S., Culhane, K. A., Hartmann, J., Evankovich, K., Mattson, A. J., Harward, H., & Morgan, A.T., Mageandran, S.-D., Mei C. (2010). Incidence and clinical presentation of dysarthria and dysphagia in the acute setting following paediatric traumatic brain injury. *Child: Care, Health and Development, 36*(1), 44–53.
8. Spreen, O., & Strauss, E. (1991). *A compedium of neuropsychological tests. Administration, norms, and comentary.* New York: Oxford University Press.
9. Teasdale, G. A. and Jannett, B. (1974). Assessment of coma and impaired consciousness. *Lancet*, 1. 81.
10. Povše Ivkić, V., Govedarica, T. (2000). *Praktikum opšte defektološke dijagnsotike.* Beograd: Institut za mentalno zdravlje.
11. Vuković, M. (2012). *Poremećaji komunikacije kod traumastkih oštećenja mozga.* Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju.
12. Kaplan, E., Goodglass, H. and Weintraub, S. (1983). *Boston Naming Test.* Philadelphia: Lea and Febiger.
13. Vladisavljević, S. (1983). U Kostić, Đ., Vladisavljević, S., Popović M: *Testovi za ispitivanje govora i jezika*, (str. 179-188). Beograd: Zavod za udžbenike i nastavna sredstva.
14. Wertz, R. T., LaPointe, L. L., & Rosenbek, J. C. (1984). *Apraxia of speech in adults: the disorder and its management*. Orlando: Grune & Stratton.

CHARACTERISTICS OF LANGUAGE IMPAIRMENT AND RECOVERY OF LANGUAGE ABILITIES IN CHILDREN WITH TRAUMATIC BRAIN INJURY

Mile Vuković
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: Traumatic brain injuries (TBI) are the most common type of acquired brain injury in children. Sustaining a TBI in childhood has been found to cause persistent and complex cognitive impairments, including chronic language disorders. Language disorders may be manifested in all linguistic domains: phonology, vocabulary, syntax, morphology and semantics. Higher-order language is also impaired in TBI, including discourse skills and understanding of non-literal concepts. Considering the varied and often widespread nature of brain white matter damage, the neural correlates of language impairments after TBI remain elusive.

Method: In this work, we discuss the acquired language disorders after acquired pediatric brain trauma. The language impairment characteristics across different linguistic domain, as well as impairment discourse skills are described. We also discuss language impairment in relation to co-morbidity.

*Result*s: The factors which affect language outcome are presented in this study, as well as the nature of residual language deficits. The correlation between language impairment and severity of brain injury is pointed out. It is showed that language ability is compromised in the years after pediatric TBI. Chronic language impairments more frequently appear in children with moderate and severe brain injury in comparison to children with mild injury.

Conclusion: Children with language impairment who have dysarthria or deficits in executive functions have a higher risk for poor language outcome compared to the children without this co-morbidity. Children with acquired brain injury need assessment, detection and management of language impairments during the acute phase in order to optimize longer-term functional recovery.

Key words: children, acquired language impairment, traumatic brain injury, recovery

udc 616.831-009.11-053.2
316.356.2

Predictors of Quality of Life of Families with Children with Cerebral Palsy – Implication for Early Intervention[1]

Milena Milićević

Institute of Criminological and Sociological Research, Belgrade, Serbia

Goran Nedović

University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: *During the last two decades, families have been increasingly encouraged to take continuous care of their child with cerebral palsy. Consequently, the way of changing of family life and its quality has become a research subject in disability studies.*

Method: *The aim of this study was to explore the impact of child, family, environment and service support characteristics as potential predictors on the quality of life in families with children with cerebral palsy residing in the Republic of Serbia. The sample was recruited using convenience sampling and consisted of 110 families of children with cerebral palsy, of both genders, between 7 and 18 years of age (M=12,67, SD=3,41). A hierarchical multiple regression was calculated to predict family quality of life based on four sets of independent variables. Child and family characteristics, frequency and magnitude of perceived physical, attitudinal, and policy barriers, and parental perceptions and experiences with professional support were included.*

Results: *Child's challenging behavior was one of the strongest predictors of the quality of family life, b=-.29, t (106)=-3.18, p<.01. The household income also accounted for a significant proportion of unique variance in predicting the quality of family life, b=-.21, t(106)=-2.17, p<.05. Moreover, household income was no longer a significant predictor when the extent of challenging behavior exhibited by the child and the magnitude of perceived environmental barriers entered the regression model. The results confirm that household income and perceived everyday care-giving difficulties are associated with the reduced quality of family life.*

Conclusion: *The conclusion underlines the importance of the environment in improving the quality of family life. However, the reinforcing intervention in the domain of environmental barriers could contribute to the quality of family life by overcoming the lower income and behavioral problems.*

Key words: *quality of family life, cerebral palsy, predicting, environmental impact*

---

[1] This work resulted from the project "Crime in Serbia: Phenomenology, risks, and possibilities of social intervention" (registration number 47011) funded by the Ministry of Education, Science and Technological Development of the Republic of Serbia.

INTRODUCTION

Gradual changes in the nature of caring for children with disabilities began in the middle of the 20th century. Until then, parents were generally considered insufficiently able to raise their children with disabilities, and institutional care was imposed as the only choice (Rosenbaum, King, Law, King & Evans, 1998). Briefly, the key factors in changing the nature of caring for children with disabilities are parental advocacy for change, criticism of the medical model, the deinstitutionalization movement, the elaboration of the theory of social systems, with increased willingness of politicians to consider adopting the principles of family-centered practice (Allen & Petr, 1996).

Families with a child with disabilities are faced with numerous challenges that have an impact on various aspects of family life (Davis & Gavidia-Payne, 2009). Families have been increasingly encouraged to take continuous care of their child with cerebral palsy (CP) during the last two decades (Milićević & Klić, 2014). Consequently, the way of changing of family life and its quality has become a research subject in disability studies.

Recently, family quality of life (FQOL) is a commonly used concept in the fields of developmental disabilities study (Hu, Summers, Turnbull & Zuna, 2011; Park et al., 2003; Parpa et al., 2016; Summers, Hoffman et al., 2005; Zuna, Selig, Summers & Turnbull, 2009). In order to assess the quality of family life as satisfying, certain prerequisites must be met. More specifically, family needs need to be fulfilled; family members should enjoy a common life and have the opportunity to do those things they find important (Park et al., 2003)

The aim of this study was to explore the impact of child, family, environment and service support characteristics as potential predictors on quality of life of families with children with CP residing in the Republic of Serbia.

METHOD

Sample and procedure

Participants were recruited using convenience sampling. The inclusion criteria were as follows: children with *cerebral palsy* diagnosed according to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10; World Health Organization, 2004), both genders, aged 7–18 years, residing with their families on the territory of the Republic of Serbia. Data were gathered from June 2014 to April 2015. Informed consent was obtained from all parents/caregivers included in the study.

The final sample consisted of 110 families of children with CP, 61 (55%) boys and 49 (45%) girls. The average age of children was 12 years 8 months (*SD*=3 years 5 months).

Instruments and variables

Child and family characteristics and data on environmental barriers and professional support were operationalized and measured by several instruments. Detailed information about their conceptual basis, development, and psychometric properties have been described elsewhere (Bjerre et al., 2004; Bourke-Taylor, Pallant & Law, 2014; Hoffman, Marquis, Poston, Summers & Turnbull, 2006; King, King & Rosenbaum, 2004; McCauley et al., 2013; Milićević, 2017; Palisano et al., 2000; Palisano, Rosenbaum, Bartlett & Livingston, 2008; Park et al., 2003; Summers, Poston, et al., 2005; Whiteneck et al., 2004; Taboroši, 2015).

The 25-item *Beach Center Family Quality of Life Scale* (Hoffman et al., 2006) was used to calculate overall FQOL score as a measure of parental satisfaction with different aspects of FQOL (rated on a 5-point Likert scale from 1=*very dissatisfied* to 5=*very satisfied*).

The five-level *Gross Motor Function Classification System – Expanded* & *Revised* (GMFCS – E&R; Palisano, Rosenbaum, Bartlett, & Livingston, 2007) was used to categorize the child's present abilities and limitations in gross motor function. A higher GMFCS level indicates higher functional limitations.

The impact of developmental strengths and difficulties on independence at home was expressed by total FIM score (*Functional Independence Measure for Children* – WeeFIM; Msall et al., 1994). Higher FIM values indicate greater independence levels.

Child's behaviors that are challenging were rated by the 9-item *Child's Challenging Behaviour Scale* (CCBS; Bourke-Taylor et al., 2014). Higher CCBS scores indicate that the child exhibits behaviors that are more challenging.

Household income was categorized into five levels according to average monthly income, while family type was dichotomized as two- or one-parent family.

Two dimensions of environmental impact were derived from the *Craig Hospital Inventory of Environmental Factors for Children – Parent Version* (CHIEF-CP; McCauley et al., 2013). Frequency of perceived physical, attitudinal, and policy barriers was rated on a 5-point scale (from 0=*never* to 4=*daily*), and magnitude on a 3-point scale (from 0=*no problem* to 2=*big problem*). Additionally, a frequency-magnitude product score was calculated, indicating the overall impact of environmental barriers.

Parental perceptions and experiences with professional support were evaluated by *Measure of Processes of Care* (MPOC-20; King et al., 2004). Five MPOC-20 scores were included: *Enabling and partnership*, *Providing general information*, *Providing specific information about the child*, *Coordinated and comprehensive care*, and *Respectful and supportive care*. Higher scores indicate that parents perceive the service delivery as being family-centered to a greater extent.

Statistical analysis

The relationships among variables were investigated using Pearson correlation coefficient. A hierarchical multiple regression was calculated to predict FQOL based on several sets of independent variables. All analyses were performed in SPSS, version 23 (IBM, Armonk, NY, USA), and a significance level of .05 was established to consider the results significant.

RESULTS AND DISCUSSION

Child and family characteristics, frequency, magnitude and overall impact of environmental barriers, as well as parental perceptions and experiences with professional support were included in hierarchical multiple regression analysis. First, the relationships among these variables and overall FQOL were explored. As shown in Table 1, one family, child and environmental characteristics were found to be significantly associated with overall FQOL. Significant negative correlations were found between overall FQOL and both CCBS (*r*=-.41, *p*=.001), and CHIEF magnitude scores (*r*=-.34, *p*=.013). Among other characteristics, a significant positive correlation was identified between overall FQOL score and household income (*r*=.31, *p*=.031).

Table 1 – Relationship between the selected child and family characteristics, impact of environmental barriers and professional support and family quality of life

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Child's age	–	.04	-.03	-.04	-.13	.09	-.18	-.15	-.06	-.09	-.03	-.04	-.00	-.07	-.02
2. GMFCS		–	-.80**	-.17	-.24*	.11	-.03	.08	-.11	-.03	-.04	.04	-.03	.04	-.06
3. WeeFIM			–	.06	.22*	-.14	.14	.00	.15	.07	.09	.01	-.06	-.03	.10
4. CCBS				–	-.08	.06	.01	-.10	.03	.00	-.02	.03	.23*	.11	-.41**
5. H.income					–	-.29**	-.02	-.09	-.12	-.08	-.04	-.06	-.16	-.08	.31*
6. F.type						–	.19	.24*	.05	.22*	.16	.00	.01	-.01	-.14
7. ep							–	.64**	.70**	.77**	.76**	-.12	-.11	-.08	.17
8. pgi								–	.63**	.62**	.65**	-.07	-.01	-.09	.16
9. psi									–	.65**	.71**	-.04	.00	-.06	.17
10. ccc										–	.83**	-.14	-.10	-.13	.14
11. rsc											–	-.17	-.13	-.16	.15
12. CHIEF frequency												–	.73**	.94**	-.09
13. CHIEF magnitude													–	.80**	-.34*
14. CHIEF total														–	-.08
15. FQOL															–

Note. GMFCS – Gross Motor Function Classification System (Expanded & Revised); WeeFIM – Functional Independence Measure for Children; CCBS – Child's Challenging Behaviour Scale;

H.income – Household income; F.type – Family type; ep – Enabling and partnership; pgi – Providing general information; psi – Providing specific information; ccc – Coordination and comprehensive care; rsc – Respectful and supportive care; CHIEF frequency – frequency of barriers; CHIEF magnitude – magnitude of barriers; CHIEF total – overall impact of barriers; FQOL – overall family quality of life. Pearson's correlation coefficients are presented.

$^{*}p<.05$, two-tailed. $^{**}p<.01$, two-tailed.

Therefore, as a control strategy, household income was entered in the first block of predictors (Table 2). The next variable to be entered was parental ratings of child's challenging behavior (Step 2), followed by the ratings of a magnitude of barriers (Step 3).

Household income was a significant predictor of FQOL during Step 1 and Step 2 of the regression (Table 2). However, it failed to account for a significant proportion of unique variance during Step 3. In addition, child behavior continued to be a significant predictor of FQOL in Step 3, after being added in Step 2, irrespective of the inclusion of the magnitude of environmental barriers.

Table 2 – Summary of the hierarchical regression analysis for variables predicting family quality of life in the group of children with cerebral palsy (n=110)

Model/Predictor	Step 1 (β)	Step 2 (β)	Step 3 (β)
Household income	$.21^{*}$	$.18^{*}$	.16
Child's challenging behavior		$-.29^{**}$	$-.26^{**}$
Magnitude of environmental impact			$-.15^{*}$
Model R^2	.04	.13	.15
Adj. R^2	.03	.11	.12
ΔR^2	.04	.09	.02
F (*df1*, *df2*)	4.73 (1, 106)*	7.63 (2, 105)**	6.04 (3, 104)**

Note. β – standardized beta coefficient; R^2 – determinant multiple correlation coefficient; Adj. R^2 – adjusted multiple correlation coefficient; ΔR^2 – multiple correlation coefficient change.

$^{*}p<.05$. $^{**}p<.01$.

Furthermore, child's challenging behavior was one of the strongest predictors of FQOL, explaining 9% of its variance. The household income also accounted for a significant proportion of unique variance in predicting FQOL (4%). Nevertheless, household income was no longer a significant predictor when the extent of challenging behavior exhibited by the child and the magnitude of perceived environmental barriers were entered in the regression model, explaining 15% of the FQOL variance in total (Table 2).

A more thorough overview of the FQOL predictors showed that the higher average monthly income could mostly attribute to higher quality of family life. Negative predictors for FQOL, however, were the child's challenging behavior and the size of the problem that barriers had typically presented. Although expected, the results confirmed that household income and perceived everyday caregiving difficulties were associated with reduced quality of family life. Some studies have indicated that behavioral problems are in negative and family income in a positive correlation with FQOL, as well as that disability level has no statistical significance in FQOL predicting (Davis & Gavidia-Payne, 2009). On the other hand, the level of disability is statistically stronger FQOL predictor compared to family income (Wang et al., 2004). Our results have not confirmed the association of FQOL with CP severity nor with independence level.

However, an interesting dynamic of changes in the predictive power of selected variables was found. The child's challenging behavior continued to be an important negative predictor of FQOL, but its predictive power decreased when environmental barriers were included in the final step. As highlighted previously, financial difficulties, service unavailability, inaccessibility of information and relationship with professional staff were identified as major obstacles to improving FQOL (Čagran, Schmidt & Brown, 2011).

Similarly, household income was a significant predictor only in the first steps of regression, before both perceived professional support and social support from family were finally included in the analysis. Yet, child's behavioral problems and perceived social support remained significant predictors of FQOL regardless of the inclusion of professional support (Davis & Gavidia-Payne, 2009). In our study, the statistical significance of a correlation between professional support and overall FQOL was not confirmed preliminarily; therefore, these variables were not included in the analysis. Moreover, an absence of a relationship between these constructs suggests a possible insufficient family-centeredness of professional services in our country. Previous studies highlighted that parental perceptions and experiences with family-centered practices were one of the strongest predictors of FQOL and that family-centered helpgiving was related to positive child, parent and family outcomes indirectly, through enabling and empowering of parents of young children with disabilities (Davis & Gavidia-Payne, 2009; Dunst, Trivette & Hamby, 2007). This raises a question in terms of the quality of the services provided to families with children with CP and their effect not being reflected in the quality of family life. It is important to acknowledge that biopsychosocial frameworks require family-centeredness, not only rehabilitation interventions focused primarily on the child (Raina, 2005). Our results can be explained by the importance given to the immediate family when the quality of family life is concerned (Rillotta, Kirby, Shearer & Nettelbeck, 2012).

Our results suggested that environmental barriers that are rated as a bigger problem could predict the lower FQOL. Here, the reinforcing intervention in the domain of environmental barriers could play an important role. It has been shown earlier that barrier-free environment could lead to positive changes of community participation and quality of life of children and adolescents with CP (Law, Petrenchik, King & Hurley, 2007). As environment is potentially modifiable, previous authors suggested that interventions focused on environmental changes could contribute to the improvement of life quality (Badia et al., 2016).

Interventions aimed at improving of socioeconomic, financial and material status of families are also recommended (Meral, Cavkaytar, Turnbull & Wang, 2013).

Caring for a child with developmental disabilities, including children with CP, often represents a source of a burden that puts new demands on parents and, in addition to difficult child behavior during caregiving tasks and the persisting psychological and social problems, leads to higher and prolonged parental stress levels (Plant & Sanders, 2007; Weber et al., 2016). Frequent hospitalization, getting out of bed at night to take care of the child, physically and time demanding feeding and dressing are just some of the activities that parents do every day (Bulić, Joković Oreb & Nikolić, 2012). Child's challenging behavior was one of the strongest predictors of FQOL in our study and previous studies had confirmed the overall higher presence of behavioral problems in children with CP in comparison to their peers with typical development (Carlsson, Olsson, Hagberg & Beckung, 2008; Milićević, 2014; Sipal, Schuengel, Voorman, Van Eck & Becher, 2010). Thus, it is important to highlight that the overcoming of behavioral and emotional problems and everyday problems in caregiving should be in the focus of early intervention (Weber et al., 2016).

CONCLUSION

Bearing in mind the presented findings, empirical findings show that the role of family characteristics has to be interpreted along with interactional effects of both child and environmental characteristics when referring to the quality of family life. Our results suggest that relevant interventions should be used that promote implementation of support to family in managing the daily life of their family member with CP.

REFERENCES

1. Allen, R. I., & Petr, C. G. (1996). Toward developing standards and measurements for family-centered practice in family support programs. In G. H. S. Singer, L. E. Powers, & A. L. Olson (Eds.), *Redefining family support: Innovations in public–private partnerships* (pp. 57–86). Baltimore, MD: Paul H. Brookes.
1. Badia, M., Begona Orgaz, M., Gomez-Vela, M., Verdugo, M. A., Ullan, A. M., & Longo, E. (2016). Do environmental barriers affect the parent-reported quality of life of children and adolescents with cerebral palsy? *Research in Developmental Disabilities*, *49–50*, 312–321.
1. Bjerre, I. M., Larsson, M., Franzon, A. M., Nilsson, M. S., Strömberg, G., & Westbom, L. M. (2004). Measure of Processes of Care (MPOC) applied to measure parent's perception of the habilitation process in Sweden. *Child: Care, Health and Development*, *30*(2), 123–130.

2. Bourke-Taylor, H. M., Pallant, J. F., & Law, M. (2014). Update on the child's challenging behaviour scale following evaluation using rasch analysis. *Child: Care, Health and Development*, *40*(2), 242–249.
3. Bulić, D., Joković Oreb, I., & Nikolić, B. (2012). Angažman majki djece s teškoćama u razvoju u aktivnostima svakodnevnog života. *Hrvatska Revija Za Rehabilitacijska Istraživanja*, *48*(2), 1–12.
4. Čagran, B., Schmidt, M., & Brown, I. (2011). Assessment of the quality of life in families with children who have intellectual and developmental disabilities in Slovenia. *Journal of Intellectual Disability Research*, *55*(12), 1164–1175.
5. Carlsson, M., Olsson, I., Hagberg, G., & Beckung, E. (2008). Behaviour in children with cerebral palsy with and without epilepsy. *Developmental Medicine & Child Neurology*, *50*(10), 784–789.
6. Davis, K., & Gavidia-Payne, S. (2009). The impact of child, family, and professional support characteristics on the quality of life in families of young children with disabilities. *Journal of Intellectual and Developmental Disability*, *34*(2), 153–162.
7. Dunst, C. J., Trivette, C. M., & Hamby, D. W. (2007). Meta-analysis of family-centered helpgiving practices research. *Mental Retardation and Developmental Disabilities Research Reviews*, *13*(4), 370–378.
8. Hoffman, L., Marquis, J., Poston, D., Summers, J. A., & Turnbull, A. (2006). Assessing Family Outcomes: Psychometric Evaluation of the Beach Center Family Quality of Life Scale. *Journal of Marriage and Family*, *68*(4), 1069–1083.
9. Hu, X., Summers, J. A., Turnbull, A., & Zuna, N. (2011). The quantitative measurement of family quality of life: A review of available instruments. *Journal of Intellectual Disability Research*, *55*(12), 1098–1114.
10. King, S., King, G., & Rosenbaum, P. (2004). Evaluating health service delivery to children with chronic conditions and their families: Development of a refined Measure of Processes of Care (MPOC-20). *Children's Health Care*, *33*(1), 35–57.
11. Law, M., Petrenchik, T., King, G., & Hurley, P. (2007). Perceived Environmental Barriers to Recreational, Community, and School Participation for Children and Youth With Physical Disabilities. *Archives of Physical Medicine and Rehabilitation*, *88*(12), 1636–1642.
12. McCauley, D., Gorter, J. W., Russell, D. J., Rosenbaum, P., Law, M., & Kertoy, M. (2013). Assessment of environmental factors in disabled children 2-12 years: Development and reliability of the Craig Hospital Inventory of Environmental Factors (CHIEF) for Children-Parent Version. *Child: Care, Health and Development*, *39*(3), 337–344.
13. Meral, B. F., Cavkaytar, A., Turnbull, A. P., & Wang, M. (2013). Family Quality of Life of Turkish Families Who Have Children with Intellectual Disabilities and Autism. *Research and Practice for Persons with Severe Disabilities*, *38*(4), 233–246.

14. Milićević, M. (2014). Behavior problems and participation of children with cerebral palsy in the home environment / Problemi u ponašanju i participacija dece sa cerebralnom paralizom u kućnom okruženju. *Zbornik Instituta za kriminološka i sociološka istraživanja*, *33*(2), 73–87.
15. Milićević, M. (2017). Faktorska struktura skale porodičnog kvaliteta života: komparativna studija porodica sa detetom s cerebralnom paralizom i porodica sa detetom tipičnog razvoja. In M. Šćepanović (Ed.), *Zbornik radova 11. međunarodne konferencije „Socijalna inkluzija osoba sa invaliditetom: značaj i programi podrške"* (pp. 48–58). Novi Sad: Društvo defektologa Vojvodine.
16. Milićević, M., & Klić, I. (2014). Kvaliteta života djece s teškoćama u razvoju i kroničnim bolestima – Obilježja procjene iz perspektiva djece i njihovih roditelja. In Anamarija Žic Ralić & Zlatko Bukvić (Eds.), *Zbornik sažetaka i radova 10. kongresa edukacijskih rehabilitatora s međunarodnim sudjelovanjem „Poticajno okruženje za cjeloživotno učenje"* (pp. 22–33). Zagreb: Savez edukacijskih rehabilitatora Hrvatske.
17. Msall, M. E., DiGaudio, K., Rogers, B. T., LaForest, S., Catanzaro, N. L., Campbell, J., … Duffy, L. C. (1994). The Functional Independence Measure for Children (WeeFIM). *Clinical Pediatrics*, *33*(7), 421–430.
18. Palisano, R., Hanna, S., Rosenbaum, P., Russell, D., Walter, S., Wood, E., … Galuppi, B. (2000). Validation of a model of gross motor function for children with cerebral palsy. *Physical Therapy*, *80*(10), 974–85.
19. Palisano, R. J., Rosenbaum, P., Bartlett, D., & Livingston, M. H. (2007). *Gross Motor Function Classification System – Expanded and Revised*. Hamilton, ON, Canada: CanChild Centre for Childhood Disability Research, McMaster University.
20. Palisano, R., Rosenbaum, P., Bartlett, D., & Livingston, M. (2008). Content validity of the expanded and revised Gross Motor Function Classification System. *Developmental Medicine* & *Child Neurology*, *50*(10), 744–750.
21. Park, J., Hoffman, L., Marquis, J., Turnbull, A. P., Poston, D., Mannan, H., … Nelson, L. L. (2003). Toward assessing family outcomes of service delivery: validation of a family quality of life survey. *Journal of Intellectual Disability Research*, *47*(4–5), 367–384.
22. Park, J., Hoffman, L., Marquis, J., Turnbull, A. P., Poston, D., Mannan, H., … Nelson, L. L. (2003). Toward assessing family outcomes of service delivery: Validation of a family quality of life survey. *Journal of Intellectual Disability Research*, *47*(4–5), 367–384.
23. Parpa, E., Katsantonis, N., Tsilika, E., Galanos, A., Sassari, M., & Mystakidou, K. (2016). Psychometric Properties of the Family Quality of Life Scale in Greek Families with Intellectual Disabilities. *Journal of Developmental and Physical Disabilities*, *28*(3), 393–405.
24. Plant, K. M., & Sanders, M. R. (2007). Predictors of care-giver stress in families of preschool-aged children with developmental disabilities. *Journal of Intellectual Disability Research*, *51*(2), 109–124.

25. Raina, P. (2005). The Health and Well-Being of Caregivers of Children With Cerebral Palsy. *Pediatrics*, *115*(6), e626–e636.
26. Rillotta, F., Kirby, N., Shearer, J., & Nettelbeck, T. (2012). Family quality of life of Australian families with a member with an intellectual/developmental disability. *Journal of Intellectual Disability Research*, *56*(1), 71–86.
27. Rosenbaum, P., King, S., Law, M., King, G., & Evans, J. (1998). Family-Centred Service: A Conceptual Framework and Research Review. *Physical & Occupational Therapy In Pediatrics*, *18*(1), 1–20.
28. Sipal, R. F., Schuengel, C., Voorman, J. M., Van Eck, M., & Becher, J. G. (2010). Course of behaviour problems of children with cerebral palsy: the role of parental stress and support. *Child: Care, Health and Development*, *36*(1), 74–84.
29. Summers, J. A., Hoffman, L., Marquis, J., Turnbull, A., Poston, D., & Nelson, L. L. (2005). Measuring the Quality of Family? Professional Partnerships in Special Education Services. *Exceptional Children*, *72*(1), 65–81.
30. Summers, J. A., Poston, D. J., Turnbull, A. P., Marquis, J., Hoffman, L., Mannan, H., & Wang, M. (2005). Conceptualizing and measuring family quality of life. *Journal of Intellectual Disability Research*, *49*(10), 777–783.
31. Taboroši, M. (2015). *Roditeljska percepcija kvaliteta usluga za decu sa smetnjama u razvoju u Srbiji (master rad).* Fakultet za specijalnu edukaciju i rehabilitaciju Univerziteta u Beogradu, Beograd.
32. Wang, M., Turnbull, A. P., Summers, J. A., Little, T. D., Poston, D. J., Mannan, H., & Turnbull, R. (2004). Severity of Disability and Income as Predictors of Parents' Satisfaction with Their Family Quality of Life During Early Childhood Years. *Research and Practice for Persons with Severe Disabilities*, *29*(2), 82–94.
33. Weber, P., Bolli, P., Heimgartner, N., Merlo, P., Zehnder, T., & Kätterer, C. (2016). Behavioral and emotional problems in children and adults with cerebral palsy. *European Journal of Paediatric Neurology*, *20*(2), 270–274.
34. Whiteneck, G. G., Harrison-Felix, C. L., Mellick, D. C., Brooks, C. A., Charlifue, S. B., & Gerhart, K. A. (2004). Quantifying environmental factors: A measure of physical, attitudinal, service, productivity, and policy barriers. *Archives of Physical Medicine and Rehabilitation*, *85*(8), 1324–1335.
35. World Health Organization. (2004). *International statistical classification of diseases and related health problems (ICD10).* Geneva: World Health Organization.
36. Zuna, N. I., Selig, J. P., Summers, J. A., & Turnbull, A. P. (2009). Confirmatory Factor Analysis of a Family Quality of Life Scale for Families of Kindergarten Children Without Disabilities. *Journal of Early Intervention*, *31*(2), 111–125.

udc 364.4-056.262-053.2
316.356.2
316.728-056.262-053.2

Kvalitet života povezan sa stanjem vida dece uzrasta od tri do sedam godina[1]

Marija Anđelković, Vesna Vučinić

Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Aikaterini Tavoulari

Univerzitet u Birmingemu, Velika Britanija

Uvod: *Oštećenje vida, u sadejstvu sa socijalnim činiocima, može da dovede do teškoća u razvoju i da uspori usvajanje svakodnevnih životnih veština. Roditelji dece sa oštećenjem vida zbog gubitka slike o „perfektnom" detetu, mogu da se suoče sa gubitkom samopouzdanja što se negativno odražava na kvalitet života porodice. Stoga program intervencije treba da bude fokusiran na porodicu, porodične brige i prioritete, a uključivanju u proces rane intervencije da prethodi procena razvoja deteta i potreba porodice.*

Metod: *Cilj rada je utrvđivanje elemenata kvaliteta života povezanog sa oštećenjem vida kod dece uzrasta od tri do sedam godina. U istraživanju je korišćen Upitnik za procenu vizuelnog funkcionisanja, verzija za decu od tri do sedam godina (Children's Visual Function Questionnaire, CVFQ). Sadrži pitanja koja se odnose na vid i zdravlje deteta, uticaj stanja vida na aktivnosti deteta, reakcije roditelja na teškoće povezane sa vizuelnim i socijalnim funkcionisanjem deteta. Pitanja su podeljena u četiri subtesta: sposobnosti deteta, lične karakteristike deteta, uticaj oštećenja vida na porodicu i teškoće u tretmanu. Upitnik je popunilo 46 roditelja (29 majki i 17 očeva) dece sa oštećenjem vida, uzrasta od tri do sedam godina. Većina dece je imala blaži stepen oštećenja vida (28; 60,9%), desetoro je slabovido (21,7%) i osmoro slepo (17,4%).*

Rezultati: *U obradi dobijenih podataka korišćene su deskriptivne statističke mere: aritmetička sredina, standardna devijacija, minimalne i maksimalne vrednosti. Značajnost razlika u postignućima na primenjenom upitniku, ispitana je primenom analize varijanse (ANOVA). Utvrđeno je da uzrast, oboljenje kao uzrok oštećenja vida i stepen oštećenja vida ne utiču značajno na kvalitet života ove dece i njihovih roditelja. Vreme nastanka oštećenja vida utiče na kvalitet života i obavljanje svakodnevnih aktivnosti (p=0,027), kao i prisusutvo višestrukih smetnji (p=0,017). U porodicama gde majke nisu zaposlene roditelji*

---

[1] Rad je realizovan u okviru projekata „Kreiranje Protokola za procenu edukativnih potencijala dece sa smetnjama u razvoju kao kriterijuma za izradu individualnih obrazovnih programa" (ON 179025), čiju realizaciju finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

značajno bolje procenjuju vizuelno funkcionisanje svoje dece (p=0,012).

***Zaključak:** Procena razvoja i potreba porodice treba da prethodi procesu rane intervencije. Fokus treba da bude na porodicu, porodične brige i prioritete.*

***Ključne reči:** vizuelno funckionisanje, kvalitet života, porodica, dete sa oštećenjem vida*

UVOD

Kvalitet života porodica dece sa invaliditetom je dugo bio zanemaren u praksi i istraživanjima (Bhopti, Brown & Lentin, 2016). Bliska saradnja sa članovima porodice deteta sa smetnjama u razvoju je jedan od preduslova za uspeh rehabilitacije i podizanje njihovog kvaliteta života (Danst, Trivette & Hambi, 2007). Podizanje i nega deteta sa smetnjama u razvoju pored uobičajene roditeljske uloge zahteva specifične načine angažovanja, posebno kada su u pitanju višestruke smetnje (Bourke &Taylor, Howie & Law, 2010). Za dodatne/neočekivane aktivnosti roditelji treba da izdvoje vreme, da u masi preporučenih pregleda i tretmana, izaberu najbitnije, za šta je potrebno mnogo vremena, snage, znanja i sposobnosti (Vučinić i Anđelković, 2013). Odgovor bliskih osoba na potrebe deteta zavisi i od toga u kojoj meri su u stanju da predstave sebi kako ono vidi, šta oseća i kako razume svet oko sebe (Ljubešić, 2012).

Gubitak vida u detinjstvu ima dalekosežne posledice na razvoj deteta i kvalitet porodičnog života (DeCarlo, McGwin, Bixler, Wallander & Owsley, 2012; Messa, Mattos, Areco & Sallum, 2015; Vonikaki & Toumazani, 2015). Te posledice zavise od stepena oštećenja vida i karakteristika vizuelnog i sveukupnog funkcionisanja deteta, uzroka oštećenja vida. Prepoznavanje specifičnih odlika porodičnog sistema i uticaja koji oštećenje vida ima na vizuelno i sa njim povezano svakodnevno funkcionisanje deteta preduslov je pružanja neophodne podrške (Howe, 2006; Dragojević, 2007; Tavoulari, Katsoulis & Argyropoulos, 2014) odnosno izrade individualnog programa rada za dete i programa usluga za porodicu.

U periodu postavljanja dijagnoze i tokom lečenja, zdravstvene službe imaju ključnu ulogu u pružanju usluga, međutim način saopštavanja dijagnoze može značajno da utiče na roditelje, prihvatanje deteta, identifikovanje i razumevanje njegovih potreba (Rahi, Manaras, Tuomainen & Hundt, 2005). Roditelji često ne razumeju informacije koje dobiju od zdravstvenih radnika. Zaokupljeni pitanjima zašto se to njima desilo, ne razumeju teškoće koje dete ima, ne mogu da pročitaju poruke i signale koje šalje i ne nalaze načine za adekvatno „zastupanje" njegovog najboljeg interesa (Ferrell, 2011). U kontekstu pružanja psihosocijalne podrške detetu i porodici ističe se stalna briga vezana za dugoročnu prognozu stanja vida, hirurške zahvate, okluziju, česte odlaske na preglede i slično (Carlton & Kaltenthaler, 2011; Chak & Rahi, 2007; DeCarlo et al., 2012; Tadić et al., 2016; Van Dijk et al., 2007). "Najviše me brine činjenica da će jednog dana morati na operaciju, pa to je strašno„ (Liebermann et al, 2016:229). Rezultati brojnih istraživanja su pokazali da postoje značajne razlike između elemenata koji zabrinjavaju roditelje (stanje vida, dužina i način lečenja, odnos okoline) i načina na koji deca sagledavaju svoju poziciju u području vizuelnog i psihosocijalnog funkcionisanja (Chak & Rahi, 2007; Hatt et al., 2008; Tadić et al., 2016; Vučinić, Stanimirović, Anđelković i Eškirović, 2013). Manja ograničenja u području vizuelnog funkcionisanja prisutna su kod dece sa nistagmusom, dok su kod oštećenja u predelu vidnog puta registrovane teškoće u gotovo svim razvojnim domenima (Boulton, Haines, Smyth & Fielder, 2006). Ambliopija značajno utiče na neke aspekte porodičnog života, socijalne interakcije, obavljanje svakodnevnih aktivnosti, emocionalni život i ponašanje (Carlton & Kaltenthaler, 2011). Roditelji dece sa kataraktom su zabrinuti za njihov socijalni, emocionalni i fizički razvoj (Castañeda et al., 2016).

Deca sa oštećenjem vida, prema proceni roditelja, mogu samostalno da obavljaju oko 44% zadataka iz svakodnevnog života, dok deci tipičnog razvoja ne treba pomoć za 84% aktivnosti (oblačenje, ishrana, higijenske navike, održavanje garderobe i kuće, korišćenje novca i telefona i sl.) (Iselin & Lewis, 2002). Više puta je dokumentovano da programi rane podrške imaju pozitivan efekat na vizuelno funkcionisanje i sveukupni razvoj dece sa oštećenjem vida (Trief & Shaw, 2009; Vonikaki & Toumazani, 2015).

Cilj rada je utrvđivanje elemenata kvaliteta života povezanog sa oštećenjem vida kod dece uzrasta od tri do sedam godina. Sa tim u vezi potrebno je utvrditi koji faktori (pol, uzrast, varijable koje opisuju stepen i tip oštećenja vida, dodatne smetnje, varijable vezane za roditelje) utiču na kvalitet života dece sa oštećenjem vida.

Opis i formiranje uzorka

Upitnik je popunilo 46 roditelja (29 majki i 17 očeva) dece sa oštećenjem vida, uzrasta od tri do sedam godina. Većina dece je imala blaži stepen oštećenja vida (28; 60,9%), desetoro je slabovido (21,7%) i osmoro slepo (17,4%). Uzorak je ujednačen prema polu, 24 dečaka (52,2%) i 22 devojčice (47,8%). Najčešća dijagnoza je strabizam i ambliopija (N=21). Kod 18 (39,1%) ispitanika vizuelne teškoće su prisutne od rođenja, kod ostalih su se ispoljile posle prve godine, a kod četvoro dece su dijagnostikovane dodatne smetnje.

U istraživanju je korišćen *Upitnik za procenu vizuelnog funkcionisanja, verzija za decu od tri do sedam godina* (The Children's Visual Function Questionnaire, CVFQ) (Birch, Cheng & Felius, 2007). Sastoji iz četiri subtesta: sposobnosti deteta, lične karakteristike deteta, uticaj oštećenja vida na porodicu i teškoće u tretmanu. Za svaku tvrdnju se bira jedan od ponuđenih odgovora na petostepenoj ili sedmostepenoj skali Likertovog tipa. Svaki od odgovora na tvrdnje odgovara skoru od 1 (najbolji) do 0 (najlošiji). Ukupan skor se izračunava uzimanjem prosečnih vrednosti postignuća na svim subtestovima.

U obradi dobijenih podataka korišćene su deskriptivne statističke mere: aritmetička sredina, standardna devijacija, minimalne i maksimalne vrednosti. Značajnost razlika je ispitana primenom analize varijanse (ANOVA).

REZULTATI ISTRAŽIVANJA I DISKUSIJA

Prosečan skor kvaliteta života dece sa oštećenjem vida je 19,03. Minimalan skor je 6,45, maksimalan 30,10 (SD=7,09), što ukazuje na velike indivudualne razlike, koje mogu da budu povezane sa oboljenjem koje dovodi do oštećenja vida (Carlton & Kaltenthaler, 2011; Castañeda et al., 2016) ili načinom na koji roditelji sagledavaju sposobnosti i lične karakteristike deteta.

U istraživanju nisu utvrđene značajne razlike u ispitivanim domenima, i na skali u celini, između dece različitog uzrasta. Kada se posmatraju rezultati u celini stepen i uzrok oštećenja vida nisu izdvojeni kao značajni činioci kvaliteta života dece. Dobijeni rezulati nisu saglasni sa zaključcima prethodno izvedenih studija (Boulton et al., 2006; Carlton & Kaltenthaler, 2011; Messa et al., 2015), što može da bude povezano sa heterogenošču uzorka. Primenom analize varijanse je utvrđeno da na kvalitet života dece značajno utiče vreme kada je došlo do oštećenja vida (p=0,027). Deca sa urođenim oštećenjem vida, prema proceni roditelja, imaju značajno lošiji kvalitet života (AS=15,83) u odnosu na vršnjake kod kojih je oštećenje vida stečeno (AS=20,70) (Dale & Salt, 2007). Značajna razlika je utvrđena između dece sa izolovanim oštećenjem vida u odnosu na decu sa višestrukim smetnjama (p=0,017). U porodicama gde majke nisu zaposlene roditelji značajno bolje procenjuju kvalitet života dece (AS=22,43) u odnosu na decu čije su majke u radnom odnosu (AS=16,78) (p=0,012). Nezaposlene majke verovatno provode više vremena sa decom i utiču pozitivno na njihovo sveukupno funkcionisanje i kvalitet života, posebno na sposobnosti deteta i prevazilaženje teškoća u tremanu.

Analizom podataka o uticaju oštećenja vida na porodicu zaključeno je da je porodična briga za dete intenzivnija u porodicama gde očevi nisu zaposleni (p=0,024). To može da bude povezano i sa činjenicom da nedostatak materijalnih sredstava dodatno opterećuje roditelje jer nisu u situaciji da obezbede najbolji oftalmološki treman za dete (odlazak na preglede i tretman), i na zadovoljavajući način organizuju slobodno vreme koje provode sa svojom decom i/ili supružnikom. Oštećenje vida je predmet stalne brige roditelja vezane za budućnost deteta što utiče na porodične odnose i kvalitet života (DeCarlo et al., 2012). U nekim istraživanjima je pokazano da deca sa oštećenjem vida kvalitet života procenjuju značajno boljim nego njihovi roditelji, što je povezano sa njihovom zabrinutošću, ne samo za dete, već za sve aspekte porodičnog života (Chak & Rahi, 2007; Tadić et al., 2016; Van Dijk et al., 2007). Tome u prilog govore i podaci da stepen oštećenja i vreme gubitka vida, kao ni višestruke smetnje kod deteta ne utiču na porodične odnose, odnosno elemente tih odnosa koji su obuhvaćeni istraživanjem. Kada se ima u vidu da su u našem istraživanju obuhvaćena deca sa raznovrsnim uzrocima oštećenja vida, rezultati se razlikuju od rezulata Čaka i Rahija dobijenih na uzorku dece sa urođenom kataraktom. Naime, njihovi podaci su pokazali da oštećenje vida u značajnoj meri utiče na funkcionisanje porodice, kao i na psihički aspekt života deteta (Chak & Rahi, 2007).

Rezultati našeg istraživanja su pokazali da karakteristike oštećenja vida (stepen, uzrok i vreme nastanka) ne utiču značajno na lične karakteristike deteta (raspoloženje, sticanje prijatelja, igru), što je suprotno prethodno navedenom zaključku autora (Chak & Rahi, 2007).

Najinteresantniji segment istraživanja odnosi se na sposobnosti dece. Roditelji smatraju da deca sa stečenim gubitkom vida imaju značajno usvojenije sposobnosti (briga o sebi, samostalno kretanje i neke aktivnosti u kući) (AS=5,73) u poređenju sa vršnjacima kod kojih je oštećenje vida kongenitalno (AS=9,08) (p=0,023). Stepen oštećenja vida ne utiče na usvajanje sposobnosti, dok dodatne teškoće u razvoju kod dece sa oštećenjem vida imaju značajan negativan uticaj (p=0,030). Roditelji smatraju da očevi sa višim ili visokim nivoom obrazovanja značajno bolje sagledavaju sposobnosti svoje dece sa oštećenjem vida u odnosu na one koji su završili srednju školu ili zanat (p=0,030). S jedne strane, moguće je da imaju bolji uvid u samostalnost svoje dece, s druge strane obrazovaniji roditelji mogu da im priušte raznovrsnija iskustva koja obezbeđuju usvajanje veština i razvoj sposobnosti. Deca iz porodica gde majke nisu u radnom odnosu imaju značajno usvojenije sposobnosti (p=0,015). Može se pretpostaviti da provode više vremena sa decom i da imaju bolji uvid u njihove veštine. U više istraživanja je pokazano da deca sa oštećenjem vida, u odnosu na vršnjake tipičnog razvoja, dva puta manje aktivnosti obavljaju samostalno (Brambring, 2001; Chadha & Subramanian, 2010; Iselin & Lewis, 2002).

Iako je najčešća dijagnoza strabizam i ambliopija, koja podrazumeva stalnu primenu terapije (povez, nošenje naočara), roditeljima to ne predstavlja problem i ni jedan od posmatranih faktora nema značajan uticaj na tretman koji uključuje primenu terapije, nivo aktivnosti i negodavanje deteta tokom primene i redovnost primene.

ZAKLJUČAK

Rana identifikacija specifičnih karakteristika porodice i uticaja koji oštećenje vida ima na vizuelno i svakodnevno funkcionisanje deteta preduslov je pružanja neophodne podrške. Statističkom analizom dobijenih podataka zaključeno je da vreme nastanka oštećenja vida i prisustvo dodatnih smetnji i oštećenja značajno utiču na kvalitet života i usvajanje sposobnosti dece. Kada su u pitanju sociodemografske varijable radni status majke je izdvojen kao značajan činilac kvaliteta života deteta u celini, kao i svakodnevnog funkcionisanja. Utvrđeno je da je porodična briga intenzivnija među očevima koji nisu u radnom odnosu. Očevi koji imaju viši stepen obrazovanja su pozitivnije ocenili sposobnosti svog deteta. Imajući u vidu da je u pitanju preliminarno istraživanje, i da su upitnik popunjavali ili otac ili majka u narednom koraku treba izvršti potpuniju i detaljniju analizu faktora koji utiču na kvalitet života.

LITERATURA

1. Birch, E. E., Cheng, C. S., & Felius, J. (2007). Validity and reliability of the Children's Visual Function Questionnaire (CVFQ). *Journal of American Association for Pediatric Ophthalmology and Strabismus, 11*(5), 473-479.
2. Bhopti, A., Brown, T., & Lentin, P. (2016). Family Quality of Life: A Key Outcome in Early Childhood Intervention Services – A Scoping Review. *Journal of Early Intervention, 38*(4), 191-211.
3. Boulton, M., Haines, L., Smyth, D., & Fielder, A. (2006). Health-related quality of life of children with vision impairment or blindness. *Developmental Medicine & Child Neurology, 48*(8), 656-661.
4. Bourke-Taylor, H., Howie, L., & Law, M. (2010). Impact of caring for a school-aged child with a disability: Understanding mothers' perspectives. *Australian Occupational Therapy Journal, 57*(2), 127-136.
5. Brambring, M. (2001). Integration of children with visual impairment in regular preschools. *Child: Care, Health and Development, 27*(5), 425-438.
6. Carlton, J., & Kaltenthaler, E. (2011). Amblyopia and quality of life: a systematic review. *Eye, 25*(4), 403-413.
7. Castañeda, Y. S., Cheng-Patel, C. S., Leske, D. A., Wernimont, S. M., Hatt, S. R., Liebermann, L., ... & Holmes, J. M. (2016). Quality of life and functional vision concerns of children with cataracts and their parents. *Eye, 30*(9), 1251-1259.
8. Chadha, R. K., & Subramanian, A. (2010). The effect of visual impairment on quality of life of children aged 3-16 years. *British Journal of Ophthalmology*, 95(5), 642-645. doi: 10.1136/bjo.2010.182386
9. Chak, M., & Rahi, J. S. (2007). The health-related quality of life of children with congenital cataract: findings of the British Congenital Cataract Study. *British journal of ophthalmology, 91*(7), 922-926.
10. DeCarlo, D. K., McGwin, G., Bixler, M. L., Wallander, J., & Owsley, C. (2012). Impact of pediatric vision impairment on daily life: results of focus groups. *Optometry and vision science: official publication of the American Academy of Optometry, 89*(9), 1409-1416.
11. Dragojević, N. (2007). Prilagođavanje roditelja na ometenost deteta: stvarnost ili mit. U Radovanović D. (ed.): *Nove tendencije u specijalnoj edukaciji i rehabilitaciji*, (71-85). Beograd: Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju.
12. Ferrell, K. A. (2011). *Reach out and teach: Helping your child who is visually impaired learn and grow*. New York: American Foundation for the Blind.
13. Hatt, S. R., Leske, D. A., Adams, W. E., Kirgis, P. A., Bradley, E. A., & Holmes, J. M. (2008). Quality of life in intermittent exotropia: child and parent concerns. *Archives of ophthalmology, 126*(11), 1525-1529.
14. Howe, D. (2006). Disabled children, parent–child interaction and attachment. *Child & family social work, 11*(2), 95-106.

15. Iselin, S., & Lewis, S. (2002). A comparison of the independent living skills of primary students with visual impairments and their sighted peers: A pilot study. *Journal of Visual Impairment & Blindness, 96*(05), 335-344.
16. Liebermann, L., Leske, D. A., Castañeda, Y. S., Hatt, S. R., Wernimont, S. M., Cheng, C. S., ... & Holmes, J. M. (2016). Childhood esotropia: child and parent concerns. *Journal of American Association for Pediatric Ophthalmology and Strabismus, 20*(4), 295-300.
17. Ljubešić, M. (2012). Roditeljske vještine i rana interakcija te rana intervencija u zajednici. U V. Božičević, S. Brlas i M. Gulin, *Psihologija u zaštiti mentalnog zdravlja*. Priručnik za psihološku djelatnost u zaštiti i promicanju mentalnog zdravlja. Virovitica: Grafit Becker.
18. Messa, A. A., Mattos, R. B., Areco, K. C. N., & Sallum, J. M. F. (2015). Vision-related quality of life in children with retinopathy of prematurity. *Arquivos brasileiros de oftalmologia, 78*(4), 224-228.
19. Rahi, J. S., Manaras, I., Tuomainen, H., & Hundt, G. L. (2005). Health services experiences of parents of recently diagnosed visually impaired children. British *Journal of Ophthalmology, 89*(2), 213-218.
20. Tadić, V., Cumberland, P. M., Lewando-Hundt, G., Rahi, J. S., Dale, N., Khaw, P. T., ... & Craig, M. (2016). Do visually impaired children and their parents agree on the child's vision-related quality of life and functional vision?. *British Journal of Ophthalmology*, 101, 244-250.
21. Tavoulari, A., Katsoulis, P., Argyropoulos V. (2014). Early intervention in Greece: Present situation and proposal for the future. In M. Vuković, *The 8th International Scientific Conference Special Education and Rehabilitation today.* (pp. 117-125), Belgrade: University of Belgrade – Faculty of Special Education and Rehabilitation.
22. Trief, E., & Shaw, R. (2009). *Everyday activities to promote visual efficiency: A handbook for working with young children with visual impairments*. American Foundation for the Blind.
23. Van Dijk, J., Huisman, J., Moll, A. C., Schouten-van Meeteren, A. Y., Bezemer, P. D., Ringens, P. J.,... & Imhof, S. M. (2007). Health-related quality of life of child and adolescent retinoblastoma survivors in the Netherlands. *Health and quality of life outcomes, 5*(1), 65.
24. Vonikaki, I., & Toumazani, E. (2015). A Greek Home Visiting Program of Early Child Intervention for Visually Impaired Infants and Preschoolers with and without additional disabilities: Present Reflections and Visions. *Enabling Access for Persons with Visual Impairment*, 220-227.
25. Vučinić, V., Anđelković, M. (2011). Rana intervencija u tiflologiji – iskustva i dileme. U N Glumbić i V Vučinić, *Specijalna edukacija i rehabilitacija danas* V međunarodni načni skup. (str. 432-437) Beograd: Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju.
26. Vučinić, V., Stanimirović, D., Anđelković, M., & Eškirović, B. (2013). Socijalna interakcija dece sa oštećenjem vida – rizični i zaštitni faktori. *Specijalna edukacija i rehabilitacija, 12*(2), 241-264. doi:10.5937/specedreh12-4124

QUALITY OF LIFE ASSOCIATED WITH VISUAL STATE OF CHILDREN FROM THREE TO SEVEN YEARS OF AGE

Marija Anđelković*, Vesna Vučinić*, AikateriniTavoulari**
*University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia
**University of Birmingham, United Kingdom

Research subject: Visual impairment, along with social factors, can lead to developmental difficulties and can slow down the acquisition of daily life skills. Due to loosing the picture of "a perfect child", parents of children with visual impairment may lose self-confidence, which has a negative impact on the quality of family life.

Method: The aim of this paper was to determine the quality of life associated with visual impairment in children from three to seven years of age. Children's Visual Function Questionnaire (CVFQ) was used in this research. The questionnaire included questions related to the child's vision and health, the influence of visual state on the child's activities, parent's reactions to difficulties related to the child's visual and social functioning. The questions were divided into four subtests: Competence, Personality, Family Impact and Treatment Difficulty. The questionnaire was completed by 46 parents (29 mothers and 17 fathers) of children with visual impairment from three to seven years of age. Most children had a mild form of visual impairment (28; 60.9%), ten had low vision (21.7%), and eight were blind (17.4%).

Result: Descriptive statistics used in data processing were the following: arithmetic mean, standard deviation, minimum and maximum score. The significance of differences in achievements on the applied questionnaire was tested by the analysis of variance (ANOVA). It was determined that age, causes of visual impairment, and the degree of the impairment did not have a significant influence on the quality of life of these children and their parents. Time of onset of visual impairment had an impact on the quality of life and performing daily activities ($p=0.027$), as well as the presence of multiple disabilities ($p=0.017$). Unemployed mothers, compared to employed ones, significantly better evaluated visual functioning of their children ($p=0.012$).

Conclusion: The process of early intervention should be preceded by the evaluation of the child's development and family needs. It should be focused on the family, family concerns and priorities.

Key words: visual functioning, quality of life, family, child with visual impairment

udc 159.946.2-057.874
796.012.1-057.874

Rana intervencija kod dece sa razvojnim poremećajem koordinacije[1]

Snežana Nišević
OŠ „Boško Buha”, Beograd, Srbija
Snežana J. Nikolić, Danijela Ilić-Stošović
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Predmet istraživanja: *Predmet istraživanja je razvojni poremećaj koordinacije kod dece osnovnoškolskog uzrasta. Cilj rada je da ukaže na značaj i potrebu rane intervencije kod dece sa ovim poremećajem. Analizirana je prevalenca razvojnog poremećaja koordinacije i prisustvo pridruženih teškoća u akademskim veštinama. Diskutovana je tendencija prevazilaženja razvojnog poremećaja koordinacije spontanim sazrevanjem i naglašen značaj uključivanja ove dece u program rane intervencije.*

Metod: *Uzorak je činio 331 učenik oba pola uzrasta od 7.3 do 11 godina bez neuroloških deficita, psihijatrijskih oboljenja, somatskih ili senzornih oštećenja i intelektualnih kapaciteta u okviru prosečnih i iznad prosečnih. Za utvrđivanje razvojnog poremećaja koordinacije korišćen je Protokol za procenu motoričkog funkcionisanja, a za procenu kvaliteta pisanja, čitanja i računanja Protokol za procenu bazičnih akademskih veština.*

Rezultati: *Poremećaj u motoričkom funkcionisanju (SD<2) pronađen je kod 5,1% uzorka, a kod 11,5% su ispoljeni samo elementi poremećaja (SD<1). Poremećaj koordinacije je ujednačeno zastupljen na različitim uzrastima, a pridružene teškoće u akademskim veštinama su, pored različite distribucije u odnosu na složenost ispoljavanja, ispoljene na svim uzrastima. Do polaska u školu samo dva učenika su bila uključena u program stručne podrške. Tokom školovanja osam učenika dobija podršku nastavnika u učenju, a devetoro je uključeno u program razvojne rehabilitacije defektologa.*

Zaključak: *Obzirom na perzistenciju poremećaja tokom čitavog mlađeg školskog uzrasta, od izuzetnog značaja je uključivanje u programe rane intervencije u različitim oblastima, a u cilju prevencije poremećaja, ublažavanja teškoća i sprečavanja sekundarnih smetnji.*

Ključne reči: *razvojni poremećaj koordinacije, akademske veštine, rana intervencija*

---

[1] Rad je realizovan u okviru projekta Kreiranje Protokola za procenu edukativnih potencijala dece sa smetnjama u razvoju kao kriterijuma za izradu individualnih obrazovnih programa (179025), koji finansira Ministarstvo prosvete, nauke i tehnološkog razvoja

UVOD

Razvojni poremećaj koordinacije, kao neurorazvojni poremećaj (prema DSM–V, 2013) odnosi se na motoričke deficite razvojnog porekla koji nisu uzrokovani opštim zdravstvenim stanjem, ne mogu se objasniti intelektualnim smetnjama i nisu u sklopu pervazivnih razvojnih poremećaja. Motoričke smetnje obuhvataju značajno kašnjenje motoričkog razvoja, nespretnost, lošu senzomotornu koordinaciju i pisanje, ravnotežu i posturalnu kontrolu, teškoće u motornom učenju, strateškom planiranju, vremenskom usklađivanju i sekvencioniranju pokreta, procesiranju vizuelno prostorne informacije (Coetzee, Pienaar, 2013; Rosenblum, 2013; Fong et al., 2012; Gheysen et al., 2011; Sinani, 2011; Nikolić, Ilić Stošović, 2009; Coleman et al., 2004; Schoemaker et al., 2001). Manifestacija poremećaja ima različite efekte na dečiji život. Prisutne su zdravstvene smetnje, teškoće u aktivnostima svakodnevnog života, lošija akademska postignuća, oskudne socijalne kompetencije (Venetsanou et al., 2011), afektivne, zdravstvene i psihijatrijske sekundarne posledice u adolescentnom dobu (Piek et al., 2010; Magalhaes et al., 2011).

Pojavljuje se na ranom uzrastu, ali se obično ne dijagnostikuje formalno pre pete godine života deteta, već se, u većini slučajeva, dijagnoza postavlja na uzrastu od šeste do dvanaeste godine (Barnhart, et al., 2003). Većina dece sa blagim poremećajima ne bude identifikovana, dok je među decom sa utvrđenom dijagnozom samo 25% identifikovano u predškolskom, a ostali tokom školskog perioda (EACD) (Blank et al, 2012; Gibbs et al, 2007).

CILJ

Cilj rada je da ukaže na značaj i potrebu rane intervencije kod dece sa razvojnim poremećajem koordinacije. Intencija ovog rada je da, kroz analizu prevalence razvojnog poremećaja koordinacije i pridruženih teškoća u akademskim veštinama kod dece sa ovim poremećajem i razmatranjem tendencije prevazilaženja poremećaja spontanim sazrevanjem, istakne značaj uključivanja u program rane intervencije.

METOD RADA

Uzorak istraživanja činio je 331 učenik, oba pola, 151 dečak i 180 devojčica, uzrasta 7.3 do 11 godina, bez neuroloških deficita, psihijatrijskih oboljenja, somatskih ili senzornih oštećenja i intelektualnih kapaciteta u okviru prosečnih i iznad prosečnih. Učenici su prošli obaveznu obuku pisanja, čitanja i računanja na srpskom jeziku.

Instrumenti i procedura. Istraživanje je sprovedeno tokom školske 2013/14. i 2014/15. godine nakon dobijene saglasnosti uprave osnovne škole i pojedinačne saglasnosti roditelja za učešće u istraživanju. Prikupljeni su podaci iz školske dokumentacije i od roditelja popunjavanjem upitnika. Procenjene su opšte sposobnosti Ravenovim progresivnim matricama u boji, prema lokalnim normama testa (Fajgelj, 2007). Pisanje i računanje su grupno testirani u okviru pojedinačnih odeljenja tokom dve seanse, a zatim je testirano čitanje i motoričko funkcionisanje svakog učenika individualno od strane defektologa u dve odvojene seanse. Za utvrđivanje razvojnog poremećaja koordinacije korišćen je Protokol za procenu motoričkog funkcionisanja (Nišević, 2016) koji procenjuje kvalitet i nivo neuromaturacije, praksije i izvođenja pokreta, somatosenzorne i senzomotorne organizacije i opštu motoričku spretnost. Standardizacijom skorova na ukupnoj skali motoričkog funkcionisanja izdvojene su tri kategorije motoričke performanse: postignuća koja odgovaraju uzrastu (prosečna i iznad proseka), postignuća koja odstupaju 1SD od proseka uzorka (ukazuju na elemente poremećaja motorike) i postignuća koja odstupaju 2 SD od proseka uzorka (govore o postojanju razvojnog poremećaja motorike). Za utvrđivanje kvaliteta čitanja, pisanja i računanja korišćen je Protokol za procenu bazičnih akademskih veština (Nišević, 2016). Standardizacijom skorova na subskalama, postignuća za čitanje, pisanje i računanje razvrstana su u četiri kategorije: prosečno i iznadprosečno postignuće za sve posmatrane akademske veštine, ispodprosečno postignuće na jednoj veštini, ispodprosečno postignuće na dve veštine i ispodprosečno postignuće na sve tri veštine.

U statističkoj obradi podataka korišćene su mere učestalosti i X^2 test za utvrđivanje značajnosti međugrupnih razlika.

REZULTATI SA DISKUSIJOM

Tabela 1 – Prevalenca razvojnog poremećaja koordinacije

	Teškoće AV		Bez teškoća AV		Ukupno	
RPKOO	N	%	N	%	N	%
< 2 SD	12	3,6	5	1,5	17	5,1
< 1 SD	24	7,3	14	4,2	38	11,5
PROS	80	24,2	196	59,2	276	83,4
UKUPNO	116	35,1	215	64,9	331	100,00

Teškoće AV – prisutne teškoće u akademskim veštinama; Bez teškoća AV – bez teškoća u akademskim veštinama;RPKOO – razvojni poremećaj koordinacije; <2SD – 2SD ispod proseka; <1SD – 1SD ispod proseka;PROS – prosečno i iznadprosečno postignuće.

Na uzrastu od 7,3 do 11 godina u ukupnom uzorku 5,1% dece ispoljava razvojni poremećaj koordinacije, a kod 11,5% prisutni su deficiti u motoričkom funkcionisanju u nekim od posmatranih domena motorike (Tabela 1). Ovakvi rezultati su u skladu sa podacima iz literature o prevalenci razvojnog poremećaja koordinacije, gde se najčešće sreće podatak od 5-6% učestalosti na uzrastu pet do jedanaest godina (Zwicker et al., 2012; Missiuna et al., 2011; Polatajko et al., 2006) i prema DSM-5 klasifikaciji (2013), što ovaj poremećaj svrstava u najčešće razvojne poremećaje.

Nadalje, iz ukupnog uzorka kod 3,6% dece sa ispoljenim poremećajem koordinacije i 7,3% sa elementima poremećaja, u isto vreme, pronađena su i loša akademska postignuća u oblasti čitanja, pisanja i/ili računanja (Tabela 1).

Tabela 2 – Prisustvo motoričkih poremećaja i pridruženih teškoća u akademskim veštinama u odnosu na uzrast

Razred	RPKOO	Pridružene teškoće AV				
		3 AV	2 AV	1 AV	∑ (3AV+2AV+1AV)	0 AV
I	< 2 SD	2	0	0	2	1
	< 1 SD	1	3	2	6	4
	∑	3	3	2	**8**	5
II	< 2 SD	0	2	2	4	1
	< 1 SD	0	2	2	4	4
	∑	0	4	4	**8**	5
III	< 2 SD	0	2	3	5	2
	< 1 SD	2	2	3	7	3
	∑	2	4	6	**12**	5
IV	< 2 SD	0	1	0	1	1
	< 1 SD	1	2	4	7	3
	∑	1	3	4	**8**	4
UKUPNO	< 2 SD	2	5	5	12	5
	< 1 SD	4	9	11	24	14
	∑	6	14	16	36	19

RPKOO – razvojni poremećaj koordinacije; <2SD – 2SD ispod proseka; <1SD – 1SD ispod proseka; PROS – prosečno i iznadprosečno postignuće; AV – akademske veštine; 3AV – ispodprosečno postignuće u sve tri akademske veštine; 2AV – ispodprosečno postignuće u dve akademske veštine; 1AV – ispodprosečno postignuće u jednoj akademskoj veštini; 0AV – prosečno i iznadprosečno postignuće u sve tri akademske veštine.

Frekvenca ispoljavanja poremećaja različite težine ujednačena je na svim uzrastima, osim u trećem razredu, što se može pripisati individualnim razlikama (Tabela 2). Rezultati pokazuju da se poremećaj koordinacije zadržava tokom čitavog mlađeg školskog uzrasta, što ukazuje da se motorički deficiti ne prevazilaze spontanim sazrevanjem.

U kontekstu pridruženih teškoća u akademskim veštinama, distribucija ispitanika sa poremećajem koordinacije pokazuje međugrupnu varijabilnost, kako u odnosu na uzrast, tako i na složenost komplikacija i uslovljena je individualnim razlikama (Tabela 2). Ove teškoće perzistiraju na svim uzrastima, ali njihova slika menja složenost. Broj učenika sa ispoljenim poremećajem koordinacije se povećava sa uzrastom do trećeg razreda, dok broj onih sa elementima poremećaja raste od trećeg razreda.

Tabela 3 – Prisustvo podrške kod dece sa razvojnim poremećajem koordinacije

Razred	RPKOO	Podrška				
		bez podrške	do polaska u školu	podrška tokom školovanja		
				podrška AV	podrška defektologa	podrška logopeda
I	< 2 SD	1	0	0	2	0
	< 1 SD	8	0	0	0	1
II	< 2 SD	3	0	1	1	0
	< 1 SD	3	0	1	1	0
III	< 2 SD	3	1	2	0	1
	< 1 SD	5	1	3	0	0
IV	< 2 SD	1	0	0	1	0
	< 1 SD	5	0	1	2	0
UKUPNO	< 2 SD	8	1	3	4	1
	< 1 SD	21	1	5	3	1

Podršku u predškolskom periodu dobijalo je samo dvoje dece sa razvojnim poremećajem koordinacije, dok je sa polaskom u školu i tokom čitavog mlađeg školskog perioda, veći broj dece uključen u organizovanu podršku nastavnika usmerenu ka akademskim postignućima i/ili u razvojne rehabilitacione programe defektologa (Tabela 3). Ovo navodi na zaključak da je potreba za intervencijom prepoznata tek u školskom periodu, što se povezuje sa ispoljavanjem zaostajanja u akademskim postignućima. Možemo postaviti pitanje koliki bi bio učinak rane intervencije, sprovedene u oblasti motoričkog razvoja, na prevenciju teškoća u učenju.

ZAKLJUČAK

Polazeći od rezultata, možemo zaključiti da razvojni poremećaj koordinacije, zbog učestalosti javljanja i sekundarnih smetnji u akademskim veštinama, predstavlja značajno stanje detinjstva.

Sa druge strane, intervencija i programi podrške su za veći broj dece organizovana tek tokom školskog perioda, obzirom da implikacije razvojnog poremećaja koordinacije postaju jasno uočljive na školskom uzrastu.

S obzirom na značajan faktor rizika tokom dugog perioda detinjstva, jasna je potreba za što ranijom identifikacijom i obezbeđivanjem intervencije usmerene ka mlađoj deci. Uključivanje u programe rane intervencije u različitim oblastima i na različitim nivoima jeste efikasna intervencija (rehabilitaciona strategija) u razvojnom periodu.

Rana intervencija bi se zasnivala na pravovremenosti i pravilnoj dijagnostici (što je ranije problem detektovan, pravilno dijagnostikovan i započet tretman, šire su mogućnosti korišćenja prirodnih bioloških maturacionih resursa i veći su i izgledi postizanja željenih efekata), preventivnom delovanju na sekundarne posledice (sprečavanje nepoželjne evolucije smetnji koje mogu progresivno obuhvatati sve šire oblasti detetove ličnosti i ponašanja), višedimenzionalnosti (paralelno delovanje na dete – lični biološki kapaciteti i okruženje – funkcionisanje u kućnoj, školskoj sredini), višestepenosti i transdisciplinarnosti (dijagnostika i intervencija na različitim nivoima od školske sredine do specijalizovanih dijagnostičkih i rehabilitacionih procedura u posebnim institucijama).

REFERENCE

1. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5^{tm}). Washington, DC London, England.
2. Barnhart, RC, Davenport, MJ, Epps, SB, Nordquist, VM. (2003). Developmental coordination disorder. *Phys Ther 83*(8)*:*722-31.
3. Blank R, Smits-Engelman B, Polatajko H, Wilson P. (2012). European Academy for Childhood Disability: recommendations on the definition, diagnosis and intervention of developmental coordination disorder (long version). *Dev Med Child Neurol 54,* 54-93.
4. Chen, Y., Tseng, Mei-Hui, Huc, Fu-Chang, Cermak, A. S. (2009). Psychosocial adjustment and attention in children with developmental coordination disorder using different motor tests. *Research in Developmental Disabilities 30,* 1367–1377.
5. Coetzee, D., Pienaar, E. A. (2013). The effect of visual therapy on the ocular motor control of seven-to eight-year-old children with Developmental Coordination Disorder (DCD). *Research in Developmental Disabilities 34,* 4073-4084.
6. Coleman, R., Piek, P. J., Livesey, J. D. (2004). A longitudilal study of motor abillity and kinaesthetic acuity in young children at risk of developmental coordination disorder. *Human Movement Science 20*, 95-110
7. Dewey, D., Kaplan, J. B., Crawford, G. S., Wilson, N. B., (2002). Developmental coordination disorder: Associated problems in attention, learning, and psychosocial adjustment. *Human Movement Science 21,* p.905-918.
8. Фајгељ, С., Бала, Г., Тубић, Т. (2007). Равенове прогресивне матрице у боји – основна мерна својства и норме. *Психологија, 40 (2),* стр. 293-308.
9. Fong, S.M. S., Tsang, W.N. W., Gabriel Y.F. (2012). Altered postural control strategies and sensory organization in children with developmental coordination disorder. *Human Movement Science 31,* 1317–1327.
10. Geuze, H.R., Jongmans, J. M., Schoemaker, M.M., Smits-Englesman, C. M. B. (2001). Clinical and research diagnostic criteria for developmental coordination disorder: a review and discusion. *Human Movement Science 20,* 7-47.
11. Gibbs, J, Appleton, J., Appleton, R. (2007). Dyspraxia or developmental coordination disorder: unrevelling the enigma. *Archives of Disease in Childhood, 92,* 534-539.

12. Gheysen, F., Waelvelde, Van H., Fias, W. (2011). Impaired visuo – motor sequence learning in Developmental Coordination Disorder. *Research in Developmental Disabilities 32,* 749-756.
13. Kaplan, J. B., Wilson, N. B., Dewey, D., Crawford, G. S. (1998). DCD may not be a discrete disorder. *Human Movement Science 17,* 471-490.
14. Macnab, J. J., Miller, T. L., Polatajko, J. H. (2001). The search for subtypes of DCD: Is cluster analysis the answer? *Human Movement Science 20*, 49-72.
15. Magalhaes, C.L., Cardoso, A.A., Missiuna, C. (2011). Activities and participation in children with developmental coordination disorder: A systematic review. *Research in Developmental Disabilities 32,* 1309–1316.
16. Missiuna, C., Cairney, J., Pollock, N., Russell, D., Macdonald, K., Cousins, M., Veldhuizen, S., Schmidt, L. (2011). A staged approach for identifying children with developmental coordination disorder from the population. *Research in Developmental Disabilities 32*, 549–559.
17. Nikolić, J. S., & Ilić Stošović, D. (2009). Detection and prevalence of motor skill disorders. *Research in Developmental Disabilities 30*, 1281-1287.
18. Nišević, S. (2016). *Bazične akademske veštine kod dece sa razvojnim poremećajem koordinacije.* Doktorska disertacija. Beograd: Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju.
19. Piek, P. J., Barrett C. N., Smith, M. L., Rigoli, D., Gasson, N. (2010). Do motor skills in infancy and early childhood predict anxious and depressive symptomatology at school age? *Human Movement Science 29,* 777–786.
20. Polatajko, J. H., Cantin, N. (2006). Developmental Coordination Disorder (Dyspraxia): An Overview of the State of the Art. *Seminars in Pediatric Neurology 12*, 250-258.
21. Rosenblum, S., & Livneh-Zirinski, M. (2008). Handwriting process and product characteristics of children diagnosed with developmental coordination disorder. *Human Movement Science, 27(2),* 200–214.
22. Rosenblum, S., Regev, N. (2013). Timing abilities among children with developmental coordination disorders (DCD) in comparison to children with typical development. *Research in Developmental Disabilities 34*, 218–227
23. Schoemaker, M.M., Van Der Wees, M., Flapper, B., Varheij-Jansen, N., Scholten-Jaegers, S., Geuze, H.R. (2001). Perceptual skills of children with developmental coordination disorder. *Human Movement Science 20*, 111-133.
24. Sinani, C., Sugden, A. D., Hill, L. E.(2011). Gesture production in school vs. clinical samples of children with Developmental Coordination Disorder (DCD) and typically developing children. *Research in Developmental Disabilities 32,* 1270–1282.
25. Toussaint-Thorin, M., Marchal, F., Benkhaled, O., Pradat-Diehl, P., Boyer, F.-C., Chevignard, M. (2013). Executive functions of children with developmental dyspraxia: Assessment combining neuropsychological and ecological tests. *Annals of Physical and Rehabilitation Medicine 56,* 268–287.

26. Venetsanou, F., Kambas, A., Ellinoudis, T., Fatouros, I., Giannakidou, D., Kourtessis, T. (2011). Can the Movement Assessment Battery for Children-Test be the "gold standard" for the motor assessment of children with Developmental Coordination Disorder? Research in Developmental Disabilities 32, 1–10
27. Visser, J. (2003). Developmental coordination disorder: a review of research on subtypes and comorbidities. *Human Movement Science 22,* 479–493.
28. Zwicker, G.J., Missiuna, C., Harris, R.S., Boyd, A. L. (2012). Developmental coordination disorder: A review and update. *European Journal of Paediatric Neurology 16,* 573 –581.

EARLY INTERVENTION OF CHILDREN WITH DEVELOPMENTAL COORDINATION DISORDERS

Snežana Nišević*, Snežana J. Nikolić**, Danijela Ilić-Stošović**
*Primary special school "Boško Buha", Belgrade, Serbia
**University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: The subject of this research is developmental coordination disorders in primary school children in the aim to highlight the need for early intervention in children with disorder. It was analyzed the prevalence of developmental coordination disorders and presence of the associated difficulties in academic skills. It was discussed the tendency of spontaneous maturing overcoming of disorder in light of importance of the involvement in the early intervention program.

Method: The sample consisted of 331 pupils of both sexes aged 7.3 to 11 years with no neurological deficit, psychiatric disorders, somatic or sensory impairments and average and above intellectual capacity. It was used Protocol of motor functioning to establish developmental coordination disorder and Protocol for basic academic skills evaluation to determine the quality of writing, reading and numeracy.

Results: In 5.1% of the sample was found motor disorder (SD <2) and 11.5% manifested elements of disorder (SD <1). Coordination disorder was equally represented at different ages and the associated difficulties of academic skills was manifested in all ages with varying distribution and complexity. Two students were included in the program of professional support at preschool period and during the school period eight were supported in learning by teacher and nine through development rehabilitation by special educator.

Conclusion: Based on the persistence of disorder overall early school age there is great importance of including to the early intervention programs in the various areas in order to prevent a disorder, alleviating the difficulties and prevent the secondary disorders.

Key words: developmental coordination disorder, academic skills, early intervention

UDC 159.953.5-053.4
37.012
37.015:159.953.5-053.4

Semantička kategorizacija kod dece predškolskog uzrasta[1]

Milica Gligorović, Nataša Buha
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija
Jelena Obradović
Osnovna škola „Vuk Karadžić", Ćuprija, Srbija

Dete tokom razvoja formira kategorije na osnovu sličnosti i razlika, najpre prema perceptivnim svojstvima objekata, a potom prema semantičkim odnosima među pojmovima, koji mogu da budu uspostavljeni na komplementarnosti baziranoj na istovremenoj pojavi/aktivnosti (tematske relacije) ili sličnostima zasnovanim na zajedničkim karakteristikama (taksonomske relacije). Prema nalazima nekih istraživanja, prelaz između tematske i taksonomske kategorizacije se javlja oko sedme godine, dok druge studije ukazuju na to da se taksonomski odnosi javljaju ranije, između četvrte i pete godine života.

Cilj ovog istraživanja je utvrđivanje dinamike razvoja semantičke kategorizacije kod dece predškolskog uzrasta.

Uzorkom je obuhvaćeno sedamdesetpetoro dece tipičnog razvoja, uzrasta 4-6,11 godina (AS=5,052; SD=0,814). Uzorak čini 39 (52%) dečaka i 36 (48%) devojčica, a podeljen je u tri jednake uzrasne grupe.

Podaci uzrastu i vrtićkoj grupi dobijeni su iz pedagoško-psihološke službe vrtića koji ispitanici pohađaju.

Kategorizacija je procenjena zadacima slobodne klasifikacije i početne kategorijalne fleksibilnosti, u kojima ispitanik samostalno svrstava pojmove prema odabranom kriterijumu, i zadacima višestrukog izbora, u kojima se odgovor bira iz grupe ponuđenih mogućnosti. Beležena je uspešnost i vrsta odgovora.

Primenom multivarijatne analize varijanse utvrđeno je da je uzrast značajan činilac ukupnog postignuća na zadacima kategorizacije ($p \leq 0{,}000$), koji objašnjava 31% varijabilnosti. Statistički značajan odnos uzrasta i sposobnosti kategorizacije ustanovljen je u domenima početne kategorijalne fleksibilnosti ($p=0{,}050$) i primene perceptivnog ($p=0{,}012$), tematskog ($p=0{,}004$)

---

[1] Rad je proistekao iz projekta „Kreiranje protokola za procenu edukativnih potencijala dece sa smetnjama u razvoju kao kriterijuma za izradu individualnih obrazovnih programa", broj 179025 (2011-2017), čiju realizaciju finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

i taksonomskog (p≤0,000) pristupa kategorizacji. Post hoc analizom utvrđeno je da se značajna razlika u uspostavljanju taksonomskih odnosa javlja između četvrtogodišnjaka i petogodišnjka (p=0,046).

Prema rezultatima našeg istraživanja, taksonomski odnosi među pojmovima počinju da se uspostavljaju između četvrte i pete godine života deteta, što predstavlja smernicu za programiranje sadržaja aktivnosti u predškolskom uzrastu.

Ključne reči: *tematska kategorizacija, taksonomska kategorizacija, predškolski uzrast*

UVOD

Deca mlađeg uzrasta za grupisanje objekata koriste različite kriterijume, od kojih su najčešći perceptivna svojstva, ime i funkcija. Verbalni označitelj (ime) objekta se smatra najznačajnijim kriterijumom grupisanja u pojam (Bloom, 2001), dok je uspostavljanje veza među različitim pojmovima zasnovano na perceptivnim obeležjima, funkciji objekta, kontekstu i zajedničkim osobinama (Quinn, 2002). Kako postaju starija, deca sve više umesto perceptivnih koriste funkcionalne kriterijume za grupisanje objekata. Upotrebu funkcionalnog principa sortiranja neki autori svrstavaju u širi kontekst tematske kategorizacije, koja podrazumeva grupisanje različitih objekata prema nekom zajedničkom događaju ili temi, pri čemu su ti objekti povezani istim kontekstom i stoga dele određene prostorne, vremenske ili funkcionalne karakteristike (Booth & Waxman, 2002; Estes, Golonka & Jones, 2011).

Dete najpre ovladava kategorijama zasnovanim na akcijama nad objektima, a kasnije se iz njih postepeno izdvajaju semantičke propozicije, pri čemu akcija prelazi u drugi plan i dolazi do proširivanja propozicija na druge objekte (Perraudin & Mounoud, 2009; Pijaže i Inhelder, 1996). To stvara osnov za razvoj taksonomske kategorizacije, bazirane na povezanosti objekata nekim zajedničkim osobinama (Blaye, Bernard-Peyron, Paour & Bonthoux, 2006). U kategorizaciju pojmova u inkluzivne ili više kategorije (hijerarhijsku klasifikaciju) neposredno su uključene apstrakcija (izdvajanje relevantnih obeležja uz zanemarivanje drugih) i generalizacija (uopštavanje relevantnih obeležja) (Gelman, 2006; Gligorović, 2013; Mounoud, Duscherer, Moy & Perraudin, 2007). Vremenom dolazi do povezivanja pojmovnih (npr. *cvet*), taksonomskih (*cvet pripada biljkama*), kontekstualnih (*cvet raste na livadi*), funkcionalnih (*cvet se poklanja za rođendan*) i drugih odnosa, pa formirane kategorije i njihova međusobna interakcija omogućavaju stvaranje konceptualnog kontinuuma (Booth & Waxman, 2002).

Prema rezultatim većine empirijskih istraživanja, kriterijumi kategorizacije se tokom razvoja menjaju od perceptivnog, preko tematskog ka taksonomskom (Gelman, 2006). Neki autori smatraju da se prelaz sa tematske na taksonomsku kategorizaciju javlja oko sedme (Pijaže i Inhelder, 1996), dok rezultati drugih studija ukazuju na to da se taksonomski odnosi pojavljuju ranije, između četvrte i pete godine života deteta (Perraudin & Mounoud, 2009).

U razmatranju razvoja kategorizacije neophodno je imati u vidu i dinamiku razvoja kategorijalne fleksibilnosti, koja omogućava detetu da, primenom različitih propozicija, isti objekat svrsta u više grupa. Prvi razvojni pomaci u domenu kategorijalne fleksibilnosti zapažaju se između treće i četvrte godine, a značajniji napredak između šeste i sedme godine života deteta (Blaye & Bonthoux, 2001; Oakes, 2009; Welder & Graham, 2006).

CILJ RADA

Cilj istraživanja je da se utvrdi dinamika razvoja semantičke kategorizacije kod dece predškolskog uzrasta.

METOD RADA

Uzorak

Uzorkom je obuhvaćeno sedamdesetpetoro dece tipičnog razvoja, uzrasta 4-6,11 godina (AS=5,052; SD=0,814). Čine ga 39 (52%) dečaka i 36 (48%) devojčica, podeljenih u tri jednake uzrasne grupe.

Instrumenti i procedura

Kategorizacija je procenjena zadatkom slobodne klasifikacije i početne kategorijalne fleksibilnosti, u kome ispitanik svrstava pojmove prema samostalno odabranom kriterijumu, i zadacima višestrukog izbora.

U zadatku kojim se procenjuje klasifikacija (pojmovna i kategorijalna) i kategorijalna fleksibilnost, detetu se daje 10 izmešanih kartica sa slikama odraslih i njihovih mladunaca, sa nalogom da ih razvrsta. Ukoliko ispitanik razvrsta kartice prema pojmovnom principu, daje mu se nalog da ih sve po nečemu svrsta u dve grupe (primeni kategorijalni princip). Beleženi su uspešnost grupisanja, tip grupisanja i mogućnost izmene kriterijuma sortiranja (kategorijalna fleksibilnost).

Zadatak kojim se procenjuje preovladavajući princip kategorizacije (perceptivna ili semantička, nezavisno od tipa) se sastoji iz tri ajtema sa slikama poznatih objekata; od deteta se očekuje da, od pet ponuđenih (sličnih po perceptivnom svojstvu, funkciji, kontekstu, taksonomskoj kategoriji ili neasocijativnih), izabere sliku koja je povezana sa ciljnim stimulusom. Beleži se broj odgovora zasnovanih na perceptivnim svojstvima, semantičkim propozicijama i broj neasocijativnih odgovora.

Za procenu tipa semantičke kategorizacije primenjen je zadatak koji se sastoji iz osam ajtema, na kojima je prikazan po jedan ciljni stimulus (slike poznatih bića i objekata) i grupa od tri stimulusa (po jedan koji odgovara taksonomskom i tematskom pristupu, a treći je neasocijativan) među kojima dete bira sliku koja najviše ide uz ciljni stimulus. Beleži se vrsta tačnih odgovora i broj grešaka (Gligorović, 2013).

U statističkoj obradi podataka korišćeni su χ^2 test, analiza varijanse i Šefeov post hoc test.

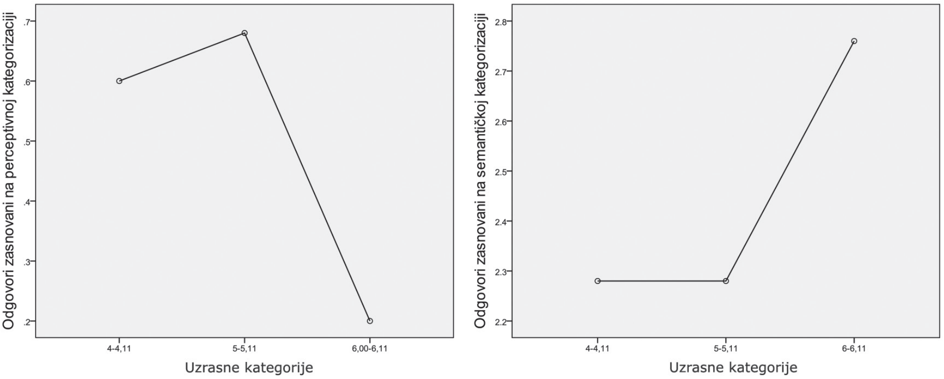
REZULTATI ISTRAŽIVANJA SA DISKUSIJOM

Na zadatku kojim se procenjuje klasifikacija i kategorijalna fleksibilnost, većina (97,3%) ispitanika grupiše kartice u parove pripadnika iste vrste. I nakon naloga ispitivača da se kartice svrstaju u dve grupe, 90,7% ispitanika je nastavilo da grupiše kartice prema pojmovnom principu, prostorno modifikujući prethodno rešenje. Kategorijalna fleksibilnost je zastupljena kod 9,3% ispitanika.

Odnos uzrasta i uspešnosti na zadatku početne kategorizacije nije statistički značajan ($F_{(2)}$=1,500; p=0,230). Iako je izmena principa sortiranja uočena kod malog broja ispitanika, odnos uzrasta i početne kategorijalne fleksibilnosti je statistički značajan (χ^2=5,987; df=2; p=0,050).

Većina dece ima iskustvo sortiranja životinja na domaće i divlje, koje mogu da primene u toku kategorizacije, dok u situaciji kada na raspolaganju imaju samo jednu od tih kategorija, treba da uzmu u obzir druge karakteristike stimulusa (Gligorović, 2013). Neki autori smatraju da trogodišnjaci mogu da klasifikuju objekte prema jednom, nepreklapajućem i stabilnom, kriterijumu (Quinn, 2002), pa se može pretpostaviti da bi naši ispitanici bili uspešniji u rešavanju zadataka jednostavnijeg dizajna, uz upotrebu već usvojenih kategorija. Dobijeni rezultati su u skladu sa nalazima studije u kojoj je, primenom zadatka sortiranja igračaka, utvrđeno da se klasifikacija prema jednom kriterijumu usavršava između četvrte i pete godine života, dok uvođenje drugog kriterijuma zahteva dodatne instrukcije, a samostalno grupisanje prema svim (boja, oblik i veličina) zadatim parametrima postaje moguće nakon sedme godine života (Smidts, Jacobs & Anderson, 2004).

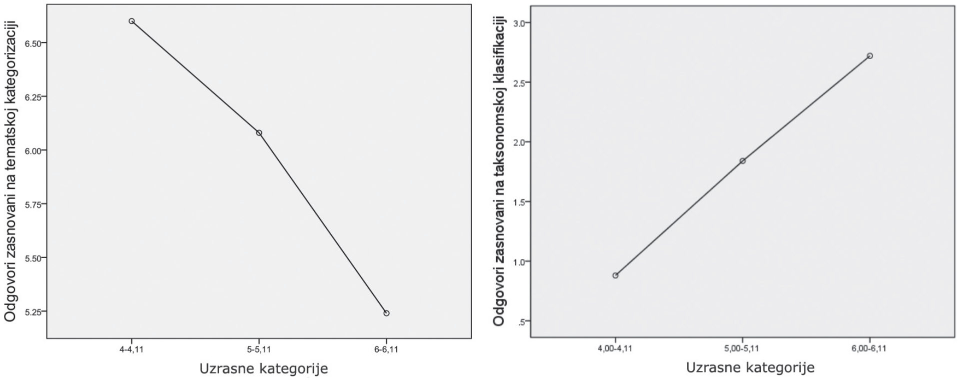
Analizom rezultata zadatka kojim se procenjuje preovladavajući princip kategorizacije, utvrđeno je da je uzrast značajan činilac zastupljenosti perceptivne ($F_{(2)}$=4,579; p=0,012) i semantičke ($F_{(2)}$=4,827; p=0,011) kategorizacije (grafikoni 1 i 2), dok se broj nedekvatnih odgovora ne menja sa uzrastom ($F_{(2)}$=0,842; p=0,435). Post hoc analizom je utvrđeno da se prema zastupljenosti perceptivne kategorizacije značajno razlikuju grupa najmlađih i najstarijih ispitnika (p=0,021), a u domenu semantičke kategorizacije četvorogodišnjaci (p=0,032) i petogodišnjaci (p=0,032) od šestogodišnjaka.



Grafikoni 1 i 2 – Zastupljenost perceptivne i semantičke kategorizacije prema uzrastu

Ovi rezultati su u skladu sa nalazima da šestogodišnjaci primenjuju veći broj semantičkih (tematskih i taksonomskih) kriterijuma za kategorizaciju nego perceptivnih (Gelman, 2006; Mirman & Graziano, 2012).

Analizom rezultata zadatka za procenu tipa semantičke kategorizacije, utvrđeno je da je uzrast statistički značajan činilac zastupljenosti tematske ($F_{(2}$)=5,870; p=0,004) i taksonomske ($F_{(2}$)=11,814; p≤0,000) kategorizacije (grafikoni 3 i 4), kao i broja neadekvatnih (neasocijativnih) odgovora (p=0,008).



Grafikoni 3 i 4 – Zastupljenost tematske i taksonomske kategorizacije prema uzrastu

Post hoc analizom je utvrđeno da se, prema zastupljenosti tematske kategorizacije, statistički značajno (p=0,005) razlikuju grupe najmlađe (4-5 godina) i najstarije (6-7 godina) dece iz uzorka, prema zastupljenosti taksonomske kategorizacije četvorogodišnjaci se razlikuju od petogodišnjaka (p=0,046) i šestogodišnjaka (p≤0,000), a prema broju neasocijativnih odgovora, četvorogodišnjaci od petogodišnjaka (p=0,050) i šestogodišnjaka (p=0,014). Razlika u zastupljenosti taksonomske kategorizacije između petogodišnjaka i šestogodišnjaka je nešto izvan statističke značajnosti (p=0,074). Sudeći prema dobijenim rezultatima, taksonomski odnosi među pojmovima počinju da se uspostavljaju između četvrte i pete godine života, ali se njihova progresija odvija postepeno.

Dobijeni rezultati su u skladu sa nalazima drugih istraživanja razvoja kategorizacije kod dece predškolskog uzrasta (Perraudin & Mounoud, 2009). Ipak, nezavisno od pojave i rastućeg trenda taksonomskih odgovora, većina petogodišnjaka i šestogodišnjaka i dalje dominantno primenjuje tematski princip grupisanja.

Uzrast je značajan činilac uspešnosti rešavanja svih primenjenih zadataka, grupisanih u model sposobnosti kategorizacije (Wilks' λ=0,981; $F_{(14)=}$4,070, $p \leq 0{,}000$; η^2=0,314). Nisu utvrđene na polu zasnovane razlike rezultata.

ZAKLJUČAK

Analizom rezultata procene kategorizacije kod dece predškolskog uzrasta utvrđeno je da se taksonomski odnosi među pojmovima javljaju između četvrte i pete godine života (p=0,046). Ipak, većina petogodišnjaka i šestogodišnjaka i dalje dominantno primenjuje tematski princip grupisanja, što potvrđuje tezu da se pun zamah kategorijalnog rezonovanja može očekivati sa pojavom operativnosti mišljenja, nakon sedme godine života deteta.

Iako je sposobnost fleksibilne izmene principa sortiranja i prelaska sa pojmovnog na kategorijalno grupisanje uočena kod malog broja ispitanika, odnos uzrasta i početne kategorijalne fleksibilnosti je statistički značajan (p=0,050), što ukazuje na postojanje razvojnog potencijala i otvara mogućnost kreiranja sistematičnog pristupa, fokusiranog na kategorijalno rezonovanje, u radu sa decom predškolskog uzrasta.

LITERATURA

1. Blaye, A., & Bonthoux, F. (2001). Thematic and taxonomic relations in preschoolers: The development of flexibility in categorization choices. *British Journal of Developmental Psychology*, *19*(3), 395-412.
2. Blaye, A., Bernard-Peyron, V., Paour, J. L., & Bonthoux, F. (2006). Categorical flexibility in children: Distinguishing response flexibility from conceptual flexibility; the protracted development of taxonomic representations. *European Journal of Developmental Psychology*, *3*(2), 163-188.
3. Bloom, P. (2001). Roots of word learning. In Melissa Bowerman and Stephen C. Levinson.Language acquisition and conceptual development (pp. 159-181). Cambridge: CUP.
4. Booth, A. E., & Waxman, S. (2002). Object names and object functions serve as cues to categories for infants. *Developmental Psychology*, *38*(6), 948.
5. Estes, Z., Golonka, S., Jones, L. L. (2011). Thematic thinking: the apprehension and consequences of thematic relations. *Psychology of Learning and Motivation,* 54, 249-294.

6. Gelman, S. A. (2006). Early conceptual development. In K. McCartney and D. Phillips (Eds.). *The Blackwell Handbook of Early Childhood Development* (pp. 149-166). Oxford: Blackwell Publishing.
7. Gligorović, M. (2013). *Klinička procena i tretman teškoća u mentalnom razvoju*. Beograd: Univerzitet u Beogradu - Fakultet za specijalnu edukaciju i rehabilitaciju.
8. Mirman, D., & Graziano, K. M. (2012). Individual differences in the strength of taxonomic versus thematic relations. *Journal of Experimental Psychology General, 141*(4), 601-609.
9. Mounoud, P., Duscherer, K., Moy, G., & Perraudin, S. (2007). The influence of action perception on object recognition: a developmental study. *Developmental Science*, *10*(6), 836-852.
10. Oakes, L. M. (2009). Categorization skills and concepts. In J. B. Benson and M. M. Haith (Eds), *Language, Memory and Cognition in Infancy and Early Childhood* (pp. 91-101). Oxford: Academic Press.
11. Perraudin, S., & Mounoud, P. (2009). Contribution of the priming paradigm to the understanding of the conceptual developmental shift from 5 to 9 years of age. *Developmental Science, 12*(6), 956-977.
12. Pijaže, Ž., Inhelder, B. (1996). *Intelektualni razvoj deteta*. Beograd: ZUNS
13. Quinn, P. C. (2002). Early categorization: A new synthesis. In U. Goswami (Ed.). *Blackwell Handbook of Childhood Cognitive Development* (pp. 84-101). Oxford: Blackwell Publishing.
14. Smidts, D. P., Jacobs, R., & Anderson, V. (2004). The Object Classification Task for Children (OCTC): A measure of concept generation and mental flexibility in early childhood. *Developmental Neuropsychology*, *26*(1), 385-401.
15. Welder, A. N., & Graham, S. A. (2006). Infants' categorization of novel objects with more or less obvious features. *Cognitive Psychology, 52*(1), 57-91.

SEMANTIC CATEGORIZATION IN PRESCHOOL CHILDREN

Milica Gligorović*, NatašaBuha*, Jelena Obradović**
*University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia
**Primary school "VukKaradžić", Ćuprija, Serbia

Research subject: During the developmental period, a child forms categories based on similarities and differences; at first according to perceptual properties of objects, and later according to semantic relations among the concepts. These relations can be based on thematic or taxonomic relations. According to the results of some researches, transition from thematic to taxonomic categorization occurs around seven years of age, while results of other studies indicate that taxonomic relations emerge earlier, between the ages of four and five.

Method: The aim of this research is to determine the developmental trend of semantic categorization in preschool children. The sample consisted of 75 children with typical development, between 4 and 6.11 years of age (M=5.052, SD=0.814). There were 39 (52%) boys and 36 (48%) girls distributed into three equal age groups.Data on age and preschool level were obtained by analyzing the records of the preschool pedagogical-psychological service. Categorization was assessed by applying the tasks of free classification and initial categorical flexibility, in which it was needed to independently sort concepts according to the selected criteria; multiple-choice tasks, in which it was needed to choose a response from the group of offered possibilities; and elimination tasks, in which it was required to identify the element that did not belong to the group. Performance was recorded, as well as the type of responses.

Results: By applying multivariate analysis of variance it was found that age was a significant factor of total achievement on categorization tasks ($p \leq 0.000$), explaining 31% of variability. Statistically significant relation was determined between age and categorization ability in the domain of initial categorical flexibility ($p=0.050$) and implementation of perceptive ($p=0.012$), thematic ($p=0.005$) and taxonomic ($p \leq 0.000$) approach to categorization. Post hoc analysis revealed that significant difference in establishing taxonomic relations occurred between the ages of four and five ($p=0.046$).

Conclusion: According to the results of our research, taxonomic relations among concepts start being established between the fourth and the fifth year of age, which can represent a guideline for activity programming for preschool age-children.

Key words: thematic categorization, taxonomic categorization, preschool children

udc 81’243:159.953.5
81’234-234-056.264-053.2
81’246.3

Total Physical Response Method in Teaching Foreign Languages to Dyslexic Children

Maja Cvijetić, Dejan Savičević
Preschool Teacher Training and Business Informatics College of Applied Studies, Sirmium, Sremska Mitrovica, Serbia

Research subject: *This paper deals with the problem of teaching English language to primary school children who have been diagnosed with dyslexia.*

Method: *The aim of this research is to investigate positive effects of Total Physical Response method in foreign language teaching to dyslexic children. The authors of the paper believe that second language learning and teaching should follow the natural process of language learner and therefore recommend combination of verbal and motor activities based on Stephen Krashen’s Natural Approach and James Asher’s Total Physical Response method. The survey was conducted on the sample of four dyslexic children of the second grade of primary school during six months. The students attended English classes in private school twice a week and followed the instructions according to the principle of Total Physical Response. They acquired language through motor movements. As oppose to majority of second language teaching that favorite left-brain learning, Total Physical Response focused on the learning process of right-brain. Language production, represented by the left hemisphere, was to follow naturally after sufficient right hemisphere learning accomplishment.*

Results: *Students’ English language knowledge was assessed by KET test at the initial and final testing. The results of Wilcoxon test and Z scores indicated statistical significance at the level p=0,05. Teaching supported by kinesthetic-tactile activities caught dyslexic students’ attention, interest and made the information more likely to be remembered.*

Conclusion: *Movement supported remembering. Repetition helped memory associations to become stronger and more easily recalled. Therefore, kinaesthetic learning is strongly recommended.*

Key words: *natural approach, second language acquisition, dyslexia, motor activity*

INTRODUCTION

Standard-Based English Language Curriculum indicates that English is taught as a second language in all Serbian primary and secondary schools. Unfortunately, there are a high percentage of students with learning disabilities who experience failures in a learning process. They often face side effects, like low marks, stress, and tiredness due to extra hours spent on studying, lack of self confidence and independence, social difficulties with classmates, teachers, and parents. The problem of inclusion in schools in Serbia became a big issue and integrating children with special needs and specific learning difficulties is one of principal aims. Therefore, teaching should be learner-centered, and lessons and curriculum materials must suit the differing abilities of pupils. The authors of this paper believe that improvements in language teaching come through the adoption of new and improved teaching approaches and methods that incorporate breakthroughs in our understanding of language and how language takes place. One of these methods is James Ahers' Total Physical Response, which is based on a notion that repetition helps memory associations to become stronger and more easily recalled (Asher, 2000). This can be gained by the combination of verbal and motor activities, combination of coordination, speech and action. These are the basic ideas supporting teaching language via movement (Richards, and Rodgers, 1997). The authors of this paper believe that second language learning and teaching should follow the natural processes of language learning (Larsen-Freeman, 2000). The theory stresses the importance of teaching foreign/second language alike the first language – "through the senses and through comprehensible input" (Werstler, 2002).

AIM

The aim of this research is to investigate positive effects of Total Physical Response method in foreign language teaching to dyslexic children. The treatment process which is to incorporate TPR approach while using visual aids, will help pupils with dyslexia perform better. Young learners tend to block out second language input if the anxiety level is high. They often feel traumatized by the traditional language teaching approach which ends up with giving up on the language. The authors of the paper investigate positive aspects of TPR in lowering the affective filter, as well as utilizing the auditory, visual and tactile learning channels, which is particularly suitable for pupils with dyslexia. Children are allowed to listen and choose the time they feel comfortable to start speaking, whereas kinaesthetic activities help dyslexic learners to develop decoding skills, vocabulary, syntactic and discourse knowledge.

METHOD

The survey was conducted on the sample of four dyslexic children of the second grade of primary school during six months. The students attended English classes in private school twice a week and followed the instructions according to the principle of Total Physical Response. Special lessons were particularly designed for re-educating dyslexic children. For the purpose of this study, the researcher used gestures, modeling pictures and realia whereby learners showed understanding by watching, touching, listening, imitating and reacting. They acquired language through motor movements. Students' English language knowledge was assessed by KET test at the initial and final testing. The results of Wilcoxon test and Z scores indicated statistical significance at the level p=0,05.

RESULTS AND DISCUSSION

Table 1 shows the results for the analyzed variables and groups in the initial and final measurement. The number of entities (N), arithmetic mean (Mean), standard deviation for each group (Std. Deviation) and minimum and maximum values at both measurements are presented.

Table 1 – Basic descriptive statistical parameters

		N	Mean	Std. Dev.	Min	max
Grammar	initial	4	5,50	0,577	5	6
	final	4	8,25	1,25	7	10
Vocabulary	initial	4	7,75	0,95	7	9
	final	4	15,75	2,62	12	18
Text Comprehension	initial	4	12,25	1,70	10	14
	final	4	18,50	1,29	17	20

Individual results were compared by Z-score, i.e. achievement index of each child was compared regarding the results of tests in the initial (Table 2) and final measurement (Table 3).

Table 2 – Achievement index in scores and Z scores in initial measurement

Name	Grammar Points.	Z value.	Vocabulary Points.	Z value.	Comprehension Points.	Z value.	∑Z scores
DP	6	-0,15	8	-052	14	1,21	0,54
MN	5	-0,92	9	0,35	12	-0,13	-0,70
DD	5	-0,92	7	-1,40	10	-1,48	-3,8
AV	6	-1,04	7	-1,38	13	-0,52	-2,94

The results presented in the Table 2 show that the child DP had the highest achievement index, whereas the child DD had the lowest achievement index.

Table 3 – Achievement index in scores and Z scores in final measurement

Name	Grammar Points	Z value	Vocabulary Points.	Z value.	Comprehension Points	Z value.	∑Z scores
DP	8	*0,15*	17	*-0,54*	20	*1,69*	**1,3**
MN	7	*-0,61*	18	*0,13*	18	*0,15*	**-0,33**
DD	8	*-0,61*	16	*-1,21*	17	*-0,61*	**-2,43**
AV	11	*-0,96*	12	*-1,25*	19	*0,45*	**-1,76**

According to these results, it can be concluded that children made progress after six months of treatment. The child DP showed the best score in the overall Z score in the final measurement but analyzing her overall achievement we can conclude that it is higher just in 0.11 points. However, by comparing the initial and final measurement we can conclude that children included in the experimental program showed positive achievement index, as well as that the child DD showed greatest achievement, whereas MN's achievement was the lowest. (Table 4.)

Table 4 – Overall achievement index

Name	∑Z score initial	∑Z score final	∑ achievement
DP	*0,54*	*1,3*	**+ 0,76**
MN	*-0,70*	*-0,33*	**+ 0,37**
DD	*-3,8*	*-2,43*	**+ 1,39**
AV	*- 2,94*	*-1,76*	**+1,18**

The child DD was reading with a lot of mistakes, which she rarely corrected; however, she understood the text and was able to retell it. However, TPR helped her overcome fear of failure and experience language learning in a completely different way. The child knew at any moment what was expected of her and she felt free to start speaking when she felt comfortable. The child MN has achieved the slightest progress, although the method was identical, but she has weaker audio memory. She had difficulties in recognizing sounds in words, sequencing sounds and letters in words in correct order, substituting words when reading aloud, expressing ideas in complete sentences, which made text comprehension more difficult.

In order to determine statistically significant differences in numerical indicators between two statistical series, Wilcoxon signed-rank test was applied. The Wilcoxon test based on two samples shows a significant difference in the results of initial and final measurement at p = 0.05, (Table 5). i.e. the experimental program resulted in statistically significant results in the vocabulary test and text comprehension.

Table 5 – Differences between the initial and final measurement results

	Grammar initial-final	Vocabulary initial-final	Text Comprehension initial-final
Z	*-1,844*	*-1,890*	*-1,890*
Sig. (2-tailed)	0,06	**0,05**	**0,05**

CONCLUSION

The results proved positive effects of TPR method while working with children with dyslexia. Body movements proved to be helpful with memorizing vocabulary items, their meaning and pronunciation. As oppose to majority of second language teaching that favorite left-brain learning, Total Physical Response focused on the learning process of right-brain. Language production, represented by the left hemisphere, was to follow naturally after sufficient right hemisphere learning accomplishment (Saville-Troike, 2006). The use of TPR and visual as treatment to dyslexic children maximized the use of senses and the structure explicit via became gestures and movement (Arnold, 1999). Dyslexic students'sensory learning channels are claimed to be mostly of tactile-kinaesthetic preferences which involves whole body movements, gestures, touching, mimics but also vocal apparatus. Teaching supported by kinaesthetic-tactile activities caught dyslectic students' attention, interest and made the information more likely to be remembered (Williams, 2001). The authors of this paper consider language-movement pairings to be beneficial for learners with dislexia. (Crary, 1993; Caruso, 1999) Lowering the affective filter thanks to kinaesthetic sensory activities helped the input to become comprehensible and acquired (Werstler 4, Peck 129). Relaxed, stress free environment enabled students to devote their full energy to learning. Therefore, the results of the research proved that TPR method positively influences English language knowledge of children with dyslexia.

REFERENCES

1. Arnold, J. Ed. (1999). *Affect in Language Learning*, Cambridge University Press.
2. Asher, J. (2000). Learning Another Language through Action, Sky Oaks Productions.
3. Caruso, Anthony and Edythe Strand (1999). Clinical Management of Motor Speech Disorders in Children, New York: Thieme.
4. Crary, M.A. (1993). Developmental Motor Speech Disorders. San Diego, CA: Singular.
5. Larsen-Freeman, D. (2000). *Techniques and Principles in Language Teaching,* Oxford University Press.
6. Richards, Jack C., and Theodore S. Rodgers. (1997). "Total Physical Approach." *Approaches and Methods in Language Teaching. Approaches and Methods in Language Teaching.* Oxford: Oxford University Press, 87-98.
7. Saville-Troike, M. (2006). Introducing Second Language Acquisition. Cambridge: Cambridge University Press.
8. Williams, Marion and Robert L. Burden (2001). *Psychology for Language Teachers*. Cambridge: Cambridge University Press.
9. Werstler, Jessica M. (2002). "Total Physical Response Storytelling: a Study in Actively Engaging Students Across the Modalities." MA thesis. Central Connecticut State University Digital Archive. Central Connecticut State University.

udc 159.922.76/056.49
616.89-008.47-053.2
159.952-056.49-053.2

Opcije tretmana za decu sa deficitom pažnje i hiperaktivnošću (ADHD)[1]

Danka M. Radulović
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Predmet istraživanja: *ADHD je sve prisutniji poremećaj među decom, a u trećini slučajeva progredira u delinkvenciju, pa je rana intervencija neophodna. No, kompleksna priroda ADHD sindroma i često prisustvo komorbidnih poremećaja otežava mogućnost iznalaženja adekvatnih formi tretmana dece sa ADHD i stvara potrebu za intervencijama namenjenim njihovim roditeljima i nastavnicima i širem socijalnom okruženju.*

Metod: *Iako postoje mnogobrojni vidovi tretmana njihova efikasnost je retko evaluirana, te su u radu razmotrene one intervencije koje se odnose na neposredni rad sa decom i na rad sa njihovim roditeljima i nastavnicima, a imaju preliminarnu empirijsku podršku.*

Rezultati: *Tretman ADHD ne predstavlja lečenje u medicinskom smislu, već je u funkciji redukcije simptoma poremećaja pažnje, impulsivnosti i hiperaktivnosti, odnosno poboljšanja bihevioralnih i emocionalnih aspekata funkcionisanja dece. Najčešći pristupi tretmanu su kognitivni i bihevioralni ili njihova kombinacija; koriste se i individualne i grupne forme psihoterapije, savetovanje i treninzi u porodičnom i školskom okruženju, a u psihijatrijskoj praksi farmakoterapija.*

Zaključak: *U planiranju tretmana, uz sagledavanje snage i slabosti deteta i njegove porodice, moraju se uzeti u obzir: uzrast i razvojni nivo deteta, najizraženiji deficiti koji otežavaju prilagođavanje i razvoj, pervazivnost simtoma i njihova situaciona varijabilnost, kao i koegzistirajući poremećaji. Generalno, najbolje rezultate obezbeđuje multimetodski pristup i prisustvo integrisanih intervencija u različitim okruženjima.*

Ključne reči: *ADHD, deca, roditelji, nastavnici, tretman*

1. PREDMET

Nedostatak pažnje, impulsivnost i preterana motorna aktivnost, simptimi su ADHD sindroma (APA, 1994) sve prisutnijeg među decom, koji u trećini slučajeva progredira u delinkvenciju (Robins, 1966, 1987, prema Radulović, 2014), te

---

[1] Rad je rezultat projekata Ministarstva prosvete, nauke i tehnološkg razvoja br. 47008 i br. 47011.

je od ključnog značaja da se što ranije otpočne sa tretmanom. Zbog složenosti ADHD sindroma (razvojni, neurofiziološki, bihevioralni) i čestih komorbidnih poremećaja (poremećaj ponašanja, opoziciono–devijantni i poremećaj učenja) postoji potreba da se intervencije kreiraju ne samo za decu, već i za roditelje, nastavnike i šire okruženje. Zato su u radu razmatrene moguće opcije tretmana dece sa ADHD s ciljem da se ukaže na prednosti i ograničenja u njihovoj primeni.

2. METOD

Mnogobrojni vidovi tretmana hiperaktivne dece koriste se u praksi, ali je relativno malo njih validirano, pa su u radu na bazi bibliotečkog i elektronskog (WoS) pregleda relevantne literature razmotrene one intervencije koje imaju preliminarnu empirijsku podršku.

3. REZULTATI

Tretman nema karakter lečenja u medicinskom smislu, već mu je funkcija u redukciji simptoma povezanih sa ADHD i u poboljšanju bihevioralnih i emocionalnih aspekata funkcionisanja dece koji su sa sindromom u vezi. Među empirijski verifikovanim opcijama tretmana su kognitivni, bihevioralni pristupi i njihova kombinacija, treninzi roditelja i nastavnika, integrisani i multimetodski pristupi i različite forme individualnih i grupnih psihoterapija.

3.1. Intervencije za decu sa ADHD

U tretmanu dece sa ADHD korisni su kognitivni i kognitivno-bihevioralni pristupi.

Među *kognitivnim* su kognitivno modelovanje, neurofidbek i metakognitivne strategije. Cilj metakognitivnih strategija je da unaprede egzekutivne funkcije kod dece starije od 7 godina. Deca uz pomoć njih uče da prate svoj misaoni tok, menjaju način mišljenja i uspešno uče. Kod neurofidbeka se uz pomoć različitih kompjuterskih programa deca uče samoregulaciji, poboljšaju pažnje i fleksibilnosti u prelaženju sa jedne aktivnosti na drugu, a uspešno se može tretirati preko 20 specifičnih kognitivnih funkcija. Dobre rezultate daje kombinacija neurofidbeka i metakognicije (Thompson & Thompson, 1998).

Kognitivno-bihevioralni pristupi kombinuju kognitivne strategije (npr. samokontrole uz samoposmatranje i samoinstrukcije) sa bihevioralnim tehnikama (potkrepljenja, samopotkrepljenja i modelovanja). Prednost im je u prilagođavanju tretmana posebnosti deteta (Abikoff & Hechtman, 1996). Nalazi govore da je njihov uspeh kratkotrajan jer ostaje potreba za nastavkom nadzora i potkrepljenja za većinu dece sa ADHD (Barkley, 2007), a neke tehnike npr.rešavanja problema ne dovode do značajnih promena u ponašanju (Pfiffner, Barkley, 1998). No, kognitivno-bihevioralni pristup je uspešan kod hiperaktivne dece sa drugim paralelnim poremećajima (poremećaj učenja, anksioznost) (Hallahan et al., 2005).

3.2. Intervencije za roditelje

Za roditelje dece sa ADHD korisni su treninzi i edukacije u primeni bihevioralnih tehnika.

U okviru *treninga* radi se na promeni njihovog ponašanja prema deci, usklađivanju zahteva i očekivanja sa uzrastom dece i vrši se kontrola njihovih postupaka u kontaktu sa decom. Evaluacije pokazuju da se programi najefikasnije sprovode sa roditeljima predškolske dece (Sonuga-Barke et al., 2001). Uz visok nivo motivisanosti i odsustvo simptoma psihopatologije roditelja efikasni su i treninzi u cilju poboljšanja odnosa i interakcija u porodici sa hiperaktivnom decom od 2 do 11 god. koja kod kuće i u školi ispoljavaju neposlušnost i devijantno ponašanje (Berkley, 1997).

Bihevioralne intervencije podesne su jer deca sa ADHD imaju teškoće u regulaciji i inhibiranju ponašanja, ne slede pravila i uputstva, a naročito kada za to izostanu posledice ili su one blage i odložene (Berkley, 1998). Od roditelja se zahteva dosledna primena dogovorenih postupaka da bi se kreiralo predvidivo, strukturirano okruženje u kome su jasna pravila i očekivanja, ali i neposredne posledice za ponašanje deteta. Intervencije su delotvorne kod komorbiditeta ADHD sa poremećajima ponašanja, prkosom i buntom, anksioznošću i poremećajem raspoloženja. Dokazana je uspešnost programa sprovođenih u grupama roditelja koji uče različite bihevioralne tehnike (Barkley, 2007) kao i generalna efektivnost pristupa (Anastopoulus et al., 1993).

3.3. Intervencije za nastavnike

Nastavnici se obučavaju za primenu antecedensno i na posledicama zasnovanih intervencija u radu sa učenicima sa ADHD (Hoffman, DuPaul, 2000). *Antencedensne intervencije* su orjentisane ka zadatku i uputstvu (DuPaul & Stoner, 1994), a uz upotrebu kompjutera i uz tutorstvo vršnjaka doprinose poboljšanju pažnje i školskog postignuća (Dunlap et al., 1994).

Na posledicama zasnovane intervencije obuhvataju pozitivne odgovore za prikladno ponašanje (npr. “token” sistem) i negativne odgovore za neprihvatljivo (“time out”, “cost” programi) (DuPaul & Hoff, 1998; Berkly, 1997). Troškovini model je znatno efikasniji od farmakoterapije u povećavanju obima željenih ponašanja (Rapport et al., 1982).

Oba pristupa se uspešno sprovode i kao komponente inkluzivnih programa, uz posredovanje grupa vršnjaka (McNail, 1995). Istraživanja potvrđuju njihovu uspešnost u smanjenju neželjenih ponašanja tokom nastave i u povećanju efikasnosti u izvršavanju školskih zadataka (Pelham et al., 1998, Pelham & Hinshaw, 1992). Ali po prestanku tretmana od strane terapeuta veliki broj učitelja i roditelja ne uspeva samostalno da primenjuje dogovorene postupke, pa se teškoće dece ponovo pojavljuju (Adesman & Wender, 1992). Najbolje je kombinovati oba pristupa jer je im je tada efikasnost veća (Charlson & Tamm, 2000).

3.4. Integrisan pristup

Proaktivan integrisan pristup temelji se na menjanju okruženja koje izaziva neželjeno ponašanje dece sa ADHD, a po Rapport-u (1998) idealan je u rešavanju problema u učenju. Primenjuje se na školskom uzrastu kao obavezan kurikulum u razredu, uz sinhronizaciju integrisano korišćenih računara, idr. materijala za treninge. Roditelji su uključeni u programe, a zadatak nastavnika je da dosledno prate i olakašavaju rad učenika. Pristup se zasniva na visoko sofisticiranoj opremi, a njegova vrednost je u preciziranju odlika proaktivno modelovanog okruženja u kome deca sa ADHD postižu najbolje uspehe u učenju.

3.5. Multimodalni pristup

Istraživanja dokumentuju da najveću efikasnost u tretmanu ima multimodalni pristup baziran na različitim kombinovanim psihosocijalnim i psihoedukativnim programima u koje se uključuju dete, roditelji, škola i relevantni drugi (Antshel, Remer, 2003). To potvrđuje i opsežno istraživanje iz 1999.god. "*NIMH Multimodal Treatment Study of ADHD*" (Wells, et al., 2006; Pelham et al., 2000) koje nalazi da je multimodalni pristup efikasniji od bihevioralnog i od programa u zajednici jer između ostalog: smanjuje agresivnost i internalizovane simptome, unapređuje čitanje, socijalne veštine i odnos dete-roditelj i donosi dugoročno bolje efekte na ponašanje.

Pored navedenih opcija tretmana, koriste se i individualne i grupne forme psihoterapija koje deci podižu nivo samopoštovanja, pomažu u prevazilaženju kriznih situacija, depresije, anskioznosti i sl. U psihijatrijskoj praksi u porastu je primena *farmakoterapije* kod dece, čak i na uzrastu od 2 do 4 god. (Rapport, Murphy & Bailey, 1982), mada uz nju osnovni simptomi poremećaja ne nestaju, a dokazani su mogući štetni efekti (iritabilnost, pojačanje tikova, violentnost, suicidalne misli, simptomi depresije i psihoze). Stoga je važno da se roditelji upoznaju sa prednostima i nedostacima farmakoterapije, koja se može primenjivati samo u kombinaciji sa psihosocijalnim pristupima. Oslanjanje na nehemijske oblike tretmana daje dugoročno povoljnije efekte (Hoffman, DuPaul, 2000; Rapport, 1998; Abikoff, 2001; Abikoff & Hechtman, 1996).

4. ZAKLJUČAK

Izbor adekvatne opcije tretmana dece sa ADHD je veoma složen. U planiranju tretmana moraju se sagledati individualne snage i slabosti deteta i njegove porodice, vrste ispoljenih simptoma, njihova situaciona varijabilnost, uzrast i razvojni nivo deteta, njegovo školsko i socijalno funkcionisanje. Tretman bi trebalo da je fokusiran na simptome deficita koji su najizraženiji i pervazivni, te su stalni izvor problema i to u oblastima koje su važne sa stanovišta aktuelnog i budućeg prilagođavanja. Bitno je uzeti u obzir i koegzistirajuće poremećaje kod deteta, ali i poremećaje prisutne kod roditelja. Studije dokazuju da, generalno, najbolje rezultate daje multimetodski pristup i primena integrisanih intervencija u različitim okruženjima (Pelham, 1999).

LITERATURA

1. Abikoff, H., & Hechtman, L. (1996). Multimodal therapy and stimulans in the treatment of children with ADHD. In E.D. Hibbs &P.S. Jensen (Eds) *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 341-369) Washington, DC: American Psychological association.
2. Abikoff, H. (2001). Tailored Psychosocial Treatments for ADHD: The Search for a Good Fit *Journal of Clinical Child Psychology, 30*(1), 122-125.
3. Adesman, A.R, Wender, E.H. (1992). "Helping the hyperactive child", *Patient Care*; 96-116.
4. American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (DSM IV). Washington DC.
5. Anastopoulus, A. D., Shelton, T., Du Paul, G. J., & Guevremont, D. C. (1993). Parent training for attention deficit / hyperactivity disorder: Its impact on parent functioning. *Journal of Abnormal Child Psychology, 21,* 581-596.
6. Antshel, K.M., Remer, R. (2003). Social skills training in children with attention deficit hyperactivity disorder:A randomized-controlled clinical trial. *Journal of Clinical Children and Adolescent Psychology; 32* pp.153-165.
7. Barkley, R. (2007). School Interventions for Attention Deficit Hyperactivity Disorder: Where to From Here?. *School Psychology Review, 36*(2), 279-286._
8. Berkley, R.A. (1998). *Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment*. The Guilford Press, New York.
9. Berkley, R.A. (1997). *Defiant children* (2nd ed.), *A clinician's manual for assessment and parent training.* New York: Guilford Press.
10. Carlson, C.I., & Tamm, L. (2000). Responsiveness of children with attention deficit – hyperactivity disorder to reward and response cost: Differential impact on performance and motivation. *Journal od Consulting and Clinical Psychology, 68*, 73-83.
11. Dunlap, G., dePerczel, M., Clarke, S., Wilson, D., Wright, S., White, R., & Gomez, A. (1994). Choice making to promote adaptive behavior for students with emotional and behavioral challenges. *Journal of Applied Behavior Analysis, 27,* 505-518.
12. DuPaul, G.J., & Hoff, K.E. (1998). Attention/concentration problems. In T.S. Watson & F.M. Gresham (Eds.) *Handbook of child behavior therapy* (pp. 99-126). New York:Plenum Press.
13. DuPaul, G.J., Stoner, G. (1994). *ADHD in schools: Assessment and intervention strategies.* New York: Guildford Press.
14. Hallahan, D.P, Lloyd, J.W, Kauffman, J.M, Weiss, M., Martinez, E.A. (2005). In Merrill, Boston at al., *Learning Disabilities. Foundations, Characteristics, and Effective Teaching.* (3rd ed) Boston MA, Allyn & Bacon.

15. Hoffman, J.B, DuPaul G.J. (2000). Psychoeducational interventions for children and adolescents with attention-deficit/hyperactivity disorder. *Child and Adolescent Psychiatric Clinics of North America. Jul, 9*(3), 647-61.
16. McNail, C.B, (1995). *The ADHD Classroom Kit: An inclusive approach to behavior management*. King of Prussia,PA: Center for Applied Psychology.
17. Pelham WE, Gnagy EM, Greiner AR, Hoza B, Hinshaw SP, Swanson JM, Simpson S, Shapiro C, Bukstein O, Baron-Myak C. (2000). Behavioral vs. behavioral and pharmacological treatment in ADHD children attending a summer treatment program. *Journal of Abnormal Child Psychology, 28*(6), 507-526.
18. Pelham, W. E.(1999). President's message: The NIMH Multimodal Treatment Study for ADHD.Just say yes to drugs? *Clinical Child Psychology Netwsletter, 14,* 1-10.
19. Pelham, W. E., & Hinshaw, S. P. (1992). Behavioral intervention for ADHD. In: S. M. Turnerr, K. S. Calhoun & H. E. Adams (Eds.), *Handbook of clinical behavior therapy* (2nd ed.), (pp. 259-283). New York: Wiley.
20. Pelham, W.E., Weehler, T., Chrinis, A. (1998). Empirically supported psychosocial treatments for attention deficit hyperactivity disorder. *Journal of Clinical Child Psychology, 27,* 190-205.
21. Pfiffner LJ, Barkley RA. (1998). Treatment of ADHD in School Settings, u: Barkley RA. *Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment*. The Guilford Press, New York.
22. Radulović, D. (2014). *Psihološke osnove poremećaja u ponašanju.* Univerzitet u Beogradu, Fakultet za specijalnu edukaciju i rehabilitaciju, Izdavački centar, Beograd.
23. Rapport, M.D. (1998). Attention deficit/ hyperactivity disorder: In V.B. Van Hasselt & M. Herson (Eds) *Handbook of psychosocial treatment protocols for children and adolescents* (pp. 65-107), Hillsdale, NJ:Erlbaum
24. Rapport, M.D., Murphy, A., Bailey, J.S. (1982). Ritalin vs: response cost in the control of hyperactive children: A within subject comparison. *Journal of Applied Behavior Analysis, 15,* 205–2016.
25. Sonuga-Barke, E.J.S., Daley, D., Thomson, M., Laver-Bradbury, C., & Weeks, A. (2001). Parent-based therapies for preschool attention-deficit/hyperactivity disorder: A randomized, controlled trial with a community sample. *Journal of the American Academy of Child and Adolescent Psychiatry,* 40, 402-408.
26. Thompson, L., Thompson, M. (1998). Neurofeedback combined with training in metacognitive strategies: effectiveness in students with ADD. *Appllied Psychophysiology Biofeedback, 23*(4), 243-63.
27. Wells. K.C., Chi, T.C., Hinshaw S.P., Epstein JN, Pfiffner LJ, Nebel-Schwain M, Owens EB, Arnold, LE, Abikoff H, Cnners CK, Elliott G, Greenhill LL, Hechtman L, Hoza B, Jensen PS, March J, Newcorn J, Pelham WE, Severe J, Swanson JM, Vitiello B, Wigal T. (2006). Treatment-related changes in objectively measured parenting behaviors in the Multimodal Treatment Study of Children with ADHD. *Journal of Consultant Clinical Psychology, 74,* 649-657.

TREATMENT OPTIONS FOR CHILDREN WITH ATTENTION DEFICIT AND HYPERACTIVITY DISORDER (ADHD)

Danka M. Radulović
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: An increasing number of children with ADHD and evidence that in third cases it progress into delinquency, means that early intervention is necessary. However, complex nature of ADHD syndrome and often presence of co-morbidity disorders make it more difficult to find appropriate forms of treatment of children with ADHD and creates the need for interventions aimed at their parents, teachers and broader social environment.

Method: Although many types of treatments are applied, their effectiveness is rarely evaluated, so in this paper we consider the interventions related to direct work with children and to work with their parents and teachers that have a preliminary empirical support.

Results: Treatment of ADHD does not means cure in medical sense, but reduction of symptoms of attention deficit, impulsivity and hyperactivity, and improvement in aspects of emotional and behavioral functioning of children. The most common approaches to the treatment are cognitive and behavioral, or their combination; individual and group forms of psychotherapy and counseling and training in family and school environment are also applied, and pharmacotherapy in psychiatric practice.

Conclusion: In planning treatment, beside considering child' s and family' s strengths and weakness, we ought to take into account: the age and child development level, the most salient areas of deficit that makes difficulties in adjustment and development, pervasiveness of symptoms and their situation variability and co-existing disorders. In general, multi-method approach and the presence of integrative interventions in different environments enable the best results.

Key words: ADHD, children, parents, teachers, treatment

udc 81’234-053.4
616.89-008.5-053.4
376.1-056.264-053.4

Razvoj vokabulara kod djece sa govorno-jezičkim poremećajima i djece tipičnog jezičkog razvoja: preliminarno ispitivanje

Bojana Vuković
Univerzitet u Istočnom Sarajevu – Medicinski fakultet, Foča, Bosna i Hercegovina
Mile Vuković
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija
Slađana Ćalasan
Univerzitet u Istočnom Sarajevu – Medicinski fakultet, Foča, Bosna i Hercegovina

Uvod: *Razvoj rječnika je dinamičan proces, koji se sa uzrastom mijenja, kako po kvanitietu, tako i po kvalitetu. Pored uzrasta, na dinamiku razvoja rječnika mogu da utiču i drugi faktori kao što su: okruženje, intelektulane sposobnosti, obrazovanje roditelja i dr. Cilj ovog rada je utvrđivanje uticaja uzrasta na razvoj rječnika kod djece sa poremećajem u govorno jezičkom razvoju i djece tipičnog jezičkog razvoja.*

Metodologija: *Uzorak se sastojao od 362 djece, oba pola, uzrasta od 5 do 7 godina. Trijažnim artikulacionim testom i testom Strip priča izdvojen je poduzorak od 32 ispitanika sa govorno-jezičkim poremećajem, koji je činio eksperimentalnu grupu. Kontrolnu grupu činilo je 32 djece ujednačenih prema polu i uzrastu sa ispitanicima eksperimentalne grupe. Ispitanici su podijeljeni u tri uzrasne kategorije. Razvijenost leksikona je procjenjivana Semantičkim testom i Test rječnikom. Istraživanje je obavljeno u predškolskoj ustanovi i školama u Foči, tokom 2016. godine.*

Rezultati: *Kada je u pitanju ukupan skor, na semantičkom testu u eksperimentalnoj grupi nije uočena statistički značajna razlika između grupa ispitanika različitog uzrasta. Međutim, poređenjem ukupnog skora na Test rječniku, jednofaktorskom analizom varijanse (ANOVA) utvrđene su visoko statistički značajne razlike između ispitanika uzrasta pet (54,50±3,50) i šest godina (72,23±3,26) (p=0,001), šest i sedam godina (88,00±4,35) (p=0,001), i pet i sedam godina (p=0,001), pri čemu su ispitanici starijeg uzrasta pokazali značajno više vrijednosti u odnosu na mlađe ispitanike. S druge strane, u kontrolnoj grupi ispitanika nisu uočene statistički značajne razlike u srednjim vrijednostima skora na Semantičkom, niti na Test rječniku između ispitanika različitih uzrasnih kategorija.*

Zaključak: *Primjenom Test rječnika, utvrđeno je da uzrast statistički značajno utiče na razvoj leksikona kod djece sa poremećajem u govorno-jezičkom razvoju, dok u kontrolnoj grupi ispitanika takav efekat nije utvrđen. Dobijeni rezultati ukazuju na potrebu ispitivanja razvoja leksikona na većem uzorku ispitanika.*

Ključne riječi: *ekspresivni rječnik, uzrast, djeca,*
poremećaj u jezičkom razvoju, tipični jezički razvoj

UVOD

Razvoj govora i jezika je dugotrajan proces u okviru koga se izdvajaju prelingvistička i lingvistička faza. Prelingvistička faza obuhvata period od prvog krika novorođenčeta do svjesne upotrebe prve riječi, što se u prosjeku dešava između desetog i dvanaestog mjeseca života. Lingvistička faza započinje pojavom prve riječi i traje sve do potpunog ovladavanja fonologijom, gramatikom i sintaksom datog jezika (Vuković, 2015).

Pojava i upotreba prve riječi je i najuočljiviji znak usvajanja jezika u ranom dječjem uzrastu, i reprezentuje razvoj leksičko-semantičkog nivoa jezičkog sistema. Razvoj leksikona se manifestuje povećanjem broja riječi u govoru i razumijevanjem njihovog značenja. Tako na primer, dijete na uzrastu 18 mjeseci može da produkuje oko 50 riječi, a na uzrastu od 5 godina oko 2000 riječi. Leksičko-semantički razvoj dovodi do formiranja mentalnog leksikona koji se definiše kao „skladište" riječi koje obuhvata sva znanja o svim riječima nekoga jezika u umu govornika tog jezika. Mentalni leksikon obuhvata kompleksne strukture i procese koji nam omogućavaju nesmetanu komunikaciju, vrlo brzo i lako govorenje, razumijevanje i pamćenje. Takođe, mentalni leksikon omogućava tvorbu novih riječi i uklapanje jezičkog znanja u opšte znanje o svijetu koji nas okružuje (Erdeljac, 2009).

Ispitivanja razvoja leksikona baziraju se na procjeni upotrebe riječi i poznavanju značenja leksičkih jedinica. Ispitivanja leksičkog razvoja na srpskom govornom području pokazala su da postoji određena hijerarhija u usvajanju značenja riječi (Vladisavljević, 1983).

S. Vladisavljević je utvrdila da se najprije razvija sposobnost pronalaženja većeg broja značenja unutar jedne riječi (homonimi), a potom se razvijaju asocijacije polariteta, tj. antonimi i to u domenu konkretnih pojmova, zatim sledi usvajanje sinonima. Na kraju dolazi do usvajanja metonima koji takođe ne predstavljaju dio aktivnog dječjeg rječnika (Vladisavljević, 1983).

Pored toga, ova autorka naglašava da sva značajna odstupanja od navedenog redosleda usvajanja leksičke građe ukazuje na siromaštvo i zaostajanje u razvoju leksičko-semantičkog nivoa jezičke strukture. Prema tome, razvijenost navedenih semantičkih kategorija je jedan od pokazatelja razvijenosti leksičke semantike. Takođe, jedan od pokazatelja razvijenosti leksikona jeste sposobnsot imenovanja vizuelno prikazanih pojmova i njihovog definisanja, što se utvrđuje primjenom specifičnih testova, kao što je Test-rječnik, na primjer.

Poremećaji u jezičkom razvoju manifestuju se fonološkim, gramatičkim, leksčkim, semantičkim i pragmatskim deficitima. Dosadašnji empirijski podaci pokazuju da leksički i leksičko-semantički deficiti predstavljaju značajan aspekt specifičnog poremećaja u razvoju jezika (Avramović, I. Vuković i Vuković, 2012; Milošević i Vuković, 2011; M. Vuković, I. Vuković & Stojanovik, 2010). Stoga je za predmet ovog rada odabrano ispitivanje razvoja leksikona kod djece sa poremećajima u jezičkom razvoju u poređenju sa djecom tipičnog razvoja.

CILJ

Cilj ovog rada bio je da se utvrdi razvoj leksikona kod djece sa poremećajem u govorno-jezičkom razvoju i djece tipičnog jezičkog razvoja.

METOD RADA

Uzorak se sastojao od 362 djece, oba pola, uzrasta od 5 do 7 godina. Trijažnim artikulacionim testom i testom Strip priča izdvojen je poduzorak od 32 ispitanika sa govorno-jezičkim poremećajem, koji je činio eksperimentalnu grupu. Kontrolnu grupu činilo je 32 djece ujednačenih prema polu i uzrastu sa ispitanicima eksperimentalne grupe. Ispitanici su podijeljeni u tri uzrasne kategorije. Razvijenost leksikona je procjenjivana Semantičkim testom (Vladisavljević, 1983) i Test rječnikom (Vasić, 1993). Istraživanje je obavljeno u predškolskoj ustanovi i osnovnim školama u Foči, tokom 2016. godine. Statistička analiza podataka je urađena pomoću SPSS 24.0 softverskog statističkog paketa.

REZULTATI SA DISKUSIJOM

Ispitanici su podijeljeni u dvije grupe, eksperimentalnu grupu činilo je 32 ispitanika. Kontrolnu grupu činilo je takođe 32 ispitanika koji su prema polu, intelektualnom statusu, kalendarskom i školskom uzrastu izjednačeni sa ispitanicima eksperimentalne grupe. U obje navedene grupe sve ispitanike u odnosu na uzrast kategorisali smo u tri grupe, u eksperimentalnoj prvu grupu činili su ispitanici od 5 godina kojih je bilo 12,5%, drugu grupu činilo je 32,8% ispitanka uzrasta od 6 godina, dok je treću grupu činilo 4,7% ispitanika uzrasta od 7 godina. Kontrolnu grupu smo kategorisali na isti način tako da prvu grupu čini 4,7% ispitanika, drugu 32,8%, a treću grupu čini 12,5% ispitanika. U eksperimentalnoj i kontrolnoj grupi bilo je po 16 (25%) dječaka i djevojčica (Tabela 1)

Tabela 1 – Distribucija ispitanika prema polu i uzrastu

Socio-demografske karakteristike ispitanika	**Grupe ispitanika** Broj (%)	
	Eksperimentalna grupa	**Kontrolna grupa**
Uzrast		
5 godina	8 (12,5)	3 (4,7)
6 godina	21 (32,8)	21 (32,8)
7 godina	3 (4,7)	8 (12,5)
Pol		
Dječaci	16 (25)	16 (25)
Djevojčice	16 (25)	16 (25)

Tabela 2 pokazuje da u eksperimentalnoj grupi nema značajnih razlika u postignutim srednjim vrijednostima na Semantičkom testu između ispitanika različitog uzrasta. S obzirom na heterogenost individualnih jezičkih sposobnosti ove populacije, smatramo da bi veći uzorak unutar uzrasnih kategorija bio reprezentativniji.

Tabela 2 – Prikaz razlika u srednjim vrijednostima ukupnog skora na Semantičkom testu unutar eksperimentalne grupe

Semantički Test	**Aritmetička sredina i standardna devijacija**		***F i p*** (između grupa)		***p*** (unutar grupa)	
	Aritmetička sredina	Standardna devijacija	***F***	***P***	**Uzrast**	***P***
Ukupan skor						
Pet godina	11,62	2,13			Šest godina	0,149
Šest godina	13,71	2,49			Sedam godina	0,898
Sedam godina	13,00	3,46	2,039	0,148	Pet godina	0,720

Tabela 3 pokazuje da u okviru eksperimentalne grupe postoji statistički značajna razlika (F=128,02; p=0,001) između ispitanika različitog uzrasta u pogledu prosječnih vrijednosti na Testu rječnik. Ispitanici uzrasta od 7 godina su pokazali najbolji rezultat (AS=88,00; SD=4,35), slijede ih ispitanici uzrasta od šest godina (AS=72,23; SD=3,26), a najniži rezultat je imala najmlađa grupa ispitanika (AS=54,50; SD=3,50). Razlika je uočljiva i unutar grupa ispitanika, između uzrasta pet i šest godina (p=0,001), šest i sedam (p=0,001) i pet i sedam godina (p=0,001) (Tabela 3)

Tabela 3 – Prikaz razlika u srednjim vrijednostima između ukupnog skora Testa rječnik unutar eksperimentalne grupe ispitanika različitog uzrasta

Test – rječnik	**Aritmetička sredina i standardna devijacija**		***F i p*** (između grupa)		***p*** (unutar grupa)	
	Aritmetička sredina	Standardna devijacija	***F***	***P***	**Uzrast**	***P***
Test rječnik – ukupan skor						
Pet godina	54,50	3,50			Šest godina	0,001
Šest godina	72,23	3,26			Sedam godina	0,001
Sedam godina	88,00	4,35	128,02	0,001	Pet godina	0,001

Između grupa ispitanika različitih uzrasta unutar kontrolne grupe uočena je visoka statistički značajna razlika u srednjim vrijednostima kada je u pitanju ukupan skor Semantičkog testa (F=9,888; p=0,001), pri čemu je ta razlika uočljiva između ispitanika uzrasta pet (AS=15,66; SD=2,08) i šest godina (AS=23,00; SD=3,11) (p=0,001) i između ispitanika uzrasta sedam (AS=23,50; SD=1,77) i pet godina (AS=15,66; SD=2,08) (p=0,001), dok između ispitanika uzrasta šest i sedam godina nije utvrđena razlika (Tabela 4). Naime rezultati našeg istraživanja, kao i rezultati istraživanja drugih autora pokazuju da su djeca starijeg uzrasta uspješnija na testu leksičkih sposobnosti (Čolić, 2013; Lazarević i Šefer, 2009; Vancaš i Kovačević, 1999).

Tabela 4 – Prikaz razlika u srednjim vrijednostima skora Semantičkog testa unutar kontrolne grupe ispitanika

Semantički Test	**Aritmetička sredina i standardna devijacija**		***F i p*** (između grupa)		***p*** (unutar grupa)	
	Aritmetička sredina	Standardna devijacija	***F***	***P***	**Uzrast**	***p***
Ukupan skor						
Pet godina	15,66	2,08			Šest godina	0,001
Šest godina	23,00	3,11			Sedam godina	0,911
Sedam godina	23,50	1,77	9,888	0,001	Pet godina	0,001

Između grupa ispitanika različitog uzrasta unutar kontrolne grupe utvrđena je visoka statistički značajna razlika u srednjim vrijednostima (F=312,93; p=0,001) kada je u pitanju ukupan skor na Testu-rječnik, pri čemu je ta razlika uočljiva između ispitanika uzrasta pet (AS=56,66; SD=3,50) i šest godina (AS=76,19; SD=3,26) (p=0,001), između ispitanika uzrasta šest (AS=76,19; SD=3,26) i sedam godina (AS=88,00; SD=4,35) (p=0,001), kao i između ispitanika uzrasta sedam (AS=88,00; SD=4,35) i pet godina (AS=56,66; SD=3,50) (p=0,001) (Tabela 5). Rezultati ispitivanja drugih autora, takođe pokazuju da se leksikon sa uzrastom ekspanzivno bogati i u domenu aktivnog i u domenu pasivnog riječnika (Veselinović, Kašić i Slavnić, 2012).

Tabela 5 – Prikaz razlika u srednjim vrijednostima između ukupnog skora Testa – rječnik unutar kontrolne grupe ispitanika različitog uzrasta

Test – rječnik	**Aritmetička sredina i standardna devijacija**		***F i p*** (između grupa)		***p*** (unutar grupa)	
	Aritmetička sredina	Standardna devijacija	***F***	***P***	**Uzrast**	***P***
Test rječnik – ukupan skor						
Pet godina	56,66	3,50			Šest godina	0,001
Šest godina	76,19	3,26			Sedam godina	0,001
Sedam godina	88,00	4,35	312,93	0,001	Pet godina	0,001

ZAKLJUČAK

Na osnovu dobijenih rezultata možemo zaključiti da se razvoj leksikona odvija kako kod djece tipičnog razvoja, tako i kod djece sa poremećajem u jezičkom razvoju. Međutim, evidentne su razlike u dinamici usvajanja leksikona između ove dvije grupe ispitanika. Kod djece sa poremećajem u jezičkom razvoju nema značajnog napretka u leksikonu između tri navedene uzrasne kategorije, prema rezultatima Semantičkog testa, dok postignuća na Test-rječniku pokazuju da se rječnik sa uzrastom uvećava i u ovoj grupi ispitanika. Postignuća ispitanika kontrolne grupe na oba testa pokazuju da se leksikon kod djece tipičnog jezičkog razvoja značajno povećava sa uzrastom.

LITERATURA

1. Avramović, I., Vuković M., Vuković I. (2012). Leksičko-semantičke sposobnosti adolescenata sa poremećajima u govornom i jezičkom razvoju. *Beogradska defektološka škola, 18*(3), 487-503
2. Čolić, G. (2013). Dinamika razvoja leksikona kod djece mlađeg školskog uzrasta. *Specijalna edukacija i rehabilitacija, 12*(2), 441-452.
3. Erdeljac, V. (2009). *Mentalni leksikon: modeli i činjenice.* Zagreb: Ibis grafiks.
4. Lazarević, E., Šefer, J. (2009). Jezik udžbenika narativnih predmeta: razumevanje reči u sedmom razredu osnovne škole. *Zbornik Instituta za pedagoška istraživanja, 41*(2), 418–436.
5. Milošević, N., Vuković, M. (2011). Leksičko-semantičke sposobnosti dece sa specifičnim jezičkim poremećajem i nespecifičnim promjenama elektroencegfalografskih aktivnosti. Beograd: *Specijalna edukacija i rehabilitacija, 10*(3), 435-443.
6. Vancaš, M., Kovačević, M. (1999). Je li leksikon logičan? Pojavnost i vrste semantičkih kategorija u djece. U L. Badurina (ur.). Teorija i mogućnost primjene pragmalingvistike. Zagreb, Rijeka: *Hrvatsko društvo za primjenjenu lingvistiku* 825-832.

7. Vasić, S. (1991). *Veština govorenja: vežbe i testovi za decu i odrasle*. Pedagoška akademija za obrazovanje učitelja.
8. Veselinovic, I., Kašić, Z., Slavnić, S. (2012). *Sposobnost imenovanja i definisanja pojmova kod djece predškolskog uzrasta*. Beograd: Specijalna edukacija i rehabilitacija.
9. Vladisavljević, S. (1983). Semantički test. U Đ. Kostić, S. Vladisavljevič, M Popović: *Testovi za ispitivanje govora i jezika (str. 179-188).* Beograd: Zavod za udžbenike i nastavna sredstva.
10. Vukovic, M., Vukovic, I., & Stojanovik, V. (2010). Investigation of language and motor skills in Serbian speaking children with specific language impairment and in typically developing children. *Research in developmental disabilities*, *31*(6), 1633-1644.
11. Vuković, M. (2015). Diferencijalna dijagnoza jezičkih poremećaja kod djece. *Zbornik radova, Govorno jezički poremećaji razvojnog doba*. Beograd: Udruženje logopeda Srbije, 49-71.

VOCABULARY DEVELOPMENT IN CHILDREN WITH SPEECH AND LANGUAGE DISORDERS AND CHILDREN WITH TIPICAL LANGUAGE DEVELOPMENT: PRELIMINARY EXAMINATION

Bojana Vuković*, Mile Vuković**, Slađana Ćalasan***
*University of East Sarajevo, Medical Faculty, Foča, Bosnia and Herzegovina
**University of Belgrade, Faculty of Special Education and Rehabilitation, Belgrade, Serbia
***University of East Sarajevo, Medical Faculty, Foča, Bosnia and Herzegovina

Introduction: Vocabulary development is a dynamic process that changes with age, both in quantity and quality. In addition to age, the dynamics of the vocabulary may be affected by other factors such as the environment, intellectual abilities and parents education. The aim of this paper was to determine the effect of age on the vocabulary development in children with the disorder of speech and language development and children with typical language development.

Methods: The sample consisted of 362 children of both sexes, aged 5 to 7 years. Using Articulation Screening Test and the Test strip tale, we isolated sub-sample of 32 children with speech and language disorders, who made the experimental group. According to this, control group comprised 32 children matched by age and sex. Examinees were divided into three age categories. Vocabulary development is estimated by Semantic test and Vocabulary test. The research was conducted in kindergarten and schools in Foca in 2016.

Results: When it comes to the total score, there was not statistically significant difference between the different age groups on the Semantic test in the experimental group. However, comparison of the total score in the Vocabulary test, using ANOVA showed significant differences between the examinees five (54.50 ± 3.50) and six years (72.23 ± 3.26) ($p = 0.001$), six and seven years (88.00 ± 4.35) ($p = 0.001$), and five to seven years of age ($p = 0.001$), where elder age categories showed significantly higher value in compared to younger categories. On the other hand, in the control group there is no statistically significant difference in total score on the Semantic, or on the Vocabulary test, between different age groups.

Conclusion: Using Vocabulary test, it was found that age significantly affects the development of the vocabulary in children with disorders of speech and language development, while in the control group that effect has not been established. The results suggest the need to examine the development of the vocabulary on a larger sample within age categories.

Key words: expressive vocabulary, age, children, speech and language disorders, typical language development

udc 616.28-008-053.32
376.1-056.263-053.32

Auditivni razvoj prevremeno rođenih beba: kriterijumi za procenu na ranom uzrastu[1]

Mina Nikolić, Sanja Ostojić-Zeljković, Svetlana Slavnić
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Poslednjih decenija ostvaren je značajan napredak u neonatalnoj nezi prevremeno rođene dece, koji je doveo do povećane stope preživljavanja ekstremno i značajno prevremeno rođene dece. Sa druge strane, povećanje stope preživljavanja u ovoj populaciji za posledicu ima veću učestalosti smetnji i poremećaja koje se registruju već tokom ranog detinjstva.

***Predmet istraživanja** bio je da se utvrde kriterijumi procene auditivnog razvoja prevremeno rođene dece na ranom uzrastu. Istraživanje je sprovedeno u okviru longitudinalne studije koja se bavila praćenjem auditivnog razvoja prevremeno rođene dece tokom prve godine razvoja. Korišćena je LittlEars® skala auditivnog ponašanja, namenjena proceni tokom preverbalne faze razvoja. Uzorak istraživanja činilo je 150 prevremeno rođene dece, čiji je razvoj praćen pri Institutu za neonatologiju u Beogradu.*

***Rezultati istraživanja** ukazuju na značajan uticaj gestacione starosti pri rođenju na karakteristike auditivnog razvoja. Deca koja su kasnije prevremeno rođena imala su više auditivno postignuće na svim ispitivanim uzrastima u odnosu na ranije prevremeno rođenu decu. Analizom funkcija auditivnog razvoja, definisanih u odnosu na korigovani i hronološki uzrast deteta, dobili smo da je za svaku nedelju veće gestacione starosti pri rođenju moguće računati na 0.39 poena viši početni nivo, odnosno 0.41 poen brži tempo auditivnog razvoja tokom prve godine života prevremeno rođenog deteta.*

U skladu sa prikazanim rezultatima, može se očekivati da tokom druge godine dolazi do sustizanja normativa razvoja definisanih u odnosu na hronološki uzrast deteta. Shodno tome, nakon 12. meseca razvoja potrebno je uvažavati delimičnu korekciju uzrasta prevremeno rođenog deteta, a između 15. i 18. meseca očekivati potpuno dostizanje normativa dece rođene u terminu. Definisanje kriterijuma procene auditivnog razvoja kod prevremeno rođene dece veoma je značajno kako ne bi došlo do odložene detekcije značajnih odstupanja od tipičnog auditivnog razvoja na najranijem uzrastu.

Ključne reči: *auditivni razvoj, prevremeno rođena deca, smetnje i poremećaji sluha, rana detekcija, rana intervencija*

---

[1] Rad je proistekao iz projekta „Uticaj kohlearne implantacije na edukaciju gluvih i nagluvih osoba", br. 179055 (2011–2017), koji finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

UVOD

Tokom poslednjih decenija ostvaren je značajan napredak u neonatalnoj nezi prevremeno rođene dece, koji je doveo do povećane stope preživljavanja ekstremno i značajno prevremeno rođene dece. Sa druge strane, povećanje stope preživljavanja u ovoj populaciji za posledicu ima veću učestalosti smetnji i poremećaja koje se registruju već tokom ranog detinjstva. Veliki broj udruženih riziko faktora kod dece rođene izrazito pre termina dovodi i do značajno povećane incidencije oštećenja sluha. Mnogi autori ističu da se značajne auditivne smetnje u ovoj populaciji registruju čak dvadeset puta češće nego kod terminski rođene dece, te da se javljaju kod 2-4‰ živorođene dece (Bielecki, Horbulewicz & Wolan, 2011; Coenraad, Goedegebure, Van Goudoever & Hoeve, 2010; Erenberg, Lemons, Sia, Trunkel & Ziring, 1999; Микић, Ђоковић, Совиљ и Пантелић, 2005, Nikolić, 2016). Zbog povišene incidencije oštećenja sluha uvedena je sistemska procena sluha kod sve prevremeno rođene dece pri otpustu iz jedinica neonatalne nege. Ipak, treba imati na umu da progresivna i odložena oštećenja nije moguće registrovati tokom neonatalnog skrininga sluha zbog čega se samo jedna procena pri otpustu smatra nedovoljnom. Imajući u vidu značaj auditivne funkcije za uredni govorno-jezički, saznajni i socio-emocijonalni razvoj deteta, postaje jasan značaj formiranja kriterijuma procene auditivnog razvoja na ranom uzrastu.

CILJ ISTRAŽIVANJA

Istraživanje je imalo za cilj da utvrdi kriterijume za procenu auditivnog ponašanja prevremeno rođene dece na ranom uzrastu. S obzirom na povišenu incidenciju smetnji i poremećaja sluha u ovoj populaciji dece, smatrali smo da je značajno formirati kriterijume procene koji bi omogućili detekciju značajnih odstupanja slušnog razvoja na najranijem uzrastu.

METODOLOGIJA ISTRAŽIVANJA

Istraživanje je sprovedeno u okviru longitudinalne studije koja se bavila specifičnostima auditivnog razvoja prevremeno rođene dece tokom prve godine (Nikolić, 2016). Sva dece iz ispitivanog uzorka praćena su pri Institutu za neonatologiju u Beogradu, kao centralnoj ustanovi za praćenje i podršku ranom razvoju prevremeno rođene dece sa teritorije Republike Srbije. Procena auditivnog ponašanja vršena je uz pomoć LittlEars® auditivne skale (Tsiakpini et al, 2004), koja ima široku primenu u praćenju slušnog razvoja tokom preverbalne faze razvoja. Podaci o auditivnom ponašanju prikupljani su od strane roditelja u četiri vremenske tačke, na korigovanim uzrastima od tri, šest, devet i 12 meseci. Korišćena je skraćena verzija skale koja se sastoji od 27 pitanja dihotomnog tipa, namenjenih praćenju faza urednog auditivnog ponašanja tokom prve godine razvoja. U svim prethodnim istraživanjima (Coninx et al., 2009; Tsiakpini et al., 2004; Weichbold, Tsiakpini, Coninx & D`Haese, 2005) registrovana je visoka, pozitivna korelacija između uzrasta i skora na upitniku, koja ukazuje na dobru mogućnost skale da meri uzrasno-zavisna ponašanja ispitanika.

Prilikom obrade prikupljenih podataka korišćene su osnovne deskriptivne analize, metode inferencijalne statistike i hijerarhijsko multivarijantno linearno modelovanje. Analiza podataka tehnički je sprovedena korišćenjem odgovarajućeg statističkog softvera (Excel 2013; HLM version 6; R, version 3; SPSS, version 23).

REZULTATI I DISKUSIJA

Opis uzorka

Uzorak istraživanja činilo je 150 prevremeno rođene dece. Uzorak je bio polno nepristrasan (χ^2=2.67, *df*=1, *p*=.12), a činilo ga je 85 devojčica (56.7%) i 65 dečaka (43.3%). Analizirajući strukturu uzorka prema gestacionoj starosti ispitanika, dobili smo da je prosečna gestaciona nedelja (gn) u trenutku rođenja bila 31.87 (*Mdn*=32.5, *SD*=2.67). Najranije prevremeno rođeno dete je rođeno u 25. gestacionoj nedelji, a najkasnije u 37. gestacionoj nedelji. Studentov t-test za nezavisne uzorke nije pokazao statistički značajnu razliku između devojčica (*M*=31.62, *SD*=2.52) i dečaka (*M*=32.2, *SD*=2.80) u odnosu na gestacionu starost u trenutku rođenja (*t*=1.33, *df*=147, *p*=.19).

Rezultati istraživanja

Kako bismo utvrdili na koji način gestaciona starost bebe u trenutku rođenja utiče na njene auditivne sposobnosti, ispitali smo odnos između prematuriteta i postignuća na LittlEars® skali (Tabela 1). U prvoj tački merenja Spirmanov koeficijent rang korelacije pokazao je nisku, pozitivnu i statistički značajnu korelaciju između kategorije prematuriteta i postignuća na auditivnom upitniku (r_s=.21, *p*=.01). Korelacija je potvrđena i u odnosu na gestacionu starost kao kontinualnu varijablu (r_s=.18, *p*=.03). Drugim rečima, ranije prevremeno rođena deca pokazala su značajno niže auditivno postignuće na korigovanom uzrastu od tri meseca u odnosu na kasnije prevremeno rođenu.

Tabela 1 – Auditivno postignuće ispitanika različitih kategorija prematuriteta

Prematuritet	3m		6m		9m		12m	
	M	SD	M	SD	M	SD	M	SD
Ekstremni	9.96	2.27	13.86	1.79	19.36	2.31	25.07	2.59
Značajni	10.15	2.46	14.37	1.82	20.15	2.30	25.38	2.57
Kasni	11.05	1.83	14.89	1.75	20.64	1.49	26.35	1.07

Na druga dva ispitivana uzrasta takođe smo dobili pozitivne korelacije (za korigovani uzrast šest meseci: r_s=.15, *p*=.07, za korigovani uzrast devet meseci: r_s=.11, *p*=.21), ali su korelacije bile niže i nisu iskazale statističku značajnost. Ovakav nalaz potvrdila je i korelacija sa gestacionom starošću ispitanika u trenutku rođenja (šest meseci: r_s=.16, p=.05, devet meseci: r_s=.15, p=.07). U poslednjoj tački merenja korelacija je bila niska, pozitivna i statistički značajna (r_s=.22, p=.01). Slična korelacija potvrđena je između gestacione starosti i postignuća dece (r_s=.23, p=.005), što implicira da kod kasnije rođenih beba možemo očekivati više postignuće na korigovanom uzrastu od godinu dana.

Ipak, prethodno prikazani rezultati daju samo poprečni prikaz ukupne slike razvoja auditivne sposobnosti prevremeno rođene dece tokom prve godine života. Zbog toga smo dalju analizu usmerili ka formiranju razvojnih trajektorija prevremeno rođene dece. Pomoću seta alternativnih regresionih analiza odredili smo oblik funkcije rasta auditivnog postignuća u funkciji uzrasta tokom prve godine života. Poredeći konkurentne modele dobili smo da je putem linearne funcije moguće na najefikasniji način objasniti odnos auditivnog postignuća i uzrasta, kako hronološkog (R^2=0.85, σ^2=2.61, df=4) tako i korigovanog (R^2=0.89, σ^2=2.29, df=4). Ovakav pristup omogućio nam je definisanje parametara funkcija auditivnog rasta – početnog nivoa i tempa slušnog razvoja za obe mere uzrasta. Primenom hierarhijskog multivarijantnog linearnog modelovanja dobili smo da je prvi procenjeni skor na LittlEars® skali u trenutku rođenja (za hronološki uzrast) iznosi 1.15 poen, kao i da ispitanici svakim mesecom u proseku napreduju za 1.75 poena (Tabela 2).

Tabela 2 – Linearni model rasta auditivne sposobnosti u odnosu na hronološki uzrast

Fiksni efekti	Koeficijent	*SE*	*t* količnik	*p*
Prosečan intercept, β_{00}	1.154	0.28	4.19	<.001
Prosečan koeficijent, β_{10}	1.748	0.02	72.36	<.001
Random efekti	Varijansa	χ^2	*Df*	*p*
Intercept, r_{0i}	3.385	199.94	128	<.001
Nagib, r_{1i}	0.013	156.11	128	.046
Greška na nivou 1, e_{di}	2.610			
Pouzdanost OLS procenjenih regresionih koeficijenata				
Intercept, π_{0i}	0.345			
Nagib, π_{1i}	0.179			

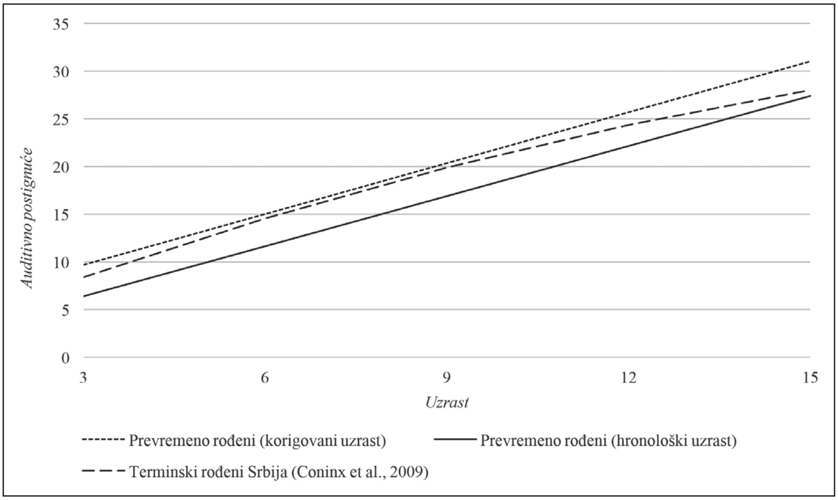
Slično prethodnom, definisani su prametri auditivnog razvoja u odnosu na korigovani uzrast deteta (Tabela 3). Rezultati pokazuju da procenjeni skor na LittlEars® skali na početnom nivou (korigovanog uzrasta) iznosio 4.35 poena, odnosno da u proseku svakim mesecom napreduju za 1.78 poena.

Tabela 3 – Linearni model rasta auditivne sposibnosti u odnosu na korigovani uzast

Fiksni efekti	Koeficijent	*SE*	*t* količnik	*P*
Prosečan intercept, β00	4.348	0.21	20.27	<.001
Prosečan koeficijent, β10	1.781	0.02	73.78	<.001
Random efekti	Varijansa	χ2	*Df*	*P*
Intercept, r0i	2.092	197.14	128	<.001
Nagib, r1i	0.020	175.56	128	.004
Greška na nivou 1, edi	2.289			
Pouzdanost OLS procenjenih regresionih koeficijenata				
Intercept, π0i	0.352			
Nagib, π1i	0.261			

Poredeći parametre razvoja definisanih auditivnih funkcija, dobili smo da se korigovanjem uzrasta ispitanika u proseku dodaju tri poena (3.19) na početku razvoja. S obzirom da je prosečna vremenska korekcija u ispitivanom uzorku iznosila 8.13 nedelja, može se proceniti da je sa svakom nedeljom veće gestacione starosti na rođenju za 0.39 poena viši početni nivo slušnog razvoja. Slično prethodnom, procenili smo i da auditivno postignuće u proseku raste za 0.41 poen svake nedelje tokom prve godine razvoja.

Konačno, uporedili smo funkcije auditivnog razvoja prevremeno i terminski rođene dece definisane u odnosu na uzrast (Grafikon 1).



Grafikon 1 – Funkcije auditivnog razvoja prevremeno i terminski rođene dece

Rezultati svedoče o tome da auditivni razvoj prevremeno rođene dece u funkciji korigovanog uzrasta prati razvoj terminski rođene dece tokom čitave prve godine. Drugim rečima, korigovanje uzrasta prevremeno rođene dece u prvoj godini razvoja predstavlja potpuno opravdan postupak kada je auditivni razvoj u pitanju. Sa druge strane, rezultati govore u prilog tome da auditivni razvoj nakon prve godine pokazuje trend sustizanja normativa hronološkog uzrasta.

ZAKLJUČAK

Prevremeno rođena deca pokazuju odstupanja u razvoju auditivnih sposobnosti i sazrevanju funkcije slušanja koji predstavljaju posledicu opšte razvojne nezrelosti, kao i višestrukih riziko faktora za nastanak oštećenje sluha. Zbog toga je neophodno sistematsko audiološko praćenje kako bi se na vreme detektovalo organsko/funkcionalno oštećenje sluha i sprovela pravovremena intervencija. Rezultati našeg istraživanja pokazali su da razvoj auditivnih sposobnosti prevremeno rođene dece tokom prve godine odgovara njihovom korigovanom uzrastu, ali i da tokom druge godine treba očekivati sustizanje normativa razvoja definisanih u odnosu na hronološki uzrast deteta. Imajući u vidu prikazani tempo razvoja auditivne funkcije, nakon 12. meseca razvoja dovoljno je uvažavati delimičnu korekciju uzrasta prevremeno rođenog deteta, a između 15. i 18. meseca očekivati potpuno dostizanje normativa dece rođene u terminu. Definisanje kriterijuma procene auditivnog razvoja kod prevremeno rođene dece veoma je značajno kako ne bi došlo do odložene detekcije značajnih odstupanja od tipičnog auditivnog razvoja na najranijem uzrastu.

REFERENCE

1. Bart, O., Shayevits, S., Gabis, L. V., & Morag, I. (2011). Prediction of participation and sensory modulation of late preterm infants at 12 months: A prospective study. *Research in developmental disabilities*, *32*(6), 2732-2738.
2. Bennett, F.C. (1994). Developmental outcome. In: G.B. Avery, Fletcher, M.A., MacDonald, M.G., (Eds.) *Neonatology: Pathophysiology and Management of the Newborn* (4th Ed). Philadelphia, PA: JB Lippincott Co, 1367-1386.
3. Bielecki, I., Horbulewicz, A., & Wolan, T. (2011). Risk factors associated with hearing loss in infants: an analysis of 5282 referred neonates. *International journal of pediatric otorhinolaryngology*, *75*(7), 925-930.
4. Chyi, L. J., Lee, H. C., Hintz, S. R., Gould, J. B., & Sutcliffe, T. L. (2008). School outcomes of late preterm infants: special needs and challenges for infants born at 32 to 36 weeks gestation. *The Journal of pediatrics, 153*(1), 25-31.
5. Coenraad, S., Goedegebure, A., Van Goudoever, J. B., & Hoeve, L. J. (2010). Risk factors for sensorineural hearing loss in NICU infants compared to normal hearing NICU controls. *International journal of pediatric otorhinolaryngology*, *74*(9), 999-1002.
6. Coninx, F., Weichbold, V., Tsiakpini, L., Autrique, E., Bescon, G., Tamas, L.,... & Brachmaier, J. (2009). Validation of the LittlEARS® auditory questionnaire

in children with normal hearing. *International journal of pediatric otorhinolaryngology, 73*(12), 1761-1768. doi:10.1016/j.ijporl.2009.09.036

7. Davidoff, M. J., Dias, T., Damus, K., Russell, R., Bettegowda, V. R., Dolan, S., ... & Petrini, J. (2006). Changes in the gestational age distribution among US singleton births: impact on rates of late preterm birth, 1992 to 2002. *In Seminars in perinatology*, *30*(1), 8-15.
8. Den Ouden, L., Rijken, M., Brand, R., Verloove-Vanhorick, S. P., & Ruys, J. H. (1991). Is it correct to correct? Developmental milestones in 555 "normal" preterm infants compared with term infants. *The Journal of pediatrics, 118*(3), 399-404.
9. DiPietro, J. A., & Allen, M. C. (1991). Estimation of gestational age: Implications for developmental research. *Child Development, 62*(5), 1184-1199.
10. Erenberg, A., Lemons, J., Sia, C., Trunkel, D., & Ziring, P. (1999). Newborn and infant hearing loss: detection and intervention. American Academy of Pediatrics. Task Force on Newborn and Infant Hearing, 1998-1999. *Pediatrics, 103*(2), 527-530.
11. Gouyon, J. B., Iacobelli, S., Ferdynus, C., & Bonsante, F. (2012). Neonatal problems of late and moderate preterm infants. In *Seminars in Fetal and Neonatal Medicine, 17*(3), 146-152. WB Saunders.
12. Микић, Б., Ђоковић, С., Совиљ, М., Пантелић, С. (2005). Отоакустичка емисија код неонатуса, деце и одраслих. У С. Јовичић, М. Совиљ (Ур.): Отоакустичка емисија – теорија и пракса, 122-140.
13. Neumann, K., Coninx, F., Schäfer, K., & Offei, Y.N. (2012). The LittlEARS® Auditory Questionnaire a screening tool beyond Newborn Hearing Screening. Paper presented at the Global Coalition on Hearing Health Annual Meeting, Pretoria, May 30 to 31, 2012. Book of Abstracts, 14.
14. Nikolić, M. (2016). Specifičnost auditivnih *sposobnosti kod prevremeno rođene dece*. (Doktorska disertacija). Univerzitet u Beogradu, Beograd, Srbija.
15. Riitesuo, A. (2000). *A preterm child grows: focus on speech and language during the first two years*. Jyväskylän yliopisto.
16. Schäfer, K. (2013). *Screening mit dem LittlEARS® (MED-EL)-Hörfragebogen – Eine empirische Untersuchung zur Möglichkeit eines zweiten Hörscreenings für Kinder im Alter von 10-12 Monaten im Rahmen der Früherkennungsuntersuchung U6*. PhD thesis, Universität zu Köln. Dostupno na (08.08.2013.): http://kups.ub.uni-koeln.de/5235/
17. Tsiakpini, L.,Weichbold, V., Kuehn-Inacker, H.,Coninx, F., D'Haese, P., & S. Almadin (2004). *LittlEARS Auditory Questionnaire*. Innsbruck, Austria: MED-EL
18. Weichbold, V., Tsiakpini, L., Coninx, F., & D`Haese, P. (2005). Development of a parent questionnaire for assessment of auditory behaviour of infants up to two years of age. *Laryngorhinootologie*, *84*(5), 328-334.

AUDITORY DEVELOPMENT OF PRETERM BABIES: EARLY AGE EVALUATION CRITERIA

Mina Nikolić, Sanja Ostojić-Zeljković, Svetlana Slavnić
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: A significant progress in neonatal care for preterm babies in recent decades has tremendously improved the survival rate of extremely and considerably premature babies. On the other hand, it has increased the rate of sensory deficits and developmental disorders that can be observed in early childhood.

Method: The objective of the study was to establish evaluation criteria for auditory development of preterm babies at an early age. Investigation was conducted longitudinally in order to follow-up auditory development of preterm babies during the first year of life. The LittlEars® auditory questionnaire was used for evaluation of auditory behavior in babies in pre-verbal phase. The sample in the study consisted of 150 preterm babies, whose auditory development was monitored at the Institute for Neonatology in Belgrade.

Results: The results of the study have shown a significant impact of gestational age at birth on auditory development of preterm babies. Babies born in later pregnancy have shown better auditory performance at all ages as compared to earlier preterm newborns. The analysis of auditory development in function of corrected and chronological age has shown that correction factor of + 0.39 points for starting point should be applied for each week of gestation and +0.41 points should be added to the timeline during the first year of life of premature babies.

Conclusion: According to the obtained results, preterm babies could be expected to achieve age appropriate auditory performance during the second year of life. The expected trend of auditory development becomes stable after 12 months of age, so only partial correction should be applied. Between 15 and 18 months of age prematurely born babies should achieve milestones of the term babies. Defining evaluation criteria for auditory development of preterm babies is extremely important in order to avoid delayed diagnosis of deviation from typical auditory development.

Key words: auditory development, preterm babies, hearing impairment, early detection, early intervention

PARALLEL SESSIONS II
STATEGIES AND CHALLENGES IN EARLY INTERVENTION SYSTEM

PARALELNA SESIJA II
STRATEGIJE I IZAZOVI U SISTEMU RANE INTERVENCIJE

udc 37.018.1
316.356.2
173.5

Efektivnost samoedukacije roditelja u redukciji eksternalizovanih problema kod dece predškolskog uzrasta[1]

Vesna Žunić-Pavlović

Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Miroslav Pavlović

Zavod za unapređivanje obrazovanja i vaspitanja, Srbija

Nenad Glumbić, Goran Jovanić

Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Edukacija roditelja smatra se najefektivnijom intervencijom u prevenciji i redukovanju eksternalizovanih problema dece predškolskog uzrasta. Edukacija roditelja obično ima formu treninga koji je zasnovan na teoriji socijalnog učenja i usmeren na promenu ponašanja roditelja kako bi adekvatno reagovali na probleme u ponašanju i podsticali kognitivni, socijalni i emocionalni razvoj deteta. Trening za roditelje može se primenjivati individualno, grupno ili u vidu samoedukacije roditelja putem knjiga, audio i video materijala, interneta i sl. U savremenoj praksi vlada veliko interesovanje za samoedukaciju roditelja, pre svega zbog mogućnosti da se odgovori na potrebe većeg broja porodica uz manje troškove. Glavni cilj ovog rada je sumiranje naučnih saznanja o efektima samoedukacije roditelja na ispoljavanje eksternalizovanih problema kod dece predškolskog uzrasta. Uvid u savremena saznanja o efektivnosti ove intervencije ostvaren je analizom rezultata objavljenih metaanaliza, sistematskih pregleda literature i studija pojedinačnih programa. Rezultati analize sugerišu da se samoedukacijom roditelja mogu značajno redukovati eksternalizovani problemi kod dece predškolskog uzrasta.

Ključne reči: *eksternalizovani problemi, predškolci, trening za roditelje, samoedukacija*

EKSTERNALIZOVANI PROBLEMI U DETINJSTVU I RODITELJSTVO

Rezultati longitudinalnih istraživanja otkrivaju da je učestalost eksternalizovanih problema najveća tokom detinjstva i da postupno opada sa odrastanjem

---

[1] Rad je proistekao iz projekta „Socijalna participacija osoba sa intelektualnom ometenošću”, br. 179017 (2011–2017), koji finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

(Bongers, Koot, van der Ende & Verhulst, 2003; Stanger, Achenbach & Verhulst, 1997). Uobičajenu razvojnu trajektoriju fizičke agresije karakteriše početak krajem prve godine, maksimalan nivo u drugoj godini i opadanje od treće godine života (Alink et al., 2006; Tremblay et al., 1999). Slične normativne razvojne putanje zapažene su i kod drugih oblika ranih eksternalizovanih problema, kao što su neposlušnost, napadi besa, destruktivnost i sl. (Shaw, Lacourse & Nagin, 2004; Smith, Calkins, Keane, Anastopoulos & Shelton, 2004).

Nalazi ovih studija sugerišu da je ispoljavanje eksternalizovanih problema uobičajeno tokom detinjstva, ali da je u većini slučajeva prolaznog karaktera. Povećanje učestalosti eksternalizovanih problema tokom prvih godina života može biti odraz razvoja osećanja autonomije kod deteta i istraživanja vlastitih kapaciteta, ali i reakcija na opadanje tolerancije roditelja i postavljanje ograničenja u pogledu ponašanja (Campbell, 2002; Gardner & Shaw, 2009). Zahvaljujući razvoju kognitivnih sposobnosti, govora i samoregulacije, većina dece preraste ovu fazu. Međutim, kod 5–10% dece visok nivo eksternalizovanih problema održava se i tokom predškolskog uzrasta (Hill, Degnan, Calkins & Keane, 2006; Shaw et al., 2004).

U konceptualnom okviru za proučavanje kontinuiteta i stabilnosti eksternalizovanih problema dece predškolskog uzrasta roditeljstvo ima centralnu poziciju. Teorijsku osnovu proučavanja povezanosti eksternalizovanih problema deteta i roditeljstva čine generalni teorijski modeli – teorija atačmenta i teorija socijalnog učenja, i iz njih izvedene teorije koje objašnjavaju razvoj eksternalizovanih problema, kao što je koerzivni model razvoja agresivnog ponašanja (videti pregled u Žunić-Pavlović i Pavlović, 2013). Dosadašnja istraživanja potvrđuju da neadekvatno roditeljstvo može doprineti održavanju i povećanju učestalosti i težine eksternalizovanih problema kod dece. Istraživanja stilova roditeljstva, kao specifičnih i ustaljenih obrazaca ponašanja roditelja, konzistentno ukazuju na vezu autoritarnog i permisivnog stila roditeljstva sa eksternalizovanim problemima na predškolskom uzrastu (Casas et al., 2006; Heller, Baker, Henker & Hinshaw, 1996). Dodatno, obimna empirijska literatura svedoči o povezanosti između eksternalizovanih problema predškolaca i različitih dimenzija roditeljstva, kao što su nizak nivo topline, podrške i uključenosti (McFadyen-Ketchum, Bates, Dodge & Pettit, 1996; Smith et al., 2004) i visok nivo hostilnosti i negativne kontrole (Combs-Ronto, Olson, Lunkenheimer & Sameroff, 2009; Rubin, Burgess, Dwyer & Hastings, 2003; Shaw et al., 2004).

Saznanja o posledicama neadekvatnog roditeljstva inspirisala su primenu edukacije roditelja o razvoju i odgajanju deteta u prevenciji i tretmanu eksternalizovanih problema dece predškolskog uzrasta.

TRENING ZA RODITELJE

U prevenciji i tretmanu eksternalizovanih problema dece predškolskog uzrasta obično se primenjuje edukacija roditelja u formi strukturirane, intenzivne i kratkoročne intervencije koja se u literaturi naziva trening za roditelje. Trening za roditelje zasnovan je na teoriji socijalnog učenja i usmeren je na promenu ponašanja roditelja kako bi adekvatno reagovali na probleme u ponašanju i podsticali kognitivni, socijalni i emocionalni razvoj deteta. Sadržaj treninga striktno je definisan i obuhvata nekoliko segmenata sa sledećim redosledom: prvo, obuhvatna procena potencijala i problema deteta i porodice, a posebno situacionih faktora koji doprinose održavanju problematičnog ponašanja deteta; drugo, unapređivanje pozitivnih odnosa između roditelja i deteta; treće, učenje veština kojima se podstiče pozitivno ponašanje deteta (postavljanje pravila i očekivanja, nagrađivanje i sl.); četvrto, unapređivanje veština praćenja i kontrole ponašanja deteta; peto, efektivno reagovanje na problematično ponašanje deteta i dosledna primena odgovarajućih kazni (Gardner & Shaw, 2009; Webster-Stratton & Taylor, 2001). U podučavanju roditelja novim veštinama primenjuju se različite tehnike, kao što su modelovanje, igranje uloga, kratka predavanja, grupne diskusije i dr., dok se za generalizaciju i održavanje naučenih veština koriste pisana uputstva i domaći zadaci. Trening za roditelje može se primenjivati individualno, grupno ili u vidu samoedukacije roditelja putem knjiga, audio i video materijala, interneta i sl.

Rezultati brojnih sistematskih pregleda i metaanaliza govore u prilog delotvornosti treninga za roditelje u prevenciji i redukovanju eksternalizovanih problema dece predškolskog uzrasta (Barlow & Parsons, 2003; Chorpita et al., 2011; Dretzke et al., 2009; Eyberg, Nelson & Boggs, 2008; Furlong et al., 2012; Michelson, Davenport, Dretzke, Barlow & Day, 2013; Piquero, Farrington, Welsh, Tremblay & Jennings, 2008; Serketich & Dumas, 1996; Tully & Hunt, 2016). U većini studija nisu nađene značajne razlike u efektivnosti treninga za roditelje u zavisnosti od karakteristika korisnika i od načina primene (Dretzke et al., 2009; Furlong et al., 2012; Michelson et al., 2013; Piquero et al., 2008). Glavna prepreka u primeni treninga za roditelje je učestalo odustajanje koje se kreće u opsegu od 10–30% (Barlow & Parsons, 2003; Tully & Hunt, 2016). Najčešći razlozi za odustajanje roditelja od treninga su: neodgovarajući raspored sesija, praktični razlozi (radno vreme, prevoz i sl.), preterani zahtevi (redovno pohađanje, domaći zadaci i sl.), nerazumevanje relevantnosti treninga i odnos sa stručnjakom (Reyno & McGrath, 2006; Spoth, Redmond, Hockaday & Shin, 1996).

EFEKTIVNOST SAMOEDUKACIJE RODITELJA

Samoedukacija podrazumeva da intervenciju primenjuju sami korisnici, eventualno uz kratke konsultacije sa stručnjakom (manje od četiri sata), obično putem telefona ili elektronske pošte, u cilju praćenja napredovanja i razmatranja specifičnih problema (Elgar & McGrath, 2003). Samoedukacija roditelja često je pozicionirana kao segment kontinuiranog sistema prevencije i tretmana eksternalizovanih problema i primenjuje se u primarnoj prevenciji i tretmanu lakših problema.

U praksi se primenjuju dva oblika samoedukacije roditelja, biblioterapija i multimedijalni programi samopomoći (O'Brien & Daley, 2011). Biblioterapija se odnosi na upotrebu pisanog materijala, najčešće priručnika koji sadrži informacije o problemu, delotvornim pristupima u rešavanju problema, domaće zadatke, instrumente za procenu i sl. Na primer, biblioterapija u *Programu pozitivnog roditeljstva* traje 10 nedelja i sastoji se iz učenja lekcija o podsticanju pozitivnog razvoja i reagovanju na problematično ponašanje deteta iz knjige i uvežbavanja primene naučenih veština prema uputstvima iz radne sveske, uz minimalne kontakte sa stručnjakom putem telefona (Markie-Dadds & Sanders, 2006). U multimedijalnim programima samopomoći naglasak je na modelovanju roditeljskih veština posredstvom video ili audio materijala, televizije ili interneta. Najpoznatiji primer je trening za roditelje putem video-traka iz programa *Neverovatne godine* (Webster-Stratton, Kolpacoff & Hollinsworth, 1988). Trening se sastoji iz 10-12 nedeljnih sesija na kojima roditelji, gledajući video-trake sa preko 250 vinjeta roditelja i dece u različitim situacijama, uče veštine interaktivnog igranja, pozitivnog potkrepljivanja, postavljanja ograničenja i reagovanja na problematično ponašanje deteta. Rezultati evaluacije opisanih intervencija svedoče o značajnim pozitivnim promenama u ponašanju deteta i postupanju roditelja (Markie-Dadds & Sanders, 2006; Webster-Stratton et al., 1988).

Studije u kojima su sumirani nalazi većeg broja istraživanja efektivnosti samoedukacije roditelja u prevenciji i tretmanu eksternalizovanih problema izveštavaju o značajnoj redukciji problema u ponašanju deteta (Montgomery, Bjornstad & Dennis, 2006), kao i negativnog raspoloženja, nivoa stresa i nekonzistentnog i grubog postupanja roditelja prema detetu (O'Brien & Daley, 2011; Tarver, Daley, Lockwood & Sayal, 2014). Međutim, u odnosu na trening za roditelje koji vodi stručnjak, pa čak i intervencije koje uključuju minimalnu dozu kontakta sa stručnjakom, samoedukacija je slabije ocenjena u pogledu efektivnosti, odustajanja od tretmana i zadovoljstva korisnika.

ZAKLJUČAK

U savremenoj praksi vlada veliko interesovanje za samoedukaciju roditelja, pre svega zbog mogućnosti da se odgovori na potrebe većeg broja porodica uz manje troškove. Pored toga, putem samoedukacije mogu se prevazići uobičajena ograničenja u primeni treninga za roditelje, kao što su: učestalo odustajanje, stigmatizacija roditelja koji pohađaju trening, mali broj stručnjaka iz ove oblasti i duge liste čekanja i dr. Rezultati prezentovani u ovom radu sugerišu da se putem samoedukacije roditelja mogu ostvariti značajni pozitivni efekti u prevenciji i redukovanju eksternalizovanih problema kod dece predškolskog uzrasta.

LITERATURA

1. Alink, L. R. A., Mesman, J., van Zeijl, J., Stolk, M. N., Juffer, F., Koot, H. M., ... van IJzendoorn, M. H. (2006). The early childhood aggression curve: Development of physical aggression in 10- to 50-month-old children. *Child Development*, *77*, 954-966. doi: 10.1111/j.1467-8624.2006.00912.x
2. Barlow, J., & Parsons, J. (2003). Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children. *Cochrane Database of Systematic Reviews*, Issue 2, Art. No.: CD003680. doi: 10.1002/14651858.CD003680
3. Bongers, I. L., Koot, H. M., van der Ende, J., & Verhulst, F. C. (2003). The normative development of child and adolescent problem behavior. *Journal of Abnormal Psychology,* 112, 179-192. doi: 10.1037/0021-843X.112.2.179
4. Campbell, S. B. (2002). *Behavior problems in preschool children: Clinical and Developmental Issues.* New York: The Guilford Press.
5. Casas, J. F., Weigel, S. M., Crick, N. R., Ostrov, J. M., Woods, K. E., Yeh, E. A. J., & Huddleston-Casas, C. A. (2006). Early parenting and children's relational and physical aggression in the preschool and home contexts. *Applied Developmental Psychology, 27*, 209-227. doi: 10.1016/j.appdev.2006.02.003
6. Chorpita, B. F., Daleiden, E. L., Ebesutani, C., Young, J., Becker, K. D., Nakamura, B. J., ... Starace, N. (2011). Evidence-based treatments for children and adolescents: an updated review of indicators of efficacy and effectiveness. *Clinical Psychology Science and Practice, 18*, 154-172. doi: 10.1111/j.1468-2850.2011.01247.x
7. Combs-Ronto, L. A., Olson, S. L., Lunkenheimer, E. S., & Sameroff, A. J. (2009). Interactions between maternal parenting and children's early disruptive behavior: Bidirectional associations across the transition from preschool to school entry. *Journal of Abnormal Child Psychology*, *37*, 1151-1163. doi: 10.1007/s10802-009-9332-2
8. Dretzke, J., Davenport, C., Frew, E., Barlow, J., Stewart-Brown, S., Bayliss, S., ... Hyde, C. (2009). The clinical effectiveness of different parenting programmes for children with conduct problems: A systematic review of randomised control trials. *Child and Adolescent Psychiatry and Mental Health*, *3*, 1753-2000. doi: 10.1186/1753-2000-3-7
9. Elgar, F. J., & McGrath, P. J. (2003). Self-administered psychosocial treatment for children and families. *Journal of Clinical Psychology, 59*, 321-339. doi: 0.1002/jclp.10132
10. Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology*, *37*, 215-237. doi: 10.1080/15374410701820117
11. Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2012). Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years.

Cochrane Database of Systematic Reviews, Issue 2, Art. No.: CD008225. doi: 10.1002/14651858.CD008225.pub2.

12. Gardner, F., & Shaw, D. S. (2009). Behavioral problems of infancy and preschool children (0-5). In M. Rutter, D. Bishop, D. Pine, S. Scott, J. Stevenson, E. Taylor & A. Thapar (Eds.), *Rutter's child and adolescent psychiatry* (pp. 882-893). Oxford: Blackwell.
13. Heller, T. L., Baker, B. L., Henker, B., & Hinshaw, S. P. (1996). Externalizing behavior and cognitive functioning from preschool to first grade: Stability and predictors. *Journal of Clinical Child Psychology, 25*, 376-387. doi: 10.1207/s15374424jccp2504_3
14. Hill, A. L., Degnan, K. A., Calkins, S. D., & Keane, S. P. (2006). Profiles of externalizing behavior problems for boys and girls across preschool: The roles of emotional regulation and inattention. *Developmental Psychology*, *42*, 913-928. doi: 10.1037/0012-1649.42.5.913
15. Markie-Dadds, C., & Sanders, M. R. (2006). Self-directed Tiple-P (Positive Parenting Program) for mothers with children at-risk of developing conduct problems. *Behavioural and Cognitive Psychotherapy*, *34*, 259-275. doi: 10.1017/S1352465806002797
16. McFadyen-Ketchum, S. A., Bates, J. E., Dodge, K. A., & Pettit, G. S. (1996). Patterns of change in early childhood aggressive-disruptive behavior: Gender differences in predictions from early coercive and affectionate mother-child interactions. *Child Development, 67,* 2417-2433. doi: 10.1111/j.1467-8624.1996.tb01865.x
17. Michelson, D., Davenport, C., Dretzke, J., Barlow, J., & Day, C. (2013). Do evidence-based interventions work when tested in the "real world"? A systematic review and meta-analysis of parent management training for the treatment of child disruptive behavior. *Clinical Child and Family Psichology Review*, *16*, 18-34. doi: 10.1007/s10567-013-0128-0
18. Montgomery, P., Bjornstad, G. J., & Dennis, J. A. (2006). Media-based behavioural treatments for behavioural problems in children. *Cochrane Database of Systematic Reviews*, Issue 1, Art. No.: CD002206. doi: 0.1002/14651858.CD002206.pub3.
19. O'Brien, M., & Daley, D. (2011). Self-help parenting interventions for childhood behaviour disorders: A review of evidence. *Child: Care, Health and Development*, *37*, 623-637. doi: 10.1111/j.1365-2214.2011.01231.x
20. Piquero, A. R., Farrington, D. P., Welsh, B. C., Tremblay, R., & Jennings, W. G. (2008). Effects of an early family/parent training programs on antisocial behavior and delinquency. *Campbell Systematic Reviews, 11*. doi: 10.4073/csr.2008.11
21. Reyno, S. M., & McGrath, P. J. (2006). Predictors of parent training efficacy for child externalizing behavior problems: A meta-analytic review. *Journal of Child Psychology and Psychiatry*, *47*, 99-111. doi: 10.1111/j.1469-7610.2005.01544.x
22. Rubin, K. H., Burgess, K. B., Dwyer, K. M., & Hastings, P. D. (2003). Predicting preschoolers' externalizing behaviors from toddler temperament, conflict, and

maternal negativity. *Developmental Psychology, 39*, 164-176. doi: 10.1037/0012-1649.39.1.164

23. Serketich, W. J., & Dumas, J. E. (1996). The effectiveness of behavioral parent training to *modify antisocial behavior in children: A meta-analysis.* Behavior Therapy, 27, 171-186. doi: 10.1016/S0005-7894(96)80013-X
24. Shaw, D. S., Lacourse, E., & Nagin, D. S. (2004). Developmental trajectories of conduct problems and hyperactivity from ages 2 to 10. *Journal of Child Psychology and Psychiatry*, *45*, 1-12. doi: 10.1111/j.1469-7610.2004.00390.x
25. Smith, C. L., Calkins, S. D., Keane, S. P., Anastopoulos, A. D., & Shelton, T. L. (2004). Predicting stability and change in toddler behavior problems: Contributions of maternal behavior and child gender. *Developmental Psychology*, *40*, 29-42. doi: 10.1037/0012-1649.40.1.29
26. Spoth, R., Redmond, C., Hockaday, C., & Shin, C. Y. (1996). Barriers to participation in family skills preventive interventions and their evaluations: A replication and extension. *Family Relations, 45*, 247-254. doi: 10.2307/585496
27. Stanger, C., Achenbach, T. M., & Verhulst, F. C. (1997). Accelerated longitudinal comparisons of aggressive versus delinquent syndromes. *Development and Psychopathology, 9*, 43-58. doi: 10.1017/S0954579497001053
28. Tarver, J., Daley, D., Lockwood, J., & Sayal, K. (2014). Are self-directed parenting interventions sufficient for externalising behaviour problems in childhood? A systematic review and meta-analysis. *European Child & Adolescent Psychiatry, 2014*, 1123-1137. doi: 10.1007/s00787-014-0556-5
29. Tremblay, R. E., Japel, C., Perusse, D., McDuff, P., Boivin, M., Zoccolillo, M., & Montplaisir, J. (1999). The search for the age of ‘onset’of physical aggression: Rousseau and Bandura revisited. *Criminal Behaviour and Mental Health, 9,* 8-23. doi: 10.1002/cbm.288
30. Tully, L. A., & Hunt, C. (2016). Brief parenting interventions for children at risk of externalizing behavior problems: A systematic review. *Journal of Child and Family Studies*, *25*, 705-719. doi: 10.1007/s10826-015-0284-6
31. Webster-Stratton, C., & Taylor, T. (2001). Nippong early risk factors in the bud: Preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0-8 years). *Prevention Sciences, 2*, 165-192. doi: 10.1016/j.chc.2009.03.002
32. Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology, 56*, 558-566. doi: 10.1037/0022-006X.56.4.558
33. Žunić-Pavlović, V., i Pavlović, M. (2013). Tretman poremećaja ponašanja u detinjstvu i adolescenciji. Beograd: Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju.

EFFECTIVENESS OF SELF-EDUCATION OF PARENTS IN REDUCING EXTERNALIZING PROBLEMS IN PRESCHOOL CHILDREN

Vesna Žunić-Pavlović*, Miroslav Pavlović**, Nenad Glumbić*, Goran Jovanić*
*University of Belgrade – Faculty of Special Education and Rehabilitation, Serbia
**Institute for Improvement of Education, Serbia

Research subject: The results of longitudinal studies reveal that the normative developmental trajectory of externalizing problems is characterized by gradual decline after the second year of life. However, in 5–10% of children a high level of externalizing problems is maintained during the preschool age. In the conceptual framework for studying the continuity and stability of externalizing problems in childhood parenting has a central position. Previous research confirmed that inadequate parenting can contribute to maintaining and increasing the frequency and severity of externalizing problems in children. Accordingly, most of the authors stand parent education as the most effective intervention in the prevention and reduction of externalizing problems in preschoolers.

Method: The main aim of this paper is to summarize the scientific knowledge on the effects of parental self-education on externalizing problems in preschool children. Insight into the current knowledge of the effectiveness of this intervention was achieved by analyzing the results of the published meta-analyses, systematic literature reviews and studies of single programs.

Results: Results of the analysis suggest that self-education of parents can significantly reduce externalizing problems in preschoolers.

Conclusion: Education of parents usually takes the form of training that is based on social learning theory and focuses on changing the behavior of parents to provide adequate responses to behavioral problems and encourage cognitive, social and emotional development of the child. Parent training can be applied individually, in groups or in the form of self-education of parents through books, audio and video materials, Internet etc. There is great interest in contemporary practice for parental self-education primarily because of the opportunity to meet the needs of more families at a lower cost. In addition, common limitations in parent training, such as a small number of experts in this field and long waiting list, high dropout rates of parents due to the requests to regularly attend sessions etc., could be overcome by self-education.

Key words: externalizing problems, preschoolers, parent training, self-education

udc 316.614-053.2(469)
159.923.5-053.2(469)

Participation of Pre-School Children in Home and Community Activities

Sofia Guichard, Catarina Grande
University of Porto, Faculty of Psychology and Educational Sciences, Portugal

Research subject: *The main goal of the present study was to promote an understanding of the levels of participation of preschool children at home and in the community setting, describing the differences between eligible children supported by Special Education Service and/or by the National Early Intervention System and non-eligible children.*

Methods: *Parents of 116 children from the Metropolitan Area of Porto (Portugal) completed an adapted version of the Young Children's Participation and Environment Measure (YC-PEM; Khetani, Coster, Law & Bedell, 2013). Forty-two of the 116 children were eligible and had support of Special Education and/or of the National Early Intervention System. To assess the children's functioning, their pre-school teachers completed 6 items of the Matrix for Assessment of Activities and Participation (MAAP; Castro, Pinto & Figueiredo, 2013), corresponding to 6 code sets of the ICF-CY Developmental Code Sets (Ellingsen & Simmeonsson, 2011).*

Results: *The results showed that eligible children had lower levels of functioning (Mdn = 16.00), when compared to non-eligible children without additional support (Mdn = 23.00; U = 2.679,00, z = 6.365, p < .001, r = -0.45).*

Conclusion: *The results are analyzed and discussed with reference to the bio-psychosocial model of the ICF-CY (WHO, 2007), considering the implications to inclusive practices in Early Childhood Education.*

Key words: *environment, functionality, inclusion, participation*

Participation is a multidimensional concept (Almqvist, Uys & Sandberg, 2007), defined by the World Health Organization (2001) as "involvement in a life situation". The concept of child participation is related to involvement in activities of daily living, play and socialization with peers, allowing the child to perform different tasks and roles (Almqvist, Uys & Sandberg, 2007). Studies focus on the concept of participation in everyday life situations as it is known to be a promoter of development, with influence on learning (Almqvist, 2006).

The perspective of functionality of the biopsychosocial model, operationalized by the International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY; WHO, 2007), emphasizes the dynamic relationship between the child and the environment (Almqvist et al., 2007). Recommended practices for Early Intervention by the Division for Early Childhood (2014) attribute relevance to the promotion of child participation through a family-centered perspective in natural and inclusive settings. It is, therefore recommended, that modifications are made to the physical and social environments to promote higher levels of participation.

However, studies have shown that children with disabilities participate less frequently and with lower levels of involvement in home and community activities than children without disabilities (Bedell et al., 2013; Law et al., 2013). Parents of children with disabilities identify more environmental barriers and fewer environmental supports at home and in the community (Bedell et al., 2013; Law et al., 2013).

AIM OF PAPER

The main goal of the present study was to promote an understanding of the levels of participation of preschool children in home and community activities, describing the differences between eligible children with support of Special Education (Decree-Law nº3/2008) and/or Early Childhood Intervention (Decree-Law nº281/2009) and non-eligible children. The study aimed to describe the differences between these two groups of children regarding (1) their levels of functioning; (2) frequency of participation and involvement in home and community activities; and (3) environmental barriers perceived in both settings.

METHOD

116 parents of pre-school children from the Metropolitan Area of Porto (Portugal) participated in this study. 83 of the 116 children were boy and 42 of the 116 children were eligible and had support from Early Childhood Intervention (ECI) and/or Special Education (SE). Children's age was between 36 months (3 years) and 65 months (5 years and 5 months) ($M = 52.64$; $SD = 6.38$).

The mother of the child was the key informant in 94 families, the father in 10 families, both in 11 families and the grandmother of the child in only one family of the sample. On average, fathers completed 10 years of schooling ($M = 9.60$, $SD = 3.44$) and mothers completed 11 years of schooling ($M = 10.60$, $SD = 3.30$). The families' monthly incomes ranged from less than 500€ to 2500€, with 62.9% of families having monthly incomes lower than or equal to 1250€.

Parents completed a brief sociodemographic questionnaire and the adapted Portuguese version of the Young Children's Participation and Environment Measure (YC-PEM; Khetani, Coster, Law & Bedell, 2013). This adapted Portuguese version of the YC-PEM (Khetani et al., 2013) provides a description of child participation and environmental factors and at home and in community settings. In each setting (home and community), for each activity, parents were asked about child frequency of participation (8-point scale, 0 meaning *Never* and 7 meaning *Once or more times per day*) and child involvement (5-point scale, 1 meaning *Not very involved* and 5, *Very involved*). Then, for each setting, environmental factors and resources were assessed in a 3 points scale, from *No impact/Usually helps/Usually yes* to *Usually makes it harder/Usually not*.

Pre-school teachers were asked to complete a measure to assess child's functioning: 6 items from the Matrix of Activities and Participation (MAAP; Castro, Pinto & Figueiredo, 2013), corresponding to 6 WHO ICF-CY Developmental Code Sets (Ellingsen & Simeonsson, 2011). The teacher rated the usual performance of the child in their daily life from a scale of 1 to 5, 1 meaning *not able* and 5 *without any difficulty*, to each dimension.

The families were recruited from a larger research project conducted in preschool inclusive settings. When the permission from the schools and teachers was obtained, consent forms were sent to parents. Teachers documented child functioning within the scope of the larger project. Parents were contacted and a meeting between them and one member of the members of the research team was settled at school or at home. In the meeting, one or both parents completed the instruments with the assistance of one member of the research team. The data collection occurred between February and July 2016.

Concerning statistical analysis of data, first, multiple descriptive analysis were conducted to describe sociodemographic variables, child functioning, child participation in home and community activities (frequency of participation and involvement) and the perception of environmental barriers by the parents in both settings. Then, composite variables were created to measure levels of participation and environmental barriers perceived by parents. The Cronbach alpha was used to assess the internal consistency of the variables, which ranged from .50 to .75.

Finally, the two groups of children were compared (C_1 – children eligible for ECI and/or SE and with support – and C_2 – non-eligible children, without support), regarding (1) their levels of functioning; (2) frequency of participation and involvement in home and community activities; and (3) environmental barriers perceived by parents in both settings. Given the size of the groups as well as the difference in size between the two groups of children, non-parametric Mann-Whitney test was used to assess the differences between groups. The results were interpreted based on the magnitude of the differences between groups, calculated by converting Z values to r values, as suggested by Rosenthal (1991) and recommended by Field (2009).

RESULTS

According to pre-school teachers, eligible children for ECI and/or SE (C_1) had statistically significant lower levels of functioning (Mdn= 16.00), when compared with non-eligible children (C_2) (*Mdn* = 23.00), U = 2.679,00, z = 6.365, p <.001, r = 0.59. – large effect size.

Eligible children for ECI and/or SE (C_1) had statistically significant lower frequency of participation in home (*Mdn* = 5.44) and community activities (*Mdn* = 3.19), when compared with non-eligible children (C_2) (*Mdn*=5.99; *Mdn* = 3.63), U = 2.134,50, z = 3.393, p < .001, r =.32 –moderate effect size for home setting – and U = 1.826,50, z = 1.99, p = .046, r = 0.19 – small effect size for the community setting.

Parents of eligible children for ECI and/or SE (C1) perceived statistically significant more barriers at home (*Mdn* = 1.29) and in the community (*Mdn* = 1.45), when compared with parents of non-eligible children (C2) (*Mdn* = 1.08; *Mdn* = 1.12), U = 747.000, z = -4.814, p < .001, r = -0.45 – big effect size for home setting – and U = 572.500, z = -5.484, p < .001, r = -0.51 – big effect size for community setting.

DISCUSSION

The present study contributes to the understanding of pre-school children participation, with different levels of functioning, in home and community activities, considering environmental barriers perceived by parents on both settings.

The study enhances that eligible children for ECI and/or SE have lower levels of functioning than non-eligible children, according to their pre-school teacher. Thus, rather than valuing aspects of nosological nature, from the biomedical perspective, the study sets a focus on functional evaluation of activities and participation to obtain a contextualized view of child performance in daily life settings.

According to parents' reports, eligible children for ECI and/or SE participate less frequently in the routines in home and community activities than non-eligible children, as previous studies reveal (Bedell et al., 2013; Law et al., 2013). However, in the present study no significant differences were found in child involvement, according to parents' report. In this regard, it would be important to conduct more studies in Portugal to assess the cultural and ecological validity of the YC-PEM (Khetani et al., 2013) and to complement this results with an observational measure to assess child's engagement. We would also recommend comparative studies among countries, since literature has assigned prior relevance to country of residence in explaining participation of children with disabilities (Fauconnier et al., 2009; Ullenhag et al., 2012).

Finally, the present study reports that parents of eligible children for ECI and/or SE perceive more environmental barriers in both settings (home and community), when compared to non-eligible children. This evidence is consistent with studies by Bedell and colleagues (2013) and Law and colleagues (2013) and highlights the importance of modifying specific environmental factors to promote child participation in everyday settings.

CONCLUSION

The present study enhances the urgency that legislative policies ensure the universal right to participation and inclusion of children in their natural contexts, with their peers, as advocated by international guidelines (Graham, 2014). Then, it is essential that the provided services establish a collaboration with families, focusing on the promotion of child functioning, with a holistic view of disability, and on the identification and modification of environmental factors, enabling all children to fulfil their developmental potential. That would increase the frequency, variety and quality of daily learning opportunities, embedded in everyday activities, in natural and inclusive contexts.

REFERENCES

1. Almqvist, L., Uys, C. J. E., & Sandberg, A. (2007) Patterns of engagement of children with and without developmental delay. *Journal of Policy and Practice in Intellectual Disabilities*, *3*(1), 65-75.
2. Almqvist, L. (2006). Patterns of engagement in young children with and without developmental delay. *Journal of Policy and Practice in Intellectual Disabilities, 3(*1), 65-75.
3. Bedell, G., Coster, W., Law, M., Liljenquist, K., Kao, Y.C., Teplicky, R., Anaby, D., & Khetani, M. (2013). Community Participation, Support and Barriers of School-Age Children With and Without Disabilities. *Archives of Physical Medicine and Rehabilitation, 94*, 315-323.
4. Castro, S., Pinto, A. I., & Figueiredo, A. (2013). *Matriz de Avaliação das Atividades e Participação*. Non-published instument. Faculty of Psychology and Educational Sciences of the University of Porto.
5. Division for Early Childhood. (2014). *DEC recommended practices in early intervention/early childhood special education*. Retrieved from http://www.dec-sped.org/recommendedpractices.
6. Ellingsen, K. M & Simeonsson, R. J. (2011). *WHO ICF-CY Developmental Code Sets.* Retrieved from http://www.icfcydevelopmentalcodesets.com/attorneys.html
7. Fauconnier, J., Dickinson, H. O., Beckung, E., Marcelli, M., McManus, V., Michelsen, S. I., Parkes, J., Parkinson, K.N., Thyen, U., Arnaud, C., & Colver, A. (2009). Participation in life situations of 8-12 year old children with cerebral palsy: cross sectional European study. *The BMJ, 338*, 1-12.
8. Field, A. (2009). *Discovering statistics using SPSS (3rd Edition).* London: Sage.
9. Graham, N. (2014). *Children With Disabilities. Paper commissioned for Fixing the Broken Promise of Education for All: Findings from the Global Initiative on*

Out-of-School Children (UIS/UNICEF, 2015). Montreal: UNESCO Institute for Statistics (UIS).

10. Khetani, M.A., Coster, W., Law, M., & Bedell, G.M. (2013) *Young Children's Participation and Environment Measure (YC-PEM).* Fort Collins (CO): Colorado State University.
11. Law, M., Anaby, D., Teplicky, R., Khetani, M. A., Coster, W., & Bedell, G. (2013). Participation in the home environment among children and youth with and without disabilities. *The British Journal of Occupational Therapy, 76*(2), 58-66.
12. Rosenthal, R. (1991). *Meta-analytic procedures for social research (revised edition).* Newbury Park, CA: Sage.
13. Sameroff, A.J. (2010). A Unified Theory of Development: A Dialectic Integration of Nature and Nurture. *Child Development, 81*(1), 6-22.
14. Ullenhag, A., Bult, M. K., Nyquist, A., Ketelaar, M., Jahnsen, R., Krumlinde-Sundholm, L., Almqvist, L., & Granlund, M. (2012). An international comparison of patterns of participation in leisure activities for children with and without disabilities in Sweden, Norway and the Netherlands. *Developmental neurorehabilitation, 15*(5), 369-385.
15. WHO (2007). *International Classification of Functioning, Disability and Health, Children* & *Youth Version: ICF-CY*. Geneva, Switzerland: World Health Organization.

udc 376.1-056.262-053.2
316.614-056.262-053.2

A Baby with Cerebral Visual Impairment: Case Study

Tatjana Petrovic Sladetić, Snježana Seitz
Day Care Centre "Mali dom", Zagreb, Croatia

Research subject: *Cerebral visual impairment (CVI) is term often used to describe visual impairment that occurs because of injury or damage to the brain, as are neurological vision loss, brain-damage-related visual impairment, and vision loss due to traumatic brain injury (American Foundation for the Blind). During the last decade, vision loss due to brain damage is in focus of increasing attention.*

Method: *In this case study with a boy with a neurological problematic and functional vision loss who was included in our initail assesment and early intervention programm is presented.*

Results: *Results of functional vision before and after intervention programm is presented with a introduction of implemented early intervention procedures. Characteristcs of cerebral visual impairment and elements of team approach is, also, emphasizeed.*

Conclusion: *Children with CVI are a heterogeneous population with a spectrum of visual abilities. Since children with CVI frequently have additional disabilities, they are often missdiagnosed. For early and better detection, recognition and intervention, professionals should be familiar with basic characteristic of CVI and have the opportunity to conduct the team approach. The team approach is a crucial element in diagnostic procedures.*

Key words: *cerebral visual impairment, detection, intervention, team approach*

DEFINITION AND TERMINOLOGY OF CEREBRAL VISUAL IMPAIRMENT

Cerebral Visual Impairment (CVI) is a temporary or permanent visual impairment caused by the disturbance oft he posterior visual pathways and /or the occipital lobes oft he brain. It is a condition that indicates that the visual systems oft he brain do not consistently understand or interpret what the eyes see (Blind Baby Foundation, 1998).

There is currently a lack of consensus about appropriate term which can be an adequate description of visual dysfunction stemming from damage to the visual centers of the brain. Cortical visual impairment is more commonly used in North

America, while cerebral visual impairment is generally used in Europe. In the literature we can finde and some other terms, like neurological visual impairment and brain damage –related visual impairment (Roman –Lantzy, 2008).

CAUSES

According Babies Count, The national registry for children with visual impairments 0-3, Cerebral visual impairment (CVI), retinopathy of prematurity (ROP) and optic nerve hypoplasia (ONH) are the most prevalent conditions among children with visual impairment. In children with these three conditions, those with ROP were diagnosed the earliest (mean, 3.4 months), and those with cortical visual impairment were diagnosed latest (mean, 7.6 months) (Hatton, Schwietz, Boyer, Rychwalski, 2007).

CVI is now the most common cause of visual impairment in children in the United States (Hatton et al., 2007).

The most common conditions associated with a diagnosis of CVI are: asphyxia, perinatal hypoxic – ishemic encephalopathy, intraventricular hemorrhage, periventricular leukomalacia, cerebral vascular accident, central nervous system infections, structural abnormalities and trauma (Roman-Lantzy, 2008).

The presence of CVI is indicated when three criteria are met: a normal or near normal eye exam; a history or presence of neurological problems; the presence of specific visual and behavioral characteristic (Roman-Lantzy, 2008). Setting up a diagnosis of CVI is a long term process which requires a collaboration of different professionals.

CHARACTERISTICS OF CHILDREN WITH CEREBRAL VISUAL IMPAIRMENT

Since the simptoms of CVI depends on location and the extent of the damage of the brain, visual characteristics of individuals can vary from suptile signs to almost totally blindness. Injury oft he brain can result in functional manifestations that are complex and multifaceted

According Roman Lantzy, there are some specific visual behaviours present with children with CVI: 1. Colour preference 2. Need for movement 3. Visual latency 4. Visual Field preferences 5. Difficulty with visual omplexity 6. Light gazing and nonpurposeful gaze 7. Difficulty with distance viewing 8. Absent or atypical visual reflex responses 9. Difficulty with visual novelty 10. Absence of visually guided reach (2). This characteristics may resolve over time. Children with CVI who are included in aimed early intervention program show steady progress (Roman-Lantzy, 2008)

CVI may coexist with ocular forms of visual impairment. When an eye condition coexist with CVi, it is difficult to make clear whether a particular behavior is due to ocular or cortical condition.

From the primary visual cortex, visual information flows in two main directions: upward toward the parietal lobe (dorsal stream) or downward to the inferotemporal lobe (ventral stream). Changes in visual functioning due to injury of dorsal or ventral stream leads to various specific visual behaviours (Hyvarinen, 2014).

If there is a damage on dorsal stream, importamt visual functions as spatial awarennes, orientation in space and eye-hand-coordination can be disturbed and within the ventral stream functions as recognition and matching, colour and motion perception are affected (Hyvarinen, 2012).

Tiredness, a nosiy environment, preoccupation with other activities, illness or seizures cause a huge fluctuations in visaul functioning. All children with CVI with "useful" vision could see better in familiar environment and when they know what to look.

Transdisciplinary approach

Children with CVI can have delays on different developmental levels (motorical, cognitive, communication, language and speech, socal-emotional) but also development can be regular.

The assesment of visual and general development of a children with visual problem has become more demending related to greater complexity due to damage of the brain. For better understanding the nature and severity of child` s functioning, the assesment and intervention sholud be conducting by medicine, educational and social service specialists (Hyvarinen, 2012). Parents or caregivers shouold be member of a team.

The transdisciplinary approach (TA) has been recognized as a best practice for early intervention (Bruder, 2000; Guralnick, 2001, according Gillian et al, 2009), and many early intervention programs adopt some form of TA (Berman, Miller, Rosen & Bicchieri, 2000, acording King, Strachan, Tucker, Duwyn, Desserud & Shillington, 2009).

ASSESMENT

The assessment should include children and persons with neurological injury as well as persons with eye impairment whose visual behavior can not be explained by changes in the eye.

The assessment is carried out by gathering information from a variety of sources: 1. Interviews with parents, caregivers, teachers, paraeducators, or any infromant who has in deph knowledge regarding the child's medical history and day-to-day functioning, 2. Observation of the child in both living and learnings settings andi 3. Direct assessment.

Interview

Parents are the best reporters about their children. The parents and other family members possess critical information about how their children respond visually and the ways in which the child may display the specific visual and behavioral characteristics typical of CVI (Roman-Lantzy, 2008).

Observation

Observations should be focused on visual and behaviours characteristic that are typically accompany with CVI, mentioned above.

Child should be observed in living and learning environments, during quiet and noisy times, in near and distance activities, with familiar and novel objects, with cluttered and simple backgrounds, with objects that move and objects that are stationary (Roman-Lantzy, 2008).

Direct assessment

It is necessary to make an assessment of visual functions and functional vision assessment.

Functional vision refers to the use of vision for a particular purpose. Even small amounts of vision can be useful, for examle, to recognise a person close up, ot to avoid objects (Keeffe, 1995).

For visual function_assessment WHO 93.27 recommends assessment of vision in four main areas of children's functioning, that exist in all cultures and in all age groups: communication and interaction, orientation and mobility, activities of daily living (ADL) and sustained near vision tasks like reading and writing (Hyvarinen, 2000; WHO, 1992).

It is also necessary to note specific visual and behaviour characteristic that are typically accompany with CVI, mentioned above.

There is nessessery to assess visuo cognitive functions which can be affected in children and is necessary to assess the following functions: perception of line direction and line length, recognition of human faces, recognition of facial expressions, recognition and understanding of image material, perception of surface and texture quality, space awareness and orientation in space etc.

Results of functional vision assessment give us information concerning remain visual functions, functional vision and possibilities for vision therapy and education. This knowledge will guide the rehabilitation professionals in developing educational and rehabilitation plans.

CASE STUDY

Boy L.P. was born in June 2013. He passed transdisciplinary assesment in Little House when he was 9 months old. Before that he was involved in medical assesment and procedures, ophtalmological results showed totally blindness. Parents stated that L.P. sometimes shows some signs of visual behaviour. His visual status was: visual acuity and contrast sensitivity are below developmental age, his visual attention was very short and disrupted by posture and sounds (L.P. couldn` t listen and look at the same time), he reacted only on shiny targets in darkness. Visual latency was long,he looked only in right side of central visual field. At the beggining of assessment he showed worse visual attention then at the end.. He looked only in the simple target and follow in horizontal directions., he was attracted to the light (window, celing light).

L.P. was included in early intervention programm. Early intervention specialist, together with parents, involved strategies for CVI in every day activities. In the beggining the focus was on light target in dark conditions (ultraviolet light, “christmas” candles), but during the period they use more and more high contrast targets on day light. All others specialists used the same strategies and tools.

After period of 3 years, his visual acuity and contrast sensitivity are better but below developmental age. Visual attention is much faster and longer, he can “tolerate” targets with few colors (prefered colours are gold and red) and well known targets. He can follow visual targets in horizontal and vertical directions. There is visualy guided reach. Now he uses different head postures and can locate and follow targets in the whole sphere of central visual field.

CONCLUSION

Because children with CVI make a heterogeneous group, all children who have a neurological risk in their history should be reffered to assesment with aim to find characteristic behaviors for CVI.

As CVI is complex as itself, the diagnosis should be carried out by the team of expert.

After the diagnosis is completed, the child needs to be transferred to an adequate support program (comprehensive early intervention program).

The assessment of visual behavior needs to be carried out from time to time to get information on the child’s progress and informations needed for treatment modifications.

LITERATURE

1. Blind Babies Foundation: Pediatric Visual Diagnosis Fact Sheets; Information and resources for families and professionals; 1998, San Francisco, CA
2. Gillian King, PhD; Deborah Strachan, MRC; Michelle Tucker, MClSc; Betty Duwyn,: BSc(PT); Sharon Desserud, BSc(PT); Monique Shillington, BScN(RN); Infants and Young Children; Vol 22, No 3; 2009 The Application of a Transdisciplinary Model for Early Intervention Services
3. Roman-Lantzy, C Cortical Visual Impairment. American Foundation for the Blind, 2008.
4. http://www.tsbvi.edu/attachments/Cerebral-CorticalVisualImpairment-RECC.doc
5. Hatton, D. D., Schwietz, E., Boyer, B., & Rychwalski, P. (2007). Babies Count: the national registry for children with visual impairments, birth to 3 years. *Journal of American Association for Pediatric Ophthalmology and Strabismus, 11*(4), 351-355.
6. Hyvarinen L. (2005). Brain damage related visual impairment. Vision1282, 578-584.
7. Hyvarinen L. (2012). Assesment of Visual Functioning of Disabled Infants and Children as Transdisciplinary Team Work; available on http://www.lea-test.fi/
8. Hyvärinen L. How to classify paediatric low vision? Extraído el, 2000 Cited 10.2.2012. Available from: www.icevi-europe.org
9. Hyvarinen L: Transdisciplinary Assesment of Vision II; available on http://www.lea-test.fi/
10. Keeffe, J. Assessment of low vision in developing Countries, Assessment of funcional vision, book 2, WHO, 1995, Melbourne, Australia
11. World Health Organization. The Management of Low Vision in Children. Report of a WHO Consultation: Bangkok, WHO/PBL/93.27. 1992)

udc 316.356.2
364.4

Quality of Early Intervention Services Under Family's Perception

Rosa Fernandez
University of Minho, Braga, Portugal
Ana Maria Serrano
University of Minho, Institute of Education, Center of Research on Education, Braga, Portugal
Robert A. Mc William
Special Education Department, University of Alabama, Tuscaloosa, USA
Margarita Canadas
Catholic University of Valencia, Department of Psychology and Education Sciences, Spain

Research subject: *This paper presents only a part of the huge work, and the focus is on the quality of early intervention service. Some authors such as Duns, among others, defined family-centered practices as quality interventions in early intervention services.*

Method: *Dr. Mc William developed a check-list (Family Finesse, 2015) that identifies how early intervention is implemented, from clinical model to family-centered practices model, and thus allows families to make an evaluation from 1 to 7, to decide what the practices they are currently receiving in their early intervention center are like, and what the ideal intervention that they would like to receive for their child with developmental delay and / or their family would be.*

Results: *Based on these assessments and with the perception of 194 Spanish families coming from different early intervention centers, all located throughout the Spanish territory in almost all its autonomous communities, we have carried out an Exploratory Factorial Analysis of the Family Finesse Scale.*

Conclusion: *We have extracted, without forcing, the main components or factors in both typical practices and in ideal practices. Through factors identified in our professional practice, we can determine the quality of early intervention services today.*

Key words: *quality, early intervention, family, exploratory factor analysis, empowerment*

This is only a part of the huge work, which is a quantitative study, where the relationship between family´s empowerment and early intervention quality services are analyzed. Focusing on the quality of early intervention services, as part of that work, some authors such as Duns, among others, defined family-centered practices as quality interventions in early intervention services. Thus, Dr. McWilliam developed a check-list (Family Finesse (2015)) that identifies how the early intervention is implemented, from clinical model to family-centered practices model, and thus allows families to make a valuation from 1 to 7, on one hand, what and how are the practices they are currently receiving in their early intervention center, and on the other hand, which and what would be the ideal intervention that they would like to receive for their child with developmental delay and / or their family. Based on these assessments and with the perception of 194 Spanish families coming from different early intervention centers, all located throughout the Spanish territory in almost all its autonomous communities, we have carried out an Exploratory Factorial Analysis of the Family Finesse Scale, from which we have been able to extract (without forcing) some main components or factors in both typical practices as in ideal practices that take into account and are identified by that scale, and therefore through those factors, all of them identified in our professional practice, we can determine the quality of early intervention services today.

INTRODUCTION

The family and how to support it, has been a constant interest in the early intervention since its beginnings but it was not until the eighties and nineties of the last century that in some countries (USA, Nordic countries) noticed the need for a conception of more targeted intervention in the family (Mc William, 2010; Espe-Sherwindt, 2008).

Probably, this focus of attention in the family, as indicated by Law et al. (2003), one of the most important precursors was Carl Rogers (1961) who with his approach “client-centered” sought to give greater prominence and control to the own client rather than the professional. It was in the sixties when the Association for the Care of Children in Hospital began to incorporate its ideas into the care of children and their families by highlighting the expression “family-centered care”. Later, other concepts and contributions have enriched what we now understand as family-centered early intervention. Dunst and Trivette (2009) point out that the key components of the construct comes from ecological approach to human development and social systems (Bronfenbrenner, 1979); the theory of “empowerment” Rappaport (1981); the works on families strengths of Stinnett, Chesser & DeFrain (1985) and social support of Gottlieb (1981); and finally work by Cronenwett and Brickmant (1982) on help-giving practices.

Today, from research and professional work, they may find different definitions, with different nuances of what is meant by family-centered intervention.

CANCHILD (Law et al., 2003) gives us a clear definition and experienced: *"The family-centered intervention is composed of a set of values, attitudes and approaches in services for children with special needs and their families. The family-centered intervention recognizes that each family is unique; that the family is the constant in the child's life; and that they are the experts on the capabilities and needs of children. The family works with professionals to make informed decisions about the services and support the child and family receive. In the family-centered intervention, they are considering the strengths and needs of all members*" (p. 2).

On the other hand, Espe-Sherwindt (2008) states that family-centered practices are a philosophy, a way of understanding the care in which recognizes and respects the central role of the family. "*In essence, the family-centered practices are a systematic way to create a partnership with families (a) involves treating them with respect and dignity; (b) honor their values and options; and (c) providing support to strengthen and promote its operation as a family*" (p. 136). In other words, professionals must create what we currently know as collaborative relationships with families, so that we can create services that ensure the empowerment of those same families.

Family´s empowerment is understood as the skills families have to manage in an efficient way its life events and the way they take control over different family´s issues (Dunst, Trivette & Deal, 1988).

From a social perspective, empowerment supposes a lot of competences that are already owned by the family, and if there are no competences, it will be possible to learn them and it will be better acquired by the family through its daily life and in their natural environment (Rappaport, 1981). When we work with families who are receiving early intervention services, our goal should aim to create opportunities for families to acquire the knowledge and skills needed to manage their own demands, thus they can promote their individual and family wellbeing and avoid dependency on the professional.

The family-centered early intervention service aims to make a family more competent in mobilizing intra-family and extra-family resources, which influence the child, parent and family´s functioning.

The contributions from Zimmerman are added to these ideas about the families´ empowerment. Zimmerman studied the multidimensional construct of empowerment, which suggests that the variation over individual level empowerment will lead to changes on his intrapersonal dimensions [i.e. perceived control, self-efficacy, control over motivation, perceived competence], interactional critical awareness, [understood as the causative agents, skills development, skills transfer, resource mobilization] and behavioral components [i.e. community and organizational engagement, coping behaviors] (Zimmerman, 1995).

Therefore, if family-centered practice empowers the family, this level of empowerment would have a direct influence on the emotional state of the intervention receptors and hence over their intrapersonal, cognitive and interactional dimensions (Speer & Peterson, 2000; Christens, 2012). This process creates an effect of constant feedback between the main goal of the intervention (empowerment) and the daily functioning of the family, implying a positive influence on the child, parents and family wellbeing as well.

Evidence says that family centered early intervention practices empower the family (Trivette et al., 2010; Dempsey et al., 2008) and that with the use of this philosophy of relation and practice, the family becomes more empowered than with others practices where the focus is just on the child.

As McWilliam (2010) points out, probably the idea of providing early attention in the natural environments is the most important ocurrence that has happened in this field since the 90´s. Family, school, community are recognized as the "means" that can potentially contribute the most on the child´s development through the opportunities generated on everyday routines. In this sense, the Work Group on Principles and Practices in Natural Environments (2008) said, *"the mission of early intervention is built on families and provides support and resources to help family members and caregivers to promote development and learning of children through everyday opportunities"*. Taking all these aspects into account is what gives quality to an early intervention services.

Research has to clear some the relations among the different and complex variables of intervention practices and family and child outcomes. Some studies point to family-centered practices like the early intervention services´ quality through which the family will have become empowered (Dunst, Trivette & Deal, 1988).

Acording to Derrington, T., Shapiro, B. & Smith, B. (1999), *"Early intervention provides different sources of social support to the family, which reduces the impact of stress on the family and enhances parent-child interaction and consequently child development"* (p.23.) From these and other reflections, and in order to identify under the perception of the families what are the practices that we are currently implementing and what would be the ideal practices or which families would wish to have, and therefore bring our early intervention services closer to the quality of what families expect and the quality determined by the evidence, McWilliam in 2015 develops the Finesse Family Scale, which is an evaluation scale that include different types of early intervention practices, from focused over a child´s needs to focused over the family´s priority in its natural environments. This scale has divided up to 19 items, which inquired about the most significant issues related to family-centered practice. On one hand, the family assesses the typical experience (i.e. the usual service they are receiving), and on the other hand, the ideal experience (i.e. the service they would like). In both, the family´s response options are through Likert Scale from 1 to 7, each score has its own descriptor for received or ideal practices. The maximum score is 7; therefore that score will be corresponding to a full involvement with family-centered practices early intervention.

METHOD

Participants

Participants were 194 Spanish families with a child [56.7% boys] aged from 1 to 144 month old [*M=51, SD=18,3]*, with some development delay or risk of it and receiving early intervention services between 3 and 71 months [*M=24, SD=13,74*]. Of which 66% are in school as well.

Procedure and data analysis

For the procedure we have collected all the Family Finesse Scale, keeping the anonymity of the families, giving and taking the study dossier in a blank envelope and keeping all the procedures required in Spain for data protection.

For the data analysis, we have used SPSS, from which we performed the exploratory factor analysis (EFA) of main components with auto values > 1, without the need to force factors to be extracted.

Table 1 – Extraction Method: Principal Component Analysis in typical practices

Typical Practices: Total variance explained

Component	Auto initial values			Sum of square saturation of extraction			Sum of square saturations of rotation		
	Total	% of variance	% accumulated	Total	% of variance	% accumulated	Total	% of variance	% accumulated
1	**8,876**	**46,718**	**46,718**	**8,876**	**46,718**	**46,718**	**3,677**	**19,351**	**19,351**
2	**1,647**	**8,668**	**55,387**	**1,647**	**8,668**	**55,387**	**3,475**	**18,289**	37,641
3	1,295	6,818	62,205	1,295	6,818	62,205	2,994	15,759	53,400
4	1,193	6,280	68,485	1,193	6,280	68,485	2,866	15,085	**68,485**
5	,866	4,559	73,043						
6	,812	4,272	77,315						
7	,642	3,377	80,692						
8	,568	2,990	83,681						
9	,501	2,638	86,319						
10	,449	2,361	88,680						
11	,402	2,114	90,794						
12	,387	2,037	92,832						
13	,277	1,460	94,292						
14	,256	1,347	95,638						
15	,206	1,082	96,720						

Table 2 – Extraction Method: Principal Component Analysis ideal practices

Ideal Practices: Total variance explained

Component	Auto initial values			Sum of square saturation of extraction			Sum of square saturations of rotation		
	Total	% of variance	% accumulated	Total	% of variance	% accumulated	Total	% of variance	% accumulated
1	**7,459**	**39,258**	**39,258**	**7,459**	**39,258**	**39,258**	**5,018**	**26,411**	**26,411**
2	**2,150**	**11,314**	**50,572**	**2,150**	**11,314**	**50,572**	**3,684**	**19,387**	**45,798**
3	**1,802**	**9,486**	**60,058**	**1,802**	**9,486**	**60,058**	**2,709**	**14,260**	**60,058**
4	1,511	7,951	68,009						
5	1,016	5,345	73,354						
6	1,003	5,281	78,636						
7	,839	4,415	83,050						
8	,672	3,539	86,590						
9	,616	3,240	89,830						
10	,391	2,058	91,887						
11	,326	1,716	93,603						
12	,266	1,402	95,004						
13	,254	1,336	96,340						
14	,210	1,105	97,445						
15	,156	,821	98,266						
16	,132	,694	98,960						
17	,099	,521	99,481						
18	,061	,319	99,800						
19	,038	,200	100,000						

We have used a Varimax rotation method for both typical practices and ideal practices, and to be as restrictive as possible, we have suppressed loading for factor allocation by less than (r = .5). From this analysis we have observed in typical practices (Table 3) and ideal practices (Table 4) the following results:

Table 3 – Extraction method: Main component analysis.
Rotation method: Varimax standardization with Kaiser.
a. The rotation has converged in 8 iterations.

Rotated Component Matrix of Typical Practices

	Componente			
	1	2	3	4
FF_q15_ET	**,835**	,131	,027	,253
FF_q13_ET	**,770**	,344	,008	,134
FF_q14_ET	**,604**	,511	,230	,136
FF_q11_ET	**,566**	,224	,419	,461
FF_q16_ET	**,494**	,420	,403	,342
FF_q7_ET	,145	**,751**	,256	,193
FF_q4_ET	,183	**,749**	,040	,353
FF_q3_ET	,427	**,704**	-,020	,170
FF_q19_ET	,170	**,567**	,510	,093
FF_q5_ET	,356	**,533**	,359	,017
FF_q18_ET	-,002	**,456**	,416	,453
FF_q2_ET	,265	,271	**,705**	,137
FF_q6_ET	-,235	-,003	**,704**	,186
FF_q12_ET	,530	,163	**,649**	,200
FF_q17_ET	,519	,312	**,568**	,142
FF_q9_ET	,133	,374	,086	**,789**
FF_q1_ET	,087	,102	,317	**,689**
FF_q10_ET	,432	-,006	,352	**,644**
FF_q8_ET	,421	,259	-,068	**,636**

Table 4 – Extraction method: Main component analysis.
Rotation method: Varimax standardization with Kaiser.
a. The rotation has converged in 5 iterations.

Rotated Component Matrix of Ideal Practices

	Componente		
	1	2	3
FF_q9_EI	**,829**		
FF_q1_EI	**,786**		
FF_q3_EI	**,746**	,441	
FF_q11_EI	**,737**		
FF_q10_EI	**,662**		,400
FF_q4_EI	**,655**		
FF_q12_EI	**,569**	,513	
FF_q19_EI	**,557**		,468
FF_q8_EI	**,466**		
FF_q13_EI		**,852**	
FF_q16_EI		**,774**	
FF_q18_EI		**,709**	
FF_q15_EI	,467	**,666**	
FF_q5_EI		**,547**	
FF_q2_EI			**,783**
FF_q7_EI			**,561**
FF_q6_EI			**,540**
FF_q17_EI			**,505**
FF_q14_EI	,403		**,475**

The consistency of the items is then analyzed by the Cronbach alpha procedure, being the total of scale $\alpha = .93$ according to the factors that we see in the previous tables and that will be detailed in results.

RESULTS

As we can see in the previous tables, we observe both typical practices and ideal practices that there is a statistical agreement between factors. In typical practices we can clearly distinguish four factors, while in ideal practices we observe three factors, detailing these factors in the following:

Table 5 – Typical Practices Factors and internal consistency of each of the factors and the full scale in relation to these items

Typical Practices Factors		***α Cronbach***
FACT.1	Intervention and objectives	.84
FACT.2	Evaluation and programming of the intervention	.77
FACT. 3	Transdisciplinarity respecting the holistic vision of the child	.68
FACT. 4	Collaborative relationship between professional and family	.73
	Alpha Cronbach Total Scale	***α.93***

Table 6. Ideal Practices Factors and internal consistency of each of the factors and the full scale in relation to these items

Ideal Practices Factors		***α Cronbach***
FACT.1	Collaborative relationship between professional and family	.83
FACT.2	Family´s Empowerment	.694
FACT. 3	Functionality of Early Intervention Practices	.58
	Alpha Cronbach Total Scale	***α.895***

As we see here, we can define as future work lines the study on confirmatory factor analysis of both typical and ideal practices.

CONCLUSION

With exploratory factor analysis (EFA), we sought to elucidate the interrelated dimensions of the Finesse Family Scale (McWilliam, 2015) both for typical and/or customary practices currently carried out by early childhood care services, as well as ideal practices for families and therefore Which they would like to receive in the future in those same services.

As we have seen previously, we can conclude that the factors that relate all the typical practices are different in the intervention and the definition of objectives; in the evaluation and therefore in the programming of the intervention; in the transdicipliny team and in its holistic view about development of the child; and the collaborative relationship established by the professional and the family. On the other hand, in ideal practices, we see the interrelation in three factors among which also highlights the collaborative relationship; family empowerment; and functionality in the daily life of the family of early intervention services.

As we saw in the introduction section, these factors are in relation with the pillars of family-centered practices, and therefore we can say that they define the quality of these services to the extent that these factors are closer to focus on family and less to practices centered just on the child and their needs and deficits.

REFERENCE

1. Allen, R. I., Petr, C. G. (1996). Toward developing standards and measurements for family centered practice in family support programs. En G. H. Singer, L. E. Powers y A. L. Olson (Eds), *Redefining family support: innovations in public-private partnerships,* 57-85. Baltimore: P.H. Brooks.
2. Bailey D., Raspa M., Olmsted M., Novak P., Samm M., Humphreys P., Nelson R., Robinson N. Guillen C. (2011). Development and Psychometric Validation of the Family Outcomes Survey-Revised. *Journal of Early Intervention, 33*(1), 6-29.
3. Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.
4. Bronfenbrenner, U., & Morris, P. (1998). The ecology of developmental processes. In R. M. Lerner (Vol. Ed.) & W. Damon (Series Ed.), *Handbook of child psychology,* Vol. 1: Theoretical models of human development (5th ed.), 993-1028. New York, NY: Wiley.
5. Bruder, M. B. (2000). Family-centered early intervention: Clarifying our values for the new millennium. *Topics in Early Childhood Special Education*, 20(2), 105-122.
6. Christens, B.D. (2012). Toward relational empowerment. *American Journal of community Psicology,* 50, 114-128. doi: 10 1007/s10464-011-9483-5.
7. Cronenwett, L., & Brickman, P. (1983). Models of helping and coping in childbirth. *Nursing Research, 32*(2): 84-98
8. Cunningham, C.C. (2000). Familias de niños con Síndrome de Down. En M.A. Verdugo (Ed.), *Familias y Discapacidad Intelectual*. Madrid: FEAPS.
9. Dempsey, I., & Kenn, D. (2008). A review of processes and Outcomes in Family-Centered servicies for children whit a disability. *Topics in Early Childhood Special Education, 28*(1), 42-52 doi: 10.1177/0271121408316699.
10. DeVellis, R.F. (1991). Scale Development: Theory and applications. Newbury Park, CA:Sage
11. Dunst, C. J. (2007). Early intervention for infants and toddlers with developmental disabilities. In S. L. Odom, R. H. Horner, M. Snell, & J. Black (Eds.), *Handbook of developmental disabilities*, 161-180. New York, NY: Guilford Press.

12. Dunst, C.J., Bruder, M.B., Espe-Sherwindt, M. (2014). Family Capacity – Building in Early Childhood Intervention: Do context ans Stting Matter?. *School Community Journal, 21*(1), 37-48
13. Dunst, C. J., Hamby, D., Trivette, C. M., Raab, M., Bruder, M. B. (2000). Everyday family and community life and children's naturally occurring learning opportunities. *Journal of Early Intervention, 23*(3), 151-164. doi: 10.1177/10538151000230030501
14. Dunst, C.J., Jenkins, V., Trivette, C.M. (1984). Family Support Scale: Reliability and Validity. *Journal of individual, Family and Community Wellness,* 1, 45-52.
15. Dunst, C.J., Trivette, C.M., Deal, A.G. (1988), *Enabling and Empowering Families.* Cambridge, MA:Brookline Books, 6, 155-157.
16. Dunst, C. J., Trivette, C. M., Hamby, D. W. (2007). Meta-analysis of family-centered helpgiving practices research. *Mental Retardation and Developmental Disabilities Research Reviews*, 13, 370-378.
17. Dunst, C. J. y Trivette, C. M. (1994). What is effective helping. En C. J. Dunst, C. M. Trivette, y A. G. Deal, (Eds), *Supporting and strengthening families – Methods, strategies and practices*, 162-170. Cambridge: Brookline Books.
18. Dunst, C.J., Trivette C.M. (1988). Toward experimental evaluation of the Family, Infant and Preschool Program. Hweiss & F. Jacobs (Eds), *Evaluating family programs*, 315-346. New York: Aldine de Gruyter
19. Dunst, C.J., Trivette, C.M. (2009). Capacity-Building Family-Systems Intervention Practices. *Journal of Family Social Work,* 12, 119-143.
20. Dunst, C. J., Trivette, C. M. y LaPointe, N. (1992). Toward clarification of the meaning and key elements of empowerment. *Family science review, 5*(1/2), 111-130.
21. Espe-Sherwindt, M. (2008). Family– Centred Practice: Collaboration, Competency and Evidence. *Support for Learning, 23*(3), 136-143.
22. FEAPS (2000). *Atención Temprana para personas con retraso mental. Orientaciones para la Calidad.* Manuales de Buena Práctica. Madrid: FEAPS. Document 55/2000.
23. Giné, C., Vilaseca, R., Gràcia, M., García-Dié, M. T. (2004). Early Intervention in Spain: Some Directions for Future Development. *Infant and Young Children, 17*(3), 236-246.
24. Gottlieb, B. H. (1981). Social Network and Social Support. Beverly Hills, Calf: Sage Publications.
25. Grupo de Atención Temprana, GAT. (2000). *Libro Blanco de la Atención Temprana.* Madrid: Ministerio de Trabajo y Asuntos Sociales. Real Patronato de Prevención y de Atención a Personas con Minusvalía.
26. INE (2008). Encuesta de Discapacidad, Autonomía Personal y Situaciones de Dependencia (EDAD, 2008). http://www.ine.es/jaxi/menu.do?type=pcaxis&path=/t15/p418&file=inebase&L=0

27. Krejcie, R.V., Morgan, D.W. (1970). Determining sample size for research activities. *Educational and Psychological Measurement*, *30*, 607-610.
28. Law, M., Rosenbaum, P., King, G., King, S., Burke-Gaffney, J., Moning, J., Szkut, T., Kertoy, M., Pollock, N., Viscardis, L., & Teplicky, R. (2003). What is family-centred service? CanChild FCS Sheet #01. Hamilton, Ontario, Canada: CanChild Centre for Childhood Disability Research, McMaster University. Retrieved January 31, 2015, from https://canchild.ca/system/tenon/assets/attachments/000/001/266/original/FCS1.pdf
29. McWilliam, R.A. (2010). *Routines-Based Early Intervention. Supporting Young Children and Their Families.* Baltimore, MD: Paul H. Brookes Publishimg Co.
30. Nirbhay N. Singh, W. Jonh Curtis, Cynthia R. Ellis, Mary W. Nicholson, Terri M.Villani & Hollis, A. Wechsler, (1995). Psichometric Analysis of the Family Empowerment Scale. *Journal of Emotional and Behavioral Disorders*, *3*(2) 85-91.
31. Powell, D. S., Batsche, C. J., Ferro, J., Fox, L. y Dunlap, G. (1997). En Strength-Based Approach in Support of Multi-Risk Families Principles and Issues. *Topics in Early Childhood Special Education, 17*(1), 1-26.
32. Rappaport, J. (1981). In Praise of Paradox: A Social Policy of Empowerment Over Prevention, *American Journal of Community Psychology*, *9*(1) 1–25.
33. Roggman, L., Boyce, L., Innocenti, M. (2008). *Developmental Parenting. A guide for early childhood practitioners*. Brookes Publishing. Baltimore
34. Stinnett, N., Chesser, B., DeFrain, J.D. (1979). Building Family Strengths: blueprints forn accion. Lincoln: University of Nebraska Press.
35. Trivette, C.M., Dunst, C.J., Hamby, D.W. (2010). Influences of Family Systems Intervention Practices on Parent-child interactions and Child Development. *Topics in Early Childhood Special Education, 30*(1), 3-19. doi: 19.1177/0271121410364250
36. Work Group on Principles and Practices in Natural Environments (2008). *Agreed-upon practices for providing early intervention services in natural environments*. Retrieve from: http://ectacenter.org/~pdfs/topics/families/Finalmissionandprinciples3_11_08.pdf
37. Zimmerman, M.A. (1995). Psychological empowerment Issues and Illustrations. *American Journal of Community Psychology, 23*(5), 581-599. Doi: 10.1007/BF02506983.

udc 373.2-056.262-053.4(497.4)
376.1-056.262-053.4 (497.4)

Sensitization of the Social Environment in Kindergartens as One of the Fundamental Principals of Work in Early Intervention in Children with Visual Impairments

Mateja Maljevac, Dragana Žunic
Center IRIS, Ljubljana, Slovenia

Research subject: *Early treatment of special needs children has not yet been completely systematically regulated in Slovenia, however, the system is relatively well designed for children in kindergartens. Children with visual impairments are entitled to additional expert assistance in the duration of up to three hours, which includes one hour of consultancy services and up to two hours of direct work with the child in or outside of the department.*

Method: *In this article, we discuss the problem of sensitization of the social environment in kindergartens and analyze the most important activities in the assistance range, which ensure a successful inclusion. The latter includes working with educators (teachers, teaching assistants and consultants) as well as the child's peer group. It is essential for educators to get to know the child's functioning and the degree and type of the impairment before the child enters the kindergarten.*

Results: *Educators of the Center IRIS usually present the child's functioning to the employees of the kindergarten during its preparation for the admission of a child with visual impairment and invite them to »open days« of our kindergarten where the information on the ways and types of support for the child and the inclusive environment provided by the Center IRIS are all gathered in one place. We also organize more in-depth seminars as a part of regular professional training, where educators receive fundamental knowledge on blindness and visual impairment. Educators exchange specific knowledge regarding particular needs of everyday work and examples of good practice when they join the group of kindergarten educators that work with children with visual impairments and who come from all over Slovenia. The group meets a few times a year. In parallel to the education of kindergarten educators, work with the child's peer group takes place. The work with the peer group includes a wide spectrum of activities with regard to individual needs.*

Conclusion: *It is essential to recognize and correct risk factors of an individual child and create an inclusive environment where children with visual impairment can actively participate and develop their potential.*

Key words: *kindergarten, educators, peers, child with visual impairments*

INTRODUCTION

The majority of blind and visually impaired preschool children with no additional disorders are included in kindergartens in their home environment in Slovenia. Center IRIS is the only professional establishment in the Republic of Slovenia that provides mobile service in regular kindergartens and schools. Children with visual impairments are entitled to additional expert assistance in the amount of up to three hours, which includes one hour of consultancy services and up to two hours of direct work with the child in the department or outside of it. One of the most important activities in this level of assistance, which ensures a successful inclusion, is the sensitization of the social environment in the kindergarten.

Falamić (2009) emphasizes that kindergartens are an ideal environment for preschool children, where the latter begin to develop social interactions, which are a basis for a lifelong social development. Anderson, Boigon, Davis in de Waard (2007) explain that blind and visually impaired children learn social skills in a different way than sighted children, since the absence of observation prevents the spontaneity of learning. Celeste (2006; 2007) reports that successful inclusion of a visually impaired child is not self-evident and that it needs to be carefully planned. She stresses the plan of encouraging social skills as a very successful working method in the social field.

Inclusion of blind and visually impaired children and special needs children among their peers enables the development of their competences and, at the same time, the acceptance and recognition of diversity and disorders that stay with them their whole lives. Children, their parents and their environment learn to understand, accept and respect every human being as an equal and appreciated individual (Bela knjiga, 1995: 58-59).

This article seeks to emphasize the importance of working with the child’s social environment in the kindergarten and present successful working methods with both educators and peers, which were developed in practice at Center IRIS.

RESULTS

Every child that is defined as a special needs child receives a Decision by the National Education Institute Slovenia; which is a national research, development and counseling institute in the field of upbringing and education. The decision includes the type and degree of the impairment or disorder, educational program, number of hours of additional professional assistance, adjustments and aids according to functional characteristics and educational needs of the child. Before the child is included, the kindergarten receives an inquiry by the National Education Institute Slovenia on meeting the conditions regarding special, material and staffing requirements. The latter are of key importance for a successful inclusion of a visually impaired child among their peers. In addition, permanent support and counseling to all participants in the inclusion process are necessary in order to insure the success of the inclusion of a child with visual impairment in kindergarten. It is equally important to equip kindergarten educators with suitable competences to work with visually impaired children and to prepare the child's peers in the kindergarten group for the inclusion of a visually impaired child.

Educators of Center IRIS usually present the child's functioning to the employees of the kindergarten during its preparation for the admission of a child with visual impairment and invite them to »open days« of our kindergarten where all the information on the ways and types of support for the child and the inclusive environment provided by the Center IRIS are all gathered in one place. In the beginning of the school year we organize a basic seminar on working with visually impaired children, where educators are provided fundamental knowledge on blindness and visual impairment, such as ways and forms of providing additional professional assistance, preparation of an individualized work program for the child, basics on visual impairment, characteristics of the development and functional specifics of a visually impaired child, information on how blind and visually impaired children play, everyday tasks of blind and visually impaired children, orientation and mobility, etc. Educators exchange specific knowledge regarding particular needs of everyday work and examples of good practice when they join in the group of kindergarten educators that work with children with visual impairments and who come from all over Slovenia. The group meets three times a year and is designed in such a way that Center IRIS educators prepare lectures with practical workshops on the topics selected by educators themselves. In addition, educators from major kindergartens present examples of good practice to their colleagues.

In parallel to the education of kindergarten educators, work with the child's peer group takes place. The work with the peer group includes a wide specter of activities with regard to individual needs. Usually, a mobile pedagogue prepares experience workshops on blindness and visual impairment according to individual scopes of the kindergarten curriculum, focusing on children's interactions and participation in free play. The workshops deal with the challenges that visually impaired children face in their everyday life during adolescence, in a way that children find interesting. When planning the content of workshops, the main emphasis is on strengths, skills or knowledge of their peer with visual impairment in order to reject peer prejudice towards blindness and visual impairment and acceptance of visual impairment as one of the child's characteristics. The child's peers also have the possibility to train their senses and get to know blindness and visual impairment by visiting the Garden of Senses at Center IRIS within the scope of workshops that vary in content and level according to the children's ages.

CONCLUSION

Sensitization of the social environment of a visually impaired child in transition from early intervention, their family and domestic environment into an inclusive environment is one of Center IRIS' key tasks. The center has a relatively short, but positive history. The origins of the above described working methods used with educators and kindergarten group of children were set up under the experiment "Operation of the Institute for Blind and Partially Sighted Children Ljubljana (now Center IRIS) as a Center for ensuring assistance in the field of inclusive education of blind and visually impaired children and youngsters" in the period from 2010 to 2012. The experiment findings have shown that, in order to ensure both physical and effective social integration of visually impaired children in preschool period, sensitization of the visually impaired child's social environment is key. The above described working methods have proven as examples of good practice for this purpose. Multiannual practice has confirmed that some of the most important positive effects of these working methods are the following: rejecting prejudice and stereotypes, preventing negative assessment of child's disorder and negative responses from the environment, raising awareness of peers on respecting diversity and their differences. Last but not least, social integration of a visually impaired child in preschool period contributes to an earlier development of the child's positive self-image and positive self-evaluation, feeling of acceptance, equality and, above all, equivalence.

REFERENCES

1. Anderson, S., Boigon, S., Davis, K. in deWaard, C. (2007). *The Oregon Project For Preschool Children Who are Blind or Visually Impaired*. (6. izdaja). Medford, Oregon: Southern Oregon Education Service District.
2. *Bela knjiga o vzgoji in izobraževanju v RS.* (1995). Ljubljana: Ministrstvo za šolstvo in šport.
3. Celeste, M. (2006). Play Behaviors and Social Interactions of a Child Who is Blind: in theory and practice. *Journal of Visual Impairment & Blindness, 100(2),* 75-90.
4. Celeste, M. (2007). Social Skills Intervention for a Child Who Is Blind. *Journal of Visual Impairment & Blindness*, *101*(9), 521-533
5. Falamić, M. (2009). Vrtić kao poligon za učenje socijalnih vještina. Dijete Vrtić Obitelj, *54*, 12-16
6. Pinterič, A., Deutsch T., dr. Franc Cankar (2014*). Inkluzivno izobraževanje slepih in slabovidnih otrok in mladostnikov.*
7. *Zaključno poročilo o uvajanju poskusa »Delovanja Zavoda za slepo in slabovidno mladino Ljubljana kot Centra za zagotavljanje pomoči na področju inkluzivnega izobraževanja slepih in slabovidnih otrok in mladostnikov«.* (2012). Zavod Republike Slovenije za šolstvo.

SENZIBILIZACIJA SOCIJALNOG OKRUŽENJA U VRTIĆIMA KAO JEDAN OD OSNOVNIH PRINCIPA RANE INTERVENCIJE KOD DECE SA OŠTEĆENJEM VIDA

Mateja Maljevac, Dragana Žunič
Center IRIS, Ljubljana, Slovenija

Rana intervencija za decu sa posebnim potrebama u R Sloveniji još nije u potpunosti sistematski regulisana, ali je sistem relativno dobro zasnovan za decu koja su uključena u redovne predškolske ustanove. Deca sa oštećenjem vida imaju pravo na dodatnu stručnu pomoć do tri pedagoška časa, uključujući jedan čas savetodavne pomoći i do dva časa neposrednog individualnog rada sa decom u odeljenju ili izvan njega. Kao jedna od naših najvažnijih aktivnosti za obezbedjivanje uspešne inkluzije deteta sa oštećenjem vida je senzibilizacija njegovog socialnog okruženja u predškolskoj ustanovi. To uključuje širok spektar aktivnosti, u kojem je neizbežan rad sa profesionalcima (vaspitačima, asistentima vaspitača i savetnicima), kao i rad sa grupom vršnjaka u koju je dete uključeno.

Ključne reči: predškolska ustanova, vaspitači, vršnjaci, deca sa oštećenjem vida

udc 376.1-056.26/.36-053.2
364.4-056.26/.36-053.2

Strategies and Challenges in Early Intervention Program at Day Care Centre *Mali Dom* Zagreb

Jasminka Gagula, Ana Validžić Požgaj, Snježana Seitz, Ivana Slavinić
Day Care Centre "Mali dom", Zagreb, Croatia

Researsch subject: *The paper is aimed to present the Early intervention program at Day Care Centre Mali dom in Zagreb.*

Method: *We discuss the problem of determination of eligibility through an evaluation conducted by a transdisciplinary team based on informed clinical opinion and utilizing a approved developmental inventory tool.*

Results: There are three categories of eligibility: 1. Infants and Toddlers with an Established Condition or Conditions, 2. Infants and Toddlers with Established Developmental Delay or Delays in two or more developmental domains, 3. Infants and Toddlers at Risk for Developmental Delay(s). The initial contact with the family provides an opportunity for discussion with family members regarding potential participation in Early Intervention. An overview of Early Intervention is given to the family. An initial IFSP meeting is held with eligible families within 45 days of involvement in program for the purpose of developing the plan. A complete review of the IFSP for a child and the child's family must be conducted every six (6) months, or more frequently if conditions warrant or if the family requests a meeting to review the IFSP. The contents of the IFSP are fully explained to the child's family and informed written consent from the parents is obtained.

Conlusion: *Children and families receive individualized services in accordance with the functional outcomes identified in the IFSP. At all ages, but especially in the years from birth through age three, children benefit from close partnerships and ongoing communication between their families and their early intervention program. High-quality early intervention programs have clear goals, and they base their curriculum on knowledge of very early development. In the face of increased attention to early childhood professional development in the practice and policy communities, there is a concomitant need for empirical efforts to examine what works for whom, within which contexts, and at what cost (Welch-Ross, Wolf, Moorehouse, & Rathgeb, 2006). The earlier a child is identified as having a developmental delay or disability, the more likely they are to benefit from strategies targeted towards their needs.At the surface, "professional development" in early childhood programs refers to a number of experiences that promote the education, training, and development opportunities for early childhood* *practitioners who do or will work with young children birth to age 3 years and their families.*

Key words: *trans-disciplinary approach, early intervention, eligibility, professional development*

INTRODUCTION

World Health Organization (WHO) and World Bank estimate that more than a billion people live with some form of disability, which equates to approximately 15% of the world's population. Among these, between 110 million (2.2%) and 190 million (3.8%) adults have very significant difficulties in functioning, but for now there are no reliable and representative estimates based on actual measurement of the number of children with disabilities (World Health Organization & Unicef, 2012). Some estimate there may be 150 million children with disabilities alone worldwide.

Children who experience disability early in life can be disproportionately exposed to risk factors such as poverty; stigma and discrimination; poor caregiver interaction; institutionalization; violence, abuse and neglect; and limited access to programmes and services, all of which can have a significant effect on their survival and development (World Health Organization & Unicef, 2012).

Evidence-based research and multi-country experiences make a strong rationale for investing in early childhood development especially for children at risk of developmental delay or with a disability: Human rights rationale, economic rationale, scientific rationale and programmatic rationale (Soriano, 2005).

Early intervention refers to necessary action and intervention being used to support any child and his/her family, as early as possible during any time in his/her education (Soriano, 2005). Guralnick (2001) defines early childhood intervention as a system designed to support family patterns of interaction that best promote child development.

The earlier a child is identified as having a developmental delay or disability, the more likely they are to benefit from strategies targeted towards their needs. As the evidence on the effectiveness of early intervention activities has grown, early intervention models, programs and services have become part of the services provided for families of children with disabilities. For children already exhibiting developmental delay, effective early intervention strategies can both alter the course of their developmental trajectories and prevent the onset of secondary complications.

Contrary to the case of North America where ECI takes place from birth to three years of age, in European countries the duration of intervention is variable (Soriano, 2005).

In Croatia, early intervention is provided to a child with early developmental impairment, developmental risk or developmental difficulties, usually up to the age of 3 and up to the age of 7 years of age. Early intervention support is provided to children with disabilities within healthcare, education and social welfare system.

Availability of early childhood services in Croatia, depends upon the region in which a family lives, and the kind of developmental disorder their child has. Families from the Zagreb region are in a far better position than those living elsewhere in Croatia. Early childhood services are also increasingly diverse, and most children attend several different education, health and other services during their early development. This diversity results in fragmentation for children and families, who often face more than one issue or need at any given time and thus may be accessing several services at once.

Early intervention program at Day Care Centre *Mali dom* Zagreb

Early intervention program at Day care centre Mali dom is oriented at family through joint recognition of their child's abilities and strengths. Emphasize is on current abilities of the child and short term goals that are possible to be realised and that way it helps parents to have more objective view of their child and yet feeling successful and getting progress because the goal we have set together with them is accomplished but accepted from them when set. So by being part in setting the goal on one way they seem to accept the realistic insight of child's abilities and then later they feel successful by achieving that goal. Experts are building slowly relationship with parents based on trust and with the guidance of Individual Education Plan they create weekly tasks for the parents that they have to incorporate in their daily routine in order to achieve a short term goal they set together and by accomplishing that given task will help parents to feel more competent in supporting development of their child and also that way they are becoming more responsive to child's needs.

Systematic approach to early intervention

Early intervention services may be directed at the child and/or family. Child-focused programs are generally carried out at centers or schools and involve the participation of a group of children in a program designed to promote developmental acquisitions and school readiness (Majnemer, 1998). Family – focused programs represents broad approach, where the focus is no longer solely placed on the child, but also on the family and the community. A family-centred perspective implies that intervention is carried out in naturalistic situations, in everyday life (Soriano, 2005).

Family-centeredness characterizes beliefs and practices that treat families with dignity and respect; individualized, flexible, and responsive practices; information sharing so that families can make informed decisions; family choice regarding any number of aspects of program practices and intervention options; parent–professional collaboration and partnerships as a context for family–program relations; and the provision and mobilization of resources and supports necessary for families to care for and rear their children in ways that produce optimal child, parent, and family outcomes (Dunst, 1995).

The development of the IEP and IFSP begins with an assessment of the child and family's strengths, priorities, and needs to develop outcomes and plan appropriate services (Gatmaitan and Brown, 2016). These documents should provide clear information how support should be provided in early intervention program.

Parents are involved in each stage of the EI service program. They are partners in creating IFSP and IEP and they are primary implementers of intervention within family routines.

Transdisciplinary Approach

According to Bruder and Dunst (2000) transdisciplinary approach in early intervention is recognized to be best practice. It is a framework for allowing members of a team – professionals from different disciplines, to contribute knowledge and skills, collaborate and integrate the expertise of team members in order to provide more efficient services that most benefit the child and family. Transdisciplinary process is looking at the child in a holistic way in a term of development. It is a big part of the system which includes whole process of analyzing and planning the treatment for the child and suggestions for parents.

Working as a transdisciplinary team reduces the likelihood of confusion for the family by reducing the number of people and disciplines with which they need to interact.

This model is less intrusive because parents only need to build one key relationship and only one service provider visits the home. Enhanced and streamlined communication is considered to be a key benefit for the family. Since no one discipline is more effective than another in providing early intervention services, particularly for children younger than 1 year of age, this cross discipline work ensures that all are working on the same comprehensive outcomes and strategies and so they are more likely to be realized. Service efficiency – more children can be served because fewer providers routinely see a child Instead of each child receiving direct assessment and intervention freeing other team members to see other children and giving families more time in their family environment rather then running around to get certain service during which both family and child are often to exhausted to benefit from it. However, it is not an esam shvatila uasy model to implement. It requires a high degree of trust between the professionals involved, and therefore works best with a stable team of experienced practitioners. New practitioners must first develop competence in their own skill areas, and then expand their knowledge to include some basic interventions from outside their own discipline. Since stable teams of experienced practitioners are not always available, it may not be feasible to expect or mandate transdisciplinary practice in every case.

Challenges

There are a number of measures and regulations focused on children with disabilities and their families within healthcare, social welfare and education, but they are often mismatched and apply to regulations within their area of activity. There is also no coordination and cooperation between these three systems. Children move between settings for many reasons, including progression between education and care services and schools, moving to a new area, and in order to have needs met in appropriate settings.Transitions may occur at any stage of a child's development. Transitions are complex and can be difficult for young children and their families and poor transitions can result in negative discontinuity for children (Hopps, 2004). Effective transitions provide continuity by building on children's prior learning and experiences, and are best supported by respectful communication and partnerships among all early childhood professionals within and across settings, and with families and children.

Parent involvement is crucial to the effectiveness of early Intervention. The style of parent-child interaction plays a central role in developmental outcomes of the child. Traditional early intervention curricula tend to emphasize directive, child-focused instruction with domain-specific developmental and functional goals serving as primary intervention targets. There is strong, consistent evidence in the research literature over the past 30 years that relationship-based intervention approaches are effective in increasing parents' responsiveness toward their children and improving the social, emotional, and communication outcomes in children with developmental challenges (MacDonald, 2004).

EI services at Mali dom are performed at the child's home primary by a expert, who is a key member of the Early Intervention Team. Home-based practice includes regular visits (once a week) from a expert who works with the child and the family according to the IFSP, having first defined outcomes and short and long-term goals with all team members and the family.

Centre-based activities are provided when there is the need for professional support from some other specific field or when services cannot be carried out at home, such as physical/occupational therapy, sensory integration, swimming, psychologist consultations, and parent groups and experience groups (parents with children). In all those activities parents are present, and all are carried out in coordination with the key staff person and all other team members. Despite their different backgrounds, corresponding to their disciplines, ECI teams/professionals should work in an inter-disciplinary way before and whilst carrying out the agreed tasks. They need to share principles, objectives and working strategies (Soriano, 2005).

CONCLUSION

In this article, we aimed to discuss the quality components of EI program at day Care Centre Mali dom Zagreb. Early childhood services must be strengthened at the national, state, and local level. Screening and early identification should be readily available. A strong rationale exists suggesting that the earlier intervention begins, the more effective it will be. The complexity of early childhood learning and development and the changing nature of the field mean that early childhood professionals need to constantly reflect on and update their skills. This can be done by professionals working in partnership with other professionals who have different backgrounds, experience and expertise

REFERENCES

1. Bruder, M.B., & Dunst, C.J. (2000). Expanding learning opportunities for infants and toddlers in natural environments: A chance to reconceptualize early intervention. *Zero to Three, 20*(3), 34-36.
2. Dunst, C. J. (1995). Key characteristics and features of community-based family support programs. Chicago: Family Resource Coalition.
3. Gatmaitan, M., & Brown, T. (2016). Quality in individualized family service plans: Guidelines for practitioners, programs, and families. *Young Exceptional Children*, *19*(2), 14-3.
4. Guralnick, M. J. (2000). Early childhood intervention: Evolution of a system. *Focus on autism and other Developmental Disabilities*, *15*(2), 68-79.
5. Guralnick, M. J. (2001). A Developmental Systems' Model for Early Intervention. In *Infant and Young Children, 14*(2), 1-18..
6. Hopps, K. (2004). Teacher communication across the preschool-school boundary. *Australian Journal of Early Childhood, 29*(1), 8-13.
7. MacDonald, J. (2004). *Communicating partners: 30 years of building responsive relationships with late talking children including autism, Asperger's syndrome, Down syndrome, and typical development*. London: Jessica Kingsley Publishers.
8. Majnemer, A. (1998, March). Benefits of early intervention for children with developmental disabilities. In *Seminars in pediatric neurology* (Vol. 5, No. 1, pp. 62-69). WB Saunders.
9. Soriano, V. (2005). Early childhood intervention. Analysis of situations in Europe-Key aspects and recommendations. *Brussels: European Agency for Development in Special Needs Education*.
10. Welch-Ross, M., Wolf, A., Moorehouse, M., & Rathgeb, C. (2006). Improving connections between professional development research and early childhood policies. *Critical issues in early childhood professional development*, 369-394.
11. World Health Organization, & Unicef. (2012). Early childhood development and disability: A discussion paper.

udc 159.922.72 (497.6)
37.032(497.6)
159.923.5-053.2(497.6)

Politika unapređenja ranog razvoja dece u Republici Srpskoj

Ljubo Lepir, Draško Gajić
Univerzitet u Banjoj Luci, Fakultet političkih nauka, Republika Srpska, BiH

Tema istraživanja: *Republika Srpska kao odgovorna društvena zajednica posljednjih godina je posvetila značajnu pažnju izgradnji i uvođenju koncepta ranog rasta i razvoja djece. Prema stavovima nadležnih institucija jedan od osnovnih ciljeva cjelokupnog razvoja Republike Srpske je poboljšanje položaja djece. Da bi ostvarili ovaj cilj, nadležne institucije su pristupile izradi strateških dokumenata koji definišu koncept ranog rasta i razvoja djece. Izrađeni su i zvanično usvojeni dokumenti „Politika unapređenja ranog rasta i razvoja djece u Republici Srpskoj za period od 2011–2016." i „Program za rani rast i razvoj djece u Republici Srpskoj, 2016–2020".*

Metod: *Ova analiza ima za cilj dati prikaz osnovnih strateških pravaca djelovanja integrisanog modela praćenja ranog rasta i razvoja djece kroz zvanične stavove institucija sistema socijalne i zdravstvene zaštite u Republici Srpskoj.*

Rezultati: *Ovi dokumenti donose strateška opredjeljenja i definišu osnovne elemente novog integralnog pristupa u tretiranju razvojnih problema djece. Sa druge strane, postojeće prakse sisteme zdravstvene, socijalne, porodične i dječije zaštite, te sistema predškolskog obrazovanja su pokazale mogućnosti ali i zablude uvođenja integralnog modela društvene brige o djeci.*

Zaključak: *Prednosti i nedostaci postojećih modela brige o djeci govore da je moguće ići u izgradnju odgovornijeg i za djecu i njihove roditelje pristupačnijeg modela sistemske podrške. Međutim, da bi se ostvarili postavljeni ciljevi neophodno je obezbijediti sistemske pretpostavke.*

Ključne riječi: *razvoj djeteta, sistemska podrška, strateški dokumenti, integrativni model podrške*

1. UVOD

Razvijenost i zrelost jedne društvene zajednice, pored ekonomskog napretka i nivoa primjene tehnoloških inovacija, mjeri se i rezultatima ukupnog socijalnog razvoja koji je posljedica razvoja javnih politika prema građanima, a posebno prema socijalno osjetljivim grupama stanovništva. Lica sa invaliditetom, žene, stari i djeca predstavljaju sigurno društveno najosjetljivije grupacija čija sudbina određuje sudbinu ukupnog društva. Zbog toga, sasvim je opravdano postaviti tezu da koliki je izgrađeni nivo osjetljivosti javnih politika prema ovim grupama toliko su veće pretpostavke za ukupni napredak jednoga društva. U tom smislu, javne politike su izraz političke volje i one predstavljaju vrijednosti, ideološke postavke i stavove države i državnih institucija prema pitanjima socijalno marginalizovanih grupa stanovništva. Javnim politikama se utiče na rješavanje problema ovih grupa. To je sve ono što jedna vlada hoće da uradi, vezano za rješavanje opšte javnog problema. Javne politike predstavljaju usvojene strategije i zakone u različitim oblastima društvenog djelovanja kao što su zapošljavanje, zdravstvena zaštita, školstvo, porodična zaštita, socijalna i dječija zaštita itd. Takođe, javne politike mogu da budu različite aktivnosti, stavovi i tendencije djelovanja pojedinih subjekata koje podržava aktuelna vlast, kao što su: kampanje, promovisanje socijalnih vrijednosti, provođenje humanitarnih akcija, ohrabrivanje korisničkih grupa, provođenje preventivnih aktivnosti i slično. Javne politike predstavljaju izraz zvaničnih stavova vlasti o razvoju pojedine oblasti (UNDP, 2010).

U ovom radu posvetiće se pažnja javnim politikama prema djeci u Republici Srpskoj sa posebnim naglaskom na koncept djelovanja institucija sistema u oblasti ranog rasta i razvoja koji je definisan usvojenim dokumentima, teorijskim postavkama, vrijednostima, praktičnim rješenjima, njihovim pozitivnim stranama i opterećavajućim problemima koji koče njegovu implementaciju.

Kao dio Bosne i Hercegovine Republika Srpska je preuzela čitav niz obaveza postupanja u sistemima socijalne politike koje proizilaze iz međunarodnih dokumenata usvojenih i ratifikovanih od strane domaćih parlamenata. Aneks 4. Okvirnog sporazuma o miru u BiH (Daytonski sporazum) predstavlja Ustav BiH koji navodi najviše standarde na polju ljudskih prava i poziva se na primjenu, pored ostalih i odredbi iz Konvencije o pravima djeteta (Aneks 1.) Prema odredbama Konvencije o pravima djeteta, država potpisnica je obavezna osigurati i obezbijediti mjere kojima je cilj zaštita djece od svih oblika diskriminacije po bilo kojoj osnovi. Članom 24. Konvencije posebna obaveza je data državi potpisnici da obezbijedi sve uslove za nesmetan razvoj djeteta i da se omogući roditeljima podrška u svim preventivnim aktivnostima koje su namijenjene poboljšanju zdravlja djeteta. Članom 23. Posebna pažnja je usmjerena na obaveze države potpisnice prema djeci sa razvojnim poteškoćama gdje se insistira na pristup djeteta javnim službama kako bi mu se pomoglo u postizanju što potpunije društvene integraciuje i individualnog razvoja.

Vođena ovim odredbama, ali i obavezama koje proizilaze iz drugih međunarodnih dokumenata, Republika Srpska je od svoga osnivanja do danas usvojila i implementirala u svoj pravni sistem mnogo zakonskih i podzakonskih akata koji usmjeravaju djelovanje sistema prema interesu djeteta i njegove porodice.

2. Zakonske mogućnosti i organizacioni kapaciteti sistemskog djelovanja u oblasti ranog rasta i razvoja

U Republici Srpskoj posebnu zaštitu porodice, majke i djeteta Ustavom je proglašena za jedno od osnovnih ljudskih prava. U skladu sa takvim Ustavnim odredbama precizirane su zakonske odredbe koje upućuju na poseban tretman djece u periodu ranog rasta i razvoja u slijedećim zakonima: Porodični zakon (Službeni glasnik RS, 54/02); Zakon o dječijoj zaštiti (Službeni glasnik RS, 4/02); Zakon o socijalnoj zaštiti (Službeni glasnik RS, 37/12); Zakon o zdravstvenoj zaštiti (Službeni glasnik RS, 106/09); Zakon o predškolskom obrazovanju (Službeni galsnik RS, 79/15).

U članu 3. Porodičnog zakona navedeno je da Republika Srpska obezbjeđuje posebnu zaštitu porodici, majci i djetetu u skladu sa međunarodno priznatim ljudskim pravima i osnovnim slobodama. U članu 6. daje se obaveza roditeljima da se staraju o životu i zdravlju svoje djece, kao i o njihovom podizanju, vaspitanju i obrazovanju. Članovima od 94 do 103. data su obaveze organu starateljstva (državi) da vrši nadzor nad vršenjem roditeljskog prava u slučajevima kada su ugrožena lična, imovinska prava djeteta i njegov interes.

U Zakonu o dječijoj zaštiti decidno se upotrebljava izraz „razvojne potrebe djeteta" ali se one ne razrađuje i ne predviđaju se konkretne aktivnosti vezane za njihovu implementaciju. Članom 2. ovoga zakona oblast ranog rasta i razvoja može se izčitavati iz opšteg određenja pojma „dječije zaštite". Pod istim pojmom se podrazumijevaju prava roditelja, djece i djelatnosti kojima se, pored ostaloga, obezbjeđuje:

1. „Stvaranje osnovnih uslova za približno ujednačavanje nivoa zadovoljavanja razvojnih potreba djece;
2. Pomoć porodici u ostvarivanju njene reproduktivne, zaštitne, vaspitne i ekonomske funkcije".

Zakonom o socijalnoj zaštiti date su osnove i pravila postupanja u slučajevi posebne zaštite djece ometene u razvoju, ostvarivanja njihovih prava, boravka u specijalizovanim ustanovama i provođenja procedura ostvarivanja mjera socijalne zaštite. Oblast ranog rasta i razvoja najviše se prepoznaje u postupku procjene potreba i usmjeravanja djece i omladine sa smetnjama u razvoju koja služi za ostvarivanja prava i usluga u sistemu socijalne, porodične i dječije zaštite kao i za potrebe obrazovnog sistema.

U Zakonu o zdravstvenoj zaštiti oblast ranog rasata i razvoja nije prepoznata od strane zakonodavca kao posebna oblast. U okviru porodične medicine organizovan je medecinski nadzor nad zdravljem djece na primarnom nivou, a pedijatrijske službe djeluju u Domovima zdravlja prevashodno na praćenju razvoja djeteta u prvim godinama života. Članom 8. regilisano je da djeca do navršene petneste godine života i majke u vremenu poroda i neposredno nakon njega imaju poseban oblik zaštite od strane države kao posebne populacione i nozološke grupe od posebnog socijalno-medicinskog značaja.

Najdetaljnije o ranom rastu i razvoju bavi se Zakon o predškolskom vaspitanju i obrazovanju. U prvih nekoliko članova obrazlaže se šta podrazumijeva, kakve sadržaje i metode rada se primjenjuju u ostvarivanju mjera predškolskog vaspitanja i obrazovanja. U članu 4. ovoga Zakona ističe se da je cilj „podsticanje fizičkog, intelektualnog, socioemocionalnog razvoja, razvoja govora i komunikacije, kreativnosti i stvaralaštva djece, učenje zasnovano na iskustvu i interesovanjima, sticanje novih iskustava i proširivanje znanja o sebi, drugim ljudima i svijetu potrebnih za dalje obrzovanje i vaspitanje i uključivanje djece u društvenu zajednicu, poštujući i uvažavajući prava i mogićnosti djece."

Ovakva zakonska regulativa daje mogućnost javnim sistemima društvene podrške da oblast ranog rasta i razvoja djece razrade do praktičnih rješenja koja su dio njihovih nadležnosti i podražavaju osnovni koncepte njihovog postojanja. Međutim, nedostaju sveobuhvatni integralni modeli djelovanja. Može se konstatovati da je oblast ranog rasta i razvoja djece zarobljena u fragmentiranom pristupu obezbjeđivanja podrške djeci i njihovim porodicama koja je regulisana pojedinačnim zakonima u različitim sistemima društvenog djelovanja.

Kada se analiziraju resursi postojećih sistema u kojima se obezbjeđuje podrška razvoju djeteta i podrška njegovoj porodici, takođe se dolazi do sličnih zaključaka. Naime, u većini ovih sistema postoje resursi koji se koriste u radu sa djecom, ali ne postoji njihova uvezanost i sihronizovano djelovanje na nivou pojedinačnog slučaja. Tako, na primjer, sistem zdravstvene zaštite najveći dio mjera koje proizilaze iz oblasti ranog rasta i razvoja djeteta, provodi kroz timove porodične medicine i službe koje djeluju u okviru domova zdravlja (centar za mentalno zdravlje, centar za rehabilitaciju u zajednici, stomatološka služba i dr).. Na sekundarnom nivou to su različite specijalističke zdravstvene ustanove kao što su: bolnice (dječija odjeljenja), zavodi za rehabilitaciju i specijalističke ambulante. Sistem socijalne, porodične i dječije zaštite dosta je oskudniji u ponudi resursa za rad sa razvojnim potrebama djece. U sistemu postoje i djeluju opštinske komisije koje vrše procjenu potreba i usmjeravanja djece i omladine sa smetnjama u razvoju. Putem centara za socijalni rad obično se vrši uočavanje potreba za podrškom i pružaju se osnovne informacije, obično roditeljima koje mogu biti od koristi u daljnjem tretmanu djece. Ukoliko su razvojni problemi težeg inteziteta centri za socijalni rad upućuju dijete na specijalističke tretmane u ustanove socijalne i zdravstvene zaštite. Broj ovakvih ustanova je veoma mali i one ne mogu odgovoriti na potrebe za ovom vrstom intervencija. Slično je stanje i u sistemu predškolskog vaspitanja i obrazovanja. Broj vrtića je veoma mali, a postojeći kapaciteti nisu ravnomjerno raspoređeni što dovodi do neujednačnosti u pristupu ovim uslugama u zavisnosti od mjesta gdje dijete i njegova porodica žive.

Međutim, ne treba zaboraviti da značajan dio resursa se nalazi u nevladinom sektoru koji sve više zagovara potrebu sistemskog bavljenja ranim rastom i razvojem kao ključnim preduslovom unapređenja zdravlja i kapaciteta djece u Republici Srpskoj.

3. Aktivnosti koje su prethodile

Potrebu uvezivanja različitih službi u cilju unapređenja podrške djeci u najranijem periodu njihovog života uočile su prvo institucije socijalne zaštite. Potreba za jačanjem saradnje i poboljšanjem koordinacije između službi različitih sistema, proizašla je iz potrebe sveobuhvatnijeg tretmana djece sa poteškoćama u razvoju. Naime, s obzirom na to da je sistem socijalne zaštite jedini provodio postupak procjene razvojnih poteškoća, veoma brzo je došao do problema kako obezbijediti cjelovitu zaštitu djece. Uprkos postojanju službi u zdravstvu i institucija u školstvu koji su, sa jedne strane zagovarali potrebu praćenja zdravstveni problema djece, a sa druge strane potrebu inkluzivnog obrazovanja, cjelovit pristup u radu sa djecom je izostao.

Projekti koji su provođeni u sistemu socijalne zaštite Republike Srpske uveliko su doprinijeli razvoju ideje o potrebi uspostavljanja integralnog modela zaštite djece, sa posebnim akcentom na oblast ranog rasta i razvoja. Prve incijative ka tome cilju pokrenute su od strane nevladinih organizacija čije su aktivnosti bile usmjerene prema unapređenje oblasti socijalne zaštite u Republici Srpskoj. Institucije sistema inertne i zaokupljene administriranjem „socijalnih slučajeva”, u početku nisu bile spremne na novi način rada kojeg su sa sobom donosile nevladine organizacije. U početku neprijateljski nastrijene prema nevladinom sektoru, ustanove socijalne zaštite su prihvatile partnerstvo sa nevladinim organizacijama i počele su zajedno sarađivati na razvoju novih modela rada korisnicima (Lepir, 2009). Socijalni rad sa djecom i porodicom bio je top tema zakjedničke saradnje u godinama koje su uslijedile. Projekat pod nazivom „Rano otkrivanje djece sa posebnim potrebama i njihovih razvojnih problema” doprinio je razvoju novih modela rada sa djecom i njihovim roditeljima u polju sistemskih intervencija. Projekat koji je prvo proveden u opštinama Srbac, Prnjavor i Kozarska Dubica, a potom i u još nekoliko opština Republike Srpske, ukazao je na čitav niz propusta sistema u tretmanu djece sa smetnjama u razvoju. Ključni nalaz istraživanja koje je provodeno u okviru ovoga projekta bio je da je značajni broj djece sa smetnjama u razvoju ostao „skriven” od institucija sistema. Naime, postojeći podaci centara za socijalni rad nisu pokazivali stvarno stanje broja djece sa razvojnim problemima u gotovo svim lokalnim zajednicamau kojima je istraživanje provedeno. To je bila poražavajuća činjenica kada se pretpostavljalo da postojeći sistemi imaju uvida u cjelokupno stanje. Sem toga, to je značilo da je značajan broj djece ostao bez sistemske podrške i stručnih intervencija bez kojih nisu mogli ostvariti maksimum svojih razvojnih potencijala. Kao razloge takvog stanja, istraživanje je pokazalo da je problem više u nesaradnji i nedostatku koordinacije službi javnih sistema, nego što je to posljedica manjka resursa. Nesaradnja i fragmentiranost sistema podrške djeci i njihovim roditeljima, prije svega, nesaradnja službi socijalne zaštite, ustanova zdravstvene zaštite, predškolskih i osnovnoškolskih ustanova, dovelo je do potpunog odsustva bilo kakve brige društva o značajnom broju porodica i djeci. Posljedice takvog stanja najviše su vidljive upravo na nivou funkcionisanja lokalnih institucija i na nivou pojedinačnih slučajeva djece koja nisu bila pravovremeno uključena u rane tretmane razvojnih problema čime je izgubljeno dragocjeno vrijeme za njihov individualni razvoj. Pokazalo se da je rano prepoznavanje razvojnih problema i pravovremeni tretman u direktnoj korelaciji sa pitanjima efikasnosti modela evidentisanja u sistemima socijalne podrške (Lepir, 2005).

Nešto kasnije, isto istraživanje urađeno je na području čitave Republike Srpske. Rezultati su bili identični. Koji su uzroci ovakvog stanja? Analiza koja je potom rađena ukazala je da se uzroci mogu naći u inertnosti i birokratizovanosti sistema evidentiranja u zdravstvenim i socijalnim ustanovama; problemima needukovanosti i stigmatizaciji roditelja, te u lošoj materijalnoj situaciji i nedostatku resursa u zajednici.

Doprinos projekta „Rano otkrivanje djece sa posebnim potrebama i njihovih razvojnih problema” bio je veliki. Rezultati projekta su ukazali da je neophodno:

- uspostaviti nove sistemske metode evidentiranja djece sa smetnjama u razvoju;
- uspostaviti kontinuirano praćenje stanja djece sa smetnjama u razvoju;
- uspostaviti jedinstvenu bazu podataka sa posebnim akcentom na uvezivanju lokalnih aktera sociajlne i dječije zaštite;
- uspostaviti mehanizme saradnje i koordinacije različitih subjekata podrške djeci na nivou lokalne zajednice („protokoli o saradnji”),
- profesionalno ojačati postojeća udruženja roditelja djece sa smetnjama u razvoju, a tamo gdje ih nema povesti aktivnosti na njihovom osnivanju;
- raditi na destigmatizaciji i jačanju svijesti o potrebi pružanja podrške roditeljima djece sa smetnjama u razvoju.

Istovremeno Vlada Republike Srpske, u saradnji sa Unicefom pokreće projekat „Jačanje sistema socijalne zaštite i inkluzije djece u BiH” (SPIS projekat) koji fokus svoga djelovanja stavlja na jačanje postojećih sistema socijalne zaštite i inkluzije djece praćenjem, analizom i unapređenjem postojećih okvira javne politike. (UNICEF, 2012).

Rezultati ovoga projekta bili su veoma značajni prije svega sa aspekta osnaživanja subjekata dječije zaštite u lokalnim sredinama. On je uspostavio novi model saradnje i koordinacije između centara za socijalni rad, domova zdravlja, predškolskih ustanova, nevladinih organizacija i roditelja djece. Ovaj projekat dao je metodološku osnovu za daljnje unapređenje sistema društvene podrške djeci u Republici Srpskoj.

U „Politici unapređivanja zdravlja stanovništva Republike Srpske do 2020. godine" doneseni su prioritetni pravci djelovanja u oblasti zdravlja stanovništva koji predstavljaju osnovu na kojoj će se razvijati budući koncept ranog rasta i razvoja. U strateškom pravcu Investiranje u zdravlje, uključivanjem u donošenje odluka o zdravlju i stvaranje zdravih lokalnih zajednica" posebno su naznačeni slijedeći pravci razvoja:

- „osiguranje zdravog početka života (promocija seksualnog i reproduktivnog zdravlja, planiranje porodice i informisanje izbora, i zaštita zdravlja majke i djeteta),
- zaštita od loših iskustava u djetinjstvu i promovisanje sigurnosti i blagostabja u djetinjstvu,
- obezbjeđivanje zdravstvenih usluga koje su prilagođene potrebama adoleascenata" (Škrbić i sar., 2012).

Uočivši probleme koji proizilaze iz nekoordinisanog djelovanja institucija sistema prema djeci i njihovim roditeljima, Vlada Republike Srpske je pristupila razvoju integrisanog modela ranog rasta i razvoja kao ključnog elementa unapređenja društvene brige o djeci. Prvi rezultati ovih aktivnosti su strateški dokumenti u ovoj oblasti: „Politika unapređenja ranog rasta i razvoja djece u Republici Srpskoj za period od 2011 – 2016. godine" (MZSZ RS, 2011) i „Program za rani rast i razvoj u Republici Srpskoj 2016 – 2020" (MZSZ RS 2016). Ovi dokumenti predstavljaju osnovu za izgradnju integrisanog modela ranog rasta i razvoja djece u Republici Srpskoj.

4. Ciljevi, principi i pravci djelovanja integrisanog modela ranog rasta i razvoja djece u Republici Srpskoj

Prema dokumentima koje je usvojila Vlada Republike Srpske osnovni cilj sistemskog djelovanja u oblasti ranog rasta i razvoja je: „Unapređivanjem ranog rasta i razvoja, a težeći najvišim standardima zajednice, stvoriti optimalne uslove za pravilan rast i razvoj djece, kako bi svako dijete, bez obzira na sredinu iz koje potiče i svoje individualne mogućnosti, imalo uslove za zdrav početak života, te kako bi dostiglo svoj puni potencijal".

U skladu sa osnovnim vrijednostima koje su definisane Ustavom Republike Srpske, pozitivnim zakonskim propisima i postavljenim zadacima u oblasti ranog rasta i razvoja djece, Vlada Republike Srpske je proklamovala ključna opredjeljenja putem kojih će ostvariti zacrtani cilj. Kao prvo, Vlada se obavezala da će raditi na unapređenju ove oblasti na način da svako dijete ima šanse da razvije svoje potencijale u skladu sa svojim sposobnostima, što predstavlja osnovnu vrijednost u izgradnji novog integrisanog modela. Takođe, uočen je nedostatak dosadašnje intersektorske saradnje i koordinacije postojećih sistema socijalne sigurnosti koji utiču na stanje kvaliteta podrške djece. U tom smislu, proklamovan je rad na stvaranju novih programa i modela saradnje kojima će se uspostaviti jedinstven sistem ranog rasta i razvoja. Na planu neposrednog rada sa djecom, istaknuto je opredjeljenje da se unaprijedi rad sa posebno socijalno osjetljivim grupama djece na polju borbe protiv diskriminacije, obezbjeđivanja minimuma socijalne sigurnosti i što ranijeg otkrivanja djece sa smetnjama u razvoju. Ključno opredjeljenje je razvoj usluga i obezbjeđivanje njihove pristupačnosti u oblasti zrdavstva, socijalne i dječije zaštite i oblasti predškolstva.

Principi na kojima će se zasnivati rad sistema u oblasti ranog rasta i razvoja predstavljaju osnovne principe stručnog rada sa djecom, a to su:

1. Princip najboljeg interesa djeteta, što podrazumijeva djelovanje u skladu sa potrebama i mogućnostima djeteta sa posebnim akcentom na rad u porodici kao najprirodnijem okruženju djeteta u njegovoj najranijoj fazi razvoja.
2. Princip nediskriminacije upućuje na djelovanje prema svoj djeci na isti način i sa istom pažnjom bez obzira na pol djeteta, pripadnost naciji, vjerskom opredjlejenju roditelja ili nekom drugom individualnom obilježju.
3. Princip individualnog pristupa podrazumijeva da se djetetu treba pristupiti na način da se uvažavaju individualne posebnosti koje ga čine jedinstvenim entitetom.
4. Princip učešća korisnika odnosi se na omogućavanje iznošenja mišljenja djeteta i njegovih roditelja i njihovom uvažavanju od strane subjekata zaštite (ustanova, profesionalaca) prilikom donošenja bilo kakvih mjera i odluka koje se tiču djeteta.
5. Princip usklađenosti intervencija sa razvojnim potrebama djeteta ključni je princip u postizanju efikasnosti mjera ranog rasta i razvoja djeteta. Njegovom primjenom obezbjeđuje se da mjere koje se implementiraju prema djetetu budu optimalne, a time i da donesu najveće benefite za ukupan razvoj djeteta.
6. Princip intersektoralnosti i multidisciplinarnosti se odnosi na potrebu usmjeravanja načina rada sistema društvene podrške i njihovih subjekata (ustanova, stručnjaka) prema novom integrisanom modelu ranog rasta i razvoja djece.

Programom ranog rasta i razvoja definisano je šest prioritetnih grupa aktivnosti (programskih opredjeljenja), u kojima učestvuju, prije svega, institucije i ustanove zdravstvene zaštite, socijalne, porodične i dječije zaštite i institucije obrazovanja i vaspitanja sa posebnim težištem na djelovanje ustanove predškolskog vaspitanja i obrazovanja.

Jačanje porodice prvo je programsko opredjeljenje koje ima za cilj uspostavljanje i razvoj aktivnosti kojima će se podsticati odgovorno, zdravo roditeljstvo kroz društvenu i ekonomsku podršku zajednice.

Obezbjeđivanje sigurnog i stimulativnog okruženja za pravilan rast i razvoj djeteta predstavlja drugo programsko opredjeljenje koje je usmjereno na djelovanje na nivou opštih uslova života u zajednici.

Treće programsko opredjeljenje je usmjereno na unapređivanje sistema otkrivanja smetnji u rastu i razvoju djece, habilitaciji i rehabilitaciji djece.

Uspostavljanje integrisanog pristupa ranom rastu i razvoju djece predstavlja četvrto programsko opredjeljenje koje će se realizovati putem jačanja postojećih i razvoja novih vidova intersektorske saradnje i koordinacije.

Peto programsko opredjeljenje je vezano za unapređivanje kvaliteta i dostupnosti usluga sistema podrške u obalsti ranog rasta i razvoja djece.

Šesto programsko opredjeljenje usmjereno je na unapređivanje međunarodne saradnje na programima ranog rasta i razvoja djece

Usvajanjem ovih šest programskih opredjeljenja jasno su definisani pravci djelovanja sistema podršek u oblasti ranog rasta i razvoja djece u Republici Srpskoj. Njihovim usvajanjem omogućeno je operativnom planiranje pojedinačnih aktivnosti u sistemima gdje se najvećim dijelom obezbjeđuje podrška djeci u ranoj fazi njihovog razvoja kada su i efekti najbolji za dijete. Ovim je Vlada Republike Srpske napravila ključni korak ka operacionalizaciji novog koncepta ranog rasta i razvoja.

5. ZAKLJUČNA RAZMATRANJA

Ovakvo postavljena programska opredjeljenja upućuju na pokušaj sveobuhvatnosti u kreiranju novog koncepta djelovanja u oblasti ranog rasta i razvoja djece u Republici Srpskoj. Međutim, u strateškim dokumentima ništa se ne govori o organizacionoj strukturi i postojanju resursa za ostvarivanje novog pristupa. Izazovi koji se pred nosiocima sistema u kojima se ostvaruje najveći dio podrške djeci i njihovim roditeljima vezani su upravo za uspostavljanje organizaione strukture i postojanje resursa provođenja novog koncepta djelovanja. Da bi se ostvario programirani modela integrisanja u oblasti ranog rasta i razvoja neophodno je uspostaviti mehanizme stručne i administrativne saradnje između ustanova sistema zdravstvene zaštite, socijalne zaštite i ustanova u sistemu predškolskog vaspitanja i obrazovanja, i to sve na nivou pojedinačnog problema. To u praksi podrazumijeva izradu protokola o saradnji u slučajevima evidentiranja, praćenja i pružanja usluga djeci i njihovim porodicama. Takođe, neophodno je uspostaviti sistemsku koordinaciju neposrednog djelovanja različitih institucija na pojedinačnim slućajevima. Naime, veoma je važno podijeliti odgovornosti za pojedine faze upravljanja procesima na ključne institucije u procesu pružanja usluga djeci i njihovim roditeljima. Na operativnom planu bilo bi neophodno uključiti Javni fond za dječiju zaštitu i Fond zdravstvenog osiguranja koji će svojim resursima i procedurama podržati razvoj i implementaciju novog koncepta u praksi sistema. Sem toga, neophodno je raditi na pojedinačnim progranskim aktivnostima koje imaju veće šanse za realizaciju, s tim, da se posebno povede raučna o međusobnoj koordinaciji između njih. Jedna od značajnih mjera je uspostavljanje saradnje sa korisničkim udruženjima. U Republici Srpskoj postoji veoma razvijena mreža udruženja roditelja djece sa smetnjama u razvoju koja bi mogla biti dobra osnova za implementaciju novog koncepta u lokalnim zajednicama. Njihova fleksibilnost u radu i mogućnost ostvarivanja neposrednog kontakta sa pojedinčnim slučajevima mogu biti od ključne važnosti za uspješnost ovog modela.

Potreba uspostavljanja integrisanog modela praćenja ranog rasta i razvoja djece od ključne je važnosti za ukupan socijalni razvoj društva. Prve godine života smatraju se najvažnijim periodom za rast i razvoj djeteta. Od rezultata razvoja djeteta u najranijoj dobi zavisiće njegov kasniji razvoj koji može donijeti čitav niz problema, ne samo roditeljima već i sistemu. Pravovremensko djelovanje prema razvojnim poteškoćama djeteta obezbjeđuje čitav niz prednost, prijesvega za dijete, njegovu porodicu, a i sistem u cjelini. Ali da bi se došlo do takvih rezultata neophodno je uspostaviti integrisani model ranog rasta i razvoja. Republika Srpska ima realne šanse da uspostavi takav model, prije svega i zbog toga što je je već izradila i usvojila dva ključna strateška dokumenta u ovoj oblasti, a koja su utemeljena u sistemskim dokumentima ključnih oblasti društvenog djelovanja.

LITERATURA

1. Lepir, Lj. (2005). Društvena briga o djeci sa posebnim potrebama – evidentiranje razvojnih problema kao preduslov. *Socijalna misao*, 50, 153-173.
2. Lepir, Lj. (2009). Procjena potreba za daljnju profesionalizaciju NVO-a i standardizaciju njihovih usluga, u: Ninković-Papić, R. ur. *Jačanje profesionalnih kapaciteta nevladinih organizacija*. Sarajevo: IBHI.
3. MZSZ RS (2011). Politika unapređenja ranog rasta i razvoja djece u Republici Srpskoj za period od 2011 – 2016. *godine*. Banja Luka
4. MZSZ RS. (2016). *Program za rani rast i razvoj u Republici Srpskoj 2016 – 2020.* Banja Luka
5. Škrbić, R. i sar. (2012). Politika unapređenja zdravlja stanovništva Republike Srpske do 2020. U Kuzmanović R. ed. *Republika Srpska dvadeset godina razvoja*. Banja Luka: ANURS.
6. UNDP. (2010). *Priručnik za strateško planiranje*. Sarajevo.
7. UNICEF. (2012). Bilten. Dostupno na: https://www.unicef.org/bih/ba/UNICEF_SPIS_Bilten_2012_BOS.pdf. Pristupljeno 12.6.2017.
8. Zakon o socijalnoj zaštiti, *Službeni glasnik Republike Srpske*, broj 37/12.
9. Porodični zakon, *Službeni glasnik Republike Srpske*, broj 54/02.
10. Zakon o dječijoj zaštiti, *Službeni glasnik Republike Srpske*, broj 4/01.
11. Zakon o zdravstvenoj zaštiti, *Službeni glasnik Republike Srpske*, broj 106/09.
12. Zakon o predškolskom obrazovanju, *Službeni glasnik Republike Srpske*, broj 79/15.

POLICY OF IMPROVING EARLY CHILD DEVELOPMENT IN THE REPUBLIC OF SRPSKA

Ljubo Lepir, Draško Gajić
University of Banja Luka, Faculty of Political Science,
the Republic of Srpska, BIH

Research subject: The Republic of Srpska, as a responsible community, has devoted considerable attention to the development and introduction of the concept of Early Childhood Development in recent years. According to competent institutions, one of the main goals of the overall development of the Republic of Srpska is to improve the status of children. To accomplish this goal, the authorities have started developing strategic documents that define the concept of Early Childhood Development. The documents "Policy of Improving Early Child Development in the Republic of Srpska for the period 2011 – 2016" and "Program for Early Child Development in the Republic of Srpska, 2016 – 2020"were also officially adopted.

Method: This analysis aims to provide an overview of the basic strategic directions for the implementation of an integrated model for monitoring early growth and development of children through the institutions of the social and health care system in the Republic of Srpska.

Results: These documents make strategic commitments and define the basic elements of a new integrated approach in treating children's developmental problems. On the other hand, the existing practices of health, social, family and child care systems, and pre-school education systems have demonstrated the possibilities and the misconceptions of introducing an integral model of social childcare.

Conclusion: Advantages and disadvantages of existing child care models suggest that it is possible to build more responsive and more accessible model of system support for children and their parents. However, in order to achieve this set of goals, it is necessary to provide system assumptions.

Key words: growth, child development, strategic documents, integrative support model

PARALLEL SESSIONS III
TEAM AROUND A CHILD AND FAMILY IN EARLY CHILDHOOD INTERVENTION

PARALELNA SESIJA III
TIM OKO DETETA I PORODICE U SISTEMU RANE INTERVENCIJE

udc 316.356.2(496)
364.4:316.356.2(496)

Characterization of The Families Participation in the Local Intervention Teams

Marta Joana de Sousa Pinto
Politécnico do Porto, Escola Superior de Saúde, Portugal
Ana Maria Serrano
Institute of Education, Center of Research on Education,
University of Minho, Portugal

Research subject: *National and international studies about the participation of families in early intervention services have led to a research project that intends to understand the participation of families in the support provided by the Local Intervention Teams, the National System of Early Intervention in Childhood (SNIPI).*

Method: *Family members of children between the ages of 0 and 6 were interviewed, fulfilling the eligibility criteria to integrate these teams, with the aim to identify what families understand by active participation and how these families participate at all times in the intervention, in line with Family-Centered Practices, as well as to identify facilitators and barriers to active family involvement, to help practitioners identify techniques and strategies that keep parental participants active in the support provided by the Local Intervention Teams. An interview and a questionnaire, the Enabling Practices Scale, were used for data collection. The interview script was developed by the author, according to the bibliographic collection previously done and with her professional practice in early intervention over the last years. Also, the author used the Enabling Practices Scale which was to be completed by family members at the end of their interview. The selected instrument came from the collection and bibliographic analysis of the available evaluation tools on the subject. Data collection took place between March and December 2016 and a total of twenty relatives were contacted in the North, Center, Lisbon, Alentejo and Algarve regions.*

Results: *The results show attitudes (perception) of the participation of the families, about the support provided to them by the Local Early Intervention Teams.*

Conclusion: *In this article, we intend to present the results obtained with the interviews conducted and with the completion of the Enabling Practices Scale by family members, characterizing the perception of the participation of the families, about the support provided to them by the Local Early Intervention Teams.*

Key words: *early intervention, family, participation, facilitators, barriers*

INTRODUCTION

Family-Centered Practices (FCP) are defined as a set of practices that recognize the centrality of the family and promote their strengths and capacities (Trivette & Dunst, 2005). Dunst (2000) and their colleagues have greatly contributed to the operationalization of FCP by Early Intervention (EI) professionals among children and families. According to this model we identify EI as priority targets to promote children's learning opportunities, support for parents and mobilization of family and community resources. Families are supported, based on their strengths, unique and differentiated as individuals and families. The role of the family is respected, being the main unit of intervention and the key element in the decision-making process and child care.

According to the recommendations of the Division for Early Childhood (2014), by Dunst, Boyd, Trivette and Hamby (2002) and Carvalho et al. (2016) we understand the participation of families in the support provided by EI teams as the active participation of families at all times of the support provided by the professional. The family should have informed knowledge and the opportunity to make decisions at all times of support. The EI professional should act as a facilitator, sharing all the information with the parents, creating opportunities for all family members to demonstrate and acquire competencies and encourage them to make decisions about the desired resources and supports.

Dunst and Trivette have identified three components that characterize effective aid practices in family-centered programs, namely the provision of aid that on the one hand empowers skills and, on the other, has repercussions on empowerment; technical quality, relational practices and participatory practices. The technical quality includes the theoretical and practical knowledge of the professional about the area in which he works. It is the result of their training and professional experience (Carvalho et al., 2016). The relational practices relate to the interpersonal characteristics and representations of the professional that influence the relational aspects of the support, namely the positive beliefs and beliefs about the competences and capacities of the family (Carvalho, 2004). Carvalho et al. (2016) refer that they are the basis for the professional to recognize and validate the existing strengths and thus use the family's capabilities to improve their functioning. Participatory practices contribute to strengthening the family's competencies and promoting new skills and positively influencing the control that the family experiences in its family functioning (Carvalho et al., 2016). Participatory practices refer to the professional's behavior aimed at the participation of the family in the decision-making process and informed choice and in the use of existing forces and developing skills to achieve the resources, supports and services desired by the family. These practices have been described as practices that are more likely to result in positive family assessments of their abilities (Dunst & Espe-Sherwindt, 2016; Carvalho et al., 2016).

We verified the importance of understanding the interactions between professionals, families and children during the intervention to verify family participation in EI programs (Dunst, Bruder & Espe-Sherwindt, 2014; Peterson, Luze, Eshbaugh, Jeon & Kantz, 2007). To better understand how families participate in the support provided by EI programs in Portugal, in line with FCP and identify the factors that contribute to participation, can guide practitioners to identify intervention techniques and strategies that keep active parents in services that support your child's learning and development.

AIM

This article is intended to present the results obtained by completing the Enabling Practices Scale (EPS) by family members supported by Local Early Intervention Teams (LIT), the National System of Early Intervention in Childhood (SNIPI) from five regions at Portugal.

METHOD

Data were collected between March and December 2016. These data are part of a set of data collected as part of a qualitative case study that serves PhD research. The sample consisted of 18 families, 5 of the Northern Region, 2 of the Central Region, 2 of the Lisbon Region 7 of the Alentejo Region and 2 of the Algarve Region, with an average of 36 years of age (s.d. 6.48). The children were mostly boys and were on average 44 months old (s.d. 18,46). The author used the EPS to fill the families of children supported by LIT. EPS was developed by Dempsey (1995), based on theoretical assumptions of training and capacity practices, with the objective of being an instrument that intends to measure practices that enable the family, used by professionals with families and individuals with special needs (Dempsey, 1995; Dunst, Trivette & Hamby, 2006). This questionnaire thus allows, evaluates and monitors the level of parental participation in EI programs (Dunst, Trivette & Hamby, 2006), which we consider in accordance with the objective of the investigation. The EPS was filled by families who had been in the program for at least six months and also at the point of program exit, fulfilling the inclusion criteria. The families indicated on a Likert Scale, selecting one of five possible answers, the value that corresponds to their relation and participation. The results were submitted to descriptive statistical analysis, using the SPSS Statistics 24. Thus, the absolute frequency of the responses obtained in each of the items was calculated.

RESULTS

From the results obtained, we verified that most of the family members responded actively to the support given to them by EI professionals, mostly selecting the option "5 – Completely true". The items that obtained the highest absolute frequency (> 80%), in option "5" were items 1, 5, 6, 9, 12, 14, 18 and 22, with item 14 reaching a total of 94% of responses. The items that obtained the highest absolute frequency for the option “4-In most cases it is true” were items 10, 16 and 17, and item 16 obtained 50% of the answers. The item 22 obtained the highest absolute frequency of answers for the option “1 – It is not entirely true”, with 22% of the answers, being the item that obtained the lowest absolute frequency for option “5”, with 11% of answers. The items 7, 10, 13, 15, 17, 19, 20 and 21 were the ones that obtained the greatest variability of responses in the range of the scale, and four of the five possible options were selected. The items that obtained the highest absolute frequency (> 80%), in option “5” were items 1, 5, 6, 9, 12, 14, 18 and 22, with item 14 reaching a total of 94% of responses. The items that obtained the highest absolute frequency for the option “4-In most cases it is true” were items 10, 16 and 17, and item 16 obtained 50% of the answers. The item 22 obtained the highest absolute frequency of answers for the option “1 – It is not entirely true”, with 22% of the answers, being the item that obtained the lowest absolute frequency for option “5”, with 11% of answers. The items 7, 10, 13, 15, 17, 19, 20 and 21 were the ones that obtained the greatest variability of responses in the range of the scale, and four of the five possible options were selected. Table 1 presents the main descriptive statistics obtained for each of the items relating to the responses of family.

Table 1 – Results obtained by completing EPS (1 – It is not entirely true; 2 – In most cases it is not true; 3 – Somewhat true; 4 – In most cases it is true; 5 – Completely true)

Items	N	Frequency %				
	18	1	2	3	4	5
1 – The team and I agreed on what is most important in the Individual Plan for Early Intervention (IPEI)..		**0**	**0**	**0**	**17**	**83**
2 –It is easy to follow the advice of the staff..		0	0	0	28	72
3 – The team has considered the opinion of my family and my friends when we discuss the IPEI.		6	0	0	22	72
4 – I have an active role in the most important decisions when building the IPEI.		6	0	0	28	67
5 – The suggestions from the team, to work with my son/daughter, make me feel comfortable.		**0**	**0**	**0**	**17**	**83**
6 – The team accepts the beliefs and values of my family.		**0**	**0**	**0**	**11**	**89**
7 – I am an equal partner in the relationship with other team members.		6	0	11	28	56
8 – Working with the team makes me feel more capable.		6	0	0	22	72
9 – It is easy to work with the team when we both plan the IPEI.		**6**	**0**	**0**	**11**	**83**
10 – I feel most responsible for the progress of my son/daughter.		11	0	11	39	39
11 – With the support of the team, I am able to quickly resolve problems.		0	0	17	28	56
12 – The suggestions that the team makes are positive.		**0**	**0**	**0**	**17**	**83**

Items	N	Frequency %				
	18	1	2	3	4	5
13 – The team encourages me to contact my family and my friends when I need advice.		11	0	17	22	50
14 – The team is concerned with my son/daughter and my family.		**0**	**0**	**6**	**0**	**94**
15 – The support the team gives me, meets the needs of my family..		0	6	6	11	78
16 – The team anticipates the concerns and needs of my family.		0	11	0	50	39
17 – I am primarily responsible for important changes in my son's/daughter's life.		6	0	11	39	44
18 – I feel comfortable in giving opinions to the team if she asks me for help.		**0**	**0**	**0**	**11**	**89**
19 – Following the suggestions from the team, I learned how to deal with the concerns of my family.		0	6	11	22	61
20 – The team offers adequate help to the needs of my family.		0	6	6	22	67
21 – We decide the goals of the IPEI..		22	0	33	33	11
22 – The team were pleased to accept my suggestions.		**6**	**0**	**0**	**11**	**83**
23 – I feel that I am able to accomplish the suggestions provided by the team.		0	0	6	28	67
24 – The suggestions that the team gives me to work with my son/ daughter at home produce good results.		0	0	6	22	72

With the data obtained by filling out the EPS by family members, we find that families recognize that professionals listen to them and care about them, respecting their cultural beliefs and personal values, and recognizing and valuing the strengths of family members (items 3, 6, 14, 22 and 23).

The majority of family members perceive that they participate actively in the support provided, although their participation in all phases of the intervention process is not verified, more specifically in the decision of the objectives of the Individual Plan for Early Intervention (IPEI) and in their implementation and monitoring in the daily life of the family. Most family members say that it is easy to work together with the team when planning the IPEI (83%), feel comfortable in giving suggestions to the team if she asks for help (89%) and that both agree with what is most important in the intervention plan (83%), although only 56% refer to being equal partners in the relationship with other team members, 67% reported having an active role in the most important decisions in the preparation of the intervention plan and 11% refer to deciding the IPEI objectives.

The family seems to recognize the positive results of the professionals' support in the development of their child, although they do not seem to be aware of their power in the intervention, according to the answers obtained in items 10 and 17.

CONCLUSION

The relationship between professionals and families, based on the principles of the FCP, is developed throughout the support process, from the first contact of the family with the LIT to the time the family/child moves to another service. The family is an active partner in all the support provided and the professional supports the family to assume the power that naturally have (Carvalho et al., 2016; Dunst, Bruder & Espe-Sherwindt, 2014). According to the results obtained with EPS, we can verify that practitioners implement practices that build authentic relationships with families (Relational Practices) and begin to implement practices that promote choices, decision-making power and family involvement in the support provided (Participatory Practices).

We are aware that these data are not representative of the support provided by EI professionals in Portugal. They are part of a qualitative case study within the scope of a doctoral research and are intended together to identify how support is being provided by EI professionals in Portugal, according to which are the national and international recommended practices.

REFERENCES

1. Carvalho, M.L. (2004). Práticas centradas na família na avaliação da criança: Perceções dos profissionais e das famílias do PIP do distrito de Coimbra. Unpublished Mestrado, Instituto de Estudos da Criança da Universidade do Minho, Braga.
2. Carvalho, L., Almeida, I. C. de, Felgueiras, I., Leitão, S., Boavida, J., Santos, P. C., … Franco, V. (2016). *Práticas recomendadas em intervenção precoce na infância: um guia para profissionais.* (1^{a}). Coimbra: Associação Nacional de Intervenção Precoce.
3. Dempsey, I. (1995). The enabling practices scale: the development of an assessment instrument for disability services. *Australia and New Zealand Journal of Developmental Disability*, 29, 40-51.
4. Dunst, C. J. (2000). Corresponsabilização e práticas de ajuda que se revelam eficazes no trabalho com famílias. In A. Serrano & L. M. Correia (Eds.) *Envolvimento parental e intervenção precoce* (123-141). Porto: Porto Editora.
5. Dunst, C. J., Boyd, K., Trivette, C.M., & Hamby, D. (2002).Family-oriented program models and professional helpgiving practices. *Family relations*, 51, 221-229.
6. Dunst, C., Bruder, M., & Espe-sherwindt, M. (2014). Family capacity-building in early childhood intervention: do context and setting matter? *School Community Journal*, *24*(1), 37–48.
7. Dunst, C.J., & Espe-Sherwindt, M. (2016). Family-Centered Practices in Early Childhood Intervention. In S. L. Odom, B. Reichow, E. Barton, & B. Boyd (Eds.), *Handbook of early childhood special education*. New York: Springer.

8. Dunst, C.J., Trivette, C.M., & Hamby, D.W. (2006). *Technical manual for measuring and evaluating family support program quality and benefits*. North Carolina: Winterberry Press.
9. Peterson, C.A., Luze, G.J., Eshbaugh, E.M., Jeon, H.J., & Kantz, K.R. (2007). Enhancing parent-child interactions through home visiting: promising practice or unfulfilled promise? *Journal of Early Intervention*, *29*(2), 119-140.
10. Trivette, C. M., & Dunst, C. J. (2005). DEC recommended practices: Family-focused practices. In S. Sandall, M. L. Hemmeter, B. J. Smith, & M. E. McLean (Eds.). *DEC recommended practices: a comprehensive guide or pratical application* (pp. 107-126). Longmont, CO: Sopris West.

udc 376.1-056.266-053.2
616.831-009.11

Community Participation and Family Quality of Life – Comparative Study of Children with Cerebral Palsy and Children with Typical Development[1]

Milena Milićević
Institute of Criminological and Sociological Research, Belgrade, Serbia
Goran Nedović
University of Belgrade, Faculty of Special Education and Rehabilitation, Belgrade, Serbia
Violeta Bogdanović Šutković
Fifth School of Economics "Rakovica", Belgrade, Serbia

Children with developmental disabilities, including cerebral palsy (CP), often experience restriction in community participation. The previous empirical and theoretical consideration of community participation of children with CP did not take into account the family quality of life (FQOL) as a potential factor that could have affected the participation of these children. The aim of this study was to examine the association between community participation of children with CP and FQOL and draw comparisons with their peers with typical development (TD). The sample of this descriptive, cross-sectional and comparative research consisted of 109 families with children with CP and 133 families with children with TD, both genders, aged between seven and 18 years. The Participation and Environment Measure for Children and Youth (PEM-CY) and The Beach Center Family Quality of Life Scale (Beach FQOL Scale) were used. The Spearman's rank-order correlation coefficients were calculated to test the strength of a relationship between two sets of data for each group separately. The results indicate interrelation between the subjective dimension of community participation as expressed through parental desire for change, and both parenting aspect of family life (ρ=-.24) and social and emotional support within the family emotional well-being (ρ=-.20) in the group of children with CP. However, a greater number of statistically significant correlations is confirmed in the group of children with TD. Comparing the distribution of results between the two groups, the most noticeable is the absence of connection between FQOL and diversity and frequency of community participation in the group of children with CP, which is confirmed in the group of children with TD. The conclusion

---

[1] This work resulted from the project "Crime in Serbia: Phenomenology, risks, and possibilities of social intervention" (registration number 47011) funded by the Ministry of Education, Science and Technological Development of the Republic of Serbia.

underlines that the reflection of changes that affect family life after the birth of a child with CP can be seen in various aspects of FQOL.

Key words: *community participation, family quality of life, cerebral palsy, family life*

INTRODUCTION

The World Health Organization's *International Classification of Functioning, Disability and Health* (ICF) defines participation as 'involvement in a life situation' while restriction is defined as 'problems an individual may experience in involvement in life situations' (WHO, 2001, 2007). Numerous studies have shown that children with developmental disabilities, including cerebral palsy (CP), often experience restriction in participation (Blum, Resnick, Nelson & St Germaine, 1991; Engel-Yeger, Jarus, Anaby & Law, 2009; Imms, Reilly, Carlin & Dodd, 2008; King et al., 2003, 2006; King, Law, Hurley, Petrenchik & Schwellnus, 2010; Law et al., 2004, 2006, 2013; Majnemer et al., 2008). Additionally, previous studies have focused on the impact of children with disabilities on family functioning, as well as on the impact of various types of family functioning on child development (Drotar, 1997; Dyson, Edgar & Crnic, 1989; Giallo & Gavidia-Payne, 2006; Hauser-Cram, Warfield, Shonkoff & Krauss, 2001; Van Riper, Ryff & Pridham, 1992). In recent years, disability studies have moved their focus from on an individual quality of life to an evaluation of the quality concerning the whole family (Hu, Summers, Turnbull & Zuna, 2011; Park et al., 2003; Parpa et al., 2016; Summers, Hoffman, et al., 2005).

The construct of family quality of life (FQOL) refers to the needs of all family members, emphasizes the family's strengths and their priorities, and highlights the importance of partnership between families and professionals (Smith-Bird & Turnbull, 2005). Still, the previous empirical and theoretical consideration of participation of children with CP did not take into account the FQOL as a potential factor that could have affected the participation of these children.

This study is part of a larger research project focused on the FQOL and participation of children with CP living in Serbia. The purpose of this part was to examine the association between community participation of children with CP and FQOL and draw comparisons with their peers with typical development (TD). To meet this objective we pursued the following aims: 1) examine the association between the pattern of community participation and FQOL in the group of children with CP, and 3) draw comparisons with their peers with TD. We hypothesized that there was a positive relationship between community participation and FQOL in the examined groups.

METHOD

Sample and procedure

Participants were recruited using convenience sampling. The general inclusion criteria were as follows: children of both genders, aged 7–18 years, residing with their families on the territory of the Republic of Serbia. The inclusion criteria of the group of children with CP were cerebral palsy diagnosis according to the 10th revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10; World Health Organization, 2004). Data were gathered from June 2014 to April 2015. Informed consent was obtained from all parents/caregivers included in the study.

The first group consisted of 109 families with children with CP, 61 boys and 48 girls, the average age of 12 years 8 months (*SD*=3 years 5 months). The second group included 133 families with children with TD, 66 boys and 67 girls, the average age of 11 years 11 months (*SD*=3 years 1 month). There were no statistically significant differences between groups in relation to age ($t(240)=1.721$, $p=.087$) and gender of children ($\chi^2(1)=.728$, $p=.394$).

INSTRUMENTS AND VARIABLES

The Serbian versions of *the Participation and Environment Measure for Children and Youth* (PEM-CY; Coster, Law, & Bedell, 2010) and *the Beach Center Family Quality of Life Scale* (Beach FQOL Scale; Hoffman, Marquis, Poston, Summers & Turnbull, 2006) were used. Both are reliable and valid parent/caregiver-report instruments. Detailed information about their conceptual basis, development, and psychometric properties have been described elsewhere (Bedell et al., 2013; Bedell, Khetani, Cousins, Coster & Law, 2011; Coster et al., 2011, 2012; Hoffman et al., 2006; Jorge, Levy & Granato, 2015; Khetani et al., 2014; Law et al., 2013; Milićević, 2017; Summers, Poston, et al., 2005).

Four PEM-CY group summary scores were calculated: 1) percentage of activities in which children never participated, as a measure of diversity (theoretical range: 0–100%); 2) average frequency excluding the *never* responses (theoretical range: from 1=*once in the last 4 months* to 7=*daily*); 3) average involvement level (theoretical range: from 1=*minimally involved* to 7=*very involved*); and 4) percentage of activities in which change was desired (theoretical range: 0–100%). The latter score represents an indirect indicator of the parents' satisfaction with the children's current participation and represents a subjective dimension of participation. The pattern of community participation represents an objective dimension of participation, which includes diversity, frequency and involvement level.

Six FQOL Scale scores were included: 1) Family Interaction, 2) Parenting, 3) Emotional Well-being, 4) Physical/Material Well-being, 5) Disability-Related

Support, and 6) overall FQOL (theoretical range: from 1=*very dissatisfied to* 5=*very satisfied*). A higher score indicates that parents are satisfied to a greater extent with different aspects of family life.

Statistical analysis

Descriptive data and inferential statistics are presented. Data independence across child variables was checked using χ^2 test and the independent-samples t-test. The Spearman's rank-order correlation coefficients were calculated to test the strength of a relationship between two sets of data for each group separately. All analyses were performed in SPSS, version 23 (IBM, Armonk, NY, USA), and a significance level of .05 was established to consider the results significant.

RESULTS AND DISCUSSION

In accordance with the findings of previous studies, overall community participation of children with CP is lower compared to the participation of children with TD (Bedell et al., 2013; Coster et al., 2011; Engel-Yeger et al., 2009; Majnemer et al., 2008; Mc Manus, Corcoran, & Perry, 2008; Michelsen et al., 2009). Children with CP participated in fewer community-based activities, less frequently and had lower levels of involvement than children with TD. More parents of children with CP confirmed that they would like to see their child's community participation change and that they were less satisfied with all aspects of family life (Table 1).

Table 1 – Community participation and family quality of life: descriptive statistics

Variables		CP group	TD group
Community participation	Diversity	49.45 (20.36)	24.81 (14.95)
	Frequency	4.04 (1.32)	4.87 (.76)
	Involvement	3.16 (1.07)	4.65 (.51)
	Change desired	72.66 (23.20)	34.66 (27.35)
Family Quality of Life	Family interaction	4.02 (.66)	4.29 (.58)
	Parenting	3.99 (.57)	4.27 (.52)
	Emotional well-being	3.54 (.72)	4.06 (.65)
	Physical/material well-being	3.66 (.65)	4.11 (.61)
	Disability-related support	3.81 (.71)	n.a.
	Overall family quality of life	3.83 (.51)	4.20 (.50)

Note. CP group – children with cerebral palsy (*n*=109); TD group – children with typical development (*n*=133); n.a. – not applicable. Values are given in M (SD) format.

Table 2 – Relationship between the pattern of community participation and family quality of life

Community participation	Family Quality of Life										
	Family interaction		Parenting		Emotional well-being		Physical/ mat. well-being		Disability-r. support	Overall FQOL	
	CP	TD	CP	TD	CP	TD	CP	TD	CP	CP	TD
Diversity	.01	-.26**	-.03	-.26**	.04	-.37**	-.04	-.25**	.00	-.01	-.33**
Frequency	.01	.28**	.04	.28**	.17	.30**	.01	.14	-.15	.04	.28**
Involvement	-.01	.12	.09	.16	-.11	.06	-.05	.10	.11	-.01	.11
Change desired	-.14	-.24**	-.24*	-.27**	-.20*	-.25**	-.14	-.23**	-.03	-.18	-.29**

Note. Physical/Mat. Well-being – Physical/Material Well-being; Disability-r. support – Disability-related support Overall FQOL – Overall FQOL Scale score; CP – group of children with cerebral palsy (*n*=109); TD – group of children with typical development (*n*=133). Spearman's rank-order correlation coefficients are presented.

**p*<.05, two-tailed. ***p*<.01, two-tailed.

According to the results, correlations are generally low, with the exception of a few moderate correlations (Table 2). In relation to the total number, far more statistically significant correlations are calculated within the group of children with TD than in the group of children with CP (14 and two, respectively). As presented, correlations are predominantly positive. Exceptions are those correlations of the variables that are defined as reversed by their nature, which includes the following two: activities in which children never participated (higher score indicates less diversity), and activities in which change was desired (higher score indicates a lower level of parental satisfaction with the participation achieved).

When it comes to the pattern of community participation, only the involvement level is not significantly correlated with the domains of quality of life of families with children with TD (Table 2). However, the frequency is positively correlated with most FQOL scores. Therefore, more frequent participation of children with TD is associated with greater parental satisfaction with family life in all domains excepting *Physical/Material Well-being*. The strength of the relationship of these variables can be interpreted as small (ρ from .28 to .30, p<.01). In the case of diversity of community participation, a greater number of activities in which children with TD participate is followed by a family life with whose quality parents are more satisfied. The strength of these correlations can be interpreted as small to medium (ρ from .25 to -.37).

There are small and negative statistically significant correlations between the number of activities in which parents of children with CP have expressed their desire for change and the *Parenting* (ρ=-.24, p<.05) and *Emotional Well-being domains* (ρ=-.20, p<.05). In other words, if parents are more satisfied with family life that relates to support for children, or activities that adult family members do to help children grow and develop, as well as with emotional and internal aspects of family life, then the level of satisfaction with community participation of their child with CP is higher (Table 2).

The level of parental satisfaction with community participation, expressed through the desire for change, statistically significantly correlates with all domains of quality of life of families with children with TD (Table 2). More precisely, if there is a greater number of activities in which change is desired, then the level of satisfaction with all aspects of family life decreases. The strength of the relationship between the variables is, however, small (ρ from -.23 to -.29, $p<.01$).

Finally, it should be noted that in the group of children with CP, the statistical significance of correlations between support for the family member with a disability and all the characteristics of community participation is not confirmed (Table 2).

Based on the results, it can be noticed that there are correlations between certain dimensions of community participation and the quality of life of both families with children with CP and children with TD (Table 2). The results, nevertheless, point to certain exceptions from the assumed correlations.

Thus, no association between diversity, frequency and level of involvement, on the one hand, and parental aspect of family life and social and emotional support within the family emotional well-being, on the other hand, was found in the group of children with CP. As opposed to that, in the group of children with TD, the association between level of involvement and all FQOL scale domains was not confirmed only. At the same time, the results show that a better quality of life at the level of the entire family could have a positive effect on certain characteristics of participation of children with CP. Furthermore, the results clearly show that CP leads to changes in the relationship between the overall well-being at the family level and the involvement of a member with CP in life situations. This finding is important and relevant for special education and rehabilitation because it explains a part of the changes that affect family life after the birth of a child with CP and whose reflection can be noticed in different aspects of the association of the child's participation in the community and the quality of family life. Consequently, the finding confirms the need for wider understanding of the factors of connection between the quality of family life and the participation of children and adolescents from this population.

CONCLUSION

Bearing in mind the presented findings, on the one hand, and the assumed outcome of the analysis, on the other hand, it cannot be confirmed that all the characteristics of community participation are positively associated with all aspects of FQOL in the examined groups. In conclusion, the initial hypothesis is not fully supported by empirical findings.

REFERENCES

1. Bedell, G., Coster, W., Law, M., Liljenquist, K., Kao, Y., Teplicky, R., … Khetani, A. (2013). Community participation, supports, and barriers of school-age children with and without disabilities. *Archives of Physical Medicine and Rehabilitation*, *94*(2), 315–323.
2. Bedell, G., Khetani, M. A., Cousins, M. A., Coster, W. J., & Law, M. C. (2011). Parent Perspectives to Inform Development of Measures of Children's Participation and Environment. *Archives of Physical Medicine and Rehabilitation*, *92*(5), 765–773.
3. Blum, R. W., Resnick, M. D., Nelson, R., & St Germaine, A. (1991). Family and peer issues among adolescents with spina bifida and cerebral palsy. *Pediatrics*, *88*(2), 280–285.
4. Coster, W., Bedell, G., Law, M., Khetani, M. A., Teplicky, R., Liljenquist, K., … Kao, Y.-C. (2011). Psychometric evaluation of the Participation and Environment Measure for Children and Youth. *Developmental Medicine* & *Child Neurology*, *53*(11), 1030–1037.
5. Coster, W., Law, M., & Bedell, G. (2010). *Participation and Environment Measure for Children and Youth*. Boston, MA: Boston University.
6. Coster, W., Law, M., Bedell, G., Khetani, M., Cousins, M., & Teplicky, R. (2012). Development of the participation and environment measure for children and youth: conceptual basis. *Disability and Rehabilitation*, *34*(3), 238–246.
7. Drotar, D. (1997). Relating parent and family functioning to the psychological adjustment of children with chronic health conditions: what have we learned? What do we need to know? *Journal of Pediatric Psychology*, *22*(2), 149–165.
8. Dyson, L., Edgar, E., & Crnic, K. (1989). Psychological predictors of adjustment by siblings of developmentally disabled children. *American Journal on Mental Retardation*, *94*(3), 292–302.
9. Engel-Yeger, B., Jarus, T., Anaby, D., & Law, M. (2009). Differences in patterns of participation between youths with cerebral palsy and typically developing peers. *American Journal of Occupational Therapy*, *63*(1), 96–104.
10. Giallo, R., & Gavidia-Payne, S. (2006). Child, parent and family factors as predictors of adjustment for siblings of children with a disability. *Journal of Intellectual Disability Research*, *50*(12), 937–948.
11. Hauser-Cram, P., Warfield, M., Shonkoff, P., & Krauss, W. (2001). Children with disabilities: A longitudinal study of child development and parent well-being. *Monographs of the Society for Research in Child Development*, *66*(3), 1–114.
12. Hoffman, L., Marquis, J., Poston, D., Summers, J. A., & Turnbull, A. (2006). Assessing Family Outcomes: Psychometric Evaluation of the Beach Center Family Quality of Life Scale. *Journal of Marriage and Family*, *68*(4), 1069–1083.
13. Hu, X., Summers, J. A., Turnbull, A., & Zuna, N. (2011). The quantitative measurement of family quality of life: A review of available instruments. *Journal of Intellectual Disability Research*, *55*(12), 1098–1114.

14. Imms, C., Reilly, S., Carlin, J., & Dodd, K. (2008). Diversity of participation in children with cerebral palsy. *Developmental Medicine & Child Neurology*, *50*(5), 363–369.
15. Jorge, B. M., Levy, C. C. A. da C., & Granato, L. (2015). Cultural Adaptation Quality of Family Life Scale for the Brazilian Portuguese. *CoDAS*, *27*(6), 534–540.
16. Khetani, M., Marley, J., Baker, M., Albrecht, E., Bedell, G., Coster, W., … Law, M. (2014). Validity of the Participation and Environment Measure for Children and Youth (PEM-CY) for Health Impact Assessment (HIA) in sustainable development projects. *Disability and Health Journal*, *7*(2), 226–235.
17. King, G., Law, M., Hanna, S., King, S., Hurley, P., Rosenbaum, P., … Petrenchik, T. (2006). Predictors of the Leisure and Recreation Participation of Children With Physical Disabilities: A Structural Equation Modeling Analysis. *Children's Health Care*, *35*(3), 209–234.
18. King, G., Law, M., Hurley, P., Petrenchik, T., & Schwellnus, H. (2010). A Developmental Comparison of the Out-of-school Recreation and Leisure Activity Participation of Boys and Girls With and Without Physical Disabilities. *International Journal of Disability, Development and Education*, *57*(1), 77–107.
19. King, G., Law, M., King, S., Rosenbaum, P., Kertoy, M. K., & Young, N. L. (2003). A Conceptual Model of the Factors Affecting the Recreation and Leisure Participation of Children with Disabilities. *Physical & Occupational Therapy in Pediatrics*, *23*(1), 63–90.
20. Law, M., Anaby, D., Teplicky, R., Khetani, M. A., Coster, W., & Bedell, G. (2013). Participation in the home environment among children and youth with and without disabilities. *British Journal of Occupational Therapy*, *76*(2), 58–66.
21. Law, M., Finkelman, S., Hurley, P., Rosenbaum, P., King, S., King, G., & Hanna, S. (2004). Participation of Children with Physical Disabilities: Relationships with Diagnosis, Physical Function, and Demographic Variables. *Scandinavian Journal of Occupational Therapy*, *11*(4), 156–162.
22. Law, M., King, G., King, S., Kertoy, M., Hurley, P., Rosenbaum, P., … Hanna, S. (2006). Patterns of participation in recreational and leisure activities among children with complex physical disabilities. *Developmental Medicine & Child Neurology*, *48*(5), 337–342.
23. Majnemer, A., Shevell, M., Law, M., Birnbaum, R., Chilingaryan, G., Rosenbaum, P., & Poulin, C. (2008). Participation and enjoyment of leisure activities in school-aged children with cerebral palsy. *Developmental Medicine & Child Neurology*, *50*(10), 751–758.
24. Mc Manus, V., Corcoran, P., & Perry, I. J. (2008). Participation in everyday activities and quality of life in pre-teenage children living with cerebral palsy in South West Ireland. *BMC Pediatrics*, *8*, 50.
25. Michelsen, S. I., Flachs, E. M., Uldall, P., Eriksen, E. L., McManus, V., Parkes, J., … Colver, A. (2009). Frequency of participation of 8–12-year-old children with

cerebral palsy: A multi-centre cross-sectional European study. *European Journal of Paediatric Neurology*, *13*(2), 165–177.

26. Milićević, M. (2017). Faktorska struktura skale porodičnog kvaliteta života: komparativna studija porodica sa detetom s cerebralnom paralizom i porodica sa detetom tipičnog razvoja. U M. Šćepanović (Ur.), *Zbornik radova 11. međunarodne konferencije "Socijalna inkluzija osoba sa invaliditetom: značaj i programi podrške"* (str. 48–58). Novi Sad: Društvo defektologa Vojvodine.
27. Park, J., Hoffman, L., Marquis, J., Turnbull, A. P., Poston, D., Mannan, H., … Nelson, L. L. (2003). Toward assessing family outcomes of service delivery: validation of a family quality of life survey. *Journal of Intellectual Disability Research*, *47*(4–5), 367–384. https://doi.org/10.1046/j.1365-2788.2003.00497.x
28. Parpa, E., Katsantonis, N., Tsilika, E., Galanos, A., Sassari, M., & Mystakidou, K. (2016). Psychometric Properties of the Family Quality of Life Scale in Greek Families with Intellectual Disabilities. *Journal of Developmental and Physical Disabilities*, *28*(3), 393–405.
29. Smith-Bird, E., & Turnbull, a. P. (2005). Linking Positive Behavior Support to Family Quality-of-Life Outcomes. *Journal of Positive Behavior Interventions*, *7*(3), 174–180.
30. Summers, J. A., Hoffman, L., Marquis, J., Turnbull, A., Poston, D., & Nelson, L. L. (2005). Measuring the Quality of Family?Professional Partnerships in Special Education Services. *Exceptional Children*, *72*(1), 65–81.
31. Summers, J. A., Poston, D. J., Turnbull, A. P., Marquis, J., Hoffman, L., Mannan, H., & Wang, M. (2005). Conceptualizing and measuring family quality of life. *Journal of Intellectual Disability Research*, *49*(10), 777–783.
32. Van Riper, M., Ryff, C., & Pridham, K. (1992). Parental and family well-being in families of children with down syndrome: A comparative study. *Research in Nursing* & *Health*, *15*(3), 227–235.
33. WHO. (2001). *International Classification of Functioning Disability and Health (ICF)*. Geneva: World Health Organization.
34. WHO. (2007). *International Classification of Functioning, Disability and Health – Children and Youth Version (ICF-CY)*. Geneva: World Health Organization.
35. World Health Organization. (2004). *International statistical classification of diseases and related health problems (ICD10)*. Geneva: World Health Organization.

udc 376.112.4
316.356.2
616.831-009.11

Odabir komunikacionog pristupa u odnosu između defektologa i roditelja

Nikola Babić
Visoka zdravstvena škola strukovnih studija u Beogradu, Srbija
Danka M. Radulović, Snežana J. Nikolić
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Predmet: *Komunikacija između defektologa i roditelja deteta sa cerebralnom paralizom zahteva visok nivo kompetentnosti i potrebno je da bude prožeta motivisanjem roditelja za aktivno učešće u habilitacionom tretmanu. Cilj rada je da se na osnovu pregleda dostupne literature postavi polazna osnova za pospešenje komunikacije na relaciji između defektologa i roditelja, koja će se posmatrati kroz prizmu načina odabira habilitacionih ciljeva. Iznete su pretpostavke o adekvatnosti odabira određenog komunikacionog pristupa u odnosu na komunikacione potrebe roditelja.*

Metod: *Na osnovu proučavanja dostupne literature, u svrhu definisanja komunikacionog pristupa defektologa, predlaže se upotreba edukativnih stilova postavljenih od strane Baumrind i određivanje komunikacionih pristupa vođenja, saradnje i na kraju podrške, odnosno autoritativosti, kooperativnosti i suportivnosti. Adekvatnim odabirom komunikacionog pristupa podstiče se progresija ka sve većem stepenu učešća roditelja u postavljanju habilitacionih ciljeva. Sa druge strane, pretpostavlja se da komunikacione potrebe roditelja koreliraju sa stadijumima prihvatanja ometenosti deteta od strane roditelja. Stadijumi prihvatanja ometenosti definisani su o odnosu na stadijume žaljenja iznete od strane Kubler Ros, a elaborirane u svrhu rada sa decom ometenom u razvoju od strane Huber.*

Zaključak: *Predlog je da se odabir komunikacionog pristupa vrši u odnosu na stadijum prihvatanja na kome se roditelj nalazi, ali je neizostavno zapažanje moguće dvosmernosti u uticajima – adekvatno odabran komunikacioni pristup trebalo bi da doprinese uspostavljanju višeg stadijuma prihvatanja ometenosti deteta. Pored eventualnog doprinosa u oblasti rada sa roditeljima dece sa cerebralnom paralizom, pretpostavka je da bi se ovakav pristup mogao implementirati i u rad sa roditeljima dece čiji je razvojni tok narušen dejstvom različitih činilaca, bez isključivosti postavljanja fokusa na motoričke poremećaje kao dominantne.*

Ključne reči: *prihvatanje ometenosti, komunikacioni pristup, cerebralna paraliza, komunikacija defektolog – roditelj*

UVOD

Suočavanje sa postojanjem ometenosti deteta predstavlja ogroman izazov kako za roditelja, tako i za funkcionisanje cele porodice. Ovaj izazov se ne umanjuje u protoku vremena. Naprotiv, istraživanje javljanja stresnih situacija u različitim životnim dobima ukazuje na to da period adolescencije ometenog deteta produkuje najteži period stresa (Kandel & Merrick, 2007).

Shodno činjenici da su i prihvatanje ometenosti deteta od strane roditelja, kao i interpersonalna komunikacija dinamični procesi, nastojanje je da se postavi okvir unutar koga će se sa najvećim stepenom efikasnosti uticati na motivisanost roditelja i na adekvatno postavljanje i ostvarenje rehabilitacionih ciljeva.

Posmatajući rezultate istraživanja na temu komunikacionih potreba roditelja dece sa cerebralnom paralizom sprovedenih od strane Krujsten-Terpstre i saradnika (Kruijsen-Terpstra et al., 2016), pretpostavka je da se kroz edukativne stilove iznete od strane Baumrindove (Baumrind, 1987, prema Đigić, 2013) mogu zadovoljiti komunikacione potrebe roditelja koji su na različitim stadijumima prihvatanja ometenosti deteta.

CILJ

Pisanje ovog rada ima za cilj pospešenje komunikacije u toku inicijalnih kontakata defektologa sa roditeljima dece ometene u razvoju. Polazeći od toga da odnos roditelja prema ometenosti deteta u značajnom meri utiče na tok rehabilitacionog procesa, svaki trud uložen u prilagođenost komunikacije stadijumu prihvatanja ometenosti smatra se opravdanim.

METOD

Iznalaženje predloga za pospešenje komunikacije između defektologa i roditelja baziralo se na proučavanju literature dostupne pregledom elektronskih baza podataka Konzorcijuma biblioteka Srbije za objedinjenu nabavku (KOBSON). Pri pretraživanju korišćene su sledeće ključne reči: parent-therapist communication, cerebral palsy, parental disability acceptance, stages of acceptance, educational styles.

REZULTATI

Rezultati pregleda literature prezentovani su kroz oblasti Prihvatanja ometenosti deteta i definisanje Komunikacionih pristupa.

Prihvatanje ometenosti deteta i stadijumi prihvatanja

Sam proces prihvatanja ometenosti deteta određen je velikim brojem činilaca. Rentink, Ketelar, Jongmans i Gorter su sve faktore koji utiču na proces prihvatanja ometenosti deteta podelili u četiri oblasti: karakteristike deteta, karakteristike roditelja, kontekstualna podrška i stadijum porodičnog života (Rentinck, Ketelaar, Jongmans & Gorter, 2006).

Huber 1979. godine navodi pet stadijuma kroz koje se prolazi u toku samog procesa prihvatanja ometenosti deteta: poricanje, bes, nagađanje, depresija i prihvatanje (Huber, 1979, prema Hodapp, 2011).

U toku prvog stadijuma roditelji ne mogu da se nose sa informacijom da će njihovo dete imati atipičan razvojni tok. Drugi je stadijum besa koji se može ispoljiti otvorenom manifestacijom besa, gnevom, zavisti. Nagađanje kao stadijum podrazumeva iracionalno vraćanje na momente u vremenu za koje je roditelj ubeđen da su mogli da budu prekretnica u razvojnom toku deteta. Stadijum depresije podrazumeva da se kod roditelja razvija duboki osećaj praznine i tuge. Poslednji je stadijum prihvatanja, u kome postoji svest o tome da je ometenost deteta postala deo svakodnevnice koji utiče na planove za budućnost (Hodapp, 2011).

Posmatrajući promenljivost stadijuma u protoku vremena, Huber navodi i da osciliranje u stadijumima prihvatanja ometenosti mora biti uvaženo (Huber, 1979, prema Ziolko, 1991).

Kandel i Merik navode četiri karakteristike procesa prihvatanja ometenosti: Prikladno opažanje veština i mogućnosti ometenog deteta, uz uvažavanje detetovih slabosti i ograničenja; Realističan pogled na dete, uz uvažavanje komplikacija koje su nastale unutar porodice; Angažovanje roditelja u razumnoj potrazi za servisima podrške; Mogućnosti roditelja da pruži ljubav ometenom detetu, bez osećaja odbacivanja ili prezaštićenosti deteta, uz postojanje svesti da ovakva privrženost ne uskraćuje pažnju ostalim članovima porodice (Kandel & Merrick, 2007).

Stadijum prihvatanja ometenosti deteta, kao najviši stadijum, nije uvek dostižan i njegovo uspostavljanje postavlja se kao cilj čijem dosezanju svaki pojedinac i celokupna društvena zajednica treba da daju doprinos.

Komunikacioni pristupi

Komunikacioni tok: autoritativnost-kooperativnost-suportivnost odnosno vođenje, saradnja i podrška postavljaju se kao sled u habilitacionom procesu dece sa cerebralnom paralizom. Svaka od ovih etapa podrazumevala bi komunikacioni pristup kojim defektolog stupa u komunikaciju sa roditeljima. Favorizovanje pojedinog polazišta umanjivaće se u jedinici vremena, u skladu sa prihvatanjem aktivnog učešća roditelja u rehabilitacionom tretmanu.

Vođenje – autoritativnost

Autoritativnost u komunikaciji terapeut – roditelj proizilazi iz inicijalne nesigurnosti i neinformisanosti roditelja sa jedne strane, i svakodnevnih susreta stručnjaka sa habilitaciono/rehabilitacionim potrebama roditelja dece sa cerebralne paralize sa druge.

Autoritativnost u momentima prvih susreta sa ometenošću može biti prihvatana kao „stručno vođenje” i olakšanje pri susretu sa visokim stepenom odgovornosti postavljenim pred roditelje deteta ometenog u razvoju. Pri tome, neophodna je svest defektologa o tome da je autoritativnost samo komunikaciono polazište. Autoritet sam po sebi biva neosnovan s obzirom na velik broj roditeljevih interpersonalnih relacija, ograničen direktan pristup okolnostima detetove svakodnevnice i na moralnu neadekvatnost postavljanja rehabilitacionih ciljeva kao prioritetnih ispred ciljeva deteta, detetove porodice i društvene sredine u kojoj dete živi (Feinstein, Fielding, Udvari-Solner & Joshi, 2009). Knežević-Florić navodi da idealnu govornu situaciju karakterišu: oformljenje iskaza koji je u skladu sa preovlađujućim socijalnim ili kulturnim normama, adekvatne gramatičke konstrukcije koje obezbeđuju razumljivost, i postignut utisak iskrenosti (Knežević-Florić, 2006).

Neretko, iako poželjna u inicijalnim kontaktima, autoritativnost u komunikacionoj dinamici ima tendenciju fiksacije i na taj način može negativno uticati na dalji tok tretmana.

Saradnja – kooperativnost

„Tek u ravni empatijske komunikacije možemo govoriti o uspešnom pedagoškom delovanju” (Kamenarac, O. 2009, str. 47). Za roditelje koji problemu svog deteta prilaze sa stadijuma nagađanja, defektolog prenosi poruku da mu je potrebna pomoć u rešavanju konkretnog problema. Na ovaj način defektolog se postavlja u ravan sa roditeljem.

Kooperativnost definisana kao proces razvijanja efikasnog odnosa u postavljanju i postizanju zajedničkih ciljeva, posmatra se kao ključni koncept pružanja usluga detetu sa cerebralnom paralizom i njegovoj porodici (King & Chiarello, 2014).

Kruijsen-Terpstra i saradnici komunikaciju posmatraju kao deo procesa osnaživanja roditelja koji će voditi većem stepenu uključivanja roditelja u rehabilitacioni proces, i samim tim efikasnijem sprovođenju tretmana. Ključne karakteristike na kojima roditelji temelje pozitivnost iskustva u kontaktu sa defektolozima su posvećivanje pažnje i iskrenost (Kruijsen-Terpstra et al., 2016).

Sa aspekta zajedničkog determinisanja ciljeva habilitacije, neizostavno je zapažanje da sa razvojem kompetencija vremenom dolazi do preklapanja očekivanja roditelja i mogućnosti deteta.

Podrška – suportivnost

U kasnijim fazama habilitaciono/rehabilitacionog procesa, kada se očekivanja roditelja poklapaju sa spektrom detetovih mogućnosti, zadatak defektologa postaje da sa svog delokruga rada, shodno interesovanjima i mogućnostima roditelja i deteta, pruži smernice daljeg angažovanja. U prvi plan postavljaja se informisanost defektologa, kako o mogućnostima unutar društvene zajednice, tako i o aktuelnostima iz ove oblasti u svetu. Takođe, neretko su roditelji ti koji dolaze do informacija o programima i organizovanim aktivnostima za decu sa cerebralnom paralizom. U ovim situacijama zadatak defektologa je da se uputi u dostupne programe i skrene pažnju na moguće prednosti jednih u odnosu na druge.

DISKUSIJA

U pojedinim zemljama praksa je da se sa roditeljem malog deteta sa cerebralnom paralizom komunicira putem vođenja dnevnika od strane roditelja, odakle proizilazi osnovna zamerka – izostanak situacije u kojoj bi defektolog saslušao roditelja. S druge strane, posmatrajući pritiske vremena u uslovima rada u našim ustanovama, i ovakav pristup verovatno bi bio okarakterisan kao napredak.

U višim stadijumima prihvatanja ometenosti deteta, komunikacione potrebe roditelja ostaju nedovoljno istražene, zajedno sa malobrojnim istraživanjima na temu primera dobrih strategija prevazilaženja kriza koje se odnose na ometenost. Objašnjenje verovatno leži u stavu stručnjaka da pobuđivanje sumnje roditelja u adekvatnost habilitacionih ciljeva opravdava odabiranje pasivne pozicije.

Neophodno je napomenuti da pojedini autori dovode u sumnju postojanje sekvencionalnih stadijuma u procesu prihvatanja ometenosti deteta (Blacher, 1984). Međutim, shodno mogućem doprinosu formiranju pozitivnog odnosa prema habilitacionom procesu, uzimanje stadijuma prihvatanja ometenosti kao polazišta u komunikaciji smatra se opravdanim.

ZAKLJUČAK

Predlog je da se odabir komunikacionog pristupa vrši u odnosu na stadijum prihvatanja na kome se roditelj nalazi. Takođe, neizostavno je zapažanje moguće dvosmernosti u uticajima – adekvatno odabran komunikacioni pristup trebalo bi da doprinese uspostavljanju višeg stadijuma prihvatanja ometenosti deteta.

Shodno heterogenosti populacije dece sa cerebralnom paralizom i različitim potrebama roditelja koje se menjaju tokom vremena, najčešće nije moguće povući preciznu demarkacionu liniju između komunikacionih pristupa, ali uvid u postojanje navedenog sleda svakom prilikom ostvaruje uticaj na odnos roditelja ometenog deteta prema prema habilitacionom tretmanu.

Buduća istraživanja mogla bi da daju potkrepljenje navedenom pristupu u komunikaciji između defektologa i roditelja dece sa cerebralnom paralizom.

LITERATURA

Blacher, J. (1984) Sequential Stages of Parental Adjustment to the Birth of a Child with Handicaps: Fact or Artifact?. *Mental Retardation*, *22*(2), 55-68.

Đigić, G. (2013) Ličnost nastavnika i stilovi upravljanja razredom, doktorska disertacija, Univerzitet u Nišu, Filozofski fakultet, departman za psihologiju.

Feinstein, N., Fielding, K., Udvari-Solner, A., Joshi, S. (2009). The Supporting Alliance in Child and Adolescent Treatment: Enhancing Collaboration Among Therapists, Parents, and Teachers. *American Journal of Psychotherapy*, *63*(4), 319-344.

Hodapp, R. (2011) International Review of Research in Developmental Disabilities, Vol 41, Elsevier.

Kamenarac, O. (2009) *Razvoj komunikacijskih komptencija – potreba i nužnost*. Monografija, Zadužbina Andrejević, Beograd.

Kandel, I., Merrick, J. (2007) The Child With a Disability: Parental Acceptance, Management and Coping. *The Scientific World Journal*, *7*, 1799–1809.

King, G., Chiarello, L. (2014) Family-Centered Care for Children With Cerebral Palsy: Conceptual and Practical Considerations to Advance Care and Practice, *Journal of Child Neurology*, *29*(8), 1046-1054.

Knežević-Florić, O. (2006) Pretpostavke teorije komunikativne akcije kao moguća osnova pedagoške komunikacije, u *Razvijanje komunikacionih kompetencija nastavnika i učenika,* Zbornik radova sa međunarodne naučne konferencije održane 23-24. septembra 2005. godine na Učiteljskom fakultetu u Jagodini, Pedagoški fakultet.

Kruijsen-Terpstra, A., Verchuren, O., Katelaar, M., Riedijk, L., Gorter, J. W., Jongmas, M. J., Boeije, H. (2016) Parents' experiences and needs regarding physical and occupational therapy for their young children with cerebral palsy. *Research in Developmental Disabilities*, *53*(1), 314–322.

Rentinck, I. C. M., Ketelaar, M., Jongmans M. J., Gorter, J. W. (2006) Parents of children with cerebral palsy:a review of factors related to the process of adaptation. *Child: Care, Health* & *Development*, *33*(2), 161-169.

Ziolko, M. E. (1991) Counseling Parents of Children with Disabilities: A Review of the Literature and Implications for Practice. *The Journal of Rehabilitation, 57*(2), 29-34.

COMMUNICATIONAL STANDPOINT SELECTION IN REHABILITATOR – PARENT RELATION

Nikola Babić*, Danka M. Radulović**, Snežana J. Nikolić**
*Higher Education School of Professional Health Studies in Belgrade, Serbia
**University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: Communication between rehabilitators and parents of children with cerebral palsy has to be accompanied with empathy and has to enhance parents' motive for taking active participation in a rehabilitation process.

Method: The aim of this paper is to, based on a review of available literature, set a starting point for enhancing communication between parents and rehabilitators, and that is to be viewed through the process of selecting rehabilitation goals. This paper shows assumptions on the possibility of selecting a particular communicational standpoint on the basis of communication needs of parents.

Results: For the purpose of defining a communicational standpoint, the use of Baumrinds educational styles is proposed, including authoritative, cooperative and, ultimately, supportive approach. The specified communicational standpoints characteristic is that they progressively increase the level of participation of parents in the rehabilitation goals setting. On the other hand, the communication needs of parents are assumed to be correlated with the stages of acceptance of child disability by the parents. The stages of acceptance, derived from the stages of mourning as presented by Kübler-Ross, were later elaborated by Huber in order to work with children with disabilities.

Conclusion: It is suggested that the choice of a communicational standpoint should be made with respect to the stage of parental acceptance of child disability, with an inevitable observation of the possible duality in influences – an adequately chosen communication standpoint should contribute to the establishment of a higher stage of child disability acceptance. Beside the possible contributions in the field of working with parents of children with cerebral palsy, the assumption is that the approach presented in this paper could be implemented in working with parents of children whose developmental course was affected by various factors, without excluding other conditions where a motor disorder is not dominant.

Key words: disability acceptance, communicational standpoint, cerebral palsy, parent – rehabilitator communication

udc 316.356.2
305-055.2
316.624

Evaluacija programa podrške za mlade očeve

Marina Kovačević-Lepojević, Milica Kovačević, Marija Maljković
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Predmet istraživanja: *U skladu sa dosadašnjom teorijom i praksom prevencije poremećaja ponašanja, primena programa podrške maloletnim majkama pre/posle porođaja nalazi svoje mesto. Sa druge strane, izveštava se o sporadičnoj primeni intervencija usmerenih na mlade očeve (u adolescenciji), njihove probleme i potrebe. Istraživački nalazi ukazuju na to da mladi očevi u odnosu na njihove vršnjake koji nisu očevi češće imaju loš školski uspeh, nizak socioekonomski status, zloupotrebljavaju psihoaktivne supstance, ispoljavaju delinkventno ponašanje i slično. Očinstvo uz to nosi čitav niz problema, kako ekonomskih, tako i onih koji se tiču komunikacije sa partnerkom, multigeneracijskom porodičnom strukturom, stigmatizacijom od strane zajednice i drugo. Posebno, izdvajaju se problemi motivisanja mladih očeva za učešće u različitim socijalnim programima.*

Metod: *Cilj istraživanja predstavlja pregled i analizu naučne literature o programima podrške koji su namenjeni mladim očevima i njihove evaluacije.*

Rezultati: *Rezultati evaluacionih studija ukazuju na to da su mladi očevi koji su prošli programe podrške uključeniji, angažovaniji i pozitivno emocionalno reaktivniji u odnosu prema [1]svojoj deci u poređenju sa kontrolnom grupom. Preporučuje se da bi programi usmereni na podršku mladim očevima trebalo da uključe i njihove partnerke, da traju do 5 nedelja, da budu zasnovani na individualnom pre nego grupnom radu, da uključuju i pomoć pri zaposlenju i drugo.*

Zaključak: *Prenatalni programi unapređivanja veština roditeljstva namenjeni mladim očevima i majkama ostvaruju značajne rezultate.*

Ključne reči: *mladi očevi, prevencija, poremećaji ponašanja, programi*

UVOD – RIZICI OČINSTVA U ADOLESCENCIJI

U sklopu nacionalne longitudinalne studije o radnom iskustvu mladih od oko 6400 mladih, 367 (5,7%) je imalo decu pre 19. godine (Elster, Lamb & Tavare,

---

[1] Rad je nastao u okviru projekta „Kriminal u Srbiji: fenomenologija, rizici i mogućnost socijalne intervencije", broj 47011 koji finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

1987). Istraživački nalazi ukazuju na to da stopa rađanja u adolescenciji ima tendenciju opadanja (Santelli, Song, Garbers, Sharma & Viner, 2017). Naime, u 142 zemlje u periodu od 22 godine beleži se snažno opadanje, i to sa 72.4/1000 u 1990. godini na 43.6/1000 u 2012. godini. U 2012. godini najmanja stopa rađanja od 15 do 19 godina bila je u zapadnoj Evropi i centralnoj Aziji, a najviša u subsaharskoj Africi. Najveće opadanje zabeleženo je u južnoj Aziji (70%), Evropi i centralnoj Aziji (63%) i na Srednjem istoku i severnoj Africi (53%). Autori opadanje objašnjavaju porastom socioekonomskog statusa i snižavanjem socijalnih nejednakosti, što se odražava na unapređivanje obrazovnog i zdravstvenog sistema (Santelli et al., 2017). Prema podacima Gradskog zavoda za javno zdravlje (2017) u Beogradu je u 2014. godini rođeno 25 dece čije su majke imale ispod 15 godina, a 422 dece čije su majke imale od 16 do 18 godina. Maloletne majke činile su 0,8% od ukupnog broja porodilja. Podaci Republičkog zavoda za statistiku RS (2017) ukazuju na stopu rođene dece majki od 15-19 godina od 17.8/1000.

Mladi očevi najčešće nisu dovoljno spremni za adekvatno učešće u životima svoje dece i to iz najrazličitijih razloga: materijalne prirode (najčešće nisu zaposledni), nedostatka znanja o razvoju deteta, loših odnosa sa majkom svoga deteta i njenim roditeljima i drugo (Elster et al., 1987; Beers & Hollo, 2009). U poređenju sa vršnjacima koji nisu imali decu, mladi očevi su u mnogo većoj meri imali loš školski uspeh, živeli su u jednoroditeljskim porodicama slabog socioekonomskog statusa, zloupotrebljavali su psihoaktivne supstance i ispoljavali delinkventno ponašanje (Elster et al., 1987).

Rezultati petogodišnje longitudinalne studije kojom je praćen 531 maloletni delinkvent po izlasku iz ustanove ukazuju na pet ključnih prediktora očinstva pre 20. godine i to: priključivanje gangu, život sa nebiološkim roditeljem, nizak socioekonomski status, alkoholizam roditelja, nizak obrazovni status majke i osuđenost nekog od članova porodice (Unruh, Bullis & Yovanoff, 2004). Istraživački nalazi ukazuju na to da je među maloletnim delinkventima 25-28% onih koji imaju bar jedno dete, što je nekoliko puta više u odnosu na opštu populaciju (Unruh et al., 2004). Uključivanje populacije delinkvenata u programe je veoma značajno u kontekstu rane prevencije antisocijalnog ponašanja njihove dece. Studija u kojoj je proučavano transgeneracijsko prenošenje kriminalnog ponašanja ukazuje na to da je trauma koju su iskusili dečaci koji su u prvih deset godina iskusili separaciju usled roditeljske odsutnosti povodom izvršenja kazne zatvora mnogo značajniji prediktor svih 14 ispitivanih oblika antisocijalnog i delinkventnog ponašanja u odnosu na druge vrste separacija (Murray & Farrington, 2005).

Evaluacija programa za mlade očeve

Mladim roditeljima nedostaju kako roditeljske veštine, tako i veštine u vezi sa obrazovanjem i zaposlenjem (učenje, traženja posla), veštine komunikacije sa partnerkom i njenim/svojim roditeljima. U odnosu na kontekst primene autori izdvajaju četiri vrste programa za rad sa mladim očevima, i to: u školi, putem kućnih poseta, u zajednici i zdravstvenim ustanovama (Beers & Hollo, 2009). Prednost školskih programa sastoji se u dostupnosti polaznika, što je i nedostatak jer isključuje one koji su već napustili školovanje. Programi koji se realizuju kroz kućne posete su obično dosta intenzivniji i pružaju najširi spektar usluga (podrška pedijatrijske službe, podrška roditeljstvu, mentorski rad sa članovima porodice). Programi koji se primenjuju u zajednici zasnovani su na intervencijama vođenja slučaja i grupnom treningu roditeljskih veština. U sklopu zdravstvenog sistema izdvajaju se ustanove koje pružaju pomoć i podršku i adolescentima i njihovoj deci (Beers & Hollo, 2009).

Involviranost mladih očeva u rizična seksualna ponašanja, zloupotrebu psihoaktivnih supstanci, nasilno ponašanje zahteva poseban tip intervencija (Beers & Hollo, 2009). Kvalitativna studija bazirana na intervjuu sa sedam mladih očeva delinkvenata je pokazala da su motivisani da budu dobri očevi i da su im za to najveće prepreke: komunikacija sa majkama svoje dece, materijalni resursi, kao i nedostatak muškog uzora. Autori sugerišu da dete može predstavljati važan resurs za distanciranje od kriminalnog ponašanja (Shannon & Abrams, 2007).

Među programima koji su namenjeni mladim očevima izdvajaju se oni koji su usmereni na širi spektar psihosocijalnih intervenicja i oni koji su usmereni isključivo na unapređivanje roditeljskih veština. Na osnovu evaluacione studije programa u koji je bilo uključeno 60 mladih očeva Afroamerikanaca izdvajaju se najvažniji rezultati: veća stopa završetka škole i zaposlenja; usvajanje veština kratkoročnog i dugoročnog planiranja karijere; korišćenje kontracepcije; razvijanje pozitivnog odnosa sa svojom decom i prijateljima; posmatranje sebe kao odgovorne osobe i drugo (Mazza, 2002). Od programa koji je bio namenjen unapređivanju roditeljskih veština izdvaja se Minnesota Early Learning Design program (MELD) u kome je učestvovalo 46 mladih očeva koji su prema rezultatima evaluacije unapredili svoje koroditeljske veštine (Fagan, 2008). Istraživački nalazi ukazuju na to da su rezultati programa za mlade očeve mnogo bolji ako su u programima učestvovali zajedno sa svojim partnerkama, i to bez obzira na strukturu, socioekonomski status porodice i etničku pripadnost (Cowan, Cowan, Pruett, Pruett & Wong, 2009).

Retke su evaluacione studije programa koji su namenjeni maloletnim delinkventima. Autori su izdvojivši 12 studija koje su obuhvatale maloletne delinkvente očeve (10 u Velikoj Britaniji i 2 u SAD) ukazali na to da je najveći broj uključivao edukaciju u vezi sa seksualnim obrazovanjem, razvojem deteta i veštine traženja pomoći u ostvarivanju svojih prava, dok je manji broj uključivao trening roditeljskih veština (Buston, Parkes, Thomson, Wight & Fenton, 2012). S obzirom da dizajn evaluacija ne samo da nije bio eksperimentalni nego čak nije postojala nikakva kontrolna grupa može se prokomentarisati da su učesnici generalno bili zadovoljni programom (Buston et al., 2012).

Autori navode razloge za probleme u realizaciji programa za mlade očeve (Kiselica & Kiselica, 2014). Prvo, mnogi programi namenjeni mladim očevima zapravo su gruba replikacija programa koji su namenjeni mladim majkama, te nisu u mogućnosti da odgovore na individualne potrebe očeva. Zatim, programe su realizovali stručnjaci koji su svoje usluge pružali u radno vreme što nije prilagođeno adolescentima čije su krizne situacije zahtevale konstantnu podršku. Strah od sankcije zbog upuštanja u vezu sa maloletnicom odvraća mlađe punoletnike od javljanja za pomoć bez obzira na odnose sa majkom deteta (Kiselica & Kiselica, 2014).

ZAKLJUČAK

Na osnovu navedenog uočava se: da se očevi suočavaju sa brojnim izazovima od teške materijalne situacije, preko emocionalnih problema do delinkventnog ponašanja; da izostaju programi podrške specijalno dizajnirani za potrebe mladih očeva kako u opštoj populaciji, tako i u populaciji adolescenata manjinske etničke pripadnosti i populaciji maloletnih delinkvenata; da postoje mnogi strukturalni problemi u realizaciji programa; kao i da su dostupne evaluacione studije programa za mlade očeve nezadovoljavajućeg kvaliteta.

Preporučuje se da bi programi za mlade očeve trebalo da osim usvajanja roditeljskih veština trebalo da uključe i oblast afektivnog vezivanja u cilju razvijanja adekvatnog odnosa sa detetom. Zatim, trening podrške majkama bi trebalo da bude sastavni deo programa za mlade očeve (npr. veštine aktivnog slušanja, značaj prisustva na porođaju). Pored roditeljstva, programi bi trebalo da budu usmereni i na obrazovanje, zapošljavanje mladih očeva. S obzirom na specifičnost romske populacije u kontekstu običaja ranog stupanja u seksualne odnose i brak trebalo bi razviti posebne preventivne programe za adolescente romske nacionalnosti. Maloletni delinkventi očevi su vrlo izazovna populacija što zahteva visoku specijalizaciju programa. Na kraju, trebalo bi raditi na unapređivanju kvaliteta primene i evaluacije programa kako bi dobri programi bili što uspešnije replicirani.

LITERATURA

1. Beers, L. A. S., & Hollo, R. E. (2009). Approaching the adolescent-headed family: A review of teen parenting. *Current Problems in Pediatric and Adolescent Health Care, 39*(9), 216-233.
2. Buston, K., Parkes, A., Thomson, H., Wight, D., & Fenton, C. (2012). Parenting interventions for male young offenders: A review of the evidence on what works. *Journal of adolescence, 35*(3), 731-742.
3. Cowan, P. A., Cowan, C. P., Pruett, M. K., Pruett, K., & Wong, J. J. (2009). Promoting fathers' engagement with children: preventive interventions for low-income families. *Journal of Marriage and Family, 71*(3), 663-679.
4. Elster, A. B., Lamb, M. E., & Tavare, J. (1987). Association between behavioral and school problems and fatherhood in a national sample of adolescent youths. *The Journal of Pediatrics, 111*(6), 932-936.

5. Fagan, J. (2008). Randomized study of a prebirth coparenting intervention with adolescent and young fathers. *Family Relations: An Interdisciplinary Journal of Applied Family Studies*, *57*, 309–323.
6. Gradski zavod za javno zdravlje (2017). Prikaz broja porođaja i rođene dece u 2014. u Beogradu. Beograd: Gradski zavod za javno zdravlje. Preuzeto sa: http://www.zdravlje.org.rs/index.php/izvestaji/centar-za-informatiku-i-biostatistiku-u-zdravstvu
7. Mazza, C. (2002). Young dads: The effects of a parenting program on urban African-American adolescent fathers. *Adolescence,* 37, 681–693.
8. Murray, J., & Farrington, D. P. (2005). Parental imprisonment: effects on boys' antisocial behaviour and delinquency through the life-course. *Journal of Child Psychology and psychiatry, 46*(12), 1269-1278.
9. Republički zavod za statistiku (2017). Statistički godišnjak Republike Srbije 2015. Beograd: Republički zavod za statistiku. Preuzeto sa: http://webrzs.stat.gov.rs/WebSite/userFiles/file/Aktuelnosti/StatGod2015.pdf
10. Santelli, J. S., Song, X., Garbers, S., Sharma, V., & Viner, R. M. (2017). Global Trends in Adolescent Fertility, 1990–2012, in Relation to National Wealth, Income Inequalities, and Educational Expenditures. *Journal of Adolescent Health, 60*(2), 161-168.
11. Shannon, S., & Abrams, L. (2007). Juvenile offenders as fathers: Perceptions of fatherhood, crime and becoming an adult. *Families in Society: The Journal of Contemporary Social Services, 88*(2), 183-191.
12. Unruh, D., Bullis, M., & Yovanoff, P. (2004). Adolescent fathers who are incarcerated juvenile offenders: Explanatory study of the co-occurrence of two problem behaviors. *Journal of Child and Family Studies, 13*(4), 405-419.

EVALUATION YOUNG FATHERS SUPPORT PROGRAMS

Marina Kovačević-Lepojević, Milica Kovačević, Marija Maljković
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: In accordance with current theory and practice of the prevention of conduct disorders, prebirth/afterbirth programs for underage mothers find their place. On the other hand, there are sporadic implementation of interventions aimed at young fathers (in adolescence), their problems and needs. The research findings indicate that young fathers in relation to their peers which are not fathers tend to have poor academic success, low socioeconomic status, substance abuse, delinquent behavior, etc. Fatherhood also carries a range of problems, both economic and those related to communication with partner, multi-generational family structure, stigmatization by the community and more. In particular, it's hard to motivate young fathers to participate in social programs.

Method: The research is aimed to summarize the scientific knowledge on young fathers support programs and evaluate their main effects.

Results: The results of evaluation studies suggest that young fathers who have gone through parenting support programs are more involved, more engaged and positively emotionally reactive in relation to their children compared to the control group. It is recommended that programs aimed at supporting young fathers should include their partners, to last up to 5 weeks to be based on individual rather than group work, to include assistance with employment, etc.

Conclusion: Prebirth parenting skills improvement programs designed for young fathers and mothers achieve significant results.

Key words: young fathers, prevention, conduct disorders, programs

udc 376.1-056.26/.36-053.2
159.942:316.356.2

Hronična tuga kod roditelja dece sa smetnjama u razvoju

Luka Mijatović, Dragana Stanimirović
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija
Irena Korićanac
Univerzitetska dečja klinika Tiršova, Beograd

Hronična tuga se odnosi na jedinstvenu emocionalnu reakciju koja se javlja kada je gubitak kontinuirano prisutan u životu neke osobe. Ovaj pojam se najpre vezivao za gubitke koji se tiču zdravstvenog stanja drugih. Poslednjih godina se primenjuje i na doživljaje patnje u vezi sa sopstvenim zdravljem. Roditelji dece sa smetnjama u razvoju se suočavaju sa snažnim osećanjem bola nakon saznanja koja se tiču dijagnoze deteta. Bol ne prestaje usled toga što se proces tugovanja ne završava. Jedinstvenost procesa hroničnog tugovanja jeste upravo u tome što vremenom ne gubi na intenzitetu, već se održava, a čak i pojačava tokom brojnih situacija (nedovoljno responzivno osoblje, promena lekara, polazak deteta u školu, iskustva stigmatizacije i dr.) koje mogu reaktivirati stanje tuge. Drugi aspekt jedinstvenosti ove pojave ogleda se u postojanju perioda stabilnosti i adaptacije, tokom kojih roditelji doživljavaju i pozitivne emocije u vezi sa stanjem svog deteta. Ciklični karakter procesa hronične tuge često dovodi do kumulativnog efekta tuge, naročito ako je povišena vulnerabilnost roditelja praćena nedostatkom razumevanja i adekvatne podrške od strane užeg socijalnog okruženja i zdravstvenog osoblja. Stanje hronične tuge se razlikuje od depresivnih i anksioznih poremećaja i od izuzetne je važnosti da na adekvatan način bude prepoznato, kako bi se smanjila mogućnost dalje patologizacije i stigmatizacije porodice deteta sa smetnjama. Tretman ovog specifičnog oblika tugovanja se pre svega odnosi na pomoć roditeljima da usvoje što adekvatnije strategije prevladavanja stresa. Redefinisanje situacije i prihvatanje neizvesnosti u pogledu budućnosti pružaju mogućnost da se oslobode i iskoriste zdravi porodični kapaciteti. Pomeranjem fokusa sa slabosti porodičnog sistema na njegove snage se, u skladu sa modelom izazova, jačaju porodične rezilijence i utire put uspešnijem prevladavanju narednih stresnih događaja.

Ključne reči: *hronična tuga, dete sa smetnjama u razvoju, roditelji, prevladavanje stresa*

ODREĐENJE POJMA

Pojam hronične tuge se javlja u literaturi od 60-tih godina XX veka, a prvi ga je upotrebio Olšanki (Olshanki) kako bi opisao bol mladih roditelja nakon rođenja deteta sa smetnjama u razvoju. Ovaj autor je prepoznao neke osobenosti ovog oblika distresa, koje ga čine kvalitativno drugačijim od ostalih oblika gubitaka. Kod ovih roditelja period tugovanja se ne završava nakon rođenja deteta sa smetnjama (ili nakon uspostavljanja dijagnoze), već se reaktivira tokom svake razvojne krize koju njihovo dete ne uspeva uspešno da prevaziđe, tj. u onim situacijama kada su primetna kašnjenja u detetovom razvoju u odnosu na decu tipičnog razvoja. Specifičnost ovog oblika tugovanja jeste upravo u tome što vremenom ne gubi na intenzitetu, već se održava, a često i pojačava kada razvojni zadaci postaju zahtevniji, pri čemu se jaz između mogućnosti deteta sa smetnjama u odnosu na ostalu decu često uvećava i postaje upadljiviji. Drugi aspekt specifičnosti ove pojave ogleda se u periodima tokom kojih stres gubi na intenzitetu i kada roditelji doživljavaju i pozitivne emocije u vezi sa svojim detetom i njegovim stanjem. Dakle, može se reći da hronična tuga predstavlja osobenu reakciju tuge koja se javlja kada gubitak nije konačan, već kontinuirano postoji u životu osobe koja tuguje (Roos, 2002, prema Rossheim & McAdams, 2010). U pitanju je realističan odgovor na doživljeni gubitak, koji može imati ozbiljne implikacije na mentalno zdravlje kada se ne prepozna i ne obradi. Među različitim autorima postoji saglasnost oko toga da je hronična tuga normalno, nepatološko stanje sveprisutne, kontinuirane, periodične i iznova oživljene tuge, u vezi sa tekućim gubicima koji se tiču bolesti i invaliditeta. Potrebu da se pravi razika između normalnog i patolološkog tugovanja prepoznao je još Frojd, a kao ključnu distinktivnu karakteristiku istakao je poštovanje sebe i brigu o sebi (Freud, 1917).

U literaturi se hronična tuga prepoznaje kao reakcija roditelja/negovatelja, ne samo dece sa senzornim, intelektualnim i motoričkim smetnjama i poremećajima, već i kada su u pitanju osobe (različitih uzrasta) sa hroničnim bolestima i teškoćama, poput epilepsije, Alchajmerove bolesti, srčanih oboljenja, multiple skleroze, dijabetesa i raznih oblika kancera (Mayer, 2001; Lee et al., 2003; Vitaliano, Zhang & Scanlan, 2003; Hobdell et al., 2007; Isaksson, 2007, prema Rossheim & McAdams, 2010).

Poslednjih godina se u definisanju hronične tuge fokus polako pomera sa gubitaka koji se tiču drugog na sopstvene gubitke. Osim simptoma koji se mogu prepoznati kod roditelja dece sa smetnjama i negovatelja hronično bolesnih osoba, hronična tuga postaje termin kojim se opisuju emocionalno doživljavanje i promene na nivou osobe čije funkcije propadaju kao posledica ometenosti ili hronične bolesti. Lični gubici, kako ih je prepoznao Alstrom (Ahlström), mogu se posmatrati na nekoliko nivoa: kao gubitak telesne funkcije, gubitak odnosa, gubitak samostalnog života, gubitak uloga, gubitak aktivnosti, gubitak identiteta, gubitak ideje o zamišljenom životu i gubitak pozitivnih emocija (Ahlström, 2007). Ovako definisanim pojmom hronične tuge mogu se obuhvatiti emocionalna iskustva pojedinaca koji doživljavaju bolan jaz između onoga što su nekada bili i onoga što su sada.

Karakteristike hroničnog tugovanja

Tugovanje se javlja kao normalna reakcija na iskustvo gubitka, i vremenom se umanjuje kao posledica obrade ovog procesa i prilagođavanja na gubitak. Reakcije tugovanja se periodično mogu ponavljati, ali postoji tendencija da se vremenom intenzitet tuge smanjuje, budući da se uzrok javlja u formi izolovanog događaja koji se desio (i završio) u prošlosti. U nekom situacijama se proces tugovanja dodatno komplikuje i usložnjava, najčešće kada tugujući nije u mogućnosti da prihvati i obradi gubitak, pri čemu se dešava da se simptomi ovog procesa održavaju tokom vremena. Kod hronične tuge uzrok tugovanja perzistira, ali ne kao rezultat nemogućnosti obrade gubitka, već se u ciklusima iznova i iznova vraća u fokus tugujućeg tokom razvojnih i drugih životnih kriza. Ciklični karakter ovog procesa često dovodi do kumulativnog efekta tuge.

Nakon početnog šoka i snažne reakcije tuge, stiče se pojam o potrebi za dugoročnom negom deteta sa smetnjama, tj. osobe sa ometenošću/hroničnom bolešću, ukoliko govorimo o odraslima. U ovoj fazi je često neophodno da se tugujući brzo vrati u funkcionalno stanje kako bi se postarao da „pacijent" dobije odgovarajući nivo zdravstvene i/ili socijalne zaštite. Tokom narednih perioda koje može karakterisati prividna stabilnost u stanju osobe sa smetnjama, roditelj/negovatelj često razvija fantazije i očekivanja u pogledu ozdravljenja i povratka na period pre pojave bolesti (Moore, 2002, prema Rossheim & McAdams, 2010). Pogoršanja bolesti i pojava pojačanih simptoma reaktiviraju osećaj gubitka, a svaka nova faza bolesti predstavlja podsetnik da će se gubici, tj. tugovanje nastaviti.

Roditelji često ističu da je prelazak deteta sa odeljenja pedijatrije na odeljenja za lečenje odraslih vrlo bolan period tokom koga se stanje hronične tuge reaktivira. Prelaz iz višegodišnjih i na neki način familijarnih uslova lečenja (koji podrazumevaju poznavanje osoblja i izvesnu predvidljivost) je neophodno izvesti postepeno (Bowes et al., 2009). Pojedini autori smatraju da su u osnovi doživljenog distresa neefikasno upravljanje hroničnom tugom u sadejstvu sa povišenom vulnerabilnošću i nedostatkom razumevanja potreba tugujućih i odgovarajuće podrške od strane porodice, prijatelja i zdravstvenog osoblja (Isaksson & Ahlström, 2008).

Brojne studije koje su se bavile simptomima depresije kod roditelja dece sa smetnjama u razvoju dosledno su potvrđivale njihovu povišenu učestalost u odnosu na roditelje dece tipičnog razvoja (Veisson, 1999; Gordon, 2009). Međutim, izuzetno je važno istaći da se stanje hronične tuge razlikuje od depresije kao psihijatrijskog poremećaja, ali i od anksioznih poremećaja. Depresija je praćena doživljavanjem osećanja tuge, bespomoćnosti, krivice, apatije, negativizma. Često se javlja nisko samopoštovanje, kao i brojni bihejvioralni pokazatelji, poput povlačenja iz društvenog života i sniženi kapaciteti za uspešno funkcionisanje u različitim kontekstima. Iako se navedena osećanja i pojedini simptomi mogu sresti kod osoba koje doživljavaju hroničnu tugu, one ipak uspešno funkcionišu u onim ulogama koje su im primarne, a pre svega u ulozi negovatelja (Roos, 2002, prema Rossheim & McAdams, 2010). Roditelji/negovatenji zapravo mogu postati aktivniji i požrtvovaniji, budući da se od njih očekuje donošenje bitnih odluka koje se tiču deteta, tj. „pacijenta". Ovakav obrazac ponašanja doživljava se kao „misija", pri čemu osoba može nastojati da konstantnim zalaganjem za negujućeg i njegovo lečenje, zapravo prikrije sopstveni doživljaj patnje (Levine & Murray, 2004).

Anksioznost povezana sa hroničnom tugom se može poistovetiti sa mnogim simptomima koji se pripisuju generalizovanom anksioznom poremećaju, uključujući poremećaje spavanja, stalnu zabrinutost i osećanje gneva. Ipak, kod hronične tuge je uvek moguće prepoznati uzrok javljanja anksioznosti, tj. može se izolovati događaj koji dovodi do prekidanja faza stabilnosti, a koji kod roditelja/negovatelja stvara snažno osećanje uznemirenosti. Stabilni periodi su uglavnom kratkog veka, budući da nove zdravstvene komplikacije iznova oživljavaju zabrinutost negovatelja u pogledu resursa i mogućnosti da pruži viši nivo nege. Obnovljeni strahovi mogu biti izazvani posebnim prilikama kao što su praznici, rođendani i godišnjice, jer se u tim situacijama tugujući prisećaju srećnijih vremena (ukoliko se radi o smetnjama koje nisu kongenitalne), ili se javljaju razmišljanja o vremenima koja će doći, a koja će sa sobom nositi i sve snažnije i zahtevnije izazove (Rossheim & McAdams, 2010).

Neki problemi u identifikaciji hroničnog tugovanja

Primećuje se da potrebe roditelja za emocionalnom podrškom često nisu prepoznate od strane zdravstvenog osoblja i to iz različitih razloga: kao posledica nedovoljne responzivnosti stručnjaka, usled organizacionih teškoća, ali i zbog nastojanja roditelja da doživljaj gubitka i negativne emocije zadrže za sebe ili ih često nisu u dovoljnoj meri svesni. Očekivane rodne razlike u izražavanju osećanja se javljaju i tokom procesa hroničnog tugovanja: budući da češće izražavaju negativne emocije i otvorenije tragaju za socijalnom podrškom, potrebe majki za pomoći bivaju češće prepoznate u odnosu na potrebe očeva. Ipak, mnoge studije su potvrdile nalaze da majke, uprkos tome što dobijaju više podrške, teže prihvataju bolest deteta, što može voditi lakšem oboljevanju od depresije (Fraley 1986, Timiko et al., 1992, prema Bowes et al., 2009). Očevi uglavnom zadržavaju osećanja za sebe i teško se otvaraju za razgovore koji se tiču njihovog emocionalnog stanja u vezi sa bolešću deteta. Od izuzetne važnosti je da postoji osetljivost zdravstvenog osoblja na rodne razlike u izražavanju osećanja, kako bi potrebe i majki i očeva za emocionalnom potporom bile u istoj meri prepoznate.

Kako se boriti sa hroničnom tugom?

Jedno od najznačajnijih oruđa u radu sa hroničnom tugom je razumevanje i prihvatanje doživljaja roditelja i njihovih koncepata o razvoju deteta. Neophodno je uspostavljanje adekvatnog balansa između intervencija koje vode razvoju punih potencijala deteta i onih koje imaju za cilj prihvatanje slabosti i ograničenja. Individualnim pristupom se može dobiti uvid u snage porodice i u dominantne mehanizme prevladavanja, kako bi se osmislili najadekvatniji programi podrške za konkretnu porodicu, pojedinačne ličnosti i sistem koji čine. Na ovaj način se mogu naglasiti porodične rezilijence i pomeriti fokus sa patološkog na zdravo, tj. sa „modela oštećenja" preći na „model izazova" (Volin i Volin, 1993). Mnogi autori smatraju da je najpoželjniji ishod procesa tugovanja vraćanje na uobičajeno psihološko i socijalno funkcionisanje (Arambašić, 2005; Jalom, 1980). Cilj tugovanja jeste „preživeti" gubitak, prihvatiti promene koje on donosi i integrisati izmenjenu verziju sebe u novi društveni kontekst u kome slika života pojedinca više nije u skladu sa očekivanom. Usled cikličnog karaktera procesa hronične tuge ovaj cilj deluje kao teže ostvariv. Kako bi imali snage da se bore sa neprestanim izazovima, potrebno je roditelje podsticati u deljenju doživljaja i neprijatnih emocija koje su u vezi sa gubitkom, kao i u nastojanjima da regulišu osećanja unutar porodice i u bliskim odnosima (Weingarten, 2012). Jedno od ključnih pravila je da nema „zabranjenih tema", te da se u otvorenim razgovorima iznalaze rešenja za svaki pojedinačni izazov. Nastojanja da se doživljaj gubitka redefiniše i prihvati neizvesnost u pogledu budućnosti, tj. da se fokus usmeri na „ovde i sada", mogu znatno doprineti uspešnijem nošenju sa hroničnom tugom. Kada porodica jednom usvoji ovakav model prevladavanja teškoća i kada u radu sa profesionalcem redefiniše sopstveni doživljaj i spozna sopstvene snage, potreba za sistemskom podrškom gubi na značaju. Tačnije, tokom svakog narednog izazova se pružena podrška ne razlikuje u mnogome od potrebe za psihološkom podrškom porodice u kojoj nema razvojnih poteškoća i hroničnih bolesti.

LITERATURA

1. Ahlström, G. (2007). Experiences of loss and chronic sorrow in persons with severe chronic illness. Journal of Clinical Nursing, 16(3A), 76–83.
2. Arambašić, L. (2005). *Gubitak, tugovanje, podrška*, Zagreb: Naklada Slap
3. Bowes, S., Lowes, L., Warner, J., & Gregory, J. W. (2009). Chronic sorrow in parents of children with type 1 diabetes. *Journal of advanced nursing*, 65(5), 992-1000
4. Freud, S. (1917). Mourning and melancholia. Reprinted (1953–1974) in the Standard Edition of the Complete Psychological Works of Sigmund Freud (trans. and ed. J. Strachey), vol. 14. London, Hogarth Press: Institute of Psycho-analysis,
5. Gordon, J. (2009). An evidence-based approach for supporting parents experiencing chronic sorrow. *Pediatric nursing,* 35(2), 115-120.

6. Isaksson, A. K., & Ahlström, G. (2008). Managing chronic sorrow: experiences of patients with multiple sclerosis. *Journal of Neuroscience Nursing, 40*(3), 180-192.
7. Jalom, I. (1980). *Existential psychotherapy.* New York, Basic Book
8. Levine, C., & Murray, T. H. (2004). *The cultures of caregiving: Conflict and common ground among families, health professionals, and policy makers.* JHU Press.
9. Rossheim, B. N., & McAdams III, C. R. (2010). Addressing the chronic sorrow of long-term spousal caregivers: A primer for counselors. *Journal of Counseling and Development: JCD, 88*(4), 477.
10. Veisson, M. (1999). Depression symptoms and emotional states in parents of disabled and non-disabled children. *Social Behavior and Personality: an international journal, 27*(1), 87-97.
11. Volin, S., Volin, S. (1993). *Rezilijentna ličnost*. Beograd: Prosveta – Nispred
12. Weingarten, K. (2012). Sorrow: A therapist's reflection on the inevitable and the unknowable. *Family process, 51*(4), 440-455.

CHRONIC SORROW IN PARENTS OF DISABLED CHILDREN

Luka Mijatović*, Dragana Stanimirović*, Irena Korićanac**
*University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia
**University Children's Hospital, Belgrade, Serbia

Research subject: Chronic sorrow refers to a specific emotional response that occurs when the loss is continuously present in a person's life. This term was primarily referred to losses related to health conditions of others. In recent years, it also applies to the experiences of suffering linked to one's own health.

Method: Based on the review of theoretical and empirical researches, the main questions of chronic sorrow in parents of disabled children are highlighted.

Results: Parents of children with disabilities are faced with a strong sense of pain after getting the information concerning the child's diagnosis. The pain does not stop because the grieving process never reaches closure. The uniqueness of the process of chronic sorrow lies in the fact that it does not lose its intensity over time; rather, the intensity of grief maintains the same or even increases during numerous situations (insufficiently responsive staff, changing doctors, starting school, experiences of stigmatization, etc.) which can reactivate the state of sorrow. Another aspect of the uniqueness of this phenomenon is reflected in the existence of periods of stability and adaptation, during which the parents are experiencing positive emotions about their child's condition. The cyclic nature of the process of chronic sorrow often leads to a cumulative effect of sadness, especially when increased vulnerability of parents is accompanied by a lack of understanding and adequate support from the narrower social environment and health personnel.

Conclusion: Condition of chronic sorrow differs from depression and anxiety disorders. In order to reduce the possibility of further stigmatization and pathologisation of families of children with disabilities, it is very important to adequately detect this state. The treatment of this specific form of grieving primarily refers to helping parents to adopt appropriate coping strategies. Redefining the situation and acceptance of uncertainty about the future provide an opportunity for releasing and using healthy family capacities. Shifting the focus from weaknesses of the family system to its strengths, according to the Challenge model, empowers family resilience and enables more successful coping with future stressful events.

Key words: chronic sorrow, child with disability, parents, coping with stress

udc 376.1-056.262-053.31
316.356.2:159.9

Nekoliko porodica sa slepom bebom koje liče jedna na drugu

Dragana Stanimirović
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Cilj ovog rada je da ukaže na sličnosti u sadržajima prikupljenim tokom individualnog savetovanja roditelja pet slepih beba. Kvalitativna analiza je obavljena na osnovu audiosnimaka i pisanih materijala.

Roditelji su zatražili pomoć nakon „saznanja” da njihovo dete nikad neće videti. Tema svakog susreta bila je određena onim što trenutno najviše brine roditelje u vezi njihovog deteta.

Analiza pokazuje da su se u svih pet slučaja pojavile iste teme. Na početku su se svi roditelji pitali: Ima li negde leka? Da li je moglo da se izbegne? Vidi li bar svetlo? Paralelno su se javljale sumnje da beba ima neku dodatnu smetnju jer: „ćuti”, „ne reaguje” i sl. Korišćene su tehnike aktivnog slušanja, reflektovanja osećanja, ali i konfrontiranje. Ishod je bio prihvatanje postojećeg stanja. To je prelomni trenutak nakon koga su roditelji bili spremni da uče o specifičnostima razvoja slepih beba. Upućeni su na relevantnu literaturu, a jedna porodica je angažovala tiflologa. I pored toga, sve roditelje je brinulo i plašilo što beba ne drži glavu pravo, ne puzi, što stavlja rukicu u oko itd. Nisu bili sigurni da li ispravno postupaju. Prorađivali smo njihova osećanja i potkrepljivali doživljaj roditeljske kompetentnosti. To je uticalo na promenu njihovih misli, osećanja i ponašanja.

Ključne reči: *slepa beba, roditelj, psihološko savetovanje*

UVOD

Period pripreme za roditeljstvo karakteriše idealizacija buduće uloge roditelja i očekivanog deteta (Mihić, Rajić, Krstić, Divljan i Lukić, 2016). Za razliku od srećne majke koja je na svet donela zdravo dete, „majka slepog deteta doživljava duboku tugu, njen ponos je ranjen, izneverena su i sva njena očekivanja vezana za budućnost deteta (…) doživljava pravi šok, povlači se, o svojim problemima ne govori ni sa prijateljima…” (Popović, 1986: 32-33).

Prihvatanje stanja deteta je bilo predmet brojnih istraživanja. Krstić (2013) navodi da su se istraživači najpre interesovali za „patološke odgovore roditelja”; potom za stadijume kroz koje roditelji tipično prolaze na putu do adaptacije; a da se u savremenoj literaturi govori o procesuprihvatanja dijagnoze i redefinisanju uloga. Roditelji deteta sa smetnjama u razvoju prolaze kroz proces menjanja reprezantacionih sistema sebe kao roditelja, svog deteta i svog odnosa sa detetom da bi mogli postati razrešeni prema dijagnozi (Marvin & Pianta, 1996). Koncept *razrešenje označava roditeljsko* emotivno i kognitivno prihvatanje detetovog stanja. Razrešeni roditelji su, za razliku od nerazrešenih, u stanju da razumeju znake koje im dete šalje i da odgovore na njegove potrebe. Ali, i kod većine razrešenih roditelja istraživanja beleže recidive tuge (Marvin & Pianta, 1996).

U razvoju sve dece postoje periodi stagnacije, pa i privremene regresije, te je kod svakog roditelja povremeno prisutna potreba za savetovanjem (Ljubešić, 2003). Roditelji deteta sa oštećenjem vida, na osnovu sopstvenih ili iskustava drugih, ne mogu da predvide ni razvojno očekivane događaje (Stanimirović i Mijatović, 2010), tako da oni predstavljaju izvor njihovih briga i problema (Stanimirović i Mijatović, 2011). To je jedan od razloga što su potrebe ovih roditelja za psihološkim savetovanjem veće. Međutim u vreme kada je najpotrebnije i najdelotvornije, u našoj zemlji im je psihološko savetovanje dostupno sporadično. Autor ovih redova je u tom domenu dala skroman doprinos,te je odlučila da za svrhu ovog rada upotrebi deo lične arhive.

Cilj rada je da ukaže na identifikovane sličnosti u temama kojima smo se bavili tokom savetodavnog rada sa roditeljima pet slepih beba.

METOD

Uporedno preslušavanje nasumice izabranih audiosnimaka i čitanje beleški sa seansi je pokazalo da su se sa nekim roditeljima ponavljale slične teme i sadržaji. Obavili smo kvalitativnu analizu sadržaja savetodavnog rada sa tim roditeljima i identifikovali teme, podteme, kao i primenjene tehnike savetovanja.

Analizom je obuhvaćeno pet porodica sa slepom bebom. Sve porodice su bile potpune. Na početku savetovanja najmlađe dete je imalo devet, a najstarije 12 meseci. Tri bebe su prevremeno rođene, bile su u inkubatoru na Institutu za neonatologiju, nakon čega im je konstatovano oštećenje retine. Ostale dve bebe su rođene na vreme (jedna mama je u trudnoći imala boginje, dok je u drugom slučaju uzrok nepoznat).

Identifikovane sličnosti

Svaki od pet roditelja (četiri mame i jedan tata)je tražio pomoć psihologa nakon što im je saopšteno da je dete slepo i da se ne može ništa učiniti u pogledu vida. Kad god je to bilo moguće na sastanke su dolazila oba roditelja. Na ovome se insistiralo jer je to pružalo prilike za rad na osnaživanju slabijeg partnera i jačanju uzajamne podrške.

Na prvim susretima svi roditelji su imali potrebu da govore o svojim reakcijama na slepoću deteta. Naizmenično su govorili da su se „pomirili sa sudbinom", „vratili uobičajenom životu", potom o uzroku („Možda je moja greška…"), pregledima koje još treba da obave („Po nalazima ne vidi svetlo, ali ja primećujem da joj smeta Sunce, treba proveriti…"; „Treba da proverimo da li je mozak oštećen jer mnogo ćuti, kad priđem ne reaguje", „Nadam se da nema nikakvih drugih problema. Svi nalazi glave i svega drugog su odlični."), onda o „medicinskim čudima" i nadi da će dete videti. Imajući u vidu potrebu roditelja da abreaguju svoja osećanja, najvažnije je bilo da ih pažljivo slušamo, saosećamo sa njima i da oni shvate da mi to činimo. Osim aktivnog slušanja, korišćena je tehnika reflektovanja osećanja tj. nastojali smo da zajednički otkrijemo šta zaista osećaju. Povremeno smo ih suočavali sa kontradikcijama u iskazima i osećanjima (tehnika konfrontiranja) i naglašavali njihove pozitivne reakcije („Jako je dobro što o njenoj budućnosti razmišljate kao da nikada neće videti".) Sve je to doprinelo prihvatanju postojećeg stanja.

Prihvatanje stanja je prelomni trenutak koji je jasno identifikovan u ovih pet porodica. Do tog trenutka nisu bili u stanju da shvate informacije koje su od stručnjaka dobijali, niti da uče o specifičnostima razvoja slepih beba. Počeli su da traže i čitaju dobijenu literaturu. S obzirom da nije bilo moguće uključiti ih u organizovane tiflološke programe predlagano im je da angažuju tiflologa, što je učinila samo jedna porodica.

Teme psihološkog savetovanjana narednim seansama bile su vezane za ono što je roditelje zbunjivalo i činilo ih nesigurnim.Sve roditelje je zbunjivalo što beba ne drži glavu pravo („Glava joj je iskrivljena u jednu stranu, a doktorka kaže da su mišići u redu, samo treba da je naučimo da drži glavu pravo…"), ne puzi, klati se ili trlja oko („Tačno znam kada je stavio rukicu u oko. Tada ispusti neki zvuk – kao kad se neko proteže, pa kaže nešto kao 'mmm'"). Roditelji su, iz literature i od tiflologa, naučili da slepu bebu nema šta da pokrene u vidnom polju da podiže glavu, gleda, pruža ruku za nečim i puzi unapred, da je slepa beba više usmerena na svoje telo nego na spoljni svet… Ali, često nisu bili sigurni da li pravilno postupaju. Povremeno su govorili o svojim „žutim minutama". Fokus savetovanja tada je bilo jačanje doživljaja roditeljske kompetentnosti, ali i menjanje konstrukata o detetu, vaspitnim postupcima…

Jedna od tema koja se provlačila u svim fazama savetovanja ticala se reakcija osoba iz okruženja. Ono što je bilo moguće postići je da roditelje te reakcije manje pogađaju, odnosno da ih vide na pozitivniji način.

ZAKLJUČAK

Savetovanje sa roditeljima pet slepih beba, čiji je sadržaj analiziran u radu, realizovano je u različitim vremenskim razdobljima, sa većinom kada autor/savetnik nije poznavala koncept razrešenosti.Ove porodice su bile potpune i funkcionalne.

Svedoci smo da i te roditelje slepoća deteta izbacuje iz ravnoteže i to ne samo prilikom saznavanja dijagnoze, već više puta u životu. Jedan od razloga za to je nepoznavanje razvojnih specifičnosti slepog deteta.

Na osnovu izvršene analize možemo zaključiti da je suštinska karakteristika koja ove roditelje razlikuje od ostalih da su veoma rano postali razrešeni, tj. da su prihvatili realno stanje deteta. Evidentno je da je psihološko savetovanje ubrzalo ovaj proces.Ključni činilac koji je na to uticao je što im je ova usluga ukazana već u prvoj godini života deteta. Sa roditeljima, naročito ako su njihove porodicedisfunkcionalne, koji na savetovanje dođu kada dete ima pet ili šest godina sve je mnogo složenije – dinamika porodičnih odnosa, problemi…, psihološko savetovanje.

LITERATURA

1. Krstić, T. (2013). Majke hronično ometene dece: Prihvatanje dijagnoze i prevladavanje stresa. Doktorska disertacija. Novi Sad: Filozofski fakultet.
2. Ljubešić, M. (2003). Od teorijskih ishodišta do primjene: Model dijagnostičko-savjetodavnog praćenja ranog dječjeg razvoja i podrške obitelji s malom djecom. U M. ljubešić (ur.), Biti roditelj: Model dijagnostičko-savjetodavnog praćenja ranoga dječjega razvoja i podrške obitelji s malom djecom (str. 8-28). Zagreb: Ministarstvo obitelji, branitelja i međugeneracijske solidarnosti.
3. Marvin, R. S., & Pianta, R. C. (1996). Mothers' reactions to their child's diagnosis: relations with security of attachment. *Journal of clinical child psychology*, *25*(4), 436-445.
4. Mihić, I., Rajić, M., Krstić, T., Divljan, S. i Lukić, N. (2016). „Naša priča" – Program podrške roditeljima dece sa smetnjama u razvoju: Primer dobre prakse u predškolskim ustanovama. *Specijalna edukacija i rehabilitacija, 15*(4), 477-498. doi: 10.5937/specedreh15-11745
5. Popović, D. (1986). Rani razvoj i prilagođavanje slepih. Beograd: Zavod za udžbenike i nastavna sredstva.
6. Stanimirović, D. i Mijatović, L. (2010). Načini rešavanja problema u porodicama sa slepim adolescentom. U D. Branković (ur.), Naučna i duhovna utemeljenost društvenih reformi (str. 293-305). Banja Luka: Filozofski fakultet.
7. Stanimirović, D. i Mijatović, L. (2011). Razlike između mladih slepih i vršnjaka tipičnog razvoja u proceni dimenzija funkcionisanja porodice. *Specijalna edukacija i rehabilitacija*, *10*(4), 673-688.

SEVERAL FAMILIES WITH A BLIND BABY THAT RESEMBLE EACH OTHER

Dragana Stanimirović
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: The aim of this study was to point out the similarities in the content gathered during individual counseling offered to parents of five blind babies. Qualitative analysis was conducted based on audio recordings and written materials.

Method: All families were complete. They asked for help of a psychologist after they "acquired knowledge" that their child would never see (the youngest child was nine and the oldest was twelve months old). This was done by four mothers and one father. Each of these parents, or parental couples, occasionally came to psychological counseling. The topic for each meeting was determined by what the parents' main concern regarding their child was at that point.

Results: The analysis showed that the same topics emerged in all five cases. Initially, all parents asked the following questions: Is there a cure? Could this have been avoided? Does he/she see the light at least? ... Furthermore, doubts that the baby had an additional disorder emerged as well, because the baby: "prefers silence", "does not react", etc. The techniques of active listening, reflection of emotions, but also confrontation, were used. The outcome was the acceptance of the current situation. This was a turning point after which the parents were ready to learn about the specifics of the development of a blind baby. They were referred to the relevant literature. In addition to that, one family took on a special educator and rehabilitator for persons with visual impairment. Nevertheless, all parents had worries and fears because their baby did not keep his/her head straight, did not crawl, put fingers into the eye, etc. From time to time they were focused on the reactions of people from their environment. They were not sure if they were doing the right thing.

Conclusion: During individual counseling, we worked on their feelings and corroborated the experience of parental competence. This had an impact on changing their thoughts, feelings and behavior.

Key words: blind baby, parent, psychological counseling

udc 364.65-058.862
316.356.1-058.862
159.922.72-058-862

Podsticanje socijalne kompetentnosti dece bez roditeljskog staranja[1]

Marija Jelić, Irena Stojković
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

U ovom preglednom radu razmatran je kvalitet socijalne podrške i zaštite dece bez roditeljskog staranja u kontekstu mogućnosti razvijanja njihove socijalne kompetentnosti. Polazeći od pretpostavke da kvalitetna socijalna podrška i zaštita dece bez roditeljskog staranja može ublažiti posledice neadekvatnog roditeljskog staranja, analiza izdvojenih radova organizovana je oko dva istraživačka pitanja: (1) Da li različiti oblici zaštite imaju različite efekte na razvijanje socijalne kompetentnosti dece bez roditeljskog staranja? (2) Da li metode i sredstva vaspitno-korektivnog rada profesionalaca u institucijama podstiču razvijanje socijalne kompetentnosti dece bez roditeljskog staranja? U skladu sa ovim pitanjima u prvom delu rada dat je prikaz dosadašnjih istraživanja o socijalnoj kompetentnosti dece bez roditeljskog staranja poređenjem njihovog socijalnog funkcionisanja u institucijama i hraniteljskim porodicama. Ostvaren stepen socijalne kompetentnosti i kvalitet socijalnog funkcionisanja dece bez roditeljskog staranja razmatran je kao pokazatelj ishoda preduzetih mera socijalne zaštite i podrške. Na tim osnovama, u drugom delu rada kritčki su analizirane metode i sredstva vaspitno-korektivne prakse u institucijama, a koje su u funkciji podsticanja socijalne kompetentnosti dece. Uvidom u teorijske i empirijske nalaze naših i stranih autora ukazano je na protektivne faktore i faktore rizika u ovoj oblasti. Na kraju rada izvedene su implikacije za praksu u smislu podsticanja socijalne kompetentnosti dece bez roditeljskog staranja.

Ključne reči: *socijalna kompetentnost, deca bez roditeljskog staranja, socijalna zaštita i podrška, metode i sredstava vaspitanja*

Kada dete zbog neadekvatnog porodičnog staranja dospe u stanje potrebe za socijalnom zaštitom, zadatak profesionalaca je da izborom adekvatnog oblika zaštite, kroz podršku i promociju detetovih prava i interesa, ovoj deci obezbede sigurne uslove za pravilan psihofizički i socijalni razvoj. „Sigurni uslovi” ne znače samo smeštaj deteta u okolinu gde će biti fizički zaštićeno od svih oblika ugroženosti koje su prethodile izdvajanju, već uključuju preduzimanje različitih mera zaštite i

---

[1] Rad je nastao u okviru projekta koji finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije, broj projekta III 47015.

podrške usmerenih na oporavak deteta od stresnih i traumatskih događaja i podsticanje njihovog daljeg razvoja. Cilj rada je da efekte socijalne zaštite i podrške na socijalnu kompetentnost dece sagledamo dvojako: kroz prikaz istraživanja o ostvarenom stepenu socijalne kompetentnosti dece u različitim oblicima zaštite i kroz analizu relevantne literature o metodama i sredstavima vaspitno-korektivnog rada.

Socijalna kompetentnost dece bez roditeljskog staranja

Relevantna literatura koja ukazuje na uslove u kojima dalje žive deca bez roditeljskog staranja uglavnom se bazira na poređenju institucionalnog i porodičnog konteksta odrastanja i njihovih različitih efekata na dalji psihosocijalni razvoj i socijalizaciju dece. Primenom Akenbakovog upitnika samoprocene dece koja žive u domovima i hraniteljskim porodicama u Hrvatskoj (Ajduković & Sladović Franz, 2004) pokazano je da samo 35% dece u domovima, u odnosu na 75% dece u hraniteljskim porodicama, ima nizak rezultat na skalama eksternalizovanih (agresivnost, laganje...) i internalizovanih problema (simptomi depresije i anksioznosti, nisko samopoštovanje...). Pošto su prethodna iskustva dece smeštene u domove i hraniteljske porodice suštinski ista, lošije funkcionisanje dece u domovima ne bi se moglo objasniti prethodnim neadekvatnim porodičnim staranjem već karakteristikama vezanim za domsku zaštitu. U prilog ovome autori navode nalaz da nivo internalizovanih i eksternalizovanih problema u ponašanju nije značajno povezan s nivoom doživljenog stresa pre izdvajanja iz porodice već sa aktuelnim nivoom svakodnevnog stresa u domu i doživljenom slabijom socijalnom podrškom. Što je duži boravak detata u instituciji, ono se prilagođava zahtevima doma ali je dete u domu u većem riziku za socijalno nekompetentno ponašanje od dece koja žive sa prirodnim roditeljima ili u hraniteljskim porodicama. I u odnosu na decu koja žive u primarnoj porodici dobijeni su slični podaci. Prema vrsti problema nešto češće se radi o internalizovanim nego eksternalizovanim problemima (Sladović Franz, 2003; Ajduković, Rajhvajn Bulat & Sladović Franz, 2007). Ovakvi nalazi dobijeni su i u našoj sredini kada su u pitanju tipična deca bez roditeljskog staranja, ali za decu sa lakom intelektualnom ometenošću je pokazano da ona u domu imaju manje emocionalnih problema nego njihovi vršnjaci sa roditeljskim staranjem (Jelić i Stojković, 2016a). U istom istraživanju potvrđeno je da deca bez roditeljskog staranja, nezavisno od intelektualnog statusa, imaju statistički značajno više problema u ponašanju nego njihovi vršnjaci sa roditeljskim staranjem. I ranija istraživanja izveštavaju da veliki procenat dece, koja su ispoljavala oblike neprilagođenog ponašanja pre dolaska u ustanovu, isto ponašanje, i to u većoj meri, ispoljava i u domu (Plut i Popadić, 2007; Vidanović, 1998). Uz nalaz da se deca bez roditeljskog staranja statistički značajno ređe prosocijalno ponašaju od dece sa roditeljskim staranjem (Ajduković, Rajhvajn Bulat & Sladović Franz, 2008; Jelić i Stojković, 2016b), saopšteni nalazi upućuju na to da metode i sredstava vaspitno-korektivnog rada u domovima ne doprinose socijalnoj kompetentnosti dece.

Socijalna podrška i zaštita – protektivni i rizični faktor socijalne kompetentnosti dece

Osnovna prednost institucionalne zaštite u odnosu na hraniteljstvo ogleda se u činjenici postojanja profesionalaca koji bi trebalo da nizom vaspitnih metoda i sredstava osiguraju detetu socijalnu pomoć i podršku. Socijalna podrška podrazumeva postojanje ili dostupnost osoba na koje se oslanjamo, koje nam daju do znanja da o nama brinu, vole nas i cene (Sarason, Sarason & Pierc, 1990). Kada su u pitanju deca bez roditeljskog staranja, posebno je važna emocionalna podrška i podrška samopoštovanju, informacijska podrška u rešavanju problema i suočavanju sa negativnim događajima ili kognitivno vođenje, instrumentalna podrška kroz materijalnu pomoć i podrška koja se odnosi na druženje i zajedničke aktivnosti u slobodnom vremenu.

Nalazi istraživanja pokazuju da deca smeštena u dečje domove percipiraju manje emocionalne i podrške samopoštovanju u odnosu na decu koja žive u hraniteljskim ili prirodnim porodicama (Pešikan i Stepanović, 2002; Sladović Franzi & Mujkanović, 2003;). Emocionalna podrška najčešće se ostvaruje putem pohvala, ohrabrenja, ispoljavanja ljubavi i pažnje, što doprinosi razvoju samopoštovanja i prosocijalnog ponašanja kod dece (Joksimović, 1999). Ovi socijalni potkrepljivači su posebno efikasni za onu decu koja pokazuju internalizovane probleme, imaju osećanje manje vrednosti, povučeni su (Lalić-Vučetić, 2007) ili imaju teškoće u razvoju (Witzel & Marcel, 2003). Analiza vrste potkrepljivača, tj. nagrade, koje se najčešće dobijaju u domu ukazuje da su u prvom redu prisutni materijalni (dupli džeparac, kupovina garderobe...), a nedovoljno često socijalni potkrepljivači (pohvale, zagrljaj, osmeh...) ili u vidu aktivnosti (ekskurzije, odlasci u bioskop, izleti...). Materijalne nagrade mogu da deluju podsticajno, ali njima se, za razliku od drugih vrsta potkrepljivača, ne može ostvariti unutrašnja motivacija. Materijalne nagrade mogu biti efikasne kada druge vrste podsticaja nije moguće primeniti ili nemaju efekte na podsticanje socijalno kompetentnog ponašanja. Standardi podsticanja treba da budu takvi da svi imaju šansu da budu nagrađeni, ali treba voditi računa da ono što je potkrepljivač za jedno dete ne mora da bude i za drugo. Zbog toga bi vaspitači trebalo da vode računa šta je (koji događaj) potkrepljivač za određeno dete, od koga ili čijim posredstvom treba da ga dobiju i to na koji način neki događaj postaje potkrepljivač.

Mada je nagrađivanje efikasno sredstvo u povećanju socijalnih ishoda u radu sa decom koja pokazuju problematične oblike ponašanja, nalazi istraživanja pokazuju da u vaspitno-korektivnoj praksi preovlađuju kažnjavanje i negativno potkrepljenje. Metode sprečavanja problema u ponašanju (krađe, vršnjačko nasilje, bežanje iz doma) uključuju mere kao što su ukidanje džeparca, zabrana izlaska, isključenje ili premeštaj u drugi dom (Barter, Renold, Berridge & Cawson, 2004; Pešikan i Stepanović, 2002; Sladović Franz, Kregar Oreškov & Vejmelka, 2007). Bez obzira o kom se prekršaju radi, čak i kao pretnja da za određeno ponašanje dete može biti isključeno ili premešteno u drugi dom predstavlja veoma ozbiljan pritisak na dete. Konvencija o pravima deteta sadrži i prava dece smeštene u dečjim domovima i naglašava da disciplinovanje dece mora biti usklađeno sa uzrastom, da isključuje bilo kakve oblike fizičkog kažnjavanja i da deca imaju pravo da znaju koje su sankcije u domu propisane. Paradoksalno, rezultati istraživanja ukazuju na grubo verbalno disciplinovanje dece i fizičko kažnjavanje od strane vaspitača (Barter *et al*., 2004; Cantwell, 2005; Plut i Popadić, 2007; Sladović Franz *et al*., 2007). Mnogo značajnije, i u suštini pomenute odredbe Konvencije, jeste da fizičko kažnjavanje najčešće ne dovodi do suzbijanja problematičnog ponašanja već ga samo privremeno inhibira, a nekada izaziva i sasvim suprotne efekte, te doprinosi ozbiljnijim formama emocionalnih i problema u ponašanju dece (Jelić, 2015). Učestale kazne dovode do osećanja nesigurnosti deteta, nepoverenja u sebe i svoje mogućnosti, a zatim i do okretanja ka vršnjacima koji dele iste vrednosi i pogled na svet i od kojih su prihvaćeni i podržavani.

Za prosocijalni razvoj dece posebno je važna indukcija, tehnika kojom odrasli ukazuju detetu na posledice njegovog ponašanja po druge. Kognitivno vođenje kroz definisanje, razumevanje i suočavanje s problemom vid je informacione podrške detetu. Ona ne podrazumeva samo objašnjenje o opštim pravilima ponašanja, već i usmeravanje pažnje na konkretnu situaciju ukazivanjem na razloge zašto se treba ili ne treba ponašati na određeni način i na efekte koji proizilaze iz različitog ponašanja. Ovim putem odrasli kod dece podstiču empatiju, a istovremeno oni se upućuju na alternativno, adekvatnije ponašanje (Krevans & Gibbs, 1996).

Pedagoške implikacije

Sudeći prema svemu navedenom moglo bi se reći da metode i sredstva, koje profesionalci u domskoj zaštiti primenjuju u cilju podsticanja pozitivnog i sprečavanja negativnog ponašanja dece, pre negativno nego pozitivno utiču na razvoj socijalne kompetentnosti dece bez roditeljskog staranja. Prikaz i analiza dosadašnjih istraživanja u ovoj oblasti ukazuju da su reakcije na agresivne i destruktivne modele ponašanja dece u institucijama najčešće oslanjaju na neki od metoda čiji je cilj sprečavanje takvih negativnih ponašanja uz nedovoljnu usmerenost na podsticanje i povećanje učestalosti alternativnih konstruktivnih vidova ponašanja. Od zaposlenih se očekuje da budu osetljivi za potrebe dece koja su pod rizikom i da u većoj meri primenjuju metode podsticanja. Kroz kognitivno vođenje, kombinovanjem pozitivnih spoljašnjih podsticaja i unutrašnjih motiva stvaraju se situacije u kojima dete doživljava uspeh. Uslov uspešnosti postupaka nagrađivanja i kažnjavanja jeste kvalitet emocionalnog odnosa između deteta i osobe koja ga vaspitava. Sami vaspitači i drugi odrasli svojim ponašanjem i komunikacijom trebalo bi da budu model ponašanja koji žele da prenesu. Deci sa negativnim porodičnim uzorima i traumatičnim iskustvom pozitivni modeli su potrebni kao sredstvo podsticaja. Za podsticanje socijalne kompetentnosti dece u institucijama od značaja je klima koju zajednički svi stvaraju i održavaju, a pre svega kompetencije zaposlenih da odgovore na konkretne potrebe dece i pruže im kvalitetnu socijalnu podršku.

LITERATURA

1. Ajduković, M., & Sladović Franz, B. (2004). Samoprocjene ponašanja djece i mladih u dječjim domovima i u udomiteljskim obiteljima u Hrvatskoj. *Društvena istraživanja*, *13*(6), 1031-1054.
2. Ajduković, M., Rajhvajn Bulat, L., & Sladović Franz, B. (2007). Značenje ljestvice depresivnosti za djecu u procjeni mentalnog zdravlja djece i adolescenata u javnoj skrbi. *Socijalna psihijatrija*, *35*(3), 107-118.
3. Ajduković, M., Rajhvajn Bulat, L., & Sladović Franz, B. (2008). Agresivno i prosocijalno ponašanje djece u dječjim domovima. *Ljetopis socijalnog rada, 15*(2), 185-213.
4. Barter, C., Renold, E., David Berridge, D., & Cawson, P. (2004). *Peer Violence in Childrden's Residential Care,* Palgrave, Basingstoke.
5. Cantwell, N. (2005). *Violence in residential facilities for children*. Background paper. Regional consultation for the UN Study on Violence Against Children. Ljubljana, 5-7 July.
6. Jelić, M. (2015). *Pedagoške implikacije razvijanja socijalne kompetentnosti dece i mladih bez roditeljskog staranja*. Doktorska disertacija. Filozofski fakultet Univerziteta u Novom Sadu
7. Jelić, M. i Stojković, I. (2016a). Teškoće u socijalnom funkcionisanju adolescenata različitog porodičnog i inteletkualnog statusa. *Nastava i vaspitanje*, *LXV*(2), 309-328.
8. Jelić, M. i Stojković, I. (2016b). Porodica i intelktualne sposobnosti adolescenata kao činioci njihovog prosocijalnog ponašanja. *Zbornik instituta za pedagoška istraživanja, 48*(1), 48-69**.**
9. Joksimović, S. (1999). Razvoj i podsticanje altruizma mladih, *Nastava i vaspitanje*, 5, 605-616.
10. Krevans, J., & Gibbs, J. C. (1996). Parents' use of inductive discipline: Relations to children'sempathy and prosocial behavior. *Child Development*, *67*(6), 3263–3277.
11. Lalić-Vučetić, N. (2007). *Podsticanje učenika pohvalom i nagradom,* Beograd: Institut za pedagoška istraživanja.
12. Pešikan, A. i I. Stepanović (2002). Sistem brige o deci bez roditeljskog staranja- viđen očima dece. U B. Kuzmanović (Ur.), *Deca bez roditeljskog staranja* (277-334). Beograd: Save the Children i Institut za psihologiju.
13. Plut, D. i Popadić, D. (2007). *U lavirintu nasilja: istraživanje nasilja u ustanovama za decu bez rodtieljskog staranja u Srbiji*. Beograd: Intstitut za psihologiju.
14. Sarason, B. R., Sarason, I. G., & Pierce, G. R. (1990). *Social support – An interactional view.* New York: John Wiley & Sons, Inc.

15. Sladović Franz, B. (2003). *Psihosocijalni razvoj djece u dječjim domovima*. Zagreb: Pravni fakultet Sveučilišta u Zagrebu i Državni zavod za zaštitu obitelji, materinstva i mladeži.
16. Sladović Franz, B., & Mujkanović, Đ. (2003). Percepcija socijalne podrške djeci u dječjim domovima i u udomiteljskim obiteljima. *Ljetopis Studijskog centra socijalnog rada*, *10*(2), 161-170.
17. Sladović Franz, B., Kregar Oreškov, K., & Vejmelka, L. (2007). Iskustvo života u dječjem domu: kvalitativna analiza izjava mladih. *Ljetopis socijalnog rada*, *14*(3), 553-578.
18. Vidanović, I. (1998). Nasilje nad decom u dečijim domovima. U M. Milosavljević (Ur.), *Nasilje nad decom* (189-201). Beograd: Fakultet političkih nauka.
19. Vidanović, I.(2002). Bivši korisnici porodičnog i domskog smeštaja U B. Kuzmanović (Ur.): *Deca bez roditeljskog staranja* (335-364). Beograd: Save the Children i Institut za psihologiju.
20. Witzel, B.S., & Mercer, C.D. (2003). Using rewards to teach students with disabilities: Implications for motivation. *Remedial and Special Education*, *24*, 88-96.

ENCOURAGING SOCIAL COMPETENCE OF CHILDREN WITHOUT PARENTAL CARE

Marija Jelić, Irena Stojković
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: In this review paper, we consider the quality of social care and support of children without parental care as contexts of the development of their social competence.

Methods: Assuming that the quality of social care and support of children without parental care can buffer the consequences of improper parental care, the analysis of selected works is organized around two research questions: (1) Do different forms of care have different effects on the development of social competence of children without parental care? (2) Do the methods and resources of educational-corrective work in institutions encourage the development of social competence of children without parental care? In accordance with these issues, the first part of the paper provides an overview of research on social competence of children without parental care by comparing their social functioning in institutions and foster families. The degree of social competence and quality of social functioning of children without parental care is considered as a result of the undertaken measures of social care and support.

Results: We critically analyze methods and resources of educational-intervention practices in institutions as important factors for encouraging social competence of children without parental care. Based on the review of theoretical and empirical research from Serbia and other countries, protective and risk factors in this area are highlighted.

Conclusion: The concluding part of the paper points out implications for practice with regard to encouragement of social competence of children without parental care.

Key words: social competence, children without parental care, social care and support, methods and resources of education

udc 365.4-056.26/.36-053.2
376.1-056.26/.36-053.2
316.356

Support to Families of Children with Disabilities During Early Childhood

Marinela Šćepanović
Society of defectologists of Vojvodina, Novi Sad, Serbia

Research subject: *On the trace of paradigm that development of children with disabilities has the specific attributes, there is no doubt that families of these children have additional need for early support their functioning, starting with child's birth or with a moment when child become sick or injured, and continuously going on during child's life. This support can be medical, social, psychosocial, educational, legal, material, and other e.g. concerning rehabilitation, conditions of life, accessibility, different services etc, and it could be institutional and/or non-institutional. The purpose of this paper is to represent review of most common kinds of early support services for families of children with disabilities which are mentioned and explained in research studies.*

Methods: *Research studies were selected and took over across Serbian Library Consortium for Coordinated Acquisition, using EBSCO, SAGE, Wiley, and Springer searching services. Searching was conducted based on words: families, parents, children, early childhood, support and disability. As the result of such a search, research studies dealing with early family support services were selected for review. In selected studies different kinds of early family support were described and proposed, depending on several conditions (age of a child, type of disability, home country, availability of services, etc).*

Conclusion: *We highlight that effective types of support for families of children with disabilities are evidence-based programs, which are applicable in early childhood with main goal to strengthen families and parents for their further specific, but unexpected, role. In Serbia there are no such types and kinds of early family support as a systematic support for children with disabilities in early childhood so we recommend establishing and development of similar programs as services for all families needing, at state, provincial and local levels.*

Key words: *family, disability, support, early childhood, program, services*

INTRODUCTION

On the trace of paradigm that development of persons and also children with disabilities has the specific attributes and its own dynamics (Potić, 2014), there is no doubt that families of these children have additional need for early support their functioning. Such a support need to start with child's birth or with a moment when child become sick or injured, and continuously going on during child's life. This support can be medical, social, psychosocial, educational, legal, material, and other e.g. concerning rehabilitation, conditions of life, accessibility, different services etc. Also, different kinds of support to families and children could be provided institutionally and/or non-institutionally.

METHOD

Research studies were selected and took over across Serbian Library Consortium for Coordinated Acquisition, using EBSCO, SAGE, Wiley, and Springer searching services. Searching was conducted based on words: families, parents, children, early childhood, support and disability. As the result of such a search, 37 research studies dealing with early family support services were selected for review. In selected studies different kinds of early family support were described and proposed, depending on several conditions (age of a child, type of disability, home country, availability of services, etc). In the following, we present the main findings of selected studies according to the kinds of early family support services.

Early family support

Findings from research into the formation of the brain have reinforced the important role of positive, supportive relationships in early childhood development (Moore, 2007, according to Warren, Vialle & Dixon, 2016).

Family-centered principles are the foundation for the delivery of early intervention services to infants/toddlers and their families (Bailey, Buysse, Edmondson & Smith, 1992; Dunst, Johanson, Trivette & Hamby, 1991, according to Kaczmarek, Goldstein, Florey, Carter & Cannon, 2004; Marshall, Tanner, Kozyr & Kirby, 2015). The provision of general information and professional support are key components of family-centred early childhood intervention services (Fordham, Gibson & Bowes, 2011).

Family-centered practice, which includes strengthening parenting skills, has been advocated by the early intervention field (Pighini, Goelman, Buchanan, Schonert-Reichl & Brynelsen, 2014). Although early intervention programs realize the importance of supporting parent–child interaction as part of family-centered practice, it has not been an emphasis of most early intervention programs (Innocenti, Roggman & Cook 2013). Some parents lament the fact that the criteria for accessing certain services are based on diagnosis, whereas children would benefit from them despite their medical 'label.' (Robert, Leblanc & Boyer, 2015).

In order to explain the role of an early interventionist in this context, it is necessary to have some understanding of the concept of family-based early intervention. Early intervention is based upon the understanding that infants and toddlers develop through trusting and caring relationships with adults (Trivette, Dunst & Hamby, 2010, according to Casses & Paquette, 2016; Sandall, Hemmeter, Smith & McLean, 2005; Shelton, Jeppson & Johnson, 1987).

Considered as a whole, studies of children with disabilities and their families indicate that family processes and children's development are mutually interrelated. Research on very young children points to the central role of mother-child interaction and, although less studied, the importance of the emotional climate of the family in promoting optimal child development (Hauser-Cram, et al. 2001). While families with complex needs differ from other families regarding service needs, researchers have warned against assuming all families with particular characteristics have similar needs and perceptions of early intervention (Ziviani, Darlington, Feeney, Rodger & Watter, 2014).

Early childhood education and care participation can increase parent wellbeing as well as their knowledge of their child's disability, and improve the quality of parent–child interactions. Parents felt that their child's development was supported by attendance at a mainstream centre, particularly in relation to communication and behaviour (Blackmore, Aylwar & Grace, 2016; McIntyre & Phaneuf, 2007).

Hiebert-Murphy, Trute & Wrigh (2008) identified four patterns of service entry associated with differing family needs for early support service: early entry, prompt entry, delayed entry and atypical entry. Correa, Bonilla & Reyes-MacPherson (2011) in their study found that mothers perceived that various professionals, such as teachers, therapists, and physicians, were either generally helpful or sometimes very helpful, while Early Childhood Intervention programs had been pointed as the most helpful.

Far from being passive recipients of care, these are ordinary families seeking appropriate information from professionals to support them in their ordinary parenting role. For them, the professionalized care service should be based on negotiated relationships of equality that give respect to parental perspectives on what is right for their child. There is much to be learned from studying the negotiated and contested interactions between parents and professionals (Goodley & Tregaskis, 2006; Villeneuve, et al., 2013). Early childhood teachers must take the initiative and remain flexible when working and partnering with families having children with disabilities (Harris, K. 2015).

Supporting parents through parent-to-parent programs may be useful in providing parents with additional sources of support from other parents of children with disabilities. In these programs, parents of children with disabilities who are trained in providing support to other parents are matched with parents who are in need of support services (Santelli, Ginsberg, Sullivan & Niederhauser, 2002). These programs have a number of positive impacts on families including improvements in parents" perceptions in their abilities to cope, get their needs met and solve problems related to their child's disability (Santelli et al., 2003: Singer et al., 1999). Likewise, interventions significantly reduce maternal stress for many parents of children with developmental disabilities. Some has found that teaching parents specific stress management procedures enhanced parent ability to cope with parenting stress. Guimond, Wilcox & Lamorey (2008) found no relations between early intervention parenting self-efficacy and child or parent age, number of children in the family, household income, or the parent-reported severity of the child's disability. Nixon and Singer (1993) evaluated the impact of a group intervention aimed to teach behavioral and cognitive techniques to help reduce parental stress. Participation in the groups was associated with significant reductions in guilt, negative automatic thoughts, internal negative attributions and depression.

Results of Baker-Ericzén, Brookman-Frazee, & Stahmer, (2005) research indicate that more attention is needed to assessing stress levels in both parents and there needs to be an increased emphasis in early education programs to address parent-related stress through specific parent-directed types of services in addition to the child-focused childcare programs.

It is noticed that some special circumstances an influence to benefits of provided support, depending on the source provider - private or public agencies (Purdue, Ballard & MacArthur, 2001). Such circumstances can be religious or nationality affiliation of the family or any of its' members. Begay, Roberts, Weisner & Matheson, (1999) highlight that public health systems will be most helpful to families when the services they provide honor, respect, and support indigenous models of belief and interaction.

Parents of children with intellectual disabilities often lack the holistic support they require to effectively care for their child in the first year of life (Douglas, Redley & Ottmann, 2016). The attainment of parenting skills specific to the intervention, safe home practices, and the understanding of child health were the outcomes of interest on parent training interventions for parents with intellectual disability (Coren, Thomae & Hutchfield 2011); also educational programs for this parents are researched (Starke, Wade, Feldman & Mildon, 2013). Parents of the most severely affected children may need specific support which, given the age trends, might be aimed at different resolution processes for parents of younger and older children (Schuengel, et al., 2009).

Family supports include linking families to community resources, providing requested information through a variety of formats, assisting families in various aspects of the special education process (e.g., Individualized Education Program meetings), and helping families in the transition to school-age programs (Kaczmarek, Goldstein, Florey, Carter & Cannon, 2004). Enabling young children with disabilities to have a voice in research has the potential to positively influence the services they receive facilitating a more truly holistic approach to early intervention practice (Carroll & Sixsmith, 2016). Also parental input is important (Mengoni & Oates 2014).

If a childs disabilities are identified before age three, the family will face moving the child from an infant-toddler program to a preschool program. The shift will require the child to have certain social, behavioral, and communication skills to meet the demands of the new setting (Hebbeler & Spiker 2016). As children with disabilities get older, the gap between children with disabilities and those without become greater in terms of their abilities (Cho & Hong, 2013). The study of Conyers, Reynolds & Ou (2003) provides evidence that a high-quality large-scale public program of early intervention can have long-term effects on special education outcome. In that context Hunt, Soto, Maier, Liboiron & Bae, (2004) recognize educational, communication and social supports as parts of early intervention family services.

Children with disabilities had greater attention paid to defining their service than their peers (Perrin, 2012). Caring for a child with a significant long-term illness or disability has major implications for the family budget (Simon, McNicholas, 2014). Although governments never say so, support to families really mostly depends of economic status of the state or region which is responsible to establish, organize and delivers support. As author Byrns (2013) finds that caring for a family member with a severe mental or physical disability involves significant costs, regardless of when that family member became disabled. Cho and Hong (2013) found that both whether a child had single or multiple disabilities and the average monthly treatment cost were significant factors that influenced the parent's quality of life indirectly through parenting stress.

Need for relationship-based services (Kubicek, Riley, Coleman, Miller & Linder, 2013) and determining what impacts early childhood programs have on families (Mannan, Summers, Turnbull & Poston, 2006) leads to prevalence of evidence-based and proved programs. No such programs of early family support are implementing in Serbia.

CONCLUSION

Effective types of support for families of children with disabilities are evidence-based programs, which are applicable in early childhood with main goal to strengthen families and parents for their further specific, but unexpected, role. In Serbia there are no such types and kinds of early family support as a systematic support for children with disabilities in early childhood so we recommend establishing and development of similar programs as services for all families needing, at state, provincial and local levels.

REFERENCES

1. Baker-Ericzén, M. J., Brookman-Frazee, L., & Stahmer, A. (2005). Stress Levels and Adaptability in Parents of Toddlers with and Without Autism Spectrum Disorders. *Research & Practice for Persons With Severe Disabilities*, *30*(4), 194-204.
2. Begay, R., Roberts, R., Weisner, T., & Matheson, C. (1999). Indigenous and Informal Systems of Support Navajo Families Who Have Children with Disabilities. *Bilingual Review / La Revista Bilingüe, 24*(1/2), 79-94. Retrieved from http://www.jstor.org/stable/25745650
3. Blackmore, R., Aylward, E., & Grace, R. (2016). 'One of the kids': Parent perceptions of the developmental advantages arising from inclusion in mainstream early childhood education services. *Australasian Journal of Early Childhood*, *41*(2), 13-17.
4. Byrns, K. (2013). Postmajority child support for children with disabilities. *Family court review, Vol. 51 No. 3*, July 2013, 502–516.
5. Carroll, C., & Sixsmith, J. (2016). Exploring the facilitation of young children with disabilities in research about their early intervention service. *Child Language Teaching and Therapy 2016, 32*(3) 313–325. doi: 10.1177/0265659016638394
6. Casses, M. M., & Paquette, K. R. (2016). Standing outside the fire: remaining objective and family-based in early intervention. *Education*, *137*(2), 123-132.
7. Cho, K. S., & Hong, E. J. (2013). A Path Analysis of the Variables Related to the Quality of Life of Mothers with Disabled Children in Korea. *Stress & Health: Journal of the International Society for the Investigation of Stress*, *29*(3), 229-239. doi:10.1002/smi.2457
8. Conyers, L., Reynolds, A., & Ou, S. (2003). The Effect of Early Childhood Intervention and Subsequent Special Education Services: Findings from the Chicago Child-Parent Centers. *Educational Evaluation and Policy Analysis, 25*(1), 75-95. Retrieved from http://www.jstor.org/stable/3699518
9. Coren, E., Thomae, M., & Hutchfield, J. (2011). Parenting Training for Intellectually Disabled Parents: A Cochrane Systematic Review. *Research on Social Work Practice, 21*(4) 432-441. doi: 10.1177/1049731511399586
10. Correa, V., Bonilla, Z., & Reyes-MacPherson, M. (2011). Support Networks of Single Puerto Rican Mothers of Children with Disabilities. *Journal of Child & Family Studies*, *20*(1), 66-77. doi:10.1007/s10826-010-9378-3
11. Douglas, T., Redley, B., & Ottmann, G. (2016). The first year: the support needs of parents caring for a child with an intellectual disability. *Journal of Advanced Nursing, 72*(11), 2738–2749. doi: 10.1111/jan.13056.
12. Fordham, L., Gibson F., & Bowes, J. (2011). Information and professional support: key factors in the provision of family-centred early childhood intervention services. *Child: care, health and development*, *38*(5), 647–653. doi:10.1111/j.1365-2214.2011.01324.x

13. Goodley, D., & Tregaskis, C. (2006). Storying disability and impairment: Retrospective accounts of disabled family life. *Qualitative Health Research*, *16*(5), 630-646. doi: 10.1177/1049732305285840
14. Guimond, A. B., Wilcox, M. J., & Lamorey, S. G. (2008). The early intervention parenting self-efficacy scale (EIPSES) scale construction and initial psychometric evidence. *Journal of Early Intervention, 30*(4), 295-320. doi: 10.1177/1053815108320814.
15. Harris, K. (2015). The Unexpected Journey Shared by Families: Using Literature to Support and Understand Families Raising a Child with Disabilities. *Early Childhood Education Journal*, *43*(6), 473-484. doi:10.1007/s10643-014-0682-1
16. Hauser-Cram, P., Warfield, M., Shonkoff, J., Krauss, M., Sayer, A., Upshur, C., & Hodapp, R. (2001). Children with Disabilities: A Longitudinal Study of Child Development and Parent Well-Being. *Monographs of the Society for Research in Child Development, 66*(3), I-126. Retrieved from http://www.jstor.org/stable/3181571
17. Hebbeler, K., & Spiker, D. (2016). Supporting Young Children with Disabilities. *The Future of Children, 26*(2), 185-205. Retrieved from http://www.jstor.org/stable/43940587
18. Hiebert-Murphy, D., Trute, B., & Wright, A. (2008). Patterns of entry to community-based services for families with children with developmental disabilities: implications for social work practice. *Child & Family Social Work, 13*(4), 423-432. doi:10.1111/j.
19. Hunt, P., Soto, G., Maier, J., Liboiron, N., & Bae, S. (2004). Collaborative Teaming to Support Preschoolers with Severe Disabilities Who Are Placed in General Education Early Childhood Programs. *Topics in Early Childhood Special Education*, *24*(3), 123-142.
20. Innocenti, M., Roggman,L., & Cook, G. (2013). Using the PICCOLO with parents of children with a disability. *Infant mental health journal,* Vol. 34(4), 307–318. doi: 10.1002/imhj.21394
21. Kaczmarek, L. A., Goldstein, H., Florey, J. D., Carter, A., & Cannon, S. (2004). Supporting Families: A Preschool Model. *Topics in Early Childhood Special Education*, *24*(4), 213-226.
22. Kubicek, L., Riley, K., Coleman, G., Miller, G., & Linder, T. (2013). Assessing the emotional quality of parent–child relationships involving young children with special needs: applying the constructs of emotional availability and expressed emotion. *Infant mental health journal*, *34*(3), 242–256. doi: 10.1002/imhj.21384.
23. Mannan, H., Summers, JA., Turnbull, A., & Poston, D. (2006). A Review of Outcome Measures in Early Childhood Programs. *Journal of Policy and Practice in Intellectual Disabilities, 3*(4) 219–228.
24. Marshall, J., Tanner, J., Kozyr. Y., & Kirby, R. (2015). Services and supports for young children with Down syndrome: parent and provider perspectives. *Child: care, health and development, 41*(3), 365–373. doi:10.1111/cch.12162.
25. McIntyre, L. L., & Phaneuf, L. K. (2007). A Three-Tier Model of Parent Education in Early Childhood. *Topics in Early Childhood Special Education*, *27*(4), 214-222.

26. Mengoni, S. E., & Oates, J. (2014). A tool to record and support the early development of children including those with special educational needs or disabilities. *Support for Learning*, *29*(4), 339-358. doi:10.1111/1467-9604.12068
27. Perrin, J. (2012). How Can Quality Improvement Enhance the Lives of Children with Disabilities? *The Future of Children, 22*(1), 149-168. Retrieved from http://www.jstor.org/stable/41475650
28. Pighini, M. J., Goelman, H., Buchanan, M., Schonert-Reichl, K., & Brynelsen, D. (2014). Learning from parents' stories about what works in early intervention. *International Journal of Psychology*, *49*(4), 263-270. doi:10.1002/ijop.12024
29. Potic, S. (2014). The importance of sensory information in a motor behavior of persons with disabilities (PhD Theses). Faculty of special education and Rehabilitation, University of Belgrade.
30. Purdue, K., Ballard, K., & MacArthur, J. (2001). Exclusion and Inclusion in New Zealand Early Childhood Education: disability, discourses and contexts Exclusion et Inclusion dans l'Éducation des Jeunes Enfants en Nouvelle Zélande: handicap, discours et contextes Exclusión e Inclusión en la Discapacidad Educativa de los Menores de Nueva Zelanda, discursos y contextos. *International Journal of Early Years Education*, *9*(1), 37-49. doi:10.1080/09669760120044178
31. Robert, M., Leblanc, L., & Boyer, T. (2015). When satisfaction is not directly related to the support services received: understanding parents' varied experiences with specialised services for children with developmental disabilities. *British Journal of Learning Disabilities* 43, 168–177. doi:10.1111/bld.12092
32. Schuengel, C., Rentinck, I., Stolk, J., Voorman, J., Loots, G., Ketelaar, M., Gorter, J., & Becher, J. (2009). Parents' reactions to the diagnosis of cerebral palsy: associations between resolution, age and severity of disability. *Child: care, health and development*, *35*(5), 673–680. doi:10.1111/j.1365-2214.2009.00951.x.
33. Simon, C., & McNicholas, N. (2014). Children living with chronic disability. *InnovAiT, 7*(8), 502-508.
34. Starke, M., Wade, C., Feldman, M., & Mildon, R. (2013). Parenting with disabilities: Experiences from implementing a parenting support programme in Sweden. *Journal of Intellectual Disabilities* 17(2) 145–156. doi: 10.1177/1744629513483523.
35. Villeneuve, M., Chatenoud, C., Hutchinson, N., Minnes, P., Perry, A., Dionne, C., . . . Weiss, J. (2013). The Experience of Parents as Their Children with Developmental Disabilities Transition from Early Intervention to Kindergarten. *Canadian Journal of Education / Revue Canadienne De L'éducation, 36*(1), 4-43. Retrieved from http://www.jstor.org/stable/canajeducrevucan.36.1.4
36. Warren, J., Vialle, W., & Dixon, R. (2016). Transition of children with disabilities into early childhood education and care centres. *Australasian Journal of Early Childhood*, *41*(2), 18-26.
37. Ziviani, J., Darlington, Y., Feeney, R., Rodger, S., & Watter, P. (2014). Early intervention services of children with physical disabilities: Complexity of child and family needs. *Australian Occupational Therapy Journal*, *61*(2), 67-75. doi:10.1111/1440-1630.12059

udc 376.1-056.26/.36-053.2
373.211.24

Kompetencije vaspitača u inkluzivnom okruženju

Marta Dedaj
Visoka škola strukovnih studija za vaspitače i poslovne informatičare – Sirmium, Sremska Mitrovica, Srbija
Snežana Nikolić, Tamara Radojčić
ŠOSO „Milan Petrović” sa domom učenika, Novi Sad, Srbija

Predmet istraživanja: *U radu su elaborirane kompetencije vaspitača neophodne za rad u inkluzivnoj predškolskoj ustanovi. Kompetentnost se posmatra kao kontinuirani proces koji obuhvata korpus profesionalnog znanja i sticanje praktičnih veština. Polazi se od konstruktivističkog i holističkog pristupa obrazovanju vaspitača.*

Metod: *Cilj istraživanja je bio da se utvrdi doprinos dostupne podrške u predškolskoj ustanovi na samoprocenjenu kompetentnost vaspitača za ranu inkluziju. Istraživanje je sprovedeno na uzorku od 130 vaspitača iz Sremskog i Južnobačkog okruga. Polazeći od specifičnosti problematike u skladu sa predmetom, ciljem i zadacima istraživanja, kao i u skladu s postavljenim hipotezama u radu je primenjena tehnika skaliranja i istrumenti: Skala samoprocene kompetencije vaspitača za ranu inkluziju i Skala podrške predškolskoj inkluziji (Kucuker i sar., 2006).*

Rezultati: *U radu su korišćeni multivarijantni postupci MANOVA i diskriminativna analiza. Rezultati ukazuju da 72,6% ispitanih vaspitača izražavaju nekompetetnost za ranu inkluziju. Ispitanici koji su završili specijalizaciju za ranu inkluziju i uz podršku defektologa, izražavaju kompetentnost za ranu inkluziju ($p < ,05$).*

Zaključak: *Možemo zaključiti da percepcija dostupne podrške značajno doprinosi objašnjenju samoprocenjene kompetentnosti vaspitača prema ranoj inkluziji. Pedagoške implikacije rezultata istraživanja odnose se na razvijanje kvalitetnih programa podrške, uključivanje defektologa različitih profila u rad predškolske ustanove i kontinuiranu edukaciju vaspitača.*

Ključne reči: *kompetencije vaspitača, podrška, rana inkluzija*

UVOD

Globalizacijski procesi postavljaju zahteve za razvoj kompetencija vaspitača neophodnih za ostvarivanje inkluzivnog obrazovanja. Kompetentnost se posmatra kao kontinuirani proces koji obuhvata korpus profesionalnog znanja i sticanje praktičnih veština. Za razvoj kompetencija vaspitača za rad u inkluzivnom okruženju, veliki značaj imaju inicijalno obrazovanje i programi stručnog usavršavanja (Gašić-Pavišić, Gutvajn, 2011; Nikolovska i Nikolovski, 2014; Štemberger i Pogorevc-Merčnik, 2014). Rezultati istraživanja (Nikolić, 2013) ukazuju da kompetencije koje vaspitači stiču kroz inicijalno obrazovanje i/ili stručno usavršavanje da bi imali uticaja na praksu, moraju biti integrisane. Uloga vaspitača u inkluzivnom okruženju usmerena je na podršku deci da se uključe i da napreduju tokom vaspitno-obrazovnog procesa. Ovu ulogu će vaspitač realizovati na taj način što će se uključiti u rad stručnog tima za inkluzivno obrazovanje i biti deo tima za dodatnu podršku deci. Posebna pažnja posvećuje se sinergiji svih usluga i društva u celini (Dedaj, Panić, 2014).

METODOLOŠKI PRISTUP

Cilj istraživanja je bio da se utvrdi doprinos dostupne podrške u predškolskoj ustanovi na samoprocenjenu kompetentnost vaspitača za ranu inkluziju. Hipoteza istraživanja koja obuhvata ceo ispitivani prostor glasi: percepcija dostupne podrške značajno doprinosi objašnjenju samoprocenjene kompetentnosti vaspitača prema ranoj inkluziji. Polazeći od specifičnosti problematike u radu je primenjena tehnika skaliranja i istrumenti: Skala samoprocene kompetencije vaspitača za ranu inkluziju i Skala podrške predškolskoj inkluziji (Kucuker, Acarlar & Kapci, 2006). Istraživanje je sprovedeno na uzorku od 130 vaspitača iz Sremskog i Južnobačkog okruga.

Tabela 1 – Uzorak istraživanja

Uzorak	f	%
Vaspitači – specijalisti za ranu inkluziju	41	31.54%
Vaspitači	89	68.46 %
Ukupno	130	100 %

Istraživanje se oslanja na kvantitativnu i kvalitativnu analizu podataka. U radu su korišćeni multivarijantni postupci MANOVA i diskriminativna analiza.

REZULTATI ISTRAŽIVANJA I DISKUSIJA

Analiza rezultata istraživanja i njihova diskusija vršiće se u cilju ukazivanja na diskriminativno dejstvo nezavisnih na zavisnu varijablu. Analiza je izvršena na uzorku od 130 ispitanika, i to: 89 vaspitača koji su završili strukovne studije za obrazovanje vaspitača (u daljem tekstu grupa A) i vaspitači koji su završili specijalizaciju za ranu inkluziju – 41 (u daljem tekstu grupa B). Analiza razlika sprovedena je u odnosu na deset sintetizovanih parametara koji čine jednu celinu: samoprocenjene kompetentnosti vaspitača prema ranoj inkluziji i percepcije dostupne podrške.

Tabela 2 – Brojčana (n) i procentualna (%) zastupljenost parametara: K1-K10

Para-metri	Uzorak	uopš.	ne slažem	ugl.	ne.slaž	del.	slaž	ugl.	slaž	pot.	slaž
		n	%	n	%	n	%	n	%	n	%
K1	Vaspitač	24	26,97	52	58,43*	13	14,60	0	0	0	0
	Vaspitač-specijalista za ranu inkluziju	0	0	2	4,88	4	9,76	33	80,49*	2	4,88
K2	Vaspitač	15	16,85	37	41,57*	32	35,96	5	5,62	0	0
	Vaspitač-specijalista za ranu inkluziju	0	0	0	0	13	31,71	3	7,32	25	60,98*
K3	Vaspitač	7	17,07	42	47,19*	34	38,20	6	14,63	0	0
	Vaspitač-specijalista za ranu inkluziju	0	0	3	7,32	12	29,27	23	56,09*	3	7,32
K4	Vaspitač	1	1,12	62	69,66*	12	13,48	14	15,73	0	0
	Vaspitač-specijalista za ranu inkluziju	0	0	2	4,88	5	12,19	32	78,05*	2	4,88
K5	Vaspitač	0	0	0	0	38	42,70	44	49,44	7	7,87
	Vaspitač-specijalista za ranu inkluziju	0	0	0	0	0	0	24	58,54	17	41,46
K6	Vaspitač	2	2,25	12	13,48	17	19,10	45	50,56	13	14,61
	Vaspitač-specijalista za ranu inkluziju	0	0	0	0	4	9,76	21	51,22	16	39,02
K7	Vaspitač	5	5,62	12	13,48	45	50,56	20	22,47*	7	7,87
	Vaspitač-specijalista za ranu inkluziju	0	0	0	0	3	7,32	26	63,41*	12	29,27
K8	Vaspitač	0	0	4	3,56	34	30,26	48	42,72	3	2,67
	Vaspitač-specijalista za ranu inkluziju	0	0	2	4,88	13	31,71	20	48,78	6	14,63
K9	Vaspitač	40	44,94*	27	30,34	12	13,48	10	11.24	0	0
	Vaspitač-specijalista za ranu inkluziju	3	7,32	6	14,63	8	19,51	20	48,78*	4	9,76
K10	Vaspitač	17	19,10	58	65,17*	12	13,48	2	2,25	0	0
	Vaspitač-specijalista za ranu inkluziju	0	0	2	4,88	12	29,27	21	51,22*	6	14,63

Legenda:

- Znanja i veštine za procenu razvoja dece sa smetnjama u razvoju (K1)
- Znanja i veštine za definisanje i ostvarivanje vaspitno-obrazovnih ciljeva za dete sa smetnjama u razvoju (K2)
- Znanja i veštine o prilagođenosti programa rada i njegovoj implementaciji (K3)
- Znanja i veštine o tome kako prilagoditi/koristiti igračke/materijale za decu sa smetnjama u razvoju (K4)
- Znanja o zakonskim propisima u okviru rane inkluzije (K5)
- Podrška i saradnja sa stručnjacima iz servisnog centra – defektolozi (K6)
- Podrška i saradnja sa roditeljima dece sa smetnjama u razvoju (K7)
- Podrška i saradnja sa stručnim timom za inkluzivno obrazovanje (K8)
- Prilike za posmatranje vaspitača sa znanjem, veštinama i iskustvom u radu s decom sa smetnjama u razvoju (K9)
- Znanja i veštine da prati, meri, vrednuje i analizira postignuća dece sa smetnjama u razvoju i preduzima mere u cilju poboljšanja vaspitno-obrazovnog procesa (K10).

Podaci u Tabeli broj 2., ukazuju na sledeće: vaspitači – specijalisti za ranu inkluziju (80,49%) u odnosu na vaspitače koji nisu završili istu specijalizaciju (58,43%) u većoj meri procenjuju da poseduju *znanja i veštine za procenu razvoja dece sa smetnjama u razvoju* (K1). Kako je p = .000 χ2 – testa, a χ= .589, može se reći da postoji umerena povezanost između grupa u odnosu na procenu parametra K1.

Za parametar K2 (*Znanja i veštine za definisanje i ostvarivanje vaspitno-obrazovnih ciljeva za dete sa smetnjama u razvoju*), kod prve grupe vaspitača (A) moguće je zapaziti da je najviše zastupljen modalitet *uglavnom se ne slažem* koji čini 37 ispitanika (41,57%) od ukupno 89, što je značajno veće od učestalosti modaliteta *uglavnom se slažem* (5 ispitanika 5,62 % p=.000) i *potpuno se slažem* (0 ispitanika 0% p=.000). Kod druge grupe vaspitača (B) zastupljenost modaliteta *potpuno se slažem* (25 ispitanika 60,98%), je značajno veće od učestalosti modaliteta *delimično se slažem* (13 ispitanika 31,71%, p=.072). Kako je p = .534 može se reći da metodom 2 – test nije utvrđena povezanost između grupa i stava prema varijabli K2.

Za parametar K3 (*Znanja i veštine o prilagođenosti programa rada i njegovoj implementaciji*) kod *prve grupe vaspitača* (A) moguće je zapaziti da je najviše zastupljen modalitet *uglavnom se ne slažem* koji čini 42 ispitanika (47,19%), što je značajno veće od učestalosti modaliteta *uglavnom se slažem* (6 ispitanika 14,63% p=.000) i *potpuno se slažem* (0 ispitanika .0% p=.000). Kod druge grupe vaspitača (B) zastupljenost modaliteta *uglavnom se slažem* (23 ispitanika 56,09 %), je značajno veće od učestalosti modaliteta *delimično se slažem* (12 ispitanika 29,27% p=.014). Kako je p = .006 χ2 – testa, a χ= .414, može se reći da postoji umerena povezanost između grupa u odnosu na procenu obeležja K3.

Znanja i veštine o tome kako prilagoditi/koristiti igračke/materijale za decu sa smetnjama u razvoju (K4), u znatno većem procentu (78,05%) poseduju vaspitači iz grupe B, dok se vaspitači iz grupe A *uglavnom ne slažu* (69,66%) i *delimično slažu* (13,48%) sa istim. Kako je p = .000 χ2 – testa, a χ= .515, može se reći da postoji umerena povezanost između grupa u proceni obeležja K4.

Vaspitači obe grupe u većem procentu smatraju da imaju *znanja o zakonskim propisima vezanim za inkluziju* (K5) (grupa A – 49,44%, grupa B – 58,54%). Kako je p = .873 može se reći da metodom χ2 – test nije utvrđena povezanost između grupa u odnosu na datu tvrdnju.

Za obeležje K6 (Saradnja sa stručnjacima iz servisnog centra – defektolozi), rezultati istraživanja ukazuju na sledeće: obe grupe ispitanika u većoj meri smatraju da saradnja sa defektolozima različitih profila ima značajnu ulogu u ranoj inkluziji (prva grupa vaspitača A – 50,56%, druga grupa vaspitača B – 51,22 %). Kako je p = .494 može se reći da metodom χ2 – test nije utvrđena povezanost između grupa u odnosu na njihov stav prema obeležju K6.

Moguće je zapaziti razliku u odgovorima vaspitača za obeležje: *Podrška i saradnja sa roditeljima dece sa smetnjama u razvoju* (K7). *Uglavnom se slažu* sa datom tvrdnjom vaspitači iz grupe B (29,27%), što je značajno više od zastupljenosti iste kod vaspitača iz grupe A (7,87% p=.006). *Uopšte se ne slažu* sa datom tvrdnjom vaspitači iz grupe A (5,62%), što je značajno više u odnosu na zastupljenost istog modaliteta kod vaspitača iz grupe B (.00% p=.020). Kako je p = .027 χ2 – testa, a χ= .515, može se reći da postoji umerena povezanost između grupa u odnosu na procenu obeležja K7.

Da postoji podrška i saradnja sa stručnim timom za inkluzivno obrazovanje (K8), smatraju većina vaspitača iz obe grupe (grupa A – 42,72% i grupa B – 48,78%). Kako je p = .159 može se reći da metodom χ2 – test nije utvrđena razlika između grupa u odnosu na parametar K8.

Za parametar K9 (*Prilike za posmatranje vaspitača sa znanjem, veštinama i iskustvom u radu s decom sa smetnjama u razvoju*) rezultati istraživanja ukazuju na sledeće: 58,54% vaspitača iz grupe B mišljenja su da uglavnom imaju prilike za posmatranje *vaspitača sa znanjem, veštinama i iskustvom u radu s decom sa smetnjama u razvoju*. Vaspitači iz grupe A *uopšte se ne slažu* sa datom tvrdnjom, njih 75,28% nemaju priliku da posmatraju vaspitače sa znanjem, veštinama i iskustvom u radu s decom sa smetnjama u razvoju. Kako je p = .000 χ2 – testa, a χ= .515, može se reći da postoji umerena povezanost između grupa u proceni parametra K9.

Statistička analiza za parametar *poseduje znanja i veštine da prati, meri, vrednuje i analizira postignuća dece sa smetnjama u razvoju i preduzima mere u cilju poboljšanja vaspitno-obrazovnog procesa* (K10), ukazuje na sledeće: 51.22% vaspitača iz grupe B *uglavnom se slaže* sa datom tvrdnjom, dok se svega 2,25% vaspitača iz A grupe odlučilo za isti modalitet. Sa istom tvrdnjom *delimično se slaže* 29,27 % vaspitača iz grupe B i 13,48% vaspitača iz grupe A. Može se uočiti razlika u odgovorima vaspitača i kod modaliteta *uglavnom se ne slažem* sa datom tvrdnjom (A grupa – 65,17% i B grupa – 4,88, p=.000). Kako je p = .000 χ2 – testa, a χ= .432 može se konstatovati da postoji razlika u odgovorima između grupa u odnosu na posmatran parametar.

Tabela 3 – Homogenost grupa za obeležja K1-K10

Uzorak	m/n	%
Vaspitači	62/89	69,66 %
Vaspitači – specijalisti za ranu inkluziju	33/41	80,49 %

Karakteristiku grupe koju čine vaspitači iz grupe A, definisanu na osnovu prethodnih analiza, ima 62 od 89 vaspitača. Homogenost grupe od 69,66% je visoka. Ukupno 27 ispitanika ispoljava karakteristike druge grupe, a ne svoje. Karakteristiku grupe koju čine vaspitači iz grupe B, definisanu na osnovu prethodnih analiza, ima 33 od 41 vaspitača – specijalista za ranu inkluziju. To govori o tome, da je homogenost grupe visoka 80,49%.

Tabela 4 – Značajnost razlika između grupa po obeležjima K1-K10

Analiza	n	F	p
MANOVA	11	3.480	.001
DISKRIMINATIVNA	11	3.445	.001

Vrednost Fišerove raspodele iznose F=3.480 i F=3.445, kao i pouzdanost (p) koja se kreće od .000 do .001 ukazuju da postoje razlike između grupa u prostoru između obeležja K1-K10. Izračunavanje pomoću postupka Multivarijantne analize varijanse (MANOVA) i upoređivanjem izračunate vrednosti F sa sa različitim vrednostima Fišerove raspodele (p = .001), zaključili smo da se prihvata hipoteza H0 koja glasi: percepcija dostupne podrške značajno doprinosi objašnjenju samoprocenjene kompetentnosti vaspitača prema ranoj inkluziji. To znači da se logički mogu izvesti karakteristike za posmatrane parametre, po redosledu stepena diskriminacije: 0.000 (K1), 0.000 (K4), 0.000 (K10), 0.006 (K3), 0.027 (K7), 0 .159 (K8), 0.494 (K6), 0.515 (K9), 0.534 (K2), 0.873 (K5).

ZAKLJUČNA RAZMATRANJA I PEDAGOŠKE IMPLIKACIJE

Većina autora (Brotherson et al., 2001; Friendly & Lero, 2002; Ryan, 2003; Bryan i sar., 2007; Conderman & Johnson-Rodriguez, 2009, prema Rundelić, Pinoza Kukurin i Skočić Mihić, 2013) ukazuju na važnost podrške koju vaspitači imaju u radu sa decom sa smetnjama u razvoju. Saradnja vaspitača, roditelja, stručnih saradnika i defektologa u radu sa decom na ranom uzrastu predstavlja snažan faktor podrške predškolskoj inkluziji. Dakle, uspešna realizacija inkluzivnog predškolskog vaspitanja i obrazovanja, podrazumeva saradnju svih raspoloživih resursa.

Možemo zaključiti da percepcija dostupne podrške značajno doprinosi objašnjenju samoprocenjene kompetentnosti vaspitača prema ranoj inkluziji. Vaspitači koji su završili specijalizaciju za ranu inkluziju i uz podršku defektologa, izražavaju veću kompetentnost za ranu inkluziju. Pedagoške implikacije rezultata istraživanja odnose se na razvijanje kvalitetnih programa podrške, uključivanje defektologa različitih profila u rad predškolske ustanove, kontinuiranu edukaciju vaspitača i unapređivanje inicijalnog obrazovanja vaspitača. Dakle, složenost obrazovno-vaspitnog rada uopšte, a posebno specifičnosti i kompleksnost rada u karakterističnom području predškolskog inkluzivnog okruženja nameće potrebu drugačijem kurikularnom pristupu obrazovanju vaspitača.

LITERATURA

1. Dedaj, M. i Panić, T. (2014). Suradnja obitelji i odgojitelja u ranom odgoju, 14. Dani Mate Demarina, Suvremeni izazovi teorije i prakse odgoja i obrazovanja, 61-68.
2. Gašić-Pavišić, S., Gutvajn, N. (2011). Profesionalna pripremljenost vaspitača i učitelja za rad u inkluzivnom obrazovanju, II naučna konferencija sa međunarodnim učešćem Inkluzija u predškolskoj ustanovi i osnovnoj školi, *Zbornik rezimea*, Beograd, Sremska Mitrovica: Institut za pedagoška istraživanja i Visoka škola strukovnih studija za vaspitače, 1-2.
3. Kucuker, S., Acarlar, F., Kapci, E. (2006). The development and psyhometric evaluation of a support scale for the pre-school inclusion. *Early Child Development and Care, 176*(6), 643-659.
4. Nikolić, M. (2013). Kako studenti škole za vaspitače procenjuju svoju pripremljenost za rad u inkluzivnim uslovima, *Ostvarivanje inkluzije u predškolskoj ustanovi i osnovnoj školi, Tematski zbornik radova*, Beograd, Sremska Mitrovica: Institut za pedagoška istraživanja, Visoka škola strukovnih studija za obrazovanje vaspitača, 47-64.
5. Nikolovska, J., Nikolovski, A. (2014). Stručnost vaspitača i nastavnika kao preduslov kvalitetne inkluzivne prakse, V naučna konferencija sa međunarodnim učešćem Inkluzija u predškolskoj ustanovi i osnovnoj školi, *Zbornik rezimea,* Beograd, Sremska Mitrovica: Institut za pedagoška istraživanja, Visoka škola strukovnih studija za vaspitače i poslovne informatičare-Sirmium, 27.
6. Rudelić, A., Pinoza Kukurin, Z., i Skočić Mihić S. (2013). Stručna znanja i materijalni resursi u inkluziji: stanja i perspektive. *Napredak, 154*(1-2) 131-148.
7. Štemberger, T., Pogorevc Merčnik, J. (2014). Pripremljenost vaspitača za inkluzivno obrazovanje, IV konferencija sa međunarodnim učešćem Inkluzija u predškolskoj ustanovi i osnovnoj školi, *Zbornik rezimea*, Beograd, Sremska Mitrovica: Institut za pedagoška istraživanja, Visoka škola strukovnih studija za vaspitače i poslovne informatičare-Sirmium, 32.

THE COMPETENCES OF PRESCHOOL INCLUSIVE TEACHERS

Marta Dedaj*, Snežana Nikolić**, Tamara Radojčić**
*School of Professional Studies for Educators and Business Informatics Sirmium, Sremska Mitrovica, Serbia
**Special Primary school Milan Petrović, Novi Sad, Srbija

Research subject: This paper discusses the necessary competences of teachers for working in inclusive kindergartens.The competence is seen as a continuous process including the corpus of professional knowledge and obtaining practical skills. It starts from the constructivist and holistic approach to the education of teachers.

Method: The aim of the study was to determine the contribution of available preschool support in the self-estimated competence of teachers in early inclusion. The research was conducted on a sample of 130 teachers from Srem and South Backa District. The collected data refer to self/competence of preschool inclusive teachers and existing support for preschool inclusion (Kucuker et al, 2006).

Results: The results indicate that 72.6% of teachers expressed incompetence in early inclusion. The respondents who completed training for early inclusion and had the support of special education teachers, expressed competence in early inclusion ($p <.05$).

Conclusion: We can conclude that the perception of available support contributes significantly to the explanation of the self-estimated competence of teachers in early inclusion. Pedagogical implications of the research results refer to the development of high-quality supportprograms, employment of special education teachers of various profiles in preschool institutions and continuing education of teachers.

Key words: competence of teachers, support, early inclusion

udc 376.1-056.262-053.2
316.356.2

Korelati roditeljskih stavova povezani sa uključivanjem/isključivanjem njihove dece sa oštećenjem vida u ranoj intervenciji

Snežana Nikolić
ŠOSO „Milan Petrović” sa domom učenika Novi Sad, Srbija
Marta Dedaj
Visoka škola strukovnih studija za vaspitače i poslovne informatičare – Sirmium, Sremska Mitrovica, Srbija
Jelena Berklović
Klinički centar Vojvodine, Klinika za očne bolesti Novi Sad, Srbija
Tamara Radojčić
ŠOSO „Milan Petrović” sa domom učenika, Novi Sad, Srbija

Predmet istraživanja: *Cilj našeg istraživanja odnosio se na ispitivanje korelata stavova roditelja prema uključenosti ili neuključenosti njihove dece sa oštećenjem vida u ranu intervenciju.*

Metod: *Uzorak je činio 71 roditelj dece sa oštećenjem vida (uzrasta od 0-6 godina starosti). Jednu grupu ispitanika činili su roditelji čija su deca bila obuhvaćena stimulativnim programom rane intervencije a drugu grupu roditelji čija deca nisu bila uključena u pomenuti program. Primenjen je Upitnik za ispitivanje ishoda porodice i test Nedovršene rečenice, koji ispituje odnos roditelja prema detetu,viđenju sebe kao roditelja i viđenju budućnosti svoga deteta.*

Rezultati: *Dobijeni rezultati istraživanja ukazuju da kod roditelja čija su deca bila uključena u program rane intervencije postoji pozitivan stav prema istoj. Ova grupa roditelja je imala viši skor na skali u subtestovima poznavanja potreba i mogućnosti svoga deteta, postojanju i korišćenja kapaciteta porodične podrške, poznavanju prava koja mogu da ostvare u lokalnoj zajednici i šire i aktivni su učesnici tima podrške svoga deteta. Za razliku od prve grupe, druga grupa roditelja nema pozitivan stav prema ranoj intervenciji jer nisu učestvovali u ovom programu, nemaju iskustva ali kod jednog broja roditelja postoji želja da svoje dete sa oštećenjem vida uključe u ovu vrstu programa.*

Zaključak: *Dobijeni rezultati ukazuju na moguće pravce daljih istraživanja koja će biti usmerena na praćenje efekata programa rane intervencije na kasnija postignuća dece sa oštećenjem vida i njihove lične i profesionalne afirmacije u društvenoj sredini. Značaj navedenog istraživanja ogleda se u neophodnosti formiranja Centara za ranu interveciju u lokalnoj zajednici. Rana stimulacija* *razvoja deteta sprečava nastanak sekundarnih smetnji, razvija kompenzatorne snage i sposobnosti i maksimalno podstiče celokupni razvoj.*

Ključne reči: *Rana intervencija, roditelji dece sa oštećenjem vida*

1. TEORIJSKI PRISTUP PROBLEMU ISTRAŽIVANJA

U savremenom pristupu ranoj intervenciji uvidelo se da porodica nije izolovani sistem, već segment šireg društvenog okruženja sa kojim je u odnosu međuzavisnosti. Ekološki pristup aktuelno najcelovitije sagledava međusobnu povezanost i recipročnost odnosa deteta sa svim elementima sredine koja ga okružuje (Bronfenbrenner, 2001). Efekti rane intervencije mogu se odnositi na samo dete, roditelje, širu porodicu i društvo u celini (De Moor, Van Waesberghe, Hosman, Jaeken & Miedema, 1993).

Rezultati brojnih studija (Arnold & Doctoroff, 2003) ukazuju da je učešće roditelja u programima rane intervencije najznačajniji faktor podsticanja dečjeg razvoja i učenja. Jedan od preduslova za adekvatan angažman roditelja u programima rane intervencije jeste prihvatanje oštećenja vida deteta. Razumevanje stanja deteta jedan je od najznačajnijih faktora u pružanju podrške razvoju deteta. Od roditeljskog stava prema oštećenju zavisi kvalitet njegovog učestvovanja u podsticanju razvoja deteta. Ukoliko proces prihvatanja oštećenja traje suviše dugo, postoji rizik da se preskoči kritični period za određene funkcije i da kasnija podrška razvoju ne donese željene rezultate.

2. METODOLOŠKI PRISTUP PROBLEMU ISTRAŽIVANJA

Stavovi roditelja su determinišući faktor uspešnog procesa (re)habilitacije dece sa oštećenjem vida, jer je proces (re)habilitacije znatno efektniji ako su stavovi roditelja kongruentni postavljenim ciljevima rane intervencije. Cilj istraživanja odnosio se na ispitivanje korelata stavova roditelja prema uključenosti ili neuključenosti njihove dece sa oštećenjem vida u ranu intervenciju. Opšta hipoteza koja obuhvata ceo ispitivan prostor glasi: Postoje statistički značajne razlike u stavovima roditelja prema ranoj inervenciji u odnosu na uključenost ili neuključenosti njihove dece sa oštećenjem vida u ranu intervenciju (H_0).

Uzorak je činio 71 roditelj sa teritorije Republike Srbije, koji su dobrovoljno pristali da učestvuju u istraživanju. Kriterijum za učešće u istraživanju je da njihovo dete ima oštećenje vida (Retinopathia praematurica) i da je uzrasta od 0 do 6 godine starosti. Istraživanje je obavljeno na Klinici za očne bolesti KC Vojvodine u Novom Sadu, ŠOSO „Milan Petrović" sa domom učenika i u Savezu slepih Vojvodine.

Na osnovu podataka o obuhvaćenosti programom rane intervencije, uzorak je podeljen na dva poduzorka, dve grupe roditelja-ispitanika. Prvu grupu ispitanika su činili roditelji čija su deca bila obuhvaćena programom rane intervencije, a drugu grupu, roditelji čija deca nisu bila obuhvaćena pomenutim programom.

Tabela 1 – Polna struktura dece koja su uključena u program rane intervencije

Pol deteta	N	%
devojčice	29	40.8%
dečaci	42	59.2%

U svrhe ovog istraživanja korišćena je tehnika anketiranja i dva instrumenta:

1. *Upitnik za ispitivanje ishoda porodice* (The Family Outcomes Survey, Part C Version, Minnesota Department of Education – Early Childhood Outcomes Center, 2010).
2. *Test nedovršenih rečenica* (Unfinished sentences, A.M. Shchetinina Diagnostics of social development of the child: Training handbookt. Veliky Novgorod, NovGu im. Yaroslava Mudrogo Publ., 2000).

Dobijeni podaci su obrađeni u statističkom paketu Statistica 5.5. Korišćeni su sledeći statistički postupci: deskriptivna statistika, Spirmanov ro test (ρ) korelacije ranga i t-test za nezavisne uzorke.

3. REZULTATI ISTRAŽIVANJA

Prva hipoteza istraživanja odnosila se na ispitivanje razlike u komponentama stavova između roditelja dece koja su bila i koja nisu bila uključena u programe rane intervencije. Tabela 2 pokazuje da postoji statistički značajna razlika između dve grupe roditelja u komponentama stava prema ranoj intervenciji (t=7,77, df=69, p<0,001).

Tabela 2 – Razlike u komponentama stavova prema ranoj intervenciji roditelja dece koja su bila i koja nisu bila uključena u ranu intervenciju

Varijabla	AS 1	AS 2	t-test	df	p	N 1	N 2	SD 1	SD 2
Razlike u stavovima o ranoj intervenciji između ispitanika dva poduzorka	40,86	28,47	7,77	69	0,000	35	36	7,27	6,12

Roditelji čija deca su bila obuhvaćena programom rane intervencije imaju pozitivniji stav prema njoj u odnosu na grupu roditelja čija deca nisu bila obuhvaćena programom. U okviru grupe roditelja koji imaju pozitivan stav prema ranoj intervenciji uočava se veći raspon stava od blago do izrazito pozitivnog (SD=7,27), dok druga grupa roditelja zbog nedovoljne informisanosti nema formiran stav o ranoj intervenciji (SD =6,12).

Zadovoljstvo ranom intervencijom procenjivano je samo na delu uzorka koji je učestvovao u ranoj intervenciji. Maksimalan skor je bio 12. Oni koji su ranu intervenciju ocenili od 3 do 6, svrstani su u grupu nezadovoljnih. Ispitanici sa skorom od 7 do 9 su svrstani u grupu delimično zadovoljnih, a ispitanici sa skorom od 10 do 12 svrstani su u grupu zadovoljnih ranom intervencijom. Nezadovoljnih roditelja efektima programa rane intervencije je bilo sedmoro (20%), delimično zadovoljnih desetoro (28,5%), a oko polovine ispitanika ovog poduzorka, 18-oro roditelja dece sa oštećenjem vida (51,5%), su izrazili zadovoljstvo primenjenim programom rane intervencije.

Druga hipoteza istraživanja odnosila se na očekivane razlike između dve grupe roditelja u razumevanju potreba svog deteta sa oštećenjem vida, tj. u poznavanju smetnji u razvoju svog deteta, prepoznavanju eventualnih posebnih zdravstvenih potreba i uočavanju napretka u razvoju uslovljenog primenom postupaka rane intervencije (usled stručne stimulacije i podrške). Rezultati t-test testa prikazani u Tabeli 3, sugerišu da postoje razlike između roditelja dva poduzorka u pogledu razumevanja potreba svoje dece (t=5,65, df=69, p<0,001).

Tabela 3 – Razlike u razumevanja potreba deteta roditelja dece koja su bila i koja nisu bila uključena u ranu intervenciju

Varijabla	AS 1	AS 2	t-test	df	p	N 1	N 2	SD 1	SD 2
Razlike između dve grupe roditelja u razumevanju potreba deteta	7,71	5,31	5,64	69	0,000	35	36	1,94	1,63

Iz priloženih podataka u tabeli 3 uočava se da roditelji čija su deca bila uključena u program rane intervencije u značajnoj meri bolje razumeju njihove potrebe (AS=7.71) u odnosu na roditelje čija deca nisu bila uključena u program rane intervencije (AS=5.31).

U okviru treće hipoteze ispitivale su se razlike između dve grupe roditelja u pružanju pomoći detetu u razvoju i učenju. Kako Tabela 4 pokazuje, postoje značajne razlike u pružanju pomoći detetu u razvoju i učenju između roditelja čija su deca bila uključena u ranu intervenciju i roditelja čija deca nisu bila uključena (t=5,78, df=69, p<0,001). Roditelji dece koja su bila uključena u program rane intervencije su u značajnoj meri bolje edukovani da podstiču razvoj svoga deteta, sigurniji su u svoje postupke i osnaženiji za pružanje podrške (AS=8,46). Roditelji dece koja nisu bila uključena u program rane intervencije su uskraćeni za informacije kako podsticati razvoj svoga deteta (AS=5,86). Nepoznavanje karakteristika deteta sa oštećenjem vida čini ih manje aktivnim, a samim tim i manje uspešnim u podsticanju razvoja svoga deteta.

Tabela 4 – Razlike u pružanju pomoći detetu između dve grupe roditelja

Varijabla	AS 1	AS 2	t-test	df	p	N 1	N 2	SD 1	SD 2
Razlike u pružanju pomoći detetu između dve grupe roditelja	8,46	5,86	5,78	69	0,000	35	36	1,88	1,90

Četvrta hipoteza istraživanja odnosila se na ispitivanje razlika između ispitanika-roditelja dva poduzorka u odnosu prema detetu i viđenju njegove budućnosti.

Rezultati t-testa pokazuju da ne postoje statistički značajne razlike između dve grupe roditelja (t=1,27, df=69, p=0,209).

Tabela 5 – Razlike u odnosu prema detetu, viđenju njegove budućnosti i uvidu o sebi kao roditelju između dve grupe ispitanika

Varijabla	AS 1	AS 2	t-test	df	p	N 1	N 2	SD 1	SD 2
Razlike u stavovima prema detetu, njegovoj budućnosti i sebi kao roditelju	10,97	10,28	1,27	69	0,209	35	36	2,24	2,36

4. DISKUSIJA

Rezultati meta-analize (Arnold & Doctoroff, 2003) ukazuju na to da su najveći efekat na dečiji razvoj i učenje ostvarili programi nege, vaspitanja i obrazovanja koji su uključivali i roditelje. Potvrdu ovih rezultata pronašli smo i u našem istraživanju gde je uočena statistički značajna razlika između roditelja dece koja su bila obuhvaćena i roditelja dece koja nisu bila obuhvaćena programom rane intervencije u komponentama stava prema ranoj intervenciji (t=7,77, df=69, p<0,001).

Roditelji obuhvaćeni programom rane intervencije ističu da im je ova vrsta podrške u velikoj meri povećala roditeljske kompetencije, u smislu razumevanja potreba svoga deteta sa oštećenjem vida i pružila uvid u sve aspekte društvene podrške koju mogu da ostvare. Takođe, roditelji dece koja su uključena u program rane intervencije znaju da su im za pružanje pomoći detetu neophodne dodatne informacije, saveti i instrukcije stručnjaka. Podrška podrazumeva poznavanje načina i sposobnost podsticanja razvoja sposobnosti, znanja i veština deteta sa oštećenjem vida i spremnost da preporučene vežbe od strane stručnog tima sprovode i realizuju kontinuirano sa detetom u kućnim uslovima. Uključivanje u program rane intervencije i rad u kućnim uslovima po savetodavnim i instruktivnim uputstvima stručnog tima, osnažuje roditelje i donosi roditeljima veći stepen prihvatanja stanja deteta, realnije sagledavanje potencijala, bolju komunikaciju i razumevanje sa detetom.

Sumirajući rezultate testa *Nedovršenih rečenica*, koji govori o odnosu prema detetu i viđenju budućnosti deteta, možemo konstatovati da je bez obzira na uključenost u programe rane intervencije kod roditelja uvek prisutna doza straha da njihovo dete neće biti nikada u potpunosti uključeno i prihvaćeno u svoje socijalno okruženje, da će vrlo teško biti samostalno i nezavisno u obavljanju svojih životnih aktivnosti. Ono što je zajedničko svim ispitanicima – roditeljima dece sa oštećenjem vida je neizvesna budućnost, kao i nemogućnost anticipacije stepena rehabilitacije na kraju procesa.

5. ZAKLJUČNA RAZMATRANJA I TIFLOLOŠKE IMPLIKACIJE

Kako bi dete sa oštećenjem vida moglo da raste i maksimalno razvije sve svoje snage i sposobnosti neophodna mu je kontinuirana specifična tiflološka podrška (Sabolič, 2006). Ovakva vrsta podrške može se realizovati u okviru programa rane intervencije. Možemo zaključiti da roditelji dece koja su bila obuhvaćena programom rane intervencije bolje razumeju potrebe svog deteta i podstiču njegov razvoj i učenje, upoznati su sa pravima koja mogu da ostvare u lokalnoj zajednici i aktivni su članovi tima za ranu intervenciju. Uključivanje dece sa oštećenjem vida u programe rane intervencije donosi višestruke pozitivne ishode, kako za dete, njegovu porodicu, tako i za društvo u celini. Shodno tome, tiflološke implikacije rezultata istraživanja odnose se na neophodnost formiranja Centara za ranu intervenciju na nivou lokalne zajednice u okviru ustanova u kojima postoje raspoloživi resursi.

LITERATURA

Andrejević, D. (2005). Rana Intervencija *U Evropi: Trendovi U 17 evropskih Zemalja.* Beograd: Zadužbina Andrejević.

Arnold, D. H., & Doctoroff, G. L. (2003). The early education of socioeconomically disadvantaged children. *Annual Review of Psychology, 54*(1), 517-545.

Bronfenbrenner, U. (2001). The bioecological theory of human development. In N. Smelser & P. Baltes (Eds.), *International encyclopedia of the social and behavioral sciences* (Vol. 10, pp. 6963–6970). New York: Elsevier.

De Moor, J. M. H., Van Waesberghe, B. T. M., Hosman, J. B. L., Jaeken, D., & Miedema, S. (1993). Early intervention for children with developmental disabilities: manifesto of the Eurlyaid working party. *International Journal of Rehabilitation Research, 16*(1), 23-32.

Sabolič, E. (2006). Rana intervencija rizične djece ili djece koja su se rodila kao rizična. *Međunarodni znanstveni i stručni skup Rehabilitacija-stanje i perspektive djece s teškoćama u razvoju i osobama s invaliditetom*, Centar za rehabilitaciju Rijeka, Rijeka, *12*(13), 82-84.

Vučinić, V., Anđelković, M., Jablan, B., & Žigić, V. (2014). Kortikalno oštećenje vida – karakteristike i tretman. *Specijalna edukacija i rehabilitacija*, *13*(3), 313-331.

Vučinić, V., Stanimirović, D., Anđelković & Eškirović, B. (2013). Socijalna interakcija dece sa oštećenjem vida: rizični i zaštitni faktori. *Specijalna edukacija i rehabilitacija, 12*(2), 241-264.

Zentner, M., & Bates, J. E. (2008). Child temperament: An integrative review of concepts, research programs, and measures. *International Journal of Developmental Science, 2*(1), 7-37.

CORRELATES OF PARENTAL ATTITUDES LINKED TO INCLUSION/EXCLUSION OF THEIR CHILDREN WITH VISUAL IMPAIRMENT IN EARLY INTERVENTION

Snežana Nikolić*, Marta Dedaj**, Jelena Berklović***, Tamara Radojčić****
*Special Primary School “Milan Petrović”, Novi Sad, Serbia
**School of Professional Studies for Educators and Business Informatics
Sirmium, Sremska Mitrovica, Serbia
***Clinical Center Vojvodina, Department of Ophthalmology, Novi Sad, Serbia
****Special Primary School “Milan Petrović”, Novi Sad, Serbia

Research subject: The aim of our research was to examine the correlates of parental attitudes linked to inclusion/exclusion of their children with visual impairment in early intervention programs.

Method: The sample consisted of 71 parents of children with visual impairments (aged between 0 and 6). One group of participants were parents whose children were included in the incentive program for early intervention and another group were parents whose children were not included in this program. Data was collected by The Family Outcomes Survey questionnaire (applied to examine the outcomes of the family) and the Test of Unfinished Sentences, which examines the parent’s relation to a child, perception of himself as a parent and a vision of his child’s future.

Results: The results showed that the parents whose children were included in the program of early intervention had a positive attitude towards it.This group of parents had a higher score on the scale of the subtests knowledge of the needs and capabilities of their child, the existence and use of the capacity of family support, knowledge of rights they can exercise in the local community and beyond and were active participants in their child’s support team. Unlike the first group, the second group of parents had a positive attitude towards early intervention because they were not participating in this program,did not have experience,and some parents had a desire to have their child with visual impairment included in this type of program.

Conclusion: The results suggest possible directions for further research which will focus on monitoring the effects of early intervention programs in later achievements of children with visual impairments and their personal and professional affirmation of the social environment.The importance of this research lies in the necessity to establish centers for early intervention in the local community. Early child development stimulation prevents secondary disorders, develops compensatory strengths and abilities and encourages maximum overall development.

Key words*:* Early intervention, parents of children with visual impairments

POSTER PRESENTATION

POSTER PREZENTACIJA

udc 373.2.022(430)
37.014(430)

How to Bridge the Gap Between Theory and Practice in Early Childhood Intervention?

Marianne Irmler
Haus Mignon, Hamburg, Germany

Research subject: *"Theory is when you know everything and nothing works, practice is when everything works and nobody knows why" (unknown). Despite the fact that the need to bridge the gap between (further) education and practice is advocated, institutes of further education and universities of applied sciences in Germany exist more or less isolated from practical institutions in early childhood intervention. Students complete block internships during their studies, which are reflected in reports and seminars, but these internships normally last one semester at most.*

Method: *The paper aims to discuss the main questions of how to bridge the gap between theory and practice in early childhood intervention.*

Results: *It is common sense that best practice in early childhood intervention needs experiences in promotion of relation and relation-promoting attributes, e.g. empathy, acceptance, appreciation and congruence. However, to build these qualities frequent experiences in practice are needed, which are continuously reflected by qualified lecturers. Discussions about factors of effectiveness in pedagogical settings, unspecific factors, e.g. relation between child and pedagogue, are becoming more and more important. On the other hand findings of studies about interaction in preschool settings show that there is a lack of quality in interaction processes between pedagogues and children. Therefore a closer cooperation between institutes of education and institutes of practice is needed for a high quality preparation of staff in early childhood intervention.*

Conclusion: *This might be the beginning of bridging the gap between theory and practice. The first attempt to combine theory and practice in further education is made in an early childhood intervention centre (Haus Mignon) in Hamburg/Germany.*

Key words: *education, early childhood intervention, theory-practice-gap*

INTRODUCTION

“Theory is if you know everything and nothing works, practice is if everything works and nobody knows why” (unknown). This saying precisely describes how important it is to combine theory and practice continuously. Nevertheless, there is still a big gap of transfer between these two aspects of early childhood intervention (ECI), which especially occurs when students finish their studies and start working in a practical field (Mischo & Fröhlich-Gildhoff, 2011). The traditional forms of internships in Germany are block internships or sometimes accompanying internships. Internships with a slowly increasing amount of hours and responsibilityas well as systematic reflection of experiences are still not established in further education of ECI. This could be one option to decrease the gap between theory and practice. Furthermore another topic of ECI strengthens this approach of education: Following discussions about impact factors in pedagogical settings, unspecific factors, e.g. the relationship between child and pedagogue, are getting increasingly important (Becker-Stoll & Textor, 2007; Gebhard & Kuhlenkamp, 2012; Hackenberg, 2003; Schlack, 2011). On the other hand findings of studies about interaction in preschool settings show that there existsa lack of quality in interaction-processes between pedagogues and children (Fried, 2008; König, 2010). Therefore, more highly reflected experiences during further education might on the one hand raise awareness of students for this part of ECI on the other hand offers a kind of self-reflecting time which is known to strengthen relationship-building attributes (Hackenberg, 2003).

AIM OF THE PAPER

The paper is aimed to discuss the main questions of how to bridge the gap between theory and practice in ECI. Furthermore, possibilities of closing this gap are provided by presenting parts of a concept for further education in an ECI centre in Northern Germany.

METHOD

A further education in ECI is planned for a group of ten to twenty participants with practical experiences and a former education. The further education will take place in an ECI centre in Hamburg/Northern Germany. Thus, the practical institution by itself is provider of the seminars. The concept includes four different parts: (1) Theoretical content which is delivered through 20 seminars, held by qualified lecturers from different disciplines (e.g. special pedagogues, psychologists, doctors, physiotherapists, speech therapists and occupational therapists), (2) practical content which is delivered by experienced practitioners from different disciplines (e.g. special pedagogues, social workers, physiotherapists, occupational therapists and speech therapists), (3) accompanied practice which increases in amount of time and responsibilityand (4) small groups of participants for peer-consulting who meet every three months to practice self-reflection and techniques of case reviews.

Especially part (3), accompanied practice, is presented in detail to claim the importance of this field in preparing participants sensitively to their future tasks (see table 1).

Table 1 – Accompanied practice in further education programme, quarter = three months, ECI = Early childhood intervention

part of further education programme	tasks in accompanied practice
quarter 1	weekly observation of one to two ECI sessions from pedagogues
quarter 2	weekly observation and documentation of one to two ECI sessions from pedagogues, monthly observation of one physiotherapy/occupational therapy or speech therapy session
quarter 3	weekly observation and documentation of one to two ECI sessions from pedagogues and tasks of preparation and postprocessing, monthly observation of one physiotherapy/occupational therapy or speech therapy session
quarter 4	weekly observation and documentation of one to two ECI sessions from pedagogues and tasks of preparation and postprocessing, monthly observation of one physiotherapy/occupational therapy or speech therapy session, observation of at least one session of assessment with standardized tests
quarter 5	weekly assistance in one to two ECI sessions from pedagogues and tasks of preparation and postprocessing, monthly observation of one physiotherapy/occupational therapy or speech therapy session, participation in at least one interdisciplinary diagnostic session
quarter 6	responsibility of one to two ECI sessions weekly (including preparation and postprocessing), one assessment of a child including a standardized test
quarter 7	responsibility of one to two ECI sessions weekly (including preparation and postprocessing), video-taoing one session and discussion of it in a peer-consulting team with other students

The accompanied practice is slowly increasing in amount of time and tasks (table 1). Furthermore, participants have the opportunity to discuss their experiences and questions in every seminar as well as in their peer-consulting groups. Participants get special tasks for observation and reflection in order to practice their competencies in self-reflection and to speak about the relevance of relationship in settings of ECI (Hackenberg, 2003).

It is planned to evaluate the effectiveness of this further education in a longitudinal study via questionnaires and interviews with participants, including assessment before, during and after the programme as well as in a follow-up one year after finishing the seminars. There is still a lack of studies about long-term effects from further education in ECI and early educational settings (Mischo & Fröhlich-Gildhoff, 2011). Herewith, the concept aims for the assessment of long-term effects, e.g. in relationship-building attributes.

RESULTS AND DISCUSSION

The further education seminars based on the discussed concept are planned to start earliest in spring 2018. Therefore, promotion will start in autumn 2017. Questionnaires and structures for interviews will be developed in summer 2017. Results of questionnaires and interviews will be analysed and compared to results during, after and from the follow-up period in order to adapt the concept to the participants needs.

Although the importance of relationship is one topic of discussion in ECI since more than 30 years (e.g. Hintermair & Mail-Consee, 1982) there is obviously still a lack in how to convey competencies in relationship-building to students as well as how to assess these competencies. Facing results concerning common or unspecific factors in the field of education, therapy and psychotherapy (e.g. Becker-Stoll &Textor, 2007; Hall, P.H. Ferreira, Maher, Latimer & M. L. Ferreira, 2010; Pianta & Stuhlman, 2004; Spilt, Koomen & Harrison, 2015; Wampold, 2001), which are neighbouring disciplines of ECI, it is necessary to develop new concepts of further education. Not just the relationship between child and pedagogue or therapist is an important unspecific factor in ECI, but also the parent-therapist relationship (Broggi & Sabatelli, 2010).

CONCLUSION

In this article the main questions of how to bridge the gap between theory and practice in ECIhave been discussed. Facing the facts about interaction-qualities in early childhood education it is obvious that there is still a need for innovating further education in this field. Furthermore, following the results about unspecific factors in ECIit is alsonecessary to make a shift in qualifying professionals in order to sensitively support students in developing relationship-building attributes. The described concept may be one possibility which has to be completed by further approaches. Approaches such as from Murray and Curran (2008) who used non-traditional and traditional methods to teaching family-centered values and practices might be useful to take into account. They included parents of children with special needs in classes for students and built teams of family members and university staff in their seminars. However, these approaches must be evaluated to reach evidence in order to know which kind of study format might be useful to offer best prepared professionals in practice.

REFERENCES

1. Becker-Stoll, F., & Textor, M. R. (2007). Die Erzieherin-Kind-Beziehung. Zentrum von Bildung und Erziehung. Berlin: Cornelsen Verlag Scriptor.
2. Broggi, M.B., & Sabatelli, R. (2010). Parental perceptions of the parent-therapist relationship: Effects on outcomes of early intervention. In *Physical & Occupational Therapy in Pedicatrics*, *30(3)*, 234-247.doi: 10.3109/01942631003757602
3. Fried, L. (2008). Professionalisierung von Erzieherinnen am Beispiel der Sprachförderkompetenz – Forschungsansätze und erste Ergebnisse. In H. von Balluseck (Ed.), *Professionalisierung in der Frühpädagogik* (pp. 265-277). Opladen: Barbara Budrich.
4. Gebhard, B., & Kuhlenkamp, S. (2012). Psychomotorik in der Frühförderung – Überlegungen aus den Perspektiven Wirksamkeit und Inklusion. In B. Gebhard, B. Hennig & C. Leyendecker (Eds.), *Interdisziplinäre Frühförderung exklusiv – kooperativ – inklusiv* (pp. 219-226). Stuttgart: Kohlhammer.
5. Hackenberg, W. (2003). Beziehung in der Frühförderung – Konsequenzen für die Ausbildung. Die teilnehmende Säuglingsbeobachtung als Methode zur Erweiterung des Verständnisses für die frühkindliche Entwicklung und für soziale Prozesse. *Frühförderung interdisziplinär, 22(1)*, 3-11.
6. Hall, A. M., Ferreira, P. H., Maher, C. G., Latimer, J., Ferreira, M. L. (2010). The influence ofthe therapist-patient relationship on treatment outcome in physical rehabilitation. A Systematic Review. *Physical Therapy, 90*, 1099-1110. doi: 10.2522/ptj.20090245
7. Hintermair, M., & Malik-Consee, M. (1982). Der Beziehungsaspekt als zentrales Anliegen in der Frühförderung. *Frühförderung interdisziplinär, 1(4)*, 156-171.
8. König, A. (2010). Interaktion als didaktisches Prinzip: Bildungsprozesse bewusst begleiten und gestalten. Troisdorf: Bildungsverlag Eins.
9. Mischo, C., & Fröhlich-Gildhoff, K. (2011). Professionalisierung und Professionsentwicklung im Bereich der frühen Bildung. *Frühe Bildung, 0*, 4-12. doi: 10.1026/2191-9186/a000001
10. Murray, M., & Curran, E. (2008). Learning together with parents of children with disabilities: Bringing parent-professional partnership education to a new level. *Teacher Education and Special Education, 31(1)*,59-63. doi: 10.1177/088840640803100106
11. Pianta, R. C., & Stuhlman, M. W. (2004). Teacher-child relationships and children's success in the first years of school. *Psychology Review, 33(3)*, 444-458.
12. Schlack, H. G. (2011, June 12). Interventionsweisen der Frühförderung und ihre Wirksamkeit. Retrieved fromhttp://www.kita-fachtexte.de/uploads/media/FT_schlackI_2011.pdf.
13. Spilt, J. L., Koomen, H. M.& Harrison, L. J. (2015). Language development in the early school years: The importance of close relationships with teachers. *Developmental Psychology, 51(2)*, 185-196. doi: 10.1037/a0038540
14. Wampold, B. (2001). The great psychotherapy debate: Model, methods and findings. Mahaw: Erlbaum.

udc 376.1-056.262-053.2
316.356.2
354.4-056.262-053.2

Rana intervencija u školi za decu sa oštećenjem vida

Danijela Petković
Škola za učenike oštećenog vida „Veljko Ramadanović”, Zemun, Srbija

Predmet istraživanja: *Tiflološka rana intervencija u našoj školi postoji od septembra 2002. godine. Nakon studijskog putovanja u Holandiju oformljen je tim koji su činila dva tiflologa, psiholog, instruktor orijentacije i kretanja, logoped i socijalni radnik. Radili su na volonterskoj bazi svesni značaja podrške koju pružaju porodicama slepe i slabovide dece. Do sada je tretmanima rane intervencije obuhvaćeno preko stotinu dece i porodica.*

Metod: *Osnovni cilj ovog rada je da prikaže rezultate usluge rane intervencije u školi za učenike oštećenog vida.*

Rezultati: *Timski rad omogućio je deci i njihovim porodicama najbolju moguću podršku, zbog toga što je uključivao sve faktore relevantne za razvoj dece u skladu sa potrebama porodice. Nakon urađene procene, zajedno sa roditeljima utvrđeni su ciljevi i napravljen je individualni plan podrške. Cilj nam je formiranje Centra za tiflološku ranu intervenciju pri školi. Želeli bismo da se u bliskoj budućnosti ispune uslovi neophodni za izvođenje tretmana u domovima porodica, kao i za pružanje inkluzivne podrške u vrtićima koje pohađaju slepa i slabovida deca do 6. godine.*

Zaključak: *Jedan od načina da se postignu projektni zadaci jeste realizacija školskog projekta „Inkluzivna podrška VO/VOVO deci predškolskog uzrasta” u okviru programa Erasmus+, Fondacije Tempus.*

Ključne reči: *rana intervencija, deca oštećenog vida*

Tiflološka rana intervencija u našoj školi postoji od septembra 2002. godine. Nakon studijskog putovanja u Holandiju oformljen je tim koji su činila dva tiflologa, psiholog, instruktor orijentacije i kretanja, logoped i socijalni radnik. Radili su na volonterskoj bazi svesni značaja podrške koju pružaju porodicama slepe i slabovide dece. Do sada je tretmanima rane intervencije obuhvaćeno preko stotinu dece i porodica.

Danas u ranoj intervenciji rade tri tiflologa u savremeno opremljenom prostoru, a sveobuhvatni pristup i procenu u svim sferama razvoja obezbeđujemo uz pomoć savremenih instrumenata i metoda u saradnji sa obučenim stručnjacima iz naše škole koji se bave procenom i tretmanima specifičnih područja razvoja. Zajedno činimo tim za ranu intervenciju: tri obučena tiflologa, psiholog, logoped, senzorni integrator, psihomotorni reedukator, tiflolozi obučeni za procenu funkcionalnog vida.

Rad tima odvija se na sledećim područjima:

- detekcija i evidencija
- dijagnostika (psihološka i defektološka)
- individulni rad sa detetom u školi
- savetodavni rad sa članovima uže i šire porodice
- konstantno stručno usavršavanje svih članova tima rane intervencije
- usklađivanje sa savremenim naučnim saznanjima na polju rane intervencije u svetu.

Rad sa porodicom i detetom se odvija isključivo u školi jer nemamo uslova za rad u porodičnoj sredini. Beogradske porodice, u zavisnosti od potreba deteta, dolaze dva puta nedeljno ili i češće. Porodice iz unutrašnjosti, prema sopstvenim mogućnostima, najčešće jednom nedeljno na tretmane od po 1,5 sat. Nakon opservacije deteta, pristupa se dijagnostici, sastaje se tim i izrađuje individualni plan podrške deteta i procenu budućeg razvoja.

Učešće u petogodišnjem projektu sa organizacijom VISIO iz Holandije omogućilo nam je da rad u okviru rane intervencije dostigne kvalitetniji i sveobuhvatniji nivo.

Nakon petogodišnje edukacije u okviru projekta, u periodu od oktobra 2012. do maja 2017, tiflolozi koji rade u ranoj intervenciji dobili su sertifikate o položenoj edukaciji na najvišem, trećem nivou. Stekli smo dodatna znanja i veštine i osposobljeni smo da, upotrebom savremenih dijagnostičkih mernih instrumenata:

- prikupimo relevantne informacije o detetu i porodici
- izvršimo procenu nivoa kognitivnog razvoja, krupne motorike, fine motorike, govorno-jezičkog razvoja, kompenzatornih sposobnosti, vizuelnog funkcionisanja i veština svakodnevnog života
- izvršimo procenu nivoa razvoja igre
- osmislimo i organizujemo kvalitetan tretman sa vizuelno oštećenom i višestruko vizuelno oštećenom decom od rođenja do 6. godine
- izaberemo adekvatan igrovni materijal shodno odgovarajućem razvojnom nivou deteta
- definišemo SMART ciljeve u dogovoru sa roditeljima
- izradimo rehabilitacioni plan za dete i njegovo okruženje
- analiziramo sopstveni rad i unapređujemo personalni stil tiflologa u ranoj intervenciji

Psiholog je neophodan član tima uz čiju pomoć se izrađuje rehabilitacioni plan za dete i njegovo okruženje i koji upotrebom psihodijagnostičkih instrumenata i intervjua sa roditeljima vrši procene, pruža psihosocijalnu podršku porodici i učestvuje u suportivnim i edukativnim grupnim radionicama za roditelje.

Logoped uzima logopedsku anamnezu, obavlja intervju sa roditeljima i daje nalaz, mišljenje i stimulativni program za razvoj govorno jezičkih i komunikativnih funkcija, načina ishrane i manipulacije ruku.

Procene u svom domenu rada vrše i senzorni integrator i reedukator psihomotorike i ukoliko se proceni da postoji potreba, dete se uključuje u programe stimulacije. Ovi stručnjaci pomažu roditeljima da i u kućnim uslovima obezbede opuštenu, bezbednu i stimulativnu sredinu kako bi se svi senzorni stimulusi organizovali i dete imalo uslove da istražuje, uči i lakše komunicira sa okolinom, kao i da stimulišu i organizuju psihomotorni razvoj.

Procena funcionalnog vida je ključna procena i prvi korak u planiranju rehabilitacionog i reedukativnog rada sa decom i roditeljima. Procenom funkcionalnog vida dobijaju se podaci koji su krucijalni u planiranju rada rane intervencije. Procene se vrše upotrebom seta testova koje koriste tiflolozi sertifikovani za vršenje procene. Rad sa slabovidom decom se, između ostalog, bazira na rezultatima PFV, odnosno preporukama na koji način dete može da koristi preostali vid. Roditelji tek nakon ovakve procene shvate šta, kako i koliko njihovo dete zapravo vidi, dobijaju preporuke za upotrebu optičkih i neoptičkih pomagala i sredstava asistivne tehnologije, savete na koji način je potrebno adaptirati životnu sredinu.

Timskim radom omogućavamo najkvalitetniju moguću podršku kroz kompletan i kvalitetan, sveobuhvatni tretman VO/VOVO dece uzimajući u obzi sve relevantne faktore razvoja deteta u skladu sa potrebama porodice. Analizom iskustava roditelja došli smo do određenih zaključaka:

- Roditelji su po prvi put dobili jasne i precizne informacije o prirodi hendikepa, mogućnostima deteta i o načinima na koje bi trebalo da rade na optimalnom razvoju svog deteta
- Upoznavanje sa drugim roditeljima im je mnogo značilo i pojedine porodice razmenjuju iskustva, druže se i pružaju podršku jedni drugima
- Prilagođavanje roditelja na hendikep dovelo je i do razvoja interaktivnog odnosa između roditelja i deteta
- Kod dece obuhvaćene tretmanom i roditelji su primetili napredak
- Deca su se lakše uklopila u odgovarajuće vaspitne i obrazovne grupe

Cilj nam je formiranje Centra za tiflološku ranu intervenciju pri školi. Želeli bismo da se u bliskoj budućnosti ispune uslovi neophodni za izvođenje tretmana u domovima porodica, kao i za pružanje inkluzivne podrške u vrtićima koje pohađaju slepa i slabovida deca do 6. godine. Jedan od načina da to postignemo je kroz realizaciju školskog projekta „Inkluzivna podrška VO/VOVO deci predškolskog uzrasta" u okviru programa Erasmus+, Fondacije Tempus. Praćenjem rada na terenu kolega iz partnerske organizacije, Centra IRIS iz Ljubljane, koji na visokom nivou pružaju inkluzivnu podršku deci u vrtićima na teritoriji cele Slovenije, želimo da doprinesemo da se i u našoj školi, u bliskoj budućnosti, inkluzivna podrška i celokupan tretman dece i porodica u ranoj intervenciji podigne na još viši nivo.

Na konferenciji povodom završnice petogodišnjeg projekta sa organizacijom VISIO, održanoj u Ljubljani u maju ove godine, započeti su pregovori sa predstavnicima iz Ministarstva prosvete, nauke i tehnološkog razvoja o budućnosti tiflološke rane intervencije u Srbiji.

EARLY INTERVENTION IN A SCHOOL FOR VISUALLY IMPAIRED CHILDREN

Danijela Petković
School for students with impaired vision “Veljko Ramadanović”, Zemun, Serbia

Research subject: Early intervention services for children with impaired vision began in September 2002 in Serbia. After a study trip experience in the Netherlands, an interdisciplinary professional team was formed, consisting of specialists in typhlology, a psychologist, an orientation and movement instructor, a speech therapist and a social worker. The professionals were working on a voluntary basis, aware of the importance of support provided by families of blind and visually impaired children. So far, the treatment in the context of early intervention has included more than a hundred children and families.

Method: This paper aims to present the results of early intervention services in a school for children withimpaired vision.

Results: Teamwork provides children and their families with the best possible support, because it includes all relevant factors of development of the child in accordance with the needs of families. After the completion of assessment, objectives were determined and an individual support plan was developed with parents’ support. In the near future, we would like to meet the conditions necessary to perform the treatment in family homes, and to provide extensive support in inclusive kindergartens attended by blind and visually impaired children up to 6 years of age.

Conclusion: One of the ways to achieve the projected objectives is through the implementation of a school project *Inclusive support VI / MDVI preschool children*, granted by Erasmus and Tempus Foundation.

Key words: Early intervention, children with visual impairments

udc 376.1-056.26/.36-053.2
371.3::51-028.31

Rane matematičke veštine kod dece s teškoćama u mentalnom razvoju[1]

Aleksandra Đurić-Zdravković, Mirjana Japundža-Milisavljević, Sanja Gagić
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Rane matematičke veštine predstavljaju osnovu za kasniji razvoj matematičkih sposobnosti koje su važne za svakodnevni kvalitetniji život osoba s teškoćama u mentalnom razvoju. Cilj rada je da uporedi kvalitet ranih matematičkih veština kod dece s teškoćama u mentalnom razvoju različitih kliničkih slika (laka intelektualna ometenost, umerena intelektualna ometenost, autistički spektar poremećaja, cerebralna paraliza, teška intelektualna ometenost). Uzorak čini 52 ispitanika uzrasta od četiri do šest godina i mesec dana. U prikupljanju podataka o kvalitetu ovladanosti ranim matematičkim veštinama ispitanika korišćen je deo Predškolske procene pod nazivom Matematičke veštine koji sadrži ajteme razvijene iz kurikuluma. Jednofaktorskom analizom varijanse ispitan je uticaj dijagnostičkih grupa na ovladanost matematičkim veštinama, pri čemu je utvrđeno da je razlika u skorovima dijagnostičkih grupa statistički značajna (p= 0,000).

Ključne reči: *rane matematičke veštine, teškoće u mentalnom razvoju, dijagnostičke grupe*

UVOD

Još od vremena Pijažea i Inhelderove, šezdesetih godina prošlog veka, istraživačima je poznato da kvalitet ranih matematičkih veština predstavlja neophodnu osnovu za kasniji razvoj matematičkih sposobnosti koje će biti utemeljene tokom školovanja (Pijaže i Inhelder, 1996). Pod ranim matematičkim veštinama se podrazumeva: upoznavanje oblika, veličine i boje predmeta, klasifikovanje predmeta prema kategorijama, upoznavanje odnosa u prostoru, nepromenljivost količine, mehaničko brojanje, prepoznavanje brojeva i pridruživanje simbola broja količini, pojam skupa i manipulisanje elementima skupova, pojmovi više-manje, jednako, malo i mnogo (Geary, 1994). Svi ovi pojmovi se usvajaju i uvežbavaju kroz predškolski kurikulum.

---

[1] Članak predstavlja rezultat rada na projektima: „Kreiranje Protokola za procenu edukativnih potencijala dece sa smetnjama u razvoju kao kriterijuma za izradu individualnih obrazovnih programa'' (br. 179025) i „Socijalna participacija osoba sa intelektualnom ometenošću'' (br. 179017), čiju realizaciju finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

U ranijim radovima utvrđeno je da deca s teškoćama u mentalnom razvoju (TuMR) kvalitativno kasne u razumevanju osnovnih osobenosti brojanja i uočavanju greški u zadacima prostornih provera, kao i jednostavnijim klasifikacijama predmeta (Geary, Bow-Thomas & Yao, 1992).

Istraživanja vezana za rane matematičke veštine kod dece s TuMR su ograničenog broja i nema dovoljno podataka o kvalitetu ranih matematičkih veština kod dece s autističkim spektrom poremećaja (ASP) (Huang, Lai & Rivera, 2010; Stahmer, Collings & Palinkas, 2005), cerebralnom paralizom (CP) (Van Rooijen, Verhoeven & Steenbergen, 2011), lakom intelektualnom ometenošću (LIO) (Lerner & Johns, 2011), umerenom intelektualnom ometenošću (UIO) (Jimenez & Kemmery, 2013) i teškom intelektualnom ometenošću (TIO) (Browder & Spooner, 2011). Zbog limitiranog broja dostupnih studija ne mogu se sagledati zaključci o kvalitetu i razvojnim trajektorijama matematičkih veština kod kliničkih slika koje pripadaju TuMR. U potrebi za bližim sagledavanjem kvaliteta ranih matematičkih veština kod dece s TuMR obuhvaćenih vrtićkom edukacijom, sprovedeno je istraživanje koje je posmatralo veštine razvijene iz zvaničnog predškolskog kurikuluma u Srbiji.

Cilj rada je da uporedi kvalitet ranih matematičkih veština kod dece s TuMR različitih kliničkih slika (LIO, UIO, TIO, ASP i CP).

METOD RADA

Uzorak i procedura

Uzorak je činilo 52 ispitanika uzrasta od četiri do šest godina i mesec dana (AS=5,42; SD=0,696). U uzorku je prisustvo dečaka značajno zastupljenije (36 ispitanika ili 69,2%) u odnosu na devojčice (16 ispitanica ili 30,8%). Uočava se disproporcija broja dečaka i devojčica u ovoj studiji, što objašnjavamo prevalencijom broja dečaka u kliničkoj slici ASP. Ispitanici su bili podeljeni u nekoliko grupa u odnosu na evidentiranu kliničku sliku.

Tabela 1 – Distribucija ispitanika u odnosu na kliničku sliku

Klinička slika		N	%
	LIO	16	30,8
	UIO	7	13,5
	ASP	19	36,5
	CP	6	11,5
	TIO	4	7,7
	Total	52	100,0

Legenda: LIO – laka intelektualna ometenost; UIO – umerena intelektualna ometenost; ASP – autistički spektar poremećaja; CP – cerebralna paraliza; TIO – teška intelektualna ometenost

Isključujući kriterijumi u formiranju uzorka odnosili su se na postojanje drugih medicinskih ili psihijatrijskih dijagnoza, neuroloških oboljenja i senzornih oštećenja.

Iz Tabele 2 se uočava da je u uzorku dominantno prisustvo šestogodišnjaka. U svim beogradskim ustanovama za decu predškolskog uzrasta u kojima je vršeno prikupljanje ovih podataka, najbrojniji su šestogodišnjaci, dok su mlađa deca prisutna u manjem broju.

Tabela 2 – Distibucija ispitanika u odnosu na uzrast

4 god.	5 god.	6 god.
6 (11,5%)	18 (34,6%)	28 (53,9%)

Istraživanje je obavljeno tokom januara, februara i marta meseca 2017. godine u predškolskim ustanovama za decu tipične populacije i u predškolskim ustanovama koje imaju razvojne grupe. Deca razvojnih grupa su u uzorku bila brojnija (31 dete ili 59,6%), dok je u istraživanje uključen 21 ispitanik (40,4%) iz predškolskih ustanova za decu tipične populacije.

Svi roditelji dali su svoju pismenu saglasnost za učešće deteta u ovom istraživanju.

Instrument

U prikupljanju podataka o kvalitetu ovladanosti ranim matematičkim veštinama ispitanika korišćen je deo interne Predškolske procene koji sadrži veštine razvijene iz kurikuluma, tj. Osnova programa predškolskog vaspitanja i obrazovanja dece od tri godine do uključivanja u program pripreme za školu (Sl. glasnik RS, 2006). Deo Predškolske procene pod nazivom Matematičke veštine sadrži devet ajtema koji obuhvataju shvatanje odnosa o količini („manje od”, „više od”), prepoznavanje simbola brojeva i brojanje unapred do 10, mogućnost prepoznavanja osam uobičajenih geometrijskih oblika, navođenje 10 osnovnih boja, grupisanje sličnih objekata u jednostavne kategorije i sortiranje objekata po boji, obliku i veličini. Ukupan broj poena na ovom delu procene je 18. Kada ispitanik pravilno reši određeni zadatak, dobija dva poena. Ukoliko ispitanik pri rešavanju zadataka koristi pomoć defektologa ili napravi do dve greške pri višesložnim zadacima dobija jedan poen, a ako zadatak nije rešen, upisuje se nula poena.

Obrada podataka

Tokom statističke obrade primenjeni su sledeći statistički postupci:

- Standardni deskriptivni statistički pokazatelji: aritmetička sredina, standardna devijacija, frekvencije i procenti;
- Jednofaktorska analiza varijanse (ANOVA).

REZULTATI ISTRAŽIVANJA SA DISKUSIJOM

Tabela 3 daje prikaz prosečnih skorova ispitanika prilikom procene ovladanosti ranim matematičkim veštinama u odnosu na vrstu kliničke slike. Uočava se vidna razlika između kvaliteta ovladanosti ranim matematičkim veštinama kod dece s LIO i dece ostalih dijagnostičkih grupa, jer su oni postigli najveći prosečan skor (AS = 11,81, SD = 3,74). Deca s ASP postižu bolje rezultate u ovoj oblasti (AS = 7,10, SD = 5,91) od dece UIO (AS = 6,00, SD = 2,38) i dece s CP (AS = 2,83, SD = 4,07). Grupa ispitanika s TIO nije osvojila poene pri ovoj proceni. Jednofaktorskom analizom varijanse ispitan je uticaj dijagnostičkih grupa na ovladanost ranim matematičkim veštinama, pri čemu je utvrđeno da je razlika u skorovima navedenih grupa statistički značajna (*F* (4,47) = 8,238, *p* = **0,000).**

Tabela 3 – Prosečni skorovi ispitanika pri proceni ranih matematičkih veština u odnosu na kliničku sliku

	N	AS	SD	Minimum	Maximum
LIO	16	11,81	3,74	3,00	18,00
UIO	7	6,00	2,38	2,00	9,00
autizam	19	7,10	5,91	,00	17,00
CP	6	2,83	4,07	,00	9,00
TIO	4	,00	,00	,00	,00
Total	52	7,37	5,65	,00	18,00
F (4,47) = 8,238, *p* = **0,000**					

Legenda: LIO – laka intelektualna ometenost; UIO – umerena intelektualna ometenost; ASP – autistički spektar poremećaja; CP – cerebralna paraliza; TIO – teška intelektualna ometenost

S obzirom na to da je dokazano da postoji statistički značajna razlika između grupa u prethodnom odnosu, iskorišćeno je post hoc poređenje pomoću Takijevog (Tukey HSD) testa da bi se utvrdilo koje se dijagnostičke grupe međusobno razlikuju u skorovima pri ovladavanju ranim matematičkim veštinama. Ovo poređenje je prikazano u Tabeli 4. Dobijenim rezultatima je utvrđeno da se kvalitet ovladanosti ranim matematičkim veštinama kod dece s LIO statistički značajno razlikuje u vrednostima postignutim u ovoj proceni od svih ostalih dijagnostičkih grupa (p<0,05). Nije utvrđena statistički značajna razlika u postignuću dece s UIO pri proceni ranih matematičkih veština i drugih dijagnostičkih grupa (ASP, CP i TIO) (p>0,05). Između dece s ASP i dece s CP nije utvrđena statistički značajna razlika u pogledu kvaliteta ranih matematičkih veština (p>0,05), ali je potvrđeno da je kvalitet ovih veština veći kod dece s ASP, nego kod dece s TIO (p<0,05). Deca s CP ne pokazuju značajnu razliku u kvalitetu procenjivanih veština u odnosu na decu s TIO (p>0,05).

Tabela 4 – Rezultati Takijevog testa za procenu ranih matematičkih veština po dijagnostičkim grupama

Dijagnostičke grupe		**Razlika proseka**	**p vrednost**
LIO	UIO	5,81*	**,049**
	autizam	4,70*	**,028**
	CP	8,97*	**,001**
	TIO	11,81*	**,000**
UIO	autizam	-1,10	,981
	CP	3,16	,716
	TIO	6,00	,228
autizam	CP	4,27	,272
	TIO	7,10*	**,047**
CP	TIO	2,83	,866

*$p<0{,}05$

Legenda: LIO – laka intelektualna ometenost; UIO – umerena intelektualna ometenost; ASP – autistički spektar poremećaja; CP – cerebralna paraliza; TIO – teška intelektualna ometenost

UMESTO ZAKLJUČKA

Preporuke za buduća istraživanja ranih matematičkih veština kod dece s TuMR odnose se na potrebe utvrđivanja veština koje su lakše i teže savladive. Rezultati ovog istraživanja ukazuju na neophodnost intenziviranja tretmana ranih matematičkih veština kod dece s težim oblicima kognitivnog deficita. Potrebno je raditi na istraživanju novih strategija koje će da podržavaju razvoj ovih veština tokom rane intervencije. Rezultati novijeg istraživanja ukazuju na činjenicu da je kod težih oblika TuMR moguće savladati ove veštine pravilno sprovedenom tehnikom (Jimenez & Kemmery, 2013). Kao mogućnost pospešivanja kvaliteta ranih matematičkih veština preporučuje se aktivno uključivanje roditelja u stimulisanju sposobnosti ranog računanja (Kleemans, Peeters, Segers & Verhoeven, 2012), kao i upotreba tehnike modelovanja (Bjorklund, Hubertz & Reubens, 2004).

LITERATURA

1. Bjorklund, D. F., Hubertz, M. J., & Reubens, A. C. (2004). Young children's arithmetic strategies in social context: How parents contribute to children's strategy development while playing games. *International Journal of Behavioral Development, 28*(4), 347-357.
2. Browder, D. M., & Spooner, F. (2011). *Teaching students with moderate and severe disabilities.* NY: Guilford Press.
3. Geary, D. C. (1994). *Children's mathematical development: Research and practical applications*. Washington, DC, US: American Psychological Association.

4. Geary, D. C., Bow-Thomas, C. C., & Yao, Y. (1992). Counting knowledge and skill in cognitive addition: A comparison of normal and mathematically disabled children. *Journal of experimental child psychology, 54*(3), 372-391.
5. Huang, H. F., Lai, L., & Rivera, H. J. (2010). Using an exploratory approach to help children with autism learn mathematics. *Creative Education, 1*(03), 149.
6. Jimenez, B. A., & Kemmery, M. (2013). Building the early numeracy skills of students with moderate intellectual disability. *Education and Training in Autism and Developmental Disabilities, 48*(4), 479-490.
7. Kleemans, T., Peeters, M., Segers, E., & Verhoeven, L. (2012). Child and home predictors of early numeracy skills in kindergarten. *Early Childhood Research Quarterly, 27*(3), 471-477.
8. Lerner, J. W., & Johns, B. (2011). *Learning disabilities and related mild disabilities,* 12th edition. Belmont, CA: Wadsworth Cengage Learning.
9. Pijaže, Ž., Inhelder, B. (1996). *Intelektualni razvoj deteta*. Beograd: Zavod za udžbenike i nastavna sredstva.
10. Službeni glasnik Republike Srbije – Prosvetni glasnik (2006). Pravilnik o opštim osnovama predškolskog programa, 14/2006.
11. Stahmer, A. C., Collings, N. M., & Palinkas, L. A. (2005). Early intervention practices for children with autism: Descriptions from community providers. *Focus on Autism and Other Developmental Disabilities, 20*(2), 66-79.
12. Van Rooijen, M., Verhoeven, L., & Steenbergen, B. (2011). Early numeracy in cerebral palsy: review and future research. *Developmental Medicine* & *Child Neurology, 53*(3), 202-209.

EARLY MATHEMATICAL SKILLS IN CHILDREN WITH DIFFICULTIES IN MENTAL DEVELOPMENT

Aleksandra Djurić-Zdravković, Mirjana Japundža-Milisavljević, Sanja Gagić
University of Belgrade, Faculty of Special Education and Rehabilitation, Serbia

Research subject: Early math skills are the basis for the subsequent development of mathematical skills that are essential for higher life quality of people with difficulties in mental development.

Method: The aim of the study was to compare the quality of early math skills in children with difficulties in mental development of different clinical pictures (mild intellectual disability, moderate intellectual disability, autism spectrum disorder, cerebral palsy, severe intellectual disability). The sample consisted of 52 examinees, aged between4 and 6 years and one month. A part of Preschool assessment, named Mathematical skills, was used in data gathering on the quality of mastering early math skills, which consisted of items derived from the curriculum.

Results: With one-way analysis of variance, the influence of the diagnostic groups on mastering mathematical skills was tested, and it was determined that the difference in scores of diagnostic groups was statistically significant ($p=0.000$).

Conclusion: The results of this study indicate the need to intensify treatment of early math skills in children with the most severe cognitive deficits. It is necessary to study new strategies that will support the development of these skills in early intervention.

Key words: early mathematical skills, difficulties in mental development, diagnostic groups

udc 376.1-056.26/.36-053.2
316.356.2

Roditelji i porodica deteta sa ometenošću kao faktor uspešnosti rane intervencije

Sanja Dimoski, Vesna Radovanović
Univerzitet u Beogradu – Fakultet za specijalnu edukaciju i rehabilitaciju, Srbija

Predmet istraživanja: *Rad daje pregled savremenih studija o psihosocijalnom funkcionisanju roditelja i porodice dece sa ometenošću tokom rane faze adaptacije na ovu okolnost. U radu je dat predlog strategija, zasnovanih na prikazanim istraživanjima koje pružaju podršku porodici. Uloga roditelja počinje još u kući, ranim detekcijama razvojnih teškoća kod deteta. Rano mobilisanje roditelja i uključenost u rane intervencija ima pozitivan uticaj na dalji tok rehabilitacije. Adaptacija roditelja na dete sa ometenošću utiče na adaptaciju samog deteta na sopstvenu ometenost.*

Metod: *Metod rada je pretraga relevantnih baza podataka na osnovu ključnih reči, pregled i prikaz istraživanja. Mnoga istraživanja pokazuju da roditelji dece sa ometenošću prolaze kroz individualne krize (npr. povećan nivo stresa, depresivana reagovanja). Teškoće (koje se tiču nege deteta, psihološke, socijalne, ekonomske) pogađaju funkcionisanje cele porodice.*

Rezultati: *Diskutovane su osobenost funkcionisanja porodice (podela brige o detetu, prisustvo/odsustvo oba roditelja, prisustvo/odsustvo socijalne podrške). Navedene su i studije koje govore da nema suštinske razlike u funkcionisanju porodice dece sa i bez ometenosti. Istraživanja impliciraju da funkcionsanje roditelja i porodice nije direktna posledica ometenosti deteta per se već je u korelaciji sa varijablama čije dejstvo savremena istraživanja proveravaju (npr. strategije prevladavanja stresa, rezilijabilnost, verovanja i stavovi roditelja).*

Zaključak: *Roditelji se smatraju neophodnim partnerima u savremeno koncipiranom tretmanu ometenosti. U radu su prikazane strategije psihološke podrške roditeljima i porodici kroz edukaciju, savetovanje i psihoterapijske intervencije. Predložene strategije su proizašle iz empirijskih potvrda navedenih u ovom radu.*

Ključne reči: *rane intervencije, deca sa ometenošću, roditelji, porodica*

Savremena istraživanja snažno potvrđuju pozitivna dejstva ranih interevencija primenjenih kod dece koja su u riziku od zaostajanja u psihofizičkom razvoju, kao i onih kod kojih je utvrđeno zaostajanje ili neka vrsta ometenosti. Ključna razlika u savremenim shvatanjima ranih intervencija, u odnosu na tradicionalne pristupe je usmerenost na porodicu i razvoj partnerskih odnosa između roditelja i stručnjaka (Ljubešić, 2012).

Smatra se da uloga roditelja počinje još u kući, praćenjem razvoja i ranim detektovanjem evenutalnih teškoća tokom razvoja. Tada je uloga roditelja preventivna, ali predstavlja neophodnu, uvodnu fazu rada koja postaje integralni deo ranih intervencija, ukoliko dođe do dijagnostikovanja razvojnih teškoća (Dimoski, 2015).

Porodica deteta sa ometenošću prolazi kroz nekoliko, psihološki neprijatnih i bolnih, pa i traumatičnih faza – od sumnji u prisutnost razvojnih teškoća, preko traženja stručne pomoći, saznavanja dijagnoze, često i u prolongiranom vremenskom periodu što je za roditelje naročito stresno, pa sve do prihvatanja utvrđenog stanja i uključenja u rane intervencije. Neka istraživanja govore da roditelji imaju doživljaj da su ostavljeni da se sami bore sa dijagnozom ometenosti kod deteta i čitavim kompleksom osećanja koja se zbog te okolnosti javljaju (Foster, O'Brien & McAllister, 2004; Godress, Ozgul, Owen & Foley-Evans, 2005; Pelchat & Lefebvre, 2004).

Sen i Jurtsevr (Sen & Yurtsever, 2007) su rekacije roditelja na ometenost kod deteta sistematizovali u: primerne reakcije (šok, odbijanje, patnja i depresija), sekundarne reakcije (osećanje krivice, ljutnja, neodlučnost i stid) i tercijalne (vezane za pregovaranje sa onima koji mogu da pomognu detetu, prihvatanje i adaptacija). U najvećem broju slučajeva reakcije roditelja su negativne i slične procesu žaljenja (Blacher, 1984; Heiman, 2002). 75% roditelja se slaže da se sa vremenom njihove početne negativne reakcije i osećanja transformišu u pozitivna i optimistička osećanja ljubavi, sreće, prihvatanja kao i snaga da se prati razvoj deteta sa ometenošću (Warfield, Krauss, Hauser-Cram, Upshur & Shonkoff, 1999). Rano mobilisanje roditelja ima pozitivan uticaj na dalji tok rehabilitacije. Cilj ranih intervenicija usmrenih na roditelje je podsticanje adaptacija roditelja na dete sa ometenošću, što pozitivno utiče na adaptaciju samog deteta na sopstvenu ometenost.

Brojne studije izveštavaju o jedinstvenim emocionalnim i fizičkim zahtevima koji se stavljaju pred roditelje pri podizanju deteta sa ometenošću (Bruce, Schultz, Smyrnios & Schultz, 1994; Hauser-Cram, Warfield, Shonkoff & Krauss, 2001; Shonkoff, Hauser-Cram, Krauss & Upshur, 1992; Wade, Taylor, Drotar, Stancin & Yeates, 1996). Imati dete sa ometenošću predstavlja visok rizik po fizičko i psihičko stanje roditelja (Ha, Greenberg & Seltzer, 2011).

Istraživanja pokazuju da su psihološke krize prisutne kod oba roditelja, mada nalazi nisu jednoznačni. Kazak i Marvin (Kazak & Marvin, 1984) utvrđuju da su roditelji dece sa ometenošću izloženi višim nivoima stresa (individualnog, bračnog i roditeljskog) u odnosu na one koji nemaju decu sa ometenošću. Najveći broj istraživanja pokazuje da je opterećenost majki u odnosu na očeve izrazitija. Pre svega, majke su mnogo češće od očeva one koje primarno vode računa o detetu sa ometenošću (Pelchat, Lefebvre & Perreault, 2003; Raina et al., 2005), što je jedan od razloga zašto njihov radni, socijalni i emocionalni status biva pogođen u većoj meri.

Raina i saradnici (Raina et. al., 2005) su sistematizovali faktore koji utiču na nivo stresa kod osoba koje brinu o deci sa ometenošću. To su: karakteristike osoba koje pužaju brigu (starost, bračni status, spsobnosti suočavanja sa stresom), karakteritike onih kojima je pomoć upućena (npr. stepen ometenosti), istorija odnosa između ovih osoba, socijalni faktori (društvena podrška, pristup društvenim mrežama), ekonomski faktori (socioekonomski status, mogućnost primanja pomoći od institucija, zaposlenost), kao i kulturni kontekst. Sve ovo ukazuje da se stres javlja u širem kontekstu od onog koji ga veže usko za aktivnosti vezane za brigu o detetu sa ometenošću.

Nalazi studija o depresiji roditelja dece sa ometenošću nisu jednoznačna. Veliki broj studija izveštava o višim nivoima depresije kod majki dece sa ometenošću (Breslau, Staruch & Mortimer, 1982; Blacher & Lopez 1997; Fisman, Wolf & Noh, 1989; Harris & McHale 1989; Hoare, Harris, Jackson & Kerley, 1998; Dumas, Wolf, Fisman & Culligan 1991; Veisson 1999). Neke studije (Bitsika & Sharpley, 2004) navode ekstremne rezultate koji govore da skoro dve trećine roditelja dece sa autističnim spektrom poremećaja imaju izraženu kliničku sliku depresije. Longitudnalna studija koja je pratila majke dece sa Daunovim sindromom, oštećenjem sluha i neurološkim oštećenjima je pokazala značanu povezanost između naivoa stresa kod majki i iskustva u roditeljstvu (Hanson & Hanline, 1990). Istražiivanja izveštavaju da je nivo depresivnosti kod majki dece sa autizmom viši nego kod kontrolne grupe (Hastings et al., 2005; Olsson & Hwang, 2001).

S druge strane, neka istraživanja daju nalaze da depresivne rekacije nisu izraženije kod roditelja dece sa ometenošću (Lambrenos, Weindling, Calam & Cox, 1996). Studije u koje su bili uključeni roditelji dece sa Daunovim sindromom nisu našli razlike u skorovima za depresiju (Van Riper, Ryff & Pridham, 1992; Scott, Atkinson, Minton & Bowman, 1997). Studija (Gowen, Johnson-Martin, Goldman & Appelbaum, 1989) nije utvrdila viši nivo depresivnosti i osećanja roditeljske kompetencije u grupama majki koje imaju decu sa ometenošću. Njihove depresivne reakcije bile su u vezi sa teškoćama vezanim za brigu o deci i kvalitetom porodičnih odnosa, što predstavlja značajan nalaz za keriranje programa podrške porodici. Razlike u nalazima studija o prisustvu depersije kod roditelja dece sa ometenošću u najvećoj meri se mogu objasniti različitim definisanjem depresije i različitim instrumetnima koji su bili upotrebljavani u studijama.

Novija istraživanja proveravaju dejstvo varijabli za koje se očekuje da su u vezi sa psihološkim funkcionisanjem roditelja tokom ranog razvoja detata sa ometenošću. Mnoga istraživanja pokazuju da je prevalencija depresivnih reagovanja kod roditelja u korelaciji sa poblemima ponašanja kod deteta (Dumas et el., 1991; Gray & Holden, 1992; Ireys & Silver, 1996; Sanders & Morgan, 1997 Hoare et al., 1998). Blaker i Lopez (Blacher & Lopez, 1997) su dali nalaze da samohrane make imaju značajno viši nivo depresivnih simptoma. Studija (Smith, Oliver &

Innocenti, 2001) izvršena na 880 porodica dece sa razvojnim poremećajima pokazuje da faktori vezni za prihode, mogućnost provođenja vremena sa detetom i socijalnu podršku imaju više uticaja na pojavu stresa kod roditelja, nego određni aspekti funkcionisanja deteta. Uprkos višim nivoima stresa u porodicama dece sa razvojnim poremećajima, načini njihovog prevladavanja isti su kod roditelja dece sa i bez ometenosti (Lopez, Clifford, Minnes & Ouellette-Kuntz, 2008). Odsustvo roditeljskih pozitivnih strategija izlaženja na kraj sa stresom ima nepovoljne efekte na dete sa ometenošću (Hadadian & Merbler, 1996). Ovaj nalaz daje smisao naporima da se roditeljima pruži trening u uobičajenim tehnikama prevladavanja stresa koje mogu biti korisne od početka započinjanja saradnje sa njima (Dimoski, 2015). Pozitivan efekat daje upućivanje na socijalnu podršku okoline, podršku supružnika, prijatelja i familije (Barnett, Clements, Kaplan-Estrin & Fialka, 2003), a uprkos procesu tugovanja moguće je da porodice dece sa ometenošću prođu i kroz proces oporavka.

Vorfild (Warfield et.al., 1999) pokazuju da se aspekti porodičnog okruženja detektuju kao faktori koji konzistentno uzrokuju stepen roditeljskog stresa u ranom periodu života deteta sa ometenošću. Veća porodična kohezija i manje negativnih životnih događaja nezavisnih od ometenosti u vezi su sa smanjenim roditeljskim stresom. Takođe, ova studija pokazuje da 93.5% roditelja prima kombinacije različitih tipova stručne podrške (psihološka podrška, psihijatrijske konsultacije, grupe podrške, socijalne službe, specijalne edukatore, volonterske organizacije) od kojih imaju različite benefite. Na taj način raste njihova informisanost i osećaj da su aktivno i praktično uključeni u situaciju što združeno može pozitivno uticati na njihovu rezilijabilnost.

Ferguson (Ferguson, 2002), autor koji sa velikom energijom brani stav da su porodice dece sa ometenošću slične ili identične porodicama dece bez ometenošću u svom zaključku o nalazima istraživanja navodi da postoji značajan broj roditelja koji navode benefite i pozitivne aspekte brige o detetu sa ometenossšću kao što su: razvoj sposobnosti suočavanja, porodična hamonija i kohezivnosti, duhovni rast itd. On naročito ukazuje na značaj etničkih i kulturnih obrazaca. Studije (Green, 2007; Walsh, 2003; Kearney & Griffin, 2001; Trute & Hiebert-Murphy, 2002) potvrđuju da postoje i neki pozitivni aspekti i dugoročni benefiti, kao što je razvijanje emocionalne bilskosti među članovima porodice, dobri odnosi sa stručnjacima, uživanje u različitim porodičnim aktivnostima, razvoj ličnih kapaciteta, naročito empatičnosti i senzibilnosti, razvoj rezilijentnosti porodice. Navedeni nalazi imaju snažne praktične implikacije, jer ukazuju na roditeljske potencijale i mogućnosti celokupnih porodica koje treba iskoristiti u ranim intervencijama.

Istraživanja impliciraju da funkcionsanje roditelja i porodice nije direktna posledica ometenosti deteta per se. Nova istraživanja treba da daju odgovore na to zašto neke porodice imaju izraženiju rezilijentnost i sposobnost adaptacije na stres od drugih. Rane intervencije koje se odnose na roditelje mogu da imaju različite forme (edukativne, savetodavne, psihoterapijske), ali moraju biti usmerene i na okruženje porodice deteta sa ometenošću s obzirom da mnogi nalazi istraživanja ukazuju na značaj sredinskih varijabli.

LITERATURA

1. Barnett, D., Clements, M., Kaplan-Estrin, M., & Fialka, J. (2003). Building new dreams: Supporting parents' adaptation to their child with special needs. *Infants & Young Children*, *16*(3), 184-200.
2. Blacher, J. (1984). Sequential stages of parent adjustment to the birth of a child with handicaps: Facts or artifact? *Ment. Retard, 22,* 55–68.
3. Blacher, J., & Lopez S. (1997). Contributions to depression in Latina mothers with and without children with retardation: implications for care-giving. *Family Relations: Interdisciplinary Journal of Applied Family Studies*, 46, 325-34.
4. Bruce, E. J., Schultz, C. L., Smyrnios, K. X., & Schultz, N. C. (1994). Grieving related to development: A preliminary comparison of three age cohorts of parents of children with intellectual disability. *British Journal of Medical Psychology*, *67*(1), 37-52.
5. Blacher J., & Lopez S. (1997). Contributions to depression in Latina mothers with and without children with retardation: implications for care-giving. *Family Relations: Interdisciplinary Journal of Applied Family Studies*, 46, 325-34.
6. Bitsika, V., & Sharpley, C. F. (2004). Stress, anxiety and depression among parents of children with autism spectrum disorder. *Australian journal of guidance and counselling*, *14*(02), 151-161.
7. Breslau N., Staruch K. S., & Mortimer E. A. (1982). Psychological distress in mothers of disabled children. *American Journal of Diseases of Children, 136,* 682-8.
8. Dimoski, S. (2015). Uloga roditelja u tretmanu dece sa razvojnim govorno-jezičkim poremećajima. U: *Zbornik radova sa Drugog kongresa logopeda Srbije „Govorno-jezički poremećaji razvojnog doba"* održanog od 15. do 17. maja 2015. godine u Beogradu. Str. 185-193.
9. Dumas, J., Wolf, L., Fisman, S., & Culligan A. (1991). Parenting stress, child behavior problems, and dysphoria in parents of children with autism, Down syndrome, behavior disorders, and normal development. *Exceptionality*, *2,* 97-110.
10. Ferguson, P.M. (2002). A Place in the Family: An Historical Interpretation of Research on Parental Reactions to Having a Child with a Disability. *The Journal Of Special Education 36*(3), 124–130.
11. Fisman, S.,Wolf, L., & Noh, S. (1989). Marital intimacy in parents of exceptional children. *Canadian Journal of Psychiatry, 34*, 519-26.
12. Foster, K., O'Brien, L., & McAllister, M. (2004). Addressing the needs of children of parents with a mental illness: Current approaches. *Contemporary Nurse, 18*(1–2), 67–80.

13. Godress, J., Ozgul, S., Owen, C., & Foley-Evans, L. (2005). Grief experiences of parents whose children suffer from mental illness. *Australian and New Zealand Journal of Psychiatry, 39*(1–2), 88–94.
14. Green, S. E. (2007). "We're tired, not sad": benefits and burdens of mothering a child with a disability. *Social Science* & *Medicine*, *64*, 150-163.
15. Gowen, J. W., Johnson-Martin, N., Goldman, B. D., & Appelbaum, M. (1989). Feelings of depression and parenting competence of mothers of handicapped and nonhandicapped infants: A longitudinal study. *American Journal on Mental Retardation*, *23(2),* 102-119.
16. Gray, D., & Holden, W. (1992). Psychosocial well-being among the parents of children with autism. *Australia and New Zealand Journal of Developmental Disabilities*, 18, 83-93.
17. Hauser-Cram, P., Warfield, M. E., Shonkoff, J. P., Krauss, M. W., Sayer, A., Upshur, C. C., & Hodapp, R. M. (2001). Children with disabilities: A longitudinal study of child development and parent well-being. *Monographs of the Society for Research in Child Development*, i-126.
18. Hadadian, A., & Merbler, J. (1996). Mother's stress: Implications for attachment relationships. *Early Child Development and Care*, *125*(1), 59-66.
19. Heiman, T. (2002). Parents of Children With Disabilities: Resilience,Coping, and Future Expectations. *Journal of Developmental and Physical Disabilities, 14*(2), 159-171.
20. Harris V. S., & McHale S. M. (1989). Family life problems, daily caregiving activities, and the psychological wellbeing of mothers of mentally retarded children. *American Journal on Mental Retardation, 94*(3), 231-9.
21. Hoare, P., Harris, M., Jackson, P., & Kerley, S. (1998). A community survey of children with severe intellectual disability and their families: psychological adjustment, carer distress and the effect of respite care. *Journal of Intellectual Disability Research*, *42*, 218-27.
22. Hastings, R. P., Kovshoff, H., Ward, N. J., Degli Espinosa, F., Brown, T., & Remington, B. (2005). Systems analysis of stress and positive perceptions in mothers and fathers of pre-school children with autism. *Journal of autism and developmental disorders*, *35*(5), 635-46.
23. Hanson, M. J., & Hanline, M. F. (1990). Parenting a child with a disability: A longitudinal study of parental stress and adaptation. *Journal of Early Intervention*, *14*(3), 234-248.
24. Ha, J.H., Greenberg, J.S., & Seltzer, M.M. (2011). Parenting a Child With a Disability: The Role of Social Support for African American Parents. *Families in Society: The Journal of Contemporary Social Services, 92*(4),405-411.
25. Ireys, H., & Silver, E. (1996). Perception of the impact of a child's chronic illness. Does it predict maternal mental health? *Developmental and Behavior Pediatrics, 17,* 77-83.

26. Kazak, A., & Marvin, R. (1984). Differences, difficulties and adaptation: stress and social networks in families with a handicapped child. *Family Relations, 33,* 67-77.
27. Kearney, P. M., & Griffin, T. (2001). Between joy and sorrow: being a parent of a child with developmental disability. *Journal of Advanced Nursing*, *34*(5), 582-592.
28. Lambrenos, K., Weindling, A. M., Calam, R., & Cox, A. D. (1996). The effect of a child's disability on mother's mental health. *Archives of disease in childhood*, *74*(2), 115-120.
29. Lopez, V., Clifford, T., Minnes, P., & Ouellette-Kuntz, H. (2008). Parental stress and coping in families of children with and without developmental delays. *Journal of Developmental Disabilities, 14*(2), 99-104.
30. Ljubešić, M. (2012). Rana intervencija kod komunikacijskih i jezično-govornih odstupanja. *Paediatra Croatia, 56*(1), 202-206.
31. Pelchat, D., Lefebvre, H. A. (2004). Holistic intervention program for families with a child with a disability. *Journal of Adv Nurs, 48,* 124–131.
32. Pelchat, D., Lefebvre, H., & Perreault, M. (2003). Differences and similarities between mothers' and fathers' experiences of parenting a child with a disability. *Journal of child health care*, *7*(4), 231-247.
33. Raina, P., O'Donnell, M., Rosenbaum, P., Brehaut, J., Walter, S. D., Russell, D., ..., & Wood, E. (2005). The health and well-being of caregivers of children with cerebral palsy. *Pediatrics*, *115*(6), 626-636.
34. Smith, T. B., Oliver, M. N., & Innocenti, M. S. (2001). Parenting stress in families of children with disabilities. *American journal of orthopsychiatry*, *71*(2), 257.
35. Sen, E., & Yurtsever, S. (2007). Difficulties experienced by families with disabled children. *Journal for Specialists in Pediatric Nursing*, *12*(4), 238-252.
36. Scott B., Atkinson L., Minton H., & Bowman T. (1997). Psychological distress of parents of infants with Down syndrome. *American Journal on Mental Retardation*, *102*, 162-71.
37. Sanders J. L., & Morgan S. B. (1997). Family stress and adjustment as perceived by parents of children with autism and Down syndrome: implications for intervention. *Child and Family Behavior Therapy, 19*, 15-32.
38. Shonkoff, J. P., Hauser-Cram, P., Krauss, M. W., Upshur, C. C., & Sameroff, A. J. (1992). Development of infants with disabilities and their families: Implications for theory and service delivery. *Monographs of the Society for Research in Child development*, i-163.
39. Trute, B., & Hiebert-Murphy, D. (2002). Family adjustment to childhood developmental disability: a measure of parent appraisal of family impact. *Journal of Pediatric Psychology*, *27*(3), 271-280.
40. Veisson M. (1999). Depression symptoms and emotional states in parents of disabled and non-disabled children. *Social Behavior and Personality*, 27, 87-98.

41. Van Riper, M., Ryff, C., & Pridham, K. (1992). Parental and family well-being in families of children with Down syndrome: a cooperative study. *Research in Nursing and Health, 15,* 227-35.
42. Warfield, M. E., Krauss, M. W., Hauser-Cram, P., Upshur, C. C., & Shonkoff, J. P. (1999). Adaptation during early childhood among mothers of children with disabilities. *Journal of Developmental* & *Behavioral Pediatrics*, *20*(1), 9-16.
43. Wade, S. L., Taylor, H. G., Drotar, D., Stancin, T., & Yeates, K. O. (1996). Childhood traumatic brain injury: Initial impact on the family. *Journal of Learning disabilities*, *29*(6), 652-661.
44. Walsh, F. (2003). Family resilience: a framework for clinical practice. *Family Process, 42*(1), 1-18.

PARENTS AND FAMILIES OF CHILDREN WITH DISABILITY AS A FACTOR OF SUCCESSFUL EARLY INTERVENTION

Sanja Dimoski, Vesna Radovanović
University of Belgrade, Faculty of special education and rehabilitation, Serbia

Research subject: This paper reviews current studies on psychosocial functioning of parents and families of children with disabilities during the early stages of adaptation to this circumstance. The paper gives a strategy proposal, based on the presented studies that provide family support. The role of parents begins in the home, with the early detection of child's developmental problems. Early mobilization and involvement of parents in early interventions has a positive impact on the further course of rehabilitation. Adaptation of the parents to the child with a disability affects the child's adaptation to their own disability.

Method: The method of work is an examination of relevant databases, based on keywords, review and presentation of research. Many studies show that parents of children with disabilities go through individual crises (e.g. increased stress levels, depressive reactions). Difficulties (psychological, social, economic, those related to child care) affecting the functioning of the whole family.

Results: We discussed the characteristic of functioning families (division of child care, the presence/absence of both parents, and the presence/absence of social support). We are also cited studies showing that there is no substantial difference in the functioning of families with and without children with disabilities. Studies imply that functioning of parents and families is not a direct result of the child's disability, but is correlated with variables whose effects are still under the scrutiny of contemporary researches (e.g., coping strategies, resilience, beliefs and attitudes of parents).

Conclusion: Parents are considered as essential partners in modern treatment of disability. The paper presents the strategy of psychological support to parents and families through education, counseling and psychotherapeutic intervention.

Key words: early intervention, children with disabilities, parents, familie

udc 613.95-055.25
613.95-055.25
159.922.7-055.25
159.922.7-055.15

Differences between Boys and Girls in Developmental Areas

Magdalena Perić
Kindergartens Mostar, Bosnia and Herzegovina
Rea Fulgosi Masnjak
University of Zagreb, Faculty of Education and Rehabilitation Sciences, Croatia

Research subject: *A long time ago neuroscientists proved the existence of differences in brain development between males and females. Basically, there is a difference in the function of a brain hemisphere during certain mental tasks such as speech. Differences in brain development also lead to developmental differences and speed of progression through developmental milestones of males and females. In addition to the neurological background, we cannot ignore the influence of the society in which gender stereotypes are accepted and in which a child grows.*

Method: *The aim of this study was to determine whether there are significant differences in the development of boys and girls in 5 development areas (cognitive development, communication development, socio-emotional development, self-care and motor development). Apart from that, the aim was to gain an insight into the development areas in which the respondents achieved the worst results. The development behavioral scale assessment of child development (Pištoljević, Zubčević, Džanko, 2016) was used for the study.*

Results: *The results do not show any statistically significant differences in the development of girls and boys in developmental areas although girls generally achieved better results.*

Conclusion: *The worst results were achieved in the areas of socio-emotional development and cognitive development, but most respondents achieved results that did not indicate developmental deviations. Are social expectations today changing and are gender stereotypes missing in the development of preschool children?*

Key words: *developmental areas, gender differences, developmental deviations*

1. INTRODUCTION

1.1. Biological and social aspects of child's development

According to Maleš (1988) there are 3 basic approaches within the developmental perspective which explain gender differences in behavior and abilities. Those are:

1. Environmental approach – emphasizes the role of environment as an important factor in adopting gender roles and formatting behavior typical for a particular gender. The root of This approach is based on a theory that everything we know is the result of social learning.
2. Biological approach – emphasizes biological bases of gender differences. There are three groups of biological theories that are explaining psychological differences between genders (hormone theory, brain development theory and evolution theory).
3. Interactional approach – according to this approach, the influence on the development of gender differences, of both biological and environmental factors is equally recognized.

Gender differences in neuroanatomy, neurochemistry and neuronal structures have been proven long ago, as well as in the structure and mode of functioning of the brain of boys and girls. Because of gender differences in brain structure and its function, researchers tried to explain differences in behavior and cognitive functioning that were observed, but it has been shown that biological factors cannot be observed without social factors (Zagni, Simoni & Colombo, 2016). This was also confirmed in psychological studies, where it prevailed that gender differences were mostly a result of male and female everyday roles defined by society (Eagly, 1987 toward Geary, 1999).

Geary (1999) based on his work on Darwin´s principles of evolution, tries to explain the evolutionary perspective of cultural and environmental factors affecting the appearance of developmental gender differences. From the aspects of biologist, the determined age and length of childhood life of certain living beings is related to the speed of reaching certain developmental milestones, and the function of childhood is development of competences necessary for survival and reproduction in adult life (Mayr, 1974 according to Geary, 1999). Gelman (1990) states that the framework of cognitive and behavioral abilities is inbread, however, formation of these abilities is under the influence of early childhood play (it involves exploring environments and social interactions).

The role of play in the development of a child is indisputable. This is confirmed by Geary (1999), stating that boys and girls play together at early childhood, what provides them with survival and reproduction behavior at an adult age, while at the same time those gender differences that are present in adulthood can already be seen in early childhood play. Some research confirms that child who is, from the earliest age under the influence of society, develops gender stereotypes. At the age of 3 to 6 years there are even greater gender differences, besides the gender specific toys, there are also differences in certain daily activities (Huston, 1983; Aubry et al., 1999 toward Trautner at al., 2005). That is not only the case with humans, but also with animals whose young show the same forms of behavior. Even in preschool age, boys and girls are trying to segregate each other by creating their own cultures. Boys create groups whose play is based on fight and competition, while girls create groups whose play prevails with empathy, nurturing, social and emotional support (Geary, 1999). During the preschool age children acquire knowledge about gender-related characteristics, and by the age of 5 to 7 the child develops very rigid attitudes toward gender roles. After that period is the phase in which children do not set such rigid boundaries between male and female roles (Trautner at al., 2005). However, those frameworks that are beginning to develop in the preschool period do not disappear, and as it states Vasta, Haith & Miller (1998) in adulthood, the role of man in society is mainly **tied to roles** that emphasize manhood and strength, and the role of woman if mainly tied to roles that emphasize tenderness and addiction.

Hence, the biological impact on gender differences that are visible from child's birth is indisputable. As mentioned earlier, some authors argue that gender differences are necessary for survival, but they do not reject neither the influence of social environment that further form the social roles of boys and girls during their development (MacDonald, 1988 toward Vasta et al., 1998).

Over the years gender differences and gender roles of boys and girls upgrade, so author Maleš (1988) writes about cumulative mode of learning gender roles, as one of the long-lasting processes, in which boys and girls are developing attitudes toward their own gender and toward members of the opposite gender. As an important social factor in the development of the attitudes of boys and girls, Maleš (1988) highlights the family. Contemporary families are facing great challenges in today´s society that affect family relationships. Earlier, we used to talk about patriarchal families in our societies, but today we are talking more about modern families where we no longer have such strict limits between male and female roles. All of these changes also lead to changes in the upbringing of children where the stereotypical role of a mother as a teacher and father as a family career gradually disappears. In support of this is the research of Low (1989), conducted on 93 cultures, showing that the socialization of boys and girls is linked to the social structure and marriage systems in specific culture. So, his main conclusion was that in polygamous cultures and stratified cultures boys manifested more aggressive and competitive behavior than in monogamous cultures.

2. PROBLEM

If we look at neighboring countries, we can tell Bosnia and Herzegovina is still very traditional and conservative country with highlight patriarchal relationships in society. So, families are also mostly patriarchal. Women are mostly expected to raise children and take care of the household, while man are generally expected to provide financial resources to families. Different historical events, different religious, cultural and ethnic systems have certainly influenced the definition of the role of man and woman, boys and girls. However, we cannot say that Bosnia and Herzegovina is isolated from the influence of the world's globalization and that it doesn't effect changes of the definition of gender roles in today´s society.

3. AIMS AND HYPOTHESES

There were two aims of this study:

1. To determine whether there are significant differences in the development of boys and girls in 5 developmental domains (cognitive development, communication development, socio-emotional development, self-care and motor development);
2. To determine developmental domain in which the results are the lowest.

Following hypotheses are set in accordance with the aims:

H1: There are statistically significant differences between boys and girls in the examined developmental domains.

H2: Boys and girls achieve the lowest results in socio-emotional developmental domain.

4. METHODOLOGY

4.1. Sample of participants

This study was carried out on the sample of typically developing N= 66 children of both sexes, N1= 45 boys and N2= 21 girls. All participants were involved in various preschool programs (all-day programs, half-day programs or short programs) in different preschool educational institutions in city of Mostar in BiH. The age range was from 3 to 7 years, with the averaged age of 5 years.

4.2. Assessment instrument

The Developmental Behavioral Scales for the Assessment of Child's Development (Pištoljević, Zubčević & Džanko, 2016) was used for collecting data. These scales allow an assessment of child development from birth to school leaving. They are divided into the following developmental areas: speech/communication, motor development, cognitive development, socio-emotional development, self-care. Reliability analysis of the measuring instrument results indicate the good measuring characteristics of the instrument on all subscales (Pištoljević, Zubčević & Džanko, 2016).

4.3. Methods of data processing

Collected data were analyzed through descriptive statistical techniques respecting the age groups. Statistical significance of differences in the examined developmental domains between boys and girls, was determined by Mann-Whitney test.

5. RESULTS AND DISCUSSION

If we look at the total average values of boys and girls aged 4 to 5 years on all subscales, girls scored higher than boys. The greatest difference was found on the subscale "Socio-emotional development", while the smallest difference was on subscale "Self-care". By looking at the total average values, we can also conclude that boys aged 4 to 5 achieve the lowest results on the "Motor development" subscale, while girls achieved the lowest results on the "Self-care" subscale (Table 1). Based on the Mann-Whitney test there were no statistically significant differences between boys and girls on all subscales for ages 4 to 5 (p > .05) (Table 2), although girls achieved better results in all developmental domains.

Table 1 – Total average values on subscales for age 4-5 years

	Ranks			
Total average	**Gender**	**N**	**Mean Rank**	**Sum of Ranks**
Speech/ Communication development	Male	12	8.25	99.00
	Female	6	12.00	72.00
	Total	18		
Motor development	Male	12	8.04	96.50
	Female	6	12.42	74.50
	Total	18		
Cognitive development	Male	12	8.13	97.50
	Female	6	12.25	73.50
	Total	18		
Socio-emotional development	Male	12	8.50	102.00
	Female	6	11.50	69.00
	Total	18		
Self-care development	Male	12	9.17	110.00
	Female	6	10.17	61.00
	Total	18		

Table 2 – Results of Mann-Whitney test on scale for age 4 – 5 years

	Test Statistics *				
	Total average				
	Speech/ Communication development	Motor development	Cognitive development	Socio-emotional development	Self-care development
Mann-Whitney U	21.000	18.500	19.500	24.000	32.000
Wilcoxon W	99.000	96.500	97.500	102.000	110.000
Z	-1.420	-1.647	-1.551	-1.182	-.389
Asymp. Sig. (2-tailed)	.156	.100	.121	.237	.697
Exact Sig. [2*(1-tailed Sig.)]	.180[b]	.102[b]	.125[b]	.291[b]	.750[b]

a. Grouping Variable: SPOL

b. Not corrected for ties.

Total average results on subscales for aged 5 to 6 indicate that boys achieve higher results than girls on all subscales except in the “Speech/ communication” and “Motor development” subscales (Table 3), but the Mann-Whitney test shows that the obtained differences in the results of boy

By examining the total average results, we can conclude that boys aged 5 to 6 achieved the lowest results in the “Motor development” subscale, while girls scored lowest on “Socio-emotional development” subscale.

Table 3 – Total average values on subscales for age 5-6 years

	Ranks			
Total average	Gender	N	Mean Rank	Sum of Ranks
Speech/Communication development	Male	33	24.32	802.50
	Female	15	24.90	373.50
	Total	48		
Motor development	Male	33	24.14	796.50
	Female	15	25.30	379.50
	Total	48		
Cognitive development	Male	33	25.17	830.50
	Female	15	23.03	345.50
	Total	48		
Socio-emotional development	Male	33	25.73	849.00
	Female	15	21.80	327.00
	Total	48		
Self-care development	Male	33	24.59	811.50
	Female	15	24.30	364.50
	Total	48		

Table 4 – Results of Mann-Whitney test for age 5 – 6 years

	Test Statistics[a]				
	Total average				
	Speech/ Communication development	Motoric development	Cognitive development	Socio-emotional development	Self-care development
Mann-Whitney U	241.500	235.500	225.500	207.000	244.500
Wilcoxon W	802.500	796.500	345.500	327.000	364.500
Z	-.139	-.298	-.492	-.917	-.072
Asymp. Sig. (2-tailed)	.889	.765	.623	.359	.943

a. Grouping Variable: SPOL

In support of the results that point to the differences between boys and girls on the subscales of "Socio-emotional development" are the research results of Šipek (2016). It was found that girls aged 7 and 8 achieve better results in some dimensions of social skills, such as academic skills, self-control, self-esteem and peer relationships. Studies confirm that girls have more prosocial behavior in relation to boys and that they are more willing to help and cooperate, as well as have higher level of empathy (Ban, 2013). All of this is evident even in the preschool period during which girls show greater interest for younger children than boys, and moreover begin to cry when they hear another child crying (Feingold, 1994). If we are talking about a "Motor development" subscale where boys achieve better results than girls, we can consider the results of research conducted by authors Pahlevanian & Ahmadizadeh (2014). They confirmed statistically significant differences between boys and girls in motor skills where boys achieved better results in the area of gross motor development (eye-hand coordination, jumping, throwing, running, balance), while girls achieved better results in the area of fine motor development. When we are talking about girls achieving better results than boys in the "Speech/ communication" subscale, we can think about early childhood development during which the differences between boys and girls in language development are noticed. Regarding that differences Özçalişkan & Goldin-Meadow (2010) explain that boys are slower in passing through linguistic milestones than girls. As an example, the development of a first pointing gesture occurs earlier in girls than in boys and that gesture precedes the development of speech, so they conclude that first words appear later in boys. Considering the above mentioned facts about the early speech development of boys and girls, the results of girls who are more successful at the subscale of "Speech/ communication" at the age from 5 to 6 years are not surprising.

6. CONCLUSION

There are different theories about gender development and differentiation. One of them is socio-cognitive theory represented by Bussey and Bandura (1999 according to Martin, Ruble & Szkrybalo, 2002) that is based on contemporary social learning theory, which argues that cognitive structure of a child, gender identity and stereotype knowledge play a very small role in relation to the influence of society.

Aims of this study were to determine whether there are statistically significant differences in the development of boys and girls in 5 developmental domains, and to determine the developmental domain in which the lowest results were achieved. In spite of some differences in developmental domains, obtained results show no statistical significance between boys and girls. Boys achieved lowest results on subscales “Speech/communication” and “Motor development” (age 5-6), while girls achieved lowest results on subscales “Self-care” and “Socio-emotional development”.

According to the results, we can tell that in preschool programs for boy, emphasis should be on physical activities in order to encourage the motor development as well as activities that will stimulate development of speech and communication. When we are talking about girls, programs should be more focused on stimulation of socio-emotional development and development of self-care. We can say that today´s preschool programs do not have enough representation of activities that encourage movement, speech development, self-care and the development of socio-emotional skills. Limitation of this study is sample which size doesn’t allow generalization but the results indicate the need of introducing specific targeted incentive preschool programs that will be different with respect to gender and be aligned with the developmental areas where boys and girls achieved the worst results. If a closer and broader family cannot provide sufficient support for development, preschool programs should replace it by encouraging the child´s overall development.

This research could be a good starting point for a more extensive research that would encompass a larger number of respondents with equal numbers of boys and girls, covering all areas of development. So, that results could be generalized and thus indicate in which developmental areas children of preschool age have the need for additional support to timely influence the structuring of programs in preschool institutions regardless of whether they are children with disabilities or their peers without disabilities.

REFERENCES

Ban, A. (2013, May). Rodni stereotipi u predškolskoj igri [Gender stereotypes in preschool game]. In Petrović-Sočo, B., & Višnjić Jevtić, A. (Ed.). *Play and playing in early childhood*. Paper presented at: European scientific and professional conference: Play and playing in early childhood, Zagreb (78-93). Zagreb: OMEP.

Feingold, A. (1994). Gender differences in personality: a meta-analysis. *Psychological Bulletin, 116*(3), 429-456.

Geary, D. C. (1999). Evolution and developmental sex differences. *Current Directions in Psychological Science, 8*(4), 115-120. doi: 10.1111/1467-8721.00027

Gelman, R. (1990). First principles organize attention to and learning about relevant data: Number and the animate-inanimate distinctions as examples. *Cognitive Science, 14*(1), 79-106.

Low, B. S. (1989). Cross-cultural patterns in the training of children: An evolutionary perspective. *Journal of Comparative psychology, 103*(4), 311-319.

Maleš, D. (1988). Obitelj i uloga spola: Utjecaj roditelja na usvajanje uloge spola kod djece [Family and gender role – Parents' influence on children's gender role adoption]. Zagreb: Školske novine.

Martin, C. L., Ruble, D. N., Szkrybalo, J. (2002). Cognitive theories of early gender development. *Psychological Bulletin, 128*(6), 903-933. doi: 10.1037//0033-2909.128.6.903

Özçalişkan, Ş., Goldin-Meadow, S. (2010). Sex differences in language first appear in gesture. *Developmental Science, 13*(5), 752-760. doi: 10.1111/j.1467-7687.2009.00933.x.

Pahlevanian, A. A., Ahmadizadeh, Z. (2014). Relationship between gender and motor skills in preschoolers. *Middle East Journal of Rehabilitation and Health, 1*(1), 1-4. doi: 10.17795/mejrh-20843

Pištoljević, N., Zubčević, S., Džanko, E. (2016). Razvojne bihevioralne skale za procjenu razvoja djeteta (uzrasta od prvog mjeseca do navršenih šest godina) [The Developmental Behavioral Scales for the Assessment of Child's Development (ages from the first month to six years of age)]. Sarajevo: EDUS.

Šipek, K. (2016). Socijalne vještine djece školske dobi: dobne i spolne razlike (diplomski rad).[Social skills of school age children: age and sex differences (graduate thesis)]. Retrived from Digitalni akademski arhiv i repozitorij. (https://urn.nsk.hr/urn:nbn:hr:147:945512)

Trautner, H. M., Ruble, D. N., Cyphers, L., Kirsten, B., Behrendt, R., Hartmann, P. (2005). Rigidity and flexibility of gender stereotypes in childhood: Developmental or differential? *Infant and Child Development, 14*, 365-381. doi: 10.1002/icd.399

Vasta, R., Haith, M. M. i Miller, S. A. (1998). *Dječja psihologija*. Zagreb: Naklada Slap.

Zagni, E., Simoni, L., Colombo, D. (2016). Sex and gender differences in central nervous system-related disorders. *Neuroscience Journal*, 1-13. doi: 10.1155/2016/2827090

udc 376.1-056.26/.36-053.2
316.356.2:159.9
364.4:316.356.2

Rana intervencija: potrebe i zadovoljstvo roditelja

Daniela Dimitrova-Radojichikj, Natasha Chichevska-Jovanova

Univerzitet "Sv. Kiril i Metodij", Filozofski fakultet, Institut za specijalnu edukaciju i rehabilitaciju, Skoplje, Makedonija

Osnova: *Roditelji imaju značajnu ulogu u procesu rane intervencije (RI) namenjene njihovoj deci sa smetnjama u razvoju. Samo mali broj istraživanja ocenjuje zadovoljstvo roditelja od usluga koje pruža RI. Cilj ovog rada je identifikovati zadovoljstvo roditelja od usluga RI u našoj zemlji, te potreba od dopunske socijalne podrške.*

Metodologija: *U online istraživanju učestvovao je šesdeset i jedan roditelj. Učesnici su popunjavali modifikovanu verziju obrazca za ispitivanje roditelja (Parent Survey-Form) (Stadnicki, 2012). Nisu prikupljeni demografski podaci o roditeljima. Roditelji su odgovarali na svako pitanje na osnovi četvorostepene Likertove skale, gde je najviši rezultat bio 4 (slažem se u potpunosti), dok je 1 bio najniži stepen rangiranja (u potpunosti se ne slažem). Odgovori na dvadeset i devet pitanja bili su analizirani kvantitativnim istraživačkim metodom.*

Rezultati: *Rezultati ovog istraživanja upućuju na to da su roditelji identifikovali nekoliko područja u koja su uvrstili potrebe. Naime, roditelji ukazuju da imaju potrebu za informisanjem o napretku deteta (84,5%), o nastavnim strategijama (93,2%) i o strategijama spravljanja sa problemtičnim ponašanjem (97,9%). Dalje, rezultati ovog istraživanja potenciraju potrebu finansijske podrške roditeljima za plaćanje za terapiju i za ostale usluge koje dobija njihovo dete (91,5%).*

Zaključak: *Roditelji nisu zadovoljni uslugama rane intervencije u Republici Makedoniji. Potrebna im je veća podrška iz različitih izvora, kao što su neformalna (porodica i prijatelji) i formalna podrška (zakonski sektor).*

Ključne reči: *rana intervencija, deca sa smetnjama u razvoju, porodice, zadovoljstvo*

UVOD

Rana intervencija za decu sa smetnjama u razvoju može poboljšati rezultate razvoja deteta, poboljšati sposobnosti roditelja da čuvaju svoju decu u kontekstu svojih potreba, i na taj način dobiće se bolji kvalitet života (Ziviani et al., 2014). U razvijenim zemljama, mnogi programi za ranu intervenciju, tačnije programi za decu od tri godine naviše, nude sveobuhvatne usluge porodicama uključujući socijalnu podršku, koordinaciju usluga, kao i informacije o razvoju deteta (Shannon, 2004). Ovakve usluge obuhvataju i socijalne i psihološke potrebe porodica. Generalno, smatra se da usluge koje omogućavaju redukciju sagorevanja i stresa u porodicama, omogućavaju roditeljima da se fokusiraju na potrebe i na brigu o detetu (Dunst, Trivette & Jodry, 1999). U literaturi, dobro je prepoznat značaj toga da se razume koji su prioriteti roditelja i kakvo je njihovo zadovoljstvo od usluga rane intervencije (Sperry et al., 1999). Prema Bajratiju (Bairati et al., 2011), „zadovoljstvo se odnosi na stepen do kojeg roditelji sagledavaju da te usluge koriste njima i njihovoj deci” (str. 135). U ovom istraživanju, cilj nam je da identifikujemo zadovoljstvo roditelja uslugama rane intervencije, te potrebe za dodatnom socijalnom podrtškom.

METODOLOGIJA

Ispitanici

Učesnici su bili šesdeset i jedan roditelj deteta sa smetnjama u razvoju. Sedamnaest (27,9%) od njih imaju dete sa kombinovanim smetnjama, šesnaest (26,2%) imaju dete sa autizmom, trinaest (21,3%) sa intelektualnim smetnjama, deset (16,4%) sa motornim smetnjama, dvoje (3,3%) imaju dete sa oštećenim sluhom i jedan (1,6%) roditelj ima dete sa oštećenim vidom. Dvoje roditelja (3,3%) nisu odgovorili kakve smetnje ima njihovo dete.

Instrumenti

Roditelji su popunjavali modifikovanu verziju obrazca za ispitivanje roditelja (Parent Survey Form) (Stadnicki, 2012). Neke tvrdnje iz originalne verzije bile su modifikovane da bi se odnosile na usluge rane intervencije u našoj zemlji. Takođe, neke tvrdnje su odstranjene jer nisu bile u saglasnosti sa našim kontekstom. Npr. tvrdnja „ja sam informisan o različitim mogućnostima dobijanja usluga za moje dete” je eliminisana jer kod nas postoji nedostatak usluga rane intervencije.

Istraživanje je sastavljeno od 31 tvrdnje, podeljene u 7 delova. U prvom delu *Razvoj programa*, roditelji su bili pitani za njihovo iskustvo u vezi osoblja i usluga rane intervencije (tri tvrdnje). Drugi deo, nazvana *Porodične potrebe*, sadrži devet tvrdnji koje se odnose na potrebe porodice i na socijalnu podršku. Deo *Finansije* (pet tvrdnji) odnosi se na procenu porodičnih potreba za finansije i za izvore povezane sa finansijama. Četvrti deo *Objašnjavanje ostalima*, sadrži pet tvrdnji o resursima porodica u toku objašnjavanja ostalima o smetnjama njihovog deteta. Sledeći deo je *Briga o detetu* (dve tvrdnje), od roditelja se tražilo da procene svoje potrebe za resursima oko brige o detetu. Šesti deo, *Spoljasnja podrška* (2 tvrdnje) raspravlja o izvorima podrške van porodica i njihovih zajednica. Poslednji deo je *Usluge zajednice* (tri tvrdnje), od roditelja se tražilo da procene njihove potrebe za resursima, kao što su lekar ili stomatolog, za njihovo dete. Istraživanje završava sa delom *Komentari* u kome se traže „dodatni komentari, zabrinutost ili sugestije” koje roditelji imaju da predlože.

U svakoj tvrdnji istraživanja, od roditelja se tražilo da odgovore na osnovu četvorostepene Likertove skale, pri tom je 4 najviša moguća ocena (slažem se u potpunosti), a 1 je najniža (u potpunosti se ne slažem).

Procedura

Bio je upotrebljen link do formulara o istraživanju roditelja (Parent Survey Form: (https://docs.google.com/a/fzf.ukim.edu.mk/forms/d/13iiEW3uhbxGnuo2sLyD-CrWeO_GIHgZ2s010_VzGpGSo/edit)) za distribuciju među roditeljima u istraživanju. Bile su poslate e-poruke roditeljima, a link je isto tako bio poslat u grupi roditelja dece sa smetnjama u razvoju na Fejsbuku.

Statistička analiza podataka

Pomoću deskriptivne statistike, obezbedili smo osnovne informacije o učesnicima u istraživanju.

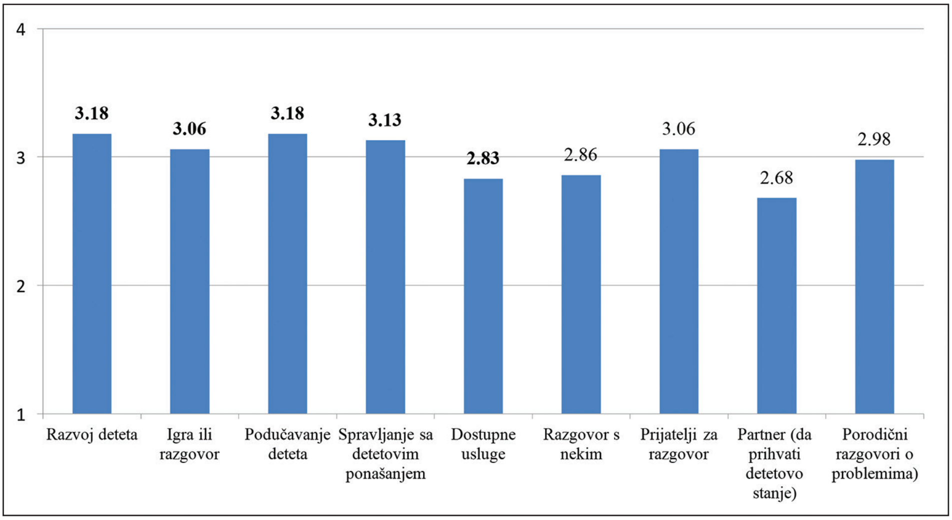
REZULTAT I DISKUSIJA

U prvom delu istraživanja, rezultati saglasnosti (3 ili 4) ukazuju da su porodice zadovoljne programom rane intervencije. Viši prosek ukazuje na veći stepen zadovoljstva. Stavovi roditelja o razvoju programa može se videti na Tabeli 1. Roditelji su bili zadovoljni sa povratnim odgovorom osoblja, sa skoro 62% saglasnosti sa tvrdnjama u ovom delu.

Tabela 1 – Razvoj programa

Tvrdnje	Slažem se / slažem se u potpunosti	M	SD
Osoblje me sluša i odgovara na moja pitanja	61.8%	2.54	0.789
Ja sam aktivni član tima	57.4%	2.57	0.743
Dobijam jasne informacije od osoblja	59.6%	2.64	0.750

U drugom delu istraživanja, rezultati saglasnosti (3 ili 4) odnose se na potrebama porodica. Zato, viši prosek ukazuje na veće potrebe porodica (Slika 1). Najveća potreba odnosi se na „kako deca rastu i razvijaju se” (3.18±0.782) i „kako da podučavam svoje dete” (3.18±0.655). Naime, roditelji ukazuju na potrebu za informisanjem o razvoju deteta (84,5%), o nastavnim strategijama (93,2%) i o strategijama za spravljanje sa problematičnim ponašanjem (97,7%).



Slika 1 – Potrebe porodice

Rezultati o potrebama za finansiskim izvorima, mogu se videti u u Tabeli 2. Ovde postoje mnoga područja za kojima porodice imaju potrebu. Najveća potreba, prema tvrdnjama, su terapija i medicinska briga.

Tabela 2 – Finansije

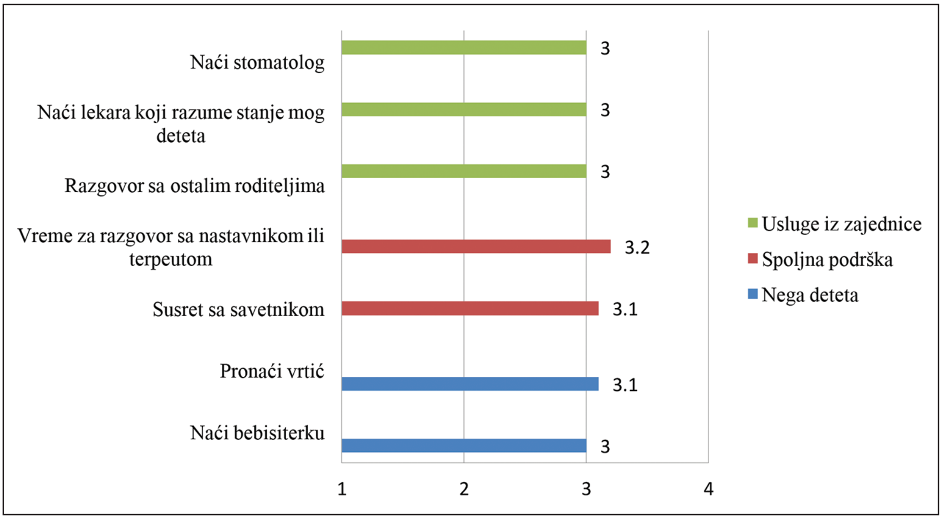
Tvrdnje	Slažem se / slažem se u potpunosti	M	SD
Plaćanje medicinske nege	79.3%	3.08	0.960
Dobijanje bilo kakve specijalne opreme	75%	3.05	0.998
Plaćanje za terapiju	91.5%	3.47	0.837
Plaćanje za bebisiterku	71.9%	3.03	0.981
Plaćanje za igračke	75.4%	2.98	0.954

Rezultati od „objašnjavanje ostalima” mogu se videti u Tabeli 3. Većina roditelja (79,9%) ukazuje na potrebu dodatanih informacija o tome kako objasniti stanje deteta drugoj deci. Takođe, imaju teškoće u pronalaženju materijala za čitanje o drugim porodicama koje imaju dete kao njihovo.

Tabela 3 – Objašnjavanje ostalima

Tvrdnje	Slažem se / slažem se u potpunosti	M	SD
Objasniti stanje mog deteta mojim roditeljima/roditeljima moga supruga	63.8%	2.82	0.819
Objasniti stanje mog deteta njegovim rođacima – braca i sestre	73.3%	2.86	0.724
Znati kako da odgovorim kada prijatelji ili neznanci pitaju za stanje mog deteta	65.5%	2.84	0.854
Objasniti stanje mog deteta drugoj deci	79.7%	3.1	0.758
Naći materijal za čitanje o drugim porodicama koje imaju dete kao moje	81.9%	3	0.685

Rezultati o potrebnim resursima za brigu oko deteta, spoljna podrška i usluge zajednice, mogu se videti na slici 2. 76,5% roditelja imaju problem da nađu bebisiterku, a 82% da pronađu vrtić za njihovo dete sa smetnjama. 85% roditelja ukazuje na potrebu za više vremena za razgovor sa nastavnikom ili terapeutom. Pri tome, većina njih ukazuje na potrebu za pronalaženje lekara (79,6%) ili stomatoliga (78,6) koji će uslužiti njihovo dete.



Slika 2 – Briga o detetu, spoljna podrška i usluge iz zajednice

Na kraju istraživanja je deo za komentare koje su ostavili roditelji, većina od njih su negativni. Neki od najznačajnih sugestija i komentara su:

- „Da država više pomaže porodicama koje imaju osobu sa smetnjama u pogledu zdravstvene zaštite, benificirani radni staž za roditelje, novčana naknada za asistente u nastavi i u vrtićima, besplatni vrtići, suplementi na pozitivnoj listi, obuka nastavnika u školama i vaspitača u vrićima, laboratorijska biohemijska ispitivanja na teret fonda (da važi i za inostranstvo), povećanje novčane pomoći porodicama i mnogo drugih stvari...”
- „Problema ima milion, samo dosad se niko nije zaangažovao za našu decu.”

ZAKLJUČAK

Roditelji dece sa smetnjama u razvoju ukazuju na mnoga područja porodičnih potreba i socijalne podrške. Oni izražavaju zabrinutost u vezi njihove uloge u susretu sa osobljem (za testiranje itd.) i osećaju da osoblje za ranu intervenciju im ne daje jasne i korisne informacije. Takođe, učesnici ukazuju na potrebu o finansijskim izvorima da bi platili terapeuta njihovog deteta. Generalno, porodice sa bebama ili malom decom sa smetnjama u razvoju nisu zadovoljni uslugama rane intervencije u našoj zemlji. Njima je potrebno da podrška i usluge rane intervencije pomognu u razvoju njihovog deteta i unaprede sopstvene sposobnosti da poboljšaju razvoj svog deteta.

REFERENCES

1. Bairati, I., Meyer, F., BambaDieyeGueye, C., Desmarais, C., Rouleau, N., & Sylvestre, N. (2011). Factors influencing parent satisfaction with preventive health services for the early detection of speech and language delay in preschool children. *Open Journal of Preventive Medicine, 1*(3), 135-142. doi:10.4236/ojpm.2011.13018
2. Dunst, C. J., Trivette, C. M., & Jodry, W. (1991). Influences of social support on children with disabilities and their families. In M. J. Guralnick (ed.), *The effectiveness of early intervention* (pp. 499–522). Baltimore: Paul H. Brookes.
3. Ziviani, J., Darlington, Y., Feeney, R., Rodger, S., & Watter P. (2014). Early intervention services of children with physicaldisabilities: Complexity of child and family needs. *Australian Occupational Therapy Journal, 61*, 67–75. doi: 10.1111/1440-1630.12059.
4. Shannon, P. (2004). Barriers to family-centered services for infants and toddlers with developmental delays. *Social Work, 49*, 301–308. doi:https://doi.org/10.1093/sw/49.2.301
5. Sperry, L., Whaley, K., Shaw, E., & Brame, K. (1999). Services for young childrenwith autism spectrum disorder: voices of parents and providers. *Infants and Young Children, 1(4),* 17-33.
6. Stadnicki, S. (2012). *Parent Satisfaction Survey of the Infant and Toddler Program at the Experimental Education Unit (Master these).* Retrieved from: researchworks/bistream/handle/1773/20829/Stadnicki_washington_0250O_10662.pdf?sequence=1&isAllowed=n

EARLY INTERVENTION: NEEDS AND SATISFACTION OF PARENTS

Daniela Dimitrova-Radojichikj, Natasha Chichevska-Jovanova
University Ss. Cyril and Methodius, Faculty of Philosophy, Institute of Special Education and Rehabilitation, Skopje, Macedonia

Research subject: Parents have an important role in early intervention (ei) of their children with a disability. a limited number of studies have assessed the satisfaction that parents feel with ei services. The purpose of these studies was to estimate parents' satisfaction with ei service and their needs for additionalsupport and services.

Method: Fifty-nine parents participated in an online survey. The participants completed a modified version of the Parent survey-Form (stadnicki, 2012). no demographic information on the participants was collected. in each question of the survey, parents were asked to respond based on a four-point likert scale where 4 was the highest possible rating (strongly agree) and 1 was the lowest possible rating (strongly Disagree). Responses to twenty-nine questions were analyzed using quantitative research methodology.

Results: The results of this study indicated that there were several areas of needs that parents identified in themselves. namely, parents indicated a need for information on child development (82.5%), teaching strategies (91.2%), and strategies for managing problematic behavior (84.2%). Furthermore, the findings of this study also highlighted a need to establish social networks and relationships with other families of young children with disabilities (84.2%) and financial support for parents who pay for therapy and other services for their child (91.1%).

Conclusions: Parents are not satisfied with early intervention services in the republic of Macedonia. They need more support from a variety of sources, such as informal (family and friends) and formal support (statutory sector).

Key words: early intervention, children with disabilities, families, satisfaction

CIP - Каталогизација у публикацији
Народна библиотека Србије, Београд

376.1-056.26/.36-053.2(082)(0.034.2)
364.4-056.26/.36-053.2(082)(0.034.2)

EURLYAID. Coference (2017 ; Beograd)
Early Childhood Intervention: For Meeting Sustainable Development Goals of the New Millennium [Elektronski izvor] : proceedings / Eurlyaid Conference 2017, Belgrade, Serbia October, 6 - 8th 2017 ; [organizers University of Belgrade - Faculty of Special Education and Rehabilitation, The European Association on Early Childhood Intervention [and] European Association of Service Providers for Persons with Disabilities]. - Beograd : University , Faculty of Special Education and Rehabilitation, 2017 (Beograd : University , Faculty of Special Education and Rehabilitation). - 1 elektronski optički disk (CD-ROM) : tekst ; 12 cm

Sistemski zahtevi : Nisu navedeni. - Radovi na srp. i eng. jeziku. - Tiraž 200. - Bibliografija uz svaki rad. - Rezimei na srp. ili engl. jeziku.

ISBN 978-86-6203-101-3
1. Faculty of Special Education and Rehabilitation (Beograd) 2. The European Association on Early Childhood Intervention (Beograd) 3. European Association of Service Providers for Persons with Disabilities (Beograd)
a) Деца са посебним потребама - Образовање - Зборници b) Деца са посебним потребама - Социјална интеграција - Зборници
COBISS.SR-ID 246737932