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CONTENTS

REGULAR ARTICLES

1-16 Attachment and preschool teacher: An opportunity to develop a secure base
Purificación García Sierra

17-32 Investigation of social supports for parents of children with Autism
Aaron R. Deris

32-45 Otistik Bozukluk Gösteren Çocuklarda Bir Müdahale Yaklaşıımı: Su İçi Etkinlikler
An intervention approach for children with Autism: Aquatherapy
Mehmet Yanardag & Ilker Yilmaz

BOOK REVIEW

46-49 Teaching Social Communication to Children with Autism
Emre Ünlü
From the Editor,

In this issue, you will find four different types of articles:

The first article written by Purificación García Sierras on preschool teacher and attachment. She focuses on secure attachment between preschool teachers and young children when alteration in attachment process happens between mothers and their young children.

The second article entitled as “investigation of social supports for parents of children with Autism” was written by Aaron R. Deris. The author tried to identify the forms of social support that parents of children recently diagnosed with autism perceive as being important. Twenty parents of children recently diagnosed with autism participated and completed a Q-sort using the forms of social support.

The third article, as invited article written by Mehmet Yanardağ and İlker Yılmaz, introduces a new therapeutic approach called aquatherapy.

The last article is a book review. Doctoral candidate Emre Unlu reviewed the book titled teaching social communication to children with autism.

Looking forward to being with you in December 2012 issue.
Attachment and preschool teacher: An opportunity to develop a secure base

Abstract

Relying on a figure that makes us feel loved, safe and protected is a basic necessity of human beings with repercussions in all the aspects of psychological development. Early Intervention is based on knowledge and detection of risk factors and intervention in creating and strengthening protective factor of development. When early relationship between mother and child is altered due to the characteristics of the child, the mother or the context, and insecure attachment is developed, preschool teachers may become secure attachment figures influencing all the fields of present and future development. In this article there are some detection indicators of possible altered affective relations as well as conduct proposals to generate secure affective connections between children and their teachers.

Keywords: Attachment, teachers, preschool years.

Introduction

Relying on one or various figures that make us feel loved, safe and protected, is a basic necessity of human beings (Bowlby, 1969/1980). This feeling of security (physical and psychological) is built over the establishment of an appropriate affective bond of attachment. The attachment connection generates from the repeated interactions between child and mother through the first three years, it consolidates during childhood and it has a repercussion across the life span (López, 1990, 1993, 2003; Heese & Main, 2000).

The affective relationships of attachment must be understood as a complex framework of bidirectional relationships, to which every component of the dyad contributes with its

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individual characteristics and in which the context where they take place also has a powerful influence. The characteristics of the mother (psychological state, pathologies, addictions, stress or background of insecure affection), of the child (disturbances, premature birth or temperament) and of the context (extreme deprivation or violent environments) leads to the development of a map of risk factors for the establishment of an secure attachment between the child and his/her attachment figure.

Early Intervention is focused on detection of risk factors and the development of strategies for strengthening protective factors. The school, during early years, plays a key role in the development of children at risk. The teacher’s role as a attachment figure is essential. He/she has the capacity to create an environment of comprehension and security where the child feels capable and loved, and his/her advances are seen as authentic progress. He/she has the capacity in essence to become an authentic secure base where to return to catch their breath in the difficult journey of learning and development.

When children are immersed in relationships of insecure attachment, they build up an image of themselves as people that don’t deserve care and protection, and tend to get isolated or to have an aggressive behavior with other children or adults in a thirst of self-defense. Furthermore, the evolutionary tasks appropriate to their age turn in many occasions into insurmountable pitfalls.

Under the light of a great number of investigations, for children that due to their own characteristics, their mothers’ or the context, have affective histories of insecure attachment, an healthy affective relationships with the teacher during preschool can become an important protection factor of development (e.g. Pianta, 1990 or Silver et al., 2005).

The purpose of this article is a brief review of the literature on risk factors for the development of a secure attachment and add some lines of work that guide the teacher in generating secure attachments with children at risk.

This article is divided into three parts. The first is dedicated to show a brief overview of the most common risk factors for the development of an affective bond of secure attachment. In the second part, we will conduct a review of the investigations centered in the study of the teacher’s role as figure of child attachment. In the third we present, show some indicators to detect children with altered affective relationships and some proposals of intervention for the classroom.

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2 Through the article, when referring to the attachment figure as the main care-giver, we will use the term mother, following Bowlby (1963, 1980), in the sense that is the mother who usually plays this role. However, this term also collects any other figure that provides care and confort to the child.
Risk factors for a secure attachment: mother, child and context

According to Isabella (1993) the origin of the type of attachment is found in the *interactional history of the dyad*. From our point of view, the affective connection of attachment must be interpreted from a systematic and ecological perspective (in terms of Bronfenbrenner, 1974, 2005). So: a) attachment relationships concern (at least) two human beings that are, both, growing; b) the interactions are influenced by the psychological and affective characteristics of the mother as well as of the child; and last, c) the affective bond of attachment is built on a context.

The precursor of a secure attachment may generically find in emotional and affective synchronicity between the child’s demands and the mother’s responses. This affective synchrony has its origin in the *maternal sensitivity* (Ainsworth & Blear. 1978). The concept of maternal sensitivity embraces a collection of aptitudes, attitudes and behaviors that are summarized in the mother’s capacity to capture baby’s signs, to adequately interpret them and to react in a reasonable and consistent way (Isabella, Belsky & Von Eye, 1989, Cantero, 2003). Ainsworth et al. (1978), defines maternal sensitivity around several attitudes: the first one is acceptance of the child in all the fields and dimensions, his/her temperament and limitations. Another attitude is cooperation and it refers to a view of the child where the adjustment between control and affection is produced in a natural way. The mother must respect the times and necessities of the child, in a way that does not interfere nor invade, adjusting and keeping in step the actions with the necessities and capacities of the baby. And in third case, a sensitive mother shows herself accessible and available when the baby requires her attention. Last, authors point out as a fundamental attitude of sensitivity, the maternal capacity to express her emotions and to provide an environment where the child can express themselves freely without being judged or punished, being taken care of without reproaches.

The children whose mothers have responded in a sensitive way and that have consistently been accessible and available figures, present greater capacity to explore the, are self-confident and be able to establishing healthy relationship with other adults and in other contexts. However, not always conditions are appropriate to ensure healthy interactions that will result in a secure attachment relationship. Since the mid-20th century, a great part of the studies of attachment carried about early interactions, have focused on the study of risks factors for the establishment of a healthy attachment.

One of the most investigated topics concerns with the mental states of the mother. The mothers’ stress from their personal or contextual stories, the suffering of psychological alterations such as depression (e.g. Main & Hesse, 1990 or Quezada & Satelices, 2009) or a history of abuse, negligence or abandonment during their childhood (e.g. Crowell & Feldman, 1990; Ainsworth and Eichberg, 1991 or Moore and Pepler, 2006), are considered predictors of insensitive and inconsistent interactions. In negative emotional situations, mothers respond inappropriately to babys’ signals (Caselles and Milner,
2000; Pons-Salvador, Cerezo & Bernabé, 2005 or Cerezo, Trenado & Pons-Salvador, 2006). Such responses are the result of a bad detection or interpretation of the demands, and of the incapacity to respond in a synchronized way (Cerezo, 2001). In conclusion, to show availability and sensitivity.

Howe (2006) points out that the theory of Attachment leaves the responsibility of the interaction on the characteristics of the main care-giver, giving little significance to the characteristics of the other part implied in the dyad: the baby. Some authors such as Poehlman (2000) find a high correlation between subclinical depression, with its origin in the birth of a premature baby, and insecure attachment. The birth of a premature child places the mother in an emotional and psychological situation of vulnerability (greater as the baby’s gestation is lower). To the concern and anxiety derived from the maternity experience, the necessity of rethinking her expectations as the care-giver of a “planned” baby is added (Ammaniti, 1989). Other stress factor for this mothers is the auto-perception of incompetence to take care and protect a baby seen as more vulnerable and needed of priority medical attention, for which the mother thinks is not ready.

Several studies (e.g. Olexa & Stern, 1999, Divitto & Goldberg, 1979 or Stern, 2000) show how mothers of premature babies interact less synchronically than other mothers. Due to their lack of maturity, these babies are psychologically and physically less organized, with greater difficulties to demand and appropriately regulate their behavior to interactions, and seen as such by their mothers (Charavel, 2000). The mothers of premature babies, carried away by the representation of the baby as fragile and vulnerable, tend to interfere more in their relationships or, in any case, to not read or interpret appropriately the baby’s needs (Cantero, 2003).

Disability is another characteristic of children that is related to the quality of the affective interactions of attachment. Children with disabilities show lower attachment behavior (crying, babble, verbalize, search or tracking, etc.) (Atkinson et al. 1999). Therefore, they have greater difficulties to respond in an appropriate way to the interactions of the mother. All these difficulties are many times the synchronizing of the interactions of the figures of attachment. Mothers are under additional stress when they don’t understand their children’s demands so that they can’t adjust their answers (Johnston et al. 2003), feeling more secure when acting as efficient caregivers (Sloper et al. 2003). These mothers tend to try to “eliminate” deficiencies perceived in their children through over-stimulation and tend to be bossier and to interfere more in their children than the mothers of normal children, which may impact in the attachment (Howe, 2006).

Lastly, another aspect of great study about the origin of attachment is the social contexts of the dyad. In this sense, families (and dyads) immersed in contexts of social risk offer an environment of development and upbringing, where affective connections are more likely to be “troubled” or insecure. Several investigations have demonstrated that the manifestation of hostility by the figures of attachment are more often and have greater consequences in families with social risk. It confirms that situations such as domestic...
violence, socio-economical problems or emotional destructuration interrupt the conditions for the upbringing and the interactions, creating insecure attachment and more frequently, disorganized attachment, reaching a 34% in families with socio-economical problems and a 77% in mistreated children (e.g. Main & Solomon, 1990 or Moore & Pepler, 2006).

Do not want to conclude this section without pointing out that despite all the risk factors that we draw (maternal psychological state, the characteristics of the child and the context), a large number of research show that acceptance and secure attachment history are better predictors of the type of attachment than isolated characteristics or alterations of the child (Down Syndrome, Autism Spectrum Disorder or other physical or cognitive deficiencies) or depressant context (e.g. Capps et al. 1994; Rutgers et al. 2004). Meanwhile, another group of research maintained that mothers with certain mental disturbances (e.g. the depression) display behaviors most warm and tight to their children after a psychological intervention program (e.g. Marvin, Cooper, Hoffman & Powell, 2002). These findings bring back the classical interpretation that was earlier discussed, regarding the central role of the attachment figure in early affective connection and show the importance of the mother’s sensitivity regardless of the features of the child or the context.

Development is a complex and multidimensional phenomenon where all the fields affect each other. From this ecological and systemic perspective, the quality of the early interactions, the nature of attachment between children and the attachment figure is a key element in the comprehensive development of the child and it has repercussions throughout life.

Preterm infants, with alterations to physical or mental, children of mentally vulnerable mothers or are born in contexts of extreme deprivation, constitute risk groups on which early intervention are key to their development. In general, such interventions are intended to the biological and cognitive areas. In recent decades, however, it has increased the interest in research and early intervention on attachment and more specifically in the study and the intervention of the role of the teacher in the development of attachment in children at risk.

In western societies more and more children of earlier ages and especially those with unfavorable conditions, have in the preschool classroom an allied of integral progress. As note Gútiez (2005) the preschool classroom is an essential context of prevention and compensation especially for children with personal or social disadvantages. This empowerment is supported in the possibilities of an effective scaffolding, and in the early detection and intervention of the professionals of Primary Education. These enabling actions of development can only be carried out by the figure of an adult: the teacher, who becomes a referential point to learn and advance, not only in the cognitive field but also socially and affectively.
Child’s attachment to the preschool teacher

Bowlby’s assumptions (1969) about the idea subsidiary figures of attachment, underlies in the notion of Attachment Net (e.g. Thompson, 1999, van Ijzendoor, Sagi and Lambergonn, 1992). This such Net refers to an emotional and affective framework whose center is the mother or the main care-giver but that shares space with other figures that are emotionally relevant for the child, specially those with whom he can constantly interact in time and space. These figures, despite the characteristics of intensity and interactions that are contextually different to those that take place in the didactic and familiar context, also follow a role to provide care and affection with the idea to provide physical and emotional security to the child.

In this sense, Crosnoe et al. (2004) and Levitt (2005) suggest that in these affective structures, children establish a hierarchy that represents the degree of proximity and emotional implication with the people that form this such Net. It not only contains the parents and family, but what really matters to us, the teachers (Kobak, Rosenthal & Servick, 2005).

Following this idea, van Ijzendoorn et al. (1992), conducted a research with children among the ages 3 and 5, with the objective to compare their behaviors with a stranger and with their teachers using the strategy of the Strange Situation. The conclusions of the work show that there is a different behavior of the children with both figures, showing attachment with the teacher, whom they approached and asked for help or comfort.

An interesting study that follows this line is conducted by Howes and Ritchie (1999). The authors analyzed the behavior of children among the ages 3 and 5 in their daily activities and their interactions with their teacher. Looking at their attitudes and behaviors, the authors classify affective relationships with teachers in three groups; a classification that follows the main patterns of basic attachment. They are the following: A group of children show conduct of physical and emotional contact with the teacher. They grab and hug the teacher, and accept his/her caresses, games or talks he/she proposes. At the same time, they can go away to play with the objects and the other children without any problem to participate in activities and to show empathy. When they feel disconcerted they look for the teacher’s company and comfort. They adequately manage their frustrations. They are usually happy. They react easily and quickly to the teacher’s demands and if he/she lies to them, they adapt their behavior to what is required. They show interest and curiosity for their classmates, toys and new tasks. These children are considered Secure children with respect to the connection with their teacher.

Another group of children are constantly distracted. They rarely establish contact with the teacher and their behavior is focused on the objects in the surrounding. When the teacher calls them, they ignore her or slowly move closer, running away quickly to continue playing by themselves. They never ask the teacher for help with complex tasks.
or difficult situations. In this last case, when the teacher approaches them they reject his/her comfort and look indifferent. They are cold and distant with other children. They are classified as *Evitative Insecure Attachment*.

A third group of children that falls under the category of *Resistant Insecure Attachment* towards the teacher, shows an emotional state of irritability and anger. This anger has its center on the teacher even if he/she is not interacting with the child. These children are easily frightened and in constant alert with the teacher, other children or any other happening in their surrounding (noise, movement, etc.), causing them to cry. The teacher’s strategies to comfort them show no result, however their demand of attention is constant. They are impatient and they are rough or hostile without any notice.

In a generic conclusion, we can point out that children with insecure attachment are irritable or isolate themselves, making demands that are incoherent and not synchronized with external events. In this occasions, the teacher has greater difficulties to understand these demands and interact with the children efficiently, since in many cases they feel their comforting or scaffolding efforts to be rejected. As we know, some individual characteristics of children or those who live in altered contexts (mental vulnerability of parents, domestic violence or extreme deprivation) have a greater probability to generate insecure attachment.

A secure affective relationship with the teacher may whether restructure the relationship with the attachment figure or build a psychological and affective space to compensate, where he/she can feel secure and confident. Looking at this premise, a secure relationship with the teacher becomes a protective factor for children with insecure attachment or with risk of suffering it (e.g. Howes, 1999; Carrillo et al., 2004 or Maldonado & Carrillo, 2006). This protection has ramifications in very diverse aspects of the child’s life. In one hand, children with secure attachment with their Primary School teachers are more sociable, cooperative and have empathy with children and teachers in other levels and educative strata (Rosenfeld, Richman & Bowen, 2000 or Crosnoe, Johnson & Elder, 2004), reducing behavioral problems and socio-economical competition (e.g. Kidwell et al. 2010), and increasing the degree of adjustment to the surrounding and the school tasks (Howes & Ritchie, 2002, Davis & Dupper, 2004 or Silver et al. 2005).

In the school as well as in the house, the construction or the affective connection of attachment is a complex framework of mutual interactions and perceptions. Children with secure attachment show, as we have seen, more attention and success with the tasks, a more coherent and empathic behavior and a greater aptitude for warm and steady affective relationships between themselves and the teacher, and other children. Their demands are coherent with the circumstances, their tone is adequate and their reactions to other children’s and the teacher’s responses are consistent and expected. This leads teachers to a better and more adjusted interpretation of the demands and reactions of the child, to feel satisfied with the cognitive and affective achievements of the child, and therefore, to generate more spontaneous interactions with more frequency, better quality
and duration. Nonetheless, just like in any other didactic relationship, the characteristics of the teacher play an essential role. The teachers that don’t properly interpret the needs and demands of children, that are or look insensitive and that don’t answer in a synchronized and contingent way to children’s demands tend to establish relationships of insecure attachment very similar to the constructing process of the affective relationship of the child with his/her primary attachment figure. In the other hand, characteristics such as sensitivity, receptivity and personal involvement have a prominent role in the establishment of this type of relationship (Howes & Ritchie, 2002) even when the characteristics or initial circumstances of the child are adverse. Barret and Trevitt (1991) consider the figure of the teacher as attachment figure to be especially important for children with insecure attachment for their role to guide and order an affective world that is unsettled, blurry and uncertain. At the same time, just like the first relationships between mother and child generate internal models of the relationship, early experiences with the teacher as attachment figure will generate a relationship model too. Such models contain the representation once again of the child as a competent being for learning in all the fields (curricular, skills, affective and social). They also contain ideas about the sensitivity and availability of the teacher for his/her demands. They also differentiate inferences between the emotion and the affection created in the teacher. At last, these internal models are once again guides to interpret context and future teachers. This way, there is a tendency to maintain the style of affective relationship with teachers in later stages in life and the attitudes towards school context, all its elements and agents (e.g. Howes et al. 2000).

How to generate secure attachment at preschool classroom: Some proposals

When the teacher becomes part of the emotional and affective net of the child, this already has or (depending on the age of the child) is building an affective connection with the mother. Researchers show contradictory results. While some authors find that children with insecure attachment with their mothers tend to establish insecure affective relationships with their teachers during Preschool (O’Connor & Kathleen, 2006; Diaz-Aguado & Martinez Arias, 2006), others studies find only a moderate relationship between styles of attachment in children with their mothers and the patterns of attachment generated with the teachers (e.g. van Ijzendoorn, 1990 or Cugman, 2007). At last, an important group of researchers find that while children with secure attachment with their mothers generate secure attachments with their teachers, more than half of the children with insecure attachment with their main care-givers generate secure attachments with their teachers when they are approachable and sensitive (e.g. Silver et al. 2005; Howes & Hamilton, 1992; Goossens & van Ijzerdoorn, 1990). These findings confirm Bowlby’s proposals (1980) and more recently Crittenden’s (2002) who says it is possible to generate new healthy attachment relationships or even reshape an insecure internal model.

Therefore, in one hand the children that have generated insecure attachments with their mothers can also generate secure ones with their teachers. And in another hand, a
relationship of security with the teacher has better psychological and academic results from early ages. It seems essential that teachers have among their priorities the construction of a good affective connection based on attitudes and behaviors of sensitivity and warmth, especially with children that have personal or social disadvantages (Bergin & Bergin, 2009).

From our point of view, the teacher’s knowledge of how the emotional and affective development is produced and how it is influenced by altered circumstances is an essential formative element that would ease in greater manner the detection and comprehension of child progress. Other indicators can be useful to find children that already have a difficult affective relationship or that show high risk of creating it with his/her attachment figures. They are the following:

- Know the personal and social history of the child. It will give essential information about his/her individual and social situation. We know that children with alterations or pathologies, or that live in very deprived social environments or are socially rejected, have a higher risk to generate insecure attachments with their usual care-givers.
- Through a collaborative work with other professional of early attention, have a clear knowledge of the pathology or the child alteration, his/her evolution as well as the repercussions in all areas of development and learning. From this knowledge we will have a fair comprehension of the affection of the child to be able to deliver or interpret affective and social indicators, routines and demands of the surroundings.
- Observe the patterns of affective behavior towards the attachment figure in daily situations. In many occasions we have the opportunity to take part of the interactions between the child and his/her attachment figure. It is obviously not a diagnosis, but to keep in mind indications that with other signs let us sketch an overview of the affective relationships among them. Situations such as separations, reunions, and chatting moments with the teacher or tutoring can provide valuable information to visualize some features of the relationship.

Some behaviors and attitudes of the child with the teacher can also be useful as signs of insecure affective history and became a risk to be perpetual with the teacher in the classroom. Regarding the didactic interactions with the child, the teacher must be able to appropriately interpret the affective demands of the child. The characteristic behaviors of these children are the hostility and indifference as a characteristic of the relationships with the teacher, the shortage, non-existence or rejection of the physical/verbal/ocular contact, the excessive or too scarce demands, the tendency to be isolated, lonely or little active. They also show tendency to avoid the teacher as a protective and comfort figure. Similarly, indicators of potential affective problems are the controversial interactions with others due to excess (children with violent or hostile behaviors) or shortcomings and isolated children from the environment, children and teacher.
Regarding the tasks, the fact that the child is never interested in a task or game, that never or very rarely feels attracted by something or that his/her behavior shows low self-esteem, distrust or fear to be frustrated even in the easiest tasks, gives us information about his/her view of him/herself as someone incapable and frightened to make mistakes, probably foreseeing negative consequences to his/her acts. We must also worry about the child that compulsively introduces actions and challenges. Children that try to challenge themselves and others with tasks above their possibilities an aptitude, constantly looking for the teacher’s approval and to compete among peers. These children are permanently demanding, calling for attention and not doubting to transgress rules or to use dangerous behaviors with the aim to be accepted and appreciated.

The ability to detect the affective configuration of the relationship between the child and the mother is fundamental because as we have seen, the teacher may be a compensatory or reaffirming figure of the altered process of the child, having repercussions not only in the present but also in the future in his/her integral development.

The crucial role of the teacher with children that show in a general and consistent way one or all of the behaviors and attitudes mentioned here, is to revert to this process as long as it is possible. In essence, the sensibility, acceptance, accessibility, availability and cooperation that we have emphasized as precursors of a secure affective relationship between mother and child, are the same than the characteristics that define the affective interactions and relationships between teacher and child. The coherence, the consistency of the answers of the teacher and the productivity are once again the elements to make a foundation of a good affective relationship.

We can summarize some recommendations for action with children with insecure attachments or at risk of suffering.

- One of the keys to the teacher’s intervention is the certainty that theses children need to feel loved and secure, although their behaviors seem to indicate otherwise. They are extremely vulnerable and dependent on the affection of an adult. That is why it is essential that the teacher openly shows his/her attention and tends to get closer physically (physical, ocular, verbal contact...) and emotionally, even if he/she is rejected or ignored, because we know children have learned to show hostility and lack of enthusiasm as a form of protection. These children need to reshape a model where he/she wasn’t taken care of or the responses were cold or even hostile. These children must understand and learn through warm contact.

- Understanding of the feelings, emotions and behaviors of the child from his personal and social history is essential, as well as to turn the classroom into a place of emotional learning. Children with alterations or altered contexts of upbringing have problems to determine their emotions and link them to the events, as well as to express them and of course to do it effectively. For this reason, is essential the teacher’s ability to understand the social and emotional behavior of the child in context and provide reconnaissance of the situation and
the labeling of the emotions and the events that cause them. Although the emotional comprehension is an developmental task (Harris, 1989), when some factors don’t favor the appropriate interpretation of the emotions and the emotional adjustment, children have more difficulties to be emotionally competent (Saarni, Mumme & Campos, 1998).

• Children with insecure attachment don’t clearly understand the clues of cooperative and combined tasks. These must be scaffolded by the teacher in a way that the child doesn’t interpret it as a competition for the approval and the praise of the teacher.

• As a consequence to the non-existence or the deprivation of their security, children with insecure attachments tend to be very alert to dissonances between emotional messages in private and in public in respect to them. It is important to find coherence between the emotions and the feelings that the child gets from the teacher in private, as a result of daily interactions, and those transferred to other adults, with special relevance to the parents. The disagreement can commit the confidence in the teacher.

• The physical environment must be able to provide physical and emotional security with simple and approachable areas, predictable activities and coherent and consistent routines to help them reshape their behavior.

• -Finally, developmental calendars and also acquisition and referential calendars in children with alterations or at risk are much more diversified than in normative populations. That is true also for children with a very disturbed or disturbing emotional history. This is why it is important that the expectations on the child are fair and the demands are therefore coherent and adjusted in time. In many occasions these children need simple tasks (even when these are under the expected level and performance) to be accompanied and scaffold. And in this case, is very important to strengthen successes and capabilities even if the child’s answer looks indifferent.

Intervention at school, as any other context of early intervention, requires a multidisciplinary approach. Likewise, detection and early intervention in school requires the participation of the significant figures of the various contexts of development: teachers and family. The involvement and coordination of all educational and social actors is essential. It is necessary to create and implement protocols for the detection and intervention and school in the area of attachment.

Conclusion

The need of affection and protection is, according to Bowlby’s proposal (and from that moment it is accepted as such) as primary as the need for food or physical care. The attachment is a dyadic construction between children and a specific figure with provides protection and safety. It is based on the mother tight and consistent response to the demands of the baby, in other words, on the sensitivity. A secure emotional base is a protective factor of development throughout the life cycle.
Early Intervention is based on knowledge and detection of risk factors and intervention in creating and strengthening protective factor of development. Preterm infants, children of mentally vulnerable mothers or children with disabilities must be understood as risk populations in the field of affective bonding attachment. These children are more likely to generate insecure attachments with their mothers. The school can become a safe environment and the teacher in an attachment figure that allows to build new development opportunities. Like Pianta and LaParo (2003) note, the establishment of a positive relationship between child and teacher must be seen as a key aspect when evaluating the quality of an educative program.
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Investigation of social supports for parents of children with Autism

Abstract

There has been an increase of children being identified with autism in the United States (Center for Disease Control, 2009), leading to an increased concern of how to best meet the needs of children with autism and their families. In response to each reauthorization of the Individuals with Disabilities in Education Act (2004), in which the roles of families have been strengthened in planning their child’s education and professionals have had more input, the field has tried to uncover the ‘best’ ways to support parents. Recommended practice suggests that parents are best able to identify their own support needs, with assistance from professionals in identifying supports to assist with these needs (Murray et al., 2007). The focus of this study was to identify the forms of social support that parents of children recently diagnosed with autism perceive as being important. Twenty parents of children recently diagnosed with autism participated in this study. These parents completed a Q-sort using the forms of social support, which allowed for a ranking from “most” to “least” important. Statistically significant correlations were found on five support items. Factor analysis was conducted to explore groups of participants with similar rankings of the Q sort items.

Keywords: Social Support, Q sort, Autism

Overview

According to the Center for Disease Control and Prevention in the US the prevalence of Autism Spectrum Disorder (ASD) is an approximate average of one child in every 88. The American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV-TR, 2000) includes in its classification of Autism Spectrum Disorders the related diagnosis of autistic disorder, Asperger’s disorder, and pervasive developmental

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disorder—not otherwise specified. For clarity and consistency, and unless otherwise stated, the term “autism” will be used throughout this paper to refer to those three disorders. Autism represents a spectrum of behaviorally defined conditions that are diagnosed by professionals using the DSM-IV-TR through clinical observation of development.

Children who have autism are mandated to receive services through the Individuals with Disabilities Education Improvement Act ([IDEA], 2004). Legislation includes families as critical partners in the education of the child. Support for the family’s emotional, physical, and educational needs has become an area of primary importance in programs, which address the ongoing needs of the child ((Murray et al., 2007; Staley-Gane, Flynn, Neitzel, Cronister, & Hagerman, 1996; Turnbull, Turnbull, Erwin, & Soodak, 2010). Support for families, including families of children with autism, should address the concerns, priorities, and resources of the family.

Social support is defined as being multidimensional, comprised of both ‘emotional’ (e.g., affection, sympathy and understanding, acceptance, and esteem from others) and ‘instrumental’ (e.g., goods, services, and information) functions that aid in mediating stress and dealing with day-to-day interactions (Dunst, Trivette, & Cross, 1986; Flynn, 1990; Krahn, 1993; Meadan, Halle, & Ebata, 2010; Valentine, 1993). The functioning of parents and child is enhanced when families receive the aid and assistance that match their identified needs and priorities (Dunst, Trivette, & Hambry, 2007; Trivette & Dunst, 1987). Both emotional and instrumental supports have been linked to reducing stress and improving the functioning and well-being of family members. Only families can identify the type of support that is important to them. Research underscores the importance of families’ having choices and decision-making opportunities about issues concerning their child and family (Allen & Petr, 1996; Trivette, Dunst, & Hamby, 2010); however, the professionals who often guide parents along this path do not receive training on deferring their own personal values (Murray & Mandel, 2004).

One of the first scales developed to document family support, The Inventory of Socially Supportive Behaviors ([ISSB] Barrera & Ainlay, 1983) suggests that the extent to which particular supports are considered important and the perceived satisfaction of recipients of those supports are key to assessing the efficacy of supports for families of young children with disabilities, including autism. Thus, family’s perspectives on the importance of support and their subsequent satisfaction with those supports should be the standard against which professionals measure their intervention behaviors. Professionals (i.e., teachers, therapists, and medical personnel) who understand the needs of families of children diagnosed with autism are better able to assist families in accessing the supports that will be most beneficial to the child and family (Croen, Grether, Hoogstrate, & Selvin, 2002; Gillberg, Cederlund, Lamberg, & Zeijlon, 2006; Fombonne, 2003).

The purpose of this study was to identify the social supports that fathers and mothers of young children recently diagnosed with autism perceive as important. This study
extends the literature by comparing the identified importance of specific support items of fathers versus mothers and with a population of families whose child had been recently diagnosed (within an 18-month period).

Method

Participants
Twenty parents consisting of mother-father dyads served as participants in the study. Inclusion criteria for parent participation were: (1) child’s diagnosis of autism was within the last 18 months, and (2) child was between the ages of three and five years old at the time of data collection. Parents were recruited through advertisement in an Autism Society newsletter, flyers at clinics and conferences, and flyers distributed by regional special education coordinators across the state.

Demographic data was obtained including parent information (age and marital status), child information (age, gender, age at diagnosis, and diagnosis), and sibling data (gender, age, and diagnosis, when applicable). On average, both parents were in their mid-30s (fathers $M=37$ years, range, 29 - 54 years old; mothers $M=35$ years, range, 24 to 52 years old). All couples were married with the exception of one that was divorced. Children ranged in age from 3 years 1 month to 5 years 4 months ($M=4$ years 1 month) comprised the children with autism (15 boys and 5 girls). The specific diagnoses varied with 12 children being diagnosed with autism, 1 child with Asperger’s syndrome, and 7 children with pervasive developmental disorder- not otherwise specified. The children were all formally diagnosed through qualified professional individuals or teams utilizing the criteria set forth by the DSM-IV-TR. The length of time for being diagnosed ranged from one month to 18 months ($M=10.7$ months).

Socioeconomic status was determined for each couple by using the Hollingshead Two Factor of Social Position (Hollingshead & Redlich, 1958). Hollingshead is an accepted research index to determine social economic status of individuals and families (Miller, 2002). Social position is assigned by occupation and education in the Hollingshead index. There are five social class categories in the Hollingshead, ‘I’ being the highest social class and ‘V’ being the lowest social class. Three families were in the highest social class, 13 families in the second social class, three families in the third social class and one family in the fourth social class. Thus, the majority of families were in the upper middle social class. Broken down by income and education, the majority of families had an income that was above $60,000 and almost all families had at least one parent with some university education beyond high school.

Design and Instrumentation

The Q-methodology or Q-sort was used to gather data (Stephenson, 1953). The Q-sort is a ranking procedure used to identify an individual’s subjectivity or personal point of view on a subject with the capability of quantitative analysis (McKeown & Thomas, 1988). The Q-sort consists of sorting items into categories using a Likert-type scale. This technique is a forced-choice method where individuals completing the sort must
place a specific number of items within columns. Ranking allows for comparison of items that may otherwise be seen as very similar or ranked similarly in importance (Stephenson, 1953).

A modified version of the copyrighted set of items from Flynn and Staley-Gane (1997) were used in this study (See Table 1). A literature review was conducted in order to determine new items that might be added to the Q-set from an extensive review of the literature on social supports for families of children with disabilities, perusal of social support family surveys (Bailey & Simeonsson, 1990; Dunst, Cooper, Weeldreyer, Snyder, & Chase, 1988; Park, Hoffman, Marquis, Turnbull, Poston, Mannan, Wang, & Nelson, 2003) and previous research (Flynn, 1990; Staley-Gane et al., 1996). No new social support items were added; only the wording a few items was modified to reflect current language.

The Q-set for this study was composed of 16 support items (modified from Flynn & Stately-Gane, 1997). The Q-set contained emotional (e.g., a friend to talk to about my concerns, a professional psychologist, involvement with a church) and instrumental (e.g., information, special equipment, financial assistance, educational services) support items (Flynn, 1990; Krahn, 1993; Unger & Powell, 1980), as identified in the previous tool.

Procedures
Q-Sort. The family’s home was used as the location for data collection to make this process as convenient and comfortable for the parents as possible. Data was collected simultaneously from both parents; mothers and fathers were asked to separately rank Q-sort items. Parents and the investigator were seated so that only the investigator could see both of the Q-sorts. Parents could not see each other’s responses and, therefore, were not influenced by one another. Parents were not previously known to the researcher and, thus, were thought to not be influenced by his presence.

Parents were instructed on the Q-sort procedure by the first author, who served as the primary investigator. Parents were given a Q-sort board with predetermined squares labeled “least to most”. A set of 16 cards with one item written on each card was given to each parent. Parents were given step-by-step instructions (Appendix A) on how to complete the sorting procedure. Their responses were recorded by the primary investigator. Upon completion of the Q-sort, parents were asked if anyone or anything was missing from the set of items. Responses were recorded verbatim by the primary investigator.

Analysis
Descriptive and inferential statistics were used to analyze the data. Correlations were conducted to determine if fathers and mothers ranked the items similarly. A factor analysis was conducted to identify groups of participants with similar rankings of the Q-sort.
Results

Results of the Q-sort completed by fathers and mothers of children recently diagnosed with autism were calculated. Parent’s responses in each column were assigned weighted values (-3 through 3) and the data was analyzed. Support Items for Both Parents. Descriptive statistics (M and SD) were calculated for each support item 1 through 16 for couples (see Table 1). Overall, the support item identified as “most” important by both parents was “information on how I can help my child” (M = 1.93, SD = 1.20). Two additional items were identified as “very important” for both parents were “involvement with early intervention (infant and toddler), preschool or school program” (M = 1.23, SD = 1.31) and “information about my child’s future” (M = .70, SD = 1.18). The support item identified as least important was “help with child or respite care” (M = -2.25, SD = 1.37). Two additional items identified as “not being as important” for both parents were “help with transportation” (M = -1.98, SD = .947) and “help with independent living skills” (M = -1.17, SD = 1.39).

Table 1
Descriptive Statistics for Each Support Item for Couples

<table>
<thead>
<tr>
<th>Support Item</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information on how I can help my child</td>
<td>1.93</td>
<td>1.20</td>
</tr>
<tr>
<td>Involvement with early intervention (infant &amp; toddler), preschool or school program</td>
<td>1.23</td>
<td>1.31</td>
</tr>
<tr>
<td>Information about my child’s future</td>
<td>.70</td>
<td>1.18</td>
</tr>
<tr>
<td>Financial help for expenses</td>
<td>.66</td>
<td>.56</td>
</tr>
<tr>
<td>Relaxing and fun activities for my child and family</td>
<td>.23</td>
<td>1.10</td>
</tr>
<tr>
<td>Information about my child’s condition or disability</td>
<td>.58</td>
<td>1.13</td>
</tr>
<tr>
<td>Contact with other parent(s) who experienced the same situation</td>
<td>.48</td>
<td>1.24</td>
</tr>
<tr>
<td>Counseling with a professional person</td>
<td>-.10</td>
<td>1.47</td>
</tr>
<tr>
<td>Discussions with medical people</td>
<td>.03</td>
<td>1.18</td>
</tr>
<tr>
<td>Help with child care or respite care</td>
<td>-2.25</td>
<td>1.37</td>
</tr>
<tr>
<td>Participation in an organized parent support group</td>
<td>-.23</td>
<td>1.08</td>
</tr>
<tr>
<td>Involvement with a church or strong religious beliefs</td>
<td>-.95</td>
<td>1.55</td>
</tr>
<tr>
<td>A close friend or family member to talk to about my concerns</td>
<td>-.40</td>
<td>1.27</td>
</tr>
<tr>
<td>Special equipment to help meet my child’s needs</td>
<td>-.75</td>
<td>1.56</td>
</tr>
<tr>
<td>Help with independent living skills</td>
<td>-1.17</td>
<td>1.39</td>
</tr>
<tr>
<td>Help with transportation</td>
<td>-1.98</td>
<td>.95</td>
</tr>
</tbody>
</table>

Correlations between both parents were calculated to examine the relationships between them to examine similarities in rankings among couples (see Table 2). Correlations
ranged from a high of .73 to a low of .06 with five statements being statistically significant. The statistically significantly correlations statements included “special equipment to help meet my child’s needs”, “involvement with church or strong religious beliefs”, “information on how I can help my child”, “financial help for expenses”, and “participation in an organized parent support group.”

Table 2
Correlations for Couples for Support Items

<table>
<thead>
<tr>
<th>Support Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement with a church or strong religious beliefs</td>
</tr>
<tr>
<td>Special equipment to help meet my child’s needs</td>
</tr>
<tr>
<td>Financial help for expenses</td>
</tr>
<tr>
<td>Participation in an organized parent support group</td>
</tr>
<tr>
<td>Information on how I can help my child</td>
</tr>
<tr>
<td>Contact with other parent(s) who experienced the same situation</td>
</tr>
<tr>
<td>Help with independent living skills</td>
</tr>
<tr>
<td>Help with child care or respite care</td>
</tr>
<tr>
<td>Involvement with early intervention (infant &amp; toddler), preschool or school program</td>
</tr>
<tr>
<td>A close friend or family member to talk to about my concerns</td>
</tr>
<tr>
<td>Help with transportation</td>
</tr>
<tr>
<td>Information about my child’s future</td>
</tr>
<tr>
<td>Information about my child’s condition or disability</td>
</tr>
<tr>
<td>Counseling with a professional person</td>
</tr>
<tr>
<td>Discussions with medical people</td>
</tr>
<tr>
<td>Relaxing and fun activities for my child and family</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01

Inferential Statistics
Factor Analysis An exploratory factor analysis was performed using Principal Components analysis (PCA). These solutions were rotated using Varimax procedure and examined interpretability and parsimony. A decision was made to look at all participants as individuals and not in terms of couples because only five items were found to be significantly correlated for the couples (see Table 2).

Inspection of the Scree plot obtained from the factor analysis indicated that solutions with three or four factor were possible to explain the variables in the instrument. The three-factor solution was selected as the one that was most interpretable and conceptually sound. Approximately 44% of the variance was explained by this three-factor solution.
Table 3

*Factor Scores for Each Support Statement*

<table>
<thead>
<tr>
<th>Support Statement</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A close friend or family member to talk to about my concerns</td>
<td>.435</td>
<td>.597</td>
<td></td>
</tr>
<tr>
<td>Discussions with medical people</td>
<td></td>
<td></td>
<td>-.505</td>
</tr>
<tr>
<td>Involvement with early intervention (infant and toddler), preschool or school program</td>
<td>.550</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special equipment to help meet my child’s needs</td>
<td>-.563</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement with a church or strong religious beliefs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxing and fun activities for my child and family</td>
<td></td>
<td></td>
<td>.667</td>
</tr>
<tr>
<td>Information on how I can help my child</td>
<td>.712</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial help for expenses</td>
<td>-.687</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information about my child’s condition or disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling with a professional person</td>
<td>.498</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in an organized parent support group</td>
<td>.706</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help with transportation</td>
<td></td>
<td>-.666</td>
<td></td>
</tr>
<tr>
<td>Information about my child’s future</td>
<td></td>
<td></td>
<td>.595</td>
</tr>
<tr>
<td>Help with child care or respite care</td>
<td>-.425</td>
<td>-.481</td>
<td></td>
</tr>
<tr>
<td>Contact with other parent(s) who experienced the same situation</td>
<td></td>
<td></td>
<td>.521</td>
</tr>
<tr>
<td>Help with independent living skills</td>
<td>.460</td>
<td></td>
<td>-.508</td>
</tr>
</tbody>
</table>

Factor one relationship items included “involvement with early intervention (infant and toddler), preschool or school program,” “special equipment to help meet my child’s needs,” “financial help for expenses,” “counseling with a professional person,” “participation in an organized parent support group,” “contact with other parent(s) who experienced the same situation.” Factor two external resources included “information on how I can help my child,” “help with transportation,” “information about my child’s future,” and “help with child care or respite care.” Factor three services included “a close friend or family member to talk to about my concerns,” “discussions with medical people,” “relaxing and fun activities for my child and family,” and “help with independent living skills.”
Discussion

The purpose of this study was to examine the “most and least” important social supports of mothers and fathers of children recently diagnosed with autism. Q-sort, the data collection technique, gave a clear indication about the importance of support items as indicated by the ranking decisions made by parents. The following sections will discuss the support items ranked as most important, least important, additional support items identified through the Q-sort method, limitations of the current study, clinical implications, and future research.

Support Items Identified as Most Important
The top three support items ranked as most important by all participants were those in the category of instrumental supports (two were information needs and one was preschool services). When a child has a disability such as autism, parents may feel that ‘information is power.’ Information about how parents can help their child may give them the knowledge and skills they feel are necessary to support their child to be successful. Previous research supports parents’ need for information to better help their child (Keen, Couzens, Muspratt, Rodger, 2010; Whitaker, 2002). Information about the child’s future outcomes or prognosis may be particularly salient for parents of children with autism because, currently, several treatment plans claim that a child’s autistic behaviors may be significantly modified if a particular treatment is followed (Erba, 2000, National Professional Development Center on Autism Spectrum Disorders, 2009). In other words, some parents may be looking for a “fix.”

Along with support items about information, both parents reported “involvement with early intervention (infant and toddler), preschool or school program” as one of the top three supports, which is similar to other recent findings (Twoy, Connolly, & Novak, 2007). All of these families had children that were either in the birth-to-three system or preschool program. Parents may have found that these services for their child were especially useful and, thus, very important in the months following their child’s initial diagnosis.

“Help with finances” was also reported by these parents as an important support. Even though most of the parents reported an annual income of over $60,000, they still identified help with finances as a need. Raising a child with autism is expensive. In particular, the cost of therapy that is frequently recommended may be high (Feinberg & Vacca, 2000; Jacobson, Mulick, & Green, 1998, Sharpe & Baker, 2007). Regardless of level of income and/or insurance options, raising a child with autism takes a financial toll on families (Jarbrink, Fombonne, & Knapp, 2003, Sharpe & Baker, 2007).

Support Items Identified as Least Important
The support item identified as “least” important by both fathers and mothers was “help with child care or respite care.” Possible explanations of this finding could be that none of the participants were in Hollingshead’s lowest social class, which may indicate that they had resources to provide for child care. Additionally, mothers may have felt that
they were the primary caregiver for their child, and therefore, the best person to provide proper care and attention for their young child.

“Involvement with church or strong religious beliefs” was also rated as ‘least important’ by parents. Some previous researchers of families of children with disabilities (Crowley & Taylor, 1994; Tarakeshwar & Pargament, 2001; Valentine, 1993) reported that religion or spirituality (Schumacher & Bauer, 2010) was an important support. However, other studies (Jones, Angelo, & Kokoska, 1998; Flynn, 1990) found that parents of children with disabilities reported church members or strong religious beliefs as not important as a support priority. This may be attributed to cultural differences between groups sampled.

“Help with independent living skills” was identified by parents in this sample as ‘least important’. Although parents of recently diagnosed children reported being concerned about their child’s future, this support need may have been perceived to be something they would need when their child becomes a young adult. These children were all between the ages of three and five and, perhaps, more age appropriate developmental milestones such as talking and playing with other children were more critical to these families than independent living skills (Koegel et al., 1992). This finding is in contrast to a finding by Pisula (2007) who reported that mothers were most concerned with their child’s dependence on the care of others.

Other Supports Identified by Participants
The support items that participants identified as lacking or missing from the available supports in the Q-sort can be found in Appendix B. These items were generally very specific needs unique to the particular participant. For example, “information about specialty schools past early intervention” and “information on helping children adjust to a missing parent in the home” were both listed as support items that were missing from the Q-sort. Other items identified as missing could be interpreted as items that were contained already in other support items in the Q-sort in broader terms. For example, “financial help that does not tie into my income or disqualify my child because of it” would be a part of the “financial help for my expenses.” Overall, a recurring theme of additional support item was not supported by the parents in this sample.

Clinical Implications
Factor analysis revealed that sampled support items clustered into three groups; however, clustered groups did not appear to be conceptually related within each cluster. Previous literature (House, 1981) has identified support items into the categories of instrumental, informational and emotional. It is assumed that a larger sample may yield a more conceptually cohesive clustering of support items. However, it is important to note that practitioners should attend to the different dimensions of support by which families of children with identified special needs may benefit.
Limitations of the Current Study
The results of this study are from a small number of fathers and mothers of children recently diagnosed with autism from a limited geographical area. The majority of the participants in the study were from a higher social economic class, which may have impacted the supports identified by participants.

Recommendations for Future Research
This study examined the perceived importance of supports of fathers and mothers of children recently diagnosed with autism. Future research of parents of recently diagnosed children should include families from a wider variety of income and education levels, as these groups may rank support items differently.

Past research (Staley-Gane et al., 1996) has found that the length of time a child was diagnosed with Fragile X influenced parents’ needs and needs varied over time. Researchers (Gray, 2006; Krahn, 1993) have cited the need for longitudinal research to determine the changing supports desired by parents of children with disabilities.

Previous research was conducted primarily with mothers rather than fathers (Meadan et al., 2010). Support priorities of both parents needs to be conducted to ensure that both perspectives are gathered. Additional studies comparing mothers and fathers are needed, especially mothers and fathers in the same family.

Future studies examining the relationship between the exact diagnosis (i.e., autism, PDD-NOS, Asperger’s syndrome) and types of support identified as important would add to the knowledge base of families of children with an Autism Spectrum Disorder.

Summary
The focus of this study was to identify the social support that fathers and mothers of young children recently diagnosed with autism perceive as being important. Twenty families completed a Q-sort, which allowed for a ranking of support items that indicated the perceptions of support priorities of families. It is crucial to ‘family-centered’ practices that families of children with disabilities are allowed to identify their own priorities. By allowing the families to identify their priorities and needs, service providers will be able to better support these families in the delivery of services.
Investigation of social supports, 27

References


Disorders, 33(4), 365-382.


Investigation of social supports, 29


Appendix A

Directions for completing the Q sort

Step 1: Take out the 16 cards and read each one. After reading the cards take out the six cards you feel are the most important to you and your family. Place the ten remaining cards to the left side of the board.

Step 2: From the six cards you feel are most important, take out the three cards you feel are most important out of these six. Place the three cards you didn’t choose on the right side of the board.

Step 3: Now from the three you chose, take out the one you feel is the most important. Place the one card you chose into the blue column labeled most. Place the two other cards in the two orange columns. Now take the cards you placed on your right and place those in the three pink columns.

Step 4: Take the remaining cards you placed on the left side of the board and read each one. After reading the cards, take out the six you feel are the least important to you and your family. Place the four cards you didn’t choose at the top of the board. Place the one card you chose into the yellow column labeled least. Place the two other cards in the two green columns. Now take the cards you placed at the left side of the board and place these in the three red columns.

Step 5: From the six cards you feel are least important, take out the three cards you feel are least important out of these six. Place the three cards you didn’t choose on the left side of the board.

Step 6: Now from the three you are holding, take out the one you feel is least important. Place the one card you chose into the yellow column labeled least. Place the two other cards in the two green columns. Now take the cards you placed at the left side of the board and place these in the three red columns.

Step 7: Take the cards that you placed at the top of the board and place those in the four middle purple columns. Look at all of the cards and make sure you have placed them correctly.

Step 8: If there was something missing from or not included in the support items that should have been included, please write it on this note card. (Additional support items identified by parents were recorded, see Appendix B).

Step 9: Now, turn the items over that you do not have or have not been available to you.
Appendix B

Additional Support Items identified by Parents as Missing

- Information about specialty schools past early intervention.
- Information on helping children adjust to a missing parent in the home.
- Financial help that does not tie into my income or disqualify my child because of it.
- Physical and alternative therapy.
- There is a gap between diagnosis and pediatric reviews
- A list of organizations who take kids with special needs (Autism), e.g., karate, dance, swim, etc.
- A church where I can go with my autistic son.
- Taking part in field trips with children and families with the same condition (autism).
- Balance time with child with autism and typically developing child.
- Therapy for interventions, such as eye contact.
- Alternate speech communication partners for child to give parents a break.
- Education professional who could refer a student who could come to our home to offer services.
- More available schooling options for my child.
- Earlier evaluation by school system to give more time to make a decision moving forward.
- A list of providers of Autism services in my community.
- Special instruction for pediatricians on the new science of autism.
- No pre-school ABA program in the parish.
- More information on adults with autism.

A broader explanation of all services available to my child’s diagnosis; not simply what is available in our parish.
Otistik Bozukluk Gösteren Çocuklarda Bir Müdahale Yaklaşımı: Su İçti Etkinlikler

Özet

Otistik bozukluk, yaşının ilk üç yılında ortaya çıkan, iletişim ve sosyal etkileşim sorunları, sınırlı/sınıflanmış ilgi ve davranışsalarak karakterize bir gelişimsel bozukluktur. Otistik bozukluk teşhis ölçütü, duyu, algı ve motor becerileri kapsayan sınırlıklar içermemesine rağmen yapılan çalışmalar ve gözlemeler, otistik bozukluk tanıtı almış bazı çocuklarının motor gelişiminde geçimler, fiziksel performans ve aktivite düzeylerinde düşüklük, duyusal uyarlara tepki süreçlerinde ve otistik bozukluk göstermemeyen çocuklara göre farklılıklar olduğunu göstermiştir. Alanyazında, su içti etkinlikler çocuklarda fiziksel performansı arttırma, duyusal tepkileri düzenleme ve sosyal etkileşimi sağlamada bir müdahale olarak kullanılmaktadır. Ancak, bu yararlı etkilerle rağmen, otistik bozukluk gösteren çocuklarda su içti etkinliklere yerinice yer verilmemekte ve uygulanması konusunda aileler, öğretmenler ve diğer uzmanlarca bazı sorunlar yaşandığını gözlemektedir. Bu çalışma; otistik bozukluk gösteren çocuklarda su içti etkinliklerin yararları, yapılacak uyarlamalar ve izlenmesi gereken yaklaşımlar, farklı yaş gruplarında yapılabilecek su içti etkinlik ve oyunlar ve etkinlik sırasında alınması gereken önlemler üzerine odaklaşmaktadır.

Anahtar kelimeler: otistik bozukluk, su içti etkinlik, oyun, uyarlama

Otistik Bozukluk Gösteren Çocuklarda Bir Müdahale Yaklaşımı: Su İçti Etkinlikler

Otistik bozukluk, otistik spektrum bozukluğu (OSB) veya yaygın gelişimsel bozukluğun (YGB) alt kategorilerinden biridir. DSM-IV-TR (2000)’e göre Otistik Bozukluk,

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A. Sosyal etkileşimde yetersizlik:
• Sosyal etkileşim için gerekli sözel olmayan davranışlarda (göz kontağı, jest ve mimik, vücut postürü) yetersizlik.
• Yaşça uygun akran ilişkileri geliştirememek.
• Başkaları ile zevk, başarı ya da ilgi paylaşımında sınırlılık.
• Sosyal, duygusal davranışlarda sınırlılık.

B. İletişim sorunları:
• Dil gelişiminde eksiklik veya gecikme.
• Karşılıklı konuştmayı başlatmadan, sürdürmede ve sonlandırmda zorluk.
• Sıra dışı ya da yinelenen dil kullanmak.
• Gelişimsel düzeyde uygun sosyal oyun veya senaryolu oyunlarda sınırlılık.

C. Sınırlı / yinelenen ilgi ve davranışlar (Stereotip):
• Belirli alanda, yoğun ve sıra dışı ilgilere sahip olmak.
• Belli düzen ve rutinlere aşırı isarcılık.
• Yinelenen ve ardışık hareket manevraları (el veya parmaklarını sallamak, kendini etrafında dönmek, durduğun yerde sallanmak)
• Nesnelerle sıra dışı ilgiler ve takıntılar şeklinde davranış özelliklerini içerir.

Otistik bozukluk tanı için, çocukun yukarıda yazılı 12 belirtiden en az altısına sahip olması; bu belirtilerden en az ikisinin sosyal etkileşim kategorisindendir, en az birer tanesinin ise, diğer iki kategoriye (iletim sorunları ve sınırlı yinelenen ilgi ve davranışlar) ait belirtileri taşması gerekmektedir. Ayrıca, bu belirtilerden en az biri hayatin ilk 36 ayından önce görülmelidir (Amerikan Psikiyatri Birliği, 2000).

Otistik Bozukluk ve su içi etkinlikler, 34

Fiziksel aktivite; yapılandırılmamış ve sistematik olmayan bir şekilde ev, okul, doğal ortamlar (park, spor salonu, havuz) ve diğer alanlarda (sokak, alış-veriş merkezi) iskelet kaslarının enerji harcayarak vücudun yer değiştirmesidir. Su içi etkinliklerde özellikle çocuk ve ergenlerin kas-iskelet sistemi üzerine yük bindirmeden, hem kuvvet ve dayanıklılık geliştirmesi hem de kalp, dolaşım ve solunum sistemlerinin verimli çalışmasını sağlayan keyif verici bir fiziksel aktivite tipidir (Miles, 2007). İyi planlanmış ve dikkatli uygulanan bir su iç etkinlik programıyla, otistik bozukluk gösteren çocuklar yaşam boyu kullanabileceği becerileri kazanarak sağlıklı ve iyilik halini sürdürabilir.

Bu makalenin amacı, otistik bozukluk gösteren çocuklarda su iç etkinlik uygulamaları sırasında izlenecek yaklaşımlar, ilkeler ve önlemleri ele alıp, alanda çalışan akademisyen, uzman ve ailelerin bu uygulamalar sırasında karşılaştıkları olası sorunlara ilişkin çözüm önerileri üzerine odaklanmaktadır. Ayrıca, çalışmadı farklı yaş grubundaki otistik bozukluk gösteren çocukların yapabileceğini su iç etkinlikler ve örnek oyunlara da yer verilmektedir.

Su İçi Etkinliklerin Yararları ve Önemi

Otistik bozukluk gösteren çocukların genelde su iç etkinliklerden hoşlandıkları, suyun onları rahatlattığı ve suyun içinde ya da sudan hemen sonra yapılan etkinliklere daha iyi katıldıkları gözlemiştir (Campion, 1985; Killian, Joyce-Petrovich, Menna ve Arena, 1984). Ayrıca, havuzdaki oyun becerilerinin çok sayıda otistik bozukluk gösteren çocuğa potansiyel öğrenme fırsatı sunabileceği belirtilmektedir (Killian ve diğer., 1984; Yılmaz, Konukman, Birkan ve Yanardag, 2010).

Suyun fiziksel özellikleri (özgül ağırlık, kaldırma kuvveti, direnç, sıvı, basınç) havuz dış ortama kıyasla, hareketlerin daha basarılı ve kolay yapılmasına olanak tanır. Spor salonu veya oyun parkı gibi ortamlarda hareket gerektiren aktivitelerde zorlanan ve bu deneyimden yeterince keyif almayan otistik bozukluk gösteren çocuk, havuzda suyun kaldırma kuvveti ve yüzdürme özelliğiyle farklı hareketleri kolaylıkla yaparak, hoş vakit sürdürlmesine yardımcı olmakta ve yaşam kalitesinin arttırmaya katkı sağlamaktadır. Otistik bozukluk gösteren çocukların fiziksel aktivite ve spor etkinliklerine katılım konusunda yapılan araştırmalar, spor ve fiziksel aktivitenin sosyal etkileşim için fırsat oluşturmaktadır (Berkeley, Zittel, Pitney ve Nichols, 2001; Yu-Pan, 2010), tekrarlı yinelenen hareketleri azaltabileceğine (Berkeley, Zittel, Pitney ve Nichols, 2001; Yu-Pan, 2010), tekrarlı yinelenen hareketleri azaltabileceğine (Berkeley, Zittel, Pitney ve Nichols, 2001; Yu-Pan, 2010), tekrarlı yinelenen hareketleri azaltabileceğine (Berkeley, Zittel, Pitney ve Nichols, 2001; Yu-Pan, 2010) ancak, otistik bozukluk gösteren çocuklarda spor ve fiziksel aktivitenin araştırılmasına son verme tienen, bu konu üzerinde yeterince durulmadığı görülmektedir (Todd ve Reid, 2006).
Otistik bozukluk ve su içi etkinlikler, 35

Otistik bozukluk gösteren çocuklarda suyun özelliklerile elde edilen yararlar sadece fiziksel boyutla sınırlı değildir. Otistik bozukluk gösteren çocuklara suda hareket etmeyi öğrendikçe, özgüven ve farkındalık duyguları gelişir (Martin, 1983), başlangıçta havuz ortamında belirsizlik nedeniyle olusabilecek endişe halı azalıp sosyal ortamdan daha fazla keyif alarak hedeflenen su içi beceriler kazandırılabilir ve böylece çocuk tarafından sergilenen uygun davranışlar daha uygun olmayan davranışlarla tepki verilir. Bu yoğun ve beklenmeyen dokunma duyusu yerine, omuz seviyesine kadar havuzda su içi etkinlikte katılmak otistik bozukluk gösteren çocuğun daha uygun bir davranış sergilemesiyle sonuçlanacaktır (Martinez, 2006).

otistik bozukluk gösteren bir çocukta on haftalık yüzme eğitiminin tekrarlı/yinelenen davranışlar üzerine etkisini incelemiştir. Çalışma sonucunda, sallama, dönüş ve kelimete trafiği gidi yinelenen davranışların süresinde azalma tespit edilmiştir. Crollick, Mancil ve Stopka (2006), uygun olmayan davranışlara sallama, dönüş ve kelime tekrarı gibi yinelenen davranışların süresinde azalma tespit etmiştir. 


Otitizmli Çocuklarda Eşlik Eden Sınırlılıklara Yönelik Uyarlama ve Etkinlikler

Otitistik bozukluk gösteren çocuklarda teşhis ölçütleri içerisinde sosyal, iletişim ve davranış sorunları yer alırken, duyusal-algsal farklılıklar ve motor yetersizlik gibi ölçütlerde yer almayan özelliklere eşlik etmesi, otistik bozukluk gösteren çocuklar arasında bireysel farklılıkların görülmesine yol açmaktadır. Mevcut bireysel farklılıklar, bu çocuklarla çalışan özel eğitim, okul öncesi, sınıf öğretmeni, fizyoterapist, iş-mesguliyet terapisti, çocuk gelişim uzmanı ve beden eğitimi öğretmeni gibi farklı disiplinlerdeki uzmanların öğretim veya etkinlik sırasında bazı uyarlamalar yapmalarını önermişlerdir.
gerekir. Otistik bozukluk gösteren çocuklarda görülebilecek sınırlı dikkat süresi, işitsel uyarılara aşırı tepki, tekrarlı yinelenen hareketler, etkileşime girme sorunları, hareket algılama bozukluğu, dokunma uyanısına tepkide bulunma ve hatırlama/anlama güçlü gibi eşlik eden sınırlılıklar için havuzda su içi etkinliklerin öğretimi veya programın uygulanması sırasında bazı uyarlamalar yapılması gerekmektedir (Lepore, Gayle ve Stevens, 1998).


İşitsel Uyarıya Aşırı Tepki: Sözel yönergeyle birlikte resimli etkinlik kartı kullanın. Tekrarlı sözel yönerge, etkililiğini kaybedebilir ve otistik bozukluk gösteren çocuk tarafından zor algılanabilir. Sözel yönergelerde bağırmak yerine, ses tonunda değiştirilmesi ve jest- mimik kullanılarak dikkat çekilmelidir.


Hareket Algılama Bozukluğu: Bazı otistik bozukluk gösteren çocuklar hareket sırasında uzuvaların tam olarak yerini ve hızını algılama ve hareket koordinasyonunu sağlamada güçlük çekerler. Havuzda su içi etkinlikler sırasında, hareket pozisyon hissini arttırmak için...
otistik bozukluk ve su içi etkinlikler, 38

chten suda türbülans (dalga) etkisi yaratılmasına çalışmalıdır. Örneğin, kollarını kullanarak suda etkinlik yapan çocuğun, omuz ve kol çevresindeki suyu hareketlendirmek üzere, öğretmen eliyle dalga oluşturun hareketini sürdürümeye çalışmasın, vucud pozisyonunu daha iyi algılamasına yardımcı olacaktır. Yine aynı etkiye açığı çıkarmak üzere, su materyallerinden yararlanabilir. Örneğin, havuzda çocuğun beline takacağı kemer veya gövdesine giyebileceğini bir ceket, sudaki hareketleri sırasında çocuğun üzerine bir miktar ağrılık oluşturarak, eklem ve kas çevresindeki suyun oluşturulduğu, kas ve eklem reseptörleri üzerine yük binnmesine ve böylece hareketin farklıda olma hissini artmasına yol açacaktır.


Giriş şarkısı aşaması; ilk defa havuza gelen otistik bozukluk gösteren çocuklar için bu aşama özellikle önemlidir. İlk gün bu aşamada yaşanacak olumsuz bir deneyim su içi etkinliğinin ilk kez yaşadıkları havuzun okulda da etkinliklere bağımlı olmaya formasyon edebilmesi ve dayanışma entelektüel bozukluk gösteren çocukların için belirli bir etkinlik programı, dört aşamada yürütülmelidir. Bu nedenle havuzda su içi etkinliklerin bitmek üzere olduğu ve havuzdan dışarıya çıkacağı hatırlatılır. Böylece çocuk keyif aldığı bu etkinlikten beklemediğini şekilde aniden uzaklaştırılmayışip bir
sonraki süreçte olacağını tahmin ederek havuz çıkışında ağırlama, bağırmma ve çıkmanın istememe gibi uygun olmayan davranışların sergilenmesini de önlemecek. Bitirir völlig, giriş çıkış gibi grup olacak şekilde ele ele tutuşup başlatılır. Girişte yararlanılan merdivenler kullanılarak havuzdan çıkış yapılır, çıkarken çocuğun arkasında durulmalıdır (Prupas, Harvey ve Benjamin, 2006).

Farklı Yaş Gruplarında Otistik Bozukluk Gösteren Çocuklar İçin Su İç Etkinlikler

Aynı yaş aralığındaki ve benzer fonksiyonel becerilere sahip tüm yaş grubundaki otistik bozukluk gösteren çocuklar için havuzda su içi etkinlikler grup olarak planlanmalıdır. Aynı yaş grubu olup yukarıda belirtilmiş gibi ortak bozukluk gösteren çocukların sınırlılıkların olması, grup içinde bire-bir öğretim düzenlemesi yapılmasına gerekşinim doğurabilir.

3-5 yaş çocuklar: Bu dönemdeki otistik bozukluk gösteren çocukların kalp-dolaşım, kas kuvveti ve dayanıklılığı ve denge gibi fiziksel uygunluk bileşenleri henüz yeterince gelişmemiş olup, denge, yer değiştirme ve el becerileri gibi temel hareket becerileri yeni gelişmektedir. Çocukların suya uyum becerilerinin de arttırılması gerekmektedir. Havuzda omuz seviyesinde suyun direnç etkisinden yararlanarak öne, yana ve arkaya yürüme çalısmaları tüm vücut kuvvet ve dayanıklılığını artırır. Su sıçratma oyunu, su üzerindeki farklı büyüklük ve renkteki topları havuz kenarındaki boş kovaya toplama oyunu üst uzuv kaslarının koordinasyonunu, su üzerinden büyük topu can simidi içerisinde atma oyunu, çalışma el-göz koordinasyonu gelişimine yardımcı olur. Havuzda çocuk dikey pozisyondayken, öğretmenin suda yaratacağı dalga ve akını dengi de becerisini geliştirmesine, havuz kenarında otururken ayakları suya daldirma ve çıkarma alt uzuvlarının kuvvetlenmesine katkı sağlar. (Lepore, Gayle ve Stevens, 1998; Lieberman ve Cowart, 1996).

Otistik Bozukluk ve su içi etkinlikler, 41


Yukarıda belirtilen yaş gruplarına yönelik çeşitli etkinlikler ve oyunlar; öğretim yapılan havuz dışında, topluma açık başka havuzlarda da tekrarlanarak otistik bozukluk gösteren çocukların öğretiliği beceri farklı havuz ortamlarında sergilesmesi ve böylece genelleme becerisinin de kazanılması sağlanmalıdır (Prupas, Harvey ve Benjamin, 2006).

Su İçi Etkinlikler Strasrasında Güvenlik Önlemleri

Otistik bozukluk gösteren çocuklara havuz gibi büyük, geniş ve çevresel uyanmanın yoğun olduğu bir fiziksel çevrede su içi etkinliklere katılmaktadır. Aynı anda birden çok çocuk böyle bir fiziksel çevrede yer alması ve bazı güvenlik kurallarını uygulaması durumunda, düşme ve çarpmaya bağlı yaralanma veya boğulma gibi yaşamı tehdit edici durumların ortaya çıkışı söz konusu olabilir. Bununla birlikte; ağlama, bağırma ve kurallara uymama gibi uygun olmayan davranışlar sergilenmeden havuz etkinliklerinin akıcı ve verimli bir şekilde tamamlanması için aşağıda belirtilen kurallara uyması önemlidir (Lepore, Gayle ve Stevens, 1998).


Sonuç ve Öneriler

Otistik bozukluk gösteren çocukların suya olan ilgisi ve havuz ortamından keyif almaları, fiziksel aktivite düzeylerini artırmak için bir fırsat oluşturmaktadır, çocukların gereksinimleri doğrultusunda belirlenen amaçlar (örn. bacak ve kalça kas kuvvetini artırma, zayıf olan dengesini geliştirmek, dokunma duygusunu artırmak) doğal oyun ortamı içerisinde yerleştirilerek topluma açık olan yüzme havuzlarında önce 2-3 kişilik küçük grup ve sonra 5-6 kişilik daha büyük grup etkinliğine en az 10-12 hafta ve haftada iki-üç seans sürdürülmelidir. Havuz ortamında otistik bozukluk gösteren çocukların havusa girişi ve çıkışı sırasında “merhaba” ve “güle-güle” gibi iletişim becerileri kullanılması teşvik edilerek diğer gelişim alanları da desteklenmelidir. Havuzda yapılacak etkinlikleri ve sırasını havuzda tüm çocuklar tarafından görülebilecek bir yere yerleştirilir ve böylelikle bir sonraki etkinliği bilmemeyen getireceği zihinsel karışıklık önlenip, hedeflenen amaçlar gerçekleştirebilirler. Havuzda giriş-çıkışlarda ve havuz içerisinde büyüklik önlemlerine uyulmalı, aksi takdirde istenmemeyen bir durum otistik bozukluk gösteren çocuklar havuzun çevresini etkisini kaybolsuna yol açabilir. Öykü planlanmış su iç etkinlikler otistik bozukluk gösteren çocukların fiziksel aktivite düzeyini arttırır, motor performansı geliştirmelere, öğrenilen sosyal ve iletişim becerilerini kullanır, uygun olmayan davranışları azaltma ve uygun davranışları artırma fırsatı sağlar. Gereksinimleri doğrultusunda su iç etkinlikler otistik bozukluk gösteren çocukların haftalık rutinleri içerisinde yerleştirilmelidir.
Otistik Bozukluk ve su içi etkinlikler, 43
Kaynaklar


Book Review/Kitap Kritiği

Teaching Social Communication to Children with Autism

by

Brooke Ingersoll & Anna Dvortcsak


Birinci bölüm olan “An introduction to parent training” kendi içerisinde üç alt bölüme ayrılmıştır. Bu alt bölümlerden ilki olan “Training parents of young children with autism: An Overview alt bölümünde aile eğitiminin önemi ve neden gerekli olduğu, etkili aile eğitim programları, daha önce otistik spectrum bozukluğu sahip çocukların 1 PhD Student and Research Assistant, Anadolu University, College of Education, Department of Special Education, Eskisehir,
aileleri ile gerçekleştirilmiş olan araştırmalar, aile eğitiminde karşılaşılan güçlük ve engeller ve ImPACT (Improving parents as communication Teachers) isimli projeden bahsedilmişdir. Ayrıca bu bölümün son kısımlarında aileler çocuklarına beceri öğretiminde kullanabilecekleri teknik, yöntem ve öğretim formatlarına ilişkin bazı ipuçları verilmiştir.


Kitapın ikinci kısımları olan “Individual Parent Training Program Sessions Guidelines” adım adım bir aile eğiticisinin nasıl yürütüleceğini anlatmaktadır. Bu kısımda ilk olarak 24 bireysel aile eğitiminin oturumu ve bu oturumların sıralanması, aile eğitiminin programlarının formatı ve ilk aile eğitiminin oturumları başlamadan önce tanımlanması gereken adımlar ele alınmaktadır. İlkinci kısımin devamında ise 24 aile eğiticinin oturumunun içeriği ve yapılması gerekenler tek tek ele alınmış ve açıklanmıştır. Her bir oturumun içeriği ve formatı farklılık göstermesine rağmen bu oturumların genelinde ortak olan noktalar şu şekildedir: a) Reviewing homework from previous sessions b) introducing the rationale for the new technique c) explaining how the technique relates to previously taught techniques d) describe the technique’s key points e) demonstrating use of technique with the child f) having the parent practice the technique while you provide feedback g) discussing and assigning homework.

Kitapın üçüncü kısmını “Group parent training program session guidelines” oluşturmaktadır. Grup formatında gerçekleştirilcek olan aile eğitiminin oturumlarını 12
oturum oluşturulmaktadır. Bu oturumların 6’sını ikişer saatlik sadece ailelerle gerçekleştiriliren oturumlar oluşturmaktadır. Diğer 6 oturumu ise 45 dakikadan oluşan ve ailelerin çocukları ile birlikte gerçekleştiriliren individual coaching sessions oluşturmaktadır. Yazarlar gerçekleştirilecek olan grup oturumlarının akım yapılması ve 45 toplamda iki saat süren oturumlar arasında mutlaka mola verilmesini önermektedirler. Ayrıca individual coaching sessions ların ise gündüz gerçekleştirilmesini tavsiye etmektedirler. Gerçekleştirilecek olan toplam 12 oturum bir grup bir bireysel oturum olacak şekilde arka arkaya gerçekleştiriliyor. Grup aile eğitimi oturumlarını şu oturumlar oluşturulmaktadır; a) Overview of the program and set up your home for success (group) b) Review of set up your home for success and goal development (coaching) c) Make play interactive and modeling and expanding language (group) d) Review of make play interactive and modeling and expanding language (coaching) e) Create opportunities for your child to engage or communicate and overview of the direct teaching techniques (group) f) Review of create opportunities for your child to engage or communicate (coaching) g) Teaching your child expressive and receptive language (group) h) Review of teaching your child expressive and receptive language (coaching) i) Teaching your child social imitation and play (group) j) Review of teaching your child social imitation and play (coaching) j) Putting it all together (group) k) Review of putting it all together (coaching).

Gerçekleştirilen oturumların altını oluşturan grup oturum formatlarında ortak olan bileşenler şu şekilde sıralanmıştır; a) Revire homework from the previous coaching session b) Conduct first half of presentation c) Take a break d) Conduct rest of presentation e) Discuss and assign homework. Oturumlarının diğer altını oluşturan individual coaching sessions ortak olan bileşenleri ise şunlardır; a) Review homework from previous session b) Provide a brief review of technique c) Demonstrate techniques with child d) Have parent practice techniques while you give feedback e) Discuss and homework. Kitabın bu bölümünde bu 12 oturumun her biri detaylı olarak açıklanmakta ve her bir oturumda kullanılacak olan powerpoint sunularına ilişkin detaylar verilmektedir. İlgili powerpoint slaytları ve kullanılan video ve ses dosyaları kitapla birlikte verilen CD de yer almaktadır.

Reference