UNIWERSYTET IM. ADAMA MICKIEWICZA W POZNANIU

INTERDYSCYPLINARNE KONTEKSTY PEDAGOGIKI SPECJALNEJ

32

Redakcja naukowa

Magdalena Olempska-Wysocka

UAM
WYDAWNICTWO
NAUKOWE

POZNAŃ 2021

INTERDISCIPLINARY CONTEXTS OF SPECIAL PEDAGOGY
The scientific journal of the Faculty of Educational Studies
Adam Mickiewicz University issued as a quarterly

EDTITORIAL BOARD
Chief Editor – Iwona Chrzanowska (Adam Mickiewicz University in Poznan)
Assistant Editor – Magdalena Olempska-Wysocka (Adam Mickiewicz University in Poznan)

Andrzej Twardowski (Adam Mickiewicz University in Poznan), Agnieszka Słopień (Poznan University of Medical Sciences), Beata Jachimczak (Adam Mickiewicz University in Poznan), Katarzyna Pawelczak (Adam Mickiewicz University in Poznan), Miron Zelina (Univerzita Komenského v Bratislave), Jana Rapuš-Pavel (Univerza v Ljubljani), William Brenton (University of Maine Presque Isle), Jacek Pyżalski (Adam Mickiewicz University in Poznan), Amadeusz Krause (The University of Gdansk), Jarmila Novotná (MBA Dubrnický technologický inštitút v Dubnici and Váhom, Masarykova Univerzita v Brně), Magdalena Olempska-Wysocka (Adam Mickiewicz University in Poznan)

SUBJECT EDITOR

Iwona Chrzanowska	(inclusive education, pedagogy of people with special educational needs)
Andrzej Twardowski	(psychology of human development, early support of child development)
Agnieszka Słopień	(psychiatry of children and adolescents)
Beata Jachimczak	(inclusive education, pedagogy of people with special educational needs)
Katarzyna Pawelczak	(psychology of people with disabilities)
Aneta Wojciechowska	(special education, logopedics)
Miron Zelina	(pedagogy, psychology)
Jana Rapuš-Pavel	(social pedagogy)
William Brenton	(special education)
Jacek Pyżalski	(media pedagogy, resocialization)
Amadeusz Krause	(special education)
Jarmila Novotná	(pedagogy)
Magdalena Olempska-Wysocka	(psychology, deaf education, logopedics)

LANGUAGE EDITORS
Karolina Kuryś (Polish)
Wendy Ross (English)
Nicol Ross (English)

STATISTICAL EDITOR
Paweł Mleczko

© Adam Mickiewicz University in Poznan , Scientific Publishers UAM, Poznan 2021

The electronic edition of the journal is distributed under the terms
of the Creative Commons licence – Attribution – NoDerivatives 4.0 International

„Tłumaczenie zawartości 8 numerów czasopisma „Interdyscyplinarne Konteksty Pedagogiki Specjalnej" na język angielski i ich wydanie – zadanie finansowane w ramach umowy 792/P-DUN/2017 ze środków Ministra Nauki i Szkolnictwa Wyższego przeznaczonych na działalność upowszechniającą naukę".

Ministerstwo Nauki
i Szkolnictwa Wyższego

ISSN 2300-391X eISSN 2658-283X DOI: 10.14746/ikps

Contents

ARTICLES

ARTICLES

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Zbigniew Tarkowski

Medical University of Lublin
Chair and Department of Psychology, Poland
ORCID: 0000-0003-4970-8512

The state of Polish speech pathology and its prospects

Abstract: Zbigniew Tarkowski, *The state of Polish speech pathology and its prospects*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 7-25. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X.DOI: https://doi.org/10.14746/ikps.2020.32.01

The article analyzes important aspects of speech pathology functioning in Poland. It focuses on many detailed issues related to the identity of the speech pathologist profession, education, specialization and standards of dealing with patients.

Key words: speech pathology, diagnosis, therapy, education, forecast

Who's who?

During an exam, Professor Leon Kaczmarek asked me when he had ceased to be a philologist and become a speech therapist. I couldn't answer, but the examiner did not have a clear opinion on this issue, either. How few people identify as logopedists and speak with pride of themselves as logopedists. In my opinion, he was and remains a linguist—a theoretician of speech therapy. I remember him carrying on a dispute with Professor Zofia Sękowska (which continues to this day) about whether speech therapy is a branch of applied linguistics, or of special education. It should be remembered that the first speech therapy specialization was established in pedagogical

IKPS 32, 2021: 7–25.

studies, not in philology. In the end, Kaczmarek admitted with some reluctance that a speech therapist is an educator, but he has never dealt with speech therapy in practice. Rather, he had the bold ambition of making logopedia an autonomous discipline of speech. He did not create a corresponding lobby consisting of representatives of speech disciplines (phoniatrics, neurology, psychology, pedagogy) in order to implement this idea. Neither did he have the support of linguists, who looked upon speech therapists with a sense of superiority. Combining logopedia with linguistics was suggested by Professor Stanisław Grabias. He wrote that "there are no grounds for this as an independent discipline of knowledge [linguistics – Z.T.] (…) to be combined with speech therapy. Reasonable attempts to do the opposite, however, do exist" (2001: 24).[1] With all due respect, I do not believe that the linguist Grabias is a speech therapist, any more than the linguist Kaczmarek was. Both professors created theoretical models for use in speech therapy which were not verified empirically. They also did not conduct research on concrete speech disorders, and were not practitioners.

Lublin stronghold

A Lublin stronghold is located in the Department / Chair of Logopedia and Applied Linguistics at UMCS [Marie Curie Skladowska University], where the PTL (Polskie Towarzystwo Logopedyczne—Polish Society of Logopedists) has its headquarters. The chairman of the General Board was usually the manager or employee of the said facility, some of whose employees fulfilled functions of responsibility on the General Board (treasurer, secretary). This solution provided some mutual benefits, but also created obvious limitations. This is similar to the situation of a married couple living "in a corner" at their in-laws.' The Department of Speech Therapy and, later, Applied Lin-

---

[1] S. Grabias, *Perspektywy opisu zaburzeń mowy*, [in:] Zaburzenia mowy, S. Grabias, M. Kurkowski (ed), Wydawnictwo Uniwersytetu Marii Curie-Skłodowskiej, Lublin, 2001.

guistics, has had and continues to have an enormous influence on how the General Board of the PTL functions. This situation has favored liberation from sectarian and narcissistic tendencies. The General Board does not have permanent collaboration with other related associations, domestic or foreign, that is to say with medical, pedagogical, rehabilitation, or educational associations. The Polish Society of Logopedia gives the impression of an armchair organization, in existence thanks to the Department and Chair of Logopedia and Applied Linguistics. The General Board meets a few times during its term of office, apparently unable to have more meetings than that. There is serious concern and resistance among its members regarding moving the General Board out of the Logopedia Department, as it is not known whether the Board would be able to function independently. Making this strategic decision is essential for gaining autonomy, without which there is no development. Having independent premises, and the reorganization resulting from this, is of fundamental importance for improving the image of the PTL and for revitalizing its activity.

Copernican revolution

In the jubilee issue of *Logopedia*, it was written that under the influence of Grabias' theory there has been a change in the way of thinking about logopedia along the lines of a Copernican revolution.[2] In my opinion, nothing like that has happened. Instead of proclaiming a Copernican revolution, one should consider whether Polish logopedia is developing…or is it mired in stagnation?

Lost illusions

The ambition of supporters of the autonomy of logopedia was to make it an independent academic discipline. This was not an easy

---

[2] J. Panasiuk, Laudacja on the occasion of the 50th anniversary of Professor Stanisław Grabias' academic work, *Logopedia*, 2018, 47-2, pp. 9-13.

task, as it had traditionally been treated as a specialization within applied linguistics, special education, or medical rehabilitation. Autonomy is not possible for logopedia within the current reform of academics and higher education, which envisages combining academic disciplines rather than dividing them.

Return to the source

Since autonomy for logopedia has not been achieved, a return to its sources can be observed: that is, to medicine (medical speech therapy) and special education (pedagogical speech therapy). It is difficult to fit linguistic speech therapy, which is a specifically Polish creation, into this breakdown. In practice there has been no significant change, as we still have two trends of speech therapy—medical and pedagogical—functioning in accordance with the rules in force from the ministries of health care and education. It should be emphasized that 90% of Polish logopedists have education in pedagogy, mostly in the areas of special education, and also of preschool and early education.

The downgrading of the *Logopedia* journal

Since the foundation of the Polish Society of Logopedia, a fundamental goal of the General Board (and chiefly its head) has been the publication of successive issues of the journal *Logopedia*. At certain times this was the only tangible evidence of the Society's activity. Unfortunately, *Logopedia* has been unduly downgraded to lower-scored academic journals (20 points; increased recently to 40 points). This may lead to authors choosing periodicals with higher scores. One reason for downgrading the academic journals is low participation of foreign authorities on its editorial board. Furthermore, for many years, the works of linguists and speech therapists from facilities in Lublin, Gdansk, Krakow, Warsaw and Katowice centers have dominated in *Logopedia*. Sporadically there also appear articles written by doctors, psychologists and educator, and in that way, the works necessary for maintaining the interdisciplinarity of logopedia. It turns out that the English-language version of *Logopedia* has not attracted specialists from other countries. It is not an easy task, as there is an ongoing struggle on the scientific journal market, demanding significant financial outlay and marketing activity. Moreover, *Logopedia* was normally an annual publication with a long delay (in recent times, two years). This bulky annual could have successfully been divided into quarterlies, which would increase the journal's ranking and at the same time ensure systematic contact with readers.

Publications on logopedia

The speech therapy publishing market is increasing, but is highly diversified. It publishes, therefore, scientific and specialist monographs which are less willingly purchased than are tutorials or collections of exercises. These arrangements of materials are addressed to parents, caregivers, and speech therapists. In this way the therapeutic workshop reaches the hands of nonprofessionals and is exploited in many, often competing, ways. Instead of protecting the tools of their trade, logopedists dispose of them for next to nothing. They do not even recommend speech therapy consultation before using exercises that, if conducted incorrectly, can lead to disturbances in many processes, such as, for example, of respiration. During the pandemic, the number of free speech therapy videos circulating on the internet grew exponentially. For comparison, the Toker platform punishes itself paying for the use of speech therapy exercises.

Logopedist union

The Polish Logopedists Union (PZL) was established at a time when trade unions had great leverage. It was hoped that the creation of this organization would strengthen the community of speech therapists – practitioners and that it would represent their interests. There is room for considerable doubt here, by tracking the actions of PZL authorities at various levels.

The primary goal of any trade union is defending workers' interests, taking care of the workplace and the fight for wages and raises, and forming a positive professional image and increasing social prestige. But the impression here is that these tasks have become secondary because the PZL focused on organizing conferences, training sessions, study trips, awarding certificates, attending outside events, and the like. Instead of promoting logopedists it sometimes strengthens the position of their competitors (psychologists, for example) and looks on passively while these gradually take over the more attractive segments of the speech therapy market. The PZL has not formed suitable alliances with trade unions that would have strengthened its position. The isolated union is a bit too weak for civil authorities to have to reckon with them. Like the PTL, the PZL does not have its own headquarters.

Speech therapy conflicts

An example of conflict was the selection of the National Neurologopedics Consultant. At first, the logopedist community was unable to propose a candidate upon whom they could agree. In accordance with the guidelines, the duties of our consultant were instead entrusted to a consultant in a related field, which constituted an exception in comparison with other medical disciplines. Later the General Board of the Polish Society of Logopedia together with the General Board of the Polish Logopedists Union went to battle for this prestigious position, which ended with a draw and impasse. This situation was taken advantage of by the little-known PTN, which quietly forced in its own candidate, who is not at all well-known.

Education

Logopedia is not a regulated field with standardized forms of education. By implementing different curricula, graduates gain various types of preparation for practicing their profession. A special element of our logopedia is its educational diversity. It can be studied in the full-time, extramural, postgraduate systems, or also over internet. Odd constructs such as “logopedia plus” (e.g., speech therapy and early development support) or “logopedia with” (e.g., speech therapy with preschool education) have also emerged. This educational mosaic undermines the foundations of the logopedist image. Logopedia organizations want to strengthen it by issuing various certificates confirming the professional competence of speech therapists, but it should be emphasized that these do not have any legal force. As in other professions, we have an excess of graduates and a shortage of specialists. The organizers of logopedic studies are not interested in the fate of their graduates, nor in the path of their professional development.

The image of logopedia and the logopedist in practice

It is not very beneficial. The stereotype assumes that logopedia is a practical discipline dealing with making sounds, and that speech therapists are “elocution mistresses.” Their private offices often have infantile names which don’t sound particularly serious. Logopedia is poorly recognized in the media, as logopedists rarely appear as experts on television or radio. Sporadically organized campaigns and activities for “Free Speech Pathology Diagnosis Day” and similar events do not improve the situation. Instead of conducting a long-term and well-thought-out process of improving the professional and social image of the logopedist, we are dealing with the phenomenon of stardom, consisting in promoting ourselves, not logopedia.

The logopedist profession

The status varies. “Speech therapist” is listed among the medical professions, and neurologopedics is treated as a medical specialization. In education, a logopedist is a teacher, and advances in his career in accordance with the education career path (intern, contract, appointed, and certified). Teacher-speech therapists (usually educators) are the most numerous. Speech therapists who work in both education and in health services feel as though they are working in a separate legal, administrative, and ethical reality. The question arises as to how to treat logopedia graduates who work only as freelancers or who have not practiced their profession for a long time. Does this not deprive them of the right to practice their trade, as is the case in other professions?

Identity

Logopedists around the world have a problem in defining their professional identity. They use various names in describing their profession: speech and language pathologist (in the USA, for example); speech therapist (as in Great Britain); orthophonist (for example in France); logopedist (for example in Russia); and the professional seals of Polish logopedists use various terms: logopedist, neuro-logopedist, surdologist, specialist of speech disorders, speech pathologist, psychologist-logopedist, educator-logopedist, linguist-logopedist, teacher-logopedist, physiotherapist-logopedist. Often various narrow specializations are added to these names, such as sensory integration therapist, alternative communication trainer, early support specialist, etc. Who, in the end, is a logopedist? On the whole, older professions are described with one word which has been established in social consciousness. It should be emphasized that, compared to other countries, the level of qualification for the Polish logopedist is high. It is a Master’s degree, often with multiple postgraduate degrees, while his western colleagues mostly stop at undergraduate studies.

Solidarity

Professional solidarity results from the regulations of professional ethical associations containing provisions on mutual relations among their members. They are intended to limit the criticism of colleagues to clients and [colleagues] attacking each other. Powerful professions are distinguished by solidarity: physicians, attorneys, councilors, stockbrokers, architects, and others. And how is it among logopedists? One could get the impression that witch-hunting is a characteristic of this profession, always divided as it is, into factions and sub-groups. This is evidenced by such behaviors as—to use sports terms—tripping over your own feet, kicking at your own goalpost, scoring suicide goals, and campaigns against persons who are proud or controversial. It's a circular process: it starts at the top, goes down, and then goes back up.

Authorities

Rev. Prof. Józef Tischner rightly observed that Poles are a strange nation that looks for authorities far away without noticing those who are nearby. This observation also applies to our logopedia. Instead of supporting our own authorities, we undermine them or consign them to the background. On the other hand, we promote what is foreign, and not necessarily valuable, with little criticism. A foreigner will easily be hailed as a first-class specialist, even though in reality he is second or even third class. As a rule, doctors and psychologists speak first at logopedia conferences, and logopedists at the end. Foreign guests appear earlier in the program, and then our representatives. Some explain it by the principle of hospitality; others, by obsequity.

The logopedia market

A speech therapist is a service provider providing various types of services. Most often these are therapeutic services, less often diagnostic, and least often, expert services. The speech therapy market can be divided according to the age of clients and by their speech disorders.

Logopedia services segments:

Individual disturbance	**A**	**D**	**DYS**	**J**	**MB**	**ORM**	**M**	**S**	**MA**	**MS**
Recipient of service										
Children										
Adolescents										
Adults										

Legend: A – aphasia, D- dysarthria, Dys. – dyslalia, J – stuttering, MB – disorderly speech, ORM – delayed speech development, M – mutism, S – schizophasia, O – oligophasia, MA – speech of autistic persons, MN – speech of hearing-impaired persons

The listed service segments are managed in various ways. Most often the service is addressed to pre-school and early-education aged children, less often to adolescents, and least often to adults. This trend is inconsistent with demographic forecasts. Polish society is aging very rapidly. Speech therapists do not draw the proper conclusions from this. They are not interested in providing services for the elderly. They prefer working with newborns or small children. The interest of logopedists in particular speech disorders is uneven. The most interest is in developmental disorders (delayed speech development, by itself or accompanying intellectual disability; autism; hearing loss; articulation disorders); less: organic disorders (aphasia, dysarthria), and least: psychogenic disorders (stuttering, mutism).

Summing up these two segments, it can be said that we have an excess of speech therapists interested in providing services to children with developmental or organic disorders, and a clear shortage of specialists dealing with adolescents and adults, especially those with psychogenic disorders.

The reasons for this situation are many, but one of the biggest ones is a logopedia education model which does not take the labor market into consideration. Speech therapy services constitute a segment of the medical and educational services markets, which are competitive, especially in the area of diagnostic and expert services. In the speech therapy services market, more and more one-person private offices are emerging. Establishing these does not require having proper training and experience. It happens that some are opened by graduates fresh out of university. It is also very easy for foreigners to conduct private speech therapy activities without going through the Nostrification process. Unfortunately, they are supported by some speech therapists, who refer unwanted patients to them.

Training

Training organized for speech therapists is a reflection of the phenomena taking place on the labor market and with temporary fads. There are decidedly more programs concerned with childhood speech disorders than those of adulthood. Training courses discussing developmental and organic disorders are conducted more often than on psychogenic ones.

Many companies have been established for training speech therapists, which do not always compete with each other using ethical methods. A few of them have been accredited by the educational authorities after undergoing a complex process of evaluation of the quality of their education. Other entities are content with the patronage of the PTL, PZL or other organizations and public figures, which is meant to heighten the importance of one-time or cyclical conferences and training events. However, the real value of training is determined by the knowledge and experience of the trainer as well as his teaching skills. Unfortunately, these are not confirmed or verified in accordance with generally accepted evaluation criteria. A rank of trainer or lecturer has not for example been established by the PTL or PZL. In this situation, one can call himself a specialist, despite not having the appropriate knowledge and experience, but having a lot of nerve.

Logopedic diagnostics

In terms of diagnostic activity, speech therapists can be divided into three main groups: active, undecided, and passive. Unfortunately, the latter are the most numerous. This is due to several important reasons:

1. Underestimation in logopedia and by logopedists of the importance of diagnosis to their professional, social, and academic position. The diagnostician has a certain significant scope of authority, as he has an influence on jurisdiction. Diagnosis is the foundation of professional autonomy. A common phenomenon is that speech therapists use someone else's diagnosis instead of preferring their own. The diagnostician is the client, and the therapist is the contractor. The statutes for the physiotherapist profession give them autonomy in terms of diagnosis. Speech therapists can only dream of such regulations. Conclusions are also to be drawn from the fact that psychologists build their prestige upon the provision of diagnostic and expert services.
2. Speech therapists employed in educational and health institutions complain that they do not have the conditions or time for diagnostic activities. An individual diagnosis cannot be made during group sessions, in an unsuitable room, with only a few minutes available. But even if an appropriate workplace were created and a sufficient amount of time given for a logopedic diagnosis, this would not automatically bring about the motivation to make a diagnosis.
3. Logopedists are not represented in district teams for assessing disabilities, where the degree of disability in people with speech disorders is decided by other kinds of specialists.
4. There is insufficient preparation of logopedists to fulfill the role of diagnostician. Only a few logopedic study programs offer the two basic subjects of: 1) speech therapy methodology, and 2) logopedic diagnostics. The conviction continues that diagnostics is learned while discussing various speech disorders, and that a graduate of logopedia or neuro-logo-

pedia should himself create a diagnostic workshop for his own use. As a result of this approach, he does not know any normalized or standardized language test, the use of which is required by the international classifications adopted in our country (ICD – 10, DSM – 5).

5. The speech therapist's obligations regarding making diagnoses are not enforced and the there is no perceptible pressure from the professional community in this respect. The publication of speech therapy standards has not improved the situation, about which I will write further on. Preschool and school speech therapists have basically been removed from the diagnostic process, since they have to use the diagnosis made at a psychological-pedagogical counseling center. The activity then of logopedists in schools is greater, yet poorly featured. In the issuing of opinions or decisions, a separate speech therapy diagnosis is often not included, or it is added on to the pedagogical diagnosis. Most logopedists feel insecure and rather uncomfortable in the role of diagnostician. In addition, there are the completely natural fears related to accuracy in making a diagnosis. Moreover, speech therapists avoid disputes over competencies.
6. In practice the scope of logopedic diagnosis is consistently limited. If this goes on, the logopedist will be able to identify only dyslalia. Currently *aphasia* is identified by a neurologist, neuropsychologist, or neuro-speech therapist; *dysarthria*—neurologist or logopedist; *stuttering*—psychiatrist, psychologist, or logopedist; *mutism*—psychiatrist, psychologist, or logopedist; *autism*—psychiatrist; *mental disability*—psychiatrist or psychologist; *delayed speech development*—psychologist or logopedist. Doctors and psychologists have thus entered into the diagnostic competency of speech therapists, and only some protest this, while the rest are passive.

It should be pointed out that the logopedist has greatest autonomy in a private office and can freely play the role of diagnostician there.

Logopedic therapy

There is no universally accepted definition of logopedic therapy, expressing its essence and scope. In medicine it is described as treatment, therapy, or speech rehabilitation while in education it is described as logopedic procedures, logopedic assistance, or speech therapy lessons. Regardless of the name, it most often associated with carrying out speech therapy exercises, that is to say, corrections or lessons. They are conducted by a speech therapist, either in his office or outside the office.

It should be pondered upon, whether logopedic exercises can be carried out without direct contact with a speech therapist, for example by using an appropriate platform on the internet, as a form of distance learning, or by using speech therapy tapes. Then it is not therapy, which is based on contact and a therapeutic relationship, but ordinary speech exercises, for which a speech therapist is unnecessary.

In the public consciousness logopedic therapy is associated with play in the case of children, and the study of speech in the case of adults. It is rare that it is treated as the ability to solve problems reported by the patient or those around him.

During logopedic therapy focused on performing exercises, directive communication (issuing orders) takes place, rather than therapeutic communication (conducting a conversation). Generally speaking, there is less and less speaking during speech therapy classes, and more and more time is spent on non-verbal activities (swallowing, chewing, eating, painting, arranging, exercising, alternative communication, etc.). Logopedists eagerly use various proposals purposely called therapeutic, towards which they are not very critical. They themselves promote their own interesting techniques and methods to some extent. Overall, logopedic therapy is becoming steadily more eclectic, forming a mosaic of various sorts of incoherent interactions. These are focused on the speech disorder itself instead of on the person with the disorder, which is not in accordance with the eagerly voiced slogans of the holistic or comprehensive approach. Speech therapy is for the most part associated with strategies that mainly involve exercise (e.g., integrative sensory therapy, hand therapy, etc.). Only a few speech therapists are interested in mastering psychotherapeutic skills. However, they are more willing to use the methods of task-based psychotherapy (e.g., relaxation or desensitization) than analytical methods (e.g., insight or therapeutic conversation). In a word, they choose techniques and methods that require more algorithmic than heuristic thinking.

It only seems that the scope of logopedia is increasing. In reality it is still focused on correcting articulation disorders and organic speech disorders. This is happening while at the same time it distances itself from psychogenic speech disorders (stuttering, mutism), the therapy of which is willingly entrusted to psychologists.

The organization of speech therapy has a profound influence on the course and effects of logopedia. Logopedists generally complain about lack of sufficient time, proper conditions, bureaucracy, and too many patients. In education settings logopedic classes are conducted in group form, without the participation of parents. They basically consist of following recommendations from opinions or decisions issued by psycho-pedagogical counseling centers, the implementation of which is scrupulously controlled by pedagogical supervision. It is difficult to refer to logopedic assistance carried out in this way as “therapy.” Its organization is slightly better in healthcare, where there is greater opportunity for individual impact. A barrier is created, however, by unfavorable contracts made with the National Health Fund by the speech therapists themselves or on their behalf. Private logopedic therapy is developing best, but tends to be treated as an auxiliary activity. Such a solution seems safe, but it is difficult to develop, standing apart.

How is it possible to speak of the effectiveness of logopedic therapy when no research is being done on it? Supporters should undertake research based on solid scientific evidence, and not simply repeating trendy catchphrases. It should be emphasized that research on the effectiveness of therapy is one of the most difficult kinds of research, and requires significant financial outlay. And if results are lacking, the word goes around. The more insistent one ensures great efficiency, not of speech therapy, but of its support methods (e.g., that of Tomatis). The effects of logopedists' work are attributed to competitive activity under the guise of cooperation and a comprehensive approach.

Standards of logopedia treatment

These are presented in the form of extensive academic textbooks containing descriptions of speech disorders along with methods for their diagnosis and therapy. But these are not standards implying a unified style of speech therapist activity independent of distinguished entities or the individual preferences of a diagnostician or therapist. Moreover, standardization of speech therapy has not gone through the necessary public consultation nor has it been agreed upon by the Ministry of Education or of Health. Standards have not been put into practice and remain an academic proposition.

Standardization is a long and complicated process, as evidenced by the standards developed for psychologists working in psychology clinics. Their greatest priority is increased professionalization of the psychologist occupation, which is meant to serve the welfare of the child. A draft of standards has gone through environmental, legal, and administrative consultation, and has been approved by the Ministry of National Education and the Ombudsman for Children's Rights. The resulting standardization model covers six stages:

1. recognizing a problem,
2. planning a diagnostic process,
3. diagnostic examination
4. reporting the diagnosis results

5. and 6. planning and implementation of an intervention along with evaluation of its effects and follow-up examinations.

At each stage, the algorithm of conduct applicable to psychologists is provided.[3]

---

[3] G. Krasowicz – Kupis, K. Wiejak, M. Filipiak, K. Gruszczyńska, Diagnoza psychologiczna dla potrzeb edukacji. Standardy dla psychologów pracujących w poradniach psychologiczno – pedagogicznych, Harmonia Universalis, Gdańsk, 2019.

Alternative

An alternative to logopedia, which is dominated by linguistics, is the pathology of speech developing in medicine. It is a scientific and practical discipline that studies people with speech disorders. It consists of three departments:

- aphasiology – concerned with persons having organic speech disorders;
- balbutology – concerned with individuals with psychogenic speech disorders;
- developmental speech pathology – concerned with children with developmental speech disorders.

One who is adept at speech pathology is a speech pathologist. If he specializes in aphasia, he is an aphasiologist; in balbutology, he is a balbutologist; and in developmental pathology, a developmental speech pathologist.

Prognosis

One can dream of an evenly-balanced development of logopedia in the areas of theory, research, and practice. This will however be very difficult due to the fact that speech therapy is not an independent scientific discipline, and its representatives have declared their affiliation to varying basic fields (linguistics, pedagogy, psychology, medicine or health sciences) and will contribute to the development of these fields. It is also difficult to expect funding for logopedia research. With this situation, logopedia should focus primarily on expanding its practice. It could be modeled after psychotherapy of physiotherapy. The future of logopedia will be determined by many factors, but most of all, by whether logopedists will have appropriate professional status and whether speech disorders will be covered by the health insurance. This can happen if logopedia becomes more closely connected to medicine than it has been up to now. Higher professional positions for logopedists in the education field is not to be expected; this field hinders its advancement by means of (sometimes absurd) legal regulations. When thinking about the future of Polish speech therapy, one can consider a prognosis:

- which is pessimistic,
- which is optimistic.

The pessimistic forecast assumes that Polish speech therapy will continue to be plunged into apathy and that there will be no major breakthroughs. Occasional attempts to revitalize it will be made, without leading to significant change. Rather, they will be efforts to keep logopedia alive in its current form. There may be those who benefit from its stagnation. On the other hand, it may be that not many really care about the development of logopedia.

The optimistic forecast does not assume a revolutionary upheaval in Polish logopedia but a possibility for an introduction of an evolution of changes, including:

1. Organization, for example:
   The General Board of the Polish Society of Logopedists as well as of the Polish Logopedist Union have their own headquarters and the financial means for effective activity.

2. Profession, for example:
   A logopedist is a graduate of logopedic studies who has entered logopedic practice. Failure to conduct such practice for three years will deprive him of his professional qualifications.

3. Image, for example:
   A uniform image of the logopedist as a specialist in speech disorders is presented.

4. Education, for example:
   Logopedia is a regulated field of study, with one same study program.

5. Training, for example:
   The training of logopedists is conducted in institutions subject to evaluation or applying for accreditation.

6. Research, for example:
   Logopedic research concerning the diagnostic-therapeutic process is promoted and subsidized.

7. Diagnostics, for example:
   "Logopedic methodology research with elements of statistics" and "Logopedic diagnostics" are compulsory subjects in logopedia studies. Logopedists are required to carry out diagnoses in accordance with accepted standards.

8. Therapy, for example:
   Logopedic therapy sessions last a minimum of 30 minutes and are conducted under office conditions. Individual therapy is preferable.

9. Standards, for example:
   The PTL and the PZL will appoint a joint team of specialists to develop standards for logopedic diagnosis and therapy. Their project will be subject to peer consultation using an online questionnaire. Cooperation will be established with the Ministry of Health and Education for implementing these standards.

Of course, this list of proposed postulates can be extended, but the point is to focus on the most important issues. Fundamental changes in Polish logopedia are possible, provided that we are committed.

References

Grabias S. , Perspektywy opisu zaburzeń mowy, [in:] Zaburzenia mowy, S. Grabias, M. Kurkowski (red), Wydawnictwo Uniwersytetu Marii Curie-Skłodowskiej, Lublin, 2001.

Krasowicz-Kupis G., Wiejak K., Filipiak M., Gruszczyńska K., Diagnoza psychologiczna dla potrzeb edukacji. Standardy dla psychologów pracujących w poradniach psychologiczno – pedagogicznych, *Harmonia* Universalis, Gdańsk, 2019.

Panasiuk J., Laudacja z okazji 50-lecia pracy naukowej Pana Profesora Stanisława Grabiasa Logopedia, 2018, 47-2, pp. 9-13.

Tarkowski Z. (ed.), Patologia mowy, Harmonia Universalis, Gdańsk 2017.

Tarkowski Z (ed.), Afazjologia. Organiczne zaburzenia mowy, Wydawnictwo Lekarskie PZWL, Warszawa, 2021.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Renata Marciniak-Firadza

University of Lodz, Poland
ORCID: 000-0001-6301-8820

What should a (neuro) logopaedic therapist know about feeding the youngest patients (0-3) with feeding disorders.
Part i. Feeding (nutrition) – meaning, types, functions

Abstract: Renata Marciniak-Firadza, *What should a (neuro) logopaedic therapist know about feeding the youngest patients (0-3) with feeding disorders. Part i. Feeding (nutrition) – meaning, types, functions*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 27-50. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https://doi.org/10.14746/ikps.2021.32.02

Food intake is an essential element to maintain homeostasis of the body, and the way of feeding. Whereas the type of feeding in the neonatal and infancy stages influence on one side the health of children and teenagers, and next adults, and on the other side, the way of feeding newborns, infants and toddlers has great impact on the development of the orofacial area being a biomechanical base of articulation.

Feeding is also a basic environmental factor having crucial influence on the development of a child's brain. Not providing the child with all of the necessary elements and energetic needs in the prenatal stage and on the further stages of development, especially in infancy, can have a negative effect on the brain's structural development (e.g., insufficient myelination of neurons), as well as interfere with its functions, for example, in terms of neurotransmitters.

In this article, I will undertake selected aspects of feeding disorders understood as both giving food and providing food, as well as feeding the offspring with their own milk.

Key words: feeding, nutrition, (neuro)logopaedic

IKPS 32, 2021: 27–50.

Introduction

In case of the youngest patients (0-1 or 0-3) with feeding difficulties/disorders there are multi-specialist and multi-disciplinary teams to care for such children with doctors (neonatologist, paediatrist, GP, gastroenterologist), dieticians, psychologists and (neuro) logopaedic therapists. The latter, in terms of feeding disorders, is responsible for: a) assessment of anatomical conditions of the orofacial area; b) assessment of oral reflex reactions connected with food intake; c) assessment of primary activities, that is, assessment of food and drink intake as biomechanical base of articulation; d) assessment of parallel development of feeding actions (primary) and articulation (secondary activities); e) assessment of skills in terms of food intake (sucking, spoon feeding, drinking, biting); f) activation and regulation of orofacial functions (sucking, swallowing, control of salivation, chewing, mimicry, articulation); g) ceasing of incorrect patterns connected with food intake; h) learning correct motoric patterns during feeding; i) assessment of a child's readiness to undertake feeding – selection of consistency and structure of foods appropriate for the child's competencies; j) assessment of sensory processing in terms of feeding; k) differentiating feeding disorder from swallowing disorder.

The subjects of primary activities, oral reflex reactions important for the process of food intake or feeding function disorder were described in logopaedic literature[1].That is why the subject of this article

---

[1] (see e.g. D. Pluta-Wojciechowska, *Połykanie jako jedna z niewerbalnych czynności kompleksu ustno-twarzowego*, „Logopedia" 2009, 38, s. 123-151; D. Pluta-Wojciechowska, *Od czynności prymarnych do czynności sekundarnych*, [w:] Pluta-Wojciechowska Danuta, *Mowa dzieci z rozszczepem wargi i podniebienia*, Wydawnictwo Naukowe Uniwersytetu Pedagogicznego w Krakowie, Kraków 2011, s. 128–129; D. Pluta-Wojciechowska, *Zaburzenia czynności prymarnych i artykulacji. Podstawy postępowania logopedycznego*, Wydawnictwo Ergo-Sum. Bytom 2013; S. Masgutowa, A. Regner, *Rozwój mowy dziecka w świetle integracji sensomotorycznej*, Wydawnictwo Continuo, Wrocław 2009; A. Obrębowski, B. Wiskirska-Woźnica, Z. Obrębowska, *Zaburzenia połykania w praktyce neurologopedycznej*, [w:] Wprowadzenie do neurologopedii, red. A. Obrębowski, Wydawnictwo Termedia Wydawnictwa Medyczne i Specjalistycz-

will be based on feeding disorders of newborns, infants, and children up to the age of 3. This wide topic, rarely presented in logopaedic literature, seems to be vital for the (neuro) logopaedic practice.

In this text, I will use terms such as *feeding* and *nutrition*. According to the definitions found in the *Dictionary of the Polish language PWN*, the verb *feed* has a slightly wider scope of meaning than the verb nourish, as *feed* means: 1. 'give food or provide food'; 2. 'about a woman or a female mammal: feeding offspring with own milk', whereas nourish is 'provide food'[2].

In this article, I will undertake selected aspects of feeding disorders understood as both giving food and providing food, as well as feeding the offspring with their own milk. In parts where I will be describing the process of providing food, I will also use the term *nutrition*.

Feeding (nutrition)-meaning, types, functions

As stated by Marian Krawczyński, feeding is one of the most important environmental factors of human development, having a vital influence on human development as early as the prenatal period[3].

Food intake is an essential element to maintain homeostasis of the body, and the way of feeding. Whereas the type of feeding in the neonatal and infancy stages influence on one side the health of children and teenagers, and next adults[4], and on the other side, the way of feeding newborns, infants and toddlers has great impact on

---

ne, Poznań 2013, s. 369-374; E. Stecko, *Logopedia małego dziecka*, Wydawnictwo ES, Warszawa 2013; J. Skrzek, *Diagnoza i terapia funkcji pokarmowych w obrębie okolicy orofacjalnej – połykania, gryzienia i żucia*, [w:] *Wczesna interwencja logopedyczna*, red. K. Kaczorowska-Bray, Stanisław Milewski, Harmonia, Gdańsk 2016, s. 337-355.

[2] https://sjp.pwn.pl/slowniki/ [15.04.2021].

[3] *Żywienie dzieci w zdrowiu i chorobie*, 2015, red. M. Krawczyński, wyd. II, WydawnictwoHeplMed, Kraków 2015, p.V.

[4] A. Blask-Osipa, J. Walkowiak Jarosław, *Błędy i nieprawidłowe nawyki żywieniowe*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 145.

the development of the orofacial area being a biomechanical base of articulation.

Feeding is also a basic environmental factor having crucial influence on the development of a child's brain. Not providing the child with all of the necessary elements and energetic needs in the prenatal stage and on the further stages of development, especially in infancy, can have a negative effect on the brain's structural development (e.g., insufficient myelination of neurons), as well as interfere with its functions, for example, in terms of neurotransmitters[5].

In medical, gastroenterological literature there are different types of feeding described. Based on food types the following can be distinguished: breast feeding (in other words natural feeding), mixed feeding and feeding with formula, the so-called artificial feeding, and based on the gastrointestinal tract the following are listed: oral alimentation, so called physiological (per os), enteral and parenteral.

Breast feeding, also called natural feeding, described as a golden nutrition standard in the first six months of a newborn, not only does it cover the demand for nutrients necessary for proper growth and development but also has a beneficial influence on developing feeding habits. Infants fed naturally learn more flavors which has a positive impact on the acceptance of specific produce in their later lives[6]. This type of nutrition, being the only physiological way of feeding infants, is currently considered to be the only correct way of nourishing infants, providing them with optimal health and development conditions[7]. It needs to be emphasized that natural feeding is vital for the physical development of the child (the components

---

[5] M. Krawczyński, *Choroby ośrodkowego układu nerwowego*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p 287.

[6] JA Mennella, GK Beauchamp, *Flavor experiences during formula feeding are related to preferences during childhood*, "Early Human Development" 2002, 68, p.71-82; CA Forestell, JA Mennella, *Early determinants of fruit and vegetable acceptance*, "Pediatrics" 2007, 120, p.1247-1254.

[7] I. Ignyś, W. Cichy, *Karmienie sztuczne niemowląt*, (w:) *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. Marian Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 92.

of the mother's milk are adjusted to the individual needs of a child), it supports the child's immune system (mother's milk aids the immune system functions), and apart from that, it has an impact on the correct emotional (close contact with the mother) and intellectual (child stimulation) development. Breast feeding is also the best training for the articulation apparatus[8].

Hanna Szajewska lists the following benefits for the child resulting from natural feeding: 1. smaller occurrence or milder course of: a) respiratory system infection; b) gastroenteritis; c) acute otitis media; d) bacterial meningitis; e) sepsis; f) urinary tract infection; g) necrotizing enterocolitis; 2. probably smaller risk of (inconclusive data from literature): a) infant sudden death syndrome; b) type 1 diabetes; c) type 2 diabetes; d) lymphoma, leukemia, non-Hodgkin lymphoma; e) overweight and obesity; f) hypercholesterolaemia; g) allergies[9].

For the natural feeding to be effective, the child needs to cover with its mouth the whole nipple with the areola. If during feeding the tips of the child's ears twitch gently, that means the breast is caught correctly and sucking is effective[10].

During breastfeeding all facial muscles are activated because:

a) the child, covering the nipple with its lips, exercises the risorius muscle thanks to which the lips prepare for pronunciation of such rounded vowels as [o], [u] and labial consonants [p], [p'], [b], [b'], [m], [m'];
b) the tongue pressures the nipple against the palate and tilts the tip up. This is the beginning of tongue elevation necessary for articulation of dental sounds [t], [d], [n], dento-alveolar

---

[8] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, 22, p. 37-41.

[9] H. Szajewska, *Karmienie piersią*, [w:] *Żywienie dzieci zdrowych i chorych*, red. H. Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, p. 12.

[10] H. Szajewska, *Karmienie piersią*, [w:] *Żywienie dzieci zdrowych i chorych*, red. H. Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, p. 8.

sounds [t′], [d′], alveolar sounds [š], [ž], [č], [ǯ], [l], [r] and postalveolar sounds [š′], [ž′], [č′], [ǯ′], [l′], [r′];

c) thejaw moves up and rhythmically moves forward which develops a correct bite. Adding to this, the child perfects chewing skills necessary for eating solid foods, and then while talking;

d) the child breathes only through the nose, does not stop sucking in order totake a breath which affects the correct shaping of breathing needed for proper speech. Thanks to this the child has higher chances to speak clearly and with a good pace[11].

If both the child and the mother are healthy, there are practically no objections tobreastfeeding. Such objections are, on the mother's side, for example, untreated infectious tuberculosis, HSV 1 infection, taking some medications, severe mental illness, drug addiction. Objections on the child's side are divided into: a) so called physical inability to ingest food (by which I understand anatomical disfunctions such as a cleft lip and palate, a serious health condition of the child, heart defects, prematurity); b) metabolic inability (galactosemia, congenital lactose deficiency)[12].

When it comes to a cleft lip and palate where there are no physical conditions for effective sucking, breastfeeding should be ceased, and expressed or pumped milk should be given indirectly. Such food does not irritate the mucous membrane and gives a chance for proper speech development, avoids overbite and acute otitis media. In terms of clefts, a half vertical or vertical position is being used, as well as special nipple plates or help using a finger to cover the leak[13].

Problems with natural nutrition can also be present among children with Down Syndrome. Obstacles such as tiredness connected

---

[11] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, 22, p. 37-41.

[12] I. Ignyś, 2015, *Karmienie naturalne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p 81, 83.

[13] I. Ignyś, 2015, *Karmienie naturalne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p 81.

with heart defects, big tongue (macroglossia) and flaccid upper respiratory system making the feeding difficult can be overcome by increasing frequency of feeding. Present food allergies can be eased by eliminating exogenous proteins from the mother's diet[14].

The role of (neuro)logopaedic therapists in such cases can be, apart from those listed in the beginning, focusing the attention on: a) peaceful atmosphere during feeding; b) feeding technique. (Neuro) logopaedic therapists can also suggest a visit in a lactation or gastroenterological clinic.

Mixed nutrition is feeding additionally with formula in cases when natural feeding is not sufficient or despite trying to breastfeed on demand the child still shows signs of hunger such as: a) screaming after feeding; b) sucking fingers: c) waking up often; d) lack of weight gain.

Feeding with formula, so-called artificial nutrition is introduced when, for some reasons (listed as examples with natural feeding), breastfeeding is not possible both on the mother's and the child's side.

It is important to successively eliminate bottle feeding together with introducing other, more mature forms of food intake.

During mixed nutrition, as well as artificial nutrition, it is important to choose proper feeding accessories, in this case a bottle and a nipple. The bottle should have a wide nipple base because with a bigger diameter the lips lay strongly on the bottle collar and the tongue must grip the nipple correctly to suck. This way both the tongue and the lips are stimulated to cooperate which leads to proper training of oral cavity motor skills. The nipple at the same time should be dynamic, that means such that it allows the food to flow only when the child wants it. Its anatomical shape and material which the nipple is made from are important. As Ewa Kaptur and Jolanta Sławek write:

---

[14] I. Ignyś, 2015, *Karmienie naturalne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p 83-84.

> The perfect nipple should be similar in shape to the breast nipple. It is important that the sizes of holes were adjusted to the age of the child and type of food given. It is best when the nipple is short, made of silicone and the hole in it is small enough for the child to put some effort into sucking. Thanks to this exercise it trains the lip, palate, and jaw muscles in a similar way to breast sucking[15].

In case of using the wrong nipple for the bottle during feeding the work of mostly tongue and lips is being disrupted, as well as sucking, swallowing, and breathing – see table 1.

Table 1. Differences between artificial and natural feeding from a logopaedic perspective (designed based on D. Pluta-Wojciechowska, *Zaburzenia czynności prymarnych i artykulacji. Podstawy postępowania logopedycznego*, Wydawnictwo Ergo-Sum. Bytom 2013; E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, 22, s. 37-41).

	Artificial feeding	**Natural feeding**
Tongue	Lays flat in the oral cavity and is pressed by the nipple	Is raised towards the palate and is tensed
Lips	Are apart, the nipple is held by the gums	Are closed and tightly wrapped around the breast
Sucking	Food is being squeezed out from the nipple with vertical jaw movements, the child lowers the jaw and intakes the food, raising it – blocks the nipple, there is no typical food suction	Sucking-chewing movements, jaw is moved up, and also works towards the front and moves back, additionally there is evening out of retrusive occlusion
Swallowing	The child often does not keep up with swallowing the food that abundantly flows through the nipple, that is why the excessive food is spat out; there is possibility of choking	The child sucks as much food as it is able to swallow; swallowing directed towards the palate has a beneficial effect on the development of the palate and jaws which visibly prevents teeth and jaw anomalies
Breathing	Breathing through the mouth, the child stops eating to get some air; it fosters later breathing through the mouth	Breathing through the nose, possible even during sucking

---

[15] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, 22, p. 37-41.

An important issue when feeding infants is the problem of reflux of the stomach content.

It needs to be remembered that the reflux, so called posseting, in a small baby is a natural occurrence that subsides on its own at about 6-8 months of age.

It is not a result of some disorderbut is a consequence of some immaturity of the digestive system. The lower oesophageal sphincter is not yet efficient enough to fully stop the reflux of stomach content.

The pH level of the oesophagus oscillates around 5-6, and the pH of the stomach is 1-2. If the acidic content of the stomach is out completely, then it is not a major problem for the child. If, however, the content just slightly moves back, then it will remain in the oesophagus and irritate the mucous membrane, as well as cause burning and pain.

Protective reaction to the irritation caused by the reflux of acidic stomach content can be: a) hyper muscle tension manifested by, for example, the child flexing; b) tightening fists; c) high positioning of the shoulders in order to avoid/eliminate pain while flexing the stomach; d) stiffening lower limbs and unwillingness to raise them above the ground; e) sensation of constant flexing; f) annoyance.

Symptoms that need to be paid attention to are: a) visible chewing of something even though the child is not being fed at the moment; b) chokingon food content (even at night) even though the child was fed earlier; c) frequent cough despite no infection present; d) burping even up to a few hours after feeding; e) visible swallowing; f) reluctance towards some activities, for example, laying on the tummy or playing with feet (these activities can increase unpleasant symptoms); g) lack of appetite, difficulties with feeding or quite the opposite, too big an appetite to ease the ailments; h) annoyance, nervousness, however, the child calms down when picked up or in any higher position; i) difficulties sleeping.

For the reflux to occur or to increase the following can contribute: a) too fast and too rapid food intake; b) ‘swallowing’ air during feeding; c) meal too big; d) feeding additionally with formula; e) laying down too quickly after feeding.

According to subject literature, the following are the ways to prevent or minimize reflux: a) carrying the child in a vertical position for about 30 minutes after feeding and next laying the child down on the left side or on the tummy (but not for sleep!); b) laying the child down for sleep on the back and on a hard, flat base; c) allowing the child to burp not only after the feeding but also during; d) for a child with reflux not using equipment which makes the child's head press towards the chest, for example, a car seat. The bent legs in the car seat increase the pressure in the abdominal cavity.

On the other hand, literature devoted to the subject of feeding cites research that suggests laying the child down on the right side may help to empty the stomach, thus the following course of action should be: feeding, holding the child vertically for 30 minutes and next for 30-40 minutes on its right side, turning to the left side, sleep on the back, flat.

Based on the feeding tract we can distinguish the following types of nutrition – traditional, oral (per os) and enteral and parenteral. The latter two concern so-called nutritive treatment.

The term *nutritive treatment* refers to the supply of nutritional ingredients (energy, proteins, electrolytes, microelements, and vitamins) in I.V. fluids or clinical diets, in native form (natural food) or artificially produced (clinical diets) to those ill who cannot be fed orally, physiologically due to the character of their initial illness or secondary malnutrition resulting from the illness. Indications for nutritive treatment are: a) weight loss over 10% with the co-existing ailment preventing the compensation of deficiencies; b) no possibility for oral feeding for longer than 3-5 days; c) raised demand for nutritive ingredients that cannot be fulfilled orally[16].

---

[16] P. Dziechciarz, A. Horvath, *Leczenie żywieniowe – enteralne i pozajelitowe*, (w:) *Żywienie dzieci zdrowych i chorych*, red. Hanna Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, p. 225; I. Ignyś, T. Demitrescu, *Żywienie enteralne i parenteralne*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 23.

The choice of nutrition and type of diet depend on the functional condition of the oesophagus and the connected basic functions.

Enteral nutrition refers to food intake through the gastrointestinal tract which is using liquid clinical diets. This method is preferred more as it is more physiological, safer and has fewer accompanying side effects[17].

If the planned enteral nutrition is less than 2 months, then it can be done with the usage of a special probe placed in the stomach or duodenum. In case the enteral nutrition is to last more than 2 months it is recommended to use percutaneous endoscopic gastrostomy (PEG) or jejunostomy (PEJ)[18].

The following, among others, are indications for enteral nutrition: a) swallowing and choking disorders (neurological diseases, cerebral palsy, children after head injuries, hypoxic ischemic encephalopathy, prematurity); b) facial bones defects; c) cancer (brain tumor); d) polytrauma and craniocerebral trauma; e) metabolic disease (cystic fibrosis)[19]. However, for PEG, the criteria are: a) oncological disease – laryngological (nasal, throat, and larynx cancers) upper digestive tract disease; b) neurological diseases – dysphagia (craniocerebral traumas, brain tumors, Amyotrophic lateral sclerosis ASL, cerebral palsy[20].

Parenteral nutrition is intravenous administration of nutrients used when gastrointestinal nutrition is not possible or insufficient, that is, it does not completely satisfy the demand for nutrients. Par-

---

[17] I. Ignyś, T. Demitrescu, *Żywienie enteralne i parenteralne*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 23.

[18] P. Dziechciarz, A. Horvath, *Leczenie żywieniowe – enteralne i pozajelitowe*, (w:) *Żywienie dzieci zdrowych i chorych*, red. Hanna Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, p. 226.

[19] I. Ignyś, T. Demitrescu, *Żywienie enteralne i parenteralne*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 24.

[20] I. Ignyś, T. Demitrescu, *Żywienie enteralne i parenteralne*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 26.

enteral nutrition products are administered directly to the blood through peripheral or central veins[21].

When it comes to oral feeding, after natural, mixed, or artificial it is time to introduce to the child's diet supplementary, solid foods. The position of the AHA (American Heart Association) supported by the American Academy of Pediatrics suggests that newborns and infants should be breastfed solely through the first 6 months and continue after introduction of supplementary products up to the 12th month of the child's life. The World Health Organisation recommends the child to be fed only with the mother's milk till the 6th month. Next, it is advised to introduce supplementary foods with the continuation of feeding with the mother's milk[22]. According to ESPGHAN's and EFA's recommendations, supplementary products should be introduced before the child finishes the 17th week, but no later than the 26th week of life. It is necessary due to the rising energy demand and the preparation of the child to a more diverse diet in later life. Introduction of solid foods into the infant's diet takes several months[23].

During this period almost all infants achieve such performance and maturity of digestive mechanisms and absorption of nutrients that allows the introduction of new foods. This is also the time when, with most infants, the skill of accepting solid foods is developed. Children can sit with support, they also reach nerve and muscle maturity allowing them to control their head and neck movements, as well as eating from a spoon. This is also the time when the instinct to remove foreign objects (typical for newborns and infants) from the

---

[21] I. Ignyś, T. Demitrescu, *Żywienie enteralne i parenteralne*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 30.

[22] I. Ignyś, W. Cichy, *Karmienie sztuczne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 92.

[23] I. Ignyś, W. Cichy, *Karmienie sztuczne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 92.

mouth subsides as it makes it difficult to feed with other foods than liquids[24].

An optimal indicator of time to introduce solid foods can be symptoms presented by the youngest: a) when breastfed the infant demands feeding 8-10 times a day; b) despite regular feeding the infant seems to be hungry; c) an infant fed artificially drinks about 1 liter of formula; d) the monthly weight increase does not exceed 400g.[25].

It also needs to be remembered that the digestive tract must achieve the level of maturity essential for solid food intake. It refers to teething, the ability to grind and swallow solid foods[26].

From a medical point of view, it is advised to: a) introduce new products gradually and separately observing the child's reaction and starting from small amounts, for example, 3-4 spoons; b) not introducing several new products at the same time; c) the order of introducing new products is definitely less important, however, literature suggests starting to expand the diet with vegetables[27]. After about 2 weeks from introducing vegetables, we give fruit to the child[28].

One of the suggestions for the order of introducing solid products in the nutrition of infants is shown in table 2.

---

[24] H. Szajewska,*Wprowadzanie pokarmów uzupełniających*, (w:) *Żywienie dzieci zdrowych i chorych*, red. Hanna Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, p. 31.

[25] A. Stolarczyk, *Karmienie sztuczne*, [w:] *Żywienie dzieci zdrowych i chorych*, red. J. Socha, Wydawnictwo Lekarskie PZWL, Warszawa 1998.

[26] I. Ignyś, W. Cichy, *Karmienie sztuczne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 93.

[27] H. Szajewska,*Wprowadzanie pokarmów uzupełniających*, (w:) *Żywienie dzieci zdrowych i chorych*, red. Hanna Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, p. 31.

[28] I. Ignyś, W. Cichy, *Karmienie sztuczne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 92.

Table 2: Order of introducing solid products in infant's nutrition (designed based on *Poradnik żywienia niemowląt. Krok po kroku od narodzin do pierwszych urodzin*, red. J. Mrukowicz, wyd. Medycyna Praktyczna, Kraków 2014; *Żywienie niemowląt i małych dzieci. Zasady postępowania w żywieniu zbiorowym*, red. H. Weker, M. Barańska, Wyd. Instytut Matki i Dziecka, Warszawa 2014).

Month of life	Solid products
4 m.	– gluten free wheat (rice and corn) – fruit and vegetable juices (carrot, apples, currants, apricots, raspberries, berries, gooseberries, grapes)
5 m.	– fruit purees, vegetable mush – vegetable soup cooked on vegetable stock (potato, carrot, parsley, cauliflower, beet root, pumpkin, kohlrabi, leek, celery, onion)
6 m.	– meat (10g) – initially white (chicken, turkey, rabbit), next all types of lean and high-quality meat
5-6 m.	– wheat products containing gluten
7 m.	– egg yolk
8 m.	– meat stocks (vegetable soup cooked using chicken broth)
11 m.	– cottage cheese
After finishing 12 m.	– highly allergic products (citruses, wild strawberries, strawberries, egg whites, fish)

Together with a new stage of nutrition, that is,the solid foods stage in a child's diet, there is a new way of delivering the meal – spoon feeding. The spoon must be round, flat, small because it should fit on the tongue's mass, hard – non-silicone, and should have rounded edges.

Spoon feeding should be started with small portions (2-3) spoons. It enables proper development of swallowing skills, biting, tongue's work and, indirectly, it also influences the skill of speech, development of the upper respiratory tract and proper breathing. The infant should be made used to spoon feeding before teething occurs as painful gums can be a reason for failure at this stage[29].

---

[29] A. Stolarczyk, *Karmienie sztuczne*, [w:] *Żywienie dzieci zdrowych i chorych*, red. J. Socha, Wydawnictwo Lekarskie PZWL, Warszawa 1998; H. Szajewska, P. Socha,

During spoon feeding:

a) the child opens the lips and lowers the jaw, next after putting in the spoon horizontally to the mouth cavity and placing it in the middle of the tongue, closing the mouth, food is gathered with the lips (work of the upper lip is extremely essential), the food is being moved towards the back of the oral cavity – thanks to these activities the child perfects the work of the risorius muscle needed for pronunciation of labial sounds [p], [p’], [b], [b’], [m], [m’], labio-dental [f], [f’], [v], [v’], rounded vowels [o], [u] and practices tongue-tip elevation;
b) the child coordinates eating with breathing out (through the mouth – introducing the food to the oral cavity) and breathing in (through the nose – preparing the food for swallowing and gulping) at the same time preparing for correct speaking, with the correct pace[30];
c) if the child does not remove the food gently, pressure the middle of the tongue with the spoon which will result in closing the lips;
d) never wipe the spoon against the upper lip to remove the food!

As highlighted by Kaptur and Sławek, not using the spoon when feeding can result in problems with articulating most of the sounds in the future[31], as proper work of the lips (especially the upper lip), their closing and rounding, as well as work of the cheek muscles and the tongue in the oral cavity connected with transferring food have essential influence on both the level of muscle tension of articulation organs and their functions[32].

A. Horvath et al, *Zasady żywienia zdrowych niemowląt. Zalecenia Polskiego Towarzystwa Gastroenterologii, Hepatologii i Żywienia Dzieci*. „Standardy Medyczne. Pediatria” 2014, 11 (3), p. 321-338.

[30] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy” 2017, 22, p. 37-41.

[31] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy” 2017, 22, p. 37-41.

[32] D. Pluta-Wojciechowska, *Zaburzenia czynności prymarnych i artykulacji. Podstawy postępowania logopedycznego*, Wydawnictwo Ergo-Sum. Bytom 2013, p. 69-70.

When introducing solid foods, it needs to be remembered that it should have proper consistency, as well as its grinding and proper position while feeding. A child knowing only liquid foods up till now starts learning new consistencies, acquires the skill to move the food from the front to the back of the tongue to swallow it.

It often happens that the parents: a) give the child food that does not require any activity from the articulatory organs, especially the risorius muscle; b) introduce later products with lumpy consistency; c) are afraid to spoon feed because they see the child chokes easily, does not manage well with biting and chewing[33]. However, the child's meals should not be in the form of a mush (see the jar with children's meals) because mushy food reinforces infantile swallowing.

Until the moment the infant masters the skill of swallowing without choking, meals with the consistency of a mush should be given. Next, we move on to mush with lumps, pieces of different products. For example, crumbled crackers, bread sticks, small pieces of raisins, dried wheats, rice, corn, cheerios can be added to a yoghurt or a mushy dessert. A more liquid base with things of different structure such as soup with noodles can be introduced. The level of food crumbling depends on the child's age: when teething starts products requiring biting and chewing should be given (initially meals containing a small quantity of little, palpable, soft bits, next meals smashed with a fork, cut into small pieces)[34].

Proper feeding position provides not only safety (prevents, e.g., choking) but also helps to sustain proper muscle tension responsible for chewing, sucking, and swallowing. A sitting position requires support of key body parts – in such a way that all muscles involved in vocalization, muscle tension of the mouth and facial region, tem-

---

[33] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, 22, p. 37-41.

[34] I. Ignyś, W. Cichy, *Karmienie sztuczne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 93.

poromandibular joints and respiratory muscles can function properly[35].

The body position for feeding is: straight back, head aligned with the torso, chin slightly moved back, legs leaning against a base. The child should sit with hip, knee, and ankle joints at a 90° angle. Children should not tilt to the sides, thus, until being able to sit firmly they should be secured on the sides with blankets, pillows, etcetera. Proper positioning of the head affects the work of temporomandibular joints which are responsible for closing the mouth, chewing, sucking, and swallowing[36]. Incorrect positioning of the head causes the omohyoid and tongue muscles to block, and in return all this affects proper breathing through the nose, ectypal sucking disorder, physiological swallowing, biting, and chewing[37]. A child with the head tilted back will open the mouth easier, however, it will close it with more difficulties. Neck tension will be felt in such a position. This tension will transfer also to the tongue, making its movement upwards difficult. Swallowing will then be difficult and not effective. The child will swallow better (better tongue and lip work) when we gently hold the child’s chin towards the front. It will prevent pushing the food out with the tongue.

The feet should be placed against the ground. That is why we should choose a feeding chair with the possibility to adjust the feet support or we place a rolled blanket, block etcetera underneath the child’s feet. Following the authors of an article dedicated to proper body posture during logopaedic exercises:

> Proper support and feet positioning during, feeding, eating, drinking, and performing other activities in a sitting or half lying position should alert logopaedic therapists. This is the area where the speech chain starts that runs through the front part of the abdomen, partially through the

---

[35] J. Sadowska, G. Dragun, A. Gutowska, R. Szczepaniak, *Znaczenie prawidłowej postawy ciała podczas ćwiczeń logopedycznych*, „Forum Logopedyczne” 2016, 24, p. 66.

[36] J. Sadowska, G. Dragun, A. Gutowska, R. Szczepaniak, *Znaczenie prawidłowej postawy ciała podczas ćwiczeń logopedycznych*, „Forum Logopedyczne” 2016, 24, p. 61.

[37] J. Sadowska, G. Dragun, A. Gutowska, R. Szczepaniak, *Znaczenie prawidłowej postawy ciała podczas ćwiczeń logopedycznych*, „Forum Logopedyczne” 2016, 24, p. 67.

> diaphragm, part of the intercostal muscles, the front part of the neck, larynx, risorius muscle and finishes at the tip of the tongue. This chain runs also through the hand to the thumb. Thus, if we wish to modify the positioning of the tongue, we can start with working with the big toe which is a part of the muscular speech chain. Its proper stimulation can help with elevating the tongue and regulating its tension[38].

And then following:

> Proper functioning of the muscle chains in correct body positions affects optimal work of the orofacial muscles which results in: isolated and properly functioning cranial nerves, proper feeling and positioning of the tongue, closed mouth and habit of breathing through the nose, correct functioning of senses of taste and smell, and correct bite. For the primary functions to develop correctly, the child should have a correct body position during breastfeeding, eating, and drinking in a sitting position[39].

Correct jaw position can be worked out by helping when the child is, for example, putting objects into the mouth, licking fingers, toys, etcetera (which is typical in a child's development). Help is based on directing the toy (object) and moving it first horizontally and next vertically.

An optimal feeding position should be ensured especially with people with dysphagia (post-stroke, as a result of neurodegenerative illnesses, cerebral palsy), laryngectomized people, with muscle tension disorder, stuttering, vocal disorders (after overloading the vocal cords as a result of occupational diseases, people with mental illnesses, neurosis, etc.)[40].

Feeding position also affects the way a child eats. If we stand above the child, the head and chin are positioned incorrectly. The

---

[38] J. Sadowska, G. Dragun, A. Gutowska, R. Szczepaniak, *Znaczenie prawidłowej postawy ciała podczas ćwiczeń logopedycznych*, „Forum Logopedyczne" 2016, 24, p. 66.

[39] J. Sadowska, G. Dragun, A. Gutowska, R. Szczepaniak, *Znaczenie prawidłowej postawy ciała podczas ćwiczeń logopedycznych*, „Forum Logopedyczne" 2016, 24, p. 67.

[40] J. Sadowska, G. Dragun, A. Gutowska, R. Szczepaniak, *Znaczenie prawidłowej postawy ciała podczas ćwiczeń logopedycznych*, „Forum Logopedyczne" 2016, 24, p. 67-68.

child should also not be fed from behind. Sitting on the side of the child or in front of the face depending on the situation and movement capabilities is also accepted.

Apart from spoon feeding, the nutritional scheme suggests drinking from an open cup (about the 8th month) and next learning to eat independently.

Proper spoon feeding prepares the child for learning how to drink from an open cup. While drinking, the child's tongue is positioned in the same way when spoon feeding (lowered medi dorsum). Learning how to drink should be started when the child knows how to eat from the spoon, sits in a stable way, and controls their head. Practicing drinking from a cup should be started from drinking dense liquids, for example,jell-o, buttermilk, thickened juice, tomato puree, thickened milk, etcetera. From the 6th-9th to 12th month of life a child should drink from a cup held by an adult. From the 12th to 16ththe child should hold it independently, but could still spill, and from the 20th month should drink on its own.

While drinking from an open cup:

a) the child learns the difficult skill of specific movement sequences connected with closing the lips, taking in the liquid, moving it around and swallowing (when drinking from an open cup after each sip there is swallowing unlike when sucking the breast);
b) when getting the liquid from the brim of the cup the child perfects the work of the risorius muscle[41];
c) the rhythm of activities: breathing in through the nose – opening the mouth, positioning the cup on the lower lip (not on the teeth), tilting the cup, getting the liquid by bilabial closure, swallowing – breathingout;
d) the initial strategy is 'sip after sip', but we are aiming at drinking without a break, in a sequential way, that is breathe in – few sips – breathe out.

---

[41] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, 22, p. 37-41.

When talking about drinking from an open cup we exclude the usage of so-called non-drip cups. Drinking from such cups slows down development of the upright reflex of the apex because a 'foreign object' in the oral cavity results in its flattening. When a raised tongue meets an obstacle, it is forced to move to the front and remain in a flat position in the bottom of the oral cavity[42].

When the child does not want to drink from an open cup, Kaptur and Sławek suggest temporally using,and as a mid-stage, a so-called 360° cup (the drink does not spill out and the soft, silicone edges stimulate the lips to work while drinking), profiled cups (with an appropriately exposed edge allowing the child to hold it with the lips), or drinking bottles with straws which enhance and activate specific muscles of the orofacial area (especially the lips and cheeks), stimulating it for active work[43].

After a child mastersdrinking from an open cup we can introduce a straw. However, it should be observed if while drinking it is not placed between the teeth.

In the calendar of food functions of a small child we also have:

a) biting off, which is parting a piece of food – the stage when the upper and lower incisors appear;
b) biting, the so-called sequence of movements, lateral tongue movements to transfer food, mix it with saliva and formation of food bolus – the stage when premolars are appearing;
c) chewing, which is smashing, grinding of hard food using force, bringing the jaw back and forth; we chew what we are unable to bite – the stage when molars appear (up to the 18th month).

---

[42] B. Mackiewicz, *Znaczenie pionizacji końca języka dla poprawnej artykulacji głosek*, [w:] *Opieka logopedyczna od poczęcia*, red. B. Rocławski, Glottispol, Gdańsk 1993, p. 74.

[43] E. Kaptur, J. Sławek, *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, 22, p. 37-41.

As training we bite cubes/belts, fruit/vegetables given in a gauze. There are different opinions as to where products for biting should be given: some neurologopaedic therapists believe that they should be placed on the molar teeth, and some underline that the child should train biting in different places of the oral cavity (compare Aleksandra Łada and Marta Szmaj).

Training of biting should be done in several stages. In the 1st stage we give the child corn puffs, crispbread like *Vasa,* matzah, crackers. The 2nd stage is the fruit and vegetables stage: we serve the child juicy, soft fruit, boiled vegetables. In the 3rd stage it can be bread cut into pieces, bread crust, and in the 4th stage – layered sandwiches (bread + slices). Last, the 5th stage, for biting training, we introduce dried fruit and hard, dried sausage which requires chewing.

A vital role in the process of feeding is polysensoric stimulation, which is visual stimulation (introduction of foods and accessories for eating that are visually attractive for the child), flavor (introducing products not only of different flavors but also stimulation of the sense of taste (also smell) with different herbs, spices, etc.), thermal (stimulation with foods of different temperatures) or auditory (encouraging the child to chew foods that make a noise, using accessories for eating that make a noise).

Conclusion

Proper child nutrition is not only satisfying hunger but also providing an appropriate amount of energy and growth components while proper feeding is adjusting its type to the needs and capabilities of the child.

Based on food types the following can be distinguished: breastfeeding (in other words natural feeding), mixed feeding, and feeding with formula, the so-called artificial feeding, and based on the gastrointestinal tract the following are listed: oral alimentation, so-called physiological (per os), enteral and parenteral.

In the process of feeding the child it is important to avoid basic mistakes.

In the neonatal period the basic mistake is not putting the baby to the breast and isolating the mother, giving extra food and/or giving not only tea, but what is worse, water with sugar[44].

In the infant stage the most common errors can result from wrong feeding technique, too rare or too often breastfeeding, non-effective feeding, too short or too long time of feeding[45]. Other mistakes are a) introduction of solid foods too late in life; b) smashing the products too much; c) irregular times of eating, meals not liked by the child, not given neatly, re-heated; d) nervous atmosphere during meals, distracting the child, not enough time, impatience.

Other feeding mistakes can result from putting the child away from the breast too late due to the child declining to eat other foods, which can result in a reluctance to eat products requiring chewing. Another mistake is introducingproducts other than milk too early. It is also stressed that a lying position during feeding can attribute to hidden otitis media among infants, which can lead to temporary hearing loss[46].

When feeding the child, it needs to be remembered that: a) if possible, breastfeed the newborn and the infant; b) introduce to the child's diet solid foods in the right moment; c) adjust the type and consistency of the food to the age and abilities of the child; d) introduce drinking from the cup and spoon feeding in the right moment.

Proper feeding and avoiding nutritional mistakes will be very beneficial for the child, especially for the development of the orofacial area which is a biomechanical base of articulation.

---

[44] A. Blask-Osipa, J. Walkowiak Jarosław, *Błędy i nieprawidłowe nawyki żywieniowe*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 145.

[45] A. Blask-Osipa, J. Walkowiak Jarosław, *Błędy i nieprawidłowe nawyki żywieniowe*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 145.

[46] A. Blask-Osipa, J. Walkowiak Jarosław, *Błędy i nieprawidłowe nawyki żywieniowe*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, p. 145.

References

Blask-Osipa A., Walkowiak J., *Błędy i nieprawidłowe nawyki żywieniowe*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, s. 145-149.

Dziechciarz P., Horvath A., *Leczenie żywieniowe – enteralne i pozajelitowe*, [w:] *Żywienie dzieci zdrowych i chorych*, red. H. Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, s. 225-230.

Forestell C.A., Mennella J.A., *Early determinants of fruit and vegetable acceptance*. "Pediatrics" 2007, nr 120, s. 1247-1254.

Ignyś I., *Karmienie naturalne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, s. 75-86.

Ignyś I., Cichy W., *Karmienie sztuczne niemowląt*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, s. 87-95.

Ignyś I., Demitrescu T., *Żywienie enteralne i parenteralne*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, s. 23-33.

Kaptur E., Sławek J., *Od karmienia do mówienia. Wpływ funkcji prymarnych na rozwój mowy*, „Forum Logopedy" 2017, nr 22, s. 37-41.

Krawczyński M., *Choroby ośrodkowego układu nerwowego*, [w:] *Żywienie dzieci w zdrowiu i chorobie*, wyd. II, red. M. Krawczyński, Wydawnictwo HeplMed, Kraków 2015, s. 287-291.

Mackiewicz B., *Znaczenie pionizacji końca języka dla poprawnej artykulacji głosek*, [w:] *Opieka logopedyczna od poczęcia*, red. B. Rocławski, Glottispol, Gdańsk 1993, s. 73-76.

Masgutowa S., Regner A., *Rozwój mowy dziecka w świetle integracji sensomotorycznej*, Wydawnictwo Continuo, Wrocław 2009.

Mennella J.A., Beauchamp G.K., *Flavor experiences during formula feeding are related to preferences during childhood*, "Early Human Development" 2002, nr 68, s. 71-82.

Obrębowski A., Wiskirska-Woźnica B., Obrębowska Z., *Zaburzenia połykania w praktyce neurologopedycznej*, [w:] *Wprowadzenie do neurologopedii*, red. A. Obrębowski, Wydawnictwo Termedia Wydawnictwa Medyczne i Specjalistyczne, Poznań 2013, s. 369-374.

Pluta-Wojciechowska D., *Połykanie jako jedna z niewerbalnych czynności kompleksu ustno-twarzowego*, „Logopedia" 2009, 38, s. 123-151.

Pluta-Wojciechowska D., *Od czynności prymarnych do czynności sekundarnych*, [w:] D. Pluta-Wojciechowska, *Mowa dzieci z rozszczepem wargi i podniebienia*, Wydawnictwo Naukowe Uniwersytetu Pedagogicznego w Krakowie, Kraków 2011, s. 128–129.

Pluta-Wojciechowska D., *Zaburzenia czynności prymarnych i artykulacji. Podstawy postępowania logopedycznego*, Wydawnictwo Ergo-Sum. Bytom 2013.

Poradnik żywienia niemowląt. Krok po kroku od narodzin do pierwszych urodzin, red. J. Mrukowicz, wyd. Medycyna Praktyczna, Kraków 2014.

Sadowska J., Dragun G., Gutowska A., Szczepaniak R., *Znaczenie prawidłowej postawy ciała podczas ćwiczeń logopedycznych*, „Forum Logopedyczne” 2016, nr 24, s. 59-70.

Skrzek J., *Diagnoza i terapia funkcji pokarmowych w obrębie okolicy orofacjalnej – połykania, gryzienia i żucia*, [w:] *Wczesna interwencja logopedyczna*, red. K. Kaczorowska-Bray, Stanisław Milewski, Harmonia, Gdańsk 2016, s. 337-355.

Stecko E., *Logopedia małego dziecka*, Wydawnictwo ES, Warszawa 2013.

https://sjp.pwn.pl/slowniki/

Stolarczyk A., *Karmienie sztuczne*, [w:] *Żywienie dzieci zdrowych i chorych*, red. J. Socha, Wydawnictwo Lekarskie PZWL, Warszawa 1998, s. 81-87.

Szajewska H., *Karmienie piersią*, [w:] *Żywienie dzieci zdrowych i chorych*, red. H. Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, s. 5-14.

Szajewska H., *Wprowadzanie pokarmów uzupełniających*, [w:] *Żywienie dzieci zdrowych i chorych*, red. H. Szajewska, Wydawnictwo Warszawskiego Uniwersytetu Medycznego, Warszawa 2009, s. 31-36.

Szajewska H., P. Socha, A. Horvath i in., *Zasady żywienia zdrowych niemowląt. Zalecenia Polskiego Towarzystwa Gastroenterologii, Hepatologii i Żywienia Dzieci*. „Standardy Medyczne. Pediatria” 2014, 11 (3), s. 321-338.

Żywienie dzieci w zdrowiu i chorobie, red. M. Krawczyński, wyd. II, Wydawnictwo HeplMed, Kraków 2015.

Żywienie niemowląt i małych dzieci. Zasady postępowania w żywieniu zbiorowym, red. H. Weker, M. Barańska, Wyd. Instytut Matki i Dziecka, Warszawa 2014.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Agata Chilman

University of Szczecin, Poland

Early development support for children with speech and language disorders from the perspective of needs and developmental tasks

Abstract: Agata Chilman, *'Early development support for children with speech and language disorders from the perspective of needs and developmental tasks*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 51-64. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https://doi.org./10.14746/ikps.2021.32.03

The purpose of the paper is to highlight the risk of child disability in the period between birth and commencement of primary education. The first part of the paper analyses differences in defining the target group of early development support and intervention, a distinction is made between disability and the risk of disability. The paper describes selected concepts of early developmental support and traditional psychological concepts regarding human development. The second part of the paper presents concepts of speech and language disorders in children. The paper discusses the dependence between linguistic competencies and global development of a child and the problem of early development diagnosis and evaluation of cognitive functions, listing the methods and tools used to examine young children.

Key words: early developmental support, developmental needs, risk of disability, preventive intervention, disability

Beneficiaries of early development support and early intervention

Early development support is defined in the Regulation of the Polish Minister of Education of 24 August 2017 on the organisation of early childhood development support as ensuring the right conditions and implementing the programme of *psychomotor and social stimulation of a child from the moment of diagnosing a disability unit the child starts school* [1] The programme also provides for various forms of cooperation and activities that support the family of a child with disabilities. The concept of early childhood development support, as it is defined in the abovementioned Regulation, responds only to the needs of persons diagnosed with a disability and their parents or caregivers. Apart from the fact that early development support is provided on the basis of an opinion determining that such support is needed, the definition contained in the Regulation requires a formal diagnosis of disability. In Poland, such assistance, financed through the State budget, is offered on the condition that a child is diagnosed with disability before starting school. In practice, early development support is a programme of interactions with children with disabilities and their families.

Another, similar type of support offered to young children is early intervention. *Early intervention* is the assistance offered by Early Intervention Centres (EIC). Such centres have existed in Poland since 1978[2]. They are financed from funds raised by the Polish Association of Persons with Intellectual Disability (PSONI), for example under contracts with the Polish National Health Fund. They offer assistance to children either on the basis of disability diagnosis or referral

---

[1] Rozporządzenie Ministra Edukacji Narodowej z dnia 24 sierpnia 2017 r. w sprawie organizowania wczesnego wspomagania rozwoju dzieci, Dziennik Ustaw Rzeczypospolitej Polskiej, Warszawa, 2017, p. 1.

[2] D. Podgórska-Jachnik, *Specyfika wczesnego wspomagania rozwoju i wczesnej interwencji logopedycznej w pracy z dziećmi z uszkodzonym słuchem* [in:] ed. K. Kaczorowska-Bray, S. Milewski, *Wczesna interwencja logopedyczna. Seria Logopedii XXI*, Wydawnictwo Harmonia, Gdańsk 2016.

from a physician (e.g. paediatrician). It should be noted that physicians issue such referral if they determine, for example, unspecified lack of expected normal physiological development in childhood, i.e. the R.62 disorder according to the ICD-10 classification[3]. There are currently 30 early intervention centres in Poland[4], operated by the Polish Association of Persons with Intellectual Disability. The do not provide assistance to all the individuals who need it.

In scientific analyses, early development support is defined as a measure that is addressed also to individuals at risk of developing a disability (by the time they start school) and their families.[5] [6] [7] [8] [9] Andrzej Twardowski proposed a concept of early development support that focuses on the family of a child. He defines early development support as a process of planned and regular activities that are supposed to stimulate the desired patterns of interactions between a child and his or her caregivers. Those activities should be performed by a team of specialists in close cooperation with the child's family. It should be noted that the beneficiaries of such support are not only young children with disabilities but also chil-

---

[3] ICD-10, *Międzynarodowa Statystyczna Klasyfikacja Chorób i Problemów Zdrowotnych. Rewizja dziesiąta.* Tom I, World Health Organization, 2008, p. 573.

[4] https://rwi.psoni.org.pl/2018/01/05/124/ (as on: 12.05.2020)

[5] D. Kopeć, *Zapobieganie niepełnosprawności intelektualnej w świetle rozważań Amerykańskiego Stowarzyszenia Niepełnosprawności Intelektualnej i Rozwojowej (AAIDD),* "Kultura-Społeczeństwo-Edukacja", 2012, no. 2.

[6] A. Twardowski, *Wczesne wspomaganie rozwoju dzieci z niepełnosprawnościami w środowisku rodzinnym, Wy*dawnictwo Naukowe Uniwersytetu im. Adama Mickiewicza w Poznaniu, Poznań 2012.

[7] B. Cytowska, *Idea wczesnej interwencji i wspomagania rozwoju małego dziecka* [in:] ed. B. Cytowska, B. Winczura, *Wczesna interwencja i wspomaganie rozwoju małego dziecka,* Oficyna Wydawnicza Impuls, Kraków 2006.

[8] A. Kloze, *Ocena fizjoterapeutyczna niemowlęcia zagrożonego nieprawidłowym rozwojem ruchowym,* [in:] "*W*czesna interwencja – wsparcie dziecka i rodziny. Materiały z sympozjum naukowego", Polskie Stwarzyszenie na rzecz Osób z Niepełnosprawnością Intelektualną, Warszawa 2018, p. 245-252.

[9] I. Chrzanowska, *Pedagogika specjalna,* Oficyna Wydawnicza Impuls, Kraków 2018.

dren who are at risk of developing a disability.[10] In this model, early development support involves revalidation and rehabilitation as well as prevention. This also extends to preventing intellectual disability.

The American Association on Intellectual and Developmental Disabilities addresses the problem of the risk of disability and early intervention by analysing three dimensions of intellectual disability prevention. The first dimension concerns the degree of intellectual disability prevention, the second – impact of factors determining intellectual disability and the third dimension is linked with the concept of *preventive support.*[11] Intellectual disability prevention as a form of support is advocated by the multi-factor and multi-generation model developed by Robert Schalock.[12] This model analyses two dimensions. The first concerns the degree of prevention (from first to third degree) and the beneficiaries of supports in the respective degrees. In first-degree prevention, the beneficiary is a child at risk of disability or a child diagnosed with intellectual disability and his or her parents/caregivers. Second and third-degree prevention is addressed to persons already diagnosed with intellectual disability. The second dimension covers support measures in areas associated with intellectual disability factors. The following support measures are identified in this model: biomedical, related to the ways of life of the parents/caregivers, and associated with accessibility of educational supports. In one of the stages of developing a plan of action for a child at risk of disability, the author emphasises access to educational support and suggests that a child should receive spe-

---

[10] A. Twardowski, *Wczesne wspomaganie rozwoju dzieci z niepełnosprawnościami w środowisku rodzinnym, Wy*dawnictwo Naukowe Uniwersytetu im. Adama Mickiewicza w Poznaniu, Poznań 2012.

[11] D. Kopeć, *Zapobieganie niepełnosprawności intelektualnej w świetle rozważań Amerykańskiego Stowarzyszenia Niepełnosprawności Intelektualnej i Rozwojowej (AAIDD),* "Kultura-Społeczeństwo-Edukacja", 2012, no. 2, p. 63-67.

[12] R. Schalock, A. Borhwick-Duy, R. Luckasson, *Intellectual Disability. Definitions, Classification and Systems of Supports. The AAIDD Ad Hoc Committee on Terminology and Classifcation. 11th ed.* Washington 2010.

cialist early intervention.[13] However, the most important element of such support is assistance addressed directly to a child's parent or caregiver, the same as is suggested in the abovementioned model proposed by Twardowski.[14]

The term *child at risk of disability* was included in the 2004 Government Programme *(Early, Specialist, Comprehensive, Coordinated and Continuous Assistance to Children at Risk of Disability and Their Parents)* and it was defined as a *child from a high pregnancy and delivery related risk group who, in the opinion of a physician, is at risk of developmental disorders,, disability or functional disorders.*[15] Children at risk of disability were beneficiaries of the programme in the years from 2005 to 2007. The programme also addressed *children with psychomotor development dysfunctions of unknown etiology.*[16] The factors that may contribute to disability in children include premature birth, birth injuries, infections and CNS microdysfunctions, congenital anomalies and genetic diseases as well as delayed development of reflexes or epilepsy.[17] Currently, the possibilities to provide (from public funds) early development support to children at risk of disability who are not diagnosed with a disability are very limited. There are only 25 Early Intervention Centres (EIC) in Poland who provide such support. Not all who need it have equal access to such assistance because of remoteness of the centres, limited number of available places and long waiting times

---

[13] D. Kopeć, *Zapobieganie niepełnosprawności intelektualnej w świetle rozważań Amerykańskiego Stowarzyszenia Niepełnosprawności Intelektualnej i Rozwojowej (AAIDD),* "Kultura-Społeczeństwo-Edukacja", 2012, no. 2, p. 63-67.

[14] A. Twardowski, *Wczesne wspomaganie rozwoju dzieci z niepełnosprawnościami w środowisku rodzinnym,* Wydawnictwo Naukowe Uniwersytetu im. Adama Mickiewicza w Poznaniu, Poznań 2012.

[15] Program Rządowy, *Wczesna, Wielospecjalistyczna, Kompleksowa, Skoordynowana i Ciągła Pomoc Dziecku Zagrożonemu Niepełnosprawnością lub Niepełnosprawnemu oraz Jego Rodzinie. Pilotaż 2005-2007,* 2004, p. 11 (as on 15.05.2019).

[16] Ibidem, p. 14.

[17] B. Cytowska, *Idea wczesnej interwencji i wspomagania rozwoju małego dziecka* [in:] ed. B. Cytowska, B. Winczura, *Wczesna interwencja i wspomaganie rozwoju małego dziecka,* Oficyna Wydawnicza Impuls, Kraków 2006, p. 20-21.

for therapy. This is particularly important in the context of rapid changes taking place in the period of a young child's rapid development.

Developmental needs and tasks in a young child in the context of linguistic development disorders

According to Erik Erikson's theory, a human being undergoes specific stages of psychosocial development each of which ends with a solution or lack of solution typical of a given stage of conflict. Each of the eight stages has a different kind of a crisis which needs to be overcome in order to move on to the next stage. The crises determine the development of an individual and their maturity in a given social and psychological area. According to that concept, a child, before reaching seven years of age (when he or she starts school), passes three stages of psychosocial development and enters the fourth stage that lasts until adulthood.[18] The first stage lasts from birth until more or less the eighteenth month of life (natal period and infancy). It is dominated by *trust vs mistrust*[19] and the positive outcome is achieving a basic sense of safety (whereas a negative solution is lack of a sense of safety and insecurity). The second stage covers the post-infancy period (1.5-3 years) and the *autonomy vs shame about oneself* crisis.[20] Achieving a positive outcome of this crisis means perceiving oneself as an independent person capable of controlling his or her own body and of influencing external events – a sense of agency. If this stage is not completed successfully, an individual develops a sense of not being able to control external events. The third stage is the middle childhood period (3 to 6 years) and in this time, an individual has to deal with a crisis that Erikson refers to as *initiative*

---

[18] E. Erikson, *Dzieciństwo i społeczeństwo*, Dom Wydawniczy Rebis, Poznań 1997.

[19] P. Zimbardo, R. Gerrig, *Psychologia i życie,* Wydawnictwo Naukowe PWN SA, Warszawa, 2018, p. 439.

[20] Ibidem, p. 439.

vs. sense of guilt.[21] Successful completion of this stage is associated with self-confidence and a sense of initiative and faith in one's own creativity. Failure, on the other hand, generates a sense of worthlessness. Another achievement for which a child prepares in the preschool age is adequacy of elementary social and intellectual skills and a sense of competence. A negative outcome may result in lack of self-confidence and a sense of failure, which prevents an individual from being successful in subsequent stages.[22]

These stages of a child development, according to Erikson's theory, coincide with the period of intense speech and language development. Developmental achievements, such as a sense of safety, agency, being in control of one's own body, being able to control events, a sense of initiative and of being competent may result from the level of development of cognitive processes and in particular the language function acquired and developed in this period. A sense of safety achieved during the first stage of development ensures the child's ability to communicate – to express their own needs, and is associated with a sense that the child's messages are understood in the way they are meant to be understood. Another achievement – a sense of agency – is also associated with the use of language – communicating and triggering the desired reaction of others in the act of communication. A sense of controlling one's own body makes it possible to acquire the speaking skill as well as non-verbal communication skills. When a child senses that he or she does not achieve these important tasks, he or she has no satisfaction with being able to control things. A sense of agency is associated with correct use of language and communication that is properly understood and implies changes around the child. Another achievement – a sense of being an initiator, a creator – requires the use of language in order to establish contact with others. Also, a sense of competence is associated with extensive use of language to solve social and intellectual problems. In this analysis, I try to emphasize that there is ev-

---

[21] P. Zimbardo, R. Gerrig, *Psychologia i życie,* Wydawnictwo Naukowe PWN SA, Warszawa, 2018, p. 439.

[22] Ibidem, p. 440.

idence that proper development of speech and language facilitates psychosocial development and that the progress of psychosocial development facilitates acquisition of linguistic skills. Moreover, any disturbances in the respective stages may increase the future risk of disability and identification of such disturbances in psychological evaluation may be a basis for a diagnosis of functional disorders and risk of disability.

Another concept that explains lifelong development is Robert Havighurst's theory. According to his theory, the developmental tasks in the infancy and early childhood period are: learning to walk, bite, speak, control the elimination of body wastes, learning sex differences and sexual modesty, forming concepts and learning language to describe social and physical reality, getting ready to read.[23] Three of these tasks are associated with language and speech development. A completely blocked development of speech in a child means a diagnosis of disability whereas any disorders in linguistic development processes that do not meet the criterion of disability may be associated with development disorders in other spheres. According to Havighurst's theory, they mean lack of achievements associated with a specific age, i.e. failure to move on to subsequent stages of developmental tasks.[24] Any partial dysfunctions in a particular sphere, by acting as feedback, could distort the functioning of an individual in other spheres and prevent the individual from achieving the developmental goals of a specific age. In psychological diagnosis founded on extensive knowledge of the needs and tasks associated with the respective stages of human life, it is possible to evaluate the level of a child's functioning and early detect any developmental delays, and prognosticate disability on the basis of achievements typical of a given age, or lack of them.

---

[23] *Psychologia Tom 2.* ed. J. Strelau, D. Doliński, Gdaskie Wydawnictwo Psychologiczne. Gdańsk, 2008.

[24] Ibidem.

Development diagnosis and evaluation of cognitive functions in a young child at risk of disability

The probability of disability (risk of disability) is when partial dysfunctions or delays in the development of respective functions are observed in a young child, but the child does not yet meet all the diagnostic criteria of a given nosological unit (in the ICD-10 or DSM-V classification). One of the indicators of dysfunctional development of a child 1-2 months old is when the child is unable to focus on external stimuli even for a short while.[25] This symptom is seen in children who are later diagnosed with global delay in the development of the cognitive sphere, although it may not necessarily be the case and the symptom is not synonymous with disability. Such fragmentary problems may be determined on the basis of a psychological and pedagogical examination (e.g. Psychomotor Development Evaluation Sheets – KOPR[26] to diagnose children as young as 1 month old). To diagnose psychomotor development of children older than 2 months, it is possible to use standardised tools, too (Child Development Scale – DSR[27]). There are also other tools, like the Short Child Development Scale (KSRD) – to examine children older than 12 months[28], or the IDS-2 Intelligence and Development Scales for Children and Adolescents[29] and many other.

Following an examination, a psychologist, pediatrician, physiotherapist, pedagogue, midwife or pedagogical diagnosis and thera-

---

[25] E. Bogacz, A. Bogacz-Rybczak, J. Gruba, *Karty Oceny Rozwoju Psychoruchowego,* Wydawnictwo Komlogo, Gliwice 2018.

[26] E. Bogacz, A. Bogacz-Rybczak, J. Gruba, *Karty Oceny Rozwoju Psychoruchowego,* Wydawnictwo Komlogo, Gliwice 2018.

[27] A. Matczak, A. Jaworowska, A. Ciechanowicz, D. Fecenec, J. Stańczak, E. Zalewska, *DSR -Dziecięca Skala Rozwoju*, Pracownia Testów Psychologicznych i Pedagogicznych, Gdańsk 2007.

[28] M. Chrzan-Dętkoś, *Krótka Skala Rozwoju Dziecka,* Pracownia Testów Psychologicznych i Pedagogicznych, Gdańsk 2018.

[29] D. Fecenec, A. Jaworowska, A., Matczak, *DS-2 Skale Inteligencji i Rozwoju dla Dzieci i Młodzieży,* Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego, Warszawa 2018.

py specialist may determine whether development is harmonious and what dysfunctions a child may have (depending on the scope of competencies of a given specialist). Concerning the diagnosis of cognitive functions, based on the knowledge of developmental psychology, the psychologist may determine the probability of disability based on functional difficulties that will be crucial in subsequent stages of development.

Cognitive functions, according to the DSM-5 classification, are language, complex attention, executive function, learning and memory, perceptual and motor functions, social cognition.[30] Jeffrey Cummings identifies language, attention and focus, memory, construction skills, calculation, abstract thinking, insight and evaluation and praxis.[31] Training these functions is important in revalidation, correction and compensation as well as prevention therapies. It is important to identify the difficulties and create the right conditions to train specific skills and develop them to make the best of a child's possibilities, using special methods.

Early development support for children with language processing impairments

Language processing is particularly important in the development of young children. Linguistic functions include spontaneous speech, understanding speech, repeating, naming, reading, writing and prosody.[32] Linguistic function impairments may be associated with a child's disability or risk of disability. One of the disorders is speech aphasia – a condition caused by brain damage with complete loss of speech production and/or comprehension skills. This is

---

[30] *Kryteria Diagnostyczne Zaburzeń Psychicznych. Wydanie Piąte.* ed. P. Gałecki, M. Pilecki, J. Rymaszewska, A. Szulc, S. Sidorowicz, *DSM-5*, Edra Urban&Partner, Wrocław 2018.

[31] J. Cummings, *Neuropsychiatria,* Wydawnictwo Medyczne Urban&Partner, Wrocław 2005.

[32] Ibidem.

an acquired set of symptoms caused, for example, by brain stroke, head injury, cerebrovascular disease, nervous tissue degeneration or brain tumor.[33] There is also developmental aphasia caused by impaired development of cerebral cortex structures.[34] Cognitive disorders with limited ability to understand or produce spoken or written language are defined as dysphasia.[35] Another concept is SLI – Specific Language Impairment, which, according to Laurence Leonard, include language and speech deficits, delayed maturation of the nervous system accompanied by lack of other developmental disorders and preserved intention of communication. In such case, lexical development is slower and verbal speech appears late into the development process and there may be some problems with understanding speech, but mostly problems concern speech production. However, the cerebral cortex is not damaged[36] and the specific linguistic impairments are not a disease according to the ICD-10 classification. Yet, a child requires early intervention. Supporting a child's development and stimulating linguistic processes should be a part of interdisciplinary support, including speech therapy, neurological speech therapy, auditory training, improving verbal and non-verbal communication and possibly alternative and augmentative communication (ACC). This is complex linguistic development training that goes beyond verbal speech impairment therapy.

Conclusions

In pedagogical practice, there are no generally available solutions focusing on disability prevention in high risk groups. If a child is not diagnosed with a specific condition, it is difficult to provide

---

[33] Ibidem.

[34] ICD-10 (2009). Międzynarodowa Statystyczna Klasyfikacja Chorób i Problemów Zdrowotnych – Rewizja X, Tom I. Światowa Organizacja Zdrowia.

[35] J. Cummings, *Neuropsychiatria,* Wydawnictwo Medyczne Urban&Partner, Wrocław 2005.

[36] L. Leonard, *SLI – specyficzne zaburzenie rozwoju językowego,* Gdańskie Wydawnictwo Psychologiczne, Gdańsk, 2006.

him or her with early development support, and access to early intervention in specialist centres (EIC) is limited due to the limited number of those centres and long waiting lists, including persons already diagnosed with disabilities. This situation reveals the major impact of the medical model of disability[37] on the solutions offered within the framework of EDS, depreciating the achievements of social science in this respect, in particular special pedagogy and developmental psychology.

The need for early development support, from the perspective of the needs and developmental tasks of a child, arises as soon as not only global impairments but also partial deficits and risk of disability are identified. The success of interaction depends on how well it is tailored to actual difficulties in specific functions. Implementation of institutional early development support for children at risk of disabilities, based on relevant legal regulations, would be a milestone in the pedagogical practice of early development support. It should also be noted that early assistance, including psychological assistance (in psychological practice, therapy is planned in such a way as to support psychomotor, emotional, social and/or cognitive development) is crucial in the context of the current *deep crisis* of Polish child and adolescent psychiatry[38].

References

Bogacz E., Bogacz-Rybczak A., Gruba J., *Karty Oceny Rozwoju Psychoruchowego,* Wydawnictwo Komlogo, Gliwice 2018.

Chrzan-Dętkoś M., *Krótka Skala Rozwoju Dziecka*, Pracownia Testów Psychologicznych i Pedagogicznych, Gdańsk 2018.

Chrzanowska I., *Pedagogika specjalna,* Oficyna Wydawnicza Impuls, Kraków 2018.

---

[37] *ICF Międzynarodowa Klasyfikacja Funkcjonowania, Niepełnosprawności i Zdrowia* (Polish translation), World Health Organization, Genewa 2009, https://www.csioz.gov.pl (as on 30.05.2019).

[38] Polskie Towarzystwo Psychiatryczne, https://psychiatria.org.pl/news,tekst,355,psychoterapia_dzieci_i_mlodziezy, (as on 30.05.2019).

Cummings J., *Neuropsychiatria,* Wydawnictwo Medyczne Urban&Partner, Wrocław 2005.

Cytowska, B., *Idea wczesnej interwencji i wspomagania rozwoju małego dziecka* [in:] ed. B. Cytowska, B. Winczura, "Wczesna interwencja i wspomaganie rozwoju małego dziecka", Oficyna Wydawnicza Impuls, Kraków 2006, s. 15-26.

Erikson E., *Dzieciństwo i społeczeństwa*, Dom Wydawniczy Rebis, Poznań 1997.

Fecenec D., Jaworowska A., Matczak A., *IDS-2 Skale Inteligencji i Rozwoju dla Dzieci i Młodzieży,* Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego, Warszawa 2018.

Gaś Z., *Profesjonalna profilaktyka w szkole. Nowe wyzwania,* Wyższa Szkoła Ekonomii i Innowacji w Lublinie, Lublin 2011.

ICD-10, *Międzynarodowa Statystyczna Klasyfikacja Chorób i Problemów Zdrowotnych. Rewizja dziesiąta.* Vol. I, World Health Organization, 2008.

Kloze A., *Ocena fizjoterapeutyczna niemowlęcia zagrożonego nieprawidłowym rozwojem ruchowym,* [in:] "Wczesna interwencja – wsparcie dziecka i rodziny. Materiały z sympozjum naukowego", Polskie Stwarzyszenie na rzecz Osób z Niepełnosprawnością Intelektualną, Warszawa 2018, p. 245-252.

Kopeć D., *Zapobieganie niepełnosprawności intelektualnej w świetle rozważań Amerykańskiego Stowarzyszenia Niepełnosprawności Intelektualnej i Rozwojowej (AAIDD),* "*Kultur*a-Społeczeństwo-Edukacja", 2012, no. 2, p. 63.

Kryteria Diagnostyczne Zaburzeń Psychicznych. Wydanie Piąte. DSM-5, ed. P. Gałecki, M. Pilecki, J. Rymaszewska, A. Szulc, S. Sidorowicz, Edra Urban&Partner, Wrocław 2018.

Leonard L., *SLI – specyficzne zaburzenie rozwoju językowego,* Gdańskie Wydawnictwo Psychologiczne, Gdańsk, 2006.

Matczak A., Jaworowska A., Ciechanowicz A., Fecenec D., Stańczak J., Zalewska E., *DSR -Dziecięca Skala Rozwoju*, Pracownia Testów Psychologicznych i Pedagogicznych, Gdańsk 2007.

Podgórska-Jachnik, D., *Specyfika wczesnego wspomagania rozwoju i wczesnej interwencji logopedycznej w pracy z dziećmi z uszkodzonym słuchem* [in:] ed. K. Kaczorowska-Bray, S. Milewski "Wczesna interwencja logopedyczna. Seria Logopedii XXI", Wydawnictwo Harmonia, Gdańsk 2016.

Program Rządowy, *Wczesna, Wielospecjalistyczna, Kompleksowa, Skoordynowana i Ciągła Pomoc Dziecku Zagrożonemu Niepełnosprawnością lub Niepełnosprawnemu oraz Jego Rodzinie. Pilotaż 2005-2007,* 2004, p. 11 (as on 15.05.2019).

Rozporządzenie Ministra Edukacji Narodowej z dnia 24 sierpnia 2017 r. w sprawie organizowania wczesnego wspomagania rozwoju dzieci (Journal of Laws /Dz. U./ item 1635).

Rozporządzenie Ministra Edukacji Narodowej z dnia 7 września 2017 r. w sprawie orzeczeń i opinii wydawanych przez zespoły orzekające działające w publicznych poradniach psychologiczno-pedagogicznych (Journal of Laws /Dz. U./ item 1743).

Rządzka M., *Znaczenie wczesnej diagnozy odruchów oralnych i oddychania dla przyszłego rozwoju mowy. Preventive. Wczesna stymulacja,* [in:] "Wspomaganie rozwoju dzieci z zaburzeniami genetycznymi", red. J. Wyczesany, Stowarzyszenie na rzecz Dzieci z Zaburzeniami Genetycznymi GEN, Pozna 2010.

Schalock R., Borhwick-Duy A., Luckasson R., *Intellectual Disability. Definitions, Classification and Systems of Supports. The AAIDD Ad Hoc Committee on Terminology and Classifcation. 11t^{h} ed.* Washington 2010.

Strelau, J., Doliński, D. (2008) *Psychologia. Tom 2.* Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2008.

Twardowski A., *Wczesne wspomaganie rozwoju dzieci z niepełnosprawnościami w środowisku rodzinnym, Wy*dawnictwo Naukowe Uniwersytetu im. Adama Mickiewicza w Poznaniu, Poznań 2012.

Twardowski A., *Wczesne wspomaganie rozwoju dzieci z niepełnosprawnościami w środowisku rodzinnym, Wy*dawnictwo Naukowe Uniwersytetu im. Adama Mickiewicza w Poznaniu, Poznań 2012.

Twardowski A., *Wczesne wspomaganie rozwoju dzieci z niepełnosprawnościami w środowisku rodzinnym,* [in:] "Wspomaganie dzieci z genetycznie uwarunkowanymi wadami rozwoju i ich rodzin" ed. A. Twardowski, Stowarzyszenie na rzecz Dzieci z Zaburzeniami Genetycznymi GEN, Pozna 2006.

Zimbardo P., Gerrig R., *Psychologia i życie,* Wydawnictwo Naukowe PWN SA, Warszawa, 2018.

Online sources

2018 Rok Wczesnej interwencji, https://rwi.psoni.org.pl, (as on 30.05.2019).

Polskie Towarzystwo Psychiatryczne, https://psychiatria.org.pl/news,tekst,355, psychoterapia_ dzieci_i_mlodziezy, (as on 30.05.2019).

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Marta Zawichrowska
Kazimierz Wielki University, Poland

The influence of individual's swallowing disorders on their functioning in the family and society. The importance of neurologopedic diagnostics. Preliminary research release

Abstract: Marta Zawichrowska, *The influence of individual's swallowing disorders on their functioning in the family and society. The importance of neurologopedic diagnostics. Preliminary research release*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 65-84. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 26580283X. DOI: https://doi.org./10.14746/ikps.2021.32.04

During my neurologopedic work with patients, I often encounter problems with swallowing that coexist with other disorders associated with neurodegenerative and cardiovascular diseases.
This article is an introductory report on the research on the impact of swallowing disorders on the functioning of individuals in the family and society. The described case study concerns a patient with additional health conditions, in whom swallowing disorders (dysphagia) are a consequence of damage to the Central Nervous System (CNS), more specifically cerebrovascular diseases. The article was written on the basis of medical documentation kept from the beginning of the disease, consultations with specialists, as well as an interview with the patient's family. A key role was also played by neurologopedic diagnosis and subsequent research conducted during the therapy, which allowed for the proper selection of therapeutic agents, proved the efficiency of the therapy, both in the neurological and social sphere.

Key words: disease, neurologopedic diagnosis, dysphagia, family, psychosocial functioning, swallowing.

IKPS 32, 2021: 65–84.

The concept of swallowing disorders (dysphagia) in the theoretical perspective

Swallowing is a process involving the mouth, throat and esophagus. *The cortical representation of swallowing is attributed to the fronto-parietal lid. The dopamine part of the limbic system plays a modulating role*[1]. In this complicated act, three phases can be distinguished: oral (which is arbitrary), pharyngeal and esophageal (both of which are reflex).

Phase I of swallowing (oral phase) lasts about 30 seconds and is conscious – controlled by the motor cortex. It consists of two stages – during the first stage: the preparatory stage, the food is chewed, crushed, mixed with saliva and formed into a bolus. For the proper course of this process, the efficiency and coordination of lip tightness, circular and lateral movements of the mandible, proper cheek muscle tone and tongue movements on many levels are necessary. The second stage is the proper oral phase, which consists in shifting the bite back (towards the isthmus of the throat), thanks to the work of the muscles of the tongue and cheeks.

The second phase of swallowing (pharyngeal phase) lasts about 1-3 seconds and is an involuntary reflex, triggered by the irritation by the bite of the receptors in the soft palate, palatine arches, the base of the tongue and pharynx. Then, the contraction of the circular muscles of the pharyngeal sphincters provokes the formation of a peristaltic wave causing the food bite to shift through the throat cavity down to the esophagus. The nasal cavity is then closed by lifting the soft palate that separates the pharyngeal cavity from the nasal cavity, there occurs a contraction of the laryngeal muscles (laryngeal occlusion) closing the vocal gap, and lifting of the hyoid-laryngeal complex, which prevents the bite from falling into the respiratory tract. This phase ends with the closure of the upper esophageal sphincter, downward displacement of the larynx, widening of the glottis and opening of the pharyngeal segment.

---

[1] Obrębowski A., Wiskirska-Woźnica B., Obrębowska Z., *Zaburzenia połykania w praktyce neurologopedycznej* [in:], *Wprowadzenie do neurologopedii,* Poznań 2012, p. 370.

Phase III of swallowing (esophageal phase) lasts about 4-10 seconds and involves the movement of the bite into the stomach. It begins with the opening of the upper esophageal sphincter. Solid foods then move slowly (thanks to the peristaltic movement of the esophagus walls), while fluids quickly pour directly from the throat into the lower esophagus. When the peristaltic wave approaches the inlet, its relaxation takes place, allowing the bite to enter the stomach[2].

> *Normal oral and pharyngeal swallowing is quick and safe, with very few rare episodes of aspiration (food entering the airways), even in the elderly. The bite is usually swallowed efficiently with minimal food particles remaining in the mouth and throat*[3].

The sites that trigger the swallowing reflex are, first of all, the palato-lingual arches, as well as *the base of the tongue, lingual-epiglottis, the posterior wall of the pharynx, epiglottis, and pharyngeal junctions; with age, the swallowing-inducing zone moves backwards*[4].

However, as a result of neurological and cardiac-related diseases, there are observed deviations from normal movements, difficulties in the act of swallowing[5] called “dysphagia”.

> *Dysphagia is a disorder that affects the ingestion and passage of food from the mouth to the throat and esophagus and it is associated with discomfort in swallowing*[6].

---

[2] Speech therapy concerns two initial stages of swallowing.

[3] Logemann A. Jeri, *Evaluation and Treatment of Swallowing Disorders* [in:] *Folia Phoniatrica Logopedica,* 47, 3, 1995, p. 140-164.

[4] Logemann A. Jeri, Pauloski B. R.., Rademaker A.W., Kahrilas J., *Oropharyngeal swallow in younger and older women: videofluoroscopic analysis. ,* Chicago 2002, p. 434-445.

[5] Wojtczak A., *Choroby wewnętrzne*, vol. 2, Warsaw 1995, p. 167.

[6] Wiskirska-Woźnica B., Proszkiewicz A., Walczak M., *Zaburzenia połykania – postępowanie diagnostyczne i zasady rehabilitacji,* [in:] *Przewodnik lekarski,* Poznań 2002, p. 102-104.

> *Dysphagia is the opposite of the globus hystericus symptom (sensation of a foreign body in the neck) in which, unlike in dysphagia, swallowing food provides relief*[7].

Swallowing disorders may be caused by damage to the CNS[8] or the structures of the oral cavity.

> *The most common causes of dysphagia due to CNS damage are vascular complications in the form of acute cerebral ischemia, embolism, and hemorrhagic lesions, where dysphagia may be of cortical, subcortical or bulbar origin. Other common causes are brain tumors and traumatic lesions*[9].

Depending on the etiology of the disease, the diagnosis of dysphagia is performed by a number of specialists: radiologists, gastrologists, neurologists, and ENT specialists. During the therapy process, a neurologist, physiotherapist, dietician and a neurologopedist work together.

Depending on the location of the difficulties, there are two types of dysphagia.

The first, upper (called pre-esophageal) phase, which includes the oropharyngeal phases, results in the loss of the ability to form a bolus and move it towards the throat, which leads to food remaining[10] in the mouth. It is 80% the result of neuromuscular disorders[11].

---

[7] Rosien U., Andersen V., Layer P., *Objawy gastroenterologiczne i ich leczenie. Dysfagia.*, Warsaw 2010, p. 135.

[8] Examples include: stroke (80%), craniocerebral trauma (70%), brainstem lesions (60%), myasthenia gravis (17-53%), extrapyramidal syndromes (e.g. Parkinson's disease – 50%) , amyotrophic lateral sclerosis (48-100%), neuromuscular diseases (85%), long-term hypoxia (80%), muscular dystrophy (70%) – data collected on the basis of Prosiegel M., Praxisleitfaden Dysphagie, Hamburg 2002, pp. 235 .

[9] Waśko-Czopnik D., Paradowski L., *Dysphagia in clinical practice,* Warsaw 1999, p. 33.

[10] Retention is the presence of food remains in the cheeks, preglottic fossils, and the posterior commissure area or on the throat wall. The reasons for the retention may be weakness of the cheek muscles, tongue, reduced lifting of the larynx during swallowing, reduced pressure on the bite during transport, weakness of the muscles of the throat wall, or impaired sensation in the oral cavity.

[11] The data comes from research by Halama A.R., *Kliniczne podejście otolaryngologa do chorego z dysfagią*, [in:] *Otolaryngologia Polska,* vol. XLIX, Warsaw 1995, p. 29-36.

If the disorders involve the oral phase, there is leakage of saliva or food from the mouth, retention of food or saliva in the mouth, or both[12].

Oral swallowing disorders may also include:

- flow of food due to insufficient closure of the mouth,
- inability to form a bite due to incorrect (limited) tongue movements or lack of tongue coordination,
- the inability to move the bolus deep into the mouth, which may be due to restriction of tongue movement,
- falling food into the vestibule of the oral cavity and its retention there due to the reduced tension of the red zone of the lip,
- falling food into the vestibule of the cheeks and retention due to the reduced tone of the cheek muscles,
- searching movements or lack of tongue coordination due to apraxia
- delayed start of the oral phase due to apraxia or decreased oral sensation,
- premature tongue movements in the initial stage of swallowing (“pushing out” of the tongue”),
- food retention on the tongue (caused by limited movement or excessive tension),
- tongue peristalsis disorder,
- limited ability to upright the tongue, causing incomplete contact between the tongue and the palate, food stagnation on the hard palate
- anterior-posterior tongue coordination disorders,
- uncontrolled, too early displacement of the bolus or fluid to the throat (caused by reduced or lifted glosso-palatal occlusion),
- swallowing in small portions.

Disorders in the pharyngeal phase include the following:

- delayed swallowing through the throat,
- extended transport time of the bite in the throat area,

---

[12] Terlikiewicz J., Makarewicz R., *Zaburzenia połykania.* Bydgoszcz 2003, p. 32.

- regurgitation – that is, penetration into the nose as a result of a weakened palatopharyngeal closure, through which food, saliva and secretions enter the nasal cavity,
- limited movement of the base of the tongue causing food retention,
- weakening of throat muscle spasm resulting in obstruction of the throat walls after swallowing,
- insufficient elevation of the larynx, and thus retention at the beginning of the respiratory tract,
- penetration – entry of saliva, secretions, food or fluid into the larynx,
- aspiration – saliva, secretions, food or fluid getting into the respiratory tract below the level of the vocal folds (into the trachea)[13].

The second type of dysphagia is lower dysphagia – related to disorders in the third phase of swallowing – the esophageal phase. It manifests itself in problems with moving a food bite (or fluid) through the lower part of the larynx. It is accompanied by coughing, choking, gagging, or regurgitation of food through the nose, leading to choking. 85% of swallowing impairments at this level is associated with structural disorders and only 15% with motor disorders.[14]

> *The patient complains (then MZ) about the feeling of conscious sensation of movement of the food or even getting stuck with solid, possibly also liquid food ingredients.*[15]

Another division of dysphagia includes:
- oropharyngeal dysphagia, in which the movement of the food bite is disturbed by the lack of coordination of the oropharyngeal phases,

---

[13] Developed based on: Czernuszenko A. *Główne objawy dysfagii w badaniach instrumentalnych,* Warsaw 2013, p. 2-3.

[14] Halama A.R., *Kliniczne podejście otolaryngologa do chorego z dysfagią*, p. 29-36.

[15] Rosien U., Andersen V., Layer P., *Objawy gastroenterologiczne i ich leczenie. Dysfagia,* [in]: *Gastroenterologia praktyczna* Volume I, Wrocław 2013, p. 135.

- mechanical dysphagia in which there is an organic obstacle in the mouth, throat or esophagus,
- functional dysphagia, occurring in the course of neuroses or diseases without an organic basis,
- odynophagia- painful swallowing, disrupting the oral, pharyngeal and esophageal phases[16].

Diagnostics of dysphagia from the medical perspective

Diagnostics of dysphagia begins with a thorough interview with the Patient, his or her family and the community in which he or she functions, concerning the symptoms, intensity and duration of occurrence, allowing to assess the location, phase and severity of the disorder, as well as its impact on psychosocial functioning (also in the smallest social cell, i.e. family). The efficiency of lifting the larynx with the hyoid bone is assessed by palpation. The diagnostics also includes the sensitivity of the oral mucosa, sensitivity to touch, and the presence of cough and throat reflexes. In addition, a physical examination, as well as radiological and endoscopic examinations are also performed. Sometimes it is also recommended to extend the diagnostics to include ultrasound, computed tomography, magnetic resonance and endoscopic ultrasound.

The Swallowing Rating Society recommended by the American Speech-Language-Hearing Society[17] turns out to be extremely valuable in the diagnosis of dysphagia. Additionally, in diagnosing very helpful are the Dysphagia Assessment Scale and the Endoscopic Classification of Neurogenic Dysphagia (according to Warnecki 2013)[18] which is as follows:

---

[16] Developed based on the article Terlikiewicz J., Makarewicz R., *Zaburzenia połykania,* Bydgoszcz 2003, p. 31.

[17] The scale is available on the website of the American Speech –Language-Hearing Society (March 13, 2020).

[18] The given classification was developed in Poland by Dr. Anna Czernuszenko, MD, PhD.

0– absent clinically significant neurogenic dysphagia
1– mild neurogenic dysphagia (accompanied by significant leaking[19] and/or retention without aspiration)
2– moderate neurogenic dysphagia: penetration/aspiration of one food consistency
3– severe neurogenic dysphagia: penetration of two or more food consistencies

As swallowing disorders affect the patient's self-esteem and very often hinder his psychosocial functioning, and reduce self-esteem and comfort of life before starting neurologopedic therapy, it is also justified to include the MDADI questionnaire (MD Anderson Dysphagia Iventory) in the examinations, thanks to which it is possible to distinguish, analyse, and then counteracting the main factors influencing the quality of life. The questionnaire consists of 20 questions, divided into four groups:

I. Overall assessment of the problem of dysphagia – question: 1
II. Emotional disorder related to difficulties in intake of food – questions: 2, 5, 6, 8, 12, 18
III. Disorders of functioning in the family and society – questions: 3, 9, 14, 15, 20
IV. Functional effects of dysphagia – questions: 4, 7, 10, 11, 13, 16, 17, 19

The patient chooses one of the five possible answers, scored according to the following scale: definitely yes- 1, yes- 2, no opinion- 3, no- 4, definitely not – 5[20].

---

[19] Leaking is the uncontrolled leakage of food from the mouth or towards the throat. The reasons for this may be impaired work of the facial muscles, sensory disturbances in the oral cavity, disturbed bite control, delayed swallowing reflex. The leakage usually results in aspiration.

[20] The MDADI questionnaire is used for self-assessment of dysphagia and is an effective method of subjective monitoring of the development of dysphagia. It enables early diagnosis and counteracting some factors that reduce the quality of life in patients with swallowing disorders.

The results are given in a numerical scale from 0 (when the quality of life was assessed as completely unacceptable by the patient) to 100 (when the respondent assessed his quality of life as excellent)[21].

Case study. Mr. Bartosz

Medical history of the patient and his family

The patient's family medical history shows that the pregnancy and childbirth proceeded correctly, and the child developed according to the standard in the first months of life. Around the age of 2, the patient began to have a somatic disease – Schönlein-Henoch disease was diagnosed, the symptoms of which recurred several times. At 9 years of age, the patient underwent surgery for a cerebellar tumour (medulloblastoma), followed by chemotherapy and cobalt therapy. After the surgery, according to mother's report, epileptic seizures began to appear, and therefore the patient is taking anti-epileptic drugs. Mother also mentioned the history of arterial hypertension I10, nicotinism Z72.0 and impaired glucose tolerance R73.0. Since childhood, the patient is under the care of Cardiology, Diabetes, Neurosurgery and Neurology Outpatient Clinics.

Bartosz's problems with swallowing began even before the last episode related to the stroke of the brainstem and cerebellum. According to mother's statement, the situation of stomach rumbling, choking and coughing up is not very comfortable for the son and causes him to be shy, causes difficulties in making new friendships and gradual withdrawal from already established relationships.

According to mother's statement, Bartosz is a calm person, a family man, who likes reading books and escaping into the world of plot. He is interested in history and floristry. He also attended

---

[21] Detailed guidelines for the use of the MDADI test are provided in the article by Stręk P., Gawlik J., Składzień J. and others, *Ankietowa samooocena zaburzeń połykania i jakości życia u chorych leczonych z powodu nowotworów głowy i szyi,* [in:] Otolaryngologia, Warsaw 2003, 2(3), 120-125.

occupational therapy workshops, graduated from vocational school and acquired the profession of a tailor. Bartosz is also very helpful – he likes household chores and helps with gardening. He feels good among people he knows, e.g. family and friends. He is strongly connected with his mother, who quit her job and took care of her son. The information collected in the interview leads to the conclusion that the situation of the disease leads to a change in the functioning of the entire family and causes the need to change the lifestyle of all its members.

The interview with the patient shows that he is aware of his difficulties with swallowing – but he cannot name the disorder. He can determine exactly at which stage of the swallowing process he feels difficulties and what they consist of (pressure, a feeling of "rebound", choking). The patient also has gag reflexes and digesta is returned through the nose, leading to gasp. It can be seen that this type of situations embarrass the patient, he often apologizes for the situation (when he happens to cough up saliva). He also says that he senses the difficulties in the work of the tongue that he has while eating and speaking – according to his account, his tongue is "lifeless".

Bartosz was able to give the reason for his stay in the hospital, he also tells about the surgery he underwent in his childhood. During subsequent meetings, he lively discusses his interests and passions. One of them is gardening. He has trouble in listing the plants (flowers, fruits and vegetables in his garden) and the activities the gardener performs. He is very fond of his family – the relationship with his mother is especially important to him. Despite the speech disorders that were noticeable in the conversation, the dialogue with the patient made it possible to conduct an interview and a neurologopedic examination.

Neurologopedic examination

Neurologopedic examination was performed both at the beginning of therapy and at the end of treatment (after 8 weeks). After admission to the department, the patient's mental condition was satisfactory – awareness was clear, orientation (including space and time orientation) was full. Aspontanic contact – the patient answers asked questions fully, to the point but slowly.

Articulation

Speech disorders concerning both understanding (to a lesser extent) and conveying messages are visible. Spontaneous speech is slow, at times poorly communicative, devoid of fluency and rhythm, scanned, loud, irregular, sometimes explosive. It is certainly influenced by Bartosz's hearing impairment and the lack of a hearing aid[22].

There is also a lack of logical intonation (matched to the convey message) – the intonation of the sentence was standardized. Some words, or whole parts of a sentence, were overstressed (and therefore inadequately), and the scanning speech appeared several times. Excessive breaks in articulation between individual words can also be observed – the fluency and pace of speech were disturbed.

Muscle tone

The posture of Bartosz's body is also important, as he slouches down on a chair and crosses his legs. There is a visible weakening of exteroceptive sensation on the right side of the face. Frequent changes in the position of the head are also observed, resulting in a change in the relationship between the oral cavity and the throat, which negatively affects the swallowing process, and exposes the patient to aspiration of the chyme (which takes place many times). Bartosz's head is tilted forward, I also observed an unnatural curve of the neck, which makes it difficult to swallow properly. In addition, there are also major balance disturbances and difficulties in performing intentional movements associated with the occurrence of left-sided ataxia. In Bartosz's case, ataxia is of acquired nature, associated with focal lesions within the central nervous system (brain tumour). It manifests itself mainly in gait abnormalities (unsteady gait, on a wider basis) and is caused by damage to the main organ

---

[22] He used a hearing aid in the past, but now he lost one of the elements (I recommended the patient a visit in the Audiological Outpatient Clinic for examination and selection of the appropriate hearing aid). The patient wears glasses.

of motor coordination – the cerebellum. Walking along the corridor, the Patient moves along its entire width, stumbles over his own legs. The muscle tension is too low, there is hypotension[23] (resulting from damage to the cerebellum, which is described in the earlier medical history).

Breathing and phonation

In the assessment of breathing and phonation, the respiratory tract was found to be improved, however, a single phase of the breathing was short and shallow. The patient's phonation time was very short – he was able to count up to 13 in one breath.

Assessment of the efficiency and structure of the articulation apparatus

During the first therapeutic meeting, a qualitative examination was carried out to assess the mobility of the temporomandibular joints. Bartosz had problems with the coordination of the articulation apparatus, which resulted in the appearance of numerous articulation errors with the features of dysarthria[24] [25]. The chaos concerned especially the tongue and lips – the tongue was trembling, when it was extended and lifted it slightly deviated to the right. The force of pressing the tongue on the cheeks – weak. When making a circular movement of the tongue along the red lips – with the mouth wide open, incoherent movements of the tongue appear. The subject is able to smack – however, smacking was quiet and the lip tension was insufficient. During the tightening and stretching of the

---

[23] This disorder is atactic in nature and is associated with difficulties in maintaining balance.

[24] Dysarthria (Greek: dys- + artroun) is the inability to express oneself clearly caused by the bulbo-phonatory-articulation disorders syndrome. Damage to the centres and pathways innervating the speech organs, there are disturbances in the tension of the muscles participating in the angle of speech formation, which results in impaired coordination of the articulation apparatus.

[25] Tested using the dysarthria diagnosis sheet "*Ocena Stanu Dyzartrii*", ed. Izabela Gatkowska.

lips (alternately snout-smile), inaccuracy appeared, and when trying to put the upper lip on the lower one, and then the lower one on the upper one, the lack of precision of movements was visible. The patient is able to hold a spatula between the lips, but the resistance of the tongue (the tongue pushes the spatula out) causes problems. Moving the lower jaw from side to side is not entirely possible – the movement of the lower jaw is limited and lacks fluidity.

Continuous changes in Bartosz's posture, combined with quivering movements of the tongue, impaired coordination of the muscles of the tongue and cheeks, prevent the transport of the bite and result in difficulties in the initiation of the act of swallowing, leading to the regurgitation of the meal through the nose, coughing and choking. The lack of coordination of the articulation organs also caused the lack of clarity of speech, which in turn resulted in stress, which intensified articulation disorders.

Examination of swallowing

Despite many years of treatment, the patient's swallowing problems so far have not been diagnosed or considered in terms of physiotherapy. It was therefore necessary to perform an endoscopic examination of the upper digestive tract[26] to exclude reflux disease[27], hiatal hernia[28] or abnormalities in the anatomy of the digestive tract. An X-ray of the oesophagus and chest was also performed, which showed functional disorders in the swallowing process. The examinations ruled out reflux, the presence of a hernia and anatomy defects.

---

[26] This examination, also known as gastroscopy, consists in inserting a flexible apparatus into the throat and then into the oesophagus, stomach and duodenum, and possibly taking samples from the mucosa for histopathological examination.

[27] Reflux disease (*gastroesophageal reflux disease* - GERD) is a chronic disease of the upper digestive tract caused by the reflux of gastric contents into the oesophagus.

[28] This is an abnormal movement of part or all of the stomach into the chest – the top of the stomach is pushed into the chest through a thinner area in the diaphragm.

Examination of the oral cavity showed the pull of the uvula to the left, and a higher position of the left palatine arch. I also performed a qualitative assessment of the mobility of the temporomandibular joints – I assessed 3 movements: mandibular abduction, forward movement of the mandible and lateral movements of the mandible to the left and right. The examination also allowed me to assess the start of movement, its path, the emerging pain and resistance (at what point they occurred and what was their nature). Weak palatal and pharyngeal reflexes were also observed, resulting in difficulty swallowing. Due to the planned manual therapy, the tenderness of the soft tissues around the temporomandibular joints and the masseter muscle were also subjected to palpation.

The act of eating and swallowing meals by the Patient was also assessed. There was a visible weakness and increasing fatigue of the mandibular muscles during biting, which resulted in a reduction in the bite force, limited mobility of the mandible and a feeling of stiffness in the temporomandibular joints.

Bartosz complained about swallowing disorders (sometimes painful[29]), regardless of the consistency of the meal. In addition, he also mentioned regurgitation of food, frequent heartburn, hiccups, distaste (bitterness) and bad breath. According to the Patient's account, he felt the fear of swallowing each bite of food. In order to avoid "backflow" (this was how the patient himself defined the phenomenon), he divided the bite into smaller parts and swallowed several times. In an interview, he admitted that eating meals takes him longer than other family members or friends, which results in impatience and irritation.

In the Dysphagia Severity Scale, Bartosz achieved level 4 (dysphagia, but it is possible to meet nutritional needs, although control and the use of supportive techniques are required). However, in the Dysphagia Rating Scale, the Patient's swallowing disorders vary between levels 4 and 5 (mild dysphagia requiring supervision,

---

[29] Pain when swallowing food is called odynophagia (gr. Odyno – pain; phagein – eat), it occurs together with dysphagia in patients after injuries and oesophagitis, and in the case of cancers of the mouth and throat.

swallowing restrictions apply to one/two consistencies).[30] The worst result was obtained by Bartosz in the MDADI questionnaire used in the study, and more precisely in the field of functional disorders: 10 points and emotional disorders: 30 points. The Patient obtained much more points in the group of questions concerning social functioning disorders – certainly the acceptance and support of the family (especially Bartosz's mother) and the understanding of the environment have a huge impact on this.

The neurlogopedic examination, the patient's medical history and the symptoms described by him clearly indicated the presence of atactic (cerebellar)[31]. It is caused by damage/atrophy of the cerebellum (resulting from damage to the cerebellum, which is described in the earlier medical history), which results in damage to the cerebellar centre of speech coordination. Dysarthritis is accompanied by moderate lower neurogenic (oesophageal) dysphagia[32].

Selected therapeutic activities

Treatment of dysphagia depends on the place, cause of the disorder and its severity and can be divided into medical and therapeutic interventions.

Medical intervention (apart from pharmacology) of a compensatory nature, used in patients with severe forms of dysphagia, may include the insertion of a nasogastric tube – however, this does not improve the swallowing process.

---

[30] Scale and evaluation sheet are available at http://polykanie.reisspartners.pl/images/pdf/DysphagiaOutcomeSeverityScale_pol.jpg (13.03.2020).

[31] It is caused by damage to the cerebellum (there is damage to the cerebellar center of speech coordination); related to asynergy, i.e. loss of the speech coordination centre [in:] Gatkowska I., *Diagnoza dyzartrii u dorosłych w neurologii klinicznej,* Cracow 2012, p. 46.

[32] Neurogenic dysphagia is caused by neurological diseases, such as neuromuscular diseases, strokes, damage to the brainstem and cerebellum, and others. Neurogenic dysphagia is associated with damage to various levels of the nervous system: supranuclear, nucleuses of motor nerves sensory nerves (involved in the swallowing process), peripheral nerves and others.

Therapeutic interventions include several areas of training. The first is to adopt and maintain a proper body posture during a meal, by which we mean a sitting position with an erect neck. The head should be in the axis of the body, not twisted or leaned back. The patient should see the meal he is consuming, as visual stimuli are a natural stimulator of the swallowing process. An important issue is also the eye contact between the patient and the feeding person (if the patient does not eat on their own) – this allows to adjust the size of the bite, the rate of feeding, give any instructions or provide help.

In addition, techniques that facilitate swallowing and eliminate the possibility of choking are also used. This increases the Patient's safety. In the case of coughing or choking after swallowing (i.e. weakened protection of the larynx or weakened movement of the tongue backwards), the so-called supraglottic swallowing is used. It consists in holding the breath while swallowing, and coughing up after swallowing. The diagram is as follows:

BREATHING IN→ HOLDING BREATH→ SWALLOWING→ BREATHING OUT WITH COUGHING UP→ BREATHING IN

Another technique is the so-called Mendelson manoeuvre, consisting in deliberately prolonging the elevation of the back of the tongue and larynx during swallowing. As a result, the upper oesophageal sphincter widens, and the bolus swallowing force increases due to the strong retraction of the root of the tongue towards the back of the throat.

If the problem with swallowing requires swallowing of one bite of food several times, the work of the back wall of the throat and the root of the tongue should be strengthened.

According to the international division according to WHO from 2001, the following methods are used in the treatment of dysphagia: restitution, compensation and adaptative.

- Restitution therapy aims to restore the neuromuscular basis necessary for physiological swallowing, namely to improve impaired (e.g. muscular) functions and to train the elements necessary to learn compensatory swallowing techniques.

- Compensation therapy aims to achieve a swallowing reflex without risk of aspiration when physiological movements are limited or only partially preserved.

Treatment of swallowing disorders by means of compensation methods involves the use of various swallowing techniques and changes in body posture[33]*.*

One of them may be a change in the mode of action during the swallowing process, e.g. turning the head.

- The aim of adaptive therapy is to increase the ability to swallow and to adjust the environment (food) to the patient's swallowing disorders. In any case, it is recommended to change the diet by initially reducing the amount of food consumed, and their consistency – they should be liquid, semi-liquid or crushed. Food portions should not be too large or too small (they do not put pressure on the tongue, palatal arches, and thus do not stimulate the swallowing reflex) – the optimal size is a bite with the volume of a large flat spoon. Place it in the centre of the tongue or on the healthy side (in case of unilateral paralysis). The taste and temperature of the meals are also very important.

Most people with dysphagia find it easier to swallow cold or very warm foods and fluids. The expressive taste and temperature are beneficial as they improve the sensation of the mouth and throat[34]*.*

In the case of beverages, the Patient may use a straw or a sippy cup at the initial stage of treatment. In the next stages of treatment (if

---

[33] Olszewski J., Zielińska-Bliźniewska H., Pietkiewicz P., *Dysphagia as interdiscyplinary diagnistic and therapeutic problem,* Łódź 2011, p. 45.

[34] Logemann J. A., *Management of dysphagia after stroke* [in:] *Recovery after Stroke*, Cambridge 2005, p. 195.

it is possible and the patient's condition improves), the consistency of the consumed food should be gradually increased and thickened, and drinking through a straw may be replaced by drinking from a cup with a rolled up edge.

The effects of therapy:

After 8 weeks of neurologopedic therapy, the follow-up examination showed the objective and subjective effects of the actions taken.

Bartosz indicated an improvement in the mobility of the temporomandibular joint, he also felt a reduction in the feeling of stiffness in the muscles, jaw and articulation organs, thanks to the correct body posture while eating.

In addition, the change in the Patient's quality of life also improved, which manifested itself in an improvement in the comfort of eating, moving and swallowing bites of food. It also influenced his family and social relations, more frequent relationships and initiating conversations. During the therapy, the density, structure and amount of food served to Bartosz were gradually increased. Initially, the patient consumed small amounts of semi-liquid dishes more often, and later crushed food. In the final phase of his stay, he ate a traditional lunch with other patients who had never been affected by swallowing disorders. Such socializing activities supported the patient not only in the treatment of dysphagia, but also influenced his psychosocial functioning. **This was confirmed by** the indicators of the quality of life in patients with dysphagia. According to the repeated MDADI questionnaire, Bartosz's score for functional disorders improved: from 10 to 30 points. The biggest improvement, however, was in the emotional area, which increased from 30 points to 80.

During the course of the therapy, his mental state improved, which was noticed by both himself and his family – he became cheerful, contented and very curious about the world. During therapy, he was attentive and concentrated. He willingly and actively participated in therapeutic classes – he asked a lot of questions, talked about his emotions and thoughts, systematically performed assigned tasks (he attached particular importance to written exercises). His motivation and commitment increased significantly, also in the face of tasks undertaken in the family (joining the housework and the life of the community in which he functions on a daily basis). The stimulus for the patient was the noticeable first effects of his efforts and the improvement of the quality of life. In addition, the patient became more socially open – he made new relationships with others initiating conversations on his own.

In conclusion, the systematic rehabilitation of dysphagia is a very important process leading to the improvement of the Patient's quality of life and *the restoration of effective oral nutrition while maintaining or developing defensive reflexes*[35]*. The prognosis* (related to dysphagia MZ*) depends on the underlying disease, appropriate treatment and prevention of acute respiratory complications*[36]. Thanks to this, it is possible to plan the therapeutic activities as accurately and individually as possible, using various methods, adapted to the patient's abilities and limitations. Their aim is not only to treat dysphagia, but above all to improve the quality of life and increase the possibilities of psychosocial functioning.

References

Chaudhury A., Mashimo H., (2015), *Zaburzenie motoryki jamy ustno-gardłowej oraz przełyku,* Boston 2015.

Czernuszenko A., (2013), *Główne objawy dysfagii w badaniach instrumentalnych,* Warsaw.

Dysphagia Outcome Severity Scale (DOSS) (O'Neil 1999), accessed on 12.01.2019. Webpage: http://polykanie.reisspartners.pl/images/pdf/DysphagiaOutcomeSeverityScale_pol.jpg

Gatkowska I. (2012), *Diagnoza dyzartrii u dorosłych w neurologii klinicznej,* Carcow.

Halama A.R., (1995), *Kliniczne podejście otolaryngologa do chorego z dysfagią,* [in:] *Otolaryngologia Polska,* vol. XLIX, Warsaw.

Logemann A. Jeri (1995), *Evaluation and Treatment of Swallowing Disorders* [in:] *Folia Phoniatrica Logopedica,* 47, 3.

---

[35] Wiskirska-Woźnica B., Obrębowski A., Żebryk-Stopa A., *Rehabilitacja zaburzeń połykania,* [in:] *Wprowadzenie do neurologopedii,* Poznań 2012, p. 379.

[36] Chaudhury A., Mashimo H., *Zaburzenie motoryki jamy ustno-gardłowej oraz przełyku,* Boston 2015, p. 167.

Logemann A. Jeri, Pauloski B. R.., Rademaker A.W., Kahrilas J. (2002), *Oropharyngeal swallow in younger and older women: videofluoroscopic analysis,* Chicago.

Logemann J. A. (2005), *Management of dysphagia after stroke* [in:] *Recovery after Stroke*, Cambridge.

Obrębowski A., Wiskirska-Woźnica B., Obrębowska Z. (2012), *Zaburzenia połykania w praktyce neurologopedycznej* [in:], *Wprowadzenie do neurologopedii,* Poznań.

Olszewski J., Zielińska-Bliźniewska H., Pietkiewicz P., (2011), , *Dysphagia as interdiscyplinary diagnistic and therapeutic problem,* Łódź.

Prosiegel M. (2002), *Praxisleitfaden Dysphagie*, Hamburg.

Rosien U., Andersen V., Layer P. (2010), *Objawy gastroenterologiczne i ich leczenie. Dysfagia.,* Warsaw.

Rosien U., Andersen V., Layer P., (2013), *Objawy gastroenterologiczne i ich leczenie. Dysfagia,* [in]: *Gastroenterologia praktyczna* Volume I, Wrocław.

Stręk P., Gawlik J., Składzień J. and others, (2003), *Ankietowa samooocena zaburzeń połykania i jakości życia u chorych leczonych z powodu nowotworów głowy i szyi,* [in:] Warsaw.

Terlikiewicz J., Makarewicz R., (2003), *Zaburzenia połykania.* Bydgoszcz.

Waśko-Czopnik D., Paradowski L., (1999), *Dysphagia in clinical practice,* Warsaw.

Wiskirska-Woźnica B., Obrębowski A., Żebryk-Stopa A., (2012), *Rehabilitacja zaburzeń połykania,* [in:] *Wprowadzenie do neurologopedii,* Poznań

Wiskirska-Woźnica B., Proszkiewicz A., Walczak M. (2002) , *Zaburzenia połykania – postępowanie diagnostyczne i zasady rehabilitacji,* [in:] *Przewodnik lekarski,* Poznań.

Wojtczak A. (1995), *Choroby wewnętrzne*, vol. 2, Warsaw.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Renata Gliwa-Patyńska

University of Lodz, Poland
ORCID 0000-0003-2231-9197

Verbal communication disorders in a patient with diagnosed progressive supranuclear palsy

Abstract: Renata Gliwa-Patyńska, *Verbal communication disorders in a patient with diagnosed progressive supranuclear palsy*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 85-99. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https//doi.org./10.14746/ikps.2021.32.05

Progressive supranuclear palsy [Steele-Richardson-Olszewski] is a neurodegenerative disease of the central nervous system. It develops mainly in men over 40 years of age. The course of PSP is rather characteristic: motor, cognitive and non-cognitive impairments develop at a fairly rapid rate. The aim of the study is to assess interactional, communicative and linguistic competencies and skills, executive abilities (breathing, phonation and articulation) as well as primary functions of a patient diagnosed with PSP. The article confirms the thesis that dementia disorders overlap with motor disorders in the course of PSP.

Keywords: progressive supranuclear palsy, dysarthria, verbal communication, non-verbal communication, dementia

1. Introduction

Progressive supranuclear ophthalmoplegia [Steele-Richardson-Olszewski] (ICD-10, G23.1) is a neurodegenerative extrapyramidal disease of the central nervous system, which develops mainly in men over 40 years of age.[1] Most people affected by this disease experience cognitive impairment which increases at a fairly rapid rate. PSP is sometimes associated with subcortical dementia, fronto-subcortical dementia, corticobasal degeneration and frontotemporal dementia.[2] The course of PSP is rather characteristic, the first period is accompanied by hypokinesia and postural instability, slightly less frequently by pseudobulbar palsy, often by disorders of voluntary eye movements, axial parkinsonism, dysphagia and dystonia (commonly at neck); bilateral pyramidal and cerebellar symptoms may appear in the late phase.[3] The picture of disorders is dominated by executive function disorders, slowed thinking as well as attention

---

[1] Conf. P. Liberski, T. Sobów, B. Sikorska, *Postępujące zwyrodnienie nadjądrowe (choroba Steele-Richardsona-Olszewskiego)*, [in:] *Neuropatologia Mossakowskiego*, ed. by P.P. Liberski, W. Papierz, Wydawnictwo CZELEJ, Lublin 2005, p. 539; J.C. Steele, J.C. Richardson, J. Olszewski, *Progressive supranuclear palsy; a heterogenous degeneration involving the brain stem, ganglia and cerebellum with vertical gaze and pseudobulbar palsy, nuchal dystonia and dementia*, „Archives of Neurology" 1963, no. 10, p. 333–359.

[2] I. Gatkowska, *Diagnoza dyzartrii u dorosłych w neurologii klinicznej*, Wydawnictwo UJ, Kraków 2012, p. 97.; K. Jendroska, M.N Rossor, C.J. Mathias, S.E. Daniel, *Morphological overlap between corticobasal degeneration and Pick's disease: a clinicopathological report*, „Movement" 1995, 10(1), pp. 111–114; A. Kertesz, W. Davidson, D.G. Munoz, *Clinical and pathological overlap between frontotemporal dementia, primary progressive aphasia and corticobasal degeneration: The Pick complex*, „Neurology" 1999, no. 10(1), pp. 46–49; H. Olszewski, *Otępienie czołowo-skroniowe. Ujęcie neuropsychologiczne*, Impuls, Kraków 2008, p. 179; M. Pąchalska, H. Kurzbauer, B. Grochmal-Bach, B.D. MacQeen, A. Urbanik, I. Herman-Sucharska, *Nietypowe zaburzenia języka i mowy u pacjentki z klinicznym rozpoznaniem zespołu Steele'a-Richardsona-Olszewskiego*, [in:] *Choroby otępienne. Teoria i praktyka*, ed. by J. Leszek, Continuo, Wrocław 2011, p. 271.

[3] Conf. P. Liberski, T. Sobów, B. Sikorska, *Postępujące…*, p. 539; B. Morales, A. Martinez, I. Gonzalo, L. Vidal, R. Ros, E. Gomez-Tortosa, A. Rabano, *Steele-Richardson-Olszewski syndrome in a patient with a single C212Y mutation in the parkin protein*, „Movement Disorders in Neurologic and Systemic Disease" 2002, no. 17(6), pp. 1374–1380; H.R. Morris, M. Baker, K. Yasojima, H. Houlden, M.N. Khan, N.W. Wood, J. Hardy, M. Grossman, J. Trojanowski, T. Revesz, E.H Bigio, C. Bergeron, J.C. Janssen, P.L. McGeer, M.N. Rossor, A.J. Lees, P.L. Lantos, M. Hutton, *Analysis of tau haplotypes in Pick's disease*, „Neurology" 2002, no. 59(3), pp. 443–445; I. Litvan, Y. Agid, D. Calne, G. Campbell, B. Dubois, R.C. Duvoisin, C.G. Goetz, L.I. Golbe, J. Grafman, J.H. Growdon, M. Hallett, J. Jankovic, N.P. Quinn, E. Tolosa, D.S. Zee, *Clinical research criteria for the diagnosis of progressive supranuclear palsy (Steele-Richard-*

and memory impairments. In addition, these disorders are often accompanied by non-cognitive changes, such as apathy, abulia, depressed mood, emotional disorders and hypochondria. The average survival of PSP patients is usually between 2 and 6 years after the onset of the disease.[4]

The aim of this study is to assess: 1) interactional, communicative and linguistic competencies and skills as well as the ability to read, write and count in the context of cognitive functioning, 2) executive abilities (breathing, phonation and articulation) 3) primary functions of a patient diagnosed with PSP.[5]

2. Methods

The article uses research material on a 62-year-old man.[6] The research was conducted in a home environment during several meetings.

The Mini Mental State Examination (MMSE)[7] and the Clock Completion Test were used for the screening assessment of cognitive functioning. In order to assess interactional, communicative and linguistic competencies and skills the author used observation, data from medical records, psychometric testing, clinical and experimental tests. They include a test elaborated by J. Szumska included in the publication titled *Metody badania afazji*,[8] selected tests from the

---

son-Olszewski syndrome): report of the NINDS-SPSP international workshop, „Neurology" 1996, no. 47(1), pp. 616–117.

[4] Conf. M. Pąchalska, H. Kurzbauer., B. Grochmal-Bach, B.D. MacQeen, A. Urbanik, I. Herman-Sucharska, *Nietypowe…*, p. 271; P. Liberski, T. Sobów, B. Sikorska, *Postępujące…*, op. cit., p. 539.

[5] J. Panasiuk, *Postępowanie logopedyczne w przypadkach chorób neurodegeneracyjnych*, [in:] *Logopedia. Standardy postępowania logopedycznego*, ed. by S. Grabias, J. Panasiuk, T. Woźniak, Wydawnictwo UMCS, Lublin 2015, pp. 955–995.

[6] The author of this article has obtained permission to conduct the study and to publish it.

[7] M.F. Folstein, S.E. Folstein, G. Fanjiang, Mini Mental State Examination. Polska normalizacja, Warszawa, 1975.

[8] J. Szumska, *Metody badania afazji*, Wydawnictwo PZWL, Warszawa 1980.

neuropsychological study by E. M. Szepietowska,[9] a test from the Boston Diagnostic Aphasia Examination (BDAE) (assessment of comprehension: complex language material, tests: 4-8, 11-12);[10] the verbal fluency test (VFT).[11] For the assessment of executive disorders, the article relies on the author's tests developed on the basis of the works by O. Jauer-Niworowska and J. Kwasiborska[12], O. Jauer-Niworowska[13], I. Gatkowska[14] and Z. Tarkowski.[15]

3. Case study

The patient has a secondary education and he worked as a clerk before being diagnosed with the disease. He is right-handed. He had a myocardial infarction in 2000. The first alarming symptoms of the disease concerned difficulties in maintaining balance, the subject's gait gradually became clumsy and slow, and for a short period the patient was suspected of having alcohol problems. No other disorders were observed throughout that period. The breakthrough took

---

[9] E.M. Szepietowska, *Badanie neuropsychologiczne. Procedura i ocena*, Wydawnictwo UMCS, Lublin 2000, p. 23.

[10] H. Goodglass, E. Kaplan, *Boston Diagnostic Aphasia Examination*, Lea & Febiger, Philadelphia 1972.

[11] Conf. E.M. Szepietowska, B. Gawda, *Ścieszkami fluencji werbalnej*, Wydawnictwo UMCS, Lublin 2011; E.M. Szepietowska, T. Hasiec, A. Jańczyk-Mikoś, *Fluencja słowna werbalna i niewerbalna w różnych stadiach i formach choroby Parkinsona*, „Psychogeriatria Polska" 2012, no. 9(4), pp. 137–148; M. Piskunowicz, M. Bieliński, A. Zgliński, A. Borkowska, *Testy fluencji słownej – zastosowanie w diagnostyce neuropsychologicznej*, „Psychiatria Polska" 2013, vol. XLVII, no. 3, pp. 475–485; R. Gliwa, *Fluencja słowna w otępieniu naczyniopochodnym – ujęcie kliniczne*, [in:] *Teoria i praktyka logopedyczna. Wybrane zagadnienia*, ed. by E. Gacka, M. Kaźmierczak, Wydawnictwo UŁ, Łódź 2018, pp. 83–102.

[12] O. Jauer-Niworowska, J. Kwasiborska, *Dyzartria. Wskazówki do diagnozy różnicowej poszczególnych typów dyzartrii*, Komlogo, Gliwice 2009.

[13] O. Jauer-Niworowska, *Dyzartria nabyta. Diagnoza logopedyczna i terapia osób dorosłych*, Wydawnictwo APS, Warszawa 2009.

[14] I. Gatkowska, *Diagnoza….*

[15] Z. Tarkowski, *Dyzartria*, Wydawnictwo Fundacji Orator, Lublin 1999.

place when the patient caused a car accident and was taken to hospital due to his injuries. MR examination of the brain showed no post-traumatic changes, and the diagnosis revealed a small vascular lesion in the frontal region, a slight widening of the left lateral ventricle as well as cerebral cortical and subcortical atrophy (mainly in the frontal and temporal lobes). The clinical picture indicated motor disturbances and clear difficulties in producing speech manifested by a significant slowing down of its pace.

The patient underwent rehabilitation yet the neurological symptoms in the motor sphere began to worsen. Despite good results in tests assessing cognitive functions, the wife of the subject began to notice significant changes in communication with the patient within one year of the accident: she had the impression that her husband did not understand the messages directed to him, and that his behavior lacked rationality.

As the neurological symptoms did not subside, the examinations were continued. Initially, the patient was diagnosed with Parkinson's disease, yet dopaminergic treatment proved ineffective, thus multiple system atrophy-parkinsonian type (MSA-P), a condition with predominant parkinsonian symptoms, was suspected.

The diagnosis was revised when the subject's wife noticed that he had developed a tendency to make quite specific head movements to look at something below or above his eyes. It was then that the suspicion of PSP was raised.

The subject was hospitalised again after approximately one and a half years due to exacerbation of the extrapyramidal syndrome symptoms. Neurological examination revealed dysarthria, abnormal upward movement of the eyeballs, hypomimia, bradykinesia, axial rigidity, increased muscle tone of extrapyramidal type in upper and lower limbs, Rossolimo's sign positive bilaterally, abnormal parkinsonian-ataxic gait with a tendency to fall to the left. A psychological consultation from this period indicates an organic basis for the disorders manifested by impaired cognitive processes, difficulty in focusing on the conversation, episodic and short-term memory disorders, impaired autopsychic and allopsychic orientation.

One year later, the patient was again admitted to a neurology clinic due to severe swallowing difficulties which persisted for a period of two weeks. A neurological examination confirmed PSP and all lesions were described as typical of cortical-subcortical dementia syndrome.[16] No swallowing disorders were found in swallowing tests. The patient was prescribed a mush diet and meals were thickened with rice gruel. The neuropsychological examination diagnosed general memory impairment, organic mood disorder, the patient's state of consciousness was assessed as confused, with a tendency to risky behaviour.

Four years after the occurrence of the first symptoms of the disease, the patient scored 35 points on the Barthel scale. He was unable to perform self-care activities independently. The patient moves around in a wheelchair. His current medical records indicate the following diagnoses: PSP, Parkinson's disease, post-myocardial infarction status.

The subject is prescribed Madopar, sedative and anti-anxiety drugs as well as cholesterol-lowering and antihypertensive medications.

4. Research results

4.1. Motor assessment of articulatory muscles and selected primary functions

The dysarthria observed in the patient is of a spastic nature, although occasional features typical of the hyperkinetic-hypokinetic form can be seen.

The patient is diagnosed with an abnormal peak respiratory trajectory which causes a significant shortening of the respiratory phase and, as a result, the phonation phase. Examining the subject's phonatory abilities, the author observed some abnormalities in the ability to initiate the emission and pauses in phonation. Major

---

[16] Vascular dementia was excluded on the basis of a proton spectroscopy study.

changes were also observed in the quality of the voice: the patient's voice is effortful, hoarse, quiet, with no possibility of modulation or gradation of its diameter.

Changes in prosody mainly concern slowing down the speech rate, standardisation of the accent and exaggerated amplification of the sound of speech in moments of nervousness.

The musculature of the face and the articulatory apparatus of the subject at rest indicates the presence of increased muscle tone. It involves the strongest of the masticatory muscles, namely the masseter and temporalis muscles, causing severe trismus. The temporomandibular joints are also affected, causing a significant distortion of the sounds produced.

Large dysfunctions were observed in the area of the the orbicularis oris muscle, the superior and inferior incisive muscles and the zygomaticus major muscles. The observed excessive tension in, among others, the risorius and the levator labii superioris alaeque nasi muscle results in the persistence of facial expressions indicating disgust, anger and distress. Significant muscle tension is also present in the cheek muscles and the depressor anguli oris, giving an expression of bitterness and resignation. The subject is unable to make purposeful movements that require the depressor labii inferioris and the mentalis to work together. Increased muscle tone is observed in the areas of the platysma muscle as well as the suprahyoid and infrahyoid muscles, which may result in the appearance of pressed voice.

Negative changes were indicated by the tests assessing the work of the tongue muscles (external muscles – genioglossus, hyoglossus or styloglossus and internal – longitudinal, inferior longitudinal lower, transverse and vertical muscles). Increased muscle tone was observed in the area of the levator and the tensor veli palatini.

The subject is diagnosed with dysphagia.[17] He has very serious problems processing a bite of solid food and transporting semi-liquid and liquid food towards the throat. Part of the food intake re-

---

[17] Conf. P. Stręk, *Diagnostyka dysfagii ustno-gardłowej*, „Terapia" 2002, no. 10(2), pp. 12–15; J. Tomik, B. Solowska, *Zaburzenia połykania*, „Neurolingwistyka Praktyczna" 2015, no. 1, pp. 27–41.

mains in the mouth, chewing time is prolonged, liquid food is spit up. Although the swallowing reflex is initiated, it is significantly slowed down. There is a significant weakening of the defensive reflexes, such as grunting and coughing.

4.2. Mini Mental State Examination

The test results indicate the presence of mild dementia. The subject has preserved auto- and allopsychic orientation.

4.3. Clock Completion Test

The subject had significant problems with the correct placement of the hands of the clock and the correct marking of the indicated time, which suggests the existence of, *inter alia*, impaired ability to plan and visualise, visual memory and motor skills disorders, and consequently visual-spatial disorders as well as abstract-conceptual thinking disorders.[18]

4.4. Assessment of the quality of non-verbal communication

The subject obtained 2 points in the Nonverbal Communication Scale.[19] Due to significant motor dysfunctions, he does not usually use non-verbal communication.

4.5. Assessment of comprehension

Tests aimed at assessing speech comprehension showed no change in the comprehension of single words, simple sentences and short stories. The patient did not recognise linguistic situational humour. The observed difficulties in responding adequately to

---

[18] Conf. S. Krzymiński, *Test rysowania zegara*, „Postępy Psychiatrii i Neurologii" 1995, no. 4 I(2), pp. 21–30.

[19] M. Pąchalska, *Afazjologia*, Wydawnictwo Naukowe PWN, Warszawa–Kraków 1999, p. 270.

long extended instructions result from impaired concentration and memory, and — to a lesser extent — from a lack of understanding of grammatical and semantic relations between words.

4.6. Evaluation of dialogue and monologue skills

The structure of the dialogue co-created by the patient was very disturbed.[20] The patient's speech was significantly impoverished and he did not initiate independent, spontaneous verbal contact. He limited himself to signalling his immediate needs verbally (in the form of imperatives and simple sentences). He tended to divide longer utterances to make up for the lack of air, but usually failed to answer questions that required a longer utterance.

The patient did not construct monologues and answered leading questions reluctantly and with single words. He did not have the ability to make a holistic assessment of the image which he saw, he failed to perceive and take into account cause and effect. The way in which he speaks indicates a clear impoverishment of his active vocabulary.

The speech of the subject revealed a lack of word fluency, semantic paraphrases, perseverations, a tendency to template utterances, the use of a telegraphic style, chanted speech, sometimes pronominal speech, a lack of word readiness, palilalia, logoclonia, a tendency to echolalic repetition, the presence of indefinite phrases and grunts.

4.7. Assessment of the implementation of automated statements

No pathological changes were indicated by tests aimed at assessing the extent to which the subject is able to reproduce verbal automatisms that require the involvement of right-hemispheric strategies.[21] During the realisation of the sequences, it was possible to

---

[20] Conf. J. Warchala, *Dialog potoczny a tekst*, Wydawnictwo UŚ, Katowice 1991.

[21] E. Szepietowska, J. Lipian, *Fluencja słowna neutralna i afektywna u chorych z uszkodzeniem prawej, lewej lub obu półkul mózgu*, „Psychiatria Polska" 2012, no. XLVI(4), pp. 539–551.

observe articulatory distortions of the produced sounds caused by dysarthric disorders, a slowing down of speech pace as well as a lack of coordination of breathing, phonation and articulation.

4.8. Assessment of repetition

The subject correctly repeated isolated vowels that did not require tongue elevation, similar results were obtained with regard to the repetition of syllables. He repeated 2-syllable and 3-syllable words relatively well. Deficits were observed in longer forms, containing consonant clusters, which were most often "broken" by a vowel. The number of words repeated was limited (usually up to three), chiefly due to impaired attention and memory as well as weakened emotional-motivational processes. The patient repeated only one structural neologism, the ability to repeat them being considered a measure of pure phonological processing.

4.9. The naming test

The subject was presented with 50 illustrations representing 10 semantic categories, of which he named 26 illustrations correctly (8 of them with a significant delay) and 24 incorrectly. The errors observed concerned the use of the superordinate category name (4), an incorrect name but belonging to the same semantic category (4), an incorrect name not belonging to the semantic category concerned (2), perception errors (2), perseveration (1), the use of descriptive constructions (9), no answer or the answer "I don't know" (2).

The subject did not use gesticulation and he did not use ideomotor praxis.

4.10. Assessment of verbal fluency

The subject mentioned 6 names in the category of animal names, of which 3 were repetitions, he named 4 words in the category of sharp objects, of which 2 were semantic errors; he produced only

3 words beginning with the “a” sound and 3 words beginning with the “k” sound in a formal fluency test. The level of performance in semantic and formal verbal fluency tests demonstrates impaired access to lexical and semantic long-term memory resources, significant impairment of executive functions as well as the functions of voluntary attention and working memory, which coordinate and monitor task performance. The subject’s responses are characterised by considerably impoverished fluency, which is manifested by a small number of elements mentioned, the presence of rather long pauses and repetitions.

4.11. Assessment of reading

During reading attempts, very severe segmental and suprasegmental abnormalities were observed, the reading speed was significantly slowed down. Numerous phonetic distortions were noted. The subject did not usually attempt to read words with more than 3-4 syllables or read only the initial word sounds, and he found it difficult to read words saturated with consonant clusters, which he usually broke up with a vowel.

The observed disorders suggest that the lexical deficits are due to cognitive, executive and motor dysfunctions involved in the reading process.

4.12. Assessment of handwriting

In all the conducted tests (rewriting, dictation, writing from memory, spontaneous writing), it was possible to observe a significant reduction in the legibility of the patient’s handwriting, numerous graphic errors, a very significant slowing down of the writing pace, difficulty in keeping the handwriting in one line, very little fluency and freedom of movement of the lines, micrographia and high fatigue of the subject. Only occasional and very short dictated texts were transcribed correctly, although they were significantly distorted graphically. When writing sentences, the subject omitted letters and words. The patient did not attempt creative writing, he was unable to construct a sentence independently.

5. Speech therapy diagnosis

Conducting a general assessment of the subject's functioning in the context of cognitive and non-cognitive changes, it should be noted that the changes observed result from dementia that develops together with the progression of PSP. This dementia is reminiscent of the picture of behavioural frontotemporal dementia with pathological changes in language and communication skills as well as dysarthria and dysphagia.

Functioning of the patient is predetermined by disorders in the emotional sphere: the lack of efficient motivational mechanisms contributes to the loss of interest in the world around him and in any activity. The subject lacks the ability to plan both simple and complex activities, which is indicative of severely disturbed executive mechanisms. His functioning is impeded by impaired concentration, reduced speed of information processing, limited ability to process the verbal material and reduced learning efficiency.[22] The patient has demonstrated selective disorders of linguistic competence as well as disorders of motoric pronunciation mechanisms. Furthermore, it is possible to notice the onset of anomie, impaired ability to construct sentences, read and write as well as loss of fluency of speech and syntactic reduction in the messages formulated by the subject.

Conclusions

The article presents a speech therapy case study of a patient with progressive supranuclear palsy. As for interactional competence and

---

[22] Conf. D.I. Dominguez, B. De Strooper, *Novel therapeutic strategies provide the real test for the amyloid hypothesis of Alzheimer's disease*, „Trends in Pharmacological Sciences" 2002, no. 23, p. 324.

skills, the subject has a preserved ability to understand non-verbal kinetic, prosodic and proxemic behaviour. Deficits in understanding verbal and non-verbal messages depend on the complexity of the messages. Creating both non-verbal and verbal behaviour is impaired. In terms of communicative competence and skills, deficits are observed in understanding and applying linguistic social, situational and pragmatic rules. The examination of language competence and skills allows the author to conclude that there are fewer deficits in the recognition of units of the phonological subsystem, prosodic features and the understanding of the morphological subsystem units than in the understanding and building syntactic structures, understanding and conducting metalinguistic operations or the realisation of phonological subsystem units, prosodic features, the ability to fluently update units of the morphological system. In addition, pathological changes result in impaired ability to perform other language tasks, such as writing or reading.

Attention is drawn to the uncharacteristic slow course of the disease in the examined patient in the light of data in the literature.[23] The research paper confirms the thesis that dementia disorders overlap with motor disorders in the course of PSP.

References

Dominguez D.I., De Strooper B., *Novel therapeutic strategies provide the real test for the amyloid hypothesis of Alzheimer's disease*, „Trends in Pharmacological Sciences" 2002, no. 23, pp. 324–330.

Folstein M.F., Folstein S.E., Fanjiang G., *Krótka Skala Oceny Stanu Umysłowego* (MMSE). Polska normalizacja, J. Stańczak, Warszawa 2010.

Gatkowska I., *Diagnoza dyzartrii u dorosłych w neurologii klinicznej*, Wydawnictwo UJ, Kraków 2012.

---

[23] P. Liberski, T. Sobów, B. Sikorska, *Postępujące…* p. 539; M. Pąchalska, H. Kurzbauer, B. Grochmal-Bach, B.D. MacQeen, A. Urbanik, I. Herman-Sucharska, *Nietypowe zaburzenia języka i mowy u pacjentki z klinicznym rozpoznaniem zespołu Steele'a-Richardsona-Olszewskiego*, [in:] *Choroby otępienne. Teoria i praktyka*, ed. by J. Leszek, Continuo, Wrocław 2011, p. 271.

Gliwa R., Fluencja słowna w otępieniu naczyniopochodnym — ujęcie kliniczne, [in:] E. Gacka, M. Kaźmierczak, *Teoria i praktyka logopedyczna. Wybrane zagadnienia*, Łódź 2018, pp. 83–102.

Goodglass H., Kaplan E., *Boston Diagnostic Aphasia Examination*, Lea & Febiger, Philadelphia 1972.

ICD 10, *Międzynarodowa Statystyczna Klasyfikacja Chorób i Problemów Zdrowotnych ICD-10*, <www.csioz.gov.pl/interoperacyjnosc/klasyfikacje/> (dostęp: 28.06.2020).

Jauer-Niworowska O., *Dyzartria nabyta. Diagnoza logopedyczna i terapia osób dorosłych*, Wydawnictwo APS, Warszawa 2009.

Jauer-Niworowska O., Kwasiborska J., *Dyzartria. Wskazówki do diagnozy różnicowej poszczególnych typów dyzartrii*, Komlogo, Gliwice 2009.

Jendroska K., Rossor M.N., Mathias C.J., Daniel S.E., *Morphological overlap between corticobasal degeneration and Pick's disease: a clinicopathological report*, „Movement" 1995, no. 10(1), pp. 111–114.

Kertesz A., Davidson W., Munoz D.G., *Clinical and pathological overlap between frontotemporal dementia, primary progressive aphasia and corticobasal degeneration: The Pick complex*, „Neurology" 1999, no. 10(1), pp. 46–49.

Kozubski W., Liberski P.P., *Neurologia. Podręcznik dla studentów medycyny*, Wydawnictwo Lekarskie PZWL, Warszawa 2006.

Krzymiński S., *Test rysowania zegara*, „Postępy Psychiatrii i Neurologii" 1995, no. 4 I(2), pp. 21–30.

Liberski P., Sobów T., Sikorska B., *Postępujące zwyrodnienie nadjądrowe (choroba Steele-Richardsona-Olszewskiego)*, [in:] *Neuropatologia Mossakowskiego*, ed. by P.P. Liberski, W. Papierz, Wydawnictwo CZELEJ, Lublin 2005, pp. 538–545.

Litvan I., Agid Y., Calne D., Campbell G., Dubois B., Duvoisin R.C., Goetz C.G., Golbe L.I., Grafman J., Growdon J.H., Hallett M., Jankovic J., Quinn N.P., Tolosa E., Zee D.S., *Clinical research criteria for the diagnosis of progressive supranuclear palsy (Steele-Richardson-Olszewski syndrome): report of the NINDS-SPSP international workshop*, „Neurology" 1996a, no. 47(1), pp. 1–9.

Morales B., Martinez A., Gonzalo I., Vidal L., Ros R., Gomez-Tortosa E., Rabano A., *Steele-Richardson-Olszewski syndrome in a patient with a single C212Y mutation in the parkin protein*, „Movement Disorders in Neurologic and Systemic Disease" 2002, no 17(6), pp. 1374–1380.

Morris H.R., Baker M., Yasojima K., Houlden H., Khan M.N., Wood N.W., Hardy J., Grossman M., Trojanowski J., Revesz T., Bigio E.H., Bergeron C., Janssen J.C., McGeer P.L., Rossor M.N., Lees A.J., Lantos P.L., Hutton M., *Analysis of tau haplotypes in Pick's disease*, „Neurology" 2002, no. 59(3), pp. 443–445.

Olszewski H., *Otępienie czołowo-skroniowe. Ujęcie neuropsychologiczne*, Impuls, Kraków 2008.

Pąchalska M., *Afazjologia*, Wydawnictwo Naukowe PWN, Warszawa–Kraków 1999.

Pąchalska M., Kurzbauer H., Grochmal-Bach B., MacQeen B.D., Urbanik A., Herman-Sucharska I., *Nietypowe zaburzenia języka i mowy u pacjentki z klinicznym rozpoznaniem zespołu Steele'a-Richardsona-Olszewskiego*, [in:] *Choroby otępienne. Teoria i praktyka*, ed. by J. Leszek, Wydawnictwo Continuo, Wrocław 2011, pp. 271–290.

Panasiuk J., *Postępowanie logopedyczne w przypadkach chorób neurodegeneracyjnych*, [in:] *Logopedia. Standardy postępowania logopedycznego*, ed. by S. Grabias, J. Panasiuk, T. Woźniak, Wydawnictwo UMCS, Lublin 2015, pp. 955–995.

Piskunowicz M., Bieliński M., Zgliński A., Borkowska A., *Testy fluencji słownej – zastosowanie w diagnostyce neuropsychologicznej*, „Psychiatria Polska" 2013, vol. XL-VII, no. 3, pp. 475–485.

Richardson J.C., Steele J., Olszewski J., *Supranuclear ophthalmoplegia, pseudobulbar palsy, nuchal dystonia and dementia. A clinical report on eight cases of „heterogeneous system degeneration"*, „Transactions of the American Neurological Association" 1963, no. 88, pp. 25–29.

Steele J.C., Richardson J.C., Olszewski J., *Progressive supranuclear palsy; a heterogenous degeneration involving the brain stem, ganglia and cerebellum with vertical gaze and pseudobulbar palsy, nuchal dystonia and dementia*, „Archives of Neurology" 1964, no. 10, pp. 333–359.

Stręk P., *Diagnostyka dysfagii ustno-gardłowej*, „Terapia" 2002, no. 10(2), pp. 12–15.

Szepietowska E.M., *Badanie neuropsychologiczne. Procedura i ocena*, Wydawnictwo UMCS, Lublin 2000.

Szepietowska E.M., Gawda B., *Ścieszkami fluencji werbalnej*, Wydawnictwo UMCS, Lublin 2011.

Szepietowska E.M., Hasiec T., Janczyk-Mikoś A., *Fluencja słowna werbalna i niewerbalna w różnych stadiach i formach choroby Parkinsona*, „Psychogeriatria Polska" 2012, no. 9(4), pp. 137–148.

Szepietowska E.M., Lipian J., *Fluencja słowna neutralna i afektywna u chorych z uszkodzeniem prawej, lewej lub obu półkul mózgu*, „Psychiatria Polska" 2012, no. XLVI(4), pp. 539–551.

Szumska J., *Metody badania afazji*, Wydawnictwo PZWL, Warszawa 1980.

Tarkowski Z., *Dyzartria*, Wydawnictwo Fundacji „Orator", Lublin 1999.

Tomik J., Solowska B., *Zaburzenia połykania*, „Neurolingwistyka Praktyczna" 2015, no. 1, pp. 27–41.

Warchala J., *Dialog potoczny a tekst*, Wydawnictwo UŚ, Katowice 1991.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Justyna Cybulska[*], Ewelina Zając[**]

University of Lodz, Poland
[*] ORCID: 0000-0002-9741-9734
[**] ORCID: 0000-0002-5076-8347

Women's knowledge of the development and communication of children with Fetal Alcohol Syndrome (FAS)

Abstract: Justyna Cybulska, Ewelina Zając, *Women's knowledge of the development and communication of children with Fetal Alcohol Syndrome (FAS)*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 101-112. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https://doi.org/10.14746/ikps.2021.32.06

The aim of the article is to analyze the results of surveys on women's knowledge about FAS and its consequences for the development of a child's speech and communication. 130 women between 18 and 50 years old took part in the survey. A significant proportion of the surveyed women are aware of the problems and consequences of Fetal Alcohol Syndrome caused by the mother's alcohol consumption during pregnancy.

Key words: FAS, communication, communication disorders, maternal awareness

Introduction

"Fetal Alcohol Syndrome (…) is the name of a disease that includes a syndrome of congenital abnormalities that can be found in some children of mothers consuming alcohol during pregnancy"[1].

---

[1] M. Banach, *Dzieci wymagające specjalnej opieki zdrowotnej*, Fundacja Oświecenia Publicznego, Kraków 2004, p. 5.

FAS is a group of physical and mental developmental disorders[2]. "Children with FASD can have many and varied developmental problems and dysfunctions of many organ systems. The manifestations of the consequences of CNS damage include:

- reduced intellectual abilities – about half of the children have diagnosed intellectual development deficits of various degrees,
- disturbed functions of direct memory, it is inefficient,
- reduced generalization and planning skills,
- difficulties in abstract thinking,
- the occurrence of visual and hearing disorders and many other functional limitations"[3],

as well as: delayed speech development, processing and memory disorders, impaired articulation, melody and speech prosody, impaired fluency in word production, speech impediments, talking to oneself, impaired phoneme differentiation, problems with understanding social behavior, problems with understanding information not given directly: metaphors , allusions, hearing disorders, including auditory self-monitoring.

Research aim and methodology

The aim of the article is to analyze the results of surveys on women's knowledge about FAS and its consequences for the development of a child's speech and communication.

---

[2] M. Klecka, M. Janas-Kozik, *Dziecko z FASD. Rozpoznania różnicowe i podstawy terapii*, Wydawnictwo Edukacyjne PARPAMEDIA, Warszawa 2009, p. 8; M. Komorowska, *Potrzeby edukacyjne dzieci z FASD*, „Remedium" 9, 2007, pp. 24-25; D. Hryniewicz, *Specyfikacja pomocy psychologiczno-pedagogicznej dzieciom z FAS*, Wydawnictwo Edukacyjne PARPAMEDIA, Warszawa 2007, p. 8.

[3] T. Jadczak-Szumiło. *Problemy diagnostyczne dzieci z Płodowym Zespołem Alkoholowym (FAS) – możliwości wykorzystania testu WISC-R w diagnozie różnicowej*, Unpublished doctoral dissertation written under the supervision of prof. E. Hornowska, UAM Poznań 2014, p. 21.

A questionnaire completed by 130 women between 18 and 50 years of age was used for the survey. The questions in the survey concerned general information about FAS, the characteristic features of children with this syndrome, and the influence of Fetal Alcohol Syndrome on speech and communication.

Characteristics of the research group

Some of the 130 surveyed women (62) are between 18 and 24 years of age, while the number of women in the remaining age groups is even, as shown in Chart 1.

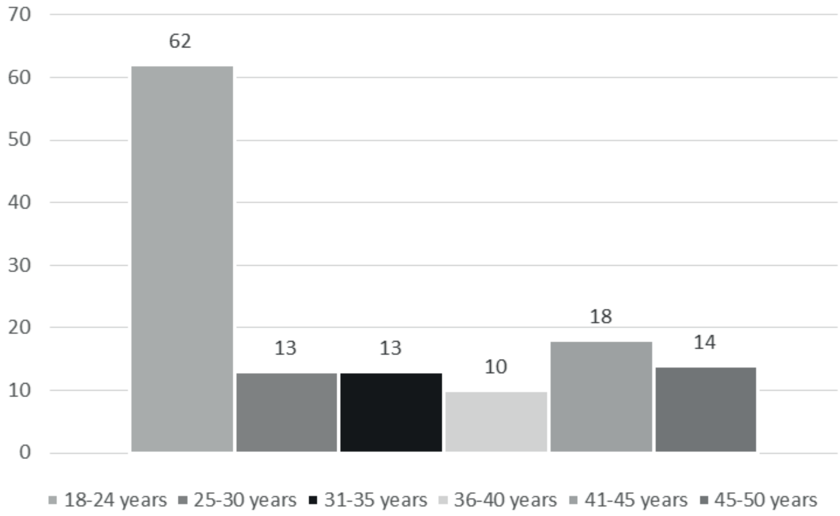

Chart 1. A numerical list of the surveyed women in individual age groups.

Source: own study.

Women participating in the survey live in villages, towns and cities. From among the respondents, only 1 woman has vocational education, while 63 has secondary and 66 higher education. Out of 130 respondents, 71 women did not have children, and the remaining 57 declared having children. 32 women have one child, 24 women have two children, and 3 surveyed women have three or more children.

A question about alcohol consumption during pregnancy was addressed to all women who have children. The answers given are as follows:

- during pregnancy, I consumed alcohol (even in the smallest amount) and I was aware of all possible consequences of consuming even the smallest amount of alcohol – 1 answer;
- during pregnancy, I did not consume even the smallest amount of alcohol, I was aware of all possible consequences of consuming even the smallest amount of alcohol – 51 responses;
- during pregnancy, I consumed alcohol (even in the smallest amount), I was not aware of the negative consequences for my child resulting from the consumption of alcohol – 4 responses;
- during pregnancy, I did not consume even the smallest amount of alcohol, I was not aware of the negative consequences for my child resulting from the consumption of alcohol – 3 answers.

Analysis of the research

90 out of 130 women knew the definition of FAS and could identify what the disorder was. 33 respondents did not attempt to answer the question, 3 people admitted the lack of knowledge in this respect, and 4 people defined FAS incorrectly. 38 women admitted having met a person with FAS once. The others replied that they had not met such a person or did not know what FAS meant.

Various answers were given to the question of where or in what circumstances the respondent first encountered the term FAS. The most common of them are presented in Chart 2.

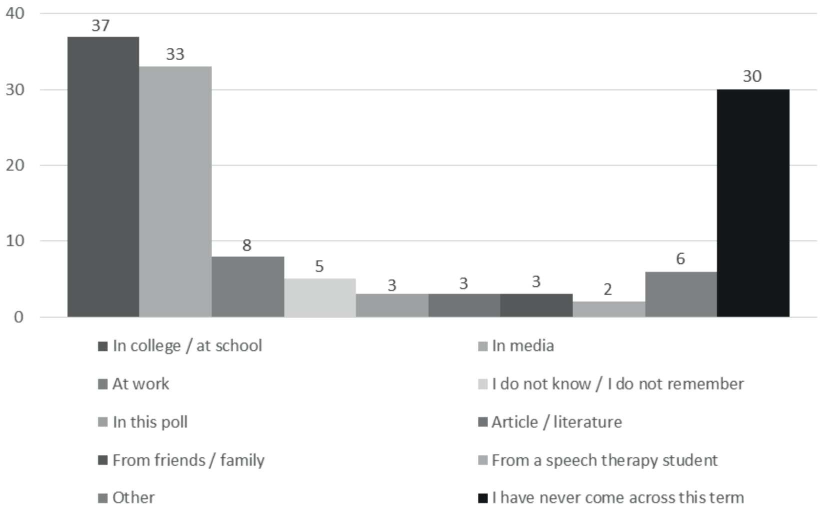

Chart 2. Circumstances of the first meeting of the respondents with the FAS term.

Source: own study.

6 people gave answers that did not fit into any of the narrow categories, which is why they were placed in the chart under the name „other", and they were: a course for a rest teacher, speech therapy clinic, banner at the bus stop, situation in the family or heard somewhere, special school attended by my daughter.

Of the 130 women surveyed, 103 answered correctly, indicating the reason for the FAS. 16 women did not know the answer, 8 answered too broadly, which could not be treated as a correct answer, 3 answers were incorrect.

Alcohol consumed in moderation during pregnancy was judged as safe by 2 women, and 3 showed ignorance in this regard. The remaining 125 women considered alcohol consumed during pregnancy, also in moderation, to be dangerous. 81 women considered each dose of alcohol harmful to the fetus; 17 women showed ignorance in this regard; 7 people decided that drinking alcohol is forbidden during pregnancy (regardless of the dose); 2 respondents indicated that it all depends on a given case, and 6 women decided that there was no specific harmful dose. The remaining 17 people administered specific doses that should not be exceeded – these responses ranged from 5 ml to 4 per mille. There were also statements that it all depends on the type of alcohol and the frequency of its consumption and among the respondents, the wine was considered to be the so-called „Healthy alcohol", the respondents allowed drinking a glass of wine from daily to once every several months.

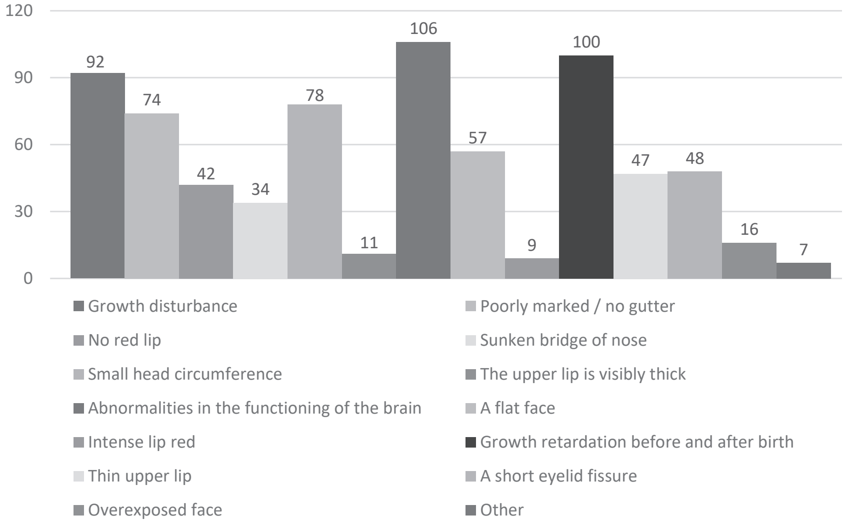

Chart 3. Respondents' answers about physical symptoms indicating Fetal Alcohol Syndrome.

Source: own study.

The participants' task was also to list the physical symptoms indicative of Fetal Alcohol Syndrome. The most common symptoms of FAS turned out to be brain abnormalities (106 responses), pre- and postnatal growth retardation (100 responses), and growth failure (92 responses). More than half of the women filling out the questionnaire considered a small head circumference (78 responses) and a poorly marked subnasal ridge or lack of it (74 responses) as a symptom of FAS. This means that the respondents' awareness of the symptoms of Fetal Alcohol Syndrome is quite high. The most numerous answers are correct, however, the symptoms of FAS also include answers that were indicated by a few respondents, e.g. a short eyelid fissure. It is worth noting, however, that incorrect responses, such as intense red lip, thickened upper lip or excessively prominent face, were given only a few times.

100% of surveyed women admitted that FAS influences the further development of the child, however 21 people declared that they did not know what impact it was. 104 women listed the following FAS effects:

- psychophysical development delay / disorder – 36 responses,
- learning difficulties – 13 answers,
- impaired intellectual development / intellectual disability / lowered IQ – 10 responses,
- social maladjustment / disturbance of functioning in society – 7 answers,
- brain disorders – 6 responses,
- executive function disorders – 4 responses,
- cognitive development disorders – 4 responses,
- speech and communication disorders – 4 answers,
- depression / personality disorders – 3 answers,
- physical fitness disorder – 2 responses,
- physical defects / disturbed appearance – 2 answers,
- emotional development disorder – 2 answers,
- CNS functioning disorders / damage – 2 responses,
- tendency to drink alcohol – 1 answer,
- ADHD – 1 answer.

There were also responses regarding the short stature of children with FAS, problems with impulse control, visual, hearing and kidney function impairments, withdrawal syndrome and withdrawing.

The next part of the study concerned the assessment of the impact of FAS on the development of speech and communication in the later stages of a child's life. Proper speech development is the key to knowledge and an important factor in shaping the personality. If the child's speech development process is correct, then the thinking process also becomes correct, and thus communication takes place properly[4]. Language difficulties resulting from memory impairment and deficiencies caused by damage to various structures in the brain have a major impact on the communication of people with FAS[5]. 22 people admitted ignorance of the influence of FAS on the development of speech and communication in the later stages of the child's life, and one person stated that FAS had no influence on it. 30 people confirmed the effect but did not mention any further consequences. The remaining people confirmed that FAS influences the development of speech and communication and indicated possible symptoms of these disorders. Among the most common answers were:

- delayed speech development – 28 responses,
- not understanding jokes – 11 answers,
- speech impediments / slurred speech – 13 answers,
- problems with establishing contacts – 8 answers,
- stuttering – 8 answers,
- difficulties in recognizing and expressing emotions – 7 answers,
- concentration disorders – 6 responses,
- low vocabulary – 4 answers,
- speech therapy problems (not specified in detail) – 4 answers,
- total speech development disorder – 3 responses.

Single responses turned out to be numerous, including: mental deficits, disturbed thought processes, illogical ordering, aphasia, linguistic errors, low muscle tension, inadequate education of the speech organ.

---

[4] H. Pawłowska-Jaroń, *Sfery zaburzonego rozwoju u dzieci z FASD*, [in:] *NOWA LOGOPEDIA.Biologiczne uwarunkowania rozwoju i zaburzeń mowy*, vol.2, eds. M. Michalik, A. Siudak, Collegium Columbinum, Kraków 2011, pp. 123-139.

[5] M. Krakowiak, *Postępowanie logopedyczne w przypadku dzieci z zespołem poalkoholowym (FAS)*, [in:] eds. J. Panasiuk, S. Grabias, T. Woźniak, *Logopedia. Standardy postępowania logopedycznego*, Wydawnictwo UMCS, Lublin 2015, p. 426.

The surveyed women also emphasized in their responses that it all depends on the degree of damage to the fetus, as well as the place and degree of damage to the central nervous system.

The participants' task was also to list the four main diagnostic features on the basis of which FAS is determined. According to the 4-Digit Diagnostic Questionnaire, it is a shortage of height, the facial system characteristic of FAS, abnormalities in the central nervous system and confirmation of alcohol consumption by the mother (during pregnancy). The responses are presented in Chart 4.

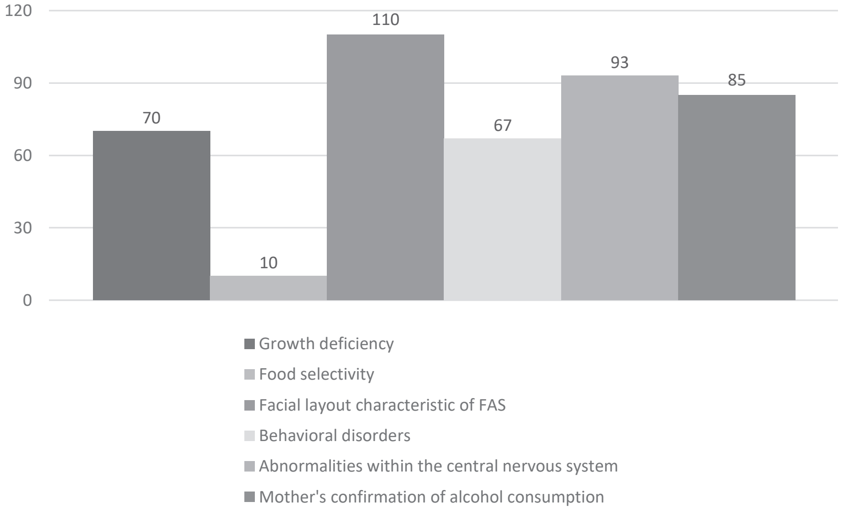

Chart 4. Main diagnostic features on the basis of which FAS is determined.

Source: own study.

Most of the selected responses were correct, but there were also inappropriate indications, e.g. behavioral disorders or food selectivity.

They were also asked about problems specific to children who had been exposed to alcohol in utero. The responses are presented in Chart 5.

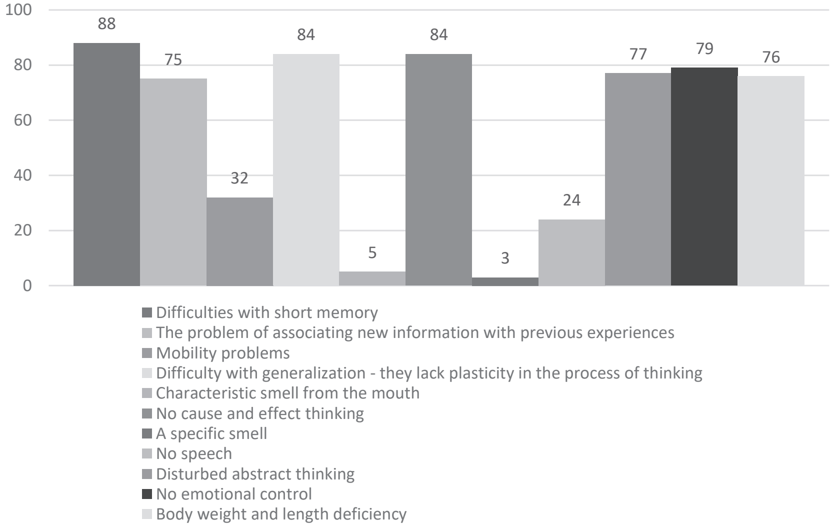

Chart 5. Problems specific to children exposed to alcohol in utero.

Source: own study.

Most of the respondents gave the correct answers. As many as 88 women were aware that exposure of a child to alcohol in utero may cause difficulties with short memory. 84 respondents knew that children of mothers who drink during pregnancy have difficulties with generalization, which means that they lack plasticity in the process of thinking and also have problems in the field of cause-and-effect thinking. The 70 correct answers also include: disturbed abstract thinking, lack of emotional control, weight and length deficiency. 64 incorrect answers were given, including: problems with movement, characteristic smell from the mouth, lack of speech, specific smell.

Summary

For the purposes of this article, a survey was conducted with 130 women. The knowledge of women about Fetal Alcohol Syndrome and its consequences for the future life of the child is quite large, however, among the respondents there were women who, despite this awareness, consumed alcohol during pregnancy. The conducted survey showed that the awareness of women aged 18-50 about FAS is selective.

"As can be seen from the list above, problems in children with FASD are disorders of a complex and multidimensional form"[6]. As a consequence, the above-mentioned effects of FAS cause health problems that hinder functioning, problems in school education and difficulties in achieving independence. In addition, they often lead to depression, addiction, conflicts with the law, thoughts and suicide attempts, as people with FAS are unable to cope with "otherness" without the help of specialists.

When analyzing the consequences of FAS for a child, it is important to consider the time the child's mother consumed alcohol. Consuming alcohol in the first trimester of pregnancy causes brain damage, facial deformities, damage to the heart and liver, and consequently, miscarriage. Drinking alcohol in the second trimester of pregnancy may cause: damage to the baby's brain, damage to its muscle, bone, skin and gland cells. A mother drinking in the third trimester may cause her child to experience delays in weight gain, may develop brain structure and functioning disorders, and may lead to premature birth[7]. FAS manifests as primary and secondary disorders. "Primary disorders are the result of brain damage in children with FASD. Secondary disorders need not arise. They are the result of a lack of adequate help for children with FASD"[8]. In addition to all the abnormalities and disorders in the development of children mentioned above, complete damage to the fetus may also occur, and consequently its death.

---

[6] M. Banach, J. Matejek, *W trosce o zdrowie dziecka i twoje. Płodowy zespół alkoholowy (FAS) – kompendium wiedzy*, Wydawnictwo ≪scriptum≫, Kraków 2016, p.44.

[7] J. Klimczak, *FetalAlcoholSyndrome – czyli skutki oddziaływania alkoholu na płód*, [in:] ed. M. Banach, *Alkoholowy zespół płodu. Teoria – Diagnoza – Praktyka*, Wydawnictwo WAM, Kraków 2011, pp. 147-155.

[8] T. Jadczak-Szumiło, K. Kałamajska-Liszcz, K. Liszcz, *Jak wspomagać dziecko z FASD w edukacji*, Państwowa Agencja Rozwiązywania Problemów Alkoholowych PARPA, Warszawa 2018, p. 23.

The summary of the answers given in the questionnaire allows us to draw conclusions that a large proportion of the surveyed women are aware of the symptoms, problems and consequences of Fetal Alcohol Syndrome caused by the mother's alcohol consumption during pregnancy. However, it is worth disseminating information about this syndrome to the few women who have not heard of it, and to those who consumed alcohol during pregnancy, exposing their children to possible tragic consequences.

References

Banach M., *Dzieci wymagające specjalnej opieki zdrowotnej*, Fundacja Oświecenia Publicznego, Kraków 2004.

Banach M., Matejek J., *W trosce o zdrowie dziecka i twoje. Płodowy zespół alkoholowy (FAS) – kompendium wiedzy*, Wydawnictwo ≪scriptum≫, Kraków 2016.

Hryniewicz D., *Specyfikacja pomocy psychologiczno-pedagogicznej dzieciom z FAS*, Wydawnictwo Edukacyjne PARPAMEDIA, Warszawa 2007.

Jadczak-Szumiło T., Kałamajska-Liszcz K., Liszcz K., *Jak wspomagać dziecko z FASD w edukacji*, Państwowa Agencja Rozwiązywania Problemów Alkoholowych PARPA, Warszawa 2018.

Jadczak-Szumiło T., *Problemy diagnostyczne dzieci z Płodowym Zespołem Alkoholowym (FAS) – możliwości wykorzystania testu WISC-R w diagnozie różnicowej*, Unpublished doctoral dissertation written under the supervision of prof. E. Hornowska, UAM Poznań 2014.

Klecka M., Janas-Kozik M., *Dziecko z FASD. Rozpoznania różnicowe i podstawy terapii*, Wydawnictwo Edukacyjne PARPAMEDIA, Warszawa 2009.

Klimczak J., *Fetal Alcohol Syndrome – czyli skutki oddziaływania alkoholu na płód*, [in:] red. M. Banach, *Alkoholowy zespół płodu teoria diagnoza praktyka*, Wydawnictwo WAM, Kraków 2011, p. 147 – 155.

Komorowska M., *Potrzeby edukacyjne dzieci z FASD*, „Remedium" 9, 2007, s. 24-25.

Krakowiak M., *Postępowanie logopedyczne w przypadku dzieci z zespołem poalkoholowym (FAS)*, [in:] eds. J. Panasiuk, S. Grabias, T. Woźniak, *Logopedia. Standardy postępowania logopedycznego*, Wydawnictwo UMCS, Lublin 2015, s. 419-435.

Pawłowska-Jaroń H., *Płodowy zespół alkoholowy – zagadnienia mowy i percepcji*, „Szkoła Specjalna" 2, 2010, p. 113-120.

Pawłowska-Jaroń H., *Sfery zaburzonego rozwoju u dzieci z FASD*, [in:] eds. M. Michalik, A. Siudak, *NOWA LOGOPEDIA. Biologiczne uwarunkowania rozwoju i zaburzeń mowy*, vol. 2, Collegium Columbinum, Kraków 2011, p. 123-139.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Jolanta Baran

Pedagogical University of Krakow, Poland
ORCID: 0000-0001-8054-1648

Between Pedagogical Therapy and Educational Support for Pupils: Discussion on Terminology and Professional Interventions in the Concept and Implementation of Inclusive Education

Abstract: Jolanta Baran, *Between Pedagogical Therapy and Educational Support for Pupils: Discussion on Terminology and Professional Interventions in the Concept and Implementation of Inclusive Education*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 113-135. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https://doi.org/10.14746/ikps.2021.32.07

The presented text reflects on the actions, understanding and use of terms related in particular to psychological and pedagogical support and pedagogical therapy and the role of specialists in educational institutions and inclusive teams of students. The considerations refer to the literature of both new and older one in order to compare the different conceptual and implementation of the assistance given to students with the respect to their needs. In conclusion, there have been presented a comparison of the support provided in chosen countries to the students with different developmental potentials, including disabilities, in inclusive education. It was meant in order to draw attention to specific solutions and the terminology used when psychological and pedagogical support is provided for pupils/students within the inclusive school.

Key words: pedagogical therapy, psychological and pedagogical support, inclusive education, educational support, specialist educational support

Introduction

In Poland, similarly to other countries where the socio-economic transformations have had quite a rapid course, legal and system-related changes in a number of areas of economy and social policy have been witnessed for at least 30 years. These changes are not necessarily characterised by a straight-line continuity and an upward tendency. It is easily noticeable that the management of education is entangled in the meanders of politics and social slogans, sometimes arising from completely disparate ideologies. Furthermore, the concept of inclusive education is also embedded in philosophical, social and even political trends[1] and even though its legal premises are not contested, the debates on the modes and benefits of its implementation never subside.[2] Nevertheless, inclusive education should be considered, to a certain degree, a natural and consecutive stage of the process of societal development. However, specific educational interventions indicated in the premises of inclusive education, the terminology assigned to them and the competence of persons performing them still induce discussions. The presented text is an attempt at updating the understanding and the application of terms related, in particular, to psychological and pedagogical assistance and pedagogical therapy, as well as the role of specialists in educational facilities and inclusive pupil

---

[1] M. Winzer, *Ruch na rzecz integracji: zmiana paradygmatu czy historyczne następstwo*? trans. by J. Baran, (in:) *Dylematy pedagogiki specjalnej*, ed. A. Rakowska, J. Baran, Wydawnictwo Naukowe AP, Kraków 2000; M. Winzer, K. Mazurek, *Views on Inclusive Schooling: A Critical Glance at Progress and Priorities*, (in:) *Chosen Topics of Supporting Persons with a Disability*, vol. 2, ed. J. Baran, D. Baraniewicz, A., Ochman, Wydawnictwo Naukowe UP, Kraków 2014; R. Operetti, Z. Walker, Y Zhang, *Inclusive Education: from Targeting Groups and Schools to Achieving Quality Education as the Core of EFA*, (in:) *Sage Handbook of Special Education*, ed. L. Florian, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

[2] M. Ainscow, *From Special Education to Effective Schools for All: Widening the Agenda*, (in:) *Sage Handbook of Special Education*, ed. L. Florian, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

teams. Furthermore, a comparison of the support offered to pupils with diverse development potential, including pupils with disabilities, in inclusive education in selected countries has been shown in order to put forward specific solutions and to apply the terminology pertaining to the organisation of psychological and pedagogical support for pupils in the school premises.

Concept of Inclusive Education and Roles of Specialists in Inclusive Classes

More and more often, attention is drawn to the fact that the role of inclusive education is understood diversely in various educational environments, without even mentioning a broader social context. The analyses of the descriptive approach (broad understanding) and prescriptive one (narrow understanding) as outlined by Grzegorz Szumski[3], are purposefully omitted here. Nevertheless, it is worth referring to certain sources in order to show the content and the modes of defining inclusive education with the aim of emphasising the multitude of approaches, e.g.:

1) “Never-ending process which involves the discovery and removal of limits to participation and learning”[4]
2) “The process of increasing the participation f students in, and reducing their exclusion from, the curricula, cultures and communities of local schools”[5]

---

[3] G. Szumski, *Koncepcja edukacji włączającej*, (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019.

[4] T. Booth, A. Dyson, za: S. Hart, M. J. Drummond, Learning Without Limits: Constructing a Pedagogy Free From Determinist Beliefs about Ability, (w:) Sage Handbook of Special Education, red. L. Florian, Sage, Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014, s. 455.

[5] M. Ainscow, T. Booth, A. Dyson, za: M. Ainscow, From Special Education to Effective Schools for All: Widening the Agenda, (w:) Sage Handbook of Special Education, red. L. Florian, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014, s.172.

3) "Restructuring of cultures, policies and practices in schools so that they respond to the diversity of students in the locallity"[6]
4) "The presence, participation and achievement of all students vulnerable to exclusionary pressures, not only those with impairments or those who are categorized as *having special educational needs*"[7].
5) "*Inclusive schooling* refers to schools that are flexible and organized to meet the unique needs of all students. Schools will change their format, teacher responsibilities, and curricula to create programs responsive to the needs of all learners".[8]

Unfortunately, the most popular interpretations in Poland feature a belief that inclusive education merely consists in the placement of pupils with disabilities in mainstream education and in the adjustment of the conditions and requirements to their needs. In this sense, inclusive education would entail piling up even more tasks on a kindergarten or a school, along with a belief about the necessity of paying special attention to the distinctness of this group of pupils, which would probably lead to the solidification of the so-called division of pupils into "similar" and "different" within the space of a single institution. Grzegorz Szumski explains that "the greatest obstacle in the realisation of high quality inclusive education is treating the education of pupils with disabilities as a separate task, an additional programme."[9]

---

[6] M. Ainscow, T. Booth, A. Dyson, za: M. Ainscow, From Special Education to Effective Schools for All: Widening the Agenda, (w:) Sage Handbook of Special Education, red. L. Florian, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014, s.172.

[7] M. Ainscow, T. Booth, A. Dyson, za: M. Ainscow, From Special Education to Effective Schools for All: Widening the Agenda, (w:) Sage Handbook of Special Education, red. L. Florian, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014, s.172.

[8] M. Winzer, K. Mazurek, Views on Inclusive Schooling: A Critical Glance at Progress and Priorities, (in:) Chosen Topics of Supporting Persons with a Disability, vol. 2, ed. J. Baran, D. Baraniewicz, A., Ochman, Wydawnictwo Naukowe UP, Kraków 2014, p. 14.

[9] G. Szumski, *Koncepcja edukacji włączającej*, (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019, p. 22.

In reference books, attention is drawn to the fact that the understanding of the sense of inclusive education requires abandonment of the hitherto mode of thinking about the psychological and pedagogical diagnosis of pupils, their skills, educational success and traditional forms and methods of teaching.[10] The philosophy of inclusive education lists key values, namely the educational outcomes that can be accomplished, but also the pupils' well-being, satisfactory and proper relations in the peer group and among pupils and teachers, a feeling of identity with the local environment. This is followed by acceptance of the pupils' diversity, irrespective of the degree of their disability and striving for an optimum response to their individual needs *(the optimum learning environment*[11]), also resulting from a worse financial standing of a given family, cultural differences or threats to emotional and social development caused by various factors.[12] The understanding that neither the accomplishments or the support received by a specific pupil should be compared with the support received by others foster a climate proper for cooperation among pupils with one another and their well-being, and it allows the teachers to arrange their work in an individual manner and in teams and to propose diversified modes of seeking/ discovering knowledge, in line with a constructivist approach to the process of

---

[10] M. Ainscow, *From Special Education to Effective Schools for All: Widening the Agenda*, (in:) *Sage Handbook of Special Education*, ed. L. Florian, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014; T. Booth, M. Ainscow, *Index for Inclusion. Developing Learning and Participation in Schools* (3rd edition), Centre for Studies on Inclusive Education, Bristol UK 2011; S. Hart, M. J. Drummond, *Learning Without Limits: Constructing a Pedagogy Free From Determinist Beliefs about Ability*, (in:) *Sage Handbook of Special Education*, ed. L. Florian, Sage, Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014; B. Jachimczak, *Nauczyciel w edukacji włączającej*, (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019; J. Rix, K. Sheehy, *Nothing Special: The Everyday Pedagogy of Teaching* (in:) *Sage Handbook of Special Education*, ed. L. Florian, Sage, Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

[11] C. Dudley-Marling, M. B. Burns, *Two Perspectives on Inclusion in The United States*. (in:) *Global Education Review*, 2014, vol. 1, No. 1, pp. 14-31.

[12] T. Zacharuk, *Edukacja włączająca szansą dla wszystkich uczniów*, (in:) "Mazowiecki Kwartalnik Edukacyjny", No. 1 (20), pp. 2-7.

teaching/ learning.[13] *Therefore, the purpose of inclusion is sustainable education, corresponding to the individual needs and fostering the building of a community.*[14]

During the implementation of the concept of inclusive education, special place is assigned to a triad encompassing an inclusive curriculum, a school and teachers; together, thanks to the adequate features characterising them, they may guarantee all pupils' engagement in the process of learning and experiencing both social and emotional well-being, along with their school accomplishments.[15] In other words, the curriculum is uniform for all (the basis), yet at the same time it is flexible (with respect to the scope); a school, within its space and educational and social culture is adjusted to diversity and the pupils' needs resulting from it, whereas the teachers are equipped with competence, thanks to which they know how to work with a diversified team and they feel responsible for all pupils.[16] In the concept of inclusive education, fulfilment of the role of the teacher understood in this manner does not take place without support on the part of other people. The significance of cooperation with other specialists is emphasised: both these who are present – depending on the needs – in the class and who work in their offices, as well as the ones that are subordinate to other facilities cooperating with the school and with the pupils' parents/ guardians. *Without disregarding the problem of access of inclusive education schools to the special education personnel, it must be emphasised that the mode of its use is of key signifi-*

---

[13] Z. Gajdzica, *Zasady organizacji kształcenia w edukacjach inkluzyjnych uczniów z niepełnosprawnością* (in:) *Niepełnosprawność. Dyskursy Pedagogiki Specjalnej*, 2019, No. 33, pp. 26-39.

[14] G. Szumski, *Koncepcja edukacji włączającej*, (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019, p. 23.

[15] R. Operetti, Z. Walker, Y Zhang, *Inclusive Education: from Targeting Groups and Schools to Achieving Quality Education as the Core of EFA*, (in:) *Sage Handbook of Special Education*, ed. L. Florian, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

[16] G. Szumski, *Koncepcja edukacji włączającej*, (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019.

cance, particularly the good cooperation of interdisciplinary teams, both at school and in a class.[17]

Even now, if there are pupils with disabilities in a class, in justified cases and in line with the rights with which they are vested, they may receive support of a personal assistant or a teacher's assistant. The case is similar in an inclusive school, where – on account of specific educational needs of pupils – teachers in cooperation with other para/ professionals are also responsible for the organisation of the process of learning. Whilst caring for the pupils, they are meant to pay attention to the best cooperation possible.[18]

Nevertheless, it turns out that the role and the presence of specialists in an inclusive school/ class is not unanimously considered to be ultimately defined or even necessary. *Special education teachers may induce educational helplessness in pupils, as well as be an obstacle in interactions with peers without disabilities. Very little is known about the actual need for specialists of this type in inclusive schools*.[19]

Various solutions are proposed in reference to the cooperation, for example in a model where two teachers work simultaneously with pupils (co-teaching) yet their tasks and levels of leadership and partnership may differ. Five types of cooperation are distinguished[20]:

---

[17] G. Szumski, Koncepcja edukacji włączającej, (in:) Edukacja włączająca w przedszkolu i szkole, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019, p. 22.

[18] Based on own observations carried out in March 2019 in one of the Finnish schools (in the Arctic Circle), in the second grade with 23 pupils, where eight were diagnosed with SPE – in line with the Finnish criteria, whereas other two required "increased attention" of the teacher. There were two teachers in the class, i.e. an early school education specialist and a special education teacher and two assistants. During the classes, close cooperation among all adults was noticeable, along with jointly undertaken interventions responding to the needs of different pupils.

[19] G. Szumski, Koncepcja edukacji włączającej, (in:) Edukacja włączająca w przedszkolu i szkole, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019, p. 21.

[20] L. A. Dieker, S. Powell, *Secondary Special Education and Inclusive Practices: Pitfalls and Potential for the Success of All*, (in:) *Sage Handbook of Special Education*, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014, pp. 666-667.

1) *leading teacher* and *supporting teacher*, applying more diversified strategies[21];
2) station teaching: every teacher works with a separate group of pupils at the so-called stations (e.g. thematic);
3) parallel teaching: teachers teach the same content in two small groups;
4) alternative teaching: division of a class into a larger and a smaller group; with respect to the smaller group, support consisting in re-teaching, pre-teaching and reinforcement is applied;
5) team teaching: both teachers have the same position and the same roles in a class (particularly recommended in integrated teaching).

Another form is collaborative teaching, which assumes negotiation of goals and meeting them in line with competence and a contract, not necessarily at the same place and time.[22]

Lisa A. Dieker and Selma Powell[23], referring to the aforementioned types of cooperation, focus on secondary schools and emphasise that it has not been ultimately determined whether in every case the second teacher in the class should be/ may be a special education teacher. The fundamental issue is his/ her substance-related and methodological preparation within the scope of a specific subject of teaching. However, the problem could be solved thanks to the performance of a specific HR policy, educating the future teachers and promoting, among the already working personnel, supplemental education in the area of special education, including inclusive

---

[21] In Poland, the role is assigned to the position of a teacher co-organising the educational process in an integrated team, with attention focused on pupils with SPE.

[22] L. A. Dieker, S. Powell, according to: J. Baran, *Kluczowe problemy w kreowaniu procesu edukacyjnego w klasie inkluzyjnej*, (in:) *Inkluzívne prístupy v edukacji detí a žiakov*, ed. V. Kušnírová, G. Vojteková, Verbum, Ružomberok, 2018, p. 234.

[23] L. A. Dieker, S. Powell, *Secondary Special Education and Inclusive Practices: Pitfalls and Potential for the Success of All*, (in:) *Sage Handbook of Special Education*, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

education[24] and pedagogical therapy with the aim of gaining specific qualifications and competence, as well as commencement of special subject studies by teachers. Such solution encounters barriers, for example financial and related to motivation. It is to be noted that the Finnish teachers have no problems with it, but the indisputable merit in this respect goes to the instruments that are applied and the state-funded acquisition of additional qualifications.[25]

On account of the clearly pronounced needs that result from individual differences among pupils and from requirements pertaining to the implementation of the process of teaching/ learning[26], it would be necessarily to seriously treat the models, but also the solutions (as, for example, in the Finnish school, as mentioned before), presuming the presence of the second teacher in an inclusive class, similarly to additional para/ professionals (e.g. assistants). Specific qualifications should account for the needs and the level of education of a team of pupils with whom such additional teachers are meant to work.

Pedagogical Therapy and Educational Facilitation: Joint Area for Pedagogical Activities Aimed at Helping the Pupils

In line with the legal document on the principles of organisation and offering of psychological and pedagogical support to pupils in

---

[24] I. Chrzanowska, G. Szumski, *Kompetencje zawodowe – jakie wyzwania*? (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019; B. Jachimczak, *Nauczyciel w edukacji włączającej*, (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019.

[25] E. Czujko-Moszyk, *Sukcesy fińskiego systemu edukacji, czyli dlaczego Finlandia szczyci się jednym z najlepszych systemów szkolnictwa na świecie – porównawcze studium przypadku*, *"Studia Edukacyjne"*, 2018, No. 48, pp. 349-365.

[26] G. Szumski, *Zróżnicowane grupy uczniów – jakie problemy?* (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019.

an educational facility[27], the basic support for a pupil takes place in a class, as part of daily work of a teacher that is integrated with activities of other specialists: "with the aim of supporting the development potential of a pupil and creation of conditions for his/ her active and full participation in the life of a kindergarten, a school or a facility and in the social environment."[28] In the entire document, apart from the term "psychological and pedagogical assistance" and "support", no other term is used in reference to the pupils. However, this last term, along with the concept of "facilitation" refers to teachers and parents with respect to whom these interventions, entrusted to specific specialists, have been envisaged. Furthermore, specialist classes listed in the above-quoted document[29] proposed as part of support are classes which can be attended by pupils with suspected disorders or diagnosed with specific disorders in development and problems with learning and functioning. They encompass specific therapeutic/ specialist interventions, proper for a given type of class from such category (i.e. speech therapy, remedial and compensatory classes, classes developing emotional and social competence and other types of therapeutic classes). It is worth drawing attention to the fact that competence entrusted to a specialist carrying out remedial and compensatory classes along with the name of the position i.e. pedagogical therapist may lead to the understanding that pedagogical therapy encompasses only activities carried out as part of remedial and compensatory activities and potentially the so-called

---

[27] Regulation of the Minister of National Education of 9 August 2017 on the principles of organising psychological and pedagogical assistance in public kindergartens, schools and institutions (Polish Journal of Laws [Dz.U.] of 28 August 2017, item 1591 as amended), p. 3.

[28] Regulation of the Minister of National Education of 9 August 2017 on the principles of organising psychological and pedagogical assistance in public kindergartens, schools and institutions (Polish Journal of Laws [Dz.U.] of 28 August 2017, item 1591 as amended), p. 1.

[29] Regulation of the Minister of National Education of 9 August 2017 on the principles of organising psychological and pedagogical assistance in public kindergartens, schools and institutions (Polish Journal of Laws [Dz.U.] of 25 August 2017, item 1591 as amended), p. 3.

"other therapeutic classes" (not specified in detail in the discussed Regulation). This obviously narrows down the understanding of pedagogical therapy. It may be considered conditionally permissible if a reservation is made about the indispensable knowledge of the broader context of the field of application and interventions of pedagogical therapy and specialists offering psychological and pedagogical assistance. Due to this, additional clarifications are necessary, along with expertise in defining and assessing the conceptual scope of pedagogical therapy and its methodology, taking into account the applied measures – at times greatly diversified, such as, for example, art therapy or therapy with the use of animals. Katarzyna Parys and Sławomir Olszewski wrote about the narrow understanding, based on the analysis of a text of Barbara Kaja, and following her trail of thought, they identified interventions of pedagogical therapy "with elimination of symptoms and decrease in difficulties and delays in learning, as well as disorders in the child's behaviour."[30] K. Parys and S. Olszewski refer the broad understanding[31] to various pedagogical interventions streamlining and supporting development of a person, i.e. as indicated in a statement by Anna Firkowska-Mankiewicz and Grzegorz Szumski: "it is every type of intervention used to create conditions supporting development."[32] A similar content pertaining to the broad understanding can be found in older reference books, in particular in the area of special education, which are also referenced by K. Parys and S. Olszewski[33]; by establishing a link

---

[30] K. Parys, S. Olszewski, Rozumieć chaos. Rzecz o terminach i znaczeniach im nadawanych w pedagogice specjalnej, Wydawnictwo Naukowe UP, Kraków 2016, p. 200.

[31] K. Parys, S. Olszewski, Rozumieć chaos. Rzecz o terminach i znaczeniach im nadawanych w pedagogice specjalnej, Wydawnictwo Naukowe UP, Kraków 2016, p. 200.

[32] A. Firkowska-Mankiewicz, G. Szumski, *Pedagogika specjalna i system kształcenia osób z niepełnosprawnościami w Polsce*, (in:) *Pedagogika specjalna, vol. 2, Podręcznik akademicki*, ed. D. D. Smith, Warsaw, Wydawnictwo Naukowe PWN, 2009, p. 331.

[33] K. Parys, S. Olszewski, Rozumieć chaos. Rzecz o terminach i znaczeniach im nadawanych w pedagogice specjalnej, Wydawnictwo Naukowe UP, Kraków 2016, pp. 200-204.

between the presence of a therapeutic aspect in the multi-dimensional pedagogical work carried out by a teacher/ teacher-supervisor in reference to the pupils requiring assistance in overcoming various types of difficulties – apart from indicating educational therapy – they also refer to the concept of therapeutic education.

Other modern studies pertaining to the issue analysed here also include the term Didactic Therapy.[34] The author of this concept notes that with respect to the interventions called in this way, "emphasis is put on the functioning of the mind, without any training in the strict sense of the term. The initiated interventions do not consist in exercises aimed at improving the rate of performance of mental operations, for example learning the speed reading or the use of mnemonic techniques. As part of Didactic Therapy, phenomenological training is carried out."[35] Three basic goals are determined for such training: accomplishing a status of interest in the environment, accomplishing a status of openness towards the environment and identification of values characterising a man's culture. Mere reference to the above-listed goals of Didactic Therapy allows for surmising that its main activities are aimed at development of a person in the sphere of his/ her self-consciousness, his/ her presence in the world and in a given culture, along with accomplishment of specific competence for making choices. And thus, Didactic Therapy does not aim directly at improving the educational situation of a pupil in the sense of remedy or compensation of disorders or difficulties at the school and daily-life functioning. In this sense, it goes beyond the framework of the issues related to pedagogical therapy that are discussed here.

Reaching to slightly older sources, yet another – albeit similar – term can be found in the study by Grażyna Szafraniec[36], who attracts

---

[34] Capital letters used in line with the author's specification, B. Trochimiak, cf. B. Trochimiak, *Terapia Dydaktyczna – założenia*, (in:) *Niepełnosprawność. Dyskursy pedagogiki specjalnej*, No. 11, 2013, pp. 123-138.

[35] B. Trochimiak, *Terapia Dydaktyczna – założenia*, (in:) *Niepełnosprawność. Dyskursy pedagogiki specjalnej*, No. 11, 2013, p. 123.

[36] G. Szafraniec, Terapia stosowana w nauczaniu – wychowanie terapeutyczne. Dokonania i perspektywy pedagogiczne, (in:) Wychowanie – Opieka – Wsparcie.

attention to the specific activities in pedagogical work, related to the understanding of the term psycho-pedagogical therapy and notes "that it should form a specific combination of psychological and pedagogical therapy."[37] Szafraniec clarifies: "Psychological therapy is aimed at rectifying development disorders with the use of psychological methods; it is an activity focused on the psychological aspect of the genesis, the mechanisms and the effects of development disorders. (…) Special combination of pedagogical and psychological therapy in line with the theory of learning interference consists in including, in the process of interaction between a therapist and child, the child's natural educational environments (families, school, peer groups). Thus, the psycho-pedagogical therapy is not only aimed at impacting the isolated subject of remedial impact, i.e. the child suffering from a development disorder, badly functioning in didactic situations, but it also results in the transformation of individual educational environments, in a direction most optimal for the main goals of remedial interventions."[38] In the light of the outlined understanding of the core of psycho-pedagogical activities, it is worth considering the premises for using this term instead of – or maybe interchangeably with – the concept of pedagogical therapy, bearing in mind common vs. similar goals and interventions assigned to them. Nevertheless, the diversity of the applied types of impacts cannot be overlooked here, which most frequently include: compensation,

---

Tradycje i doświadczenia polskiej pedagogiki oraz możliwości współczesnego wykorzystania, ed. M. Wójcik, Wydawnictwa Górnośląskiej Wyższej Szkoły Pedagogicznej, Mysłowice 2002, pp. 187-189.

[37] G. Szafraniec, Terapia stosowana w nauczaniu – wychowanie terapeutyczne. Dokonania i perspektywy pedagogiczne, (in:) Wychowanie – Opieka – Wsparcie. Tradycje i doświadczenia polskiej pedagogiki oraz możliwości współczesnego wykorzystania, ed. M. Wójcik, Wydawnictwa Górnośląskiej Wyższej Szkoły Pedagogicznej, Mysłowice 2002, pp. 188-189.

[38] G. Szafraniec, Terapia stosowana w nauczaniu – wychowanie terapeutyczne. Dokonania i perspektywy pedagogiczne, (in:) Wychowanie – Opieka – Wsparcie. Tradycje i doświadczenia polskiej pedagogiki oraz możliwości współczesnego wykorzystania, ed. M. Wójcik, Wydawnictwa Górnośląskiej Wyższej Szkoły Pedagogicznej, Mysłowice 2002, pp. 188-189.

correction, stimulation, improvement and even prevention[39], incorporated into the area of basic, not only pedagogical, impacts, the application and the understanding of which is very extensive. Namely, this refers to the assistance and support/ facilitation, as well as intervention.[40] All of them may refer to numerous areas of human life. After all, specification – as it takes place in the case of educational support/ educational facilitation (as discussed further) – allows for directing attention to specific entities: persons and environments along with expected impacts.

Educational and Specialist Support/ Facilitation

The discussion in the paper leads to a conclusion that in relation to the ongoing transformations in education and the expectations pertaining to the realisation of inclusive education and the position of specialists and special education teachers in facilities organising such education, the application of the term pedagogical therapy in reference to the specific educational interventions may raise a number of doubts, turn out to be problematic, controversial or

---

[39] Cf. K. Parys, S. Olszewski, Rozumieć chaos. Rzecz o terminach i znaczeniach im nadawanych w pedagogice specjalnej, Wydawnictwo Naukowe UP, Kraków 2016, pp. 200-202; W. Dykcik, Formy postępowania terapeutyczno-wychowawczego, (in:) Pedagogika specjalna, ed. W. Dykcik, Wydawnictwo Naukowe UAM, Poznań 2001, pp. 73-81; I. Czajkowska. K. Herda, Zajęcia korekcyjno-kompensacyjne w szkole, WSiP, Warsaw 1989, pp. 49-56.

[40] Cf. Regulation of the Minister of National Education of 9 August 2017 on the principles of organising psychological and pedagogical assistance in public kindergartens, schools and institutions (Polish Journal of Laws [Dz.U.] of 25 August 2017, item 1591), p. 1, G. Gajewska, Wsparcie dziecka w rozwoju. Konteksty opieki i edukacji, Oficyna Wydawnicza UZ, Zielona Góra 2009; Dykcik, Wprowadzenie w przedmiot pedagogiki specjalnej jako nauki, (in:) Pedagogika specjalna, ed. W. Dykcik, Wydawnictwo Naukowe UAM, Poznań 2001, p. 31; W. Dykcik, Zakres i przedmiot zainteresowań pedagogiki specjalnej, (in:) Pedagogika specjalna, ed. W. Dykcik, Wydawnictwo Naukowe UAM, Poznań 2001, p. 63; W. Dykcik, Formy postępowania terapeutyczno-wychowawczego, (in:) Pedagogika specjalna, ed. W. Dykcik, Wydawnictwo Naukowe UAM, Poznań 2001, pp. 73-81;

even harmful. An important argument is the fact that this term has been overused for a number of years in the pedagogical publications and pedagogical praxeology. Acknowledgement that nowadays it is used more often not so much in reference to the type of undertaken interventions, but with respect to a specific addressee[41] seems no longer adequate with respect to the postulated methodology of work in a diversified team of pupils and organisation of inclusive education. It is necessary to consider whether the content instilled in the concept of educational support/ facilitation does not advocate assigning this name to the tasks set for the teachers with respect to paying attention to all pupils, as well as the ones that are considered in need of greater care and incorporation of additional measures into work with them. On the other hand, in reference to the interventions of specialists that are meant to support the teachers in their daily work with a diversified team and individual pupils requiring intensified intervention and assistance, it would be advisable to use the term specialist educational support/ facilitation. It must also be noted that the sole understanding of support in reference to the thought formulated above, having the noun-based root, specifies the type of action, but it may also refer to individual, *ad-hoc* activities or short-term or occasional ones. On the other hand, facilitation should be understood as a certain process lasting over time and related to the additionally introduced, specific and intensified stages of educational work, systematic and subject to frequent evaluation, along with the monitoring of outcomes and modification of goals and a potential decision on partial or full withdrawal of facilitation if such goals have been met. Depending on the stage of operation, the educational support/ facilitation would first be offered by the teacher, followed by specialist support/ facilitation that accompanies the work of the teacher and has been entrusted to a specialist who is called the educational support specialist.

---

[41] K. Parys, S. Olszewski, Rozumieć chaos. Rzecz o terminach i znaczeniach im nadawanych w pedagogice specjalnej, Wydawnictwo Naukowe UP, Kraków 2016, p. 204.

It is worth adding that Wanda Hajnicz[42] examines the concept of educational support bearing in mind:

- educational activities for which the basic concepts and knowledge include: knowledge, skills, competence, process of learning, process of teaching, as well as implementation of processes, neurological foundations of learning, the zone of proximal development and the knowledge about efficient techniques of content presentation and collaboration in reaching the intended result;
- social support where the basic concept is support and resources.

Educational interventions as well as social support rely on and require active interaction of both entities of the teaching/ learning process, i.e. the teacher and pupil. "The expectations pertaining to what a given individual should learn and how the process of teaching should look like" underlie the educational interaction. "In the relation of support, such asymmetry is expressed in the resources held: the supported person does not have the sufficient resources at his/ her disposal in order to handle the task that he/ she has encountered; the task is difficult or too difficult for him/ her. The supporting person has at his/ her disposal the possibilities of supplementing the resources of the person who encountered such difficult or too difficult task. The supplementation is meant to allow the supported person to handle the difficulty."[43]

The content presented in the text pertaining to educational support is nothing new if practices that are in place in the countries with an advanced level of realisation of inclusive education are to be mentioned. Table No. 1 presents a comparative breakdown of selected examples, i.e. educational facilitation for pupils in the United States

---

[42] W. Hajnicz, Działania o charakterze wsparcia edukacyjnego, (in:) Indywidualne wsparcie edukacyjne, ed. W. Hajnicz, A. Konieczna, Wydawnictwo APS, Warsaw 2015, pp. 11-12.

[43] W. Hajnicz, Działania o charakterze wsparcia edukacyjnego, (in:) Indywidualne wsparcie edukacyjne, ed. W. Hajnicz, A. Konieczna, Wydawnictwo APS, Warsaw 2015, p. 12.

of America and Canada, Finland and the offer of psychological and pedagogical assistance in Poland.

Its purpose is to show not only the organisation of educational support for pupils, but also to highlight the types of interventions undertaken in this respect, as well as the terminology applied to them. The concept of *Response to Intervention* (RTI[44]) that functions in the western countries refers to a hierarchically (with respect to methodology and organisation) arranged sequence of activities supporting the pupil as part of three possible levels of work. Moving to the next level is related to the absence of outcomes accomplished in work with a pupil at a given level and a decision about increasing the intensity of interventions as part of the foreseen RTI procedures.

Table 1. Support models in selected countries (USA and Canada, Finland and Poland) in a general education/ inclusive school

Interventions/ procedures	**American model (USA, Canada) known as the RTI (response to intervention)**	**Finnish model**	**Polish model**
I level of support			
Types of interventions, applied terminology:	Basic instructions and strategies: preventive activities and activation of pupils	Basic support	Assistance, support
For whom?	All pupils	All pupils	All pupils
Venue:	Classroom	Classroom	Classroom
Responsible persons/ providers:	Teacher	Teacher aided by an assistant and an individual assistant (for the pupil) and special education teacher	Teacher

---

[44] The concept was prepared in the USA at the beginning of the 21st century, cf. P. M. Björn, M. Aro, T. Koponen, L. S. Fuchs, D. Fuchs, *Response-To-Intervention in Finland and the United States: Mathematics Learning Support as an Example*, (in:) *Frontiers in Psychology*, 2018, No. 9, pp. 1-10. https://doi.org/10.3389/fpsyg.2018.00800

Frequency:	On an ongoing basis, in every-day work with pupils, 45-90 minutes per day, depending on the level and area of education	On an ongoing basis, in every-day work with pupils	On an ongoing basis, in every-day work with pupils and as part of integrated activities of teachers, supervisors of educational groups and specialists
Control and evaluation of outcomes:	Monitoring on an ongoing basis and in line with the schedule of periodical tests	Monitoring on an ongoing basis and in line with the schedule of periodical tests	Monitoring on an ongoing basis and in line with the schedule of periodical tests[45]
Maximum time of performance:	Continuous, for some pupils together with level II and III	Not specified/ continuous	Not specified/ continuous
II level of support			
Types of interventions and applied terminology:	Strategic supplementary intervention adjusted to the needs of specific pupils – within the scope of manifested difficulties (SEN)	Intensified support	Psychological and pedagogical assistance in the form of educational and remedial classes, specialist classes and other therapeutic and revalidation classes.
For whom?	Pupils with SEN, manifesting evident difficulties, who fail to accomplish the expected outcomes (did not respond to the intervention) as part of level I (approx. 10% and 15% pupils)	Pupils with SEN; the decision about the offering of assistance is negotiated in a multi-disciplinary team for supporting the pupils and the pupil's parents	Pupils with SEN; decision about the offering of assistance is subject to the consent of the pupils' parents.

---

[45] Current provisions do not impose an obligation of documenting the efficiency of aid offered to pupils during ongoing work. However, they do not release the teachers from the obligation of observing the functioning of the pupils and ongoing modification/ adjustment of the modes of work with a given pupil during ongoing work. This means that also in this respect the teachers should verify whether the activities pursued by them produce the expected results. The class supervisor is responsible for the planning and coordination of support offered to pupils during ongoing work and as part of integrated activities of teachers and specialists (§ 20 Section 1-4 of Regulation of the Minister of National Education of 9 August 2017).

Venue:	Classroom, potentially work in smaller homogeneous separate groups	Classroom	Classroom and specialist's office at school and/ or in a psychological/ educational clinic
Responsible persons/ providers:	Teacher and specialist/s	Teacher aided by an assistant and an individual assistant (for the pupil) and special education teacher and other specialists	Teacher, special education teacher and other specialists
Frequency:	20-30 minutes, 3-5 times a week (in total, 60-90 minutes a week) apart from basic instructions and strategies as at level I	On an ongoing basis during educational classes	Adequately to the type of classes: 1-2 times a week
Control and evaluation of outcomes:	Monitoring of progress at least once every two weeks, maintenance of additional documents	On an ongoing basis and periodically	On an ongoing basis and periodically
Maximum time of performance:	Two rounds at 8-12 weeks are recommended with documented modifications of the applied strategies and measures for the purpose of full adjustment to the pupils' educational needs, carried out together with level I	Not specified, uninterrupted	Not specified, uninterrupted
	III level of support		
Types of interventions and applied terminology:	Intense intervention, adjusted to and based on up-dated data from the pupil's current diagnosis	Strongest form of support in learning that requires a formal administrative decision and an expert's report after completion in a multi-task group supporting pupils and parents	Intense support and psychological and educational assistance in pursuance of the individualised teaching path, specialist and other therapeutic classes or in a therapeutic class, requiring an in-depth diagnosis and an administrative decision upon the consent of the pupil's parents

For whom?	Pupils with evident difficulties who fail to accomplish the expected outcomes (*did not respond to the intervention*) as part of level 1 and 2 (1%-5%).	Pupils with serious difficulties in learning and behaviour	Pupils with serious difficulties/ disorders in learning resulting from disability or specific learning disorders
Venue:	Specialist's office, 1-5 pupils, homogeneous small groups or individual work	In class or during work in small therapeutic teams	Specialist's office, therapeutic class
Responsible persons/ providers:	Educational therapy specialist or other specialist	Teacher aided by an assistant and an individual assistant (for the pupil) and special education teacher and therapist	Special education teacher and therapist, teachers with additional qualifications (preparation within the scope of teaching pupils with specific learning difficulties working in a therapeutic class)
Frequency:	Not less than 30 minutes, 5 days a week, apart from basic instructions and strategies pursued at level I	Regularly, every day as part of educational classes	On an ongoing basis and periodically, depending on the place of classes, i.e. 1-2 hours a week with a specialist and/ or special education teacher in the office, as part of individual educational path – specified by the school headmaster
Control and evaluation of outcomes:	Weekly monitoring of progress with measures based on the curriculum	On an ongoing basis and periodically	On an ongoing basis and periodically
Maximum time of performance:	Long-term and regular work Pupils may be moved back to level II, after short-term goals from level III have been accomplished	Depending on the results of evaluation, return to a lower level is possible	Depending on the results of evaluation, return to a lower levels is possible

Source: author's own study based on: P. M. Björn, M. Aro, T. Koponen, L. S. Fuchs, D. Fuchs, *Response-To-Intervention in Finland and the United States: Mathematics Learning Support as an Example*, (in:) *Frontiers in Psychology*, 2018, No. 9, pp. 1-10. https://doi.org/10.3389/fpsyg.2018.00800,

M. Czarnocka, *Diagnoza – obszary, sposoby, narzędzia*, (in:) *Edukacja włączająca w przedszkolu i szkole*, ed. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warsaw 2019; E. Czujko-Moszyk, *Sukcesy fińskiego systemu edukacji, czyli dlaczego Finlandia szczyci się jednym z najlepszych systemów szkolnictwa na świecie– porównawcze studium przypadku*, "Studia Edukacyjne", 2018, No. 48, pp. 349-365; http://www.rtinetwork.org/, access 21.09.2020; Tyler ISD, *Response to Intervention. Operating Guideline Handbook 2012-2013*, USA, author's own materials: printout.

Recapitulation

The presented discussion and, simultaneously, the postulated interventions supporting the process of teaching/ learning together with a reflection on the terminology applied within the scope of psychological support and educational therapy trigger a discussion and attract attention to the decisions made by the ministry in this area. In the era of introduction, but also continuous searching for solutions for efficient organisation of inclusive education in Poland, the issues tackled here are of great importance.

References

Ainscow, M., *From Special Education to Effective Schools for All: Widening the Agenda,* (w:): (w:) Sage Handbook of Special Education, red. L. Florian, Sage, Los Angeles, London, New Delhi, Singapore, Washington D.C, 2014.

Baran J., Kluczowe problemy w kreowaniu procesu edukacyjnego w klasie inkluzyjnej, (w:) Inkluzívne prístupy v edukacji detí a žiakov, red. V. Kušnírová, G. Vojteková, Verbum, Ružomberok, 2018

Björn P. M., Aro M., Koponen T., Fuchs L.S., Fuchs D, *Response-To-Intervention in Finland and the United States: Mathematics Learning Support as an Example*, (w:) *Frontiers in Psychology*, 2018, nr 9, s. 1- 10. https://doi.org/10.3389/fpsyg.2018.00800.

Booth T., Ainscow M., Index for Inclusion. Developing Learning and Participation in Schools (3rd edition), Centre for Studies on Inclusive Education, Bristol UK 2011.

Chrzanowska I., Szumski G., Kompetencje zawodowe – jakie wyzwania? (w:) Edukacja włączająca w przedszkolu i szkole, red. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warszawa 2019;

Czarnocka M., Diagnoza – obszary, sposoby, narzędzia, (w:) Edukacja włączająca w przedszkolu i szkole, red. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warszawa 2019.

Czujko-Moszyk E., Sukcesy fińskiego systemu edukacji, czyli dlaczego Finlandia szczyci się jednym z najlepszych systemów szkolnictwa na świecie– porównawcze studium przypadku, „Studia Edukacyjne", 2018, nr 48, s. 349-365.

Dieker L. A., Powell S., Secondary Special Education and Inclusive Practices: Pitfalls and Potential for the Success of All, (w:) Sage Handbook of Special Education, Sage: Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

Dudley-Marling C., Burns M. B., Two Perspective on Inclusion in The United States. (w:) Global Education Review, 2014, vol.1, no.1. s. 14-31.

Dykcik W., Formy postępowania terapeutyczno-wychowawczego, (w:) Pedagogika specjalna, red. W. Dykcik, Wydawnictwo Naukowe UAM, Poznań 2001.

Dykcik W., Wprowadzenie w przedmiot pedagogiki specjalnej jako nauki, (w:) Pedagogika specjalna, red. W. Dykcik, Wydawnictwo Naukowe UAM, Poznań 2001.

Dykcik W., Zakres i przedmiot zainteresowań pedagogiki specjalnej, (w:) Pedagogika specjalna, red. W. Dykcik, Wydawnictwo Naukowe UAM, Poznań 2001.

Firkowska-Mankiewicz A. , Szumski G., *Pedagogika specjalna i system kształcenia osób z niepełnosprawnościami w Polsce*, (w:) Pedagogika specjalna, t. II, red. D. D. Smith, Wydawnictwo PWN, Warszawa, 2009.

Gajdzica Z., Zasady organizacji kształcenia w edukacjach inkluzyjnych uczniów z niepełnosprawnością (w:) Niepełnosprawność. Dyskursy Pedagogiki Specjalnej, 2019, nr 33, s. 26-39.

Gajewska G., Wsparcie dziecka w rozwoju. Konteksty opieki i edukacji, Oficyna Wydawnicza UZ, Zielona Góra 2009.

Hajnicz W., Działania o charakterze wsparcia edukacyjnego, (w:) Indywidualne wsparcie edukacyjne, red. W. Hajnicz, A. Konieczna, Wydawnictwo APS, Warszawa 2015,

Hart S., Drummond M. J., Learning Without Limits: Constructing a Pedagogy Free From Determinist Beliefs about Ability, (w:) Sage Handbook of Special Education, red. L. Florian, Sage, Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

Jachimczak B., Nauczyciel w edukacji włączającej, (w:) Edukacja włączająca w przedszkolu i szkole, red. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warszawa 2019;

Operetti, R., Walker, Z., Zhang, Y., Inclusive Education: From Targeting Groups and Schools to Achieving Quality Education as the Core of EFA. W: L. Florian. Sage Handbook of Special Education, Sage, Los Angeles, London, New Delhi, Singapore, Washington D.C., 2014.

Parys K., Olszewski S., Rozumieć chaos. Rzecz o terminach i znaczeniach im nadawanych w pedagogice specjalnej, Wydawnictwo Naukowe UP, Kraków 2016.

Rix J., Sheehy K., Nothing Special: The Everyday Pedagogy of Teaching (w:) Sage Handbook of Special Education, red. L. Florian, Sage, Los Angeles, London, New Delhi, Singapore, Washington D.C. 2014.

Rozporządzenie Ministra Edukacji Narodowej z dnia 9 sierpnia 2017 r. w sprawie zasad organizacji i udzielania pomocy psychologiczno-pedagogicznej w publicznych przedszkolach, szkołach i placówkach pedagogicznej (Dz. U. z dnia 25 sierpnia 2017 r., poz. 1591),

Szafraniec G., Terapia stosowana w nauczaniu – wychowanie terapeutyczne. Dokonania i perspektywy pedagogiczne, (w:) Wychowanie – Opieka – Wsparcie. Tradycje i doświadczenia polskiej pedagogiki oraz możliwości współczesnego wykorzystania, red. M. Wójcik, Wydawnictwa Górnośląskiej Wyższej Szkoły Pedagogicznej, Mysłowice 2002.

Szumski G., Koncepcja edukacji włączającej, (w:) Edukacja włączająca w przedszkolu i szkole, red. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warszawa 2019.

Szumski G., Zróżnicowane grupy uczniów – jakie problemy? (w:) Edukacja włączająca w przedszkolu i szkole, red. I. Chrzanowska, G. Szumski, Wydawnictwo FRSE, Warszawa 2019.

Trochimiak B., Terapia Dydaktyczna – założenia, (w:) Niepełnosprawność. Dyskursy pedagogiki specjalnej, nr 11, 2013, s. 123-138.

Tyler ISD, Response to Intervention. Operating Guideline Handbook 2012-2013, USA, materiały pozyskane własne: wydruk.

Winzer, M., Mazurek, K., *Views on Inclusive Schooling: A Critical Glance at Progress and Priorities*, (w:) *Chosen Topics of Supporting Persons with a Disability*, vol. 2, red. J. Baran, D. Baraniewicz, A., Ochman, Wydawnictwo Naukowe UP, Kraków, 2014.

Winzer, M., Ruch na rzecz integracji: zmiana paradygmatu czy historyczne następstwo? (w:) Dylematy pedagogiki specjalnej, red. A. Rakowska, J. Baran, Wydawnictwo Naukowe AP, Kraków 2000.

Zacharuk T., Edukacja włączająca szansą dla wszystkich uczniów, (w:) „Mazowiecki Kwartalnik Edukacyjny", nr 1 (20), s. 2-7.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Beata Borowska-Beszta*, Aleksandra Pakieła

Nicolaus Copernicus University, Poland
* ORCID 0000-0002-2133-4400

Acquired disability during foreign missions in male war veterans
Case study report of wives' voice

Abstract: Beata Borowska-Beszta, Aleksandra Pakieła, *Acquired disability during foreign missions in male war veterans. Case study report of wives' voice*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 137-171. Adam Mickiewicz University Press. ISSN 2300-391X . eISSN 2658-283X. DOI: https://doi.org/10.14746/ikps.2021.32.08

The article is a qualitative research report written from the theoretical perspective of disability studies. Qualitative research, case study, carried out for the purposes of this article, concerns learning about disabilities acquired in husbands a war veterans by their wives. The place of research is military culture, while the aim is to understand the essence of what wives learned about the disability of their husbands during the entire process of adaptation to life with a disability after returning from a mission, against the background of life in military culture. The theoretical part of the article contains a review of world literature with an emphasis on defining acquired disability. The very phenomenon of acquiring disability by veterans during military missions and its background, i.e. the anthropological phenomenon of culture shock, were analyzed. The empirical part of this article is a qualitative report of 3 case studies and 3 voices of war veterans' wives. The research question in this report was formulated as follows: What did the wives learn about the acquired disability of their own veterans' husbands after their return from military missions abroad? Research results generated after coding and categorization analyzes (Gibbs, 2011) indicate categories that answer the main research question and sub-questions in the following contexts: (a) acquired disability, (b) military support, (c) veterans' privileges (d) auto-marginalization of veterans (e) wives' infirmity, (f) alcohol and domestic violence, (g) before suicide, (h) wives suggesting changes in the support of veterans with acquired disabilities. The results of the analyzes indicate that the

IKPS 32, 2021: 137–171. © The Author(s), Adam Mickiewicz University Press, 2021.

wives learned about the symptoms and characteristics of their husbands' disabilities (mental and physical) and, additionally, they learned about the secondary disability (auto-marginalization, alcohol or drug addiction, domestic violence, escalation of suicidal thoughts) during adaptation after military missions.

Keywords: acquired disability, war veterans, males, learning, wives

Introduction

Foreign literature in the field of social and medical sciences as well as Polish indicate precisely the fields of difficulties experienced by war veterans after returning from foreign missions. These are i.a. complex psychological, psychiatric and health problems such as depression, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), chronic pain, substance addiction analyzed by Weiss and Albright[1], chronic diseases e.g. diabetes and hypertensive disease, described by McGeary, Ford, McCutchen and Barnes[2] orthopedic problems and visible, recognizable acquired disability including loss of arms or legs. Sometimes, the need for wheelchair use by veterans arises. This suggestion results from two reasons related to the acquired disability: firstly, males who acquire disability are members of the military culture community[3]-[4] and secondly, their acquired disability is strongly related to the cultural context of acquiring disability what means during foreign missions in cultures of Asia or the Middle East separate from

---

[1] E., L., Weiss, D., L., Albright *Introduction to the Special Issue: Mental Health Care for Military Service Members, Veterans, and Their Families: Opportunities for Social Work*, "Social Work in Mental Health", (2014), 12(5-6), pp. 387-390, DOI: 10.1080/15332985.2014.927408

[2] M., McGeary, M.,A., Ford, S.,R., McCutchen, D.,K., Barnes *A 21st century system for evaluating veterans for disability benefits*, "Committee on Medical Evaluation of Veterans for Disability Compensation" Board on Military and Veterans Health, 2007, pp 65–66.

[3] B., Borowska-Beszta, *Artefakty i technologia kultur wojskowych wspierająca weteranów z niepełnosprawnością*, „Kultura Współczesna", 2018, 3(102), s. 27-41.

[4] B., Borowska-Beszta, *Reedukacja weteranów z niepełnosprawnością nabytą–urazowym uszkodzeniem mózgu (TBI). Założenia teoretyczne i rozwiązania praktyczne*. "Niepełnosprawność. Dyskursy Pedagogiki Specjalnej", 2019, 34 s. 176-192.

European ones. For this reason, the theme of culture shock analyzed by Oberg[5]; Gullahorn and Gullahorn[6]; Irving[7]; Borowska-Beszta[8], Dutton[9] will be included in the following analyzes of the theoretical part. It should be noted that a research on acquired disability by war veterans during foreign missions is not sufficiently represented in Polish disability studies, special and social pedagogy or social work. The existing complexity of the life situation of families with war veterans is less known to educational researchers of adulthood and disability. These facts also became the reasons for the research and this report. The following research report covers 3 case studies and is located in military culture analyzed by Borowska-Beszta[10]-[11]. In addition, the intention of the researchers was, on the one hand, to generate a picture of the complex process of learning by wives about the husband's acquired disability in a given family, and the way of life with a war veteran. The empirical part of the research report presented in the article is based on raw data collected remotely in 2020 by the second author of this article as part of her master's thesis[12]. The second author of this

---

[5] K., Oberg, *Culture Shock.* Presentation to the Women's Club of Rio De Janeiro, 3. Aug, Brazil 1954.

[6] J., Gullahorn, J., Gullahorn, *An Extension of the U-Curve Hypothesis*, "Social Issues", 1963, 19 (3), pp. 33-47.

[7] R., Irwin, *Culture shock: negotiating feelings in the field*, „Anthropology Matters Journal" 2007, 1(9), pp. 1-11. https://www.anthropologymatters.com/index.php/anth_matters/article/view/64/124 (Accessed: 4. Apr 2021)

[8] Borowska-Beszta, B. *Anatema szoku kulturowego w andragogice specjalnej*, „Edukacja Otwarta" 2008, 2(2), s. 163–180.

[9] E., Dutton *Towards a Scientific Model of Culture Shock and Intercultural Communication*. "Journal of Intercultural Communication", 2011, 27, (Accessed 4.Apr. 2021) https://immi.se/intercultural/nr27/dutton.htm

[10] B., Borowska-Beszta, *Artefakty i technologia kultur wojskowych wspierająca weteranów z niepełnosprawnością*, „Kultura Współczesna", 2018, 3(102), s. 27-41.

[11] B., Borowska-Beszta, *Reedukacja weteranów z niepełnosprawnością nabytą–urazowym uszkodzeniem mózgu (TBI). Założenia teoretyczne i rozwiązania praktyczne.* "Niepełnosprawność. Dyskursy Pedagogiki Specjalnej", 2019, 34 s. 176-192.

[12] A., Pakieła *Weterani wojenni z niepełnosprawnością nabytą w opiniach żon. Trzy studia przypadków.* Niepublikowana praca magisterska. Wydział Filozofii i Nauk Społecznych, UMK w Toruniu 2020.

article has also prepared an answer to the detailed research question 1.2. concerning military support (category 2) and veteran privileges (category 3). This report is based on a review of the literature, theoretical analyzes, assumptions of the research project, analyzes of the generated categories (1,4,5,6,7,8) and codes as well as the conclusions of the research conducted by the first author of the article. The text of the report is preceded by the theoretical part, taking into account the definition of the issues of acquired disability, adaptation of veterans to disability, analysis of the phenomenon of culture shock, and selected theoretical threads of the problems of family functioning. The empirical part of this report includes details of the research assumptions, a description of the purposive sample, data collection assumptions and analyzes, a discussion of the conditions of triangulation, the results with conclusions and, moreover, suggestions for pedagogical support and social workers of families and veterans having acquired disabilities.

Acquired disability and cultural shock as a contexts of veterans return from missions

Acquired disability is a broad category that includes disabilities that have been acquired by humans in the life cycle as a result of external traumatic or disease factors. According to Dunn and Brody "«acquired physical disability» covers a wide range of disabilities resulting from injury or disease; thus, the loss of a limb due to an accident at work or eye damage due to a brain tumor falls under this category, as do the mental and physical consequences of depression following a stroke or myocardial infarction"[13]. An acquired disability is, inter alia, acquired brain injury (ABI) or traumatic brain injury (TBI). ABI according to the Australian Institute of Health (AIHW) is the occurrence of "<< multiple disabilities resulting from damage to the brain

---

[13] D., S., Dunn, C., Brody, *Defining the Good Life Following Acquired Physical Disability* "Rehabilitation Psychology" 2008, 53 (4), p. 413.

acquired after birth >>"[14]. Various causes of ABI include head trauma or lack of oxygen to the brain's blood vessels as a result of the injury; a disease, infection, stroke or tumor affecting the brain; or long-term substance abuse[15]. According to Rushworth[16], acquired brain injury is sometimes described as "hidden disability" because the related brain injury is not visible and difficult to identify. Tallman and Hoffman[17] indicate the following acquired disabilities "eye damage, spinal cord injury (SCI), traumatic brain injury (TBI), amputation, burns, pain conditions and cardiac incidents"[18]. Dorsett adds that acquired disability, associated with spinal cord injury (SCI), causes additional health and social complications. The author adds that the acquisition of a disability results in both body paralysis, dependence and the need to use a wheelchair, changes in body functions, as well as changes in life roles[19]. Lejzerowicz and Tomczyk[20] after Brzezińska[21]

---

[14] Australian Institute of Health and Welfare, (AIHW) 2007. Disability in Australia: Acquired Brain Injury. Cat. No. 96. https://www.aihw.gov.au/reports/disability-services/disability-australia-acquired-brain-injury/contents/table-of-contents. Australian Institute of Health and Welfare, p. 2.

[15] Australian Institute of Health and Welfare, (AIHW) 2007. Disability in Australia: Acquired Brain Injury. Cat. No. 96. https://www.aihw.gov.au/reports/disability-services/disability-australia-acquired-brain-injury/contents/table-of-contents. Australian Institute of Health and Welfare, p. 2.

[16] N., Rushworth, *Out of Sight, Out of Mind: People with an Acquired Brain Injury and the Criminal Justice System. Brain Injury* Australia 2011 https://www.braininjuryaustralia.org.au/wp-content/uploads/CJSpolicypaper FINAL.pdf. (Accessed 4. Apr 2021)

[17] B., A., Tallman, A., C., Hoffman, *Meaning making concerning acquired disability* In E. M. Altmaier (Ed.), "Reconstructing meaning after trauma: Theory, research, and practice", 2017, pp. 133–151. Elsevier Academic Press.

[18] B. A., Tallman, A., C., Hoffman, *Meaning making concerning acquired disability* In E. M. Altmaier (Ed.), "Reconstructing meaning after trauma: Theory, research, and practice", 2017, pp. 133–151. Elsevier Academic Press, p. 140.

[19] P., Dorsett, *The Importance of Hope in Coping with Severe Acquired Disability*, "Australian Social Work", 2010, 63(1), p 83.

[20] M., Lejzerowicz, D., Tomczyk *Acquired disability: self-esteem and identity integration*, "Polish Psychological Bulletin" 2018, 49(2), pp. 262–271 DOI – 10.24425/119494

[21] A., Brzezińska, *Dzieciństwo i dorastanie: korzenie tożsamości osobistej i społecznej [Childhood and adolescence: the roots of personal and social identity.* In: A. Brzezińska,

also emphasize the social aspect of acquired disability, i.e. the emergence of dependence on other people. The authors write that "accidents or diseases causing disability give a whole new dimension to the existing living conditions. A person who suddenly fell ill becomes seriously dependent on others, often unable to live independently, thus experiencing a lack of autonomy and integrity."[22] Summarizing the above definitions, it should be indicated that the acquired disability may be visible or invisible and, consequently, causes two types of effects that model the further life of a person with acquired disability. These are health effects related to health and the need for rehabilitation (medical, psychological) and re-education as well, analyzed by Borowska-Beszta[23]. Additionally, acquired disability has social consequences, such as changing one's own autonomy into dependence on other people and changing social roles. Most often, people, including war veterans, who acquire disabilities lose their previous professional privileges, e.g. able-bodied soldiers and their current social position.

Thinking about war veterans, as members of family, and also part of a broad military culture (dominated by hegemonic masculinity) – Borowska-Beszta[24] indicates that the state of acquired disability provokes in previously fit or ultra-fit and healthy males, loss of the valued value of this culture – fitness and health, and it causes a change in the body image. Males who become veterans remain in military culture after returning from missions, but in changed roles, related to the loss of professional position and social privileges of healthy soldiers, and in a changed autonomy to greater dependence. After soldiers with acquired disabilities return from their missions, a difficult process of adaptation takes place in the subjective dimen-

---

A. Hulewska, & J. Słomska (Ed.), „Edukacja regionalna" [Regional Education], Wydawnictwo Naukowe PWN, Warszawa 2006, s. 47–77.

[22] M., Lejzerowicz, D., Tomczyk *Acquired disability: self-esteem and identity integration*, "Polish Psychological Bulletin" 2018, 49(2), DOI – 10.24425/119494 p. 263.

[23] B., Borowska-Beszta, *Reedukacja weteranów z niepełnosprawnością nabytą–urazowym uszkodzeniem mózgu (TBI). Założenia teoretyczne i rozwiązania praktyczne*. "Niepełnosprawność. Dyskursy Pedagogiki Specjalnej", 2019, 34 s. 176-192.

[24] B., Borowska-Beszta, *Artefakty i technologia kultur wojskowych wspierająca weteranów z niepełnosprawnością*, „Kultura Współczesna", 2018, 3(102), s. 27-41.

sion: (a) to their own disability and (b) to family life in families to which the veterans return from missions, cultural, (c) military culture and professional environment, and to (d) the cultures of origin after returning, e.g. from a mission in Asia or the Middle East. A veteran, therefore, experiences a complex process of subjective adaptation to own acquired disability, body image, and cultural adaptation. This means re-adaptation in the culture of origin in the micro-cultural (family, friends) and macro-cultural (military culture, homeland) dimensions. The first process, the *subjective adaptation* of a veteran, is discussed by the authors who analyze the issue of the effects of acquiring given types of disability as a result of traumatic events, e.g. traumatic brain injury (TBI). Jacobs et al. associate the acquired disability of veterans after traumatic brain injury (TBI) with the effects of: deformation of sensory and cognitive functioning, problems in the motor and emotional sphere, personality changes or depression.[25] In addition, traumatic brain injury (TBI) can cause permanent effects in the form of epilepsy as mention Englander, Cifu, and Diaz-Arrastii[26]. The second, the process of *cultural adaptation* of the veteran, accompanies the former and thus the situation of a veteran with an acquired disability on a foreign mission is more complex than if the veteran became disabled in the culture of origin. The process can be illustrated as follows: (1) going on a mission to Asia or the Middle East, (2) acquiring a disability in the battlefield in a foreign culture, (3) returning to the culture of origin and adaptation to life in a family, military culture and homeland. These three stages that constitute the background of the acquisition of disability by a veteran are often accompanied by a culture shock, which may occur both when adapting to a separate culture in which military ac-

---

[25] K., Jacobs, L., A., Hendricksc D., J., Sampsonc E., Nardonea A., Lopezd K.B., Rumrilld P., Staufferd C., Eliasb E., Scherere M., Dembed J. *Project Career: Perceived benefits of iPadapps among college students with Traumatic Brain Injury (TBI)*, "Work" 2017, 58, pp. 45–50, https://content.iospress.com/download/work/wor 2596?id=work%2Fwor2596 (Accessed 15.05.2018) p. 46.

[26] J., Englander, D., Cifu, R., Diaz-Arrastii *Seizures after Traumatic Brain Injury*, "Arch Phys Med Rehabil.", 2014, 95 (6), pp. 1223–1224.

tivities are carried out, and after returning to the culture of origin – country. Culture shock is researched and analyzed for years. The process of culture shock as an anthropological phenomenon was illustrated by anthropologists, ranging from Oberg[27] to Irving[28] and Dutton[29], indicating its characteristics and stages. For Irving, culture shock may or may not be a disease. The author writes:

> Culture shock is not necessarily an acute illness. The 'shock' refers to the rapidity of the physical movement, but the emotions and feedback emotions may occur over a relatively long period of time. There are myriad symptoms and signs of culture shock, including general unease with new situations, irrational fears, difficulty with sleeping, anxiety and depression, homesickness, preoccupation with health, and feeling sick or nauseous. Simply stated, any sort of mental or physical distress experienced in a foreign location could be a symptom of culture shock[30].

Significant remark was made by Dutton[31] after Gullahorn and Gullahorn[32], who indicated the clear phases of culture shock previously described by Oberg[33] and emphasized that culture shock also manifested during adaptation to one's own culture after returning

---

[27] K., Oberg, *Culture Shock.* Presentation to the Women's Club of Rio De Janeiro, 3. Aug, Brazil 1954.

[28] R., Irwin, *Culture shock: negotiating feelings in the field*, „Anthropology Matters Journal" 2007, 1(9), pp. 1-11. https://www.anthropologymatters.com/index.php/anth_matters/article/view/64/124 (Accessed: 4. Apr 2021)

[29] E., Dutton *Towards a Scientific Model of Culture Shock and Intercultural Communication.* "Journal of Intercultural Communication", 2011, 27, (Accessed 4.Apr. 2021) https://immi.se/intercultural/nr27/dutton.htm

[30] R., Irwin,*Culture shock: negotiating feelings in the field*, „Anthropology Matters Journal" 2007, 1(9), pp. 1-11. https://www.anthropologymatters.com/index.php/anth_matters/article/view/64/124 (Accessed: 4. Apr 2021) p.2.

[31] E., Dutton *Towards a Scientific Model of Culture Shock and Intercultural Communication.* "Journal of Intercultural Communication", 2011, 27, (Accessed 4.Apr. 2021) https://immi.se/intercultural/nr27/dutton.htm

[32] J., Gullahorn, J., Gullahorn, *An Extension of the U-Curve Hypothesis*, "Social Issues", 1963, 19 (3), pp. 33-47.

[33] K., Oberg, *Culture Shock.* Presentation to the Women's Club of Rio De Janeiro, 3. Aug, Brazil 1954.

home, calling it "reverse culture shock". Coll, Weiss, and Yarvis[34] emphasize, however, that some soldiers will return from missions with problems far more than culture shock. According to the authors, these will be physical disabilities, acquired on the battlefield, and sometimes less visible and hidden, but present emotional or psychiatric disorders. The authors emphasize post-traumatic stress disorder (PTSD) as a particularly destructive phenomenon diagnosed in veterans. PTSD – post-traumatic stress disorder, if not supported by professionals in the field of psychology or psychiatry, may, according to Coll, Weiss and Yarvis[35] or Weiss and Albright[36], cause a veteran's desire to help himself, by consuming excessive alcohol and drug use. After returning to their families, veterans with acquired (visible or hidden) disabilities have various personal problems, e.g. already indicated health, sexual problems, as Breyer et al.[37] mention, and often family, home problems[38]. Breyer et al.[39] writing about the sexual problems of veterans indicates a certain mechanism of PTSD treatment related to the sexual dysfunctions of veterans.

---

[34] J., E., Coll, E., L., Weiss, J., S., Yarvis, *No one leaves unchanged. Insights for civilian mental health care professionals into the military experience and culture*. "Social Work in Health Care", 2011, 50 (7), pp.487-500.

[35] J., E., Coll, E., L., Weiss, J., S., Yarvis, *No one leaves unchanged. Insights for civilian mental health care professionals into the military experience and culture*. "Social Work in Health Care", 2011, 50 (7), pp.487-500.

[36] E., L., Weiss, D., L., Albright *Introduction to the Special Issue: Mental Health Care for Military Service Members, Veterans, and Their Families: Opportunities for Social Work*, "Social Work in Mental Health", (2014), 12(5-6), pp. 387-390, DOI: 10.1080/15332985.2014.927408

[37] B., N., Breyer, B., E., Cohen, D., Bertenthal, R., C., Rosen, T., C., Neylan, K., H., Seal, *Dysfunction in Male Iraq and Afghanistan War Veterans: Association with Posttraumatic Stress Disorder and Other Combat-Related Mental Health Disorders: A Population-Based Cohort Study*. "J Sex Med." 2014, 11, pp. 75–83.

[38] Lambert, S. M., Morgan, Michael M., *Supporting Veterans and Their Families: A Case Study and Practice Review*. "The Family Journal: Counseling And Therapy For Couples And Families", 2009, 17(3), pp. 241-250 Doi: 10.1177/1066480709337800.

[39] B., N., Breyer, B., E., Cohen, D., Bertenthal, R., C., Rosen, T., C., Neylan, K., H., Seal, *Dysfunction in Male Iraq and Afghanistan War Veterans: Association with Posttraumatic Stress Disorder and Other Combat-Related Mental Health Disorders: A Population-Based Cohort Study*. "J Sex Med." 2014;1, pp. 75–83.

"Being prescribed psychiatric medications appeared to significantly increase the risk of sexual dysfunction with the greatest risk in veterans with PTSD"[40]. Hutchinson, Banks-Williams[41] and Lambert and Morgan[42] describe the problems that arise after returning home and family as follows:

> „upon returning home, veterans often feel less ''at-home'' than they or their families expect. They have to adjust and find their place in a system that has learned to function without them while they were gone. Family members often ask if they have killed anyone and seem overly cautious in their approach to the returning soldiers" (Hutchinson and Banks-Williams[43], in Lambert and Morgan[44]).

The authors indicate that during home adaptation, PTSD veterans abuse more verbal and physical violence in families[45] than veterans without PTSD. The authors Hutchinson and Banks-Williams[46]

---

[40] B., N., Breyer, B., E., Cohen, D., Bertenthal, R., C., Rosen, T., C., Neylan, K., H., Seal, *Dysfunction in Male Iraq and Afghanistan War Veterans: Association with Posttraumatic Stress Disorder and Other Combat-Related Mental Health Disorders: A Population-Based Cohort Study*. "J Sex Med." 2014;1, p 81.

[41] J., Hutchinson, L., Banks-Williams, *Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan*, "Primary Psychiatry", 2006, 13, 66-71.

[42] S. M., Lambert, M., Morgan, *Supporting Veterans and Their Families: A Case Study and Practice Review*. "The Family Journal: Counseling And Therapy For Couples And Families", 2009, 17(3), pp. 241-250 Doi: 10.1177/1066480709337800.

[43] J., Hutchinson, L., Banks-Williams, *Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan*, "Primary Psychiatry", 2006, 13, 66-71.

[44] S. M., Lambert, M., Morgan, *Supporting Veterans and Their Families: A Case Study and Practice Review*. "The Family Journal: Counseling And Therapy For Couples And Families", 2009, 17(3), p. 245 Doi: 10.1177/1066480709337800.

[45] J., Hutchinson, L., Banks-Williams, *Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan*, "Primary Psychiatry", 2006, 13, 66-71.

[46] J., Hutchinson, L., Banks-Williams, *Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan*, "Primary Psychiatry", 2006, 13, 66-71.

and Lambert and Morgan[47] emphasize that family members, spouses, partners of a veterans who returned home experience anxiety, exclusion from friendly groups, experience helplessness when it comes to understanding the veteran, hopelessness, depression and problems related to parental functions. Lambert and Morgan conclude that "soldiers' coping skills can quickly become taxed and the often aggressive, violent, or isolating behaviors that they reactively employ can effectively distance the people that they need most for support and healing."[48]

To sum up, the life of a veteran with an acquired disability becomes a difficult path of subjective and complex adaptation to one's own culture of origin, family and adaptation to the changed status of a veteran a lower position in the military professional culture. This configuration creates a picture of the multi-context and difficult life situation of a veteran with an acquired disability and his family. The whole process of difficult adaptation to the acquired disability involves both family members: wives and children. The complicated situation of families with veterans who returned from the mission is described abroad. Among others Weiss and Albright[49], pointing to problems related to veterans' addiction to substances. Additionally, there are problems of a sexual nature, mentioned previously[50] and a tense family home situation may be-

---

[47] S. M., Lambert, M., Morgan, *Supporting Veterans and Their Families: A Case Study and Practice Review*. "The Family Journal: Counseling And Therapy For Couples And Families", 2009, 17(3), pp. 241-250 Doi: 10.1177/1066480709337800.

[48] S. M., Lambert, M., Morgan, *Supporting Veterans and Their Families: A Case Study and Practice Review*. "The Family Journal: Counseling And Therapy For Couples And Families", 2009, 17(3), p. 245. Doi: 10.1177/1066480709337800.

[49] E., L., Weiss, D., L., Albright *Introduction to the Special Issue: Mental Health Care for Military Service Members, Veterans, and Their Families: Opportunities for Social Work*, "Social Work in Mental Health", (2014), 12(5-6), pp. 387-390, DOI: 10.1080/15332985.2014.927408

[50] B., N., Breyer, B., E., Cohen, D., Bertenthal, R., C., Rosen, T., C., Neylan, K., H., Seal, *Dysfunction in Male Iraq and Afghanistan War Veterans: Association with Posttraumatic Stress Disorder and Other Combat-Related Mental Health Disorders: A Population-Based Cohort Study*. "J Sex Med." 2014, 1, pp. 75–83.

come a place of escalation of domestic violence[51]-[52]. Difficult and complicated family situations, escalation of helplessness and constant refusal to accept help or the lack of professional support may end for a veteran with homelessness is analyzed by Byrne and Taglia[53], Kropkowska and Borowska-Beszta[54] or suicide, described by Kang and Bullmann[55] Rozanov and Carli[56], Weiss and Albright[57], Hester[58] and Peterson et.al[59] 2020). The authors, Kang and Bullman write that in the case of the suicides of veterans of the Iraq war, "the most common methods of suicide were by firearm (73%) and by hanging (21%)"[60]. The above analyzes indicate that veterans

---

[51] J., Hutchinson, L., Banks-Williams, *Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan*, "Primary Psychiatry", 2006, 13, 66-71.

[52] E., L., Weiss, D., L., Albright *Introduction to the Special Issue: Mental Health Care for Military Service Members, Veterans, and Their Families: Opportunities for Social Work*, "Social Work in Mental Health", (2014), 12(5-6), pp. 387-390, DOI: 10.1080/15332985.2014.927408

[53] T., Byrne, D., Treglia, D., Culhane, J., Kuhn, V., Kane, *Predictors of Homelessness Among Families and Single Adults After Exit From Homelessness Prevention and Rapid Re-Housing Programs: Evidence From the Department of Veterans Affairs Supportive Services for Veteran Families Program*, "Housing Policy Debate", 2016, 26, (1), pp. 252-275, DOI: 10.1080/10511482.2015.1060249

[54] J., Kropkowska, B., Borowska-Beszta, *Mężczyźni bezdomni o aktywnościach codziennych: Etnograficzne studia przypadków*. „Niepełnosprawność. Dyskursy Pedagogiki Specjalnej" (tekst w toku wydawniczym) 2021.

[55] H.,K., Kang, T.,A., Bullman, *Risk of suicide among US veterans after returning from the Iraq and Afghanistan war zones*. „JAMA" 2008, 300, pp. 652–653.

[56] V., Rozanov, V., Carli *Suicide among War Veterans*. "Int. J. Environ. Res. Public Health", 2012, 9, pp. 2504-2519 doi:10.3390/ijerph9072504

[57] E., L., Weiss, D., L., Albright *Introduction to the Special Issue: Mental Health Care for Military Service Members, Veterans, and Their Families: Opportunities for Social Work*, "Social Work in Mental Health", (2014), 12(5-6), pp. 387-390, DOI: 10.1080/15332985.2014.927408

[58] Hester R., D., *Effective Strategies to Combat High Suicides and Trauma Among American Veterans*. "J Trauma Treat" 2017, 6, pp. 1-3. doi: 10.4172/2167-1222.1000403

[59] A., Peterson, M., Bozzay, A., Bender, M., Monahan and J., Chen *Those left behind: A scoping review of the effects of suicide exposure on veterans, service members, and military families*, "Death Studies" 2020, pp. 1-10. DOI: 10.1080/07481187.2020.1802628

[60] H.,K., Kang, T.,A., Bullman, *Risk of suicide among US veterans after returning from the Iraq and Afghanistan war zones*. „JAMA" 2008, 300, p. 652.

and their families experience serious family crises in the process of adapting to an acquired disability, which may end for a veteran with the unfortunate outcome of e.g. homelessness or suicide. At the same time, the lives of family members, wives, and children experiencing an escalation of mental and physical domestic violence by a veteran are analogously complicated and difficult.

The following empirical part of the article, a report on qualitative research, is a case study of learning about an acquired disability in 3 veterans by their wives. The empirical part is grounded in anthropological thinking about the community, the army, and treats it as a military culture described by Borowska-Beszta[61]-[62]. Adapting Schein's[63] model – military culture, like professional organizational culture, contains artifacts (material, linguistic, behavioral), values, norms and assumptions deeply hidden in structural layers. The following research report is written from the perspective of pedagogical disability studies, it points to the theoretical conclusions to research on disability in military culture, as well as recommendations for educators and social workers to work with military families.

Research design and Method

The main purpose of this report on qualitative research, based on suggestions by Flick[64]-[65] and Silverman[66] and the case study method

---

[61] B., Borowska-Beszta, *Artefakty i technologia kultur wojskowych wspierająca weteranów z niepełnosprawnością*, „Kultura Współczesna", 2018, 3(102), s. 27-41.

[62] B., Borowska-Beszta, *Reedukacja weteranów z niepełnosprawnością nabytą–urazowym uszkodzeniem mózgu (TBI). Założenia teoretyczne i rozwiązania praktyczne*. "Niepełnosprawność. Dyskursy Pedagogiki Specjalnej", 2019, 34 s. 176-192.

[63] E., H., Schein, *Organizational Culture and Leadership*. Jossey-Bass, San Francisco 2004.

[64] U., Flick, *Projektowanie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2010.

[65] U., Flick, *Jakość w badaniach jakościowych*. Wydawnictwo Naukowe PWN, Warszawa 2011.

[66] D., Silverman *Prowadzenie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2008.

by Yin[67], is to learn and understand the knowledge acquired by 3 wives about the disability of 3 husbands war veterans, against the background of the process of adaptation of veterans. Therefore, in this research report, the following main research and detailed questions will be answered:

1. What did the wives learn about the acquired disabilities of their own veterans' husbands after their return from missions abroad?

In addition to the needs of this report, detailed research questions have been formulated:

Detailed research questions were formulated as follows:

1.1. What acquired disabilities were revealed in the veterans?
1.2. What military support did the veterans receive?
1.3. What areas of infirmity have revealed in family life?
1.4. What preceded veterans' suicides?
1.5. What changes in support, according to wives, should be made in the structures of the military to prevent suicide of veterans?

Purposive sample and data collection

Data for 3 case studies were collected with 3 wives of war veterans, Poles who acquired a disabilities during foreign military missions in Afghanistan and the Middle East, i.e. in areas affected by global military conflicts. Data collection was performed remotely using Skype in May 2020, during the ongoing Covid-19 pandemic and quarantine in Poland. The interviews were conducted and the data was collected by the second author of this article, in accordance with the methodological procedure of Flick[68]. Recruitment of Informants 1,2,3 for interviews was based on the 'snowball' strategy by Maxwell[69]. Personal data of

---

[67] R., K., Yin, *Studium przypadku w badaniach naukowych. Projektowanie i metody* Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2015.

[68] U., Flick, *Projektowanie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2010.

[69] J., A., Maxwell, *Qualitative Research Design: An Interactive Approach, Applied Social Research Methods Series*, SAGE, London 1996

the informants were coded as: Informant1, Informant2, Informant3. Deeper coding assumed coding and anonymizing the age of informants, the shape of the family, and place of residence in Poland. The husbands' age, rank, time spent on missions as well as geographical details and locations of veterans during foreign missions in Asia and the Middle East have been also anonymized. We only inform that these were missions in Afghanistan and the Middle East. The data that we indicate as important for the research illustrate the emphasis by the Informants 1,2,3 that their husbands participated in more than one foreign mission and that their disability was acquired during the next, for example, 2nd or 3rd missions. The data collection procedure included the pre-interviewing of online interviews with telephone conversations with the Informants 1,2,3. Data collection was carried out using the Skype communicator, in accordance with the created matrix of a partially structured interview[70]. We want to emphasize that collecting data on learning about acquired disability in husbands revealed an additional background. Firstly, the purposive sample, consisting of 3 Informants, turned out to be an attempt with a higher degree of difficulty in collecting data on acquired disability, which the Informants1,2,3 indirectly indicated as the background to the reality of the functioning of military culture. This means that the issue of the health of husbands who acquired disability in military culture was a delicate topic, related to the specificity of access to information about the life of military families, where especially the issues of husbands' work are tabooed and kept silent, in accordance with the internal norms of military culture. It happens that the lifestyle of military families is also silenced, especially where there is a crisis, e.g. in the case of alcohol use etc. Secondly, the case studies included the Informants 1,2,3 whose husbands, after returning from the mission, committed suicide in the given process of adaptation to disability. We would like to point out that the recruitment of 3 Informants whose disabled husbands committed suicide (after returning from the mis-

---

[70] S., Kvale, *Prowadzenie wywiadów*. Wydawnictwo Naukowe PWN, Warszawa 2010.

sion) was not the key to selecting the purposive sample, but it was revealed during the collection of data, thanks to the 'snowball' technique of interviewing 3 Informants whose husbands returned from foreign missions and manifested acquired disability. The data collection process revealed, inter alia, that the husband – of Informant1, manifested mental disorders after returning from the mission (depression, anxiety, persecutory thoughts), the husband of Informant2 acquired a serious leg injury during a foreign mission ("the gunshot almost torn his leg apart"), while Informant's3 husband lost his hand during a foreign mission. The above configuration of factors meant that the Informants1,2,3 revealed some tensions in general related to the disclosure of data about the military and the process of adaptation of husbands to the life of a veteran with an acquired disability. However, Informants 1, 2, 3 gave interviews stressing that they hope their voices will be heard. Informant1 stated, for example, that this is "the first time someone asks her and is interested in her opinion about her husband with an acquired disability". Informant3 stated, "I am very grateful that I can tell this story" (Informant3). Data collection was conducted in a calm, tactful manner, and discussions were conducted with respect to the boundaries of content disclosure, in line with the methodologists' recommendations as Silverman[71], Denzin and Lincoln[72], Flick[73], Kvale[74] and Rapley[75]. What characterized the manner of expression by Informants 1,2,3 was related to the regulation of the disclosed content about disability in military culture. 3 Informants mentioned that they were unable to open up to third parties (from outside

---

[71] D., Silverman *Prowadzenie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2008.

[72] N., K., Denzin, Y., S., Lincoln *Wprowadzenie. Dziedzina i praktyka badań jakościowych*, w: „Metody badań jakościowych", red. N. Denzin i Y. Lincoln, Wydawnictwo Naukowe PWN, Warszawa 2009, T.1 2009, s. 19-57.

[73] U., Flick, *Projektowanie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2010.

[74] S., Kvale, *Prowadzenie wywiadów*. Wydawnictwo Naukowe PWN, Warszawa 2010.

[75] T., Rapley, *Analiza konwersacji, dyskursu i dokumentów*. Wydawnictwo Naukowe PWN, Warszawa 2010.

the military culture) because, as they said, "they are afraid of the consequences" that the "state" could draw from the conversations. Such attention was also respected during data collection, where the limits of the depth of data disclosure and the limits of transcription were set by the Informants 1,2,3 themselves. The data, as we mentioned, was collected by the second author of this article, taking into account the respect of the ethics of data collection[76]. Each Informant read the research consent form and gave her verbal consent to collect the data, according to Green and Bloome[77]. The consent form[78]-[79] contained the purpose of data collection, information on the purpose of the data. In addition, the conditions for the participation of each Informant 1,2,3 and the anonymization of personal data have been precisely defined. The deeper data coding level was ensured, and the handling of the collected materials, used to write the research report, was defined. The audio data was destroyed after the transcription was performed.

Analysis, Credibility and Limitations

Data from the transcription of 3 interviews was analyzed using the coding and categorization technique, according to Gibbs[80]. The coding, categorization and interpretation in this research report were done on transcripts by the first author of this article. The credibility of qualitative research and case studies was ensured thanks to the triangulation

---

[76] T., Rapley, *Analiza konwersacji, dyskursu i dokumentów*. Wydawnictwo Naukowe PWN, Warszawa 2010.

[77] J., L., Green, D., Bloome, *Ethnography and ethnographers of and in education: a situated perspective*. In: Flood J., Heaths S.B., Lapp D. (Ed.). "Handbook for literacy educators: research in the community and visualarts" Macmillan, New York 1997, pp. 181–202.

[78] U., Flick *Projektowanie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2010.

[79] T., Rapley *Analiza konwersacji, dyskursu i dokumentów*. Wydawnictwo Naukowe PWN, Warszawa 2010.

[80] G., Gibbs, *Analizowanie danych jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2011

of data sources from Informants 1,2,3, now widows of military veterans with acquired disabilities[81]. A purposive sample drawn up to 3 case studies, which provokes a workable procedure of internal generalization of research results, limited only to a purposive sample, what mentioned Maxwell[82]. The conclusion is therefore limited to 3 cases.

Findings

The following qualitative analyzes based on coding and categorization revealed the following categories and detailed codes that provided answers to the research questions posed. The following categories are among the generated ones, which provide answers to the main research question and specific questions posed in the article. The main question was:

1. What did the wives learn about the acquired disabilities of their own veterans' husbands after their return from missions abroad?

The detailed questions of the researchers were as follows:

1.1. What acquired disabilities were revealed in the veterans?
  - *acquired disability* (codes: mental disorder – depression, physical disability – serious leg injury, physical disability – arm amputation),

1.2. What military support did the veterans receive?
  - *military support* (code: help),
  - *veteran privileges* (code: money),

1.3. What areas of infirmity have revealed in the home life?
  - *automarginalization of veterans* (code: refusal, doubts, marginalized masculinity),
  - *wives' infirmity* (code: emotional overload, mission dissuasion, failures in conversations with her husband about his medical treatment,

---

[81] U., Flick, *Jakość w badaniach jakościowych*. Wydawnictwo Naukowe PWN, Warszawa 2011.

[82] J., A., Maxwell, *Qualitative Research Design: An Interactive Approach, Applied Social Research Methods Series*, SAGE, London 1996.

    - *alcohol and domestic violence* (codes: drinking to forget and not to think, drinking and beating, alcoholic arousing fear),

1.4. What preceded veterans' suicides?
    - *before suicide* (codes: suicidal thoughts, faithful drinking mates, loss of a hand, loss of masculinity),

1.5. What changes in support, according to the wives, should be made in the structures troops to prevent veterans from suicide?
    - *wives about changes in the support of veterans with acquired disabilities* (codes: state duties, against unpreparedness).

The following analyzes contain detailed verbatim data (raw data from transcripts) and answers to research questions. Research question 1. concerned the answers to the types of acquired disability in the transcripts of the interviews with Informants 1,2,3. The results of the analyzes revealed that the wives found out about two dimensions of acquired disabilities of the veterans, related to their mental functioning disorder and physical disabilities.

1. Category: Acquired disability

CODE: mental disorder – depression

Informant 1.

"Upon his return, my husband did not resemble himself in his behavior."
"He was a different man than before the mission..."
"He was afraid to leave the house."
"When he heard a sound, a sound similar to a shot, his whole body was paralyzed"
"Another time, he ran away and dragged me along the street"
"His smile vanished from his face."
"After the mission, he couldn't enjoy the simplest things as before."
"My husband <<hung up>> while talking to anyone.
"He did not answer questions."
"He looked as if he would be absent in a given room"
"He always wondered if he killed anyone."

CODE: physical disability – serious leg injury
Informant 2.

"First time injured" (during mission 3.)
"Escape to the shelter, mine was shot in the leg"
"The gunshot tore his leg almost to pieces"
"Thanks to his friend's quick reaction, he survived"

CODE: physical disability – hand amputation
Informant 3.

"Our conversations on the first mission were about 5-7 minutes each day."
"We had nothing to talk about, but I could talk and talk."
"But on the other side, all I could hear was what he had for breakfast, lunch and dinner, and that nothing had
happened."
"He did not allow himself to think that he no longer had his hand"
"He was closing more and more often"
"For him, losing an arm is losing bravery."
"He had fears, depression. He didn't take care of our son. "
"He had no joy in life."

Informants 1,2,3 precisely describe the nature and functioning of the husbands after returning from a foreign mission and the type of acquired disability. Husband of Informant1 manifested mental disorders related to depression, anxiety and persecutory thoughts. He was afraid to leave the house and he felt scared with loud noises and seemed sad and absent. Husband of Informant2 – acquired a physical disability, serious leg injury, as a result of being shot during his third participation in a foreign mission. Husband of Informant3 also acquired a physical disability – he lost his hand and experienced anxiety and depression. Informant3 indicates that in the understanding of the veteran, her husband – the loss of an arm was closely related to the loss of "bravery." The above data also indicate the functioning of husbands in families (Informant1, Informant3), consisting in auto-marginalization, withdrawal from relations with the family, including children.

Detailed research question 1.2., formulated in this report and article, concerned the type of support received from the army. Coding and categorization revealed two categories as answering the question posed, and thus they indicated what wives learned about the support of their disabled husbands by superiors, military culture and the state. The two generated categories are 2. Military support and 3. Privileges of veteran.

2. Category: Military support
CODE: Help
Informant 1.

"Of course, he got money for the mission, the allowances."
"No, he didn't get any other support"
"As for help, my husband didn't get any. He was not even referred to a psychologist, in fact he needed a psychiatrist!"
"I thought that someone who was above him, although would call my husband asking about his health, asking if anything he needs, or would send him directly to a psychologist/ psychiatrist"

Informant 2.

"Money."

Informant 3.

"Yes, the state helped us when my husband was injured."
"They organized a trip to see my husband for me.

The above data shows that one of the three Informants received support from the state in the form of a trip abroad to visit her husband shortly after acquiring a disability (Informant3). All Informants 1,2,3 confirm the financial support they received from the army. At the same time, however, Informant1 emphasizes the lack of psychological and psychiatric assistance from the military and the lack of professional psychological or psychiatric monitoring of this support by the military.

3. Category: Privileges of veteran
CODE: Money
Informant 1.

"My husband did not need the privileges because he was unable to leave the house."
"In order to get help quickly, one had to get a veteran ID first. How was my husband supposed to do this, if he claimed that he was fine, because he did not want to admit that it was too much for him?... "
"How was he supposed to submit the application and all the papers that are needed for the veteran's ID to get free aid from the state? He had to apply for this help himself!"

Informant 2.

"I do not know."

Informant 3.

" After leaving the hospital, my husband was on a rehabilitation camp."
"I read a lot about subsidies, after all, as a veteran, the victim had priority for examinations and treatment."

The results of the research indicated the interpretation of the category of "privileges" in the opinions of Informants 1,2,3. In two cases (Informant1, Informant3), the wives of veterans knew that their husbands, as veterans with disabilities, had certain privileges. It was knowledge about the possibility of getting a veteran's ID card, using subsidies and going to a rehabilitation camp. Informant1 indicates the existing bureaucracy in the background of acquiring privileges of veterans who have to apply for this help and support on their own, being disabled for a short time. This means that the veterans found themselves on a difficult adaptation path to their own disability and were unable to do their own errands. Informant1 and Informant3 found out about subsidies due to their husbands and about priority for examinations and treatment. Informant's3 husband went through a rehabilitation stay because he asked for this kind of help himself. Informant2 did not know the privileges of a veteran with an acquired disability.

Research question 1.3 concerned the examination of the areas of difficulties that appeared in family life after the return of a veteran with an acquired disability from the mission, and what the informants learned about it. The results of the research revealed 3 categories of infirmity in 3 families. The first one concerned the veteran himself and his auto-marginalization (category 4) in family life, as well as constant withdrawal from interpersonal relations, negation and refusal to accept professional help, doubts in everyday existence (Informant2), subjective feeling of loss of masculinity (Informant3) against the background of the progressing process alcohol addiction. The second category of infirmity concerned the wives themselves (Informants 1,2,3) and their inability to help her husband and witness the degradation of the husband's personality, his increasing violence and alcohol addiction. Informant2 clearly mentioned the abuse of her alcohol-addicted husband, and the fact that she had been beaten. The third category to describe family difficulties is alcohol itself and domestic violence (category 6).

4. Category: Veterans auto-marginalization
CODE: Refusal
Informant 1.

"He said he didn't need any help."
"And it was getting worse and worse with him."
"The husband did not want any help from anyone, he did not sleep at night. Because of it all, he reached for alcohol. He got drunk to the point of unconsciousness, because only then could he sleep normally... "
"He was starting to feel suicidal, he talked about it more and more."

Informant 2.
CODE: Doubts

"Would you like such a life? (husband did not want to)"

CODE: Marginalized masculinity
Informant 3.

> "Fortunately, my husband had a series of surgeries and survived."
> "He had a lot of wounds, scars and burns on his arm."
> "When my husband returned to the country, he underwent a series of operations."
> "He did not want to cooperate with doctors, he argued, he did not want to see anyone."
> "He wasn't even interested in me and our son because he wanted to go back on a mission to help colleagues."
> "My husband didn't even want to pick up his son."
> "He kept repeating that he was unable to provide his own child with a decent life."
> "He was worried who would earn for a house or family"
> "He did not want to be a << housewife >>"

The above data indicate that Informants1,2,3 learned about the complex process of auto-marginalization of 3 veterans with acquired disabilities, against the background of adaptation. This process described by the wives, Informants1,2,3, is analytically based on three detailed codes: refusal – characterizing in particular the process of adaptation of the husband of the Informant1, but also of the Informant2 and Informant3. Veterans refused to accept help. Moreover, on the doubts – characterizing the process of adaptation of Informant's2 husband, marginalized masculinity – was characterizing the process of adaptation to the disability of Informant's3 husband, who associated acquired disability with masculinity, gender and change of role and position in the family. Auto-marginalization in the families of veterans, their refusal to obtain professional psychological help was a constant element of disappointment and serious difficulties in the family life of Informants 1,2,3.

5. Category: Wife's infirmity
CODE: Emotional overload
Informant 1.

> "I was terrified, I didn't know what to do."
> "I didn't recognize my husband, much less I didn't know how to help him."

"My heart was breaking as I watched it get worse each day."
"As a wife, I have never been on such a mission and I don't know, I can't even imagine what my husband felt then, he had to go through emotionally"
"Of course, I supported him as much as I could, but I did not help him as much as a specialist psychologist/ military psychiatrist would help."

CODE: Insistence on relinquishing mission
Informant 2.

"I told him not to go on missions anymore."
"The first was in Afghanistan"
"One would be enough for him. It was still not enough for him"

Informant 3.
CODE: Failures in conversations with my husband about treatment

"That was so many of our conversations, and they made me feel like we were moving apart."
"We live in the countryside and other people are not interested in the fact that my husband survived the trauma, but in how much he earned on the mission."
"The husband was in a critical condition in the hospital."
"I couldn't go to him, hug him, I didn't know what was happening to him and whether he would survive at all."
"I explained to him that there is a prosthesis."
"That we will do everything to make him have a hand."
"I was sending him to a doctor, a psychiatrist."
"After three visits, he stopped visits."
"I asked him, I begged him."
"But I couldn't force him for treatment."
"My requests did not work."

Moreover, Informants1,2,3 learned about their own infirmity during the adaptation to the disability of veterans' husbands. Category 5. has been described as – Wife's infirmity, has revealed its detailed content and contexts. The wives' infirmity manifested itself in the form of emotional overloads (Informant1), insistence on relinquishing mission (Informant2) and failures in conversations with husband about treatment (Informant3). It should be emphasized, however, that in the context of the next generated categories, the wives (Informants1,2,3) experienced emotional overloads, learned about their own infirmity, while helping their husbands.

6. Category: Alcohol and Domestic Violence
Informant 1.
CODE: Drinking to forget and not to think

"Because of it all, he reached for alcohol."
"He got drunk until he passed out because only then could he sleep normally."
"My husband started drinking, in the beginning it was drinking to forget. Drinking so that one can fall asleep for
a moment not to think about it. Later, however, it was only worse. "

Informant 2.
CODE: Excessive alcohol use and beating

"He started to drink."
"He was drinking so much, he was beating me that I had no strength anymore."
"Not only was he an alcoholic, but he also abused me."
"Instead of spending money on a sick mother, he preferred to drink and beat."

Informant 3.
CODE: The fear-inducing alcoholic

"My husband came after the rehabilitation camp with an alcohol problem."
"According to him, he felt no pain while drinking, he forgot that he was no longer valuable."
"He became an alcoholic."
"I was slowly starting to fear my husband."

Category 6 is an additional context of the revealed infirmity of wives, indicated in category 5. The Informants 1,2,3 learned that the process of adaptation to the disability of disabled veterans is accompanied by their husbands' addiction to alcohol. This process turned out to be destructive to the functioning of the domestic life. Husbands were sometimes aggressive, arousing fear in their wives (Informant1, Informant3) or they used physical violence – beatings (Informant2). Wives showing a great deal of understanding of the situation experienced by their husbands with disabilities were left to deal with the problems generated by their husbands' behavior.

The answer to the 1.4 detailed research question of this report, defined as – what preceded the veterans' suicides – indicated category 7. Before suicide. The process of adaptation of veterans with acquired disabilities was a gradual process based on specific elements: a sense of inability to cope with disability, refusal to accept or resign from help, denial, becoming addicted to alcohol (Informant1,2,3) and other stimulants (Informant3). In addition, disability adaptation was unfortunate and ended with the suicide of 3 veterans. It should therefore be pointed out that the suicides of 3 veterans were not a sudden phenomenon, but rather an articulated conclusion by the veterans of a complex process of unfortunate adaptation to disability. Additionally, it is worth emphasizing that members of the military culture – colleagues – increased the addiction of a disabled veteran to alcohol. Informant2 talks about "faithful friends by the glass" and Informant3 talks about coming from a rehabilitation camp with an alcohol problem. An additional thread emphasized before the suicide was the subjective loss of masculinity after losing an arm, articulated by Informant3 about her husband.

7. Category: Before suicide

CODE: Suicidal thoughts

Informant 1.

"He was starting to feel suicidal, he talked about it more and more."

"It certainly contributed to my husband's taking such actions."

"As I said. I could support him, be with him. But what more could I really do?"
"I talked to him, he told me the same thing every time that he could see a picture, he couldn't sleep. But I am not a qualified psychologist, I was not able to help him. "
"In my opinion, as I said, a visit to a psychologist should be obligatory and the consequences if any of the soldiers did not show up for it. I think a psychologist would direct him to the right specialists to help him with alcohol, his suicidal thoughts. "
"He claimed that he shouldn't live in this world, that he couldn't make it."

CODE: Faithful colleagues "by the glass"
Informant 2.

"Yes, he could count on his friends by the glass."
CODE: Loss of a hand, loss of masculinity
Informant 3.

"During the camp, he and his friends drank beer if they didn't want to do anything else."
"A few beers, then they drank more and more."
"At the end there were other stimulants to forget."
"After the camp, he came back as a different person, I did not know if he would fall for other stimulants when going back for treatment."
"He committed suicide. The loss of a hand was a loss of masculinity for him. "

Answer to the research question 1.5. it was a suggestion of what the wives learned about the process of adaptation to disability and what changes they indicate in the procedures of supporting veterans in the military structures and by the state. The following content illustrate the wives' suggestions for changes that they believe would help other disabled veterans returning from a foreign mission and to adapt. The generated categories are the obligations of the state, and in the face of unpreparedness.

8. Wives about changes in the support of veterans with acquired disability

CODE: State responsibilities
Informant 1.

"Let the state introduce an obligation to visit a psychologist and it will be one very good help. I think this one visit will help a great many soldiers in the rest of their lives. "
"Let the state not deceive the soldiers what they will do in the war. Because for my husband it was supposed to be only a stabilization mission, i.e. training others. And it turned out that he will fight there, that he must have a gun with him. "
"He wasn't even referred to a psychologist, left alone but he needed psychiatrist."
"Men cannot ask for help, left alone have the courage to go to a psychologist. Even more so, my husband as a veteran who was in the war could not admit that this war simply surpassed him and is unable to cope on his own. Therefore, no privileges, allowances, etc. helped him before committing suicide "

Informant 2.

– (silence and no answer)
CODE: In the absence of readiness

Informant 3.

"I think my husband had a lot of opportunities to overcome the trauma after leaving."
"Unfortunately, he himself did not want this help."
"Everyone wanted to help him, but he did not want this help"

The observations and suggestions of the wives (Informants1, 3) illustrate 2 categories of problems that should be solved and changed. The first concerns the obligations of the state, which should obligatorily refer veterans to visits to psychologists or military psychiatrists. Additionally, wives indicate the specificity of male gender functioning (Informant3), where “males are reluctant to ask for help and support”. The second aspect worth considering and changing is, according to Informants1,2,3, not explicitly expressed but advisable to undertake systematic actions encouraging the military culture and the state against the revealed lack of readiness of veterans to accept psychological or psychiatric help. The analyzed data indicated that the military culture in the case of 3 war veterans was unprepared to properly support its own members with acquired disabilities. Military culture did not support the wives as well. A veterans adapting to a complex disability had to apply for help on their own.

Conclusion

The presented research results concern 3 case studies of learning in the family by wives about acquired disabilities of their husbands, war veterans after returning from a mission. The wives learned that the husbands from the mission returned psychologically changed in health, and having acquired disabilities. In addition to the answers about the acquired disability itself and the context of life with the husband veteran, the Informants1,2,3 also learned about their husbands’ disabilities through the prism of the support of the army (superiors). Additionally, the Informants 1,2,3 learned about the areas of self-infirmity in home life, which was associated with participation in the self-marginalization of husbands, escalation of consumption of alcohol and drugs and the use of domestic violence – “abuse” (Informant2). One by one, Informants1,2,3 found out about their husbands’ suicidal thoughts and the implementation of the suicide. Therefore, the wives learned but also participated together with the veteran in their processes of adaptation to disability, life in the family, military culture and in the state. The data indicate that Informants 1,2,3 were disappointed with the support of veterans by their superiors, military culture and the state. Even sympathetic solidarity of colleagues soldiers worked against the veterans, exacerbating their addictions. It is not difficult to see that the Informants 1,2,3 received no support and were left to fend for themselves with the escalating problems of domestic violence. It is worth adding that the problem of the voluntary use of psychological or psychiatric help by a veteran who, in the opinion of 3 Informants, is not appropriate. In the opinion of the Informants1,2,3, the information was particularly disappointing that the military culture and the state sent soldiers on missions, gave incomplete information about the purpose of the mission, but above all, it does not properly care for soldiers after returning from missions, as veterans with acquired disabilities. Although the Informants 1,2,3 mentioned financial support and allowances after their husbands lost their health – such help, in their opinion, was insufficient. Informants 1,2,3 stressed that the military and superiors should obligatorily refer veterans with acquired disabilities to psychiatric treatment or permanent psychological consultations. Veterans in Poland are left to their own decisions regarding their own treatment, especially of mental disorders, which is not good in the opinion of the 3 wives, Informants. Their reports showed a clear process of gradual degradation of family life as a result of the lack of proper help for a disabled veteran, which means directed from above by the military and superiors, and not left to the choice of veterans. The Informants1,2,3 assumed the burden of everyday life with veterans with acquired disabilities who had difficulties adapting to disabilities, using alcohol and drugs, using violence and mental and physical abuse of their wives, reported suicide and ended their own lives. Informants 1,2,3 were completely infirm in the face of the problems of their husbands loss of health, escalation of domestic violence, abandonment of their husbands by their superiors in the army, husbands' refusal to receive psychiatric treatment and participation in psychological therapy. In the accounts of three informants, military culture did not support their husbands sufficiently. Firstly, social abandonment and the lack of interest of superiors in the fate of subordinate soldiers, one could say quasi tabooing disability as a phenomenon in military culture, and secondly, the inappropriate loyalty of colleagues "by the glass", who deepened the alcohol addiction of veterans with disabilities. Additionally, the results of the research indicated an existing thread of identifying acquired disability (loss of a hand) with the loss of masculinity by a veteran (Informant3). Informant3 says: "he committed suicide. Losing a hand was for him a loss of masculinity "- which should also be investigated and analyzed in further research on disability acquired in military culture. Informant3 emphasizes "males cannot ask for help, left alone have the courage to go to a psychologist", which also indicates that refusal to accept help may be related to gender. 3 war veterans with acquired disabilities, recalled by their wives, Informants 1,2,3 – considered their own death to be the only solution to a given moment of personal infirmity in the process of adaptation to acquired disability. The process of adaptation of 3 veterans illustrates, apart from disability in the somatic and mental sphere, also an additional disability generated socially and culturally related to the lack of proper support for 3 families in military culture. The secondary disability of 3 veterans was revealed in the process of: auto-marginalization, addiction to alcohol and drugs, escalating domestic violence, articulating suicidal thoughts and suicides of 3 veterans. Additionally, when considering acquired disability in the perspective of the social and cultural model, specialist literature indicates the problem of social stigma in the army, among colleagues and the command, especially when the veteran's problem concerns PTSD traumatic stress "unfortunately, recent studies have found that concern about *stigma* (how a soldier will be perceived by peers and leadership) was disproportionately greatest among those most in need of help from mental health services (Hoge et al[83]). The indicated problem of the *stigma* of disability in the army should also be taken into account when planning re-education activities[84] or supporting the families of a veterans with an acquired disability.

---

[83] C. W., Hoge, C. A., Castro, S. C., Messer, D., McGurk, D. I., Cotting, R. L. Kofman, *Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care*, "The New England Journal of Medicine", 2004, 351, pp. 13-22.

[84] B., Borowska-Beszta, *Reedukacja weteranów z niepełnosprawnością nabytą–urazowym uszkodzeniem mózgu (TBI). Założenia teoretyczne i rozwiązania praktyczne*. "Niepełnosprawność. Dyskursy Pedagogiki Specjalnej", 2019, 34 s. 176-192.

References

Australian Institute of Health and Welfare, (AIHW) 2007. Disability in Australia: Acquired Brain Injury. Cat. No. 96.https://www.aihw.gov.au/reports/disability-services/disability-australia-acquired-brain injury/contents/table-of-contents. Australian Institute of Health and Welfare, 2015.

Borowska-Beszta, B., *Anatema szoku kulturowego w andragogice specjalnej*, „Edukacja Otwarta" 2008, 2(2), s. 163–180.

Borowska-Beszta, B., *Artefakty i technologia kultur wojskowych wspierająca weteranów z niepełnosprawnością*, „Kultura Współczesna", 2018, 3(102), s. 27-41.

Borowska-Beszta, B., *Reedukacja weteranów z niepełnosprawnością nabytą–urazowym uszkodzeniem mózgu (TBI). Założenia teoretyczne i rozwiązania praktyczne*. "Niepełnosprawność. Dyskursy Pedagogiki Specjalnej", 2019, 34 s. 176-192.

Breyer, B., N., Cohen, B., E., Bertenthal D., Rosen, R., C., Neylan, T., C., and Seal K., H., *Dysfunction in Male Iraq and Afghanistan War Veterans: Association with Posttraumatic Stress Disorder and Other Combat-Related Mental Health Disorders: A Population-Based Cohort Study*. "J Sex Med." 2014, 11, pp. 75–83.

Brzezińska, A., *Dzieciństwo i dorastanie: korzenie tożsamości osobistej i społecznej [Childhood and adolescence: the roots of personal and social identity.* In: A. Brzezińska, A. Hulewska, & J. Słomska (Ed.), „Edukacja regionalna" [Regional Education], Wydawnictwo Naukowe PWN, Warszawa 2006, s. 47–77.

Byrne, T., Treglia D., Culhane, D., Kuhn J., and Kane, V., *Predictors of Homelessness Among Families and Single Adults After Exit From Homelessness Prevention and Rapid Re-Housing Programs: Evidence From the Department of Veterans Affairs Supportive Services for Veteran Families Program*, "Housing Policy Debate", 2016, 26, (1), pp. 252-275, DOI: 10.1080/10511482.2015.1060249

Coll, J., E., Weiss E., L., Yarvis, J., S., *No one leaves unchanged. Insights for civilian mental health care professionals into the military experience and culture*. "Social Work in Health Care", 2011, 50 (7), pp.487-500.

Denzin N., K., Y., S., Lincoln *Wprowadzenie. Dziedzina i praktyka badań jakościowych*, w: „Metody badań jakościowych", red. N.. Denzin i Y.. Lincoln, t.1 Wydawnictwo Naukowe PWN, Warszawa 2009, s. 19-57.

Dorsett, P., *The Importance of Hope in Coping with Severe Acquired Disability*, "Australian Social Work", 2010, 63(1), pp. 83-102.

Dunn, D., S., Brody, C., *Defining the Good Life Following Acquired Physical Disability* "Rehabilitation Psychology" 2008, 53 (4), pp. 413–425.

Dutton E., *Towards a Scientific Model of Culture Shock and Intercultural Communication*. "Journal of Intercultural Communication", 2011, 27, (Accessed 4.Apr. 2021) https://immi.se/intercultural/nr27/dutton.htm

Englander J., Cifu D., Diaz-Arrastii R. *Seizures after Traumatic Brain Injury*, "Arch Phys Med Rehabil.", 2014, 95 (6), pp. 1223–1224.

Flick U., *Projektowanie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2010.

Flick U., *Jakość w badaniach jakościowych*. Wydawnictwo Naukowe PWN, Warszawa 2011.

Gibbs G., *Analizowanie danych jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2011.

Green, J., L., Bloome, D. *Ethnography and ethnographers of and in education: a situated perspective*. In: Flood J., Heaths S.B., Lapp D. (Ed.). "Handbook for literacy educators: research in the community and visual arts", Macmillan, New York 1997, pp. 181–202.

Gullahorn J., Gullahorn, J., *An Extension of the U-Curve Hypothesis*, "Social Issues", 1963, 19 (3), pp. 33-47.

Hester R., D., *Effective Strategies to Combat High Suicides and Trauma Among American Veterans*. "J Trauma Treat" 2017, 6, pp. 1-3. doi: 10.4172/2167-1222.1000403

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., and Koffman, R. L. *Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care*, "The New England Journal of Medicine", 2004, 351, pp. 13-22.

Hutchinson, J., Banks-Williams, L., *Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan*, "Primary Psychiatry", 2006, 13, 66-71.

Irwin, R. *Culture shock: negotiating feelings in the field*, „Anthropology Matters Journal" 2007, 1(9), pp. 1-11. https://www.anthropologymatters.com/index.php/anth_matters/article/view/64/124 (Accessed: 4. Apr 2021)

Jacobs K., Hendricksc l., A., Sampsonc D.J., Nardonea E., Lopezd A., Rumrilld K.B., Staufferd P.,Eliasb C.,E., Scherere M., Dembed J. *Project Career: Perceived benefits of iPadapps among college students with Traumatic Brain Injury (TBI)*, "Work" 2017, 58, pp. 45–50, https://content.iospress.com/download/work/wor2596?id=work%2Fwor2596 (Accessed 15.05.2018).

Kang, H.,K., Bullman, T.,A., *Risk of suicide among US veterans after returning from the Iraq and Afghanistan war zones*. „JAMA" 2008, 300, pp. 652–653.

Kropkowska J., Borowska-Beszta, B., *Mężczyźni bezdomni o aktywnościach codziennych: Etnograficzne studia przypadków*. „Niepełnosprawność. Dyskursy Pedagogiki Specjalnej" (tekst w procedowaniu wydawniczym) 2021.

Kvale S., *Prowadzenie wywiadów*. Wydawnictwo Naukowe PWN, Warszawa 2010.

Lambert, S. M., Morgan, M., *Supporting Veterans and Their Families: A Case Study and Practice Review*. "The Family Journal: Counseling And Therapy For Couples And Families", 2009, 17(3), pp. 241-250 Doi: 10.1177/1066480709337800.

Lejzerowicz M., Tomczyk D., *Acquired disability: self-esteem and identity integration*, "Polish Psychological Bulletin" 2018, 49(2), pp. 262–271 DOI – 10.24425/119494

Maxwell, J., A., *Qualitative Research Design: An Interactive Approach, Applied Social ResearchMethods Series,* SAGE, London 1996.

McGeary M., Ford M.A., McCutchen S.R., Barnes D.K. *A 21st century system for evaluating veterans for disability benefits*, "Committee on Medical Evaluation of Veterans for Disability Compensation" Board on Military and Veterans Health, 2007, pp 65–66.

Oberg, K., *Culture Shock.* Presentation to the Women's Club of Rio De Janeiro, 3. Aug, Brazil 1954.

Pakieła A., *Weterani wojenni z niepełnosprawnością nabytą w opiniach żon. Trzy studia przypadków*. Niepublikowana praca magisterska WFiNS, UMK 2020.

Peterson A., Bozzay, M., Bender, A., Monahan M., Chen J., *Those left behind: A scoping review of the effects of suicide exposure on veterans, service members, and military families*, "Death Studies" 2020, pp. 1-10. DOI: 10.1080/07481187.2020.1802628

Rapley T., *Analiza konwersacji, dyskursu i dokumentów*. Wydawnictwo Naukowe PWN, Warszawa 2010.

Rozanov V., Carli V. *Suicide among War Veterans*. "Int. J. Environ. Res. Public Health", 2012, 9, pp. 2504-2519 doi:10.3390/ijerph9072504

Rosof B.,M., Hernandez L.,M., *Gulf War Veterans. Treating Symptoms And Syndrome*, National Academy Press Washington, D.C. Military Culture, 2001 https://www.defense.gov/ News/Article/Article/1213804/translating-military-culture-to-the-civilian-workplace/ (Accessed 18.May2018).

Rushworth, N., *Out of Sight, Out of Mind: People with an Acquired Brain Injury and the Criminal Justice System. Brain Injury* Australia 2011 https://www.braininjuryaustralia.org.au/wp-content/uploads/CJSpolicypaper FINAL.pdf. (Accessed 4. Apr 2021)

Schein, E., H., *Organizational Culture and Leadership*. Jossey-Bass, San Francisco 2004.

Silverman D., *Prowadzenie badań jakościowych*, Wydawnictwo Naukowe PWN, Warszawa 2008.

Yin R., K., *Studium przypadku w badaniach naukowych. Projektowanie i metody* Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2015.

Tallman, B. A., Hoffman, A., C., *Meaning making concerning acquired disability* In E. M. Altmaier (Ed.), "Reconstructing meaning after trauma: Theory, research, and practice", 2017, pp. 133–151. Elsevier Academic Press.

Weiss E., L., Albright D., L., *Introduction to the Special Issue: Mental Health Care for Military Service Members, Veterans, and Their Families: Opportunities for Social Work*, "Social Work in Mental Health", (2014), 12(5-6), pp. 387-390, DOI: 10.1080/15332985.2014.927408.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Ewelina Sobocha

Pedagogical University of Krakow, Poland
ORCID: 0000-0003-1184-5167

Management of leisure time by young adults with deeper intellectual disability

Abstract: Ewelina Sobocha, *'Management of leisure time by young adults with deeper intellectual disability*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 173-184. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https://doi.org/10.14746/ikps.2021.32.09

The aim of this article is to identify competences in the field of free time management by young people with deeper intellectual disabilities and the possibility of using it in terms of preferred forms and organizations.
For the purposes of this publication, research was carried out on a group of 30 people with more severe intellectual disability with the use of two research tools. The necessity of further research on the given topic was emphasized.

Key words: leisure time, deeper intellectual disability, activity

Introduction

Active spending of the leisure time by people with deeper intellectual disability as a way to participation in social life.

In the era of reform of the education system in pedagogical literature, the need for broadly understood activation of students in both didactical and leisure time activities is stressed.

Contemporary pedagogists give priority to the use of multiple activisation methods in social rehabilitation as well as in the didactic and educational work.

Spending leisure time in the manner that is satisfying is essential in the life of each person and that includes people with deeper intellectual disability. .

This is important for maintaining good physical and mental health and contributes to a better quality of life. It is of particular importance in the case of young people with deeper intellectual disabilities in order to avoid social isolation and develop individual interests. The manner in which it is implemented is important for the development of mutual relations, as well as for the intensification of the social integration process[1].

Free time is an important topic in the context of the social functioning of young people with deeper intellectual disabilities, yet it is ignored, downplayed and underestimated in society. Taking into account its role, skills in the field of resourcefulness, independence, assertiveness and self-development are developed [2].

Currently, the emphasis is on searching for and applying innovative methods to activate people with deeper intellectual disability in the process of education, upbringing and social rehabilitation. The leitmotif of this approach is to prepare these young people for active participation in social life

As Małgorzata Czajkowska (2005) emphasizes, the synchronization of the emotional and volitional spheres while taking into account socially recognized moral principles, allows to multiply positive stimuli, develop socially useful activity, and at the same time influences self-esteem and independence. Therefore, creative revalidation, called "creative therapy"[3]. has a special place in the revalidation process. Participation in creative therapy allows these people to experience a different dimension of humanity, to encoun-

---

[1] L. Melbøe, B. Ytterhus (2017) Disability leisure: in what kind of activities, and when and how do youths with intellectual disabilities participate?, Scandinavian Journal of Disability Research, 19:3, s. 245-255.

[2] W. Sroczyński, L. Ploch L., Czas wolny i niepełnosprawność. Warszawa, 2017, s. 108.

[3] M. Czajkowska, Kompensacyjna funkcja internatu w procesie socjalizacji młodzieży upośledzonej umysłowo, Oficyna Wydawnicza Impuls Kraków, 2005, s. 33-41.

ter beauty, something unusual and unique. All forms of artistic creativity for people with intellectual disabilities are often the only way of expressing themselves, their feelings, complaints and dreams. Therefore creative therapy appears to be one of the forms of self-revalidation.

Activity is an essential element of the mental development of a human being. By influencing the shaping and regulation of relations with the surrounding environment, a person is subject to their own, individual changes, as well as inflences the surrounding reality. The forms of activity are shaped and changed as a person develops. Its progressive nature manifests itself in the change in the scope of a person's activities and the quality of their performance. In the case of people with intellectual disabilities, triggering, developing and strengthening various types of activity has a very significant impact on the process of their own development[4].

In general, activation is a form of mobilisation and provokes the will to act. This should be categorized as exerting some kind of influence on a person. In a situation where a person is activated, and consequently motivated to act, you can give support by creating different opportunities and helping identify and create different means of implementation. The activation process takes place in three stages. From passive, it turns into active, ready to act, and the finale is an independent action. In summary, a non-disabled person as well as a person with intellectual disabilities learn mainly through experience. According to this, the activation process is understood in terms of inspiration, encouragement, persuasion, colaboration – "activation of the development potential"[5]. With regard to people with disabilities, and in particular to people with intellectual disabilities,

---

[4] W. Dykcik, Szychowiak B. (red.) Nowatorskie i alternatywne metody w teorii i praktyce pedagogiki specjalnej. Przewodnik metodyczny, Wydawnictwo UAM Poznań, 2001, s. 79-88.

[5] A. I., Brzezińska, A. Resler-Maj, Aktywizacja dzieci i młodzieży z grup ryzyka [w:] A.W. Brzezińska, A. Hulewska, J. Słomska-Nowak (red.), Edukacja kulturowa. Społeczność – aktywizacja – uczenie się, Wydawnictwo WSZ „Edukacja" Wrocław 2010, s.83-99.

the form and manner of spending free time plays an important role in the activation process.

As emphasized by Beata Cytowska (2011), the issue of free time is of interest to many researchers in various scientific fields (economists, psychologists, educators). However, it is the educators who attribute to themselves the greatest responsibility and role in this respect[6]. It is inextricably linked with the purpose of education of young people with deeper intellectual disability, which emphasizes the comprehensive development of each person according to their individual abilities and maximum preparation for life – thus participation in social life[7].

Reflecting on the value of free time, Maria Jolanta Stąpór (2005) emphasizes early cognitive and social experiences. According to the author, proper management of free time can set a goal and give meaning to the lives of people with deeper intellectual disabilities It can serve as a unique reward after difficult and burdensome everyday tasks and, above all, mobilize for further effort. One must also agree with her position that the essence of free time is to experience a sense of freedom and relaxation, freedom to decide about yourself, regeneration of physical and mental strength and the chance to gain new experiences, as well as a completely different form of realization of desires. Free time creates an opporunity for exercising one's own choice and experiencing appropriate motivation. It allows to be guided by an individual selection of specific situations and behaviors, permits the development of interests and creative desires and facilitates improvement in a selected field [8].

---

[6] B. Cytowska, Dorośli z niepełnosprawnością intelektualną w labiryntach codzienności. Analiza badań – krytyka podejść – propozycje rozwiązań, Wydawnictwo Adam Marszałek Toruń 2011, s. 359 – 383.

[7] M. Kościółek, K. Parys, D. Wolska, [w:] P. Pilecki (red), Usprawnianie, wychowanie i nauczanie osób z głębszym upośledzeniem umysłowym, Wydawnictwo Naukowe AP Kraków 2002 s. 193-202.

[8] M. J. Stąpór, Czas wolny w procesie rehabilitacji osób niepełnosprawnych, [w:] J. Rottermund, A. Klinik, S. Wrona (red.), Wybrane uwarunkowania rehabilitacji osób niepełnosprawnych, Oficyna Wydawnicza Impuls Kraków 2005, s. 263-273.

The importance of the close relationship between the activity conducted in the family environment and the effects of social rehabilitation was also noticed. The frequent lack of continuation of activities in the home environment that leads to the absence of new positive behaviors, socially accepted games and activities after returning to the facility were indicated[9].

The autonomy of people with intellectual disabilities is implied by their active inclusion in social life. The task of specialists, parents and legal guardians of people with intellectual disabilities is to support the process of becoming an autonomous member of society – the right to decide on forms of spending free time, the right to decide about oneself, the right to establish interpersonal contacts. Proper management of free time for these people is one of the most important elements of adulthood and active social adaptation (M. Kościółek, K. Parys, D. Wolska 2002, s. 193-202).

Free time should be the property of every person, both able-bodied and intellectually disabled. Leisure time varies depending on the phase of a person's life. Its appropriate organization plays a very important role in the general development of a person with intellectual disability, as it enriches his intellectual and physical sphere, develops him morally and aesthetically, and has an important compensatory and socializing function. Introducing people with intellectual disabilities to the rational use of free time requires creativity from specialists working with these people (Your guide to. Leisure for people with a learning disability, 2008, Mencap, London).

At the turn of recent years, research interests in this area of human life have acquired a slightly different meaning. Free time is recognized in terms of health, entertainment and educational importance, as well as its culture-forming impact. Timeless and still valid is the statement that "free time is used to relieve mental tensions, counteracts overloads resulting from obligatory life tasks and should be considered as a factor of comprehensive, dynamic,

---

[9] M. J. Stąpór, Czas wolny w procesie rehabilitacji osób niepełnosprawnych, [w:] J. Rottermund, A. Klinik, S. Wrona (red.), Wybrane uwarunkowania rehabilitacji osób niepełnosprawnych, Oficyna Wydawnicza Impuls Kraków 2005, s. 263-273.

positive development, shaping the personality at the optimal level appropriate for a person. Therefore, introducing a person into the circles of social life, facilitating the process of getting to know oneself, streanghtening one's self-esteem, defining one's own identity is also done by using tradition as the content of culture, customs, commonly accepted social forms of behavior (regulating the behavior of an individual), as well as customs cultivated by rituals, celebrations, practices. determining the type of social relations "[10].

Own Research

30 young people aged 13 to 32 with more severe intellectual disability participated in the research.

Tools applied in this research:

- Adaptive Behaviour Skale for Children, Youth and Adults by Ray Fostera, Max Shellhaasa, Henry Lelanda , translated, modified and adapted by Janusz Kostrzewski.

Part I, category – (VIII) self-control (initiative, persistence, organization of free time) was used for the study.

The mentioned research tool belongs to the category of observational scales. It is a grading scale dedicated to the study of people with intellectual disabilities, socially maladjusted individuals and people with emotional disorders[11]. The study was conducted twice in order to check whether the study group had acquired greater competences in the study area after one year.

- Poll diagnostic method using the questionnaire technique[12]. Questinnaire was addressed to young adults with deeper in-

---

[10] M. J. Stąpór, Czas wolny w procesie rehabilitacji osób niepełnosprawnych, [w:] J. Rottermund, A. Klinik, S. Wrona (red.), Wybrane uwarunkowania rehabilitacji osób niepełnosprawnych, Oficyna Wydawnicza Impuls Kraków 2005, s. 266.

[11] J. Kirenko, M. Parchomiuk, Edukacja i rehabilitacja osób z upośledzeniem umysłowym, Wydawnictwo Akademickie WSSP Lublin 2008, s. 116-117.

[12] T. Pilch, T. Bauman, Zasady badań pedagogicznych. Strategie ilościowe i jakościowe, Wydawnictwo Akademickie Żak Warszawa 2001, s. 79-82.

tellectual disability. The questions developed in the questionnaire concerned the preferred forms and organization of free time.

Table 1. Age of the surveyed people with more severe intellectual disability

Age range	**Study group**	
	L	**%**
13 – 19	15	50
20 – 29	10	33
30 – 32	5	17

Source: own study.

Table 2. Study Group – spare time

Range/ Indicators	**Study Group Study 1**					**Study group Study 2**					
	M	**SD**	**Me**	**Min**	**Max**	**M**	**SD**	**Me**	**Min**	**Max**	**p**
Iniciative	**6,93**	1,17	7,00	4,00	9,00	**7,63**	0,81	8,00	6,00	9,00	0,0007
Endurance	**8,90**	1,49	9,00	6,00	12,00	**9,73**	1,26	10,00	7,00	12,00	0,0001
Spare time organisation	**2,40**	0,86	2,00	1,00	4,00	**3,23**	0,77	3,00	1,00	4,00	0,0001
Self-control	**18,23**	2,33	18,00	13,00	22,00	**20,60**	1,90	21,00	16,00	24,00	0,0000

Source: own study.

The data presented in the above tables, relating to the study group, confirm the existence of statistically significant differences in terms of all indicators. Comparing the differences in the arithmetic mean value between the first and the second measurement, it can be stated that the study group obtained results after one year , indicating some increase in the ability to organize free time. The following factors influenced the obtained results: age, level of intellectual disability, individual characteristics, favorable conditions, and the attractiveness of classes.

On the other hand, in the conducted surveys, the issues related to the organization, decision-making, place and forms of spending free time by young adults with deeper intellectual disabilities were analyzed.

Table 3. Free time-who do you spend it with and who would you like to spend it with?

	Who do you mostly spend your free time with?	Who would you like to spend your free time with?
With Friends/ Acquintances	8,6%	71,4%
Family	68,6%	20,0 %
With Partner	0,0%	5,7 %
Alone	22,8 %	2,9 %

Source: Own Study

The conducted research shows that people with more severe intellectual disability spend most of their free time with their family (68.6%), even though they would like to spend it to a large extent with friends / acquaintances (71.4%). The respondents show a great need for contact with friends and acquaintances. It is worth noting that 22.8% of respondents spend their time alone, although only 2.9% declare such a need.

The attractiveness of forms of spending free time is very important in the life of a person with a deeper intellectual disability. It has an impact on maintaining physical and mental health and promotes a better quality of life. Spending free time in a creative manner allows these people to acquire new experiences and skills, as well as learn about their own preferences, abilities and limitations. Despite the fact that there are many arguments in favor of promoting and implementing free time management skills in this group, young people with more severe intellectual disability most often spend time at home, 62.9%. Less often with family 20%, in public places 14.3% and with friends 2.8%.

In the study group, 68.6% of the respondents do not participate in organized activities, while 31.4% are people participating in organized activities, e.g. sports, theater workshops, etc. The reason for this may be due to the fact that third parties are more often involved. as the level of functioning and individual limitations of a person with a deeper intellectual disability demand such support.

It is important to learn how to spend free time properly, "from an early age the family and school should shape children to spend their free time in a conscious, pleasant and valuable way"[13]. The family plays an important role in developing and shaping interests and the ability to spend free time in an appropriate way. It is a source of model forms of spending free time as the child learns through imitation. It is within the family where he learns how to properly use his free time. In the research group, more people prefer the passive spending of their free time 51.4% while 48.6% chose an active form.

An important function of leisure time is self-education and self-improvement, which allows you to achieve autonomy. Acquiring knowledge and new skills is aimed at personality formation and self-improvement. Working on oneself is connected with finding one's place in society and the development of subjectivity[14] (Orłowska, Błeszyński 2016, p. 36). Working on oneself has also a cultural and educational significance. Thanks to it, personal development is possible. It consists of assimilating and expanding one's knowledge, acquiring new skills.

---

[13] K. Kwilecki, Rozważania o czasie wolnym wybrane zagadnienia. Górnośląska Wyższa Szkoła Handlowa GWSH, Katowice 2011, s. 6.

[14] M. Orłowska, J. J. Błeszyński, Czas wolny jako środowisko życia. Perspektywa pedagogiczna. Warszawa 2016, s. 36. Przegląd Pedagogiczny 2018, nr 1.

Tab. 4. Free time – organisation and decision making

	Decision making in the field of spare time management for people with deeper intellectual disability
Myself	68,6 %
Decision made by other people	31,4 %
	Who organises spare time
Myself	34,3 %
My family	62,9 %
Friends	2,8 %

Source: Own Study

In the conducted research, attention was paid to the issue of decision-making in the area of free time. According to the research, the organizer of leisure time of a person with more severe intellectual disability are family members (62.9%), less often it is organized by the person concerned – 4.3%. On the other hand, the choice of activity is more often made by a person with more severe intellectual disability (68.6%). This picture is undoubtedly influenced by the age and degree of disability as well as the place of residence.

Summing up, it is worth noting that people with more severe disabilities, despite many limitations, show a need and willingly undertake activities aimed at participating in various forms of leisure activities. The barrier may be insufficient competences in the field of free time management. An important aspect is the preparation of these people at every stage of their development, taking into account the environment (family, school, peer), supporting and implementing trainings that will equip them with appropriate skills, taking into account their individual potential, but also limitations resulting from their disability.

Summary

Free time becomes the basic value of everyday life that facilitates personal development of a person with deeper intellectual disability. The joy and satisfaction derived from fruitfully spent free time translates into an improvement in the quality of life. It is important that the free time is so arranged that a person with a deeper intellectual disability derives positive benefits[15].

In educational as well as rehabilitation work with people with deeper intellectual disability, it is important to recognize the importance of the ability to manage free time. It is of particular importance in the context of preparing young people for a fuller participation in social life. Systematic, consistent work on acquiring competences in the field of managing free time influences: an increase in the sense of satisfaction with the activities undertaken, awareness of one's own limitations and possibilities, and thus building a positive self-image, increase in skills in establishing and maintaining social relations, acquiring knowledge about social norms, improves the psychophysical condition and the development of emotional intelligence, favors the pursuit of dreams. All these elements contribute to a significant improvement in the quality of life of young adults with deeper intellectual disabilities[16].

Modern technologies and continuous modernization allow for greater accessibility and elimination of barriers that contributed to the isolation of this group of people. Free time influences the development of personality and increases the effectiveness of the revalidation process. Properly organized, gives a chance to compensate for other failures. At the same time, it can become an area of unlimited rehabilitation prospects. Creative and at the same time useful free time satisfies the need for belonging, expression or action.

References

Brzezińska A. I., Resler-Maj A., Aktywizacja dzieci i młodzieży z grup ryzyka [w:] A.W. Brzezińska, A. Hulewska, J. Słomska-Nowak (red.), Edukacja kulturowa.

---

[15] L. Ploch, Czas wolny dzieci i młodzieży z niepełnosprawnością [w:] W. Sroczyński, L. Ploch (red.), Czas wolny i niepełnosprawność, Warszawa 2017, s. 168-182.

[16] Magiera, Czas wolny osób niepełnosprawnych Studia Ekonomiczne. Zeszyty Naukowe Uniwersytetu Ekonomicznego w Katowicach ISSN 2083-8611 Nr 392, Katowice 2020 s. 59-68.

Społeczność – aktywizacja – uczenie się, Wydawnictwo WSZ „Edukacja" Wrocław 2010, s.83-99.

Cytowska B., Dorośli z niepełnosprawnością intelektualną w labiryntach codzienności. Analiza badań – krytyka podejść – propozycje rozwiązań, Wydawnictwo Adam Marszałek Toruń 2011, s. 359 – 383.

Kirenko J., Parchomiuk M., Edukacja i rehabilitacja osób z upośledzeniem umysłowym, Wydawnictwo Akademickie WSSP Lublin 2008, s. 116-117.

Kościółek M., Parys K., Wolska C., [w:] P. Pilecki (red), Usprawnianie, wychowanie i nauczanie osób z głębszym upośledzeniem umysłowym, Wydawnictwo Naukowe AP Kraków 2002, s. 193-202.

Magiera A., Czas wolny osób niepełnosprawnych Studia Ekonomiczne. Zeszyty Naukowe Uniwersytetu Ekonomicznego w Katowicach ISSN 2083-8611 Nr 392, Katowice 2020 s. 59-68.

Melbøe L , Ytterhus B. (2017) Disability leisure: in what kind of activities, and when and how do youths with intellectual disabilities participate?, Scandinavian Journal of Disability Research, 19:3, s. 245-255.

Orłowska M., Błeszyński J. J., Czas wolny jako środowisko życia. Perspektywa pedagogiczna. Warszawa 2016, s. 36. Przegląd Pedagogiczny 2018, nr 1

Pilch T., Bauman T., Zasady badań pedagogicznych. Strategie ilościowe i jakościowe (Wydanie drugie poprawione i rozszerzone). Wydawnictwo Akademickie Żak Warszawa 2001, s. 79-82.

Ploch L., Czas wolny dzieci i młodzieży z niepełnosprawnością [w:] W. Sroczyński, L. Ploch (red.), Czas wolny i niepełnosprawność, Warszawa 2017, s. 168-182.

Sroczyński W., Ploch L., Czas wolny i niepełnosprawność. Warszawa, 2017, s. 108.

Czajkowska M., Kompensacyjna funkcja internatu w procesie socjalizacji młodzieży upośledzonej umysłowo, Oficyna Wydawnicza Impuls Kraków, 2005, s. 33-41.

Dykcik W., Szychowiak B. (red.) Nowatorskie i alternatywne metody w teorii i praktyce pedagogiki specjalnej. Przewodnik metodyczny, Wydawnictwo UAM Poznań, 2001, s. 79-88.

Kwilecki K., Rozważania o czasie wolnym wybrane zagadnienia, Górnośląska Wyższa Szkoła Handlowa GWSH Katowice 2011, s. 6.

Stąpór M. J., Czas wolny w procesie rehabilitacji osób niepełnosprawnych, [w:] J. Rottermund, A. Klinik, S. Wrona (red.), Wybrane uwarunkowania rehabilitacji osób niepełnosprawnych, Oficyna Wydawnicza Impuls Kraków 2005, s. 263-273.

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

Sharon Kellerman

Adam Mickiewicz University, Poznan, Poland

Attitudes of a multi-disciplinary team regarding sexual education among students with Developmental Cognitive Disabilities (DCD)

Abstract: Sharon Kellerman, *Attitudes of a multi-disciplinary team regarding sexual education among students with Developmental Cognitive Disabilities (DCD)*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 185-212. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https://doi.org/10.14746/ikps.2021.32.10

This quantitative study examines the attitudes of multidisciplinary staff regarding sex education among students with developmental intellectual disabilities and compares the attitudes of teachers working in regular education and those working in special education, and attitudes of religious versus non-religious teachers.

One hundred and twenty teachers from various schools in the State of Israel participated in the study. The vast majority were women (91.7%), and the rest were men (8.3%). The prevailing level of religiosity in the study was secular (47.5%), and religious (43.3%). Most teachers had no experience working with children with special needs (60%).

The study participants completed a demographic survey. The questionnaire used to examine the research questions was The Sexual Attitude Scale (SAS) (Hudson, Murphy, & Nurius, 1983) – a 25-item summated category partition scale that was designed to measure the extent to which an individual adheres to a liberal or a conservative orientation concerning sexual expression. One question was removed from the original questionnaire (statement 18: heavy sexual petting should be discouraged) and 5 statements were added, focusing on attitudes toward sex education for students with developmental intellectual disabilities.

The study findings show that the level of conservatism among special education teachers was lower than the level of conservatism among regular education teachers, i.e., special education teachers expressed more positive attitudes. The study find-

IKPS 32, 2021: 185–212.

ings show that the level of conservatism among religious teachers was higher than the level of conservatism among non-religious teachers, i.e., non-religious teachers expressed more positive attitudes. It was also found that there is a positive and significant relation between the seniority of teachers and their degree of conservatism: the more years of experience teachers had, the more negative were their attitudes regarding the sexual education of students with Developmental Cognitive Disabilities (DCD). In contrast, there was no significant connection between age and level of conservatism. The study also examined the relationship between the role of the teacher and his attitudes. The study reveals surprising findings that show that the highest degree of conservatism was found among teachers and counselors, then, among professional teachers, and finally, school therapists who demonstrated the lowest level of conservatism. This means that the most positive attitudes were among the paramedical caregivers and the more negative among the educators and counselors. These findings suggest that training is needed for teachers in regular education, and among religious teachers, who are more conservative concerning sex education for people with special needs. It was also found that there is a connection between the teacher's role and his attitudes, and that the teacher's discipline should be addressed in the training. Veteran teachers have shown more negative attitudes, which is why training, for both teaching students and young teachers, and especially to veteran teachers, has an impact on their attitudes towards sex education among people with special needs. This training, beyond the knowledge provided, will facilitate changes of social attitudes to another, more positive view, towards people with special needs.

Key words: sexual education, Developmental Cognitive Disabilities (DCD), attitudes, multi-disciplinary team members, sector

Introduction

Sexual behavior is a normative part of human behavior. All humans have sexual needs, from birth to death. It is the inalienable and legal right of every human being, including people with special needs. Every person is a social-sexual creature and is therefore entitled to express and fulfill these social needs, as well as the sexual needs. Sexuality is a very complex issue for anyone, and specifically concerning people with Developmental Cognitive Disabilities, in which case addressing the issue is particularly problematic and sensitive. The bio-physical development of many people in special education is congruent with their chronological age, while their cognitive development and emotional maturity are incongruent with physical development. This situation creates a real gap – increasingly growing over the years – between them and their peers in the general population. Without guidance and attention, this gap complicates the addressing of an issue which is, in itself, a difficult and complex challenge. This shows that even nowadays when awareness of the subject has greatly increased, many schools are still not adequately coping with social-sexual education. A significant part of the gap between the sexual education policy in Israel and its implementation in state schools stems from a lack of the following factors: appropriate training, acquisition of research-based and up-to-date knowledge, professional tools, skills, and competencies among those who are required to teach sexual education in the classrooms – the educators and the educational consultants. sexual education is a difficult task in regular education, and all the more so in special education. Sexual education is even more necessary for special education pupils. However, this need is often not addressed. In the proposed study, we examined the attitudes of multidisciplinary staff members regarding sexual education for pupils with Developmental Cognitive Disabilities. We compared the attitudes of teachers working in regular education to those working in special education and compared between religious and non-religious teachers.

Literature review

The Israeli mainstream education system

The complexity of Israeli society and its human diversity is reflected in the country's educational system. The educational system's heterogeneity is manifested in various facets of the structure and budgeting of the system, and the existence of many types of educational institutions tailored to the needs of different sectors. The structure of the educational system in Israel is usually described according to four main divisions: age, the legal status of the educational institution, type of supervision, and sector[1]. The current study involved multidisciplinary teams from state, state religious, and special education schools.

Special education in Israel

Pupils with special needs in Israel study in two main tracks: 58% (about 115,000) are integrated into the regular education system; the rest (42%) study in special education frameworks for pupils with various disabilities. The professional body through which the Special Education Act is implemented is called the Regional Education Support Center (*MATYA*). Every such center coordinates the support of children with special needs who attend institutions under its responsibility, in both regular and special education institutions. It provides various services – eg support of instruction and learning processes, pedagogic diagnosis, lending of equipment and aids, and para-medical treatments for special education pupils. The centers also develop additional services for the pupils. In addition, every center coordinates between the entities that provide services to children with special needs and works with ministries and municipalities as well. The center is a hub of professional knowledge for teachers, regarding a variety of disabilities[2]

As mentioned, 42% of the pupils (about 80,000) attend special education institutions. These are special frameworks for special education pupils – special education kindergartens, special education schools, and special education classes in regular schools. Special education frameworks are designated frameworks for pupils with various disabilities.

---

[1] E. Weissblei, The Education System in Israel. Knesset Research and Information Center, 2013. [Hebrew]. https://fs.knesset.gov.il/globaldocs/MMM/21556b58-e9f7-e411-80c8-00155d010977/2_21556b58-e9f7-e411-80c8-00155d010977_11_7137.pdf

[2] E. Weissblei, *Education for Children with Special Needs in Israel – Data and Key Issues*, The Knesset Research and Information Center, 2015. [Hebrew]

The present study examined the attitudes of multidisciplinary staff concerning sex education. We will now review the term "sexual education."

Sexual education

All sexual beings share the basis of one principle called ‚sexuality'. This concept includes the person's personality – his identity, sexual function, and behavior, his feelings, and the way he communicates with others. Therefore, sexuality is an essential trait that we have; it is an essential part of being humans. As such, one can claim that almost every human behavior includes a sexual aspect. Hence, sexuality is present in almost every human domain, and certainly in education (Harpaz, 2010).

Over the years, there have been many debates regarding the issue of sexuality in the Israeli educational system[3], being a topic laden with values and moral issues[4] . For years, many sub-groups in Israeli society debated whether sex education should be taught and how. Disagreements arose due to the differences between those groups as well as temporal trends[5]. Part of the opposition stemmed from concern that exposing students to information about sex might arouse their curiosity and may even encourage them to realize their sexuality early in their lives[6]. Naturally, parents are expected to mediate sexual education issues for their children, as part of their role as educators[7] but studies have shown that only a hand-

---

[3] K. Arnan, *Life Skills for 5th-6th Grades: Skills, developmental and preventive issues for the state and state religious primary schools*, Maa'lot, 1995. [Hebrew]

[4] E. Firstater, Y. Lapidot-Berman, Sex education – why bother? The contribution of a course in human sexuality to teaching students, *Rav Gvanim: Mekhkar va'Siach, 16*, 81-53, 2018. [Hebrew]

[5] N. Guvrin, Flowers, butterflies and bees: Sex education for children and youth in the Land of Israel, *Olam Katan, 3*, 82-66, 2007.

[6] K. Arnan, *Life Skills for 5th-6th Grades: Skills, developmental and preventive issues for the state and state religious primary schools*, Maa'lot , 1995. [Hebrew]

[7] S. L. Finan, Promoting healthy sexuality: guidelines for infancy through preschool, *The Nurse Practitioner*, *22*(10), 79-80, 1997.

ful of parents talk to their children about it; moreover, it is found that parents' disregard of sexual education and the educational system's reluctance, may lead to violent sexual behavior among students. Therefore, it is all the more important to address education to sexuality in this current era, in which there are far-reaching changes in the traditional family structure, in accepted sexual identity and gender roles, and increased exposure to information and content through the media[8] . Since sexuality is a significant component in human identity, educational processes have an impact on its evolvement and hence the importance of sexual education. In most of the Western world, there is a consensus that sex education should be part of the curriculum, addressing a wide range of topics such as anatomy, physiology, gender identity, sexual orientation, STD prevention, and contraception. Addressing those aspects may impart knowledge and shape attitudes among young people[9] . For sex education to be optimal and productive, and reduce dangerous sexual behaviors such as disease transmission, unwanted pregnancies, and abusive sexual cases, it must be delivered to students by a team of professionally trained teachers. Lack of training, lack of knowledge, or incorrect knowledge can lead to erroneous programs and even to disturbances in sexual image and functioning. Alternatively, competent educational staff can bring about a real change in students' perceptions[10] .

Sex education should include more than sexuality information and Q&A. Learning sex education should be held in a safe and enabling environment that will have the best impact in the long run as well. Children will thrive when teachers and parents support their sexual development, and when adults they will provide knowledge-

---

[8] E. Weissblei, *Sex education in the education system.* Knesset Research and Information Center,2010, ttps://www.knesset.gov.il/mmm/data/pdf/m02462.pdf

[9] E. Firstater& Y. Lapidot-Berman, Sex education – why bother? The contribution of a course in human sexuality to teaching students, *Rav Gvanim: Mekhkar va'Siach, 16*, 81-53,2018. [Hebrew]

[10] K. Kukulu, Gürsoy, E., & Sözer, G. A. Turkish university students' beliefs in sexual myths, *Sexuality and Disability*, *27*(1), 49-59,2009.

able responses to their questions and behaviors. By creating a reality where appropriate responses are provided, children are more likely to develop a healthy sense of sexuality[11].

Sexual education in Israel

The Israeli Ministry of Education is currently the entity in charge of sexual education in schools through the unit for education for sexuality, relationships, and family life in the counseling psychological service. The program is taught in elementary and middle schools as part of the "Life Skills" classes. The programs' implementation in schools is partial and the unit does not have supervisory or enforcement powers. In addition, there is no compulsory program in high schools and kindergartens. The sex education classes are delivered by the educators under the guidance of the educational counselors; however, some teachers feel uncomfortable addressing those contents and therefore the educational counselor takes over the task. If there is no counselor, the teachers are responsible for delivering the subject. The program is adapted in various ways to both the state-religious sector and the state sector, while the discourse on sexuality in Ultra-Orthodox institutions is completely absent. In addition to the Ministry of Education, the Ministry of Health also takes part in school sexual education through public health nurses. However, the subject is discussed within a single session, in the 6th grade. Studies have shown that most students did not receive sex education at all, or engaged in the subject at school for a limited number of hours. Moreover, it was found that sex education usually provides an ad-hoc response to a specific event, views it as threatening, and does not address questions that concern teens[12] .

---

[11] M. Sciaraffa & T. Randolph, "You want me to talk to children about what?": Responding to the subject of sexuality development in young children, *YC Young Children*, *66*(4), 32.

[12] E. Weissblei, (2010), *Sex education in the education system,* Knesset Research and Information Center, 2011. https://www.knesset.gov.il/mmm/data/pdf/m02462.pdf

Sexual education for students with Developmental Cognitive Disabilities (DCD)

For years, people with cognitive-developmental developmental disabilities were considered asexual – people who do not need satisfying sexual relations with others. Individual rights to sexuality, which is essential to human health and quality of life, were denied. Moreover, the public had old-fashioned views on the sexuality of people with developmental disabilities and retardation.

In 2002, the American Association on Mental Retardation determined that people with intellectual disabilities and developmental disabilities have rights regarding their sexuality: they have the right to sexual expression according to their age; they must be provided with information that enables informed decisions, including sexual social education on topics such as safe sex, sexual orientation, sexual exploitation, and STDs. They are entitled to protection against sexual abuse, as well as against physical, sexual, and emotional exploitation.

In the State of Israel, the Unit for Sexuality, Relationships and Family is responsible for sexual education in special education. National and district instructors who are responsible for the social and sexual education in special education, help to integrate the topic into the core curriculum of special education. The core curriculum binds all special education frameworks. The studies included in the core curriculum encompass preparation for life as well. This field includes social life in the community, the labor market, recreation culture, use of community services, health, and personal hygiene, social-sexual education, family life, living and housing in the community, being careful, and road safety.

In 2007, the department of educational programs and the department of special education in the Ministry of Education issued a guide to special education staff members: "Towards sexual maturity – aspects of sexual education in social outlook"[13] . The goals

---

[13] Y. Lachover, & R. Argaman, *Towards Sexual Maturity – Aspects of Sex Education from a Social Perspective, A Guide for Special Education Teams*, Maa'lot, 2007. [Hebrew]

of the guide are to increase awareness regarding the importance of sexual education; to expand general knowledge; to present the need for systemic intervention in teaching the subject; to help plan the instruction for adolescents and young adults, and to propose a work plan for developing sexual awareness and assertiveness.

In the past ten years, there is evidence that many special education schools have been addressing this important issue, and have been writing curricula for the social education system that are adapted to the characterization of the pupil population and their level of development and chronological age. Studies indicate a great willingness of teacher trainees to teach social-sexual education and relate to sexual and gender diversity. At the same time, most of them report that they have not received adequate training to address all aspects of sexual education and provide a professional response that is tailored to the needs of the pupils[14][15][16] [17]

Attitudes regarding sexual education among people with Developmental Cognitive Disabilities (DCD)

Sexuality and disability are two taboo issues in Western societies. Combining them challenges myths of areas considered "natural"[18] . Over the years, social attitudes regarding the sexuality of people with developmental disabilities have been extreme, including avoidance

---

[14] K. Zamir, *Education is stepping out of the closet: teachers' attitudes in Israel towards homosexuality and their willingness to address the subject in the classrooms*, [Unpublished M.A Thesis], Tel Aviv University, 2003. [Hebrew]

[15] A. Brosh, *Awareness, knowledge and willingness to deal with sex education in school among teaching students, Research report*, Mofet Institute, 2007, [Hebrew]

[16] M. Assoulin and H. Barnea, *Survey on Operating Programs in Sex Education and Family Life Education, Ministry of Education, Pedagogical Administration*, 2002, [Hebrew]

[17] A. Forer-Eilam, "And I did not know if I had the tools at all to help her deal with it or to share this big secret": attitudes of educational counselors in Israel towards gay and lesbian students, [Unpublished M.A. Thesis], The Hebrew University of Jerusalem, 2012, [Hebrew]

[18] T. Sanders, T, The politics of sexual citizenship: commercial sex and disability, *Disability & Society*, *22*(5), 439-455, 2007.

attitudes that see a person with developmental disabilities as a child in an adult body with no interest and needs in the sexual-social area; approaches that view them as people who do not understand their sexuality and as potential victims of exploitation and abuse; perceiving of their sexuality as disturbed, uncontrollable and dangerous. These perceptions led to sexual repression, restrictions, and legislation that prevented opportunities for adapted education and respectful conditions for the fulfillment of sexual-social needs[19][20][21].

Attitudes regarding sexuality have been a decisive factor in excluding people with CDD from the community. Furthermore, in various countries, they have led to the enactment of laws that allow massive coerced sterilization of people with CDD as well as the prevention of expression and sexual contacts between people with CDD, and between people with no disabilities and those with CDD[22][23]. These actions were taken to:

A. Prevent the possibility of pregnancy and the birth of other children with CDD.
B. Suppress the expression of sexual needs, for fear of child sexual abuse.
C. Protect them from sexual exploitation and abuse situations[24][25]

---

[19] R. Wright, Young people with learning disabilities and the development of sexual relationships, *Mental Health and Learning Disabilities Research and Practice, 8*(1), 2011.

[20] W. Kempton & E. Kahn, Sexuality and people with intellectual disabilities: A historical perspective, *Sexuality and Disability*, *9*(2), 93-111, 1991.

[21] M. Box & J. Shawe,The experiences of adults with learning disabilities attending a sexuality and relationship group: “I want to get married and have kids”, *Journal of Family Planning and Reproductive Health Care*, *40*(2), 82-88, 2014.

[22] R. King & D. Richards, Sterilization and birth control. In D. Griffiths, D. Richards, P. Fedoroff, & S. L. Watson (Eds.), Ethical dilemmas: Sexuality and developmental disability, NADD Press. 227-254, 2002.

[23] I. Grenon & J. Merrick, Intellectual and developmental disabilities: eugenics, *Frontiers in Public Health*, *2*, 201, 2014

[24] M. G. Gunn,. Sexual rights of mentally handicapped, Division of Legal and Criminological Psychology of BPS, 1986.

[25] A. F. Tredgold K. SoddyR.F. Tredgold & E.W. Dunkley, *Textbook of Mental Deficiency (subnormality): By RF Tredgold and K. Soddy, with the Assistance of EW Dunkley [et Al.]*, Baillière, Tindall, and Cox, 1963

In the late 1960s, with the development of genetics and rehabilitation, and the shift from the medical model to social models and the development of the normalization philosophy and community approach, there was a gradual recognition of the rights of people with disabilities. In the 1970s, the social attitude toward the sexuality of people with disabilities gradually changed, and the philosophy of normalization led to the development of a "sexual normalization" approach – i.e. recognition of the basic right to sexual expression. In the 1980s, the self-advocacy movement argued that legitimacy for sexuality was insufficient and that assistance in meeting these needs should be provided. Since then, consistently and gradually, we have witnessed a development in the sexual-social field. Although historical attitudes and approaches are now more enabling, there is still a complexity of attitudes regarding the relationship between sexuality and CDD, and a great deal of influence on the creation of responses and conditions that will allow the realization of sexuality in an appropriate manner[26] This area, unlike others, evokes various feelings among family members and staff: anxiety, caution, responsibility, rejection, threat, fear of abuse, unwanted pregnancies, inappropriate sexual behavior, unrealistic expectations, disappointment, frustration, and uncertainty about the future[27] . There are still many myths about the connection between sexuality and CDD, and perceptions of the sexuality of people with CDD are more conservative compared to people with no disabilities. Nissim[28] mentions nine main myths that nurture these attitudes: people with disabilities are asexual (lacking sexuality); people with disabilities are children inside an adult body and therefore need protection from contact with others; people

---

[26] G. di Giulio, Sexuality and People Living with Physical or Developmental Disabilities: A Review of Key Issues, *Canadian Journal of Human Sexuality*, *12*(1), 2003.

[27] R. Aloni, Sexual therapy of people with mental retardation, In A. Duvdevani et al., (Eds.), *Parenting and Developmental Disabilities in Israel*, pp. 151-163, Magnes, 1998. [Hebrew]

[28] D. Nissim, Social attitudes towards the sexuality of the mentally retarded person. *Issues in Special Education and Rehabilitation, 13*(1), 44-49, 1997, [Hebrew]

with disability have increased, uncontrollable sexual urges; people with disabilities cannot reach sexual satisfaction; sexual problems of people with disabilities are a result of their disability; people with disabilities give birth to children with disabilities, so any possibility of sexual contact should be avoided, using birth control; disabled people should maintain social and marital relationships only with other disabled people; people without disabilities who contact people with disabilities have problems; parents of children with disabilities are not interested in providing sexual education to their children. Developments in the field reinforce the importance of a systemic approach and the connection between environmental attitudes to the development of responses and the sexual behavior of people with CDD. For example: believing that people with CDD do not control their sexual urges may be strengthened if the individual does not have privacy moments or does not learn the concept of privacy and therefore he will manifest sexual behavior in socially inappropriate ways. His sexual behavior will reinforce the belief that he or she does not control sexual urges and therefore s/he should be restricted and prevented from expressing his or her sexuality[29] . Public discourse often ignores the sexuality of people with disabilities. They are subject to infantilization, especially those perceived as "dependent," and are considered emotionless and sexually incapable, similar to children[30][31] (; Brown, 1994; Rogers, 2010; Shakespeare et al., 1996; Shildrick, 2007; Tepper, 2000).

The sexuality of people with disabilities has two levels of social discourses: The first is the discourse on the relative vulnerability of people with disabilities, especially women and children, to sexual abuse (Schaaf, 2011; Shildrick, 2007; Tepper, 2000).

---

[29] W. Kempton & E. Kahn, Sexuality and people with intellectual disabilities: A historical perspective, *Sexuality and Disability*, *9*(2), 93-111, 1991.

[30] H. Brown, ‘An ordinary sexual life?’: A review of the normalization principle as it applies to the sexual options of people with learning disabilities, *Disability & Society*, *9*(2), 123-144, 1994.

[31] S. Bonnie, Disabled people, disability and sexuality, *Disabling barriers-Enabling Environments*, *19*, 124-132, 2004.

The second is the perception of sexual expressions of people with disabilities as aggressive, abnormal, or disgusting (Brown, 1994; Bonnie, 2004; Lyden, 2007; Shakespeare et al., 1996; Shildrick, 2007).

It is evident that all over the world, sex education programs for people with disabilities deal primarily with the negative aspects of human sexuality rather than sexual pleasure and sexuality as part of relationships. The social context that silences, distorts or downgrades the value of sexuality of people with CDD causes many of them to internalize these attitudes, negatively affecting their self-worth (di Giulio, 2003; Shildrick, 2007; Tepper, 2000), sometimes causing them to avoid intimacy (Yoshida, 2004).

Methodology

Participants

The current study involved 120 teachers from various schools in Israel. The vast majority were women (N = 110, 91.7%) and the rest were men (N = 10, 8.3%). The mean age of participants was 38.06 (SD = 9.04). The youngest teacher was 23 years old and the oldest was 68 years old. The mean years of seniority were 11.01 (SD = 8.36). The teacher with the longest seniority has been working in the education system for 38 years and the youngest has been working there for only one year. “classroom educator” was the most prevalent role (N = 41, 34.2%) followed by “subject teacher” (N = 30, 25%) and “therapist” (N = 30, 25%). Almost all female participants were married (N = 101, 84.2%). The more common levels of religiosity in the study were “secular” (N = 57, 47.5%) and “religious” (N = 52, 43.3). In addition, the majority of teachers had no experience in working with children with special needs (N = 72, 60%) compared with those who did (N = 48, 40%).

Data collection methods

The present study combines quantitative research with qualitative research. In the quantitative part, participants completed a questionnaire, and the qualitative part included interviews. This article presents the findings of the quantitative study.

Research tools

In this study, I used the Sexual Attitude Scale (SAS) (Hudson, Murphy, & Nurius, 1983), a 25-item summated category partition scale that was designed to measure the extent to which an individual adheres to a liberal or a conservative orientation concerning sexual expression. Each item is scored on a 5-point "agree-disagree" continuum, and all but two items are worded and scored so that a higher score represents a more conservative orientation. The SAS is scored as a bipolar agree-disagree continuum, and the total score ranges from 0 to 100 with a midpoint score of 50. A score below 50 indicates a more liberal sexual attitude, and a score above 50 indicates a more conservative sexual attitude. Concerning reliability, the scale has been investigated to have an alpha coefficient of .90 or larger. Concerning validity, the scale has been investigated to have validity coefficients of .60 or greater (Hudson, Murphy, & Nurius, 1983). The following are examples of the items on the scale: "sex education should be restricted to the home;" "I think sex should be reserved for marriage;" and "there is too much sex on television. For the present study, I omitted one statement (no. 18: heavy sexual petting should be discouraged) and added 5 statements that focus on attitudes towards sexual education for people with Developmental Cognitive Disabilities (no. 25-29)

Descriptive statistics

The independent variables in the study were the level of religiosity and the educational setting in which the teacher worked (regular or special education). The dependent variable in the study was "attitudes toward sexual education among children with special needs". The mean of attitudes in the study (degree of conservatism) was 2.44 (SD = 0.61). An examination of the questionnaire's internal reliability shows that the statements were consistent with one other, with a Cronbach α of 0.92, indicating high internal reliability.

Findings

To compare the attitudes of teachers working in special education with those of teachers working in regular education, a t-test was performed for independent samples. A significant difference was found between the groups: t (117) = 3.46, p <.01. Results indicate that the level of conservatism among special education teachers (mean=2.30) was lower than the level of conservatism among regular education teachers (mean=2.68), as shown in Figure 1.

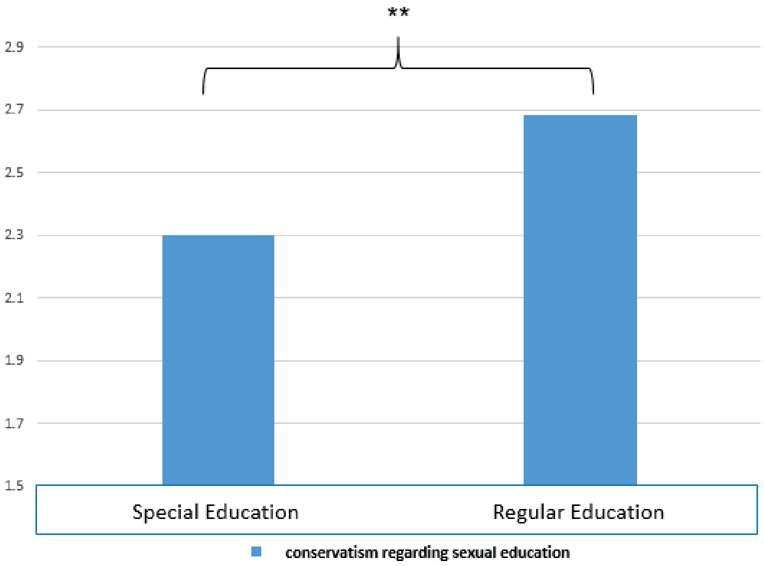

Figure 1. Differences in the level of conservatism between regular education teachers and special education teachers.

To compare the attitudes of religious versus non-religious teachers, a t-test was performed for independent samples. A significant difference was found between the groups: t (118) = 10.66, p <.01. Results indicate that the level of conservatism among religious teachers (mean=2.85) was lower than the level of conservatism among non-religious teachers (mean=1.99), as shown in Figure 2.

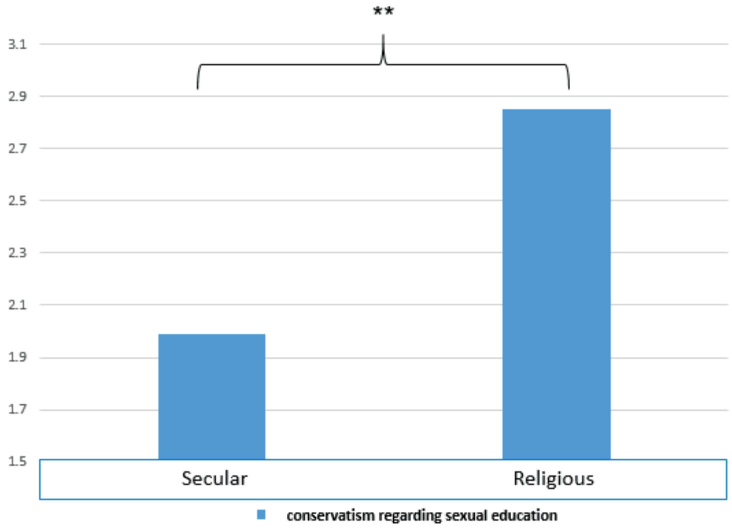

Figure 2. Differences in the level of conservatism between religious and non-religious teachers.

I examined the correlation between teachers’ attitudes and levels of conservatism in relation to their seniority and age. The results indicate a positive and significant correlation between the teachers’ seniority and their degree of conservatism, r = .32, p <.01, as shown in figure 3. This association suggests that teachers with greater seniority were more conservative regarding the sexual education of pupils with intellectual disabilities, meaning that the senior teachers' attitudes were more negative. However, there was no significant relation between the teachers’ age and their level of conservatism, r = -. 10, p = .28.

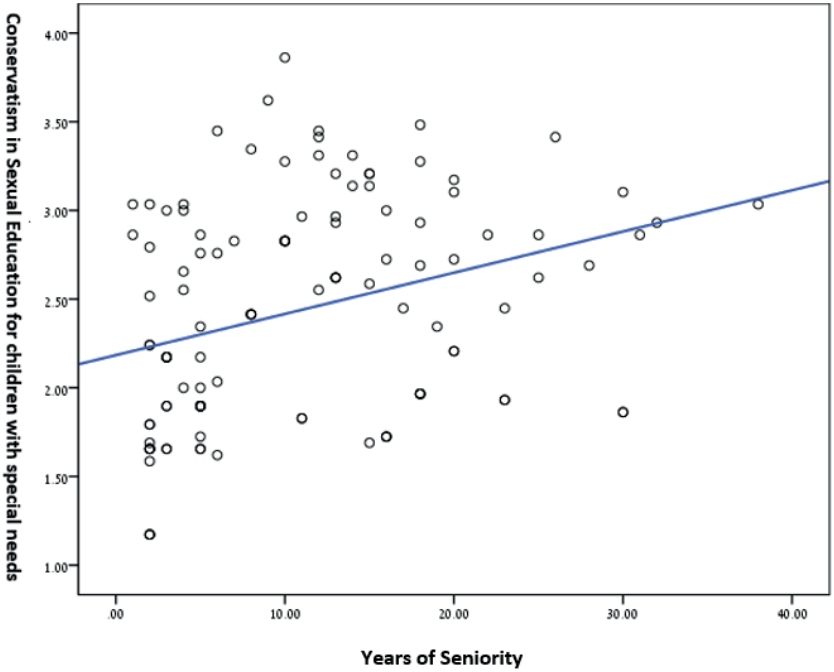

Figure 3. Diagram of the distribution of the relationship between teachers' seniority and the degree of conservatism regarding sexual education.

The study also examined whether the teacher's role at school was related to her attitudes toward sexual education and how conservative she was regarding sexual education for children with special needs. The roles of the study's participants were those of educator, subject teacher, therapist, and counselor, I performed a one-way analysis of variance (One Way ANOVA) to examine whether there was a difference in attitudes – i.e. the degree of conservatism – between the different role groups. As shown in Figure 4, there was a significant difference in the degree of conservatism F (3,109) = 5.32, p <.01. The highest degree of conservatism was found among educators (mean=2.66) and counselors (mean= 2.61). They were followed by subject teachers (mean=2.36). The school therapists displayed the lowest level of conservatism (mean=2.12).

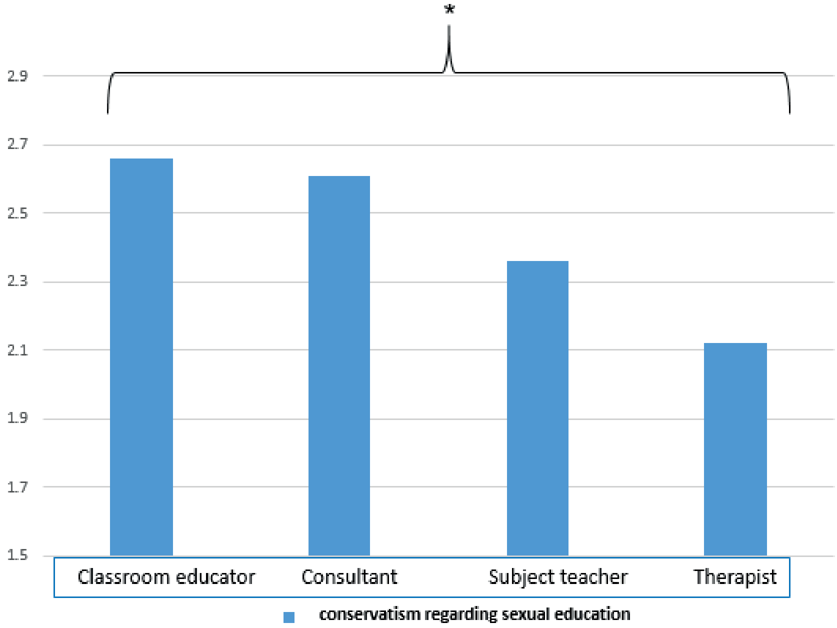

Figure 4 Differences in the average degree of conservatism by role at school.

Discussion

In recent years, there is evidence of more sex education activities – in both the mainstream population and in special education in particular.

Studies also indicate that people with intellectual disabilities face challenges related to their sexuality differently from their non-disabled peers[32]. People with CDD have difficulty making decisions, they are inexperienced, and do not have the appropriate

---

[32] D. Schaafsma, J. M. Stoffelen, G. Kok & L.M. Curfs (2013), Exploring the development of existing sex education programmes for people with intellectual disabilities: an intervention mapping approach, *Journal of Applied Research in Intellectual Disabilities*, *26*(2), 157-166.

skills needed to form healthy relationships. They have difficulty setting clear sexual boundaries, potentially entering into sexual exploitation situations[33]

In the past, sex education for students with intellectual disabilities was characterized by reluctance and confusion[34], and teachers reported a lack of materials adapted to the students' special needs[35]. Currently, however, special education schools are engaged in this important field, writing sexual education school curricula that are tailored to the students' level of development and chronological age. Nevertheless, most professional staff report not having received appropriate training in their institution to fully address all aspects of sexual education and to provide a professional and adapted response to the students[36] [37][38][39].

It was therefore important for us to explore the attitudes of the multidisciplinary team in this field. This quantitative study examined the attitudes of multidisciplinary staff regarding sex education among students with developmental intellectual disabilities. We

---

[33] A. Swango-Wilson (2009), Perception of sex education for individuals with developmental and cognitive disability: A four cohort study, *Sexuality and Disability*, *27*(4), 223

[34] M. P. McCabe(1993), Sex education programs for people with mental retardation, *Mental Retardation*, *31*(6), 377.

[35] W. J. Blanchett & P. S. Wolfe, A review of sexuality education curricula: Meeting the sexuality education needs of individuals with moderate and severe intellectual disabilities, *Research and Practice for Persons with Severe Disabilities*, *27*(1), 43-57, 2002.

[36] M. Assoulin & H. Barnea (2002), *Survey on Operating Programs in Sex Education and Family Life Education, Ministry of Education, Pedagogical Administration*, [Hebrew]

[37] A. Brosh, *Awareness, knowledge and willingness to deal with sex education in school among teaching students*, *Research report*. Mofet Institute, 2007. [Hebrew]

[38] A. Forer-Eilam, "And I did not know if I had the tools at all to help her deal with it or to share this big secret": attitudes of educational counselors in Israel towards gay and lesbian students, [Unpublished M.A. Thesis], The Hebrew University of Jerusalem, 2012. [Hebrew]

[39] K Zamir, *Education is stepping out of the closet: teachers' attitudes in Israel towards homosexuality and their willingness to address the subject in the classrooms*, [Unpublished M.A Thesis]. Tel Aviv University, 2003. [Hebrew]

were interested to learn whether there are differences in attitudes between religious and secular teachers; between regular education and special education teachers, and between educators in different roles at schools.

The study findings show that the level of conservatism among special education teachers was lower than the level of conservatism among regular education teachers, i.e., special education teachers expressed more positive attitudes toward sexual education. Presumably, the training that special education teachers receive, and their actual work with this population, contribute to their positive attitude. This finding is consistent with Pebdani's study[40], which examined the attitudes of people working in care homes for people with intellectual disabilities, and found that training and mentoring have a positive effect on their attitudes towards the sexual rights of people with intellectual disabilities.

The findings also indicated that the level of conservatism among religious teachers was higher than the level of conservatism among non-religious teachers, i.e., non-religious teachers expressed more positive attitudes. This finding is consistent with the findings of Berger et al. (2004), who found that teachers with a high level of faith in God disagree with gender equality, homosexuality rights, abortion or contraceptive methods, as well as with the teaching of the social component of sexual education before the age of 15.

The findings are also congruent with those of Ionescu and colleauges[41], who found that participants who rated their religious level as high presented a conservative approach to teaching sex education, while those rating their level of religiosity as lower tended to

---

[40] R. N. Pebdani, Attitudes of group home employees towards the sexuality of individuals with intellectual disabilities, *Sexuality and Disability*, *34*(3), 329-339, 2016.

[41] C. E. Ionescu, A. S. Rusu & C. Costea-Bărluțiu, Attitudes of Special Education teachers towards sexual education of students with intellectual disabilities: Effects of religiosity and professional experiences, *Educatia 21* (17), 102-111, 2019.

talk about sex education, and their general attitude towards sexuality was more positive.

It was also found that there is a positive and significant relation between the seniority of teachers and their degree of conservatism: the more years of experience teachers had, the more negative were their attitudes regarding the sexual education of students with Developmental Cognitive Disabilities (DCD).

This finding is consistent with the study of Ionescu and colleagues[42] who investigated the relationship between teachers' age and teachers' attitudes toward teaching sex education in special education schools. They found that the older the teacher, the more negative his attitudes. Although we did not find a connection between attitudes and age, it is likely to assume that teachers with more years of experience/greater seniority are mostly older. Hence, teachers with more seniority and greater teaching experience do not necessarily have more open-minded and less conservative attitudes. Veteran teachers also need training in sex education, for their attitudes to be more positive.

The study also examined the relationship between the role of the teacher and that teacher's attitudes. The study reveals surprising findings – the highest degree of conservatism was found among teachers and counselors, followed by professional teachers and then school therapists – who demonstrated the lowest level of conservatism. This means that the most positive attitudes were found among the paramedical therapists and the more negative – among the educators and counselors.

The fact that therapists presented the most positive attitudes is not surprising: the results of this study are consistent with other studies discussing caregivers' perceptions of sexuality among people with special needs. Studies indicate that, in general, therapists

---

[42] C. E. Ionescu, A. S. Rusu & C. Costea-Bărluțiu, Attitudes of Special Education teachers towards sexual education of students with intellectual disabilities: Effects of religiosity and professional experiences, *Educatia 21* (17), 102-111, 2019.

have positive perceptions about sexuality and intimate relationships of adults with CDD[43][44][45][46][47][48]

The surprising finding is the attitudes of the educators, who manifested a high degree of conservatism, and more negative attitudes, towards sex education. One would expect that educators, who are in daily and intensive contact with students, would be aware of the need for sex education, and that their attitudes would be positive, and less conservative. This finding can be explained by the ambivalence that educators feel: on the one hand, they are aware of the need, while on the other hand, they are also aware of the disability. Other studies show that people can have contradicting perceptions, as for example, in the results of Wilkinson's[49] study. These findings showed that while therapists related to people with intellectual disabilities as "normal" and "as having the same rights of others", they also referred to their functional impairments, and viewed their sexuality as problematic.

---

[43] M. Aunos & M. A. Feldman, Attitudes towards sexuality, sterilization and parenting rights of persons with intellectual disabilities, *Journal of Applied Research in Intellectual Disabilities*, *15*(4), 285-296, 2002.

[44] G. Bazzo, L. Nota, S. Soresi, L. Ferrari, & P. Minnes, Attitudes of social service providers towards the sexuality of individuals with intellectual disability, *Journal of Applied Research in Intellectual Disabilities*, *20*(2), 110-115, 2007.

[45] M. Cuskelly, & R. Bryde, Attitudes towards the sexuality of adults with an intellectual disability: parents, support staff, and a community sample, *Journal of Intellectual and Developmental Disability*, *29*(3), 255-264, 2004.

[46] L. Gilmore, L & B. Chambers, Intellectual disability and sexuality: Attitudes of disability support staff and leisure industry employees, *Journal of Intellectual and Developmental Disability*, *35*(1), 22-28, 2010.

[47] V. J. Wilkinson, K. Theodore & R. Raczka, ‘As normal as possible’: Sexual identity development in people with intellectual disabilities transitioning to adulthood, *Sexuality and Disability, 33*(1), 93-105, 2015

[48] K. Ćwirynkało, S. Byra & A. Żyta, Sexuality of adults with intellectual disabilities as described by support staff workers, *Hrvatska Revija za Rehabilitacijska Istrazivanja*, *53*, 77-87, 2017.

[49] V. J. Wilkinson, K. Theodore & R. Raczka, ‘As normal as possible’: Sexual identity development in people with intellectual disabilities transitioning to adulthood, *Sexuality and Disability, 33*(1), 93-105, 2015

The results of the present study are consistent with previous studies[50][51][52][53][54] . Similar to the results found by Wilkinson and colleagues[55], the therapists in the present study seemed caught between different perceptions. On the one hand, they presented people with CDD as 'normal' and having the same rights as others; and on the other hand, they subscribed to societal ideas about their functional deficits, perceiving their sexuality as a problem.

Practical implications

Studies indicate that most adolescents with intellectual disabilities have only limited knowledge about sexuality and fewer opportunities to learn about it [56][57]. Hence, discussing sexual education with students with CDD is the role of the multidisciplinary staff members.

---

[50] M. Aunos & M. A. Feldman, Attitudes towards sexuality, sterilization and parenting rights of persons with intellectual disabilities, *Journal of Applied Research in Intellectual Disabilities*, *15*(4), 285-296, 2002.

[51] G. Bazzo, L. Nota, S. Soresi, L. Ferrari & P. Minnes, Attitudes of social service providers towards the sexuality of individuals with intellectual disability, *Journal of Applied Research in Intellectual Disabilities*, *20*(2), 110-115, 2007.

[52] M. Cuskelly & R. Bryde, Attitudes towards the sexuality of adults with an intellectual disability: parents, support staff, and a community sample, *Journal of Intellectual and Developmental Disability*, *29*(3), 255-264, 2004.

[53] L, Gilmore & B, Chambers, Intellectual disability and sexuality: Attitudes of disability support staff and leisure industry employees, *Journal of Intellectual and Developmental Disability*, *35*(1), 22-28, 2010

[54] V. J. Wilkinson, K. Theodore & R. Raczka, ‘As normal as possible’: Sexual identity development in people with intellectual disabilities transitioning to adulthood, *Sexuality and Disability, 33*(1), 93-105, 2015

[55] V. J. Wilkinson, K. Theodore R. Raczka, ‘As normal as possible’: Sexual identity development in people with intellectual disabilities transitioning to adulthood, *Sexuality and Disability, 33*(1), 93-105, 2015

[56] M. M. Cheng J. R. Udry, Sexual behaviors of physically disabled adolescents in the United States, *Journal of Adolescent Health*, *31*(1), 48-58, 2002.

[57] G. H. Murphy & A. O'callaghan, Capacity of adults with intellectual disabilities to consent to sexual relationships, *Psychological Medicine*, *34*(7), 1347, 2004.

These findings suggest that training is needed for teachers in regular education, and among religious teachers, who are more conservative concerning sex education for people with special needs. Findings also suggest that there is a connection between the teacher's role and her attitudes, and that teachers' training should take into account their respective disciplines. Veteran teachers have shown more negative attitudes, which is why training, not only among teaching students and young teachers but also among veteran teachers has an impact on their attitudes towards sex education among people with special needs. This training, beyond the knowledge provided, will facilitate changes in social attitudes and promote a more positive view towards people with special needs.

This study adds to the body of knowledge on sex education among special education students, as well as the attitudes of members of the multidisciplinary staff. The study has responded to the call to turn the spotlight on the training of teaching students, the training of veteran teachers, and the training of religious teachers – given the potential and value of such training to the changing of attitudes, and promoting a less conservative standpoint. It is hoped that such training will result in an effective sexual education among special education students, thus promoting maximal quality of life in the sexual domain as well.

Study limitations and Future Research

The current study involved mainly women, both religious and secular, with very few male teachers and Ultra-Orthodox teachers. It is recommended to conduct a similar study and examine the relationship between gender and attitudes toward sex education. In light of the significant changes taking place in Ultra-Orthodox society regarding sexual education, I would recommend conducting research examining the attitudes of Ultra-Orthodox staff, of both genders, towards sexual education among people with CDD.

References

Aloni, R. (1998). Sexual therapy of people with mental retardation. In A. Duvdevani et al., (Eds.), *Parenting and Developmental Disabilities in Israel*, pp. 151-163. Magnes. [Hebrew]

American Association on Mental Retardation. (2002*). Mental retardation*: definition classification, and systems of supports (10th Ed). AAMA.

Arnan, K. (1995). *Life Skills for 5th-6th Grades: Skills, developmental and preventive issues for the state and state religious primary schools*. Maa'lot. [Hebrew]

Assoulin, M. and Barnea, H. (2002). *Survey on Operating Programs in Sex Education and Family Life Education. Ministry of Education, Pedagogical Administration*. [Hebrew]

Aunos, M., & Feldman, M. A. (2002). Attitudes towards sexuality, sterilization and parenting rights of persons with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, *15*(4), 285-296.

Bazzo, G., Nota, L., Soresi, S., Ferrari, L., & Minnes, P. (2007). Attitudes of social service providers towards the sexuality of individuals with intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, *20*(2), 110-115.

Blanchett, W. J., & Wolfe, P. S. (2002). A review of sexuality education curricula: Meeting the sexuality education needs of individuals with moderate and severe intellectual disabilities. *Research and Practice for Persons with Severe Disabilities*, *27*(1), 43-57.

Bonnie, S. (2004). Disabled people, disability and sexuality. *Disabling barriers-Enabling Environments*, *19*, 124-132.

Box, M., & Shawe, J. (2014). The experiences of adults with learning disabilities attending a sexuality and relationship group: "I want to get married and have kids". *Journal of Family Planning and Reproductive Health Care*, *40*(2), 82-88.

Brosh, A. (2007). *Awareness, knowledge and willingness to deal with sex education in school among teaching students***.** *Research report*. Mofet Institute. [Hebrew]

Brown, H. (1994). 'An ordinary sexual life?': A review of the normalisation principle as it applies to the sexual options of people with learning disabilities. *Disability & Society*, *9*(2), 123-144.

Cheng, M. M., & Udry, J. R. (2002). Sexual behaviors of physically disabled adolescents in the United States. *Journal of Adolescent Health*, *31*(1), 48-58.

Cuskelly, M., & Bryde, R. (2004). Attitudes towards the sexuality of adults with an intellectual disability: parents, support staff, and a community sample. *Journal of Intellectual and Developmental Disability*, *29*(3), 255-264.

Ćwirynkało, K., Byra, S., & Żyta, A. (2017). Sexuality of adults with intellectual disabilities as described by support staff workers. *Hrvatska Revija za Rehabilitacijska Istrazivanja*, *53*, 77-87.

di Giulio, G. (2003). Sexuality and People Living with Physical or Developmental Disabilities: A Review of Key Issues. *Canadian Journal of Human Sexuality*, *12*(1).

Finan, S. L. (1997). Promoting healthy sexuality: guidelines for infancy through preschool. *The Nurse Practitioner*, *22*(10), 79-80.

Firstater, E., & Lapidot-Berman, Y. (2018). Sex education – why bother? The contribution of a course in human sexuality to teaching students. *Rav Gvanim: Mekhkar va'Siach, 16*, 81-53. [Hebrew]

Forer-Eilam, A. (2012). "And I did not know if I had the tools at all to help her deal with it or to share this big secret": attitudes of educational counselors in Israel towards gay and lesbian students. [Unpublished M.A. Thesis]. The Hebrew University of Jerusalem. [Hebrew]

Furey, E. M. (1994). Sexual abuse of adults with mental retardation: Who and where. *Mental Retardation*, *32*(3), 173.

Gilmore, L., & Chambers, B. (2010). Intellectual disability and sexuality: Attitudes of disability support staff and leisure industry employees. *Journal of Intellectual and Developmental Disability*, *35*(1), 22-28.

Grenon, I., & Merrick, J. (2014). Intellectual and developmental disabilities: eugenics. *Frontiers in Public Health*, *2*, 201.

Gunn, M. G. (1986). Sexual rights of mentally handicapped. Division of Legal and Criminological Psychology of BPS.

Guvrin, N. (2007) Flowers, butterflies and bees: Sex education for children and youth in the Land of Israel. *Olam Katan, 3*, 82-66.

Ionescu, C. E., Rusu, A. S., & Costea-Bărluțiu, C. (2019). Attitudes of Special Education teachers towards sexual education of students with intellectual disabilities: Effects of religiosity and professional experiences. *Educatia 21* (17), 102-111.

Kempton, W., & Kahn, E. (1991). Sexuality and people with intellectual disabilities: A historical perspective. *Sexuality and Disability*, *9*(2), 93-111.

King, R., & Richards, D. (2002). Sterilization and birth control. In D. Griffiths., D. Richards, P. Fedoroff, & S. L. Watson (Eds.), Ethical dilemmas: Sexuality and developmental disability. NADD Press. 227-254.

Kukulu, K., Gürsoy, E., & Sözer, G. A. (2009). Turkish university students' beliefs in sexual myths. *Sexuality and Disability*, *27*(1), 49-59.

Lacey, P., & Lomas, J. (2013). *Support services and the curriculum: A practical guide to collaboration*. Routledge.

Lachover, Y., & Argaman, R. (2007). *Towards Sexual Maturity – Aspects of Sex Education from a Social Perspective, A Guide for Special Education Teams*. Maa'lot. [Hebrew]

Lyden, M. (2007). Assessment of sexual consent capacity. *Sexuality and Disability*, *25*(1), 3-20.

Manor-Binyamini, I. (2003). Collaboration within a multidisciplinary team at a special education school**.** *Issues in Special Education and Rehabilitation, 18* (1), 61-74. [Hebrew]

Manor-Binyamini, I. (2009). Multidisciplinary teamwork – theory, research, and application. Ministry of Education, publications division.

McCabe, M. P. (1993). Sex education programs for people with mental retardation. *Mental Retardation*, *31*(6), 377.

Murphy, G. H., & O'callaghan, A. (2004). Capacity of adults with intellectual disabilities to consent to sexual relationships. *Psychological Medicine*, *34*(7), 1347.

Nissim, D. (1997). Social attitudes towards the sexuality of the mentally retarded person. *Issues in Special Education and Rehabilitation, 13*(1), 44-49. [Hebrew]

Pebdani, R. N. (2016). Attitudes of group home employees towards the sexuality of individuals with intellectual disabilities. *Sexuality and Disability*, *34*(3), 329-339.

Rogers, C. (2010). But it's not all about the sex: Mothering, normalisation and young learning disabled people. *Disability & Society*, *25*(1), 63-74.

Sanders, T. (2007). The politics of sexual citizenship: commercial sex and disability. *Disability & Society*, *22*(5), 439-455.

Schaaf, M. (2011). Negotiating sexuality in the convention on the rights of persons with disabilities. *SUR-International Journal on Human Rights*, *14*, 113.

Schaafsma, D., Kok, G., Stoffelen, J. M. T., & Curfs, L. M. G. (2017). People with intellectual disabilities talk about sexuality: implications for the development of sex education. *Sexuality and disability*, *35*(1), 21-38.

Schaafsma, D., Stoffelen, J. M., Kok, G., & Curfs, L. M. (2013). Exploring the development of existing sex education programmes for people with intellectual disabilities: an intervention mapping approach. *Journal of Applied Research in Intellectual Disabilities*, *26*(2), 157-166.

Sciaraffa, M. (2012). Suzie's Mommy Is Having a Baby: Don't Freak out! Healthy Sexuality Development in Young Children. *Exchange: The Early Childhood Leaders' Magazine Since 1978*, *207*, 104-108.

Sciaraffa, M., & Randolph, T. (2011). "You want me to talk to children about what?": Responding to the subject of sexuality development in young children. *YC Young Children*, *66*(4), 32.

Shaked, L. (2006). Implementation process of the Special Education Law in Israel. [Unpublished Ph.D. dissertation] Bar Ilan University. [Hebrew]. https://www.nli.org.il/he/dissertations/NNL_ALEPH002523741/NLI

Shakespeare, T., Gillespie-Sells, K., & Davies, D. (1996). The Sexual Politics of Disability. Cassell.

Shildrick, M. (2007). Contested pleasures: The sociopolitical economy of disability and sexuality. *Sexuality Research & Social Policy*, *4*(1), 53.

Swango-Wilson, A. (2009). Perception of sex education for individuals with developmental and cognitive disability: A four cohort study. *Sexuality and Disability*, *27*(4), 223.

Tepper, M. S. (2000). Sexuality and disability: The missing discourse of pleasure. *Sexuality and Disability*, *18*(4), 283-290.

Tredgold, A. F., Soddy, K., Tredgold, R. F., & Dunkley, E. W. (1963). *Textbook of Mental Deficiency (subnormality): By RF Tredgold and K. Soddy, with the Assistance of EW Dunkley [et Al.]*. Baillière, Tindall, and Cox.

Weissblei, E. (2010). *Sex education in the education system.* Knesset Research and Information Center. https://www.knesset.gov.il/mmm/data/pdf/m02462.pdf

Weissblei, E. (2013). The Education System in Israel. Knesset Research and Information Center. [Hebrew]. https://fs.knesset.gov.il/globaldocs/MMM/21556b58-e9f7-e411-80c8-00155d010977/2_21556b58-e9f7-e411-80c8-00155d010977_11_7137.pdf

Weissblei, E. (2015). *Education for Children with Special Needs in Israel – Data and Key Issues*. The Knesset Research and Information Center. [Hebrew]

Wilkinson, V. J., Theodore, K., & Raczka, R. (2015). 'As normal as possible': Sexual identity development in people with intellectual disabilities transitioning to adulthood. *Sexuality and Disability, 33*(1), 93-105.

Wright, R. (2011). Young people with learning disabilities and the development of sexual relationships. *Mental Health and Learning Disabilities Research and Practice, 8*(1).

Yoshida, K. K. (1994). Intimate and marital relationships: An insider's perspective. *Sexuality and Disability*, *12*(3), 179-189.

Zamir, K. (2003). *Education is stepping out of the closet: teachers' attitudes in Israel towards homosexuality and their willingness to address the subject in the classrooms***.** [Unpublished M.A Thesis]. Tel Aviv University. [Hebrew]

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

IWONA LILLY
University of Łódź, Poland

Dear Mother Victoria

ABSTRACT: Iwona Lilly, *'Dear Mother Victoria*. Interdisciplinary Contexts of Special Pedagogy, No. 32, Poznań 2021. Pp. 213-226. Adam Mickiewicz University Press. ISSN 2300-391X. eISSN 2658-283X. DOI: https://doi.org/10.14476/ikps.2021.32.11

Motherhood is by many, especially women, one of the greatest experiences in life. The ultimate goal that women, if not all than many, should achieve. Nowadays, we are flooded with help books, websites, guides that lead us through pregnancy and then assist us during the first months of our new born baby. This blessed state seems to be cherished now above all, however, this view was not always the same. Throughout history we can see many women for whom maternity was not meant to be and still they were able to fulfil their life-time goals devoting themselves to other areas of life. For some, maternity was rather a political aspect that would secure the future of the nation. In my article I will focus on the aspect of motherhood through the eyes of Queen Victoria for whom, indeed, maternity was rather an unwelcomed addition to her royal life. I will discuss her own rigid upbringing which can help to understand her later attitude towards her own children. The trend, where there were no proper roles ascribed to parents in terms of their influence on their children, was predominant in the 19th century and based on this we can see how important it was for character creation.

KEY WORDS: Queen Victoria, upbringing, royal children, Prince Albert, Kensington System

Motherhood is considered by many to be one of the greatest and most amazing experiences in life. This is an ultimate goal that women, if not all then many, should achieve. For this reason, nowadays women are flooded with maternity help books, websites providing a step-by-step guide through pregnancy, blogs, vlogs and many more; all to aid the healthy, modern, undisturbed upbringing of future generations.

However, this godly attitude towards the blessed state was not always cherished as such. History reveals many women aiding in the idea that children are not always what everyone should yearn for – Queen Elizabeth I, Jane Austen, Florence Nightingale, Beatrix Potter and many more, famous in many areas, give solid proof that having offspring might not always be a life-time goal. Nevertheless, bearing children, especially boys, was believed to be the utmost luck and ensured the families of different social statuses that there will be continuity of the blood line. Of course, for those for whom the fortune foresaw a broom and the bad end of the street, children often meant expenses and worry. However, for those who had a crown or riches in their cards, it was often a race to be the first with the child brought into this world.

The 19th century is when the world went through many turbulent events. England is considered to be a country that has undergone many of those. The very beginning of it brought an unsteady situation on the court and it only ended with a succession race that began in 1817 with the death of Princess Charlotte, the granddaughter of George III. King George III's surviving daughters were either childless or past their bearing age. The unmarried sons began the charades of marriage in order to produce legitimate heirs. In the end, after many tumultuous events, the crown of the Albion was passed on to a young girl of only 18 years – Alexandrina Victoria – or as more commonly known – Queen Victoria.

Queen Victoria was and is and perhaps will be the most cherished and beloved queen. Her monuments adorn the squares of many cities in the world. Nicknamed the Grandmother of Europe, she assured that her lineage was linked to the most influential royal households of Europe. A doting mother to her people across the globe, on the homefront she was far from the ideal picture of warmth and love. However, to understand the implications influencing her character and attitude towards motherhood, it is vital to understand the importance of her own upbringing. What one is subjected to as a child indefinitely shapes the future character and frames the approach one has towards having their own children and the style of raising offspring. In the case of Queen Victoria, undoubtedly, her own experience played a vital role in her future position as a mother. One would say, quite a distant mother whose approach stood greatly in opposition to the parenting style presented by her husband, Prince Albert, who, just like Victoria, did not have an easy childhood himself. Thus, the question remains: was the cold, structural, rule-regulated upbringing the cause of Victoria's mothering style?

Victoria was the child of Prince Edward, Duke of Kent and Strathearn, who was the fourth son of King George III and Princess Victoria of Saxe-Coburg-Saalfeld. She was born on May, 24, 1819 as the only child of the couple. At that time, Victoria was fifth in line to the throne. Her father, before marrying Princess Victoria, had been involved in some liaisons of which the most known is the one with Madame de Saint-Laurent. She was the wife of a French colonel whom she left for Prince Edward in order to spend almost 28 years with. They went together to Canada where the Prince was commander-in-chief of British forces in the Maritime Provinces of North America.[1] Victoria's mother, Princess Victoria of Saxe-Coburg-Saalfeld, when marrying Prince Edward, had already been married once to Charles, Prince of Leiningen, with whom she had two children. However, she was widowed in 1814. After her first husband died, she became a regent of the Principality during the time his son, Carl, was a minor. Following Princess Charlotte's death, her widowed husband Prince Leopold of Saxe-Coburg, who was Victoria's brother, foresaw the succession crisis and thus suggested Princess Victoria as the wife of Prince Edward. They got married in 1818. A year after and heavily pregnant, Princess Victoria and Prince Edward travelled across Europe to reach England in order to have their child born on English land. The marriage was considered a happy

---

[1] Worsley, L., *Queen Victoria: daughter, wife, mother, widow*, Hodder & Stoughton, London, 2018, p. 17.

one. Prince Edward was fully devoted to his wife and put aside his long-time mistress. However, their happiness did not last long as the Prince, while staying in Sidmouth, contracted pneumonia and died on January 23, 1820.[2] Even though Victoria was deprived of the loving father figure, throughout her life she was quite fond of him – especially the fact that he was a military man. For her, being the daughter of a soldier was something she often mentioned.[3] Indeed, she felt a void that throughout the years she did try to fill with different male paragons – Lord Melbourn, King Leopold, Prince Albert, or even John Brown.

The missing father figure left an imprint on her upbringing that was lacking proper fatherly love. Instead, Victoria was left in the hands of her mother, Duchess Victoire and Sir John Conroy, who was an executor of Prince Edward's will. By many, he was a vile and cruel person "whose name is absent from the *Dictionary of National Biographies*".[4] His sole purpose was to shape Victoria to his liking and only for the purpose of gaining control and influence over the future queen. In order to achieve this somewhat gruesome aim, Conroy, with the silent consent of Duchess Victoire designed a system that would allow him to be fully in charge of little Victoria's life. It was known as 'the Kensington System' or simply 'the System'.[5] This hostile, demanding, and oppressive set of rules subjecting the princess to isolation, was targeted at creating a proper, devoted, most respectable and etiquette-versed princess. In this vile environment there was no place for regular, warm emotions that would be given to a child by a loving mother. Of course, she did love her mother as it was her duty, however, it was her governess, Lehzen, her dear half-sister Feodora, and Uncle Leopold

---

[2] Ashdown, D., *Queen Victoria's Family*, Robert Hale & Company, London, 1975, p. 20.

[3] Ibid

[4] *Queen Victoria's early letters,* edited by Raymond, J., Batsford Ltd, London, 1963, p. 4.

[5] Vallone, L. *Becoming Victoria*, Yale University Press, NY, 2001, p. 8.

who created or at least had given Victoria something resembling family love.[6]

Studying the relationship Victoria had with her own mother one can realise that this was a rather toxic relation that cast a shadow on Victoria's own relations with her nine children. The scrutiny she was subjected to till the moment she became Queen was unbearable. "Morning and evening, day and night, there was no relaxation of the maternal vigilance. The child grew into the girl, the girl into the young woman; but still she slept in her mother's bedroom; still she had no place allowed her where she could sit or work by herself."[7] It needs to be noted that the control Victoria was subjected to, in present times is perceived to be completely irrational, even pathological. She was not allowed to walk down the stairs without someone holding her hand, play time was regulated, education was to be executed with the highest standards. She was supposed to have her education moderated at the early age of five in a way that would make her fit to be the sovereign, or if not, that hold a position within the Royal Family.[8] This ill-conceived protection of Victoria lasted till the moment of the King's death and her abrupt succession to the throne. She had managed to overcome the tyranny she was subjected to by the hands of her own kin, and from that moment onwards she cut off all virtual strings that were attached to her body, mind, and soul. She removed herself from her mother's bedroom, disposed of Conroy, and denied her mother any insight into the ministerial meetings. This was the end of Victoria's childhood – a childhood that was deprived of parental love, stability and devotion.[9]

This emotional structure that shaped the Queen influenced her future relationship with her children, as well as the overall and general perception of motherhood which was not positive in any

---

[6] Strachey, L., *Queen Victoria*, First Harvest/HBJ Edition, 1978, p. 36.

[7] Ibid, p. 43.

[8] Benson and Esher, *Letters of Queen Victoria 1837-1861,* ed.1908, vol. I as found on https://www.gutenberg.org/files/20023/20023-h/20023-h.htm#pagei.8 access on 17/02/2021.

[9] Ashdown, D., op. cit., p. 39.

manner. It is widely acknowledged and agreed upon by many historians that the Queen, even though she gave birth to nine children, was not a fond and doting mother. Victoria considered pregnancy as an unwanted, sad result of an intimate relationship with Prince Albert. She absolutely enjoyed this relationship as she often proved herself to be passionate and ultimately devoted to her Angel. And for this passionate reason she detested having children. She conceived distressingly soon after the wedding, "I was in for it at once & furious I was"; "the greatest horror of having children and would rather have none".[10] She described herself when pregnant as "ugly & enormously fat, more like a barrel than anything else".[11]

Within seventeen years, Victoria gave birth to nine children – five girls: Victoria (1840), Alice (1843), Helena (1946), Louise (1848) and Beatrice (1857); and four boys: Albert (1841), Alfred (1844), Arthur (1850) and Leopold (1853). When Vicky was born, Victoria was greatly disappointed for the child to be a girl as she knew that now she would have to get pregnant again in order to produce a male heir to the throne. She remarked "It would have been better politics to have produced a male heir straight away, as she and Albert had so hoped and wished for. We were, I am afraid, sadly disappointed."[12] Victoria did attend to some extent to her first born, Victoria or Vicky as she was referred to by all. However, she did not see very much of her daughter. The care and upbringing of the royal babies was so well professionalised and outsourced that the Queen only saw Vicky naked in the bath only twice in the first five weeks of the child's life.[13] Nevertheless, with time, when more children came, she felt as if all were the same, she could not tell them apart. Besides, as Victoria

---

[10] As quoted in Pakula, H., *An uncommon woman*, Weidenfeld & Nicolson, NY, 1997, p.104.

[11] RA VIC/MAIN/QVLB/ 10 November 1840 as found in Worsley, L., op. cit., p. 151.

[12] As quoted in Woodham-Smith, C., *Queen Victoria,* Black Five Books, 1972, p. 216-217.

[13] Worsley, L., op. cit., p. 159.

thought, "children were not terribly interesting, mere little plants for the first six months."[14]

For Victoria, her children were those who kept her dear Albert away from her. At one point she stated, "all the numerous children are as nothing to me when he is away; it seems as if the whole life of the house and home were gone."[15] "I find no especial pleasure or compensation in the company of children, I only feel properly a mon aise & quite happy when Albert is with me."[16]

Victoria's children were able to tell that their mother shared quite mixed feelings towards them and as a result, they grew up to be rebellious and dysfunctional. They did undergo a rigorous educational regime designed by their father as he had high expectations and standards of intellectual achievements and self-control.[17] If the children turned to be unruly their behaviour would be corrected by force. Albert did not shy away from beating the children even for the smallest error, "they had almost more than their share of corporal punishment from the hands of their father."[18]

After each pregnancy, Victoria retreated from politics more and more, becoming more dependent on her husband. When she gave birth to Vicky, she did return to her state quite swiftly. However, after giving birth to Bertie, she suffered rather severe postnatal depression, "my poor nerves were so battered… I suffered a whole year from it."[19] The Queen experienced vision impairment "spots on peo-

---

[14] As quoted in Pakula, H., *An uncommon woman*, Weidenfeld & Nicolson, NY, 1997, p.105.

[15] Benson and Esher, *Letters of Queen Victoria 1837-1861,* ed.1908, vol. 3, as found on https://www.gutenberg.org/files/20023/20023-h/20023-h.htm#pagei.240 access on 17/02/2021.

[16] As quoted in Ponsonby, F., *Recollections of Three Reigns: Prepared for the Press with Notes and an Introduction by Colin Welch,* London, ed. 1951, p. 85.

[17] Worsley, L., op. cit., p. 169.

[18] Anon., *The Private Life of Queen Victoria*, ed. 1901, p. 42 as found on https://babel.hathitrust.org/cgi/pt?id=loc.ark:/13960/t9n30j31n&view=1up&seq=64.

[19] Weintraub, S., *Uncrowned King: The Life of Prince Albert,* Simon & Schuster, New York, 1997, p. 137.

ple, which turned into worms", "coffins floated before her eyes".[20] Victoria understood that her mental state was an illness that came and went but was distinctly connected with pregnancies. She clearly addressed the discomfort of being pregnant so quickly. However, Albert persisted on having more children. He also hoped that they would occupy the Queen to such an extent that would allow him to assume more power and responsibility.[21] As much as the fact of being pregnant and having children was not too much of a pleasing state for Victoria, she did, however, enjoy the intimate relations she had with Albert that led to having children in the end. And it is truly fortunate that in the midst of the XIX century the Queen and Prince Consort never lost a child, and in the end, they welcomed nine little princesses and princes between the years 1840 and 1857.

Victoria was quite ashamed of her fertility and thought very low of women who were frequently pregnant. She often compared them to rabbits or guinea pigs.[22] She strongly opposed breastfeeding and always had a wet nurse employed. Many years later, her own two daughters, Vicky and Alice breast fed their own babies and at one time even Vicky breast fed one of Alice's children when the latter was ill. It is perhaps with some spitefulness on Victoria's side that soon after she had found out how maternal her daughters were one of her cows was named 'Princess Alice'.

The Queen never enjoyed being around small babies as she detested them and for her, they were ugly and unruly. She preferred to see them dressed nicely, quiet and docile.[23] Her own offspring was seen by her only for a limited time as they tended to annoy her. There were perhaps just a few occasions when the Queen actually had to take care of her own children. However, she was completely perplexed and did not know much of what had to be done. Such a stance happened once on their way from London to Windsor when on a train, together with her ladies-in-waiting, she was left with her

---

[20] Worsley, L., op. cit., p. 172.

[21] Ibid.

[22] Ashdown, D., op. cit., p. 63.

[23] Ibid.

own children as the nannies were parted from them and were placed elsewhere. From the very beginning it was made clear that Victoria would not be the one overlooking and raising the children. This duty fell upon Prince Albert who made it his priority to make the children suitable for the top places in government and European society. Their education not only had to be perfect, but their characters had to be moulded and shaped in order to express the best possible features of character and high moral standards. Thus, he was the one that would spend countless hours playing with them, dragging them along the Buckingham corridors,[24] simply spending time with them. His never-ending worry and planning for their future was manifested by the tedious educational regime introduced by Prince Albert. Vicky, the Princess Royal, the first child, was the most promising in terms of the intellect, wit and learning abilities. By the age of four, the little princess managed to master French to such an extent that she was able to perform some lines of poetry. At the same time, the same features were not bestowed upon the Prince of Wales, future king, Bertie. He seemed to be reluctant to learn, even resistant to the knowledge he was being taught. Where Vicky was quick and bright, Bertie was slow and somewhat dim. This situation was the reason for Vicky constantly teasing her younger brother. She had a real conviction of her importance and superiority and even teased her brother on his intellectual inferiority. She believed for years that it was her who would sit on the throne at some point, and she made it extremely difficult to be convinced otherwise.[25] This belief led to her feeling superior to others and treating people with little respect. It was an arduous task to teach her appreciation and reverence.

With the family becoming bigger and bigger the system of upbringing the children improved. However, both Victoria and Albert strongly believed that the children under no conditions should be spoiled. For this reason, their nursery was small, food was plain, and their clothes expressed economy. However, education was not to be

---

[24] Ibid, p. 69.

[25] Ibid, p. 63.

treated cheaply. The whole process was divided into three stages: first was the elementary stage under the supervision of Lady Lyttelton, called Laddle by the children. She was the one who took over after the dismissal of Lehzen. Laddle was responsible for the children even after entering the next stage of their education where they were to focus on different subjects under the lead of English, French and German governesses. The final phase was devoted to having their knowledge polished and perfected by individual tutors. Apart from a well-structured curriculum, Albert believed that the children should express other vital skills. And that is why at Osborne, their summer retreat house at the Isle of Wight, they had a Swiss cottage installed where they could learn such skills as cooking, hosting, gardening or even carpentry.[26]

Even though Victoria did not express many maternal feelings, she did participate to some extent in the upbringing of her children. She taught the Princess Royal religion and attempted the same with the Prince of Wales, but it was too strenuous and often ended with the Queen scolding the young prince. In fact, it was only when her daughters and sons were adults when she finally came to understand them and share a closer relationship, especially with Vicky and Alice. She did resent them as they took her Albert away from her.[27] The four eldest children were quite a self-contained group with Vicky and Bertie being noisy enemies. Bertie found his younger sister, Alice, to be much more devoted as a sibling than the older Vicky. The four younger ones would spend time together and only the baby, Beatrice, would be on her own. Both Helena and Arthur were the least troublesome of the lot, turning to be placid and quite obedient. Louise, perhaps the most artistically talented one, would often act out as a grande-dame, supercilious and superior. She was quite independent and even studied at the National Art Training School. After Albert's death, Louise proved herself to be of secretarial use to the Queen. However, she was quite bored with the mundane and

---

[26] Ibid, p. 75.

[27] Ibid, p. 73.

repetitive schedule full of replying to letters, dealing with political correspondence and being Victoria's companion. And for this reason, the Queen was reluctant to allow Louise to marry. Nevertheless, Louise being a desirable match, Victoria did not want her to be part of Prussian or Dutch marriage biddings. What is more, Louise did not want to marry any prince as for her it was not what she had desired. She set herself upon marrying John Campbell, Marquess of Lorne. This match was not favoured by the Queen as Louise would not be marrying into royalty. Victoria found it hard to let go of her daughter citing she "felt painfully the thought of losing he".[28] Louise, unlike her siblings, was an unconventional royal. When travelling, she preferred to be addressed simply as Ms Campbell. She was well-known for her charity work, sculptures and various rumours surrounding her private life.

Perhaps the most particular problem was presented by Prince Leopold as he was the only male who manifested the royal illness that was spread throughout Europe – haemophilia. Leopold was a sickly child, even though Victoria claimed his birth to be the easiest one of all due to the usage of chloroform.[29] The obvious danger was that any severe wound would not heal as the blood would not clot as it should causing the sufferer to die. However, even though Leopold was aware of his condition, his behaviour was far from being preventive of injuries and he despised being supervised expressing his strong spirit.[30] However, with time, when he entered an adult age, he came to terms with his condition and, to his mother's pleasure, he confided himself to more academic pursuits resembling his father in doing so.

The youngest of the royal lot was Princess Beatrice. She was only three years old when her Papa passed away, however, she managed to spend more time with her parents than any of her brothers and sisters. She was able to get away with some mischief which would never be the case with the other children. She was destined by the

---

[28] RA/QV, 1884 as found in Worsley, L., op. cit., p. 296.

[29] Ashdown, D., op. cit., p. 72.

[30] Ibid, p. 72.

Queen to remain by her side at all times and eventually she did resign herself to her fate. Even though there were many suitors, Victoria strongly opposed any idea of her ‘Baby’ leaving her. Since the age gap between her and her other siblings was quite vast and the closest in age to her, Prince Leopold who was forbidden from any childlike activities due to his haemophilia, Beatrice grew up in solitude. With time, Beatrice took over the role of Victoria’s secretary and eventually even being admitted to the Queen’s private journals. No matter how hard Queen Victoria tried to keep Beatrice at her side, she could not have foreseen that when Beatrice attended Louise’s wedding at Darmstadt she would fall in love with Prince Henry of Battenberg. Victoria gave her consent to this union, however, under the condition that the couple would remain by her side. And thus, Beatrice spent the following 16 years assisting Victoria with all. After the Queen’s death, she undertook the strenuous task of rewriting and censoring Victoria’s journals. It needs noting that the Queen was more than just a prolific writer. Her journals spanning from as early as 1831, consisted of day-to-day records. Numerous letters, private correspondence, notes were either destroyed or edited in order to keep Victoria’s memory untarnished.

With time, and with all her children somehow settled in more or less convenient marriages, Victoria regained her balance and optimism. The great loss of her husband dwindled down to a permanent ache. She was now ready to enter, what would later be known as the ‘golden age’, a new stage in her life. This stage was accompanied by new companions and new emotions.

All of the above paints Victoria in a completely different light to what the readers of common works or commercial film viewers are accustomed to. She emerges as a woman driven by physical passion towards her husband, willing to become submissive and agreeing to ascend to an inferior to her husband’s role. Still a Queen in name, but more often a Hausfrau to her Albert. Throughout the years of their marriage, she showed herself to be extremely emotional and vivacious which had to be trimmed down by her husband. She enjoyed his company, however, did not so much enjoy the company of their children. She resented her own offspring, preferring them to be rather out of sight. After Albert's death, the resentment she had towards her children turned into an obsessive control that lasted till Victoria's death in 1901. She made sure that her children always remembered she was not only their mother but also their Sovereign. So when one could rebel against their mother one could not do so against their Queen. It might even be dared to state that the later relationship Victoria had with her children was rather pathological. Victoria's person is a perfect example showing that improper child development in early years, as well as later, as was the case with the Queen and her upbringing, deeply influences future relations with their children. Victoria, being stripped from role models of her father and mother, was unable to emulate or learn correct and appropriate maternal actions and reactions towards her own children. Her example pictures quite a common trace in 19th century England, where in certain social circles the role of a mother was not as we understand it today. This also allows us to see the importance of proper roles ascribed to the parents or caretakers and how they can affect the character creation.

References

Primary Sources

The Letters of Queen Victoria. A selection from Her Majesty's correspondence between the years 1837 and 1861, ed. by A. Ch. Benson and R. B. B. Esher, vol 1-3, London 1908 https://www.gutenberg.org/files/20023/20023-h/20023-h.htm# access on 17/02/2021

Queen Victoria's early letters, edited by Raymond, J., Batsford Ltd, London, 1963

Secondary Sources

Anon., *The Private Life of Queen Victoria*, ed. 1901, p. 42 as found on https://babel.hathitrust.org/cgi/pt?id=loc.ark:/13960/t9n30j31n&view=1up&seq=64

Ashdown, D., *Queen Victoria's Family*, Robert Hale & Company, London, 1975

Pakula, H., *An uncommon woman*, Weidenfeld & Nicolson, NY, 1997

Ponsonby, F., *Recollections of Three Reigns: Prepared for the Press with Notes and an Introduction by Colin Welch,* London, ed. 1951

Strachey, L., *Queen Victoria,* First Harvest/HBJ Edition, 1978

Vallone, L. *Becoming Victoria*, Yale University Press, NY, 2001

Weintraub, S., *Uncrowned King: The Life of Prince Albert,* Simon & Schuster, New York, 1997

Woodham-Smith, C., *Queen Victoria,* Black Five Books, 1972

Worsley, L., *Queen Victoria: daughter, wife, mother, widow*, Hodder & Stoughton, London, 2018

Interdisciplinary Contexts of Special Pedagogy
NUMBER 32/2021

NATALIA MICHALAK

Adam Mickiewicz University, Poznań, Poland

Review of "Artistic speech therapy"

„Artistic speech therapy" is a monograph from series "Speech therapy of XXI century". It is a project carried out by the Harmonia Univeralis publishing house. The extensive collection of monographs organizes information about speech therapy, which is an interdisciplinary field. The series is written under the scientific editorship of prof. UG dr hab. Stanisław Milewski and prof. UG, dr hab. Ewa Czaplewska. The official patron is the Polish Speech Therapy Society. All parts of the series are prepared on high substantive level and concern a specific area of speech therapy, making them a valuable source of knowledge.

In 2016, a volume entitled "Artistic speech therapy" was published and edited by Barbara Kamińska and Stanisław Milewski. The history of artistic speech therapy and growing popularity make that this topic required a separate publication. Still, few speech therapists deal with artistic speech therap. Moreover, on social awareness this concept is not yet know. It is understood as work on clear intentionally and articulately correct speech, but we should remember that speech therapy in the field od art also deals with biological conditions, elimination of realization disorders, development of linguistic and communication competence and skills, as well as the ability to self-present in official situations. It is worth noting that when within the field of artistic speech therapy, a new part has emerged, namely media speech therapy. It is responsible for skills of realization of utterances of people who make public appearances. The publication "Artistic speech therapy" captures the topic from multiple perspectives. It is divided into five parts in the following order:

1. Artistic speech therapy- an introduction to the subject
2. Language, pronunciation, and prosody- normative and descriptive aspects, directions of change

IKPS 32, 2021: 227–229.

3. Speech and voice in normality and pathology – qualities and evaluation
4. Public speaking from the perspective of theory and practice.
5. Working with words, that is artistic speech therapy in practice

Arranging the material in this way clearly organizes information. It begins with theory and ends with practical application. All parts form thirty chapters, each dealing with a different problem. Twenty-seven specialists worked on the preparation of the content, so the publication is reliably prepared. First part prepared by Jolanta Maćkiewicz, Wacław Bork, Barbara Kamińska, Mirosław Michalik is a standard introduction to the subject of artistic speech therapy. Reference to the sources of the tradition of public speaking is presented in a interesting way. Moreover, it describes history and relation to other disciplines. Second and third part describes issues of speech, pronunciation, prosody, and voice from linguistic, orthophonic, acoustic- auditory, medica, neurobiological, psychological, and vocal perspectives. In my opinion the most important chapters are this written by Jolanta Panasiuk about cerebral conditioning of the speaking process and by Anna Walencik-Topiłko about anatomical and physiological basis of voice. This understandably presented contents will provide a base of knowledge that will help the reader to study monograph more effectively. Fourth part deals with self-presentation and public speaking undertaken by politicians, lawyers, businessman and priests. The last part is prepared by practitioners, therefore it shows artistic speech therapy from different sides with emphasis on practical work. It is worth noting that in this part, in Maria Bończykowa's chapter, CD has been included. Record on CD is called "Learning to listen to informative text" performed by lector Maciej Jabłoński. It presents utterances with incorrect use of accenting and intonation and with correct one. This record allows the reader to understand differences between spoken sentences in practical and simple way.

The individual chapters are structured in the same coherent way. They start with a short introduction, then the topic is developed, and at the ends of chapters is summary, which systematizes the knowledge as well as instructions and control questions, which are helpful in analyzing the test and selecting the most important information contained in it. Moreover, at the end of the monograph is a common list of bibliography, arranged according to chapters, so reader can easily find the necessary sources. "Artistic speech therapy" is a position wort recommending. It is difficult to find another book that covers this topic in such a cross-sectional manner. This text is proposition worth recommending to speech therapists, students of speech therapy, as well as voice coaches, actors, singers, or people interested in subject of public speaking. The publication contains valuable comments from specialist who are trying to introduce the concept of artistic speech therapist.

To conclude, this book is very consistent and straightforward. Although the authors declared in the introduction that: *topic presented in this monograph do not exhaust all the complexity of issues covered in artistic speech therapy,* people who are interested in this subject will easily find answers to their questions. What is more, this monograph can inspire to broaden knowledge. In my point of view, it is currently one of the best literary proposition about the issue of artistic speech therapy.

Published on the basis of an authorised copy

Projekt okładki: Izabella Grzesiak
Redaktor techniczny: Dorota Borowiak
Łamanie komputerowe: Marcin Tyma

WYDAWNICTWO NAUKOWE UNIWERSYTETU IM. ADAMA MICKIEWICZA W POZNANIU
61-701 POZNAŃ, UL. A. FREDRY 10
www.press.amu.edu.pl
Sekretariat: tel. 61 829 46 46, faks 61 829 46 47, e-mail: wydnauk@amu.edu.pl
Dział Promocji i Sprzedaży: tel. 61 829 46 40, e-mail: press@amu.edu.pl

Ark. wyd. 11,75. Ark. druk. 00,00.

DRUK I OPRAWA: VOLUMINA.PL DANIEL KRZANOWSKI, SZCZECIN, UL. KS. WITOLDA 7–9