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Preschool and Kindergarten Teachers' Assessments of Children with Special Needs and Influences on Their Assessments

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ABSTRACT

Early assessment of children with special needs is important as a basis for subsequent support in preschool, kindergarten, and beyond. In this study, we examined the accuracy of preschool and kindergarten teachers' assessments of children's problematic behaviors incorporating the effects of five factors that influence the accuracy of such assessments: age, years of work experience, self-learning time, training time, and face-to-face communication time with parents.

In our analysis results, we identified that the assessment scores in the high self-learning time and high training time groups were significantly higher than those of the low self-learning time and training time groups, suggesting that those assessments were more accurate. The results also indicated more accurate assessments among the group with more face-to-face communication time with parents. In contrast, age and years of work did not affect the assessment scores for attachment and developmental disorders, although more broadly, we found significant positive correlations between face-to-face communication time with parents and both age and years of work experience. We do note that it might be valuable to measure experience in specific terms, such as years of experience working with children with developmental or other disabilities.

These results suggest that training is essential for improving the accuracy of caregivers' assessments of children with challenging behaviors and that increasing face-to-face interaction with parents can lead to more accurate assessments of their children. It is necessary to further examine the causes of these results to increase the accuracy of assessments of children whose behaviors pose challenges.

< Key-words >

Preschool and Kindergarten Teachers, Children with special needs, Assessment

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I. Introduction

Caregivers have designated many children in preschools and kindergartens as having special needs^{1,2)}, frequently because of problematic behaviors³⁻⁶⁾.

However, there is no standardized definition of “children with special needs” in this context⁷⁾. For example, Kuboyama et al. defined a child with special needs as one who “may have a disability but has not yet been diagnosed, or whose behavior makes it difficult to know whether it is due to the disability or the environment”⁸⁾. Hongo et al. defined a “child with special needs” as “a child who has no delay in intellectual development, but who is characterized by restlessness, frequent trouble with other children, and inability to control his or her emotions”⁹⁾. Hidaka et al. defined children with special needs as “children, including children with developmental disabilities, who are of concern to caregivers in childcare settings”¹⁰⁾. In other words, the term “children with special needs” is not a technical term with a fixed conceptual and operational definition¹¹⁾. Therefore, in this study, we define children with special needs as children who have not received a clear diagnosis but have some background issues and whose caregivers are having difficulties caring for them.

In recent years, developmental disabilities have often been considered a background cause of problematic behaviors in children with so-called special needs¹²⁻¹⁴⁾. For instance, one case study was a functional assessment of a 5-year-old child with intellectual disability¹⁵⁾. Another case assessed a 4-year-old child diagnosed with mild intellectual disability, marked hyperactivity, and attention-deficit/hyperactivity disorder (ADHD)¹⁶⁾. In addition, researchers have studied assistance and guidance for children with high-functioning autism^{17,18)} and integrating autistic children into child care activities¹⁹⁾. In other words, as Shiromoto et al. observed, the number of children with developmental disabilities is increasing in the child care and education fields²⁰⁾, there are many children display worrisome behaviors, possibly because of a developmental disability such as ADHD, autism spectrum disorder (ASD), or intellectual disability, such as aggression or defiance, tantrums or panic, or simply difficulty fitting in with a group at preschool or kindergarten. However, Okada states that developmental disabilities are largely attributable to genetic factors. It is unlikely that such functional disorders of the nervous system would rapidly increase in a short time. Instead, genetic factors and acquired nurturing and environmental factors should be considered when tracing the roots of children’s “difficult” behaviors^{21,22)}.

Nurturing and a child’s environment, for instance, the cultural and regional characteristics of a country^{23,24)} or inappropriate nurturing attitudes of caregivers at home^{25,26)}, are key drivers of children’s early behaviors. For instance, Ikeda et al. found one cause of children’s problematic behaviors in preschool and kindergarten was poor attachment formation during infancy^{27,28)}. Inappropriate nurturing such as neglect, over-intervention, and abuse under the guise of discipline can negatively affect attachment

formation between mother and child and the child's normal development. In other words, attachment formation is considered an important background to children's problematic behavior.

In addition, previous researchers have found individual differences in the behaviors of newborn infants, suggesting that children display innate dispositional characteristics from infancy onward that even influence mothers' nurturing attitudes and the formation of mother-child attachments²⁹⁻³²). Furthermore, parents' mental disorders can contribute to their inappropriate child-rearing and, in turn, negatively affect children's development³³).

As indicated so far, children with problematic behaviors can have any number of internal diagnoses that contribute to their challenging behaviors, such as those related to ADHD, ASD, and intellectual disabilities. Also, unhealthy conditions at home, such as parents' inappropriate nurturing and even children's characteristics, can motivate troubling behaviors.

Overall, although any child labeled as having special needs likely displays distinct characteristics, the outward-facing behaviors of designated children do share similarities. For example, Ikeda et al. identified that some of the characteristics of "children with special needs" as reported by their caregivers, such as inability to listen, hyperactivity, restlessness, and difficulties with group activities, are similar to characteristics of children with mild developmental disabilities³).

Additionally, poor attachment is one reason for problematic behaviors. Children who fail to form key attachments in their early years can exhibit problematic behaviors, such as lack of self-control, defiant attitudes and actions, and high aggression. Many of these symptoms are similar to those caused by developmental disabilities³⁴). In addition, Sugiyama identified that it is not uncommon for strong emotional disturbances caused by inappropriate child-rearing, such as abuse, to manifest themselves in the form of hyperactive behavior disorder³⁵). In other words, it is difficult to attempt to categorize children as having special needs based solely on their surface behaviors.

However, it is highly ineffective to provide the same support to all "children with special needs" simply because it is difficult to identify the causes of their problematic behaviors accurately. For instance, as Yonezawa reported, even within the same category, developmental disorders, ADHD entails support with behaviors because of the significant problems with executive functions. In contrast, ASD requires more support for cognition, and attachment problems require support for emotions³⁶). In other words, providing effective support for coping with children's problematic behaviors requires comprehensive considerations of children's backgrounds for more accurate assessments.

In addition, Ishikura et al. stated that "delays in support due to difficulties in determining the causes of stumbling and responding to secondary problems after they have occurred can result in a great deal of energy being expended by both the individual and those around them"³⁷). And the Commentary on the Daycare Guidelines for Nursery

Schools also stated that “daycare centers need to accurately grasp the actual situation of each child, including children with disabilities, and provide childcare with a perspective that allows all children to fully demonstrate themselves”³⁸⁾. Therefore, it is important to assess and respond to children’s stumbling blocks and issues at an early stage³⁹⁾.

In light of the above, we believe that appropriate child care assessments should consider children’s problematic behaviors from multiple perspectives and consider multiple possible backgrounds and solutions. However, given the multidimensional nature of the origins of children’s so-called problematic behaviors, what factors can help caregivers give accurate assessments of the children in their care?

The first factor is often the age of the caregiver. Older child care providers are generally more specialized, have more social skills, and are better able to deal with problems than are younger providers^{41,42)}.

The second factor is years of experience, which can relate to age. Caregivers with more experience working with different types of children are overall better able to interact with them^{41,42)}.

The third factor is training. Kitano cited enhanced in-service training as essential to improving the quality of child care providers⁴³⁾. And Ogawa identified that in caring for children with disabilities, it is important for child care providers to improve their knowledge and skills through daily training and study to respond to diverse demands⁴⁴⁾. Common training methods include lectures by experienced teachers and experts, workshops, observation of public child care, and case studies^{45,46)}.

A fourth factor we can mention is self-learning time. Ogawa found that some caregivers emphasized personal learning by reading specialized books and articles in addition to participating in exhaustive in-service training⁴⁴⁾.

Finally, the fifth factor we see as critical is face-to-face communication time with parents. In caring for children with disabilities or developmental issues, caregivers are expected to work closely with parents and families, communicating with parents about children’s home and school lives and deepening their understanding of the children in their care^{39,47,48)}. In addition, some daytime caregivers use contact notes to communicate with parents indirectly^{49,50)}. But these notes tend to focus more on transmitting information from the school than on communicating what happens in the home. Indeed, Zhang et al.^{49,51)} found that misunderstandings related to note-writing style and note content made direct face-to-face interaction during pick-up and drop-off times more effective for communicating.

The research findings suggested that high levels of these five factors would enable more accurate assessments of children with problematic behaviors. Verifying our hypothesis requires first understanding the actual assessment status among caregivers, including examining the impacts of the aforementioned factors on assessment. Previous researchers examined the impacts of factors, such as years of service, training to improve teacher quality, understanding children, and kindergarten teachers’ and child care providers’

responses to parents ^{41,52,53}). However, as far as we know, there is no research on how the multiple influences on children's behaviors affect the accuracy of assessments of those behaviors.

Based on the above literature findings, for this study, we conducted a questionnaire survey and interviews with preschool and kindergarten caregivers to examine the actual status of the assessment and the factors that might affect its accuracy. We aimed to test whether older age, longer worker experience, and more self-learning time, training time, and face-to-face communication time with parents would increase the accuracy of caregivers' assessments of children's difficult behaviors.

II. Methods

1. Survey collaborators and survey methods

We conducted the surveys for this study with a questionnaire and with telephone interviews. The questionnaire survey was anonymous, and we ultimately administered it to a total of 72 people (33 kindergarten teachers and 39 preschool teachers working in 6 kindergartens and 5 preschools) who cooperated in the survey. Our response rate was 100%, but we had to exclude four incomplete questionnaires, leaving 68 completed surveys for the analysis. We also conducted telephone interviews with 11 preschool and kindergarten representatives familiar with the actual conditions of the schools where they worked.

We distributed the questionnaires by mail and collected responses by mail from mid-November to mid-December 2017 or from late November to the end of December 2018. We conducted the telephone interviews later but asked the participants to recall the time when they responded to the original questionnaire. We explained the study's purpose and method to all participants in advance, and their intentions were respected even if they did not wish to cooperate with the study.

2. Survey details

1) Questionnaire

For the demographic portion of the questionnaire, we asked the participants to enter their gender, age, class, and years of work and to choose from the following five options for the total time they had spent participating in group training in the past one year: ① 0 hours, ② approximately 1 to less than 10 hours, ③ 10 to less than 20 hours, ④ 20 to less than 30 hours, ⑤ more than 30 hours. We also asked the respondents to choose from the following five options for the amount of time they spent studying individually during the week: ① approximately 0 hours, ② less than 1 hour, ③ 1 to 2 hours, ④ 2 to 3 hours, ⑤ more than 3 hours.

For the case study portion of the questionnaire, we developed four case studies of

problematic behaviors commonly seen in 5-year-old “children with special needs.” We created the cases using the American Psychiatric Association and World Health Organization’s definitions of attachment disorder, ADHD, ASD, and pervasive developmental disorder (PDD)^{54,55} using examples of support for attachment disorder, socialization disorder, and developmental disorder⁵⁶.

For each case study, we identified six possible causes of children’s problematic behaviors: For factors related to attachment formation, we offered excessive discipline by caregivers in the home and caregivers’ indifference to the child; for factors related to developmental disorders, we selected ADHD, ASD, and delayed intellectual development; and for factors related to the child’s temperament, we selected the child’s personality.

In all the cases, any of the six factors could have been a cause of the problematic behavior. However, the question in Case 1 was formulated so it would be appropriate to choose “highly likely” for ADHD and the caregiver’s indifference to the child. We set the other cases similarly so that it would be appropriate to select “highly likely” for ADHD and excessive caregiver discipline in Case 2, ASD and excessive caregiver discipline in Case 3, and delayed intellectual development and caregiver indifference to the child in Case 4. To confirm the objectivity and validity of the case studies, we asked three university professors in psychology, development, and special needs and five psychology graduate students to review and revise the studies for accuracy.

The instructional text read as follows: “The following are examples of problematic behaviors of five-year-old children. Please circle the number to the extent that you think it applies as a possible cause of such behavior: 1 = unlikely, 2 = somewhat unlikely, 3 = undecided, 4 = somewhat likely, 5 = highly likely.”

2) Telephone Interview

For the telephone interviews, we asked the respondents about their average daily face-to-face communication time between caregivers and each parent at their respective schools and other means of interaction in the absence of direct interaction with parents.

III. Results

1. Assessment points

For each case, we summed the respondents’ ratings from 1 to 5 for each factor. We used the two factors with the most responses in each case as the assessment points. The assessment points for each case ranged from 1 to 10 points, and if the assessment was appropriate for all four cases, the full assessment score for all four cases was 40 points. Table 1 presents the mean assessment scores, standard deviations, and F values for each case. On multiple comparisons, there were no significant differences in the mean assessment scores for each case. Therefore, we summed the assessment scores for each case to obtain the total assessment points ($M = 29.12$, $SD = 3.92$).

<Table 1> The Mean Assessment Scores, Standard Deviations, and F Values for Each Case

	Case1 (N=68)		Case2 (N=68)		Case3 (N=68)		Case4 (N=68)		F(df)
	M	SD	M	SD	M	SD	M	SD	
Assessment Points	7.63	1.56	7.31	1.59	7.28	1.54	7.28	1.41	.86 (3.268)

2. Group classification

In the analysis, we divided the participants into groups based on their age, years of work experience, self-learning time, training time, and face-to-face communication time; we took the means for learning time, training time, and face-to-face communication time and divided each factor into two groups, low and high: self-learning time, low: -1.79 hours, $N = 33$ and self-learning time, high: 1.79 hours or more, $N = 35$; training time, low: -10.4 hours, $N = 40$ and training time, high: 10.4 hours or more, $N = 28$; and face-to-face communication time, low: 3 minutes or less, 6 preschools, $N = 39$ and face-to-face communication time, high: 3 minutes or more, 5 preschools, $N = 29$. We divided the respondents by age into low (20–25 years old, $N = 35$) versus high (26–65 years old, $N = 33$), and we divided years of service into low (1–4 years old, $N = 38$) versus high (5–45 years old, $N = 30$) as well.

3. Correlations between variables

Table 2 presents the correlations between each of the five independent variables. We found significant positive correlations between age and years of work, years of work and face-to-face communication time, self-learning time and training time, and face-to-face communication time. Regarding correlations between each independent variable and the dependent variable, the age and years of work did not correlate with the assessment points, in contrast with self-learning time, training time, and face-to-face communication time.

<Table 2> Correlations Between each Variable

	1	2	3	4	5	6
1 Age	-	.71 ^{***}	.04	-.17	.12	.05
2 Years of Work		-	.07	.03	.28 [*]	.22
3 Self-Learning Time			-	.54 ^{***}	.13	.33 ^{**}
4 Training Time				-	.26 [*]	.56 ^{***}
5 Face-to-Face communication time					-	.63 [*]
6 Assessment Points						-

* $p < .05$ ** $p < .01$ *** $p < .001$

4. Hypothesis testing

Table 3 presents the results of a one-way analysis of variance with age, years of work, self-learning time, training time, and face-to-face communication time as independent variables and the mean of the assessment points as the dependent variable. The analysis results showed no significant differences in assessment points between the high and low age groups and between the high and low years of workgroups. In contrast, the high self-learning time group had significantly higher assessment points than those of the low group. The high training time group had significantly higher assessment scores than the low group. In addition, the high face-to-face communication time group had higher scores than the low group.

<Table 3> Mean Assessment Scores for Each Factor by Group

	group	N	M	SD	F(df)
Age	Low-group	35	29.00	3.84	.06(1.66)
	High-group	33	29.24	4.06	
Years of Work	Low-group	38	29.05	3.99	.02(1.66)
	High-group	30	29.20	3.90	
Self-Learning Time	Low-group	33	28.00	3.76	5.57*(1.66)
	High-group	35	30.17	3.82	
Training Time	Low-group	40	27.76	3.62	16.11**(1.66)
	High-group	28	31.31	3.40	
Face-to-Face communication time	Low-group	39	28.22	.87	3.55†(1.66)
	High-group	29	30.76	1.05	

†p<.10 *p<.05 **p<.001

IV. Discussion and Conclusion

In the analysis results from this study, first, caregiver age and years of work did not significantly affect the accuracy of the assessments of children considered to have special needs. However, previous researchers have shown that caregivers with long experience have more skills and expertise than those with less experience⁵⁷⁾. Therefore, it is necessary to compare and examine the assessment abilities of caregivers in each age group in more detail in the future.

We also found that the assessment points from the high self-learning time and high training time groups were higher than those from the low self-learning and low training time groups. This finding suggests that, although experience might be important for accurate assessment, even young child care providers working for short periods might

make more accurate assessments if they can secure time for self-learning and training.

Notably, the assessment scores of the high face-to-face communication time group were higher than those of the low group, and in the low face-to-face communication time group, 50% of the preschools mainly used contact notes. This suggests that indirect interactions such as contact notes are insufficient for proper assessment and that increasing face-to-face communication time with parents might improve the accuracy of assessments of children. In the above results, caregivers' self-learning time, training time, and face-to-face communication time affect assessment accuracy, partially supporting our hypothesis.

However, because the survey did not ask about the training method, it will be important in the future to consider not only the quantity but also the quality of training, such as what training formats and content can improve caregivers' assessment abilities. Future researchers should collect and analyze individual caregivers' face-to-face communication time with their children's parents rather than averages.

We also note that we measured caregiver experience by age and year of work experience, but relevant experience could include specifically caring for children with disabilities. For example, Tomita described that experience in caring for children with disabilities leads to better understanding and responses⁵³). Therefore, in the future, it will be necessary to examine these causes further and aim to improve caregivers' assessment skills and qualifications further.

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