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### Professional Culture of the Specialist of the Future

#### EDUCATIONAL INTERVENTION FOR TREATMENT OF SELF-ESTEEM IN PRE-SCHOOLERS WITH OPERATIONAL COMMUNICATION DISORDERS

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#### *Abstract*

Early identification and intervention of self-esteem issues in children can help avoid development of disruptive personality features. The purpose of the study was to examine characteristic aspects of intervention for treatment of self-esteem issues in older pre-school children with various severity levels of operational communication disorders. The study involved pre-schoolers enrolled in the Chelyabinsk kindergarten No. 430 (N=108) and consisted of three stages: desktop analysis, experimental research, and data analysis. We got an expert evaluation of operational disorders severity levels. We studied self-esteem using a modified version of Lipkina's staircase technique and Osgood's semantic differential technique. Data analysis was conducted using statistical methods for data processing (factor analysis,  $\phi^*$ -test of Fisher's angular transformation, Spearman's coefficient). The empirical study found a discrepancy of evaluations on the potency scale between pre-schoolers with high and low severity levels of operational disorders and did not find any discrepancy of evaluations on the activity scale. On the evaluative dimension ("nasty/nice", "stupid/clever", "bad/good"), children in both groups tend to perceive themselves positively; however, on the "bad/good" scale there are significant differences between the two groups. The identified differences support the assumption of a relationship between severity levels of operational communication disorders and self-esteem patterns in older pre-school children.

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**Keywords:** Disruptive behaviour disorders, intervention, older pre-school children, operational communication disorders, self-esteem.



## **1. Introduction**

A review of available literature provided evidence supporting the significance of the research topic and yielded some relevant insights.

The development of self-esteem is largely determined by children's early relationships and interactions with immediate surroundings (Owens & Shaw, 2003; Zagvyazinsky, 2016).

Older pre-school age is the initial stage of a child's development of self-esteem and interpersonal communication patterns (Leontiev et al., 2017).

Research shows a fairly wide range of relationship types among pre-school age children (LaFrenière et al., 1992; Smirnov, 2013).

Still, researchers focus mainly on the positive side of these relationships, and only few studies deal with associated challenges and related negative emotions (Dudina & Dolgova, 2016a; Meunier et al., 2011; Larsson et al., 2011).

Operational communication disorders refer to problems caused by underdevelopment of a child's executive functions (e.g. play skills and abilities) and failure to develop relationships with peers (Schoemaker et al., 2014).

## **2. Problem Statement**

The research problem is that insufficient intervention of individual operational communication disorders in pre-school children, especially with respect to self-esteem, often carries a range of negative implications for further personality development. Early identification and intervention of disorders can help avoid these outcomes. We have assumed that there is a negative correlation between self-esteem and severity level of operational communication disorders, namely: the children with operational communication disorders manifested at a high level tend to evaluate themselves less favourably than those who are at a low severity level of operational communication disorders, and vice versa.

## **3. Research Questions**

The research questions concern factors of the development and intervention of self-esteem in older pre-school children with various severity levels of operational communication disorders.

We addressed characteristic aspects of educational intervention for treatment of self-esteem issues in two groups of pre-schoolers — those who experience operational communication disorders at high and low severity levels, respectively. Self-assessment included three dimensions: the evaluative, the potency, and the activity factors.

We also focused on the question of the relationship between self-esteem and severity level of operational communication disorders in older pre-school children.

## **4. Purpose of the Study**

The purpose of the study was to examine characteristic aspects of intervention for treatment of self-esteem issues in older pre-school children with various severity levels of operational communication disorders.

To achieve the named purpose, we set the following empirical goals: to identify operational communication disorders in older pre-school children; to explore self-esteem patterns in children with operational communication disorders; to reveal relationship between self-esteem patterns and severity level of operational communication disorders in older pre-school children; to determine methods of educational intervention for the treatment of self-esteem issues and operational communication disorders.

## 5. Research Methods

*Description of the sample.* The study involved educators and pre-schoolers enrolled in the Chelyabinsk kindergarten No. 430. The sample comprised 108 children from five to six years old (including 61 per cent girls).

*Stages of the study.* The study consisted of three stages.

Stage 1. Desktop analysis. At this stage, we worked together with educators to conduct a theoretical review of communication disorders in older pre-school children as well as to present a categorization of operational disorders and describe their features and identification criteria.

Stage 2. Experimental research. At this stage, we worked together with educators to identify typical behavioural characteristics associated with disorders in question; to get an expert evaluation of operational communication disorders severity levels; and to study self-esteem using a modified version of staircase technique and semantic differential technique.

Stage 3. Data analysis.

We used research methods that can be divided into four groups.

*Observation.* This technique was used to formulate an exact list of typical behavioural characteristics associated with operational disorders. While observing we kept track of key forms of communication (responding to peers, responding to adults, facial expressions, body language (open or closed posture, etc.), tone of voice, gestures, loudness of voice, crying, whining, weeping and wailing). We observed children with high severity level of operational communication disorders and focused on behavioural patterns of this group.

*Expert evaluation.* This method was used to determine severity levels of operational communication disorders among children in both groups. We engaged 6 representatives of the kindergarten staff as experts: four educators who work with both studied groups on an ongoing basis, a supervisor and a psychologist. The severity level of operational disorders (physically fights, yells, teases or calls names, engages in hidden and furtive behaviours, whines, complains) was measured by the actual behavioural frequency (“hardly ever”, “sometimes”, “often”, “most of the time”).

*Tools for assessing self-esteem.* To study self-esteem, we used a modified version of staircase technique and semantic differential technique. Children were asked to rate themselves on three dimensions: the potency (“weak/strong”, “small/large”, “non-threatening/threatening”), the activity (“passive/active”, “cold/hot”, “quiet/noisy”), and the evaluative (“bad/good”, “stupid/clever”, “nasty/nice”) factors.

*Statistical methods for data processing.* The study used statistical data processing methods (Zabrodin & Pakhaliyan, 2015; Krivenko, 2014) such as factor analysis (to identify typical behavioural characteristics associated with operational communication disorders in older pre-school children),  $\phi^*$ -test of Fisher's angular transformation (to compare the two groups in terms of the frequency of occurrence of

operational communication disorders) and Spearman's correlation coefficient (to examine the relationship between the frequency of occurrence of operational disorders and the children's tendency to evaluate themselves positively or negatively on the potency, activity and evaluative factors).

## 6. Findings

To answer the research questions, we first measured pre-school children's self-esteem on the potency dimension. The findings for the two groups of children, respectively, are summarized in Table 1.

**Table 01.** Self-assessment on the potency dimension by pre-school children with high and low severity levels of operational disorders

Scale	Low self-esteem (1–2 points)		Moderate self-esteem (3 points)		High self-esteem (4–5 points)	
	HL	LL	HL	LL	HL	LL
	% of the total number of children in each of the two groups					
Small/large	27.58	10	27.58	30	44.84	60
Non-threatening/threatening	72.41	60	13.79	26.67	13.80	13.33
Weak/strong	20	6.67	16.67	10	63.33	83.33
Average value on the potency factor	40	25.56	19.35	22.22	40.65	52.22

HL — children with high severity level of operational disorders.

LL — children with low severity level of operational disorders.

Table 1 shows that, on the potency factor, children in the HL group on average tend to be significantly more negative about themselves than those in the LL group. This may be due to the fact that children with LL are indeed more socially adept to form good relationships with peers and adults, they are more confident and comfortable participating in group activities and enjoy greater peer acceptance than children with HL. For this reason, they perceive themselves as strong. Children with HL, in turn, mostly fail at attempting to earn peer approval. As a result, their self-efficacy and self-esteem will probably decline.

Socially impaired children often recognize their vulnerable position in the group and feel distressed. At first, although not chosen to play, they try to establish contact with peers, but inability to control their behaviour and develop relationships with others eventually makes them experience continuing difficulties in group activities, which leads to disruptive behaviours and negative personality traits such as touchiness, resentment, resistance, vindictiveness, aggression. Impulsive children who score low on empathy are especially likely to exhibit these traits, which concurs with other authors' findings (Brassart & Schelstraete, 2015; Mesman et al., 2001).

If we look at self-evaluation scores on each scale separately, it becomes clear that children tend to rate themselves high on the “weak/strong” scale (this is the case in both groups, although more pronounced in the group of children with LL) and low on the “non-threatening/threatening” scale (this is especially true for children with HL). To put it otherwise, children with HL tend to perceive themselves as strong, but small and non-threatening, whereas in the group with LL there is shift towards more moderate estimates on

the “non-threatening/threatening” scale. However, by and large, we observe similar trends on each scale included in the potency factor.

Note once again that on the “weak/strong” scale children with HL are more likely to consider themselves weak as compared to children with LL ( $\varphi_{emp} = 1.57$ ;  $p \leq 0.01$ ). Similarly, on the “non-threatening/threatening” scale children with HL are more likely to consider themselves non-threatening as compared to children in the second group ( $\varphi_{emp} = 1.26$ ;  $p \leq 0.05$ ).

There are also differences between evaluations of the two groups on the “small/large” scale: children with HL give themselves significantly lower scores than do their counterparts. The reason for this may be that these children feel smaller, more helpless and incompetent in their relationships with peers than do children with LL ( $\varphi_{emp} = 1.18$ ;  $p \leq 0.01$ ), as their need for proper interaction with others is not adequately satisfied. During the intervention process, educators should keep in mind that such children often have limited opportunities to engage in play (as compared to children with low severity level of operational disorders), resulting in a decline in self-esteem and self-efficacy.

The second part of our research of individual operational communication disorders in pre-school children focused on the activity factor which is represented by three scales: “quiet/noisy”, “passive/active”, and “cold/hot”. The findings of the survey for the two groups of children are summarized in Table 2.

**Table 02.** Self-assessment on the activity dimension by pre-school children with high and low severity levels of operational disorders

Scale	Low self-esteem (1–2 points)		Moderate self-esteem (3 points)		High self-esteem (4–5 points)	
	HL	LL	HL	LL	HL	LL
	% of the total number of children in each of the two groups					
Quiet/noisy	66.67	83.33	20	16.67	13.33	0
Passive/active	33.33	36.67	20	26.67	46.67	36.67
Cold/hot	30	23.33	6,67	6.67	63.33	70
Average value on the activity factor	43.33	47.78	15,56	16.67	41.11	35.56

Table 2 shows that, on the activity factor, the study did not report any significant differences between the two groups. In other words, children with both HL and LL evaluate themselves on this dimension more or less equally. In both groups, self-evaluations on the activity factor are distributed, for the most part, between low and high scores. Moderate rates are less frequent.

We could assume that children tended to give socially desirable responses, given that “quietness” is more approved of as opposed to “noisiness” (in both groups, children gave themselves low scores on the “quiet/noisy” scale) and, similarly, “activity” is more socially acceptable than “passivity”.

Still, it should be noted that, in the group of children with LL, self-evaluations on the “quiet/noisy” scale are more shifted towards low scores as compared with HL children. What is more, no one in the LL group reported a high score on this dimension, whereas in the HL group high scores were reported by 13.33% of children. Although no statistically significant differences were found, this fact cannot be ignored and should be taken into consideration in the intervention process.

The reason for these findings can be that children with HL have to be noisier in order to attract attention of both other children and adults. This is consistent with evidence that such children are also more likely to display aggressive behaviours and tend to cry and complain more often — obviously generating a certain “noise” along the way (Dolgova, Mamylyna et al., 2016; Smortchkova, 2017).

The third part of our research of individual operational communication disorders in pre-school children dealt with the evaluative factor. This factor includes the following scales: “nasty/nice”, “bad/good”, and “stupid/clever”. The survey findings are presented in Table 3.

**Table 03.** Self-assessment on the evaluative dimension by pre-school children with high and low severity levels of operational disorders

Scale	Low self-esteem (1–2 points)		Moderate self-esteem (3 points)		High self-esteem (4–5 points)	
	HL	LL	HL	LL	HL	LL
	% of the total number of children in each of the two groups					
Nasty/nice	16.67	16.67	10	16.67	73.33	66.67
Bad/good	6.67	20	13.33	23.33	80	56.67
Stupid/clever	10	13.33	3.33	6,67	86.67	80
Average value on the evaluative factor	11.11	16.67	8.89	15.56	80	67.78

According to Table 3, children in both groups tend to ascribe to themselves positive personality traits. However, there are significant differences between the two groups on the “bad/good” scale: children with HL tend to evaluate themselves less favourably than do children with LL ( $\varphi_{emp} = 1.57$ ;  $p \leq 0.05$ ).

This can be attributed to a number of factors. First, when children with HL see their multiple attempts to engage in play with peers consistently fail, they often find no other alternative but to opt for the simplest explanation: “I am not good enough to play with other children”. Second, faced with aggressive behaviours and continuous complaints, educators generally respond with phrases like “Good children don't behave like this”, “It is bad”, etc.

The findings have the following implications for the intervention process. As children with HL are shown to exhibit aggressive and complaining behaviours significantly more often, we can assume that negative evaluations from others are also more frequent and therefore more likely to be adopted by children. This contributes to emotional tension (Becker et al., 2014; Dolgova et al., 2016), affects personality development in general and hinders social integration (Dudina & Dolgova, 2016b; Lachowicz-Tabaczek & Bajcar, 2017; Kergilova et al., 2017).

## 7. Conclusion

The identified differences support the assumption of a relationship between severity levels of operational communication disorders and self-esteem patterns in older pre-school children. The study findings suggest that self-esteem patterns are related to the frequency of occurrence of operational disorders. Children with high severity level (high frequency) of operational disorders are more likely to ascribe to themselves negative attributes and less likely to evaluate themselves favourably, whereas children with low severity level (low frequency) of operational disorders tend to be less negative about themselves.

In the total sample, the study identified two “risk groups” that truly need intervention on the part of educators: these are children who exhibit extremely high levels of aggressive operational disorders and children who consistently display absolutely zero aggression. Note that both groups face similar communication issues such as reduced intensity of interactions (i.e. frequency of contacts with peers), narrow social network, withdrawal from stable companionships and group play activities.

This may indicate both that play skills and abilities are absent or not fully developed and that children don't know how to build relationships with peers. In any of these cases, targeted educational intervention for treatment of self-esteem is required.

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