Strategies of the therapeutic educator in promoting inclusion in early stimulation according to the principles of Maria Montessori

(overview essay)

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Abstract: *The paper deals with the issue of supporting inclusion through early therapeutic-pedagogical stimulation using Marie Montessori's concept. It presents the results of qualitative research, on the basis of which the therapeutic strategies of the therapeutic pedagogue were identified in the context of early stimulation. The research presents verbal and combined verbal-physical-activity strategies in early therapeutic-pedagogical stimulation according to M. Montessori. Therapeutic-pedagogical early stimulation according to Maria Montessori's concept is a specific therapeutic approach within a broader understanding of early intervention. The goal is to maximize the participation of a child with at-risk development in the life of the family and community in the context of supporting inclusion.*

Keywords: *early intervention, early therapeutic-pedagogical stimulation, Montessori pedagogy, Montessori therapeutic pedagogy, Montessori therapy, inclusion, risky development*

1 Introduction

A family with a child with at-risk development at an early age is faced with many problems and difficulties. Parents of these children visit several specialist clinics. They leave most of them with only a report in hand and basic information. Parents lack a deeper understanding of the issues and guidance. In the context of early stimulation, the therapeutic educator offers early support to families with a child at risk of development through early therapeutic educational intervention. At the child's early age, one of the optimal therapeutic-educational approaches is the concept of therapy according to the principles of Maria Montessori's pedagogy. One of the underlying aims is to facilitate the inclusion of these children and families into the wider community.

2 Promoting inclusion through early therapeutic-pedagogical stimulation using the Marie Montessori concept

2.1 The importance of early stimulation as part of early intervention in promoting inclusion

Early stimulation is part of a broader understanding of early intervention. Kohli--Lynch, Tann, and Ellis (2019) report that in most EU countries, early intervention is broadly understood as support for the early years child and his/her parents, including early identification of a problem, early diagnosis, and early support. In this broader context, early childhood intervention includes all medical, therapeutic, educational, psychological, and special education services. Hradilkova et al. (2018) write about stimulation in early intervention as the provision and reinforcement of stimuli from the environment so that the child has enough sensations and strong enough stimuli to respond to. It is imperative that the early intervention practitioner is knowledgeable about the various stages of child development and has the skills necessary to comprehensively stimulate a child's development. Early stimulation is, in the author's opinion, one of the most effective means to promote a child's learning. According to Guralnick (2005), in the context of the developmental systems model of early intervention, the principle of inclusion represents all efforts to maximize the participation of children and their families in typical home and community activities. Although inclusion is often thought of in the context of promoting interactions between children with developmental risk and other children, it is more broadly about promoting the full participation of all children in the life of the community. Pretis (2009 according to Slanej et. al. 2017) writes about the involvement of parents in the process of early intervention, which deviates from the diagnosis of the child as the center of interest in early intervention. Practitioners in early intervention have begun to focus on the competencies and internal resources of the family system. According to Guralnick (2005), early intervention programs are relevant to promoting inclusion, with the goal of maximizing the participation of children with developmental risk in home and community life. Families with children with at-risk development should be encouraged to seek services close to where they live and to engage their children in natural childhood peer activities. 'Inclusion' is to be included as an underpinning goal in intervention plans for children with disadvantages. This considers family functioning and community contexts. Jacob, Olisaemeka & Edozie (2015) consider an inclusive approach to be the most effective means of combating discriminatory attitudes in creating accepting communities and achieving the right to education for all. The positive effect of inclusion is also achieved from an economic point of view, in terms of saving resources in the social and health sectors. Hebbeler et al. (2007) say that early intervention has many benefits, especially in the context of promoting

the inclusion of children with developmental delays. Early intervention programs can minimize, or in some cases prevent, developmental delays in children at risk of health or social disadvantage or in children with already identified causes of health and social disadvantage. They can reduce the need for special education and related services when a child enters compulsory schooling and promote independence. Families benefit from early intervention by being better able to meet their children's needs from an early age throughout their lives.

2.2 Early therapeutic-pedagogical stimulation

At an early age, parents provide early stimulation to their children, ideally naturally, if they are able to recognise, respond to and meet their needs. Parents provide children with a natural upbringing. Sometimes conventional parenting practices are not enough for an individual child or family for a variety of reasons. This occurs for two main reasons. The first is a problem on the part of the child and the second is a problem within the child's narrower or wider social ecosystem – that is, within the family or on the part of the parents (e.g., the vulnerable parent) and other caregivers. This is where the need for parents/carers to seek help often comes in. The solution is to offer therapeutic-educational intervention – of a preventive-curative nature. The therapeutic educator offers to accompany parents in improving their parenting skills. She models for parents how they can prepare an appropriate stimulating environment to support the child's healthy development, how to respond with their parenting behaviour to the child's expressed needs, and how to meet the child's needs practically and effectively. In the case of a child whose development is altered from the norm due to various internal or external circumstances – e.g. delayed, disturbed, at-risk, uneven, etc., the therapeutic educator initially makes a diagnostic assessment of the underlying problem and proposes therapeutic solutions. In the context of early therapeutic pedagogical intervention, children are often worked with who show only certain delicate symptoms of problems, which may stem from a variety of causes. The aetiology of the problem and the complex diagnostic conclusions may not yet be known at the time. In young children, these may be symptoms of future deeper problems or more complex medical diagnoses that cannot yet be concluded at that age. The second group may be children whose development is only transient and uneven, which can be corrected to normal with early intervention. According to Guralnick (2005), preventive early intervention programs are recommended not only for children with confirmed medical or social disadvantages, but also for children who are categorized as developmentally at risk. The philosophy and principles of Maria Montessori's pedagogy are a firm part of the theory and practice of therapeutic pedagogy (Horňáková, 2012). Therapeutic pedagogy focuses on education that promotes the health, optimal development of a person with a handicap, or in a situation of

threat by adverse life circumstances, who needs individual professionally guided help in coping with life tasks. Her competences are based on knowledge from medicine, psychology, sociology and in practical terms on the use of methods and techniques of therapeutic approaches that use movement, play, music, drama, literary art and activities (Horňáková, 2007). The role of the therapeutic educator is in an unobtrusive way of guiding the child, helping in such a way and offering activities that copy the child's developmental level. From the offered activities, the child then chooses the one that interests him/her the most and that responds to the fulfilment of his/her inner needs. The child chooses the activity, the place of work, the rhythm of his/her activity and whether to work independently or invite someone to cooperate (Tichá, 2017). The rediscovery of Montessori pedagogy as a therapeutic pedagogy is an idea that Lore Anderlik, a Montessori educator and therapist who is a close collaborator of Professor Theodor Hellbrugge at the Sonnenschein Children's Centre in Munich, based on her own experience, brings to the table (Anderlik, 2019).

2.3 Specifics of early stimulation according to M. Montessori's concept

Pretis, Barlová, and Hradilková (2020) talk about Montessori pedagogy in connection with approaches in early intervention that promote the child's independence. The authors consider that theoretical approaches aimed at promoting the child's own activity and independence are more strongly represented in Europe than in the USA. According to Valente (2017), Kozelkova (2013), and Anderlik (2019), the basic principles of the Montessori method valid in both Montessori pedagogy, Montessori therapeutic pedagogy, and Montessori therapy include respect for the child's natural development – his/her "sensory periods", learning through movement and activity and unconscious absorption of surrounding facts ("absorbing mind"), respect and trust for the child and his/her ability to learn independently (the non-interference method), the child's freedom ("Teach me to do it by myself"), the child's normalization (the process of regaining psychological balance through deep concentration on the activity), and a stimulating environment prepared for the child. According to Kozelkova (2013), the idea of introducing the Montessori method into therapy arose from Montessori therapeutic pedagogy. Professor Hellbrügge of the University of Munich contributed to the introduction of this method into therapeutic work with children with various disabilities. Montessori therapy integrates the findings of neurophysiology, neuropsychology, pediatrics, social pediatrics, developmental rehabilitation, genetics, and pedagogy. Anderlik (2019) writes that Montessori therapy seeks to compensate for missing opportunities in a child with a medical or social disadvantage at an early stage of development, using similar tools to Montessori pedagogy. The challenge is to find „tailored solutions" for these children in therapy. For children with at-risk development, different paths lead to cognition. Montessori

pedagogy, Montessori therapeutic pedagogy, and Montessori therapy share the same goal, only the paths to achieving it differ. The goal of all approaches is to achieve the highest possible level of independence in the child. The child is freed from dependence on the adult. Even in clients with severe forms of social and health handicaps, the aim of Montessori therapy is to build the foundations of independence. The task of Montessori therapy is to eliminate the problems, prepare the environment, and aid so that even a child with handicaps can achieve independence. According to Kozelkova (2013), in Montessori therapy, we use more direct motivation and limitation of free choice of activity (what will be worked with is alternately chosen once by the child and once by the therapist), whereas in Montessori pedagogy there is more emphasis on the child's spontaneous activity and free choice of activities. According to Anderlik (2019), Montessori therapy offers the child with a disability, in addition to many tasks and goals, preparation for the child's integration into a social group. According to Kozelkova (2013), Montessori therapy uses the same tools that are used in Montessori pedagogy. They are clearly structured and arranged in a prepared environment and build on each other. In the therapy sessions, the therapeutic materials are offered to the child client in the context of a thoughtful gradation of difficulty that the activity presents. The progression is from the simplest, isolated activities, – to more complex activities requiring serial thinking (the ability to follow multiple meaningful steps in sequence). Each new therapeutic activity presents the child with an offer to practice and master an isolated issue of varying difficulty. According to Dattke (2014), for the Montessori therapist, Montessori aids are also diagnostic material. They enable him or her to continuously obtain up-to-date information about the child's developmental level during participant observation of the child's work with these aids. Also, Luborsky (2014) argues that the prepared environment according to the M. Montessori concept is rich in activities that provide the adult with a wealth of information about the child. Observing what work the child is engaged in, or what work the child avoids, is a valuable source of information about the child's strengths, but also about the child's reserves in the following areas. These areas are executive functions: self-regulation, attention, planning, organization, seriality, working memory; musculoskeletal functions: postural strength and control and motor skills. According to Valente (2017), respectful communication with the child is key. The author recommends using polite expressions toward the child, speaking calmly and without shouting, getting down to the child's level when talking to him/her, and looking into each other's eyes. This means basing the relationship with the child on mutual respect and esteem.

3 Qualitative research

3.1 Methodology

In this research, we used qualitative methodology, a method of thematic analysis. According to Silverman (2005), the methods used by qualitative researchers convey a deeper understanding of social phenomena. The emphasis is on 'immersing' oneself in naturally occurring events in order to gain first-hand knowledge. According to Gavora (2006), qualitative research aims to reveal how people interpret the world. In qualitative research, an inductive approach that moves from data to theory is prevalent. Each individual or group study is a unique case for the researcher. Generalization is only possible if it involves other individual cases that have been deeply, comprehensively, and/or intensively studied. Silverman (2005) recommends the use of qualitative methods when researchers choose to study people – their life stories. Those methods can provide a 'deeper' understanding of social phenomena. They favour analysis of words rather than numbers; observation over experiment; unstructured observation/interview rather than structured; meanings rather than descriptions of behavior; and inductively linked research rather than deductive.

3.2 Research aim and research questions

The aim of the research was to identify and analyze the communication and therapeutic strategies used by the therapeutic educator during therapeutic sessions in the context of early therapeutic stimulation according to M. Montessori's concept. We formulated the following research questions:

1. What therapeutic-communication and counselling strategies does the therapeutic educator use during therapeutic-pedagogical sessions?
2. Which of the identified therapeutic strategies are primarily based on verbal approach and which combine verbal, activity, and physical access in the context of therapeutic-pedagogical therapy?

3.3 Research Set

The research sample of the qualitative case study consisted of a mother with a child with at-risk development who participated in therapeutic-educational sessions conducted according to M. Montessori's concept and a therapeutic educator who was present. At the time of the research, the child had not yet completed the formal diagnostic process with diagnostic conclusions. The selection of the research sample was deliberate.

3.4 Methods of data collection and processing

Data collection was conducted through participant observation and conducting video analysis. The video recordings of each treatment-education session were continuously transcribed into records made up of transcripts and descriptors. We then broke down the transcribed qualitative data into discrete units of meaning. We assigned a numerical code to each meaning unit. The transcripts thus numerically coded were ready for ongoing analysis. The objectively observed data were categorized into lower (second) and then higher (first) order categories. On the basis of the collected, transcribed, and continuously analyzed data, we theoretically elaborated 8 themes – lower order categories. 2 categories denote therapeutic strategies of a purely verbal nature and 6 categories denote combined therapeutic strategies – verbal, activity, and physical. The individual categories represent themes that offer a theoretical overview of the therapeutic strategies of the therapeutic educator in the context of the case study of early therapeutic pedagogical stimulation according to M. Montessori's concept.

3.5 Limits

A limitation of the research was the limited number of participants – 1 mother with one child at risk and one therapeutic educator.

3.6 Research findings

The research identified 2 main first-order categories (themes) and 8 second-order sub-categories (themes), which were thematically labelled and saturated with individual units of meaning (numerically coded) with 2 second-order categories classified as verbal and 6 second-order categories were verbal-physical-activity categories.

We labelled the higher-order categories as follows:

1. Verbal strategies of the therapeutic educator in early therapeutic-pedagogical stimulation according to M. Montessori's concept
2. Combined verbal-physical-active strategies of the therapeutic pedagogue in early therapeutic-pedagogical stimulation according to M. Montessori's conception

Under the two higher-order categories, we have grouped 6 lower-order categories and labelled them as follows:

1 Verbal strategies of the therapeutic pedagogue in early therapeutic-pedagogical stimulation according to M. Montessori's concept
   1.1 Verbal accompaniment
   1.2 Verbally instructing the child

2 Combined verbal-physical-activity strategies of the therapeutic educator in early therapeutic-pedagogical stimulation according to the M. Montessori concept
   2.1 Movement accompaniment of the child
   2.2 Presentation of work with the aid
   2.3 Intentional guidance of the child's attention
   2.4 Bringing system and order
   2.5 Involving and activating the parent
   2.6 Unconditional acceptance

In the following, we formulate the research divided by each category.

In the following, we further elaborate on the research findings by each category.

4 Verbal strategies of the therapeutic pedagogue in early therapeutic-pedagogical stimulation according to the concept of M. Montessori

4.1 Verbal accompaniment

The number of cases within this category was 133. The aim of this therapeutic technique is to immediately offer the child conceptual representations of current events and a model speech pattern from the adult during the therapy. The therapist verbally accompanies the child for the duration of the therapy session ('tracking') during the different therapy exercises. The purpose of this strategy is to comment on the child's actions verbally, the actions of the therapeutic educator himself, and other persons present in the therapy session (e.g., the actions of the parent). The therapeutic educator also mirrors the child's emotional experience. The therapist clearly, comprehensibly, and slowly names the steps of the activity for the child, using concrete and distinct terms. The terms are chosen very deliberately. They are simple, precise, concise, and often repeated by the therapist. The therapist does not overwhelm the child with too much verbalization, but rather 'spares' the words. Verbalisation is participatory – the therapist interacts with the child on a physical level, e.g. sitting with the child on the carpet. An important principle of such commenting is the perceptive presence of the therapist and responsiveness to the child's actual expressions. The principle is to follow the child physically and verbally accompanying his/her expressions. The therapist balances the degree of following the child with offering new stimuli. This must be in balance. This category emerged as the most saturated in the research, as evidenced by the fact that this strategy is the most frequently used by the therapeutic educator in therapy. The occurrence of this category was recorded

in a total of 133. A few specific examples documenting this category are provided. 1.57 TE: "You threw the shells out. I'll put them here, on the shelf"; 1.64 TE: "I'll throw the chips out". This also includes examples where the therapist comments on various situations that occur accidentally during the therapy: 1.85 TE: "Never mind, we'll fix it, we'll pick it up". For the therapeutic educator, this is a way of expressing to the child that he or she is close, that he or she is present, and that he or she sees everything and is interested. If the child performs the action-activity with the aid correctly, the therapeutic educator avoids praise, describes the situation, and thus gives feedback to the child. This is about building intrinsic motivation. The aim is that the child performs the activity with the aid for the sake of the activity itself and the satisfaction and pleasure the child gets from it, and not for the sake of external praise – extrinsic motivation. Examples of this are 3.110 TE: "Finished. We put all the chips in. We'll put it away."; 4.9 TE: "You put all the shells in.".

4.2 Verbally instructing the child

This is a category of a therapeutic strategy that occurred in a total of 66 cases of semantic units. Within the category of 'giving verbal instructions, this is purely verbal support of the child's direct action (no active demonstration by the therapist or adult). Verbal instructions serve as external guides for the child's first active participation in playing with a particular material. They also serve for his subsequent instruction in further independent activities (or attempts at activities). The strategy in question is part of a procedural therapeutic-pedagogical diagnosis in which the therapist ascertains the child's current understanding of speech. This initially involves building passive vocabulary (speech understanding). The therapist ascertains whether the child's previous repeated experience of a particular activity or working with aid has also created a conceptual representation (whether the child associates a correct concept with a particular activity or thing). They may not yet verbalize at this stage. If the child understands the verbal instruction, he or she will carry it out independently or with assistance. This is to prepare the child for participation in mainstream kindergarten, where it is essential to understand and follow the teacher's instructions. The goal is to build the child's work on demand. Within the framework of therapy, the child's ability to perform simple actions on the basis of verbal instruction alone is gradually built up. This must be preceded by a comprehensive demonstration of the play exercise by the therapist and the child's experience of the correct use of the therapeutic material. In doing so, we follow the principle in therapy: "once you, once me" depending on the child's attention span. For example, the therapist demonstrates throwing two chips into a box and then offers the child to try it out. Instructions are simple and easy to understand, such as 8.107 TE: "Put in."; 8.112 TE: "Put in some more. Look, open."; 2.15 TE: "Oliverko, take out the square, put it out.".

5 Combined verbal-physical-activity strategies of the therapeutic pedagogue in early therapeutic-pedagogical stimulation according to the concept of M. Montessori

5.1 Movement accompaniment of the child

The second most frequently occurring category, closely related to the previous category, is the category "movement accompaniment of the child", which occurred a total of 67 times. This category presents situations in which the therapist provides tactile and kinetic guidance to the child. The therapist motorically copies the child's positions in relation to the environment (e.g., the child is lying on his/her stomach during play, sitting in a Turkish sit-up, or leaning on a table), the positions the child is in during play, and the movements the child makes during play. The therapist does not do the activities for the child but offers only the necessary physical support/support. The challenge is to sensitively balance the therapist's interventions and the child's willingness to do a play exercise/activity on his/her own. Often it is more a matter of just kinetically directing the trajectory of the child's hand movement when performing a certain activity. Sometimes the therapist will place the child's hand on his/her arm so that the child can feel the direction of movement and the force needed in the chosen activity. In this way, the child is able to experience the activity sensorially through the therapist's hand movements during a particular activity. This is a model experience of the precision and purposefulness of individual hand actions. The activity is thoughtfully divided into individual acts and at the same time, the child is provided with a model in its overall complexity. This is to encourage the child to practise an individual skill that can be learned when using an individual therapeutic aid. The therapist also provides physical accompaniment by appropriately adapting the child's position in the space to the current position when playing with the material ('movement mirroring, tracking'). For example, sometimes she sits opposite the child, sometimes behind the child, and sometimes beside the child, in order to provide the best possible physical support for the child. An example of this is the following situation: 7.92 "The therapeutic educator folds another ring with both hands." 8.58 "The therapeutic educator adjusts the child's grip. He also engages his other hand." 8.103 "Educator takes the child's hand and directs it to the opening of the box".

5.2 Presentation of working with the aid

The category occurred 59 times. The therapeutic educator presents the child with a demonstration of working with play material – very precisely, rather slowly, and sequences it into individual distinct steps. The presentation of the demonstration is

also verbally accompanied by the therapeutic educator. But in this therapeutic strategy we are only concerned with verbal accompaniment during the demonstration. The choice of vocabulary must also be well thought out. During the demonstration it is necessary to "save words", not to overwhelm the child with words, to name only exactly what is necessary. The therapist himself must have the exercise very well mastered and rehearsed. He must be aware of the steps and their sequence. The demonstration presents the child with the exact procedure and thus develops serial thinking – the ability to work systematically and to remember the sequence of steps. Alongside this, it also develops the child's memory skills. The demonstration is presented to the child at an adequate speed (neither very slowly nor very quickly). The demonstration begins by naming the activity as a whole or by naming the material itself. E.g. "Today you have chosen spillover." "Today I'm going to show you the pink tower." "These are stringing rings", etc… Always adapt the demonstration to the child – his interest and the length of his ability to concentrate. If the child is not able to endure watching the therapist's demonstration all the way through (in its entirety), the therapist chooses to actively engage the child during the demonstration. The child's work with the new material is always preceded by a demonstration of the therapist's work with the material. This prevents the child from experiencing failure, demotivation, and also unfair handling of the material or its subsequent damage. The intention of the aid is to teach a specific skill. Therefore, an initial demonstration of how to work with the material is essential for the child. Here are some specific examples from the research: 1.41 "The therapeutic educator opens the first drawer, takes out a shell and places it on the cabinet." 1.46 "The therapeutic educator puts the shells in the bottom and closes the drawers." 1.58 "The therapeutic educator collects the shells and places them on the shelf." 2.20 "The therapeutic educator puts the circle back into the plate." 3.60 "He slowly runs his finger around the circumference of the circle." 3.71 "The therapeutic educator slides the hand back onto the carpet and slowly puts the circle back in." 4.24 "The therapeutic educator slowly makes a presentation of the aid." 4.27 "The therapeutic educator slides the bullet back into the box." 4.29 "The therapeutic educator puts the bullet into the hole on the box." 4.104 "The therapeutic educator picks up the lock and holds it in the air."

5.3 Deliberately directing the child's attention

Within this therapeutic strategy, occurring 81 times, the therapist directs the child's attention "from the outside." He or she directs the child's attention both verbally and non-verbally. This category also aims to support the child's learning to be able to focus on the chosen activity for a period of time and not be distracted by other external or internal stimuli. The child learns not only to start the activity but also to bring it to an end and to stay with it. If the child stops the activity for any reason, he or she

learns to return to the activity again and complete it. The treatment educator's strategy in these situations is for the child to bring his or her attention back to the activity. From a personality perspective, the child's persistence and constancy of attention are encouraged. If there is another child in the room who is working with the aid, the child is naturally guided to wait for the desired aid or possibly join the other child in sharing it. This also contributes significantly to the development of concentration. We observed verbal guidance of attention in situations such as 4.158 TE: ,,Look Oliver, can I show you something? Today we have a novelty."; 7.88 TE: ,,Look. I'll put it down.". Non-verbal attentional guidance, where the therapeutic educator uses a pointing gesture or a tapping of the finger on the object to direct or bring the child's attention back to the aid and work with it, was more frequent. This was observed, for example, in the following situations: 7.144 "The therapeutic educator points at the door on the box." 2.21 "The therapeutic educator taps the handle on the inset of the square." 4.142 "The therapeutic educator points with a finger at the cup to which the next smaller cup belongs."

5.4 Bringing system and order

Another category expressing the therapeutic strategies of the therapeutic educator is the bringing of and 'adherence to system, and order' and the resulting stability and some permanence to the work with play therapy materials. We identified this category in the number of 38 semantic units. It is an essential part of therapeutic work with the child in the context of the principles of M. Montessori's pedagogy. All the aids have a stable place in the prepared environment, which does not change. For the child client, this means fulfilling the need for security by making events and things around him predictable. This corresponds to the child's need for stability, system, order and some predictability. Particularly for vulnerable children with more severe forms of disability, it is important for the adult to persist in adhering to the ways of working and handling aids as well as to his or her own constant behaviour and communication. It requires a fair amount of self-control, sensitivity and adaptability on the part of the adult to the child's needs. The environment is prepared with aids that correspond to the child's natural developmental period and are therefore appealing to the child. The child naturally saturates his/her developmental needs when working with them. In such an environment, the child feels safe and secure, and this is one of the basic conditions for learning. Most activities are prepared in a defined place (e.g. on a shelf), in certain containers or on certain defined surfaces (e.g. in boxes, in baskets, on trays) – in ordet to teach children to orient themselves in the environment. The child has all the components of the activity ready in one place, does not have to search for them, and their intrinsic motivation to work is harnessed. The aids are also visually and aesthetically unified to encourage the child to work spontaneously

with the activity. The fundamental principle is that the activities are freely available in a space for the child to freely choose and use. This removes the unnecessary barrier for the child of having to ask or beg for activities from an adult. He simply chooses what he currently wants to work with in the environment according to his inner interest and current developmental need. The adult – therapist or parent – is part of the prepared environment in the sense of the stability of the child's actions and his stable and predictable reactions. The adult's role is to continuously prepare the prepared environment for the child and to teach him maintain order. By being aesthetically arranged, the activities also serve as a strong initial stimulus for the child to begin working with the material spontaneously, without prompting. He simply comes, sees the stimulus, chooses, picks it up, takes it to the work area and begins to work independently. This promotes the child's independence from permanent adult teach. In the case of children with disabilities, this is an important aspect, as they are often over-assisted, leading to a stage of permanent 'dependency'. In a prepared environment, the child decides what to play with, where to play, for how long, with whom and with what possible variations within the limits and possibilities of the material. In addition to practising certain skills and acquiring certain knowledge when playing with the equipment, the child is also supported personally in terms of developing his autonomy and independence. Naturally, other personal qualities are also developed in the child, e.g. respect for external material things and for the overall situation in the prepared environment (e.g. respect for the duration of the therapy session or the rules for handling materials, etc.). An important aspect of the therapeutic encounters is also to support the child to subconsciously 'notice' and then respect the arrangement and aesthetics of the material things in the environment, the overall culture of the environment. The aids themselves are made of valuable materials (wood, glass, porcelain, metal…) and thus the handling of valuable objects leads to prudence and delicacy in handling them. The child sees where the object belongs and is guided to return it there after use. This builds in him a sense of responsibility and a sense of order for the rest of his life. At the same time, a culture of calmness, gentleness and responsibility towards the world around them is being internalised. Gradually, the child's overall psychological calming and stabilisation – in Montessori's words, 'normalisation' – takes place. 6.57 The therapeutic educator placed the matryoshka in the child's hands, went to the shelf and pointed with his finger at where the aid was kept. 6.58 TE: „This is where the matryoshka belongs. Here is its place." The system in handling the aid and storing the parts of the aid on the work surface supports the child's skills and heTEs to avoid chaos and confusion that can demotivate the child. This aspect of the orderly environment is demonstrated, for example, in the following situations: 6.27 "The therapeutic educator places the matryoshka in two opposing rows consisting of the upper parts of the matryoshka on one side and the lower parts of the matryoshka on the other side." 7.27 "After a while, the therapeutic educator

approaches the child. He collects the scattered shells and places them on the cabinet, arranging them each over one drawer."

5.5 Involving and activating the parent

We identified the given category in 19 situations. The intention of the given communication strategy of the therapeutic educator is to work simultaneously with the parent in the therapeutic session with the child. Gradually, the parent is invited to take an active part in the child's games. The aim is to make the parent understand that he or she is part of the therapeutic process. It is about his/her activation and self-actualisation in the context of his/her parenting competencies. The parent needs to be convinced that he or she is capable of accompanying his or her child with developmental risks. In the process of therapy, the parent has to discover his/her competence to follow the needs of his/her child and to support him/her effectively in his/her development. This is done through non-directive prompting and encouragement of the parent by the therapist. The therapist avoids the directive, direct "coaching, rehearsing, or training" of the parent. Rather, it is about guiding and exploring the parent's parenting competencies in the sense of "empowering" the parent in his or her parenting role. This is done in the protected, safe environment of a therapeutic playroom with a therapist present. The aim is to gradually transfer these acquired or 'awakened' parenting competencies to their home environment. This involves therapeutic accompaniment of the parent of a child with developmental risk in a situation of "changed parenting". The therapist offers model patterns of behavior and approach to the child according to M. Montessori's concept and allows the parent to practise the ways of supporting the child as observed by the therapist during the therapy sessions. Through individualized therapy sessions with the therapeutic educator, the parent attempts to introduce new approaches to the child and break out of often dysfunctional patterns of parenting behavior. The parent sees in the therapist that some new approaches of communication and action toward the child work better and tries to adopt them into his or her behavioral repertoire. On the part of the therapeutic educator, this requires a high degree of empathy for the parent. He adapts the offers to the parent individually in terms of the parent's availability, e.g. in his ability, adjustment, or speed to accept change, in his openness or closedness to the new. Inviting and involving the mother in the therapy was observed e.g. in situations: 7.105 TE: „Will you try again? Try with Mommy, Oliver."; 7.155 "The therapeutic educator walks away and gestures to the mother to come forward." 8.14 "The therapeutic educator moves the tray closer to the mother and nonverbally indicates to her that she is the one who should carry out this activity with the child. The therapeutic educator engages and invites the mother to work with the child usually indirectly, through an activity, situation or gesture."

5.6 Unconditional Acceptance

Within this category, we identified situations that are related to another essential therapeutic strategy of the therapeutic educator, which is related to unconditional acceptance. We identificated 15 semantic units. Every person deserves respect and regard for the way they live their life and what they need. The client is always part of a larger whole, a certain system of relationships. It is a closer and wider social environment that the therapist must take into account. The task is therefore to work in therapy not only with the child client himself, but also with his environment (family, educational institutions, other support institutions, etc.). We concentrate on developing the client's full potential and on finding ways to support him/her in the surrounding environment. The aim is to promote interactive action or responsive accompaniment of the child by the relational persons in his/her vicinity. According to M. Montessori, the child deserves respect and respectful treatment. Montessori pedagogy, Montessori therapeutic pedagogy and Montessori therapy are based on the same principles that M. Montessori observed and developed in children. She communicates them in two leitmotifs: "Teach me to make it on my own." and "To take me from grasping to understanding" (Anderlik, 2019). According to M. Montessori, children have a strong sense of personal dignity. Adults are often unaware of how often they hurt this feeling (Montessori, 2012). In our research we identified situations of fostering respect for the child client e.g. here: 2.5 TE: , "Welcome Oliver, hello. (pause) Looking around to see what we have here." 3.2 TE: „Hello. Welcome Oliver."; 3.113 TE: „Done for today Oliver. Come on mommy get you dressed and you go home. I'll look forward to seeing you next time. Have a nice day." Respect is also shown by the therapeutic educator by thanking the child for the favour in the same way as an adult and using the word , "Like" when handing an object or aid: 4.30 TE: , "Try you, Oliver. Like."

6 Conclusion

Early therapeutic stimulation according to the concept of M. Montessori has its specificities and benefits in the therapy of children with developmental risks. The initial prerequisite is appropriate therapeutic strategies of a verbal-physical-activity nature. In our research we have identified effective therapeutic strategies, of different nature, in the framework of early therapeutic-pedagogical stimulation. The most prominent verbal therapeutic strategy from the category of Verbal Therapeutic Strategies with the label „Verbal Accompaniment" is also defined by the authors Kocabas and Bavli (2022), who identify the position of the educator according to the concept of M. Montessori in the context of communication with the child as a guide, counsellor and teacher. The authors talk about the communication style of the educator, which

reflects the needs of children and the differences between them. They stress the importance of observation, which is crucial in communication. Communication is built up gradually, on the basis of trust, and reflects the child's emotional needs and developmental level. The next most saturated strategy in our research was 'Verbal Instruction' in the sense of verbal support for the child's direct action. Kocabas and Bavli (2022) also point out the need for individual communication between the teacher and the child, the so-called one-to-one communication approach, which reflects the individual differences, pace, needs and readiness of the child. During communication with the child it is important to be concise, clear, direct, trustworthy, caring and to use appropriate verbal terms. In the context of the second group of therapeutic strategies – called Combined Verbal-Physical-Activity Strategies of the Therapeutic Educator in Early Therapeutic Stimulation according to the concept of M. Montessori, we identified a therapeutic strategy called, "Movement Accompaniment of the Child". Vodičková (2021, p. 73) states: "Life means movement. Movement in humans is a response to sensory stimuli. In a broader sense, a person uses movement to reflect on what is happening in his or her environment. Movement expressions tell about one's psychological state, physical attributes, self-characterization, and inclusion in the wider community. Psychomotor activities promote freedom, liberty, cooperation, sharing, working with rules, respecting and understanding one's own and others' boundaries, relaxation, good mood, togetherness, cooperative skills and abilities. Participants in movement games learn to play fair play, compromise, negotiate, affirm their self-worth in interaction, self-knowledge, self-reflection in movement, but also to strengthen individual psychological functions through movement, etc. All this has a rich inclusive potential." Another identified therapeutic strategy is "Presentation of the work with the aid". Anderlik (2019) states that every child, even the most handicapped, needs stimuli, needs teach to use the stimuli. The teach must be appropriate so that the child can manage the work, but at the same time so that his self-esteem does not suffer. In Montessori therapy, the author recommends offering each new object first so that the child can look at it long and well enough. As in Montessori pedagogy, it is necessary in therapy to name the characteristics of the object in a way that is understandable to the child. In this way, we offer him experiences through which he learns to recognise objects and their properties that he would never have come to know of his own volition. The therapeutic strategy "Intentional attentional guidance" is also defined by Kozelkova (2013) as a basic principle of therapeutic work in Montessori therapy and consists in inducing the child's concentration. The child should discover and experience the prepared environment with the senses on his/her own. Christl (2009) says that it is necessary to achieve polarisation of attention in therapy in the child as often as possible, because this has an impact on the construction of his personality. The child feels and perceives himself as a person in his work. Due to the process of self-discovery, he is able to handle more challenging tasks and more

challenging task complexes. It is a process of "self-education". Achieving polarisation of attention in the child in therapy is possible even when the child's sensory phases for certain areas have already been completed. The specific therapeutic strategy , "Parent involvement and activation" finds an echo in the arguments of Anderlik (2019), who emphasizes the role of parents within Montessori therapy. According to the author, Montessori therapy is completely dependent on the collaboration with parents. The latter is set up to ensure the most ideal conditions for the child with developmental risks, but on the other hand it must not put the family under pressure. In Montessori therapy we try to link the support of the child and the consideration of the family's possibilities. The author does not recommend giving parents any homework that the therapist would then check and thus burden the family. The emphasis is on involving the parents in finding a path that leads through the child's real interests. The goal is for the child to be able to participate in the life of the family as best as possible. A creative approach and creative solutions on the part of the parents are encouraged. Valešová Malecová (2018) states that the therapist in early intervention also focuses on imparting knowledge and teaching parents (or other relatives) to learn skills related to supporting child development. The relational person builds these skills by observing the therapist in therapeutic activities with the child, then in independent direct work with the child under the supervision of the therapist, and also by way of referrals from the therapist. A reference to a therapeutic strategy called "Unconditional Acceptance" can be found in Kocabas and Bavli (2022). The authors suggest promoting it through accepting communication with the child. In doing so, they discuss specific practices such as lowering oneself to the child's level, ensuring eye contact with the child, greeting the child and sharing emotions while doing so. Educators pay attention to the child's moods, needs, and current reality.

Early therapeutic-pedagogical stimulation within the framework of early intervention according to M. Montessori's concept in the field of therapeutic strategies has its specifics. Their aim is to promote inclusion in the context of the closer and wider social environment of the family with a child with development at risk. The issue requires further research in the area of parental involvement in supporting the therapeutic process.

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