

## FORMATION OF SELF-CARE SKILLS IN CHILDREN AND ADOLESCENTS WITH SEVERE MULTIPLE DEVELOPMENTAL DISABILITIES

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**Annotatsiya:** Maqolada og'ir aqliy va jismoniy rivojlanish buzilishlari bo'lgan bolalar va o'smirlarning o'z-o'ziga xizmat ko'rsatish ko'nikmalarini shakllantirish bo'yicha tajriba ishlari taqdim etilgan.

**Kalit so'zlar:** o'z-o'ziga xizmat ko'rsatish ko'nikmalarini shakllantirish, harakat buzilishlari, og'ir ko'p qirrali rivojlanish buzilishlari bo'lgan bolalar, ijtimoiylashuv

**Аннотация:** в статье представлен опыт работы по формированию навыков самообслуживания у детей и подростков с тяжелыми интеллектуальными и двигательными нарушениями.

**Ключевые слова:** Формирование навыков самообслуживание, двигательные нарушения, дети с тяжелыми множественными нарушениями развития, социализация

At present, there is no consensus in the specialized literature regarding the concept of "severe multiple developmental disorders" (SMDD). In a broad sense, this term encompasses individuals with combined impairments in the motor, sensory, and intellectual spheres (Bazileva T.A., Levchenko I.Yu., Zhigoreva M.V., Tkacheva V.V.).

Contemporary researchers emphasize the necessity of creating special conditions for educating children in this category. One of their key characteristics is the need to pay particular attention to the development of life skills in daily situations, such as self-care, dressing and undressing, going to the store, purchasing food, preparing meals, and social interaction. The formation of these life skills ensures the child's active engagement with the surrounding world. Among the life skills, self-care abilities are the most relevant and essential for children with SMDD, and their development is a primary focus of educators, special educators, and specialized psychologists.

Originating from the satisfaction of natural needs, self-care skills become tools for the child's independence and autonomy. By developing self-care skills, we teach the child to meet basic needs such as food and warmth, while also fostering social skills based on these biological needs. During interactions with caregivers in activities related to daily hygiene and meals, the child receives the first transmission of uniquely human ways of acting.

Self-care skills also involve practical, object-based activity, initially carried out with the caregiver's hands and later by the child independently, forming the foundation for higher mental functions. Teaching self-care expands children's understanding and knowledge of the world, enriches sensory experience, develops fine motor skills, visual-motor coordination, and imitation, and teaches the child to follow a model and maintain a specific sequence of actions. Exploration of the object world and participation in creative activity occur through practical, play-based, and accessible labor activities. These object-based activities help children develop essential and universally needed skills.

The child learns to perceive objects by fixing gaze on them and tracking their movement. To develop this skill, brightly colored and sound-producing objects, such as rattles and bells, are used. This is followed by exploration of the object through visual, oral, olfactory, and other senses, recognition of its properties, comparison of two identical objects, and understanding of



their similarity. Simultaneously, children are taught how to act with objects, first with the guidance of an educator and then independently.

Children and adolescents with SMDD must be taught to manipulate objects in various ways, including throwing, rotating, twisting, opening, closing, pressing, squeezing, and so on.

Through practical, play-based, and accessible labor activities, qualities of the emotional-volitional sphere are developed, including motivation, perseverance, the ability to work for extended periods with quality, and the ability to complete tasks.

The development of social and daily living skills represents a transition from lower to higher levels of mental activity and reflects a holistic process of interacting qualities formed in the child. For children and adolescents with severe multiple developmental disorders, this is especially important. The most significant milestone for them is mastering self-care skills, which enable adaptation to daily life.

Our approach is based on having the child perform the entire sequence of self-care actions continuously, while placing special emphasis on training and refining the operations that fall within their zone of proximal development.

The development of self-care skills in children with severe intellectual and motor impairments is a long and uneven process. Overprotection or the adult's desire to do everything for the child can lead to what L.S. Vygotsky called a "social dislocation." As a result, the child will fail to acquire essential and necessary skills and will struggle to socialize and adapt to society. Caring for the child and their well-being means giving them the opportunity to master skills independently.

When teaching self-care skills, it is important to follow these principles:

1. Each skill is broken down into smaller operations. The child learns these sequentially and over time until each operation is fully mastered.

2. The skill being taught should be clearly defined with maximum precision. For example, the goal is not simply "learning to eat independently," but specifically "bringing a spoon from the plate to the mouth."

3. The child must be ready to learn the skill at the time of instruction—a kind of "mindset." If the child is tired or unwell, it is necessary to allow rest and wait until they are ready, as motivation for learning and skill acquisition is crucial.

4. Actions should be algorithmic, consistent, and follow a clear sequence.

To form the operations of a skill, we use techniques such as:

1. Demonstration – direct showing of the action, collaborating with the child, and ensuring the child understands and accepts the action.

2. "Hand over Hand" – teaching with gradually reduced physical support. First, provide a task appropriate to the child's readiness. Stand beside the child, take their hand (specifically the back of the hand), and physically guide them through the task. It is essential to ensure the child is ready to act. This method allows the child to feel that they are performing the task themselves, giving a sense of personal success, while also feeling the readiness of the adult to assist.

Case Example: Seva D., 18 years old, Down syndrome, severe neurological motor impairments, profound intellectual disability. The boy mostly sits in a special chair or on a couch, does not walk independently, can stand with support, and bears weight on his legs well. Vision is almost completely absent.

Mood is even and positively oriented. Maintains contact based on mood and is capable of emotional-level interaction. Responds only to adults he knows well. Often engages in stereotypical movements (rocking, clapping hands when holding an adult's hand, playing pat-a-cake). Produces stereotypical sounds. Uses vision minimally, mainly relies on hearing. Does not understand spoken language or simple instructions and has poor spatial orientation. Expressive speech is undeveloped. Cognitive activity is present at the minimal level accessible to him; he shows no interest in objects (except a spoon), may briefly hold a toy and perform non-purposeful



manipulations. Attention is unstable, with no sustained concentration. Fatigue is high. Interacts selectively with other children.

He eats pureed food, holds a spoon well, and brings it to his mouth independently. Until recently, he ate with adult support; now he eats independently because he has learned to scoop food and can now feed himself.

Seva does not like washing his face. Washing itself is a fairly complex skill to master. In this case, we followed a specific algorithm. During face washing, both in the morning and evening, Seva showed signs of aggression. We began explaining to Seva what we were going to do: “Seva, it’s morning (or evening), you woke up, got dressed, now we are going to the bathroom, and we will wash your face.” Then we explained step by step what we would do together: “We will turn on the tap, run water to wash, and brush our teeth...” Gradually, Seva got used to washing and began holding the toothbrush on his own. This is the first stage in mastering the skill.

Kristina T., 14 years old, cerebral palsy, spastic tetraparesis, brain development disorder, profound intellectual disability. She has divergent concomitant strabismus. Kristina is constantly in a special chair and has difficulty holding her head upright. Establishing emotional contact with Kristina is easy; she responds to her name, turns her head, and focuses her gaze on an adult’s face. She enjoys this interaction. She is very friendly and smiling. She understands spoken language directed to her and follows simple instructions. She can point to a required object in a picture and can name some objects. She knows colors, body parts, and shapes, and can compare sizes. Expressive speech consists of isolated words and sounds; she is beginning to acquire phrase speech, but articulation is difficult due to physiological defects. She is well oriented in space, recognizes familiar people, and knows their names. Her memory functions are preserved, and she has imitation skills. She can reproduce isolated sounds. Fine motor development is challenging for her, and her movement repertoire is limited. Play activity is developed, and cognitive activity is present at the maximum level accessible to her. Attention is stable, with brief periods of concentration during activities, but she tires quickly, requiring breaks every 7–9 minutes.

Initially, we brushed Kristina’s teeth for her. Then we used the “hand-over-hand” method, gradually reducing adult assistance. Now, Kristina brushes her teeth independently with minimal support from the educator.

Amantur B., 11 years old, severe motor impairments, spastic tetraparesis, profound intellectual disability, hydrocephalus. Establishes emotional contact easily. Responds to his name, turns his head, and focuses on an adult’s face. He does not walk independently and sits in a special wheelchair. His emotional tone is even, mostly positive. The boy is friendly and smiles often. He partially understands spoken language; expressive speech is undeveloped. He has a highly developed imitation skill and tries to repeat everything the adult demonstrates (within his movement and object activity repertoire with toys). Play activity is well developed, and cognitive activity is at a high level. He is easily engaged, with voluntary and stable attention and high—but brief—concentration. His memory functions are preserved; he recalls actions from the previous week and can reproduce movements. Fatigue is fairly high, but with each session, he can maintain attention on play for increasingly longer periods. He enjoys observing other children and adults and actively seeks adult attention. He eats pureed food independently.

Until recently, Amantur categorically refused to eat on his own. Feeding him was difficult. We realized he refused because eating was strongly associated with taking tablets, usually distributed by a nurse before breakfast, lunch, and dinner.

We decided to separate these two situations. Now, Amantur takes his tablets in the playroom after meals. He began to understand that breakfast, lunch, and dinner are enjoyable and tasty. A natural motivation to eat emerged. He soon began feeding himself with a spoon, experiencing no



negative emotions or difficulties. His refusal to take medication persists but has significantly decreased.

The skills our students acquire help them become more independent in daily life. They expand their abilities and allow them to learn more about themselves and the surrounding world.

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