Early Education for children between 0 and 6 years

Erasmus+ Programme, Key Action 2: Strategic Partnerships:

“Designing Curriculum for pre-school teachers who work

in inclusive classroom settings”

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1. Introduction

This paper is one of the outcomes of the output 2 (O2) of the Erasmus+ Project "Designing Curriculum for pre-school teachers who work in inclusive classroom settings- Teachers to Teachers". The project is financed by the European Union Erasmus+ Programme and coordinated by the Turkish National Agency (Directorate of European Union Education and Youth Programmes Centre, Turkish Ministry of European Union Affairs).

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The output 2 of the project is devoted to the development of a new tool to evaluate and examine inclusive preschool settings in the perspective of global quality based on the idea of inclusion (Evaluation Tool Kit). This product provides a new point of view to the policy makers in an under researched but most important field of education. The present document represents one of the first steps in the development of the tool. The purpose of this paper, written by experts working at an inclusive preschool of the German partner organisation, is to provide quality indicators for inclusive preschool settings. In particular, the objectives, means, concepts and implementation in the field of Early Education will be discussed below.

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2. Definition of Early Education

According to Dr. Hans-Joachim Schmutzler, lecturer in Montessori pedagogy and author of the popular handbook of foundational research *Introduction to the early education of disabled children*, early education means:

> *"(...) education of children from birth till start of school. Thereby the term includes every didactical, pedagogical and methodical measure to encourage, guide and optimise the development of all basic human competences, like language and intelligence, motor function and perception, emotionality and sociality and all corresponding inborn abilities to learn. Early education acts methodically well-planned and is based on interaction with the child implying clear defined didactical and methodical aims of education. Even childcare is part of the early education as the quality of contact (tender etc.) influences social and emotional learning abilities. Through these early experiences the child learns how humans act with each other, what means that thereby children acquire moral concepts and attitudes towards life."*[1]

3. Objectives of Early Education

If a child shows delays, difficulties or abnormalities in its development, Early Education and Intervention can often mitigate or remedy possible consequences as in the early childhood it is still achievable to influence the development. Institutions of child support shall not only provide appropriate child care, but also adress the affected parents with information, suggestions and guidance to help their child. One of the special tasks of early childhood education is to help parents to deal with the possible impairment/s of their child and to accept it/them, to provide them with assistance in education and to inform and advise them about legal conditions and financial assistance.

[1] Hans – Joachim Schmutzler (Herder Verlag, 2006) Handbuch Heilpädagogisches Grundwissen

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The objectives and priorities depend on the problems identified. The aim of the Early Intervention is to recognize impending or already occurring disability as early as possible and to specifically support the child in his physical, mental and social abilities by means of appropriate support and treatment measures. Depending on the area in which particular problems occur, specific funding priorities are set.

Beyond the treatment of causes and symptoms, important educational goals for the child are:

- promoting the perception of the child, movement, interaction and communication as well as language;
- Imparting techniques to compensate for possible deficits, for example through other skills;
- support in the development of life skills;
- Support social and emotional development.

4. Concepts of Early Education and Early Intervention

Early support is always based on a holistic approach to help. It involves concerted medical, psychological, social, and educational interventions that work together to involve the child as well as their immediate environment, the family. In this sense, the offer of Early Intervention includes:

- Diagnostics, usually by the pediatrician, if necessary with specialist involvement, or - after medical referral - by a social pediatric center,
- Therapy,
- Educational support,
- Advice, guidance and support of parents.

In accordance with this holistic concept, different occupational groups are involved in early intervention, which complement each other. These are, for example, physicians of pediatric and adolescent medicine, psychologists, educational and curative specialists, specialists in speech therapy, physiotherapy and occupational therapy. Through this combination of different qualifications, the special support measures can be implemented quickly and easily.

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5. Comprehensive diagnostic

A treatment plan for Early Education and Intervention should always be prepared based on comprehensive diagnostics, including:

- Investigation of general development and intelligence,
- Physical and neurological examination,
- Psychological findings
- Assessment of the child's social behavior and emotional development as well as the conditions of development, the strengths and resources of the family,
- Clarification of the origin and course of the disorder.

Based on the results of the study, an individual development and treatment plan will be prepared in cooperation with the parents. Of course, this should be geared to the circumstances in the family and in everyday life so that the support measures can actually be implemented.

6. Types of Early Education in Germany

a) General Early Education

Main priority of general early education is the methodology of special education which provides development advancement. These methods are mostly realised in a playful way at nursery schools by external persons with appropriate vocational training. General early education aims at children between 0 and 6 years who show a cognitive or psychical disability or are at risk of it.

b) Special Early Education

Special early education aims at children with sensory disability, like blindness, visual impairment, deafness or hardness of hearing. This kind of early education is mostly applied in schools by trained special education teachers.

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7. Assumption of costs and Data reports

In Germany there are more than 1000 facilities and jobs of early education, but with big differences on regional level, for instance there are fewer centers in rural areas. Paediatricians are mostly the first contacts and they are generally able to mention adequate places nearby or help with searching those places. Parents even may ask the local health office.

If the pediatrician prescribes the treatment it will be paid by health insurance. There is also the possibility to settle the costs on the basis of the Federal Social Assistance Act and the Children and Youth Welfare Act via the social assistance agencies.

The achievements for early education and early detection of children with special needs or in danger of it are legally defined at § 30 of the ninth social code. Because the arrangement of these achievements is not settled with full details, differences depending on every single German federal land are possible.

The OECD (Organisation for Economic Cooperation and Development) publication of 2015 *Starting Strong IV: Monitoring Quality in Early Childhood Education and Care* provides a summary overview of Early Childhood Education and Care (ECEC) inputs, outputs and outcomes in Germany comparing to other OECD countries. Regarding the data the share of gross domestic product (GDP) devoted to ECEC in Germany is similar to the OECD average (0.8% of GDP). The share of private funding for pre-primary education is somewhat above the OECD average (20.9% and 17.1% respectively). Annual expenditure per child in ECEC is above the OECD average (USD 10 542 and USD 8 618 respectively).

8. Advantage of Early Education in figures

In 2015, two-thirds (66%) of 2-year-olds attended Early Childhood Education and development programs in Germany. Participation in early childhood education is almost universal among those aged 3 to 5: 93% of 3-year-olds, 97% of 4-year-olds and 98% of 5-year-olds attend pre-school education. Participation in Early Childhood Education of high quality is particularly important for later educational outcomes. Later measures are less efficient as they take place at a time when the children's "development window" has already closed. An analy-

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sis of data from the OECD International Student Assessment Report (PISA) found that in most countries, students who had attended at least two years of Early Childhood Education generally performed better than students who did not, even after accounting the socio-economic background. For example, in Germany the percentage of 15-year-old students who did not achieve the basic level of competence in science was 21% among those who had less than one year of Early Childhood Education and 18% among those, who had participated for 1-2 years. These proportions fall to less than 7% and 5%, respectively, for those who had attended Early Childhood Education for 2-3 years or over 3 years. Thus a 15-year-old student, who has completed less than a year of Early Childhood Education, after accounting for socio-economic status, is about four times more likely to fail the requirements of the basic science level than a student who took at least one year part of Early Childhood Education. Regarding this numbers it is clear, that early investment in children's development and education can lead to high returns as it provides a crucial basis for future learning.

9. Therapy

Often general early education is supported by different therapies. The pediatrician or the social pediatric center of the pediatric clinic decides which extra therapy fits to which child. To implement the therapy it is possible that the child visits an external facility (doctor´s consultation, a practice for special education or a special center for the particular matter) or the therapist visits the nursery school or the child´s home.

The most applied therapies in Germany are:

I. Physiotherapy (remedial gymnastics)

Physiotherapy is useful for every type of physical damage, to sustain, improve or re-establish the mobility. Beneath the basic treatments of Bobath and Vojta disability-specific treatment methods are implemented. The Vojta Therapy is applied in case of movement disorders and muscle or respiratory diseases. Through targeted pressure on certain stimuli, reactions throughout the whole organism are triggered. The body responds with innate movement patterns. Thus, the muscle activities are intensively trained which is necessary for the stabiliza-

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tion of the posture and for the control of the limbs. The Bobath therapy, however, is used especially in diseases of the central nervous system. Through targeted treatment techniques and motivation it is for example possible to strengthen movement sequences and transitions, to exercise equilibrium reactions and to improve body awareness.

The children's physiotherapy is based on age- or development-related movement patterns and uses everyday practical activities in real situations. It includes numerous treatment areas and a variety of concepts. The entire spectrum of physiotherapy does not only include orthopedic but also neurological and even internal medicine. If the early childhood movement development is disturbed, it is essential to consult a physiotherapist for a special treatment adjusted to the special need of the child. Physiotherapeutic treatments and physiotherapy for children with or without special needs have been spread throughout Europe since the beginning of humanism. In the 18th century, the French physician Nicolas Andry founded the orthopedics and observed systematically the frequent postural weaknesses and deformities in children and prescribed special gymnastic exercises for therapy and prophylaxis. The Swiss physician Jean-André Venel (1740-1791) opened the first orthopedic clinic in the world in 1780. Johann Christoph Friedrich Gut's Muths founded the "Gymnastic Association" in Germany and Franz Nachtigall (1777-1847) in 1798 in Copenhagen. From their physical training the Swede Pehr Henrik Ling developed therapeutic gymnastics, as today still carried out with "movements of everyday life". He combined his treatments with massages for special muscle groups. Doctor Albert C. Neumann brought the "Swedish healing gymnastics" to Germany. In 1853 he opened the first gymnastics school for women. Especially in England but also in other European countries, the need for physiotherapeutic treatments grew due to the World Wars and to rising work and traffic accidents.

Remedial gymnastics and physiotherapy are widespread treatments for young children with or without special needs in whole Europe. One of the most popular physiotherapy with babies and young children is the “Vojta-method”, according to the Czech children's neurologist Vaclav Vojta (1917-2000). In Germany there are many Vojta children's therapists but also in Croatia, Norway, Austria, Poland, Romania, Spain, France and Italy there are Vojta courses and therapists working with this method. The treatment method is used primarily for disorders of the central nervous system and the musculoskeletal system.

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II. 2. Speech therapy or language support

Speech therapy describes a medico-therapeutic subject which deals with the functions and disorders of the language and speech system in the widest sense. This includes the area of voice and speech in the sense of articulation, speech and swallowing.

In addition to diagnostic and therapy of disorders of the mentioned areas, prevention and teaching are also an element of the specific field. Various occupational groups are represented in the area of speech therapy.

Talking about speech therapy it is important to consider that language development of children is very variable and there are many economical, social, psychological or familiar reasons why language development may be conspicuous without a direct speech disorder. In this case no therapy is needed. Often it is enough to support the "language-weak" children in a special way. Language support is generally aimed at strengthening and developing existing skills in the areas of speech melody, grammar or vocabulary. This happens, for example, through playful language programs in the nursery school. Also a consultation of the parents by a speech therapist is sometimes useful to show how the language development in everyday life can be supported. There are special offers, like the so called "Heidelberger Elterntraining", suitable for parents of "late speakers", children aged 2 years, who do not speak 50 words and do not combine words.

Children with a diagnosed speech disorder, on the other hand, do definitely need a speech therapy. A general language support can not help them. Usually the therapy is carried out as a single treatment, but occasionally also together with other children in a group. The treatment is playful and adapted to the symptoms, the age of the child and his level of development.

The most common language disorders are **pronunciation disorders**. If, in addition to the sound formation, other language skills such as sentence structure, vocabulary and / or speech understanding are disturbed, this is called **language developmental disorder**. If a child does not speak fluently, has speech impediments or repeats words or parts of words, there may be a **speech flow disorder**.

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If speech development is part of a more extensive developmental disorder, an ergotherapeutic treatment may be necessary. In the case of children with disabilities, the logopedic treatment is usually part of the Early Intervention Program and is coordinated as part of the support or treatment plan in the overall treatment team.

A differentiated language diagnostic is urgently needed and the basic requirement for every child with a linguistic conspicuousness. Only a clear diagnostic may ensure that the child gets what it needs: language support or speech therapy. This logopedic diagnosis is possible from the age of two to three years. It should always be ensured that language programs for children with speech disorders do not become fallbacksThe area of speech therapy, logopaedia or speech correction is a wide field. In whole Europe many children with special needs, speech difficulties, with a delay in the language development and/or with verbal developmental dyspraxia are treated in special speech therapies. There are many different methods depending on the specific child. One of the methods used in many countries of Europe, like Germany, Spain, England or Italy is the association method of McGinnis which was developed in the USA for the treatment of children with developmental speech disorders. Another famous method in Germany is the speech therapy of Barbara Zollinger. It is a holistic approach, which also includes other areas, such as game development. The child with his world of experience is the center of the therapy. This method is especially useful for young children knowing only few words. A famous stutter therapy used in whole Europe is the one of Van Riper, where stuttering should not be avoided, but a controlled stuttering reaction to the individual stuttering process should be learned.

III. Occupational Therapy

Occupational therapy is aimed at children who have deficits in the areas of perception, coordination, communication and / or motor skills. The manner of occurrence may vary and manifest as obvious behavioral disorder, or occlude, e.g. in the form of withdrawal or loss of motivation. Usually children with neurological, psychiatric and / or orthopedic disorders are treated by occupational therapy. The following disorders are treated by occupational therapy:

- Developmental delays

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- Perception disorders
- Disorders of coarse or fine motor skills
- Physical and / or mental disability
- Attention Deficit Disorder (ADD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Disorders of concentration
- Dyslexia
- Dyscalculia
- Mental and behavioral problems

Occupational therapy can help children to become more capable of acting to foster their independence in everyday life. Likewise, motor skills and the development of coordination, perception and communication should and can be improved. These advances are achieved primarily through playful therapeutic approaches.

Before the therapy an assessment of findings takes place. The child is closely observed in free play and also in concrete tasks in order to be able to define the state of development, the abilities and also the difficulties. Motor skills and visual perception are controlled by specific tasks and / or standardized tests. Of course, there are also personal talks with the parents.

For occupational therapy, working with therapists from other disciplines (such as doctors, psychologists, physiotherapists) may be useful. Also, conversations with the child's teachers or caregivers and educators may help for successful use of occupational therapy strategies in everyday school life or nursery school.

Occupational therapy is less symptomatic than holistic. The basic forms of movement developed in physiotherapy are deepened in this type of therapy. Playful behavior and life-practical exercises characterize the procedure. Generally the processes are used according to Kiphard, Ayres or Frostig. If e.g. the child has problems with correct holding of the pin, it is often necessary to first work on the application of force in the gross motor area and the coordination ability to achieve progress in the field of fine motor skills.

Depending on the problem area, different therapy concepts are used. Therapeutic approaches are above all:

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- Sensory integration therapy
- Concentration Training
- Behavior modification
- Psychomotor therapy
- Parental advice or advice for close caregivers
- Advice on the environment (kindergarten, school, etc.)
- Bobath concept

The occupational therapy is widely used as an adjunct to other language or motoric therapies across Europe, but is also oftentimes prescribed by pediatricians as a sole therapy, especially for children with special needs. The profession of occupational therapist is originated in the early twentieth century in the United States and was independently developed by different professional groups such as doctors, social workers, nurses, artists, crafts teachers and architects. In Germany, the profession occupational therapist developed from the merger of occupational therapy and work therapy. fter the Second World War, employment and occupational therapeutic methods were used for the first time in Germany by British nurses. In 1953 the first teaching facility for occupational therapy in Hannover was founded. Today the vocational training as a state-approved occupational therapist takes place in Germany at over 200 state-approved schools for occupational therapy and takes usually three years. In Netherlands there are 9 Regional Ergotherapeutic Networks (REN) formatting professional occupational therapists. In Spain in the decade of the 1950s the welfare movement was deployed and the SER (Spanish Society of Rehabilitation) was created, recognizing in 1969 the Rehabilitation as a medical specialty. The National Rehabilitation Center was funded, which includes an occupational therapy department. In France there are currently 23 training institutes in occupational therapy (IFE), some are private non-profit, other public. In Belgium currently 7 schools offer occupational therapy training in French and 8 schools in Dutch. The 15 schools are recognized by the World Federation of Occupational Therapists and give the title of "Bachelor in Occupational Therapy" in accordance with European standards. In Italy the academic path for occupational therapists foresees a first level qualification directly qualifying, and a second level master's degree. The course is present on 10 universities. The only university whose diploma is recognized by the WFOT (World Federation of Occupational Therapy)

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is the University of Milano, which has passed the minimum standards for a degree valid in any country in the world.

IV. Therapeutic Riding

Hippotherapy or equine therapy is a special form of physiotherapy, where the patient, unlike a rider, does not act in an active way with the horse. The therapy is based on the positive relationship with horses. The movement of the animal requires a corresponding adaptation reaction from the patient which leads to an encouragement of the system of support and balance. Furthermore horse riding leads to an improvement in overall body coordination. Therapeutic riding is considered as a holistic treatment, which appeals body, mind and soul and shall help to heal, prevent and alleviate psychosocial and physical disorders. (Deutsches Kuratorium für Therapeutisches Reiten e.V. 1997). Due to the German association of Neuropaediatrics and the German association of Social Paediatrics and Youth Medicine this is especially true for the therapy of children. Internationally, animal-assisted therapies are given no small importance. In the International Association of Human-Animal Interaction Organizations (IAHAIO) the national activities of many countries are bundled with the aim of organize and amplify the theoretical basics, to stimulate therapy studies and to increase the interest in the therapy in relevant international committees.

The use of horses in the therapy of somatic, psychosomatic and mental illness has long been practiced in European countries, like United Kingdom (i.e. www.epsomrda.org.uk), Germany, Spain (i.e. https://www.aedeq.org/, http://www.terapiasalpaso.org/), Greece (i.e. https://www.trag.gr/en/homepage/), Scandinavia, France (i.e. https://www.fentac.org/) or Italy (i.e. http://www.equitabile.it/ippoterapia-in-italia/) and has often been noticed to be a particular helpful variant. Already in 1875 the first study of the value of riding as therapy was reported by the French physician Cassaign, who used riding as a treatment, and concluded that it was helpful in the treatment of certain kinds of neurological disorders by improving posture, balance and joint movement, as well as psychological improvements. With the beginning of the 20th Century England recognized riding for people with disabilities as a beneficial form of

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therapy and offered riding therapy for wounded soldiers. In 1946 riding therapy was also introduced in Scandinavia. (http://rdatas.org.au/history-of-therapeutic-riding).

While in Germany therapeutic riding is a vocational training or part of the study field of horse science at the Free University of Berlin (http://www.osa.fu-berlin.de/pferdewissenschaften/studium/ueber_das_studium/index.html), at the University of Barcelona it is even a Master study (http://www.uab.cat/web/postgrado/curso-en-monitor-en-equinoterapia/informacion-general-1206597475768.html/param1-2477_es/param2-2005/).

V. Psychomotricity, Mototherapy and Motopedagogics

The perception of one's own body through playful behavior is a core element of psychomotricity. Because learning, perception and movement are closely linked. Psychomotricity describes this connection as a close and interrelated combination of psychical processes and movement. By now, there are many different approaches to psychomotricity with different focuses and definitions. Starting out from psychomotricity, the concept of motology has developed and established as a scientific discipline. Motopedagogics makes use of the close connection between perception, experience and action for learning processes and promotes the development of children and adolescents through their natural movement impulse. In mototherapy, the perception of the body and of the self-determined action is used for prevention and also for therapy. Especially obesity and ADHD (hyperactivity) are main fields of application of mototherapy, which is also used in working with old and disabled people as well as in the therapy of behavioral disorders. (www.psychomotorik.com)

The psychomotor specialty in France and Denmark came into being in the 1930s. Bernard Aucouturier is the founder of the "psychomotor practice Aucouturier", a deep psychology, independent approach of psychomotricity in France. The founder of German psychomotorics Ernst J. Kipphardt began his studies in the 50s in the specialist clinic for child and adolescent psychiatry in Gütersloh. Based on his work psychomotricity became a big field in Germany. The spread of psychomotor knowledge is a central concern of the German Academy - Aktionskreises Psychomotorik (DAKP), the cell of psychomotor science in Germany. With the degree course Motology at the Philipps-University in Marburg (Germany) the motology had

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finally reached the leap to science. Related to the field of psychomotricity are the areas of curative education, starting with the French founder Jean Itard (1775-1838) and the educational concepts according to the Italian physician and educator Maria Montessori (1870-1952) whose educational concepts are still being implemented in numerous kindergartens and schools in Europe (http://vmrz0100.vm.ruhr-uni-bochum.de/spomedial/content/e866/e2442/e11185/e11282/e11374/e11386/index_ger.html)

10. Field reports of affected parents

Nowadays the internet provides not only information in the field of Early Education and support of children with special needs, but also the possibility of network in all circumstances. Especially parents are using the internet forum to get in touch with each other. Even if there is a risk that medically erroneous information is given, the exchange of experiences, worries and concerns creates intimacy and closeness. The following reports give an inside in the life of affected families.

Comment of a mother with nickname "olestra" at the Internet Forum "urbia.de"

My son is 3,5 years old and delayed in his language development. He speaks little, often very indistinctly and uses 3-4 word sentences. (…) We stared a treatment with the speech therapist. He likes to go there. The therapy consists almost only of games. They are singing, painting and the speech therapist tries to elicit a few sentences from him. He has made some progress in recent months. His vocabulary has become bigger and his pronunciation is not quite so mischievous anymore. Now our prescription has ended and I wanted to make new appointments yesterday. Since the speech therapist said to me that further sessions of their opinion would make no sense at first because our son could not concentrate enough. Max. 5 minutes would not be enough attention for "correct" logopedic work. She recommended us to make an occupational therapy and to go to the Social pediatric center, as he would probably suffer from a perceptual disorder. (…) (https://www.urbia.de/archiv/forum/th-3678154/sprachentwicklungsverzoegert-jetzt-auch-noch-ergo.html)

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Comment of a mother called “Susi“ at the Internet Forum “rehakids.de”

Hello everybody, our diagnosis is VDD (verbal developmental dyspraxia). Fabian (5 years) is treated with the association method of McGinnis and makes it great with. The doctors and his speech therapist have told us that the journey is long and difficult and nobody can tell us yet where he will be in 10 years. We can only support him the way he allows it. At the moment he is making great progress. He tries a lot to repeat what he never did before. Fabian will go to a speech therapy school. I do not care if he talks perfect later or not. We will certainly support him wherever possible, but we will be able to live with it if he can not speak reasonably (which is a hard word if you rarely write it). Fabian knows his disability and can handle it. In the report of the social pediatric center stated: "It seems that Fabian knows his limitations and knows how to assess his expressive language skills well." He always used to shut up when you did not understand him. Since doing the therapy, he realizes that it works and when he realizes that he can not express himself verbally, he tries to show it to me. Here's an example from last week: Fabian says "to teh" to me. I did not know what he meant and I told him "I do not know what you mean". I asked him if he could show me what he means. He answered "No," then I asked him if he could paint that for me, and he did. He took a paper and painted a large circle on it. Then he painted strange creatures on it. He then called as a lion and said “chibchib” (this means his favorite animal, the penguin). Then I finally knew what he meant: " to teh = go to zoo". (…) We try to make the best out of it without overstraining it. (https://www.rehakids.de/phpBB2/ftopic47554.html)

Comment of a mother with nickname “Rotersand“ at the Internet Forum “physio.de”

Hello, my daughter is 3.5 years old and has been diagnosed with verbal developmental dyspraxia six months ago. She speaks in complete sentences, grammatically complete, the vocabulary is inconspicuous, but her pronunciation is a disaster. She verbalizes all vowels, as well as L, M, and N. She does not pronounce any other consonant and is therefor only understood by us. She goes to the speech therapy twice a week. The therapy does not really seem to work, because she does not learn new sounds, even if she enthusiastically distinguishes and paints letters. Does anyone have a hint, which forms of therapy could support the sound initiation?

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The diagnosis was made at the University Hospital Hamburg. The speech therapist we work with keeps her reliable. I was glad to get an answer, in my hometown all speech therapists / pediatricians / neurologists / pediatricians said "Oh, how interesting, that will grow out again, the child has nothing, don´t get hysteric." A speech therapist said to me a year ago, he would not treat us because we are classical educated middle classes (I am an English teacher, my husband is a lawyer) and the child would not be neglected. Pia also communicated with gestures for a long time, meanwhile she does not do that anymore, because we understand her dialect and she understood that strangers can not understand her gestures. But when she is impatient, she still tries abstract ways of communication; she sings the melody of the song "Do you know how many stars are standing?" when she wants to have the t-shirt with the star from a saleswoman. As a layman, I have the impression that the current therapy may not be a good idea until later, when she can make more sounds but confuses them. But I do not need to clean up a cupboard containing only three books. How do you teach a person to produce sounds that he obviously does not have in his program? After this short excerpt of our recent "Journey," you may understand how great it is for me to try to help me. THANK YOU!!! (http://www.physio.de/forum/logopaedie/verbale-entwicklungsdyspraxie/4/26477/26507/&v=f)

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