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Original Article

Family-centered support for young children in Kazakhstan: the mismatch between specialist readiness and parent experience

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ABSTRACT

This article assesses the family-centered competences of early intervention specialists working with young children in Kazakhstan, compares them with what parents report receiving, and identifies the areas where the two views diverge most. A cross-sectional study included 40 specialists and 60 parents of children aged 12-36 months. To collect data, the authors formed questionnaires around six spheres of family-centered practice. The analysis used three non-parametric tests: the Mann-Whitney, χ^2 goodness-of-fit, and Spearman's rank correlation. Specialist scores ran above parent scores in every sphere and on the total measure (Md = 4.17 vs 3.33; U = 2,203.5; P < 0.001; r = 0.71). Shared decision-making (r = 0.49) and partnership (r = 0.39) held the two widest gaps. Trained specialists substantially outscored untrained colleagues on the total measure (U = 376.5; P < 0.001; r = 0.81). Sphere scores were not significantly linked to parent satisfaction. The results point to a consistent gap between what specialists claim to be ready for and what parents actually experience, most evident in partnership and shared decision-making. These also highlight how much targeted training matters for the growth of family-centered practice in Kazakhstan.

Keywords: Family-centered practice, Psychological support, Educational support, Specialists' competences, Parent satisfaction, Responsive caregiving

Introduction

Current international guidance on early childhood development is clear that the family sits at the center of the so-called "nurturing care", including health, nutrition, safety and early learning, and that health and education services need to support parents in that role [1]. Under UNICEF and UNESCO initiatives, early-support programs are treated as a way to protect children, secure a safe developmental environment, and support the adults caring for them, especially during socio-economic crises and periods of instability [2, 3]. The WHO guidelines on improving early childhood development distinguish between two intervention types: support for responsive caregiving and support for early learning. That guidance emphasizes reaching not only children but also the adults caring for them, and it treats psychosocial support as part of the service package for families with very young children [4, 5].

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Research findings show that programs which include responsive caregiving components have a stronger effect on cognitive development, parenting practice, and the quality of parent-child interaction than programs without those components [6, 7]. This matters especially in low- and middle-income countries, where the family often remains the main (sometimes the only) source of support available to a child when specialist services are hard to reach, and where family-centered work can partly cover that gap [8].

Within the family-centered approach, early intervention is understood as a partnership between a specialist and family rather than a one-way action on the child: goals and methods are worked out together, and the services themselves start from a given family's strengths and priorities [9]. An analysis of Yurkevich's pedagogy also emphasizes cooperation between families and educational institutions in children's upbringing [10]. Competency frameworks for early intervention specialists describe family-centered practice as a mix of knowledge about child development, an understanding of family systems, communication skills, joint planning, coaching for parents, and cross-disciplinary coordination [11, 12]. Theoretical work on adolescent social intelligence similarly links communication skills with socioemotional understanding and reflection on one's own behavior [13]. Thus, two types of practice have to be distinguished. On the one hand, engaging practices give families real access to resources and support. On the other hand, relational practices focus on the quality of the specialist-family relationship but are not backed by concrete actions or social-pedagogical tools [14]. The first type better predicts how actively parents participate in the support process [15, 16]. Friendly communication alone is not enough. Parents need real involvement in decisions and planning, grounded in the specialist's knowledge and skills.

Like most of Central Asia, Kazakhstan is still building its early support systems for young children. Two international frameworks in particular, nurturing care and family-centered support, are being reworked (not without friction) to match local practice. Preschool organizations and early-intervention services are slowly bringing family work into their routines. However, targeted research that aligns specialist self-reported readiness with parent experience is scarce, particularly for programs serving children aged 12-36 months. Without that kind of data, it is hard to judge how well current practice meets the ideals of partnership, shared decision-making, and emotional support, and which family-centered areas need the most attention first [3].

In this regard, both conceptual and empirical work on family-centered practice is worth pursuing, especially where systems are still developing (for example, in Kazakhstan). The competency frameworks for family-centered practice built for the international context [11] offer a shared reference point for measuring specialists' readiness.

This article aims to assess specialists' family-centered competences, compare them with what parents say they actually receive, and identify the areas of greatest divergence in early-support organizations for young children in Kazakhstan. The main research question is: how well does specialists' self-reported readiness for family-centered work match parents' experience?

Three hypotheses were set:

- H1: Specialists will rate family-centered practice higher than parents do.
- H2: The widest gap will appear in shared decision-making and in work with parental anxiety.
- H3: Specialist training in family work will be positively associated with higher specialists' readiness.

Materials and Methods

We used a quantitative cross-sectional design with two respondent groups: specialists and parents who interact within early-support programs for young children. The design rests on parallel questionnaires that allow scoring the same spheres of family-centered practice from two angles: professional and parental. This approach is recommended for analyzing the mismatch between specialists' self-reports and parents' perceptions within a family-centered frame [15].

Object, sample and context

The research object is family-centered practice in early-support organizations for young children in Kazakhstan, along with specialists' competences and parents' experiences. Forty specialists took part in the study, including educational psychologists, special education teachers, speech therapists, and social workers. All had worked with families of children aged 12-36 months for at least three months. We also enrolled 60 parents whose children in the same age range were receiving early support services. The five centers are spread across three cities: two in Almaty, two in Astana, and one in Pavlodar. That gave us a mix of urban settings, but not one we would call representative of the whole country.

Inclusion and exclusion criteria

Inclusion criteria for specialists are as follows: employment at an early-support organization, direct contact with families of young children for at least three months, and involvement in planning and delivering support activities. For parents: a child aged 12-36 months, participation in an early-support program for at least three months, and consent to take part in an anonymous survey. We left out specialists in administrative roles who do not work directly with families, and parents whose command of the questionnaire language was not strong enough to follow the wording.

Instruments

The main instrument was a set of parallel questionnaires (one for specialists, one for parents) covering six key spheres of family-centered practice. The spheres were drawn from principles set

out in current competency frameworks [11, 12] and adapted to the tasks of this study **(Figure 1)**.

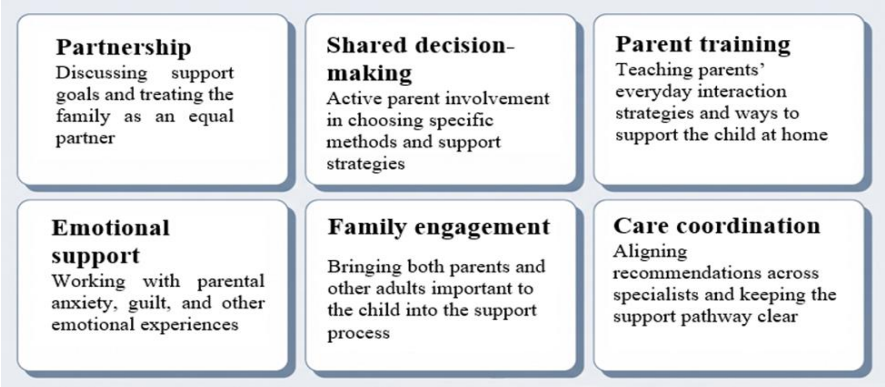

Figure 1. Spheres of family-centered practice.

Wording for specialists focused on their own actions ("I discuss support goals with parents", "I include parents in choosing methods"). Wording for parents focused on the experience they had ("Support goals were discussed with me", "I took part in choosing methods and decisions"). Responses ran on a five-point Likert scale from "strongly disagree" to "strongly agree". The specialist questionnaire also included a block on training in family work, cross-disciplinary experience, and years of service. The parent questionnaire included a matching block on satisfaction with support, the understandability of the recommendations, and involvement in decision-making.

Specialist training in family work was defined by two conditions: baseline education in the social-humanitarian field (pedagogy, psychology, social work, etc.) and at least one formal course or continuing education program on working with families of young children. A specialist was counted as "trained" if the questionnaire showed both conditions. If even one was missing, they fell into the "untrained" group. The variable was recorded as binary based on self-report.

Data collection procedure

Data were collected in 2025 at the named early support organizations. Specialists completed the questionnaire either in person or online during working hours, after being told the study objective and assured of anonymity. Parents completed theirs after consultations or group sessions, and through secure online forms, i.e., a setup that eased participation for busy parents and lowered barriers [17]. Before the main stage, we ran a pilot with a small group of specialists and parents to check that the wording came across clearly and that completion did not take too long. Contentious items were then adjusted [18].

Statistical methods

Given the data (Likert scores, modest sample sizes, and no assumption of normality), we used non-parametric statistics.

- To describe the sphere data, we used medians and interquartile ranges, along with the share of respondents choosing the higher agreement levels.
- For H1 (comparing specialist and parent scores by sphere), we used the Mann-Whitney test for independent samples.
- For H2 (finding spheres of widest divergence, and looking at links to parent satisfaction), we analyzed differences in medians and ran rank-based analysis across spheres with Spearman's coefficient.
- For H3 (link between specialist training and level of family-centered practice), we used the Mann-Whitney test to compare the total score between specialists who had and had not taken family work training. The training variable was binary (trained/untrained).
- For categorical indicators (share of parents satisfied with involvement in decision-making), the χ^2 goodness-of-fit test was used.

The threshold for statistical significance was $P < 0.05$. Effect size and practical significance were also considered, in line with current approaches to evaluating family-centered interventions [19].

Results and Discussion

Specialist and parent scores across all six spheres of family-centered practice diverge, and specialists rate the practice higher in every case **(Table 1)**.

Table 1. Specialist and parent scores across the spheres of family-centered practice.

Sphere	Specialists Md [Q1-Q3]	Parents Md [Q1-Q3]	U	P	r
Partnership	5.0 [4.0-5.0]	4.0 [3.0-4.0]	1,759.0	< 0.001	0.39
Shared decision-making	4.0 [3.8-5.0]	3.0 [3.0-4.0]	1,898.5	< 0.001	0.49

Parent training	4.0 [3.0-5.0]	3.0 [3.0-4.0]	1,584.0	0.003	0.27
Emotional support	4.0 [3.0-5.0]	3.0 [3.0-4.0]	1,738.5	< 0.001	0.38
Family engagement	4.0 [3.0-5.0]	3.0 [3.0-4.0]	1,705.5	< 0.001	0.36
Care coordination	4.0 [3.0-4.0]	3.0 [3.0-4.0]	1,580.5	0.004	0.27
Total score	4.17 [3.83-4.38]	3.33 [3.17-3.67]	2,203.5	< 0.001	0.71

Note: Md is a median; Q1-Q3 is an interquartile range (25th and 75th percentiles); U is the Mann-Whitney statistic; P is the level of statistical significance; r is an effect size

Each of the six spheres and the total score showed a statistically significant gap between specialist and parent scores ($P < 0.01$ throughout).

Table 2 shows the breakdown at the high end of the scale (respondents at 4 or above); both groups participate here, but not evenly. Some spheres show a much wider gap than the others.

Table 2. Share of respondents at the high agreement level (score ≥ 4) by sphere.

Sphere	Specialists (%)	Parents (%)
Partnership	77.5	51.7
Shared decision-making	75.0	38.3
Parent training	70.0	46.7
Emotional support	65.0	35.0
Family engagement	72.5	45.0
Care coordination	60.0	41.7

The widest divergence appears in shared decision-making. The narrowest sits in parent training and care coordination.

Parent satisfaction with three aspects of the support experience was nearly even, with no clear tilt either way **(Table 3)**.

Table 3. Share of parents satisfied with the support received.

Indicator	Satisfied (n (%))	Not satisfied (n (%))	χ^2	P
Shared decision-making	33 (55.0%)	27 (45.0%)	0.60	0.439
Emotional support	29 (48.3%)	31 (51.7%)	0.07	0.796
Clarity of recommendations	36 (60.0%)	24 (40.0%)	2.40	0.121

Note: χ^2 is the chi-square goodness-of-fit statistic; P is the level of statistical significance.

None of the shares diverge significantly from an even 50/50 distribution.

The link between a sphere score and the matching parent satisfaction indicator was weak across all three pairs **(Table 4)**.

Table 4. The Spearman's rank correlation between sphere score and parent satisfaction.

Sphere	Satisfaction indicator	ρ	P
Shared decision-making	Satisfaction with involvement in decisions	-0.07	0.589
Emotional support	Satisfaction with emotional support	-0.11	0.399
Care coordination	Clarity of recommendations	0.10	0.447

Note: ρ is the Spearman's rank correlation coefficient; P is the level of statistical significance.

None of the three coefficients is statistically significant. The total score also differs between specialists with and without training **(Table 5)**.

Table 5. Total specialist score by training status.

Group	n	Md [Q1-Q3]	U	P	r
Trained	24	4.25 [4.17-4.50]	376.5	< 0.001	0.81
Untrained	16	3.83 [3.50-4.00]	-	-	-

Note: n is a subgroup size; Md is median; Q1-Q3 is an interquartile range; U is the Mann-Whitney statistic; P is the level of statistical significance; r is an effect size.

The difference is statistically significant, and the effect size is substantial.

The data support H1: across all six spheres and for the total score, specialists rate their practice higher than parents perceive it (Md = 4.17 vs Md = 3.33; U = 2,203.5; $P < 0.001$; $r = 0.71$). In our opinion, what matters is not only the median gap but the shape of the distribution: for parents, the interquartile range is narrower, and extreme ratings appear less often. That tells us less

about parents being more critical than about their experience being less polarized, i.e., the support comes across as "okay," not as "excellent." A systematic review notes the same mismatch: specialist self-report drifts from family perception, and the extent of that drift depends on service characteristics and parent attitudes [20].

H2 was only partly confirmed, and this is probably the most substantive finding of our study. As expected, the widest gap fell in shared decision-making ($r = 0.49$): specialists claim they involve parents in choosing methods more often than parents feel like real participants in that choice. A similar picture emerges in Passeti da Costa Vida and Baptista da Silva [21], where relational forms of support dominated participation-based practice. Support was focused more on the child than on the family as a system. The emotional-support sphere also ranked among the top three widest-divergence areas ($r = 0.38$), confirming the second half of the hypothesis.

What surprised us was that the second-widest gap fell in Partnership ($r = 0.39$), i.e., a category not mentioned in the hypothesis, whereas Family engagement finished only fourth ($r = 0.36$). In other words, the widest distance between claimed and experienced practice lies not so much in the involvement of specific family members as in the basic sense of partnership: specialists call themselves partners of the family more confidently than parents do, well before the question of engaging the family or coordinating between practitioners even comes up. A conceptual analysis of university music education similarly emphasizes dialogic relationships based on mutual respect and equal participation [22]. The difficulty of including a second parent, which parents themselves report as a matter of work schedules and organizational barriers, does not disappear. It just turns out not to be the biggest source of the gap. This fits the argument that family-centered practice needs change not only in individual effort but in the organizational culture and procedures of the services themselves [19, 23].

The second part of H2, that the size of the gap across spheres would be linked with parent satisfaction, did not hold up, and this deserves its own comment. The share of satisfied parents did not differ significantly from a 50/50 split, and correlations with sphere scores were close to zero (ρ ran from -0.11 to 0.10; $P > 0.3$ in every case). When we lined up parent answers against higher and lower sphere scores, it became clear that satisfaction is driven less by formal agreement with the questionnaire items than by factors this study did not measure directly, such as parents' starting expectations or how long they had been in the program. Parents with low scores on particular spheres were not necessarily unhappy, and this gap between rating and satisfaction is worth keeping in mind when reading surveys of this kind in the future.

H3 was confirmed, and the association ($r = 0.81$) was stronger than we predicted: trained specialists scored higher on the total measure than colleagues without it ($Md = 4.25$ vs $Md = 3.83$; $U = 376.5$; $P < 0.001$). This lines up with the idea that targeted training in family work and shared-planning skills is a necessary condition for building durable competences [11]. At the same time, a higher self-rating from trained specialists does not automatically translate into higher parent satisfaction: if training is not paired with changes in how staff and families interact and with time set aside for family work, its effect can end up mostly in the specialist's professional identity rather than in the family's experience [15], which lines up with what we found for the second hypothesis.

Taken together, the picture fits what is already known about the family-centered approach. Specialist involvement in family upbringing and parents' acquisition of new knowledge depend not only on the model itself but on how well it lands at the level of specific services [20]. Our data show exactly that gap between the declared model and its delivery. Studies that compare types of family-centered practice show that practice grounded in active family involvement in problem-solving and skills-building predicts parent participation more strongly than purely relational practice [15]. Shared decision-making, which showed the largest gap in our analysis, corresponds directly to that category [24].

Technology can broaden family involvement and strengthen a sense of competence, but it requires specialized training and adapted communication formats [19, 25]. This fits our finding of a strong link between training and level of practice. Research shows that programs built on responsive-caregiving principles are more effective for children's development than programs without this component [6, 7], reinforcing the importance of the family-centered spheres measured in this study.

Thus, our finding of a weak link between spheres and parent satisfaction runs slightly against Strobel *et al*. [26]. Satisfaction and the actual delivery of practice may measure different, only loosely related, sides of the support experience. Future work should clarify this question.

The findings show how parallel specialist and parent questionnaires, combined with non-parametric comparative analysis, can pin down specific areas of divergence in family-centered practice and inform continuing education programs. Bringing competency frameworks together with local data lets researchers design courses and supervision programs aimed at strengthening basic partnership with the family, shared decision-making skills, and care coordination, i.e., precisely the spheres where the data show the widest gap [11, 27].

At the organizational level, organizations must create the conditions to deliver family-centered principles: time set aside for family work, flexible formats for parent involvement, procedures for joint planning, and cross-agency coordination [28]. In the Kazakhstani context, policymakers can build these changes into early support and preschool education systems by considering findings from studies like this one when drafting standards and programs [3].

The sample was limited to urban organizations and does not cover rural or regionally diverse settings. The parent questionnaire did not record respondent gender or whether both parents were present in the household, making it impossible to say whether perceptions of family-centered practice differ along those characteristics. The parallel questionnaires were piloted for wording clarity, but their psychometric properties (internal

consistency and factor structure of the spheres, test-retest reliability, convergent validity) were not evaluated.

Conclusion

Comparing specialist self-report with parents' experience across six spheres of family-centered practice revealed a gap in the specialist-family partnership in early support organizations for young children in Kazakhstan. Contrary to what we expected, the gap does not concentrate in individual specialist functions (emotional support or family engagement). Its source is broader: specialists see themselves as partners of the family, but the family does not experience the relationship that way.

One negative finding is worth flagging too: parent satisfaction with the support is not statistically linked with scores on the individual spheres of practice. This suggests that formal compliance with procedures and the family's subjective experience are different, and that support quality cannot be judged by the first measure alone.

The practical implication touches training. A higher level of family-centered practice among trained staff has to be anchored not only in their professional identity but in the actual formats of interaction with the family. Otherwise, parents will not feel the growth in specialist competency. For Kazakhstan's early support system, this means specialist training must go hand in hand with a rethink of shared decision-making and partnership procedures, not stop at course content.

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