IDENTIFICATION, RE-EDUCATION AND PSYCHOTHERAPY OF BEHAVIORAL AND EXPERIENTIAL DIFFICULTIES AND DISORDERS

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Abstract: *Behavioral and experiential difficulties and their comparison to behavioral disorders and personality disorders listed in the International Classification of Diseases (ICD). Through an exploratory analysis of casuistry of pedagogical and psychological counseling centers and the Delphi method, 10 diagnostic units which differ from the behavioral and personality differences listed in the International Classification of Diseases were defined. A theoretical concept of difficulties was designed and practical consequences for pedagogical and psychological counseling centers, school psychologists (educational counselors) and teachers working with children with difficulties proposed.*

Key words: *behavioral difficulties, behavioral disorders, research, difficulties, personality disorders, diagnostics, identification of difficulties, rectification of behavioral difficulties and disorders, re-education, psychotherapy*

Introduction

Behavioral and experiential difficulties and disorders in children and young people constitute a very serious social problem determining the further psycho-social development of the young generation.

A competent pathopsychological and psychopathological classification and identification of such difficulties and disorders is a prerequisite for an adequate approach, or rather a re-education, re-socialization and rectification thereof.

In the Czech Republic, the first monograph, *Závady a poruchy chování v dětském věku* (*Behavioral Difficulties and Disorders in Children)* by Pavel Vodák, a physician, and Antonín Šulc, an educator, was published in Prague in 1964. Disorders in psychological development were also explored by Josef Švancara (1974). Individual issues related to behavioral difficulties and disorders in children were addressed by Pavel Říčan in his book, *Agresivita a šikana mezi dětmi (Aggression and Bullying among Children)*, published by the Prague-based Portál (1995). In 1997, Marie Vágnerová published her *Psychologii problémového dítěte školního věku (Psychology of the Problem Schoolchild),* and in 2008, with Jarmila Klégrová, *Poradenská psychologická*

diagnostika dětí a dospívajících (Counseling and Psychological Diagnostics of Children and Adolescents). a short monograph on aggression in children was also published by Ivo Čermák (1998).

In Slovakia, the first important monograph on this topic was published by Ladislav Košč, Julius Marek and Ladislav Požár *et al.* in 1975 under the titles *Patopsychológia (Patho-psychology)* and *Poruchy učenia a správania (Learning and Behavioral Disorders)*. In 1975, J. Jakabčic and L. Požár's *Všeobecná psychopatológia* (*General Psychopathology*) was also published in Slovakia.

Psychológia a patopsychológia dieťaťa, Pedagogika, Pedagogická orientace and *Speciální pedagogika* were among periodicals which contributed the most to work in the field of behavioral difficulties and disorders in children and young people.

This paper ***proposes a scientific and practical classification of ten categories of difficulties (behavioral difficulties)*** and their general distinction from behavioral disorders and personality disorders. The main method employed to define the categories was an analysis of case documentation of pedagogical and psychological counseling centers and psychiatric counseling centers for children and young people.

The general aim of education developed, balanced personality exhibiting maturity appropriate to the age group concerned. However, a fairly large number of children fails to reach this condition in the educational process. Due to a whole host of factors, problems occur in the development of behavior and personality in a significant percentage of children and youth. Education sciences must seek ways for more effective work with children's mental preconditions and potential personality so as to achieve good adaptation and success in life. Educators are often the first ones able to identify various behavioral and experiential difficulties which signal a threat to normal, healthy mental development of the pupil, together with the consequences for the pupil's social and professional integration.

Children with such behavioral and experiential difficulties require non-standard, often more tolerant and truly individual approach from the educator, still ultimately with not very satisfactory or even unsatisfactory outcome.

The term behavioral and experiential difficulty is deemed to be synonymous with the term difficulty.

In this paper, we will not primarily focus on the causes and rectification of behavioral difficulties but rather on their classification and identification. If we want to determine the correct **individual approach**, the correct type of educational incentives, stimulation, motivation and activation of the child, we first need to realize what type of personality we are dealing with. The types of educational stimulation used for children with a complex personality will differ from those used for pupils with reduced or disharmonious mental faculties, minimal brain dysfunction, neurotic or psychopathic children, etc. a differentiated approach has to be applied to form positive attitudes and personality traits in different types of problem children.

The theory of difficulties is addressed by **pathopsychology** as a science studying mental processes, conditions and traits on the borderline between the standard and pathology, and as a science studying accompanying mental phenomena which contribute to the occurrence, process and consequences of any life insufficiency but

which do not reach the level and quality of mental abnormality or pathology (Košč *et al*., 1975).

In conformity with Smékal (1961), we are of the view that difficulties are those educational and learning difficulties which still fall within a broader standard, and as such are not primarily organic, psychopathic, psychotic or oligophrenic.

Difficulties are partly or completely ***reversible***. While they are developmentally inappropriate (dysontogenetic), they are ***non-pathological*** and ***defect-free*** mental states which are manifested socially (and possibly also subjectively) through unfavorably viewed behavior and experience.

Difficulties may be ***multi-conditional, poly-etiological***, which is important for both their diagnostics (which ought to be based on personality and comprehensive) and treatment.

In the diagnostics of difficulties, we rely on behavioral and experiential manifestations in children and youth. The distance of a specific form of behavior from the actual essence of the child's personality allows us to organize the child's behavioral manifestations on a certain scale which can be used in diagnostics. The **symptoms** are as follows:

random – completely untypical of the personality,

secondary – more frequently occurring insignificant manifestations, more typical for the group or age, subsidiary,

central – manifestations which mark the specific individuality of the personality precisely,

cardinal – very important, significant, permanent manifestations decisive for the recognition of the dominant traits of the personality in question, forming a **behavioral syndrome** which refers directly to the relevant personality traits.

Therefore, we always need to ask ourselves whether the behavior observed is random, secondary, central or cardinal. Unlike personality disorders and behavioral disorders, difficulties are more frequently only manifested by random or secondary symptoms; such symptomatic levels tend to be more closely associated with exogenous, in particular social conditions, and are less inherent in the personality itself. On the other hand, personality disorders and behavioral disorders are often conditioned on more permanent (endogenous) factors and personality traits (e.g., genetic).

Compared to behavioral disorders and personality disorders, difficulties:

- ***are of a shorter-term nature***
- ***have less intense manifestations***
- ***are less socially consequential***
- ***tend to be conditioned on and caused by exogenous, situational and social factors, rather than endogenous, personality, genetic or biological factors***
- ***are more often reversible in terms of prognosis (i.e., there is a more optimistic prognosis***)

Classification of children and youth with behavioral and experiential difficulties

According to **symptomatology** (i.e., the symptoms manifested) which can help us as the search methodology for the **identification** of individual types of children, the main areas of behavioral and experiential difficulties (occasional, shorter-term, situational, not yet reaching the quantitative and qualitative levels and severity of personality disorders and behavioral disorders listed for instance in the International Classification of Diseases (ICD) published in Geneva) can be divided into ten categories:

1) increased mental tension
2) infantilism
3) behavior outside the social and educational norm
4) increased intropunitivity
5) partial defects in communication abilities and skills (in particular in spoken and written speech) and cognitive processes
6) motor, locomotion and praxis difficulties
7) psychomotor instability
8) social, educational and cultural neglect
9) problems in school performance
10) problems in professional and study orientation and adaptation

It needs to be stressed that problem behavior (difficulties) may also occur in combination or change or transform, especially in children. If we provide a symptomatological classification, we also need to note by way of an introduction that in order to diagnose a difficulty, not all the symptoms need to be present, and in some cases, a single one is sufficient (e.g., the child stammers occasionally, suffers from a reading difficulty, etc.). Certain symptoms are of an unspecific nature and can occur in several different types of difficulty.

Every symptom has to be assessed in terms of quantity as well: e.g., does not manifest itself (0) manifests itself seldom (1), frequently (2), very frequently (3).

To a competent expert, symptoms which manifest themselves very frequently (3rd degree) in certain combination then may indicate a disorder, rather than a mere difficulty.

1. Increased mental tension

Manifestations of ***mental tension*** include the following:

- *examination fright, tremor, shaking hands, voice (0 – 1 – 2 – 3)*
- *overly sensitive reaction to failure, compunction, tearfulness (0 – 1 – 2 – 3)*
- *daydreaming, absent-mindedness (0 – 1 – 2 – 3)*
- *bad mood (seems discontent) (0 – 1 – 2 – 3)*
- *anxiety over one's appearance and its changes (0 – 1 – 2 – 3)*
- *increased mental vulnerability, low self-esteem (0 – 1 – 2 – 3)*
- *emotional deprivation (0 – 1 – 2 – 3)*
- *change of face coloring, blushing, blotches, pallor (0 – 1 – 2 – 3)*

- *fear of ordinary things (e.g., heights, solitude, dark, animals) (0 – 1 – 2 – 3)*
- *nail-biting (0 – 1 – 2 – 3)*
- *headache, stomach ache, subjective weakness despite no medical findings (0 – 1 – 2 – 3)*
- *increased sweating (0 – 1 – 2 – 3)*
- *blinking, facial tics, arm tossing, shrugging (0 – 1 – 2 – 3)*
- *throat clearing, sniveling without a cold (0 – 1 – 2 – 3)*
- *rubbing one's ear, chin, twisting one's hair, pinching, finger sucking (0 – 1 – 2 – 3)*

The frequency of the occurrence and intensity of the tension is determined by the specific mental and physical condition of the child and the social environment affecting the child.

A special, specific group of children with increased mental tension is represented by *physically and mentally abused children* (Vágnerová, 1997) who are frequently abused by the very people who were supposed to be their source of certainty and security. All this frequently damages the overall personality development.

We have to distinguish difficulties manifested only by an increased mental tension from various neurotic disorders.

Neurotic disorders are divided according to prevailing clinical manifestations, e.g., into phobic anxiety disorders, panic disorder and the obsessive-compulsive disorder. A phobic anxiety disorder is characterized primarily by various phobias, e.g., a phobia of sharp objects, water, flying, enclosed space, insects, snakes, disease, blood, etc. These are specific phobias.

Agoraphobia is a fear of open spaces, as well as large enclosed spaces, such as an airplane, subway, department store, etc. It includes the fear of leaving one's home, traveling. It is a separate diagnostic unit which occurs twice as often in women, as do specific fobias, a generalized anxiety disorder and panic disorder. Agoraphobia tends to be associated with the panic disorder, secondary depression and various physical complaints. *Social phobia* is in a category of its own. It occurs in men and women equally. An individual suffering from social phobia is excessively fearful of embarrassing himself/herself in his/her contacts with people and in social situations (he/she blushes, sweats, has a tight throat, shaking hands and voice and various vegetative symptoms). Anxiety symptoms lead to unpleasant emotional states, concerns that one would be observed and viewed in an unfavorable light, avoidance of unpleasant situation, general evasive behavior, social isolation, and, in extreme cases, to suicide. And yet, the sufferers are aware of the fact that their concerns and behavior are excessive, inappropriate.

A periodic, recurrent massive anxiety is typical of the *panic disorder*. It occurs suddenly, without any objective threat. The panic arises suddenly and lasts several minutes. The state is accompanied by an unbearable fear of losing control, going insane, dying. An attack experienced once leads to a certain fixation and repetition.

Generalized anxiety disorder is a different diagnostic unit. It includes permanent, excessive concerns, anxieties and bad premonitions of a general nature, associated with everyday life events. The sufferers live in a constant state of anxious tension and expectations. The symptoms are not triggered by any specific situations. Anxiety disorders constitute a significant burden and lead to social maladptation of the sufferer.

Obsessive-compulsive disorder is characterized by persistent thoughts, ideas (obsessions) or acts (compulsions). The obsessions include fear of dirt, infection, damage, loss, of something not having been done or something not having been done in a required fashion. Compulsions (acts) alleviate the anxiety brought about by the obsessions (ideas). Entire compulsive rituals which in the patient's belief are to prevent a future "catastrophe", avert a threat to the patient or his/her loved ones or prevent evil the patient could cause are encountered frequently. These disorders are treated by *psychotherapy* which – depending on the severity of the various symptoms and associated disorders – is supplemented with *pharmacotherapy*. Analytical and dynamically oriented psychotherapy and cognitive –behavioral therapy (CBT) tend to be applied. In addition to CBT, many cases respond favorably to hypnosis and additional support therapy involving relaxation techniques. Social skill training, group psychotherapy and social support also tend to be effective.

2. Infantilism

Typical symptoms of ***infantilism*** which can be easily established by observation and interview, include the following:

- *psycho-social behavior corresponds to a lower age (0 – 1 – 2 – 3)*
- *age-inappropriate playfulness (0 – 1 – 2 – 3)*
- *excessive use of diminutives in speech (0 – 1 – 2 – 3)*
- *inappropriate need for caressing (0 – 1 – 2 – 3)*
- *inappropriate naivety (0 – 1 – 2 – 3)*
- *emotional instability (0 – 1 – 2 – 3)*
- *lack of independence (0 – 1 – 2 – 3)*
- *egocentricity (0 – 1 – 2 – 3)*
- *fantasizing (0 – 1 – 2 – 3)*
- *lack of interest in work (0 – 1 – 2 – 3)*
- *excessive dependency on assistance from others at work, when dressing (0 – 1 – 2 – 3)*
- *preference for friendships with mostly younger or mostly older people (0 – 1 – 2 – 3)*
- *emphasis on conspicuous clothes, hairstyle and footwear (0 – 1 – 2 – 3)*
- *neglects to perform assignments (0 – 1 – 2 – 3)*
- *generally infantile behavior and experiencing (0 – 1 – 2 – 3)*

All of the above with intelligence within the norm.

Manifestations of immaturity and inaptitude have an extremely significant impact on the child's adaptation with regard to the beginning of primary school attendance and later on to choice of career and study.

The beginning of school attendance means an important change for the child, a serious milestone in the child's life. Until now, the child was carefree and could play but now it will have to work in a disciplined manner. Until now, the child could simply abandon its play when it grew bored with it, and start doing something else. Now it will have to be able to concentrate and make a sustained conscious effort in order to fulfill work assignments, including those the child will not find interesting. While the child can

now move spontaneously without permission, it will soon have to follow the teaching with discipline, accept assignments, work on them and complete them by a stipulated deadline.

A child who is ***still too immature (not yet capable of) for school attendance*** manifests for instance the following typical behavior when examined at the pedagogical and psychological counseling center:

- does not want to leave its parents, resists, cries
- does not establish contact, is negativistic, does not talk, acts scared
- shows no inhibitions, is excessively relaxed, treats adults in a familiar fashion, is obtrusive
- is unable to follow commands without individual assistance
- is easily distracted, does not concentrate
- interrupts work, refuses to continue, leaves the work station, sings while working
- has difficulty expressing itself, is difficult to communicate with
- has an obviously small vocabulary
- appears too infantile and playful overall
- appears to be mentally retarded
- defective articulation (lisping, mumbling, cluttering, stammering, etc.);
- is obviously restless
- poor graphic expression
- behavior appropriate to a lower age
- underdeveloped hygienic routines
- is not looking forward to starting school yet.

Infantilism must be distinguished from mental retardation and dementia.

Mental retardation is an affliction involving a slight, medium, serious and severe retardation of development of intellectual abilities and skills, different development of certain mental traits and social behavior disorders. Mental handicap or mental retardation refers to a permanent diminishment of intellectual abilities caused for instance by organic damage to the brain.

An infantile personality may be manifested at a higher age by immaturity in professional and study orientation and adaptation.

3. Behavior outside the social and educational norm

The following symptoms of **behavior outside the norm** may occur:

- *aggression, destructive tendencies, torturing animals and insects, bullying peers (0 – 1 – 2 – 3)*
- *outbursts of rage (0 – 1 – 2 – 3)*
- *maliciousness (0 – 1 – 2 – 3)*
- *stealing, cheating, lying (0 – 1 – 2 – 3)*
- *impertinence, vulgar language, rudeness (0 – 1 – 2 – 3)*
- *negative attitude towards authority, arguments and disputes with adults (0 – 1 – 2 – 3)*
- *truancy, vagrancy, spending nights away from home, little or no remorse for misdeeds (0 – 1 – 2 – 3)*

- *membership in problem groups, choice of unsuitable friends (0 – 1 – 2 – 3)*
- *inciting resistance against teachers, wardens, overseers (0 – 1 – 2 – 3)*
- *poor self-control (0 – 1 – 2 – 3)*
- *undesirable values, consumption of alcoholic beverages (0 – 1 – 2 – 3)*
- *obscene talk, premature sexual experience (0 – 1 – 2 – 3)*
- *experiments with unsuitable tattoos (0 – 1 – 2 – 3)*
- *tendency to nicotine dependency (0 – 1 – 2 – 3)*
- *drug use experiments (0 – 1 – 2 – 3)*

Dissocial personality disorder (F 60.2) has to be distinguished from behavior outside the social and educational norm. The former is manifested for instance by a permanent edginess and behavioral disorder during childhood and adolescence, disregard for other people's feelings, utter and permanent irresponsibility and lack of respect for social standards, rules and obligations, low tolerance for frustration and low aggression threshold, a marked tendency to blame others (marked extrapunitivity) and a *severe behavioral disorder* (F 91) within the meaning of the International Classification of Diseases (10th revised edition) which includes very serious symptoms – a problem individual may, for instance, use a gun which can cause grievous bodily harm to other people (e.g., a bat, brick, broken bottle, knife, firearm); manifests physical cruelty towards other people (e.g., ties, cuts or burns the victims), deliberately starts fires with the risk of causing serious damage or intending to cause same, commits a crime involving confrontation with the victim (including the grabbing of a handbag, extortion, mugging and strangling), imposes sex on another person, breaks into a house, building or car of another person.

Depending on the severity of the threat to society, behavioral disorders are classified as follows:

Dissocial behavior: Usually occurs in a certain stage of development (e.g., adolescence) but may also be caused by a minimal brain dysfunction or neuroses. It is constituted by difficult, inappropriate, unsocial behavior which may be managed by means of adequate educational procedures under certain circumstances. It may be influenced positively. Examples: disobedience, various misdeeds, talking back, etc.

Asocial behavior: Is manifested by more serious problems which are in conflict with social norms. The child violates moral norms, social norms, but does not break the law. An asocial person lacks adequate social feelings and empathy. Examples: truancy, running away from home, addictive behavior.

Antisocial behavior: It is basically constituted by criminal activity. The individual violates the law and usually causes damage to himself/herself and the people around him/her in the process. Examples: theft, organized crime, sexual crimes, etc.

If education fails for any reason and the behavioral difficulty or disorder becomes very severe, the child is placed into institutional or protective educational institutions where the state acts as a surrogate family through institutional education.

This occurs for instance in those cases where:

- the parents are unable to secure conditions required for their child's healthy development in the family;
- the behavioral disorder is of such degree and severity that it jeopardizes the child's healthy development; where due to the behavioral disorder, the child

violates the law and its conduct would constitute a criminal act were the child criminally liable;
- where the child violates the law as a result of the behavioral disorder, is criminally liable and institutional (protective) education is ordered (imposed) as alternative punishment;
- where the child violates the law as a result of the behavioral disorder at the age of 12–15 in a way that would earn exceptional punishment to an adult. (Pipeková, 2006, p. 366)

This includes: children's homes (for children without behavioral disorders), children's educational institutions, educational institutions for youth, children's reform institutions and youth reform institutions. The decision on the child's placement depends on the severity of the difficulty or disorder, age, sex and type of school attended.

Voluntary reform institutions have been established recently. Children and juveniles are sent there at the request of their parents, rather than a court order. This relates for instance to Educational Care Centers (SVP) or institutions for juvenile mothers ordered to stay in institutional care. (Helena Pelcová, 2008).

4. Increased intropunitivity

A person with increased ***intropunitivity*** for instance:

- *suffers from fear or shyness in front of strangers (0 – 1 – 2 – 3)*
- *is mentally highly vulnerable (0 – 1 – 2 – 3)*
- *tends to take even a mild reprimand very badly (0 – 1 – 2 – 3)*
- *overreacts to any failure (0 – 1 – 2 – 3)*
- *tends to succumb to the rule of excessive motivation (0 – 1 – 2 – 3)*
- *tends to speak in a low voice during examinations (0 – 1 – 2 – 3)*
- *is unable to use his/her knowledge, has low self-confidence (0 – 1 – 2 – 3)*
- *finds adaptation to new situations difficult (0 – 1 – 2 – 3)*
- *tends to refuse verbal communication (0 – 1 – 2 – 3)*
- *needs to be reassured that his/her approach is correct, requires systematic educational guidance to boost his/her self-confidence and adaptable communication (0 – 1 – 2 – 3)*
- *tends to act in an insecure and "suspicious" manner when any misdeeds are being investigated despite his/her innocence (0 – 1 – 2 – 3)*
- *tends to be a loner (0 – 1 – 2 – 3)*
- *self-depreciation (0 – 1 – 2 – 3)*
- *inability to form close relations (0 – 1 – 2 – 3)*
- *withdrawn, frequently manifests quiet resistance, is passive aggressive (0 – 1 – 2 – 3)*
- *tends to be shy, overly submissive (0 – 1 – 2 – 3)*
- *overestimates other people (0 – 1 – 2 – 3).*

Intropunitive children are sometimes referred to as children with **communication problems** (Vágnerová, 1997). The term "child with a communication problem" is deemed to be superior to the term intropunitive personality orientation.

Further communication problems may be caused for instance by health handicaps and sensory disorders (in particular hearing, sight, touch, react, receptive or expressive element of speech, etc.).

A passive type of social adaptation, intropunitive personality orientation is closely related to the self-esteem of children, juveniles and adults.

Intropunitivity is fairly easy to diagnose by observation and interview alone, or further by means of a questionnaire and projection techniques.

Intropunitive difficility needs to be distinguished from personality disorders (formerly referred to as psychopathy).

Personality disorders are constituted by permanent character deviations which create a disharmonious, unbalanced and abnormal personality in which certain elements of the personality and psyche are excessively prominent or suppressed and minimized due to maladaptation. Such disorders include the following: paranoid, schizoid, dissocial, emotionally unstable, histrionic, anankastic, anxiety, avoidant, addictive, etc.

Re-education and psychotherapy

It is *advisable* to supplement the *re-education* of intropunitivity with tailored psychotherapy.

Rational psychotherapy offers adequate, logical explanation comprehensible to the client, advice (persuasion), explication and clarification of the substance and causes of problems and recommendation of measures and procedures in the area of mental hygiene. It may be supplemented with long-term regulatory or psychagogic guidance towards healthy life and work style and an adequate value system. It is close to education and mental hygiene.

Suggestive psychotherapy and hypnotherapy offers one-off or systematic therapeutic suggestions which may either be applied directly in hypnosis or, in a situation of mere wide-awake rapport in less hypnable individuals. It does not primarily appeal to the logical thinking and actions of the client, but rather on the client's emotivity and suggestibility. Some clients respond better to authoritative, "fatherly" suggestions of the therapist, some to more permissive, convincingly applied "motherly" suggestion accompanied by social support.

Abreactive psychotherapy, or rather abyssal abreactive psychotherapy (AAP), or rather regression therapy, employs associative memories of mental and psychosomatic problems experienced by the person in the past in stressful and traumatizing situations when the person was in a state of narrowed consciousness or even unconsciousness to induce abreaction. In some cases, various psychopharmaceuticals inducing a state between wakefulness and sleep are used.

Training psychotherapy consists of cognitive behavioral and descent exercise techniques and programs. It involves for instance systematic desensitizing exercises in gradually aggravating adverse conditions.

Principles designed to strengthen introspection, self-confidence and effort of will focusing on self-correction (the ability to correct one's own mistakes and insufficiencies) are applied in order to improve mental health. The clients learn to face obstacles, not to bow down in front of them and not to succumb to them. They exercise to improve their muscle tone, learn to walk upright, proudly. Autogenous training is also employed.

Imagination psychotherapy techniques. Unhealthy attitudes and reactions are gradually reduced and clients guided towards adult, responsible and mature actions. The Katathym imaginative psychotherapy (KIP) developed by Hans Carl Leuner (1997) can also be used. It is a technique of controlled daydreaming based on abyssal and psycho-dynamically oriented therapy the theoretical bases of which are derived from Jung's analytical psychology and psychoanalysis. It is based on the presumption that the content of day dreams reflects, on a symbolic level, preconsciousness, unconsciousness and inner conflict (Svoboda, 2003)

A combined eclectic and integrating psychotherapy is prescribed at the discretion of the psychotherapist involved (Kratochvíl, 2006). For instance, rational psychotherapy is combined with relaxation techniques (using various discs as well), individual psychotherapy is combined with group therapy. Art therapy is also employed.

Eclectic-synthetic and integrating concept of psychotherapists treating difficulties is also possible.

5. Partial defects in communication abilities and skills (in particular in spoken and written speech) and cognitive processes

The symptoms of this difficulty, or disorder, as the case may be, include the following:

- *impaired sound of speech, for instance, mumbling (0 – 1 – 2 – 3)*
- *impaired fluency of speech and diction, for instance, cluttering (0 – 1 – 2 – 3)*
- *impaired articulation, for instance, lisping (0 – 1 – 2 – 3)*
- *speech defects accompanying other dominant handicaps (0 – 1 – 2 – 3)*
- *voice defects (0 – 1 – 2 – 3)*
- *reading and language learning difficulties, although the pupil may be doing well in mathematics, for instance (0 – 1 – 2 – 3)*
- *confusing words and letters – at the end of first grade or later, the pupil confuses letters similar in shape or sound, e.g., r-z, k-h, d-t, n-m, a-e, p-g, d-b (0 – 1 – 2 – 3)*
- *syllabification, unable to follow the content while reading (even in higher grades)(0 – 1 – 2 – 3)*
- *putting even simple words together with difficulty (0 – 1 – 2 – 3)*
- *difficulty in pronouncing more difficult groups of consonants and unknown words when reading (0 – 1 – 2 – 3)*
- *swapping or leaving out sounds and syllables, especially end ones, when reading (0 – 1 – 2 – 3)*
- *swapping or leaving out sounds and syllables when writing (0 – 1 – 2 – 3)*
- *writing with grammatical mistakes (0 – 1 – 2 – 3)*
- *inventing endings and syllables (often with mistakes) (0 – 1 – 2 – 3)*
- *confusing letters similar in shape or sound: s-z, p-q, m-n, h-k, z-c, b-d, t-j (0 – 1 – 2 – 3)*

The ability to distinguish between mirror letters is related to the development of conscious recognition of the right and left sides. In some cases, reading is merely markedly slow, cumbersome, but without typical mistakes. In writing, the child often

leaves out and adds letters, does not distinguish between hard and soft syllables: di-dy etc., letters are misshapen, the child confuses them, writes the letters in a word in a wrong order (dysorthography is associated with dyslexia in about 60% of cases).

Motor difficulties and disorders in connection with dyslexia were studied as early as the 1960s. In 1960, Z. Žlab compiled a set of tests designed to diagnose laterality and minimal brain dysfunction (MBD) which is still used today in some facilities. It consists of seven tests focusing on perception and motorics: throwing and catching a tennis ball, coordination of lower and upper limbs when marching on the spot (by wall bars), visual-motoric test with a colored circle, left-right orientation test, Z. Matějček's tracing test, rhythm reproduction test and speech examination with a focus on specific disorders. Motorics is stressed even in the classic work by Otakar Kučera *et al*. (1962) devoted to slight encephalopathies in children. Z. Třesohlavá (1974) in her extensive research focused on children with MBD pays great attention to the development of motorics and diagnostics of motor development. The combined occurrence of dyspraxia and dysgnosia (a developmental disorder of the ability to recognize objects) was described by Ivan Lesný (1989) who referred to it as the dy-dy syndrome, i.e., the dysgnosia – dyspraxia syndrome. Lesný classifies it as minimal brain damage and believes it is mostly caused by a disorder located in the mesencephalon. Much scholarly information on perception and motorics in MBD sufferers is contained in the publication by M. Černá *et al*. (1999).

The recognition of the relationship between dyslexia and motor disorders was already obvious in the preceding decades. The battery of tests used in the 1980s by H. Tymichová, the principal of the first school for dyslectics in Karlsbad, included J. Míka's orientation test of dynamic practice. In his book, Dyslexia (1987), Z. Matějček refers to the connection between poor articulation, poor fine motorics and poor coordination of fine motorics in writing.

Diagnostika specifických poruch učení (*Diagnostics of Specific Learning Difficulties)* by J. Novák (2002) includes a fine motorics test which is based on Lurij's neuropsychological examination. Long-term verification showed that the current examination according to J. Míka and I. Lesný contains items which lack sufficient diagnostic merit for the respective purposes. In another treatise, J. Novák differentiates between motor dysgraphia and orthographic dysgraphia (more often referred to as dysorthography). Together with J. Smutná, they discovered a dependency between the fine motorics level and auditory analysis and synthesis (1996).

The brief overview provided above shows that the Czech approach to specific learning difficulties and minimal brain dysfunctions always included motorics and motor coordination. As the diagnosis becomes more accurate, re-education improves, and so does the understanding of the child's problems (Zelinková, 2003).

A more severe *specific reading disorder* (F81.0) which is included in specific developmental disorders of school skills in the International Classification of Diseases must be manifested by the following two symptoms:

1) the accuracy or comprehension score deviates by at least two standard degrees from the level expected with a view to the chronological age and general intelligence of the child, where both the reading skill and the IQ is assessed by means of an individually administered test standardized for the culture and educational system concerned.

2) anamnesis of more severe reading difficulties or test scores meeting the above criterion at an earlier age, and written test score which deviates by at least two standard degrees from the level expected with a view to the chronological age and IQ of the child.

The specific reading disorder is not caused directly by defects in visual or auditory acuity or neurological disorder.

Other partial defects of cognitive functions include for instance reduced performance in the area of certain mental functions; disorders in speech development; counting on fingers; difficulty in abandoning an opinion and difficulty in conceiving numerical notions – ***dyscalculia***, great difficulty in drawing and painting – ***dyspinxia*** etc.

Children with compromised communication abilities and skills are usually integrated in mainstream primary schools. However, most primary school teachers only have theoretical or no experience with compromised communication abilities. The integration of children with compromised communication abilities in primary schools would therefore benefit from the presence of a special pedagogist – speech therapist.

According to Kateřina Walková (2007), adequate development of communication abilities and skills also requires:

- correct speech model from the child's early age;
- inspiring and stimulating speech environment;
- logopedic depistage – purposeful identification of individuals with suspected impaired communication abilities;
- effective collaboration between the family, speech therapist and school;
- systematic, regular and long-term speech therapy in case of more severe difficulties and disorders;
- further education of kindergarten and primary school teachers in speech therapy issues.

6. Motor, locomotion and praxis difficulties

The following symptoms are found in individuals with these problems:

- *extremely untidy drawings and art work (0 – 1 – 2 – 3)*
- *difficulties in spatial orientation (0 – 1 – 2 – 3)*
- *cramped, excessively forced handwriting (0 – 1 – 2 – 3)*
- *clumsiness and lack of independence in self-service (0 – 1 – 2 – 3)*
- *lack of manual skills (0 – 1 – 2 – 3)*
- *difficulties in precision drawing (0 – 1 – 2 – 3)*
- *clumsiness in sports, awkwardness (0 – 1 – 2 – 3)*
- *uncoordinated walking(0 – 1 – 2 – 3)*
- *falls, accidents, injuries (0 – 1 – 2 – 3)*
- *partly paralyzed arm, leg, limping (0 – 1 – 2 – 3)*
- *retrained left hand because right hand cannot be used (0 – 1 – 2 – 3)*
- *crossed laterality (0 – 1 – 2 – 3)*
- *non-descript laterality (0 – 1 – 2 – 3)*
- *grimacing (0 – 1 – 2 – 3)*
- *tremors, tics (0 – 1 – 2 – 3)*

- *uncontrolled movements (0 – 1 – 2 – 3)*
- *defects in organization, fluency and coordination of active volitional movements (0 – 1 – 2 – 3)*
- *impaired self-perception of the body (0 – 1 – 2 – 3)*

A material prerequisite for success in school is the attainment of a certain developmental level of motor skills. That is why the diagnostics of such motor development is important also with respect to various disorders of the central nervous system. Motorics is one of the basic behavioral aspects and as such needs to be monitored in behavioral assessment.

Ozereckij's scale is used to assess the adequacy of motor development. This method was designed by ***N. I. Ozereckij*** and its original version published in Russia in 1923. It is designed to assess the adequacy of motor development. The test was modified several times. The most recent version of the test is the modified American one from 1978.

Description of the test: N. I. Ozereckij viewed coordination, accuracy and fusion of various movements as important indicators of motor development. The test consists of 46 items of such orientation, divided into 8 subtests. For every age group, there are several tasks to be performed by a child of that age. The test makes it possible to assess the level of individual motor competencies: it helps measure both gross motor skills, i.e., the agility of the body and lower limbs, and fine motor skills, i.e., manual skills and agility of the hands, or rather fingers. An abbreviated version consisting of only 14 items is also available.

The scale can be used as part of the battery of tests in clinical and counseling practice for individual examination of children where motor skills development or overall retardation is suspected, e.g., as part of a more comprehensive disorders, such as mental retardation. It is also recommended for diagnostics of children with minimal brain dysfunction, or ADHD syndrome, and of children with specific learning difficulties.

The American psychologist Joy Paul Guilford (1897-1987) tried to create a 2D matrix of psychomotoric skills through which he observed parameters such as strength, impulse, speed, static accuracy, dynamic accuracy, coordination and agility, gradually observing the whole body: trunk, limbs, hands, fingers (Smékal, 2002).

Various tests have been designed for the assessment of the ability of motor coordination; for instance, the composite movement test (two levers are used simultaneously to control the movement of a spike which is to follow a curved line). Studies have shown that there is a close connection between success in these tests and the controlling of machinery (Sillamy, 2001).

The diagnostics or therapy of these children is addressed in detail for instance by the English pediatrician A. Kirby in her book *Clumsy Child Syndrome* (2000).

Motor, locomotion, praxis and laterality disorders needs to be distinguished from *stereotyped movements disorders* listed in the International Classification of Diseases under diagnosis code F98.4. This behavioral disorder is manifested by the child (juvenile) producing stereotyped movements to such extent that he/she causes physical injury to himself/herself or that normal activities are greatly impaired. The disorder must persist for at least one month and the sufferer does not suffer from any other mental or behavioral disorder.

Further, disorders with *organic or somatic causes,* e.g., consequences of infantile cerebral paralysis, must also be distinguished from the above.

7. Psychomotor instability

Typical symptoms of **psychomotor instability** include for instance the following:

- *great liveliness, agility bordering on restlessness (0 – 1 – 2 – 3)*
- *unable to sit still, fidgets, leaves his/her place (0 – 1 – 2 – 3)*
- *talks without invitation, interrupts others (0 – 1 – 2 – 3)*
- *acts rashly, on impulse, without thinking (0 – 1 – 2 – 3)*
- *unable to cooperate satisfactorily (0 – 1 – 2 – 3)*
- *moves rashly, bumps into objects, falls (0 – 1 – 2 – 3)*
- *unable to focus on any game, activity, work for any length of time (0 – 1 – 2 – 3)*
- *does not pay attention, is distracted, attention problems, unable to concentrate (0 – 1 – 2 – 3)*
- *tires easily (0 – 1 – 2 – 3)*
- *moodiness, disputes, conflicts (0 – 1 – 2 – 3)*
- *conspicuous alternation of days when he/she is doing very well and days when he/she is completely out of control and does very badly at everything (0 – 1 – 2 – 3)*
- *inappropriate exclamations (0 – 1 – 2 – 3)*
- *does not observe the appropriate distance (0 – 1 – 2 – 3)*
- *engages in other activities while working (0 – 1 – 2 – 3))*
- *minor and more serious accidents (0 – 1 – 2 – 3).*

Zelinková (2003) focuses on specific learning difficulties and disorders and their causes, dyslexia, dyspraxia and MBD, also in connection with motor skills.

Newly introduced terms are syndromes abbreviated as ADHD and ADD.

The ADHD diagnostic category is used for behavioral disorders characterized mainly by hyperactivity, impulsiveness and attention disorders. Disorders of fine motor development, including specific speech disorders, can be referred to as dyspraxia. The term ADHD refers to an attention deficit disorder combined with hyperactivity. ADD is an attention deficit disorder without hyperactivity, ODD is an oppositional defiant disorder. Further classification is ADHD without aggression and ADHD with aggression.

Minimal brain dysfunction (MBD) is used to refer to a number of manifestations in the child based on structural changes of the CNS which deviate from the norm. They thus appear to be unusual, conspicuous and strange (markedly uneven development of intellectual abilities, conspicuous manifestations and disorders in the dynamics of mental processes, hyperactivity or hypoactivity, attention deficit, insufficient perseverance, impulsiveness, rashness, mood and intellectual performance swings, physical clumsiness, perception disorders, etc. (Slowík, 2007).

Hyperkinesis is referred to as motoric restlessness. Certain *hyperkinetic children* (with ADHD) may also suffer from a specific developmental motor function disorder

manifested as marked dyspraxia, clumsiness and awkwardness (clumsy child syndrome); such children for instance find it difficult to hit a target with a ball, to tie their shoelaces, to string beads, to write or draw tidily. They tend to be reprimanded for breaking or damaging things often, they usually get bad grades in physical education and may become the source of mockery because of their clumsiness. They are fairly frequently left-handed.

About one half of children with tic disorders is afflicted with hyperkinetic symptoms at the same time. Tics are repetitive, involuntary and irregular muscle convulsions which most frequently affect mimic muscles (blinking, sniffing, mouth opening) but may affect other muscle groups as well. Tics may further be auditory and vocal: the child produces various disturbing sounds, exclaims certain words or fragments of sentences. a combination of muscle and vocal tics is typically found in a severe form of the tic disorder – Tourette's syndrome, which may also include a compulsive exclamation of vulgar expressions (Drtílková, 2007).

Education based on love and respect for a higher order is the most effective prevention of all mental and psychosomatic illnesses, and as such of restlessness in man and among people.

For gross motor skills – long walks, trips, mountain hikes (but not taking a cosy ride on the funicular but making the hard climb on foot), cycling, rowing, jumping on the trampoline, jumping in a sack, dancing, jazz gymnastics, clearing of snow, sweeping, gardening – hoeing, weeding, etc.

For fine motor skills – all types of handiwork without using electrical appliances: filing, modeling, crocheting, knitting, fruit picking, cleaning of vegetables (potato or apple peeling), dough kneading, string spooling (Prekopová, Schweizerová, 2008).

Under certain circumstances, psychomotor instability can be referred to as ***hyperkinetic disorder*** in accordance with the International Classification of Diseases (10th edition), diagnosis code F90, which may be specific to home or to classroom.

The condition is for instance that the combination of certain selected symptoms must persist for at least 6 months and the symptoms have to be sufficiently severe to be maladaptive and in conflict with the child's developmental level. The disorder manifests itself before the 7th year of age, not later.

Monographs on children suffering from ***ADHD*** (Attention Deficit Hyperactivity Disorder) have been written for instance by Gordon Serfontain (1999), a child neurologist at the Sydney children's hospital. Serfontain claims that these disorders occur in as much as 20% of boys and 8% of girls.

In the Czech Republic, the ***LDE*** concept (Kučera, 1961) was applied in connection with this disorder.

8. Social, educational and cultural neglect

Individuals with this difficulty manifest for instance the following symptoms:

- *poor preparation for school (0 – 1 – 2 – 3)*
- *educational problems, although the child's intellectual gifts are within the norm (0 – 1 – 2 – 3)*
- *poor understanding of information newly presented at school due to large gaps in knowledge (0 – 1 – 2 – 3)*

- *primitive and vulgar forms of social communication (0 – 1 – 2 – 3)*
- *small vocabulary (0 – 1 – 2 – 3)*
- *developmental problems in speech and written language (0 – 1 – 2 – 3)*
- *poor grooming (0 – 1 – 2 – 3)*
- *disorder in private things (0 – 1 – 2 – 3)*
- *lack of interest in reading magazines and books (0 – 1 – 2 – 3)*
- *lack of interest in cultural matters (0 – 1 – 2 – 3)*
- *lack of interest in theatre plays and serious cinema (0 – 1 – 2 – 3)*
- *retarded somatic development, stunted growth, low weight etc. (0 – 1 – 2 – 3)*
- *poor hygienic routines (0 – 1 – 2 – 3)*
- *unpleasant bodily odor (0 – 1 – 2 – 3)*
- *dirty aids (0 – 1 – 2 – 3)*

Families of socially neglected children often tend to be primitive (simple), providing few psychosocial and cultural incentives, or even defective (alcoholism, drug abuse, criminal activity, mental illness), and generally insufficient in terms of upbringing.

A disturbed family (incomplete, defective, in crisis) creates worse prerequisites for the formation of its children's development than a complete and undisturbed family. a broken family, especially due to divorce, correlates positively with anxiety symptoms, for example.

Manifestations of psychosocial neglect are frequently accompanied by further problems and disorders: increased mental tension or even neurosis, antisocial behavior, etc.

The hostile relationship between the parents and the child often leads to child mistreatment, abuse (e.g., sexual), sometime even to the child's physical liquidation.

Socially neglected children have to be distinguished from *children with a socio-cultural handicap*. The latter may for instance concern children of immigrants who find adaptation to the new environment difficult because of national customs or language barrier.

9. Problems in school performance

Individuals with problems in school performance:

- *suffer from learning difficulties (0 – 1 – 2 – 3)*
- *have results below average despite significant effort (0 – 1 – 2 – 3)*
- *do not learn logically and rationally (0 – 1 – 2 – 3)*
- *have a negative attitude to school and learning (0 – 1 – 2 – 3)*
- *fail to comprehend (á) (0 – 1 – 2 – 3)*
- *tend toward mechanical memorizing (0 – 1 – 2 – 3)*
- *are slow to understand new information (0 – 1 – 2 – 3)*
- *seem to be overworked, mentally exhausted (0 – 1 – 2 – 3)*
- *tend to suffer from low self-confidence (0 – 1 – 2 – 3)*
- *feel inadequate or even inferior (0 – 1 – 2 – 3)*
- *are passive aggressive, refuse social communication (0 – 1 – 2 – 3)*
- *have a poorly developed ability to abstract (0 – 1 – 2 – 3)*

- *find it difficult to apply rules in practice (0 – 1 – 2 – 3)*
- *have poor understanding even of common notions and ideas (0 – 1 – 2 – 3)*
- *tend to be intellectually passive (0 – 1 – 2 – 3)*

Where grades are very bad and lack of success at school marked, it first needs to be established what type of failure is involved, whether it is a more permanent and general, ***absolute*** school failure (i.e., learning insufficiency stemming from insufficiently developed intellectual abilities), or whether it is an occasional or partial, ***relative*** school failure (the pupil has poor results for reasons unrelated to his/her intellect), which can usually be rectified. Where relative school failure is concerned, the pupil's performance is poorer than his/her intellectual (mental) abilities and qualifications. This may be due to a crisis, increased tendency to fatigue, neurotic reactions, temporarily reduced motivation, etc.

Absolute and relative school failure both reflects and is the consequence of individual differences between pupils which we find not only in the pupils' personalities (e.g., the level and structure of gifts, nature, interest in learning, emotivity, motivation, harmonious or disharmonious personality development), but also in the different conditions of their upbringing in their families. Low grades and school failure are usually not caused by a single cause but rather by multiple causes. All the cases of poor results are caused by an individual combination of causes and conditions, and display their own individual developments and dynamics.

Relative school failure may be caused by socio-psychological, biological-psychological and intrapsychic factors. a single isolated handicap (e.g., worse conditions in the family) does not automatically have to have a determining impact on the pupil's success at school. School failure is usually due to a combination of several conditions and causes.

10. Problems in professional and study orientation and adaptation

The following are deemed to constitute problems in professional and study orientation and adaptation:

- *indecisiveness in the choice of career or school (0 – 1 – 2 – 3)*
- *lack of interest in further study (0 – 1 – 2 – 3)*
- *lack of interest in a specific profession (0 – 1 – 2 – 3)*
- *laziness (0 – 1 – 2 – 3)*
- *absence without excuse (0 – 1 – 2 – 3)*
- *tendency to job hopping (0 – 1 – 2 – 3)*
- *failure to observe sanitary rules at work (0 – 1 – 2 – 3)*
- *failure to observe safety rules at work (0 – 1 – 2 – 3)*
- *inadequate and unrealistic choice of career (study) in terms of ability or motivation etc. (0 – 1 – 2 – 3)*
- *lack of involvement in the choice of career or study (0 – 1 – 2 – 3)*
- *passive or indifferent approach to one's own future (0 – 1 – 2 – 3)*
- *manifestation of difficult adaptation to the chosen field of study or profession (0 – 1 – 2 – 3)*
- *manifestation of negative attitude to the chosen field of study or profession (0 – 1 – 2 – 3)*

- *effort to change or leave the field (0 – 1 – 2 – 3)*
- *tendency to professional liability within the specific profession (0 – 1 – 2 – 3)*

Professional orientation of schools and psychological counseling play an important role in the process of self-recognition and self-understanding and maturing for the choice (selection) of career (study). Psychological examination of the pupil's personality and prognosis of school and later on professional performance (comparison of the pupil's personality traits with a professiogram) is often very valuable. Most people can practice a variety of professions because they there is ample room for various compensations, outweighing of weaknesses by strengths and in particular learning of various specific professional skills and routines.

Information on the results of a psychological examination may play an important role in the process of teachers getting to know the pupil, as well as the process of the pupil's self-recognition and self-evaluation. a pupil who understands himself/herself well is more likely to adapt well than a pupil with a poor level of self-recognition and self-understanding. Self-recognition and self-understanding basically mean that one can precisely describe one's strengths, weaknesses, experience, requirements and goals, can predict one's behavior and manage and control one's behavior more easily. Self-recognition and self-understanding contributes to an appropriate self-acceptance which is one of the goals of psychological counseling. After all, counseling strives to inform the subject of examination of the level of his/her individual personality traits with a view to psycho-correction and self-education of his/her interpersonal relations, the relationship to himself/herself and success in the chosen profession (or study).

People who are more cognizant of their personality and work environments make better career choices than people who are less well informed. The adequacy of career choice is also partly determined by age because passage of time offers more opportunities to gather information. People with more adequate career choices posses more differentiated knowledge of professions and are aware of professiographic requirements of individual professions.

Problems in professional and study orientation and adaptation often occur in infantile, immature children with infantile personality traits.

Ondřej Janovec (2009) notes than young people are put under an escalating pressure during study, study requirements are growing, the number of highly specialized study programs is also on the rise. In the world of great possibilities and opportunities where a young woman or man can choose a field tailored to his/her abilities and wishes, young people are sometimes "confused" and unable to find their bearings in the offers and alternatives related to further study which thus shape their paths for the near future. Whether this situation is caused by indecisiveness in their choices or lack of interest in their future fate, the people around them should intervene and help the young man/woman in his/her self-recognition and choice of study field corresponding to his/her ideas, as well as abilities and skills. There are many specialized facilities offering career advice. For some people, it is sufficient to hint at various alternatives while others need several sessions to arrive, with the expert's assistance, at the recognition of themselves and their abilities, and to realize whether their ideas and wishes are realistic.

Advice focusing on assistance in the education and upbringing of children and career and study orientation has been on offer within our educational system since the 1960s. It was provided for in Decree No. 130/1980 Sb. of the Ministry of Education of the Czechoslovak Socialist Republic. In 2005, a new decree on the provision of advice at schools and educational counseling facilities (No. 72/2005 Sb.) entered into force.

Pedagogical and psychological counseling centers provide in particular comprehensive pedagogical and psychological examination of children and adolescents. Most frequently addressed issues include the identification of causes of learning and behavioral difficulties, career and study orientation (career advice), etc. a special type of educational counseling centers is represented by counseling centers for special psychology which work with pupils with health handicaps. These provide special pedagogical and psychological advice to children with impaired sight, hearing, mental or physical handicap, help prepare individual educational plans for integrated pupils and provide methodological support to schools.

Counseling provided directly at schools can be considered the most important element in the prevention of educational and pedagogical problems. Every pupil or student should enjoy suitable conditions both for his/her education and the development of the personality-linked qualities of his/her life. Primary and secondary school principals are responsible for the quality of school counseling. Pedagogical and psychological counseling is usually procured by a teacher – career advisor, in-house prevention methodologist, in-house special educator, psychologist from a pedagogical and psychological counseling center or an in-house psychologist. The counseling team at the school ought to identify pupils, students and entire classes at risk, in particular with a view to prevention of school failure and undesirable behavior. On the other hand, the counseling team should provide support in the choice of an educational path which leads to career success, to support and integrate children with special educational needs. These are usually extremely gifted pupils or pupils with developmental learning disorders, sometimes also individuals coming from other cultural environments. All those require individual support in the modification of educational method, or professional help in the design of an individual educational plan.

As the question of future career is sometimes a difficult one for primary school pupils, the Ministry of Labor and Social Affairs and the National Educational Fund came with the idea of a calendar which would help pupils in their last year decide "where to go from there". The calendar was first issued in 2001. The calendar was designed in order to create a basic material which would serve as a basis for decision-making and facilitate discussion on future careers between pupils, teachers, parents and career advisors.

To decide on future career is very difficult for a young person, and his/her choice may significantly influence the entire further future life of the young girl or boy. Not all young people certainly give their ideas a long-term consideration and are able to imagine what exactly their chosen field and profession involve.

A mandatory consultation of the pupil's ideas of his/her future choice of career or school with a career specialist competent to assess whether the young person's plans are realistic and what the prognosis is therefore desirable.

Re-education and psychotherapy of difficulties

Re-education refers to special pedagogical methods which develop or correct impaired functions and activities.

Behavioral and experiential difficulties must be given special attention because their early identification and intervention may mean that the development of serious behavioral disorders, personality disorders and illnesses in children and youth can be arrested. The educator is often the first person who is able to recognize various peculiarities, behavioral and experiential difficulties and disorders which indicate a threat to the normal, healthy mental development of the pupil (student) and consequences for his/her social integration. By alerting specialists (psychologists, psychiatrists etc.) to the problems and assisting in the resolution of the problems in cooperation with those experts, the educator actually performs depistage and prevents further escalation of the difficulties. Children with such behavioral and experiential difficulties require non-standard, often more tolerant and truly individual approach from the educator, still ultimately with not very satisfactory or even unsatisfactory outcome, especially with a view to the growing number of problem children in recent years. Problem children and youth could in many cases be diagnosed as children and youth with difficulties. Difficulties may generally be rectified either by psychological means, or by special pedagogy or therapeutic and pedagogical means.

Psychotherapy as a method and technique of treatment may generally be rational, suggestive, abreactive, training, imagination or combined, individual or group.

Rational psychotherapy offers adequate, logical explanation comprehensible to the client, advice (persuasion), explication and clarification of the substance and causes of problems and recommendation of measures and procedures in the area of mental hygiene. It may be supplemented with long-term regulatory or psychagogic guidance towards healthy life and work style and an adequate value system. It is close to education and mental hygiene.

Suggestive psychotherapy and hypnotherapy offers one-off or systematic therapeutic suggestions which may either be applied directly in hypnosis or, in a situation of mere wide-awake rapport in less hypnable individuals. It does not primarily appeal to the logical thinking and actions of the client, but rather on the client's emotivity and suggestibility. Some clients respond better to authoritative, "fatherly" suggestions of the therapist, some to more permissive, convincingly applied "motherly" suggestion accompanied by social support.

Abreactive psychotherapy, or rather abyssal abreactive psychotherapy (AAP), or rather regression therapy, employs associative memories of mental and psychosomatic problems experienced by the person in the past in stressful and traumatizing situations when the person was in a state of narrowed consciousness or even unconsciousness to induce abreaction. In some cases, various psychopharmaceuticals inducing a state between wakefulness and sleep are used. Narcotics which can be inhaled are also available. Tensions, anxieties and fears are released in a controlled fashion. Also abyssal abreactive psychotherapy or regression therapy.

Training psychotherapy consists of cognitive behavioral and descent exercise techniques and programs. It involves for instance systematic desensitizing exercises in gradually aggravating adverse conditions.

Principles designed to strengthen introspection, self-confidence and effort of will focusing on self-correction (the ability to correct one's own mistakes and insufficiencies) are applied in order to improve mental health. The clients learn to face obstacles, not to bow down in front of them and not to succumb to them. They exercise to improve their muscle tone, learn to walk upright, proudly. Autogenous training is also employed.

Imagination psychotherapy techniques. Unhealthy attitudes and reactions are gradually reduced and clients guided towards adult, responsible and mature actions. The Katathym imaginative psychotherapy (KIP) developed by Hans Carl Leuner (1997) can also be used. It is a technique of controlled daydreaming based on abyssal and psycho-dynamically oriented therapy the theoretical bases of which are derived from Jung's analytical psychology and psychoanalysis. It is based on the presumption that the content of day dreams reflects, on a symbolic level, preconsciousness, unconsciousness and inner conflict (Svoboda, 2003)

A combined eclectic and integrating psychotherapy is prescribed at the discretion of the psychotherapist involved (Kratochvíl, 2006). For instance, rational psychotherapy is combined with relaxation techniques (using various discs as well), individual psychotherapy is combined with group therapy. Art therapy is also employed.

Eclectic-synthetic and integrating concept of psychotherapists treating difficulties is also recognized as possible.

If we wish to identify the correct individual type, or rather re-educational approach, the right type of educational incentives, stimulation, motivation and activation of the child, we first need to realize what type of behavioral difficulty, behavioral or personality disorder we are dealing with. The types of educational stimulation used for children with a complex personality will differ from those used for pupils with reduced or disharmonious mental faculties, minimal brain dysfunction, neurotic or psychopathic children, etc. a differentiated approach has to be applied to form positive attitudes and personality traits in different types of problem children.

Impaired motor skills may affect a number of school abilities, skills and performance. The child may struggle with the selection of activities in physical education due to physical clumsiness, integration into the group, clumsiness during games due to poor fine motor skills, lower agility of organs of speech, all of which affect communication, self-perception of the body and space, and last but not least, causes writing difficulties.

Deficits in cognitive functions are manifested in connection with motor skills. These include for instance insufficient development of graphomotorics which may be manifested by slow writing, difficulty in emulating the shapes of letters. The child may further struggle with geometry and other subjects requiring at least some degree of manual skill. Motor skills are one of the tools of cognition, allow us to handle objects, and thus serve as a basis for the understanding of mathematical operations.

Serfontein (1999) advises us how children with gross and fine motor difficulties and disorders may appear to teachers, and offers certain practical solutions.

Children with *gross motor* difficulties or disorders seem clumsy, ungainly, their movements uncoordinated. They can hardly compete with their peers during physical education classes, and in the classroom, they tend to "stumble" over desks, chairs and other furniture. This goes hand in hand with self-depreciation and sense of inferiority. Gross motor skills concern all muscle groups, the ability to move various parts of the

body in a controlled fashion and to coordinate movements depending on external and internal factors, such as gravity force, side orientation and gravity center of the body. The aim of the exercises is to teach the child to move fluently and efficiently, and last but not least, to improve the child's spatial orientation and self-perception of the body. a child with a gross motor skill disorder needs a tailored exercise regimen. Including such child in group exercises and games is not advisable at first. The teacher should focus on overcoming the specific problem troubling the child.

Teaching methods designed to improve gross motor skills include basic exercises, such as walking backward, forward and to the sides. The child follows a straight, zigzag, broad or narrow route, may be required to negotiate various obstacles while keeping his/her arms in a certain position. a more demanding activity for children with gross motor skill disorder is represented by rope skipping which combines both technique, rhythm, balance and coordination of movement.

Pupils with *fine motor skill* difficulty or disorder usually have problems with the handling of objects and activities requiring precise fingerwork. Their problems are manifested in writing, drawing, tying of shoelaces, buttoning, joining of objects and cutting with scissors. Handiwork and drawings of such pupils resemble work of much younger children. Some may be very gifted in terms of gross motor skills but their fine motor skills tend to be below average.

In this context, Serfontein (1999) proposes activities such as tracing, pouring water into a vessel, cutting with scissors, buttoning and tying of shoelaces which help develop fine motor skills and coordination. For older children, embroidery is an example of a suitable activity.

Teachers and parents need to select age-appropriate exercises for the development of motor skills. Pupils at senior primary school ought to be given more difficult exercises, or simple exercises ought to be made more demanding.

Correct development of motor skills includes **self-perception of the body.** According to Serfontein (1999), this notion refers to the recognition of one's own body and its abilities. The activities are conceived in such a way so as to help the child develop correct ideas of the position and function of individual body parts. They include the naming of body parts. The child makes a life-size outline of his/her schoolmate with chalk on the ground or with pencil on a sheet of paper. The children then swap their roles in terms of tracing. The pupils draw in details into the outlines of their own bodies – facial features, fingernails, etc. Cracking a puzzle. Pantomime. The children mimic various professions and activities – a bus driver turning the steering wheel, a policeman directing traffic, a postman delivering mail, and a chef busy in the kitchen.

The notion of a body scheme which is, according to Kotasová (2000), used by authors studying processes at the root of comprehensive motor action, is related to this. They face the complexity of relations between the motor, gnostic a emotional systems, and try to explain how the coordination between the systems takes place in the course of motor action. On a more general level, this notion can be viewed as an effort to capture and describe, based on the achieved level of cognition, the diversity and specificity of relations between physical (neuro-physiological basis of the execution of motor reaction) and mental (gnostic and emotional component of a motor act) attributes of a motor expression of the individual.

Deviations in the development of grapho-motor skills in a child with difficulties are manifested in particular by an uneven development, or development which is retarded with a view to the child's age. During school attendance, when the pupil is learning to write, deficiencies in grapho-motor skills could signal problems and disharmony in psycho-motor abilities.

Grapho-motor problems and disorders are most frequently manifested by a poor coordination of body movements and articulation organs which makes correct pronunciation difficult. This is due to the relationship between motor functions and the child's psyche and the maturing of his/her nervous system. Early detection of individual problems and deficiencies in the child's grapho-motor development may therefore play an important role in the prevention of writing disorders which would otherwise only be manifested during school attendance. Sluggish writing pace and insufficient automation of grapho-motor movements would then cause the child serious problems in all his/her attempts at written expression (not only in writing classes). Should problems with mastering the correct letter shapes persist, the child's handwriting would be not only untidy, cramped and messy but also difficult to read and comprehend. Moreover, if the child becomes more aware of his/her problem, it may weaken its inner motivation as far as writing is concerned, and that leads to written expression which is poor in content and uncreative (Lipnická, 2007).

In the Czech Republic, there is an educational counseling system which, pursuant to a decree on educational counseling, includes educational counseling centers: pedagogical and psychological counseling centers and special pedagogy centers, as well as in-house counseling centers at primary and secondary schools. The Ministry of Education, Youth and Sports established the Institute for Pedagogical and Psychological Counseling which provides methodological guidance to the entire educational counseling system (Pešová, Šamalík, 2006). Pedagogical and psychological counseling centers are staffed by psychologists, special pedagogists, prevention methodologists, social workers, and in some cases, also social pedagogists. Special pedagogy centers staffed by psychologists, special pedagogists, and social workers are intended to work with children with certain handicaps. In-house counseling centers at schools are staffed by an in-house psychologist, in-house special educator, in-house prevention methodologist and career advisor. In the counseling work, less and more severe difficulties must be distinguished. Where the disorders are more severe, cooperation is required, not only with the family and school, but also with a psychiatrist or other health specialists.

Re-education means renewed education using special pedagogic procedures and work methods designed to develop impaired or undeveloped functions.

There is no single re-educational approach suitable for all children: it needs to be based on the individual child and the specific manifestations of his/her difficulty or disorder. Re-education has to be based on quality diagnostics of problems, their severity and manifestations, as well as the condition of mental functions.

Re-educational methods and tools and areas on which activities should be focused are identified. Re-education starts at a level where the child can still manage, and only then demands are escalated. For instance, deficiencies and disorders in motor skills, locomotion and praxis are first addressed by exercising perceptive-motor functions which are the cause of the problems and which needs to be addressed and developed.

For instance, where the child suffers from dysgraphia, the training starts with relaxation exercises of the entire hand, with a focus on both gross and fine motor skills; coordination of movements is also practiced. Where the disorder is combined with dysorthography or dyslexia, sensory perception exercises are also included – visual and auditory perception. Reeducation employs an approach involving as many senses as possible, in combination with the word, movement and rhythmization. It is important to design exercises targeting the specific problem, and to monitor their effect. Some children require further care in their regular school environment even after the reeducation process is completed; for instance, a slower writing pace, poorer handwriting quality and layout need to be tolerated. a sensitive personalized approach to the child and his/her parents is a must.

As with other difficulties and disorders, the sooner we start working with the child, the greater the chances of improvement. Reeducation is a long-term process. The main objective is to teach the child to live in regular living conditions. The situation is more serious in those cases where the difficulty or disorder was not adequately diagnosed. In a regular class, individual approach may be difficult for the teacher who, however, may help the pupil with a learning difficulty or disorder by giving him/her more time to complete assignments, by allocating shorter assignments to the pupil, by using various aids. The teacher should first and foremost assign tasks which can be fulfilled and should know how to praise.

Conclusion

Personality development is not the same in all children, and is often not ideal. Educators and psychologists must seek ways for working with the mental abilities and potential personality of all pupils, more effectively than ever before, so as to help their pupils be successful at school, in the work process and in life.

Special attention needs to be paid to behavioral difficulties in children and youth, their detection, classification, prevention and rectification.

Ten categories of behavioral difficulties were proposed; these need to be distinguished precisely from behavioral disorders and personality disorders.

If the school is to work successfully with problem children, school staff need to be informed not only about the basis of learning difficulties and behavioral disorders, but also about forms of depistage of children with behavioral difficulties and disorders, about interventions and options for continuous and systematic cooperation with pedagogical and psychological counseling centers, bodies involved in child and family care, courts, police, etc.

Behavioral disorders caused by personality disorders, neurosis, mental retardation or dementia need to be addressed in collaboration with psychiatric facilities for children and youth.

Difficulties, i.e., educational and learning difficulties which still fall within the broader norm, can be resolved by means of pedagogical and psychological tools.

Difficulties are usually determined by an entire complex of conditions and causes which is important both for their diagnostics and rectification.

The conditions and causes for the occurrence of behavioral difficulties can be the following:

- *biogenous* – congenital factors, including heredity
- *sociogenous* – e.g., parentogeny (caused by the family), pedagogeny (caused by upbringing or education – Helus, 1991)
- *psychogenous* – due for instance to intellectual passivity, escalated pubescent changes of nature, etc.

Educators need to exert a deliberate, purposeful and consistent influence over the individuals being educated so as to ensure positive development of their personalities.

For such efforts to be effective, we first need to get to know the children in the educational process well. Such knowledge is a must. That is why we perform pedagogical diagnostics during our educational efforts. The detected condition then serves as a basis for an individual re-educational approach to the children, as well as the procurement of further adequate specialized professional help, if required.

IDENTIFIKACE, REEDUKACE A PSYCHOTERAPIE DIFICILIT A PORUCH CHOVÁNÍ A PROŽÍVÁNÍ

Abstrakt: Závady v chování a prožívání (dificility) a jejich srovnání s poruchami chování a poruchami osobnosti uvedenými v Mezinárodní klasifikaci nemocí (MKN). Explorativní analýzou kasuistik pedagogicko-psychologických poraden a metodou Delphi bylo na základě výzkumu stanoveno 10 diagnostických jednotek, které se liší od poruch chování a poruch osobnosti uvedených v Mezinárodní klasifikaci nemocí. Byla vytvořena teoretická koncepce dificilit a byly navrženy praktické konsekvence pro práci pedagogicko-psychologických poraden, školních psychologů (výchovných poradců) a učitelů s dificilními dětmi.

Klíčová slova: závady chování, poruchy chování, výzkum, dificility, poruchy osobnosti, diagnostika, identifikace dificilit, náprava dificilit a poruch chování, reedukace, psychoterapie