

Psychopathology II

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1 Stressful Situations: Coping with Them and Their Consequences from the Viewpoint of Psychopathology



Objectives

After studying this chapter you will have an overview of the individual types of stressful situations and their influence on an individual's psyche. You will be able to distinguish the types of defensive reactions through which an individual copes with stress. You will learn about the mental disorders that originate as a result of stress. You will realise the significance of stressful situations on the shaping of an individual's personality.



Terms to Remember (Key Words)

- stressful situations
- frustration
- conflict
- stress
- trauma
- crisis
- deprivation
- coping
- ego-defence mechanisms
- denial
- repression
- suppression
- rationalization
- sublimation
- projection
- acute stress reaction
- post-traumatic stress disorder
- dissociative disorders

1.1 Types of Stressful Situations

1.1.1 Frustration

Frustration occurs every time an individual encounters an obstacle on the way to satisfying a need. The term 'frustration' is used to define frustration as a situation and frustration as an internal experience:

- a **frustration situation** represents an obstacle that becomes a burden on the individual,
- **frustration** as an experience is subjective and leads to a certain behaviour by the individual.



Theoretical work focused on frustration was published in the 1930s by the American psychologist Saul Rosenzweig. Until today, the Rosenzweig Picture-Frustration Study (P-F Study) is used in consulting practices to detect patterns of behaviour in frustration situations. Rosenzweig also introduced the term 'frustration tolerance' to psychology.

The level of resistance against a frustration situation is called **frustration tolerance**. The genetically conditioned component of frustration tolerance is governed by overall organism stability, emotional balance, flexibility of reactions to various situations, and the ability to relax and recover quickly. This resistance can be positively increased by learning and mediating personal experience when coping with problems.

Frustration tolerance depends on (Vágnerová, 2004):

- congenital preconditions,
- achieved developmental level,
- individual experience,
- the current overall state of the individual.

1.1.2 Conflicts

Inter-individual (interpersonal) conflicts are clashes between a person and other persons due to different opinions and methods of conduct as well as objectives that should be achieved.

- Usually it is easier to resolve **factual conflicts** in which the difference is related only to the situation's objective parameters.
- It is more difficult to resolve **personal conflicts** in which it is about defeating the other side at any price.
- However, most frequently there are **mixed conflicts** in which personal problems are projected into factual issues (Bedrnová et al., 1999).

Intrapsychic conflicts are internal processes where an individual has to decide between incompatible or mutually exclusive objectives or ways of behaving. Internal conflicts also arise if two internal motives or needs are at odds with each other.



In our society there are most frequently strong conflicts between two motives (Atkinson, 2000):

- **Independence versus dependence.** In stress, we may wish to escape to childlike dependence and to find someone who will take care of us and resolve our problems. On the other hand, it is emphasised to us that we have to be able to take care of ourselves.
- **Intimacy versus loneliness.** A desire for a close relationship with another person may be in conflict with a fear of rejection.
- **Co-operation versus competition.** Our society puts a great emphasis on personal success; competition starts to appear in early childhood among siblings, continues at school, and peaks in business and professional rivalry. At the same time, we are forced to co-operate and help others.
- **Satisfaction of urge impulses versus moral principles.** Sex and aggressiveness are the two primary areas in which our impulses often become conflicted with moral principles whose breaching may cause feelings of guilt in us.

1.1.3 Stress

Stress is a situation of direct or expected threat, or a response to any significant strain – physical or psychological. In stress, defence mechanisms are applied that enable the survival of the threatened organism.

One of the first authors of a theory on stress was Hans Selye who investigated the physiological reaction of the organism to stressors. He defined stress as a **general adaptation syndrome** with three stages (Selye, 1978):

1. Alarm reaction (the organism becomes mobilised),
2. Resistance, an effort to maintain adaptation (the organism actively tries to cope with the threat),
3. Exhaustion of the organism.

The organism reacts to stress in a complex manner: the hypothalamus, which controls the sympathetic nervous system and the adrenocortical system, is activated. The effect of the stress hormones distributed by blood and the neural activity of the sympathetic nervous system prepare the organism for a defensive reaction – fight or flight. Overall, body metabolism increases, while pulse frequency, blood pressure, breathing frequency and muscle tension are higher. Pain-suppressing endorphins are excreted into the blood.



The effect of long-term stress thus repeatedly causes these physiological reactions in the organism, which can negatively affect an individual's health condition and contribute to the development of mental and physiological problems (Eysenck, 2002).

A **stressor** is an agent or an event which places extraordinary demands on an individual's adaptation abilities and threatens normal bodily functions. Stressors can be divided into categories:

1. Biological – resulting from exposure to bacteria, viruses, mould or parasites.
2. Chemical – from the effects of toxic chemical substances.
3. Physical – from an individual's exposure to extreme heat, cold, noise, pressure changes, radiation, etc.
4. Physiological – caused by strenuous physiological activity, injury, hunger, lack of sleep, etc.
5. Psychosocial – from the demands placed on an individual by the society, interpersonal conflicts, work strain, lack of time, etc.

Psychology focuses primarily on the study of the processes related to psychosocial stressors. Holmes and Rahe created a scale of life events according to which one can measure **stress in terms of life changes** (see Table 1).

Table 1. Social Readjustment Rating Scale – (Holmes and Rahe, 1967, cited in Atkinson, 2000)

Life Event	Life Change Units	Life Event	Life Change Units
Death of a spouse	100	Change in responsibilities at work	29
Divorce	73	Child leaving home	29
Marital separation	65	Trouble with in-laws	29
Imprisonment	63	Outstanding personal achievement	28
Death of a close family member	63	Spouse starts or stops work	26
Personal injury or illness	53	Beginning or ending school	26
Marriage	50	Change in living conditions	25
Dismissal from work	47	Revision of personal habits	24



Marital reconciliation	45	Trouble with boss	23
Retirement	45	Change in residence	20
Change in health of a family member	44	Change in schools	20
Pregnancy	40	Change in recreation	19
Sexual difficulties	39	Change in church activities	19
Gaining a new family member	39	Change in social activities	18
Business readjustment	39	Change in sleeping habits	16
Change in financial state	38	Change in eating habits	15
Death of a close friend	37	Vacation	13
Change to a different line of work	36	Christmas	12
Foreclosure of mortgage or loan	30	Minor violation of law	11

An individual's **psychological reactions to stress** also evidence themselves in emotional and cognitive areas (Atkinson, 2000). Common **emotional reactions to stress** include:

- anxiety – an unpleasant state related to feelings of concern and tension,
- anger and aggression,
- apathy, depression, withdrawal into oneself.

People exposed to strong stressors often show a **weakening of cognitive functions**, have problems concentrating and with the logical order of thoughts, and their performance in difficult tasks worsens. This impairment of cognitive functions can have two causes:

1. The high level of emotional activation can impair information processing (the more anxious, angry or depressed one is, the higher the probability of weakened cognitive functions).

2. The weakening of cognitive functions can be caused by the disruptive thoughts that run through one's head upon encountering the stressor.

For instance, students who are afraid of an exam are afraid of failure and their own inability. They can be so upset by these negative thoughts that they cannot do what they have been assigned, are unable to grasp the questions, or



understand the questions incorrectly. As their concerns grow, they have a hard time recalling even the facts that they revised well.

The effect of stress on health depends on the **physiological reaction** that occurs in the body during the stressful situation. Particularly long-term excessive activation of the sympathetic nervous system and adrenocortical system has a direct negative influence on physiological health, can cause damage to the arteries or organ systems, and can lower the resistance of the immune system.

An individual under permanent pressure by stressful situations has fewer opportunities to take care of his/her health and often reacts by engaging in harmful **behaviour**.

For instance, students revising for an exam do not sleep all night and this is usually repeated several nights in a row. They also do not eat regularly and tend to opt for quick (non-quality) refreshment. People in stress stop exercising regularly and a sedentary way of life prevails.

At the same time, unhealthy behaviour can enhance the subjective experience of stress. Regular excessive alcohol consumption impairs cognitive functions, results in lethargy and fatigue, and lowers an individual's ability to effectively cope with stressful situations or even with the common demands of everyday life. People who lack sleep can suffer from, for instance, the impairment of memory, learning, logical thinking or decision-making (Atkinson, 2000).

1.1.4 Trauma

Psychological trauma is a type of damage to the psyche, a mental state which occurs as a result of a traumatic event, i.e. exceptionally disturbing situations that are outside the daily human experience (e.g. a serious injury, an accident, a death in the family, rape, abuse, bullying, natural catastrophes, war events).

The severity of the trauma can be assessed according to many criteria. According to Calhoun and Tedeschi (1999, cited in Mareš, 2007), a traumatic event is usually:

- A shocking event – appearing suddenly, unexpectedly and unforeseeably.
- A non-influenceable event that the individual can neither control nor manage.



- The fault for the course of events does not lie with the individual; what has happened is usually not his/her fault.
- The individual faces physiological or psychological damage or its negative effects are already showing.
- The circumstances of the event are not at all common for the individual; on the contrary, they are extraordinary and exceptional for the individual.
- The event brings long-term and often irreversible problems to the individual.
- The individual moves to another, much more vulnerable stage of his/her development.

After a traumatic event, most people experience a **specific sequence of psychological reactions**. At first the victims are stunned and dazed and it seems as if they are not aware of the injury or danger (they may confusedly wander around and thus expose themselves to the risk of additional injury). In the next stage the victims are passive and unable to start doing something on their own, but they can easily follow others; they let themselves be led and obey instructions and demands. In the third stage the victims start to feel anxiety and concern and their thoughts return to the experienced event (Horowitz, 1986, cited in Atkinson, 2000).

As a result of the experienced trauma, mental disorders can develop; according to ICD-10, these are most often **acute stress reaction** and **post-traumatic stress disorder** (see section on *Mental Disorders Whose Onset Is Significantly Affected by Stress*).

Experts' attention has recently been devoted to the formative influence of traumatic experiences. A challenging life event does not have to have only a negative impact. After some time, a positive impact, called **posttraumatic growth**, can appear in some cases. Posttraumatic growth includes positive changes that occur in the individual after having coped with the traumatic event. In the personality, changes in the perception of one's 'self' can be described in five areas (Calhoun and Tedeschi, 2006, cited in Mareš, 2007):

1. The individual discovers new facets of his/her personality he/she has not been aware of.



2. New possibilities become open to the individual which he/she has not considered yet.
3. His/her relationships with other people change.
4. His/her understanding of life changes and life values are re-arranged, and a deeper understanding of life sets in.
5. There are changes in the spiritual area, and some people shift towards faith.

In general one can say that during posttraumatic growth the individual acquires inner strength and inner resilience through suffering. His/her psychological readiness for adverse events is developed. The re-construction of the individual's world up to then results in his/her higher psychological resilience.

However, it has to be added that posttraumatic growth is not a universal experience and does not occur in all people exposed to trauma. Studies have encountered posttraumatic growth in 30% to 80% of the researched persons. The occurrence of positive influences after an experienced trauma depends on the type of trauma, the peculiarities of the personality, and the characteristics of the social environment. Posttraumatic growth is a process which may occur after several months, years or even decades (Mareš, 2007).

1.1.5 Crisis

When a **crisis** occurs there is an impairment of psychological balance as a result of the sudden escalation of a situation or a long-term increase in problems. This is a situation the individual is unable to overcome or to cope with the related external and internal strain of using his/her own strategies. This can be a consequence of, for instance, an escalated conflict in the family, debts, loss of employment, somatic disease, life changes, etc.

Assistance during a psychological crisis is called **crisis intervention**, which is a comprehensive approach adapted to the peculiarities of the person in crisis. Crisis intervention includes not only individual psychotherapy, but also family and social intervention, the use of group psychotherapy, and in necessary cases the prescription of psychopharmaceutical treatment or short-term hospitalisation. Crisis intervention is usually provided over the phone (help-line) or by outpatient crisis facilities or inpatient crisis centres.



Crisis support should begin as soon as possible and without delay. The therapist considers the degree of strain on and the level of danger to the client. He/she tries to identify the factors that led to the crisis and focuses the intervention on the problem. The basic **principles for approaching a person in crisis** defined for general practitioners (Klimpl, 1998) can be an inspiration for anyone who encounters a person in acute crisis:

1. Quickly establish contact between the client and therapist focused on the creation of a therapeutic relationship. *The readiness of the physician to deal with the patient's acute problems supports the creation of a therapeutic relationship. On the side of the physician it is particularly about the ability to listen actively and to cope with one's own anxiety, which is often caused by the urgency of the patient's problem.*
2. Create an overview of the events that led to the crisis occurring. *Focusing on the moments that caused the crisis leads to an understanding of the development of the problem and enables the client to reconstruct its development and its causal and temporal context.*
3. Understand more clearly the false adaptation reactions through which the client is trying to cope with the crisis. *Instead of defence mechanisms one should support the client in the development of adaptation strategies that include a crisis plan.*
4. Focus on the crisis. *The main objective of crisis intervention is to work on the problems that caused the crisis. It is not the object of crisis intervention to, for instance, achieve deeper changes in the client's personality; this is the task of systematic psychotherapy provided by a trained psychotherapist.*
5. Teach effective adaptation reactions to overcome the crisis.
6. Prevent symptoms from forming. *The majority of clients manifest physiological or psychological symptoms. An exclusive interest in these symptoms leads crisis intervention to a dead-end. Physiological or psychological problems have to be accepted as part of the client's psychological reality, but it is essential to strive for a change in the problematic areas that have led to the origin of the crisis.*
7. Support as high a level of client independence and initiative as possible.



8. End the intervention as soon as it is clear that the crisis has been overcome and the client is able to recognise what led to the crisis and how he/she can overcome it.

1.1.6 Deprivation

Deprivation is a state of suffering resulting from the long-term non-satisfaction of significant biological or psychological needs. This stressful situation is very severe and, particularly in childhood, can have a strongly pathological influence on an individual. According to the areas where one's needs are not met, we distinguish:

1. **biological deprivation** (malnutrition, lack of sleep),
2. **stimulus deprivation** (lack of stimuli),
3. **cognitive deprivation** (in upbringing and education),
4. **emotional deprivation** (lack of emotional relations),
5. **social deprivation** (restricted contact with people).

Important Czech psychologists Josef Langmeier and Zdeněk Matějček studied the consequences of deprivation and wrote a monograph on the issue of **mental deprivation in childhood**.

Mental deprivation is a psychological state which results as a consequence of life situations in which the subject is not provided with the opportunity to satisfy some of his/her basic psychological needs to a sufficient extent and over a longer period. (Langmeier and Matějček, 1974, p. 22)

- A **deprivation situation** is perceived as a life situation in which the child has no opportunity to satisfy his/her important psychological needs.
- **Mental deprivation** is the distinctive individual processing of stimulus deprivation in which the child arrives in a deprivation situation – it is a mental state.

Mental deprivation is a result of the long-term non-satisfaction of one's **basic psychological needs**, which include:

1. **The need for a certain number, variability and type of stimuli.** The satisfaction of this need enables the achievement of a desired level of mental activity. Deprivation as a lack of stimulation occurs where the



social environment does not provide a sufficient number of stimuli, be it due to materialistic conditions or the attitude of carers.

2. **The need for basic conditions for effective learning.** Deprivation as a lack of a meaningful social environment is caused by an upbringing that is neglectful or scattered and provides only superficial guidance. Naturally, the child tries to discover certain rules in his environment and tries to make some sense of it. If the environment does not enable him/her to discover regularities and order, the child cannot react in a purposeful and differentiated manner towards the environment.
3. **The need for initial social relationships (primarily with a motherly figure).** The establishment of a stable emotional relationship brings the child a feeling of life certainty and is a condition for the desirable internal integration of the personality. The child faces the non-satisfaction of this need in situations in which he/she does not have one close person to which he/she can create an emotional bond. This occurs when the child receives motherly care by many persons at the same time or in turns in early childhood, for instance in institutional care. Emotional deprivation also occurs in family care where the parents have a rejecting and hostile attitude toward the child or are incapable of an emotional relationship with the child.
4. **The need for social success enabling the acquisition of social roles and valuable objectives.** A healthy awareness of one's 'self' or one's own identity stems from this need. In this area, deprivation occurs if the child does not encounter clearly defined values in his/her immediate environment to which he/she can orient his/her behaviour in a purposeful manner or if, for instance in institutional care, he/she has not experienced the different roles of father, mother and younger or older siblings.
5. **The need for an 'open future'.** Its satisfaction gives the human life a time range and stimulates and maintains its activity. The non-satisfaction of this need leads to stagnation in development.

The state of mental deprivation originates when a child is deprived of the input of desirable stimuli and thus has no possibility to develop his/her basic psychological needs and apply them to his/her environment. These basic psychological needs must be satisfied to an adequate extent if the child is to develop a mentally healthy and competent personality (Matějček and Dytrych, 1994).



The **symptoms of mental deprivation in children** can vary widely. Deprivation is reflected with varying severity in individual components of development and there can be a **delay in the development** of speech and intellect, social and hygienic habits, soft motor skills, and scholastic readiness. Mental deprivation is also manifested by **behavioural and emotional disorders**. Severe and long-term deprivations usually cause deep changes, which can be permanent, in the child's psychological structure. The younger the child and the longer the deprivation, the more severe the expected consequences. **Remedying the consequences of deprivation** is a difficult, long-term process, but one cannot unambiguously say that the consequences of deprivation are permanent and unchangeable. Many deprived children achieve satisfactory social inclusion at a later age (Langmeier and Matějček, 1974).

Currently, **mental subdeprivation** is a more frequent problem. Its definition corresponds to the definition of mental deprivation. In the case of subdeprivation, this is the same set of symptoms in a less significant, less concrete and less dramatic form. The individual deviations are usually just slight and inconspicuous. They become a problem only when combined as a whole, for they essentially affect the child's relationship with his/her social environment.

In the case of mental subdeprivation there is emotional and psychosocial impoverishment which makes the individual less capable of an emotional social response. Mental subdeprivation can occur in children from families that neglect them in general but also in families with good material security and education who are, however, lacking in the emotional area. The **behaviour of their parents is manifested by** (Vágnerová, 2004):

- **lower acceptance of the child and minimal emotional engagement** – the parents speak too critically about the child, assess him/her negatively, and do not find anything good about him/her as if the child were a burden to them,
- **lower empathy** – the parents do not understand the needs and feelings of their child,
- **few interactions between the parents and the child** – the parents do not occupy themselves with the child much, communicate with him/her too little, and do not spend leisure time with him/her; the child is often home alone, and even when the parents are present no one notices him/her.



People who were emotionally deprived in childhood tend to have problems with self-valuation and interpersonal relations even in adulthood and are not satisfied with their life. This is then negatively reflected in all important aspects of their life, in their roles as partners and parents, and in their professional employment and overall social adaptation.

1.2 Coping with Stressful Situations

The methods of coping with a situation that is stressful for an individual can be called **defensive reactions** and these can be divided into several groups: fight, flight, coping, and ego-defence mechanisms.

1.2.1 Fight

Fight is an active option and expresses the tendency to battle the threatening situation. Aggression can be focused directly on the source of danger or on a substitute object. It can also be focused on oneself.

1.2.2 Flight

Flight expresses a tendency to run away from a situation that seems unresolvable. It can take the form of an actual escape, a transfer of responsibility to a different person to resolve the problem, or resignation.

1.2.3 Coping

American psychologist Richard Lazarus (1966) focused on coping with stressful situations and distinguished two stages in the appraisal of stress that are of key importance for the choice of a coping strategy:

- primary appraisal – finding out the severity and type of threat,
- secondary appraisal – mapping the possibilities and methods of resolution.

Coping is the conscious choice of a certain strategy of coping with a stressful situation. One can distinguish two basic coping strategies (Lazarus and Folkman, 1984, cited in Atkinson 2000): problem-focused coping and emotion-focused coping.

Problem-focused coping is based on the idea that it is possible to solve the problem. Problem-solving strategies include:

1. defining the problem,



2. looking for alternative solutions,
3. considering the alternatives in terms of their pros and cons,
4. choosing among the alternatives,
5. implementing the chosen option.

Emotion-focused coping, which focuses on the preservation of mental balance and the reduction of negative experiences, is applied in situations that we are convinced cannot be changed. Emotion-focused coping is also used when we want to protect ourselves against being inundated with negative emotions that would prevent us from concentrating on the solution to the problem. The methods of managing negative emotions are based on the use of:

- a. **behavioural strategy** – the use of various means to alleviate the urgency of the problem, e.g. sport, seeking psychological support from friends, drinking alcohol, venting anger, etc.,
- b. **cognitive strategy** – for instance, removing the problem from consciousness temporarily, changing one's perception of the situation, or re-appraising one's objectives.

The majority of people cope with difficult situations using both problem-focused coping and emotion-focused coping. Some of the behavioural and cognitive strategies can be **adaptive** (i.e. they help the individual to cope with the problem), while others are **maladaptive** and can even increase stress. *For instance, an escape from the problem by using drugs can be considered maladaptive behaviour which results in other problems; the difficult life situation is not resolved; on the contrary, it becomes even more complicated.*

Proactive coping (Aspinwall and Taylor, 1997, cited in Kassin, 2004) lies in the activation of strength to prevent the stressor from acting or to change it so that it is not as strong. This is the continuous prevention of stressful situations that we apply in many daily decisions.

1.2.4 Ego-Defence Mechanisms

Ego-defence mechanisms belong among the defensive reactions that are not completely conscious. These mechanisms were described primarily by psychoanalytically oriented authors. The defence mechanisms operate in order to preserve the integrity of our ego and to protect it against the threatening influence of emotions and unpleasant situations. This defends us against, for instance, feelings of guilt, pangs of conscience, fear, or resistance.



Denial is a frequent defence mechanism, with the individual admitting only such information that does not pose a threat to him/her. *For instance, parents who have been informed by a teacher that their son bullies his classmates react typically by saying: 'This can't be true. Our child would never do such a thing.'*

In difficult situations, denial may provide a person with time to cope with the situation at hand and also preserves some hope for the individual (e.g. when a person falls ill with an incurable disease).

Less marked forms of denial can be found in individuals who consistently ignore criticism, are unable to perceive that others are angry at them, or overlook all of the signs hinting at the fact that their partner is having a love affair. In such cases denial is maladaptive, as it preserves the pathological situation and postpones an effective solution until the situation escalates.

Denial can have fatal consequences regarding illness and health if a person does not acknowledge the warning signs of an illness and does not visit his/her physician in time (e.g. a woman who is in denial about a lump in her breast possibly being malignant puts off a visit to the doctor until her condition is practically irreversible).

Repression leads to the exclusion of threatening or painful feelings, incentives or thoughts from consciousness. Sigmund Freud, the founder of psychoanalysis, considered repression the basic and most important defence mechanism and at the same time believed that repression is seldom completely successful. Repressed impulses enter into consciousness and lead to feelings of anxiety.

Suppression is a process of deliberate self-control through which a person controls his/her impulses and wishes. Individuals are aware of suppressed thoughts, but they are unaware of repressed impulses or memories.

Suppression may lead to an opposite effect than the one desired. People who try to suppress certain thoughts in the end focus on these undesirable thoughts more than people who tell them to other people. Suppressing thoughts leads to a person thinking more often about them than if he/she stops suppressing them (Wegner, 1987, cited in Atkinson, 2000). When people speak about their traumas or write about them in their diaries, their tendency to constantly think about these traumas decreases, which can even result in improved health. Verbal expression of fear and other emotions helps them cope with the trauma more easily (Pennebaker, 1997, cited in Atkinson, 2000).



Rationalisation is based on a logical re-appraisal of information which leads to a distortion of reality. *For instance, we blame our having failed an exam on bad luck; we do not admit our own imperfections.*

Sublimation is based on a substitutional method of satisfying one's needs. This substitutional activity helps decrease tension when the basic urge is thwarted.

Sigmund Freud believed that sublimation was the most satisfying way of coping with aggressive and sexual impulses. Basic urges cannot be changed, but one can change the objects which they are directed towards. Erotic impulses can be expressed indirectly, e.g. by creative, artistic activity. Aggression can find a socially acceptable expression in team sports.

Projection is a tendency to project one's own worries, motives, opinions and intentions onto the conduct of other people. The unconscious mechanism of projection protects us against the recognition of our own undesirable traits by ascribing them to other people.

All defence mechanisms include an element of self-deceit and are used by everyone at some point, as they help us overcome unpleasant situations until we are ready to cope with them more effectively.

Defence mechanisms can be seen as a manifestation of a maladaptive personality only if they become one's primary method of dealing with problems (Atkinson, 2000).

1.3 Consequences of Stressful Situations with Regard to Psychopathology

Generally one can say that stress belongs among the important factors in the onset of many categories of mental disorders defined by the International Classification of Diseases (ICD-10, 2010).

Stressful situations (stress) can contribute to the onset of neurotic, psychotic, affective and addiction disorders. However, stress is not the only or primary agent in the development of these disorders, and its influence is usually in addition to the personal disposition or vulnerability of the affected individual.

The following text is devoted to the description of such mental disorders whose onset is significantly affected by stress and the mechanisms of coping with stress.



1.3.1 Mental Disorders Whose Onset Is Significantly Affected by Stress

In severe stress, even fully mentally healthy and competent individuals can develop a mental disorder of a temporary or more persistent nature. ICD-10 distinguishes two disorders that can be diagnosed as a reaction to having experienced trauma: acute stress reaction and post-traumatic stress disorder.

Acute stress reaction (F43.0) develops as an immediate response to exceptional physical and/or mental stress and usually subsides within several hours or days. Mental functions disintegrate and adaptation mechanisms fail. The cognitive component fails and the affected person is unable to understand or orient him/herself in the situation. The traumatised person is in a state of complete helplessness, unable to act purposefully. Emotional reactions to having experienced trauma can vary: some may experience emotional blunting and a temporary loss of the ability to react emotionally, while others show very strong and tumultuous affective reactions.

Post-traumatic stress disorder (F43.1) is a delayed or protracted response manifested by the persistence of psychological and somatic problems. The incidence of post-traumatic stress disorder is directly proportional to the severity of the traumatic event, i.e. the intensity of the stressor and its duration determine the intensity of the incidence of this disorder.

In the history of psychiatry, post-traumatic stress disorder was called 'shell shock' in the context of war. In children it was researched by Anna Freud, for instance, who focused on children evacuated from bombarded London during WWII and on the relationship between the reactions of them and their mothers.

Typical symptoms of post-traumatic stress disorder are:

1. Episodes of recurrent revival of the trauma in memories or dreams. The traumatic event returns as images, sounds and other impressions which are related to the moment of the traumatic event.
2. Avoidance of percepts that could remind the affected person of the traumatic event.
3. In the somatic area, one can observe a state of increased vegetative hyper-activation which is manifested by sleep disorders, increased irritability, a distorted ability to focus, persistent anxiety, and increased fright reactions.



Many life events that seem manageable from the viewpoint of the observer can be subjectively perceived by an individual as very stressful. Such a situation can trigger an **adjustment disorder** (F43.2), in which the individual reacts with depression, experiences anxiety, and is unable to manage tasks and fulfil duties in almost all areas of life. The adjustment disorder usually starts within one month from the occurrence of the stressful event or life change and the symptoms rarely last longer than six months. It is assumed that this condition would not occur without a stressful situation.

Adjustment disorders, i.e. states of subjective distress and emotional disorders that usually disrupt social functioning and performance, develop during the period of adaptation of an individual to a significant life event (e.g. change of residence or school) or to a stressful life event (death in the family, serious somatic illness). The stressful situation represents a change in the individual's social network (bereavement, separation) and in the wider system of social support and values.

1.3.2 Dissociative Disorders

Ego-defence mechanisms that should prevent or restrict the conscious experience of tormenting psychological content and unacceptable facts can result in diverse manifestations of a mental disorder which used to be called 'hysteria' or 'hysterical neurosis'.

ICD-10 gathers these disorders in the category of **dissociative (conversion) disorders** (F44). The common theme of the disorders in this group is a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. The symptoms are closely time-related to traumatic events or unsolvable or unbearable problems.

Dissociation means a 'splitting' of mental unity, detachment, the independence of mental content and functions, and separation of conscious control over one's own activities (e.g. loss of memory as a defence against traumatic experiences).

Conversion is manifested by a temporary loss of a certain bodily function without a corresponding physiological cause. It is a conversion of suppressed affects into physical symptoms, e.g. blindness without a real impairment of sight or a loss of the ability to move one's lower extremities without there being any neurological damage (Kassin, 2004).



Even though the symptoms may look like deliberate simulation, it is not so. The individual does not know why his/her troubles originated and often is unaware of the problems or difficulties that could be obvious to others. Unpleasant experiences are repressed into unconsciousness and are manifested as symptoms that cannot be controlled by volition. Dissociative (conversion) disorders include, for instance:

- **dissociative amnesia** – loss of memory related to stressful events,
- **dissociative fugue** – all the features of amnesia plus a seemingly purposeful departure from home (in essence, this is an unconscious escape from something that is unacceptable for the individual),
- **dissociative stupor** – profound diminution or absence of volitional movements; the individual remains 'stiff' in one position for a longer period of time,
- **dissociative motor and sensation disorders** – there is a loss or impairment of movements and sensations; the individual seems as if he/she is somatically ill (e.g. paralysed or blind), however, no somatic disorder can be found to explain the symptoms,
- **dissociative convulsions** – these mimic epileptic seizures closely and are quite difficult to distinguish from those of a genuine seizure disease.

The symptoms, onset and termination can be sudden, and the course of dissociative disorders is usually short, normally subsiding within three months of the diagnosis. Disorders following traumatic life events tend to be shorter. Disorders related to unsolvable problems tend to be chronic.

Often it takes longer to determine a diagnosis (as these disorders seem like a disruption of the health condition) and to prove that the symptoms are not somatically based but are the result of psychological defence mechanisms.

Determining the diagnosis of a dissociative disorder and its therapy is difficult even for experts. A layperson dealing with an individual with symptoms of a dissociative disorder may conduct him/herself erroneously. For instance, parents can unjustifiably accuse their child of simulating problems and punish him/her for manifestations he/she does not have under his/her volitional control. On the other hand, they can easily succumb to excessive concern, as the symptoms look as if the child is seriously ill. They behave hyper-protectively and transfer feelings of anxiety to the child, which can contribute to the worsening of his/her problem.



The objective of treating dissociative disorders is to achieve insight and to remove the sources of the problems. The main means is psychotherapy, and when working with children it is necessary to include the family in the psychotherapeutic process. Hypnosuggestive methods also tend to be effective.

1.4 Importance of Stressful Situations for Personality Development

A person's development is influenced by one's everyday life, one's activities and one's interaction with other people. **Stressful situations, which are a natural part of human life**, are of great importance for the development and shaping of the personality. In overcoming them the individual builds tolerance against stress, and volitional and character features are created.

Even a **severely stressful situation (trauma)** does not have to have an exclusively negative impact, as was already mentioned in connection with posttraumatic growth. Overcoming stress and coping with a difficult situation can help shape personality traits in an individual which he/she would not have gained had he/she not encountered a difficult life event. This fact is expressed in the adage: *'That which does not kill me makes me stronger.'*

In children, stress resilience can be formed by the demands that are exacted from the environment in which they are raised. In various contexts, the term 'demands' can be replaced with 'obstacles', 'troubles', 'strain', 'stress', 'demanding life situations' or 'tasks'. The child either copes or does not cope with stress according to his/her experience and character. The personality is positively formed particularly by appropriate demands that should be defined individually with regard to the child's real abilities (Čáp and Mareš, 2007):

- with a lack of demands, the personality does not develop or develops weakly,
- with appropriate demands that slightly exceed the child's current capabilities, the traits on which these demands are placed develop positively,
- demands that are too high have negative effects and personality development is impaired.



Review Questions



1. Explain the difference between the terms 'frustration situation' and 'frustration as an experience'.
2. Describe the general adaptation syndrome that originates in a stressful situation.
3. Mark any situations on the *Social Readjustment Rating Scale* that you have experienced yourself and assign a number of life change units (a value from 0 to 100) to them according to the subjective (as perceived by you) rate of stress. In a group discussion, make a comparison of whether all people perceive the respective situations as similarly stressful.
4. Explain the mechanisms of the influence of stress on health.
5. What types of deprivation can we distinguish?
6. Find updated contact information on institutions near you which provide professional crisis intervention.
7. Describe the problem-focused and emotion-focused coping strategies.
8. What purpose do ego-defence mechanisms serve and on what principle do they function?
9. To the onset of what mental disorders does stress contribute significantly?
10. Think about any educational methods that could be used to appropriately strengthen stress resilience in children.



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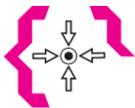
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2 Health Psychology



Objectives

After studying this chapter you will have an overview of important psychological theories that describe health-supporting factors. You will realise what influence the school environment has in terms of stress and protective factors.



Terms to Remember (Key Words)

- health
- quality of life
- health psychology
- protective factors
- salutogenesis
- sense of coherence
- hardiness
- resilience
- locus of control
- dispositional optimism
- social support



2.1 Definition of Health

According to the WHO definition, **health** is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

The term 'health' is currently closely linked with how we perceive our **quality of life**. The relationship between health and quality of life stems from the premise of directing life, and health can be perceived as a means of achieving one's life objectives. Health is an essential prerequisite for an individual's subjective satisfaction with the fulfilment of his/her desires and wishes (Seedhouse, 1995).

So, broadly defined, we can understand the term 'health' as an **ideal** toward which we direct our educational efforts in our work with pupils.

In the past few decades, the field of **health psychology** has developed which strives to find a deeper and broader view of the issues of health and healthcare than the one offered by classical medicine. Health psychology focuses on the psychological factors that affect the development of health and consequentially influence health and illness. Priority is given to the psychological aspects of preserving and strengthening health, and instead of therapy it deals with questions of preventing the impairment or harming of health. It emphasises individual responsibility for one's own health condition.

During the last century, the structure of the illnesses that lead to death changed. While people died of primarily infectious diseases at the beginning of the 20th century, the most frequent cause of death at the beginning of the 21st century is from illnesses that are lifestyle-related (cardiovascular diseases, tumours, injuries, chronic illnesses, etc.). Frequent causes of death also include injuries sustained in traffic accidents, suicides, and homicides. A merely biological perspective is no longer adequate. It is obvious that not only a biological dimension, but also a psychological and a social one are integral components of perceiving health and illness (Křivohlavý, 2001).

2.2 Factors Affecting Health

The health of an individual is affected by multiple factors in the environment, e.g. biological, chemical and physical conditions.

Psychology focuses on **psychosocial factors**, i.e. on influences that are related to the respective mental dispositions and experiences of an individual



and with an individual's integration into society. These factors can be divided into two basic groups:

1. risk
2. protective

The risk of falling ill is a result of the mutual influence of both groups of factors. Risk factors are the source or trigger of problems, while protective factors function to protect an individual's health.

2.2.1 Protective Factors and Salutogenesis

Protective factors are features that decrease the negative effect of risk factors. They include diverse agents that help an individual overcome problems and cope with demanding situations and stress. Protective factors can decrease the effect of a risk factor (stress) by strengthening the individual's psychological characteristics and problem-solving abilities.

The term '**salutogenesis**' was used for the first time by Aaron Antonovsky (1987). Salutogenesis is perceived as a study of the origin of health and its strengthening and support.

Antonovsky was a sociologist who focused on the issues of health sociology starting in 1960. For instance, he investigated the relationship between poverty and health in his studies.

Antonovsky was instrumental in reversing etiopathogenetic thinking. Before, medicine asked why a certain person had fallen ill; is it not more suitable to ask why some people did not fall ill, even though they were exposed to the same conditions as the sick? Salutogenesis is perceived as the antithesis of pathogenesis, which means the origin of a disease.

When studying children on the island of Kauai in the 1950s, developmental psychologist Emmy Werner noted that a large number of children had a very poor and miserable background. In a longitudinal observation of the development of these disadvantaged children, it was shown that a third of them had grown up into competent citizens. In connection with this finding, a host of other psychologists tried to find out how these children had overcome the adversity of fate and had successfully coped with serious life situations (Křivohlavý, 2001).

In psychology, a large number of variables have been described which the authors are convinced distinguish resilient individuals from non-resilient by



acting as a protective factor against the harmful effects of stress. The most important concepts are described below.

2.2.2 Sense of Coherence

Antonovsky (1987) developed the concept of a **sense of coherence**, which includes three components:

- 1. Comprehensibility of the situation** – a method of understanding the world as something logical and comprehensible. The whole seen world and its details make sense to an individual; they have a system and order. The comprehensibility of the situation does not apply only to objects, but also to people, e.g. to the rules of social interaction and communication. It is important for psychological well-being that such a perception of the world gives an individual certainty, the rules are permanent and fixed, and that situations are predictable and one can trust them and rely on them. The opposite of comprehensibility is perception of a world full of chaotic, difficult, unclear and unpredictable situations.
- 2. Meaningfulness** – this characterises the attitude of a person who is convinced that the situation in which he/she is and its solution make sense. It is worth his/her investing energy, time and effort into resolving the situation, as there is an obstacle to be overcome to reach an objective that has a certain value for him/her. The opposite is alienation from and emotional non-engagement in what is happening.
- 3. Manageability** – this is the perception of the possibilities that a given person has to manage demands. The person has a feeling that the situation can be managed and believes in his/her abilities. The opposite is hopelessness; the person is aware of the fact that resolving the situation is beyond his/her powers.

To measure the aforementioned components of coherence, Antonovsky created the SOC diagnostic method. In his studies he showed that people with a higher coherence value measured by the SOC method cope with stress and life hardships better than those who give up fighting against stress.

2.2.3 Hardiness

The perception of invincibility according to American psychologist **Suzanne Kobasa**, who introduced the term '**hardiness**', also has three components:



1. **Control** – how the individual perceives his/her abilities to manage and control (influence) the events around him/her,
2. **Commitment** – to what extent a person identifies with what he/she is doing,
3. **Understanding a difficult situation as a challenge to fight.**

In Kobasa's research work, it was shown that people who achieve higher values in the hardiness dimension better cope with, for instance, health problems following heart surgeries, are physically and psychologically healthier, take better care of themselves, and seek and use social support more often, etc. (Křivohlavý, 2011). In general, one can say that people who feel invincible have a clear idea of their value system, objectives and abilities. They are strongly convinced that their existence is meaningful and that they can determine their own fate. They are highly interested in their affairs (work, family, etc.) and have a tendency to actively and purposefully adapt to demands.

2.2.4 Resilience

The ability to manage a confrontation with markedly adverse circumstances is called **resilience** by many authors. In the 1980s resilience was perceived as a personality trait which predisposed its bearer to withstand unpleasant circumstances. Currently the majority of authors consider resilience to be a changeable process of interaction between the individual and his/her environment. Support for this view was shown by the results of longitudinal studies which showed that failure to adapt can change into successful adaptation over time and vice versa. Furthermore, it has been shown that resilience is differential – a successful overcoming of one type of problem does not automatically mean a successful overcoming of another type (Šolcová, 2009).

The term 'resilience' was used by Emily Werner during her aforementioned longitudinal study of children on the island of Kauai. Based on her studies (Werner and Smith, 1992) she described three groups of protective factors that differentiated children with high and low resilience:

1. **At least average cognitive abilities** together with a disposition towards pleasant and sociable conduct which results in a responsive reaction from other people.



2. Kind and warm-hearted relations with adults that allow the child to develop trust, autonomy and initiative.

3. Ability to establish contact with the school environment and with supportive civic organisations such as the church, youth groups and other out-of-school organisations, and to rely on them.

2.2.5 Locus of Control

In the 1960s Julian Rotter described the differences between people according to their **locus of control**, i.e. according to whether they felt the centre of possibilities in resolving problems was in themselves or in their environment. In stressful situations, people with an **internal locus of control** use their own actions, their own abilities, and their own activity and initiative. People with an **external locus of control** believe that their fate depends more on coincidence and on circumstances they cannot do anything about, and expect the situation to be resolved from the outside. According to this theory, an internal locus of control leads to higher resilience.

2.2.6 Dispositional Optimism

Scheier and Carver (1985, cited in Magill, 1996) defined **dispositional optimism** as a resilience-enhancing feature. This is a personality trait in people who expect that the events they participate in will have a positive outcome. Optimism leads to managing life demands more successfully and to better coping with illness.

Are you an optimist or a pessimist? According to you, is the glass half full or half empty? Do you expect to encounter pleasant events or do you follow the motto that if something can go wrong, it will go wrong? Based on the answers to similar questions, Scheier and Carver divided students into several groups and found that the optimistic students showed fewer symptoms of illness during the term than the pessimists. It appears from other studies that optimists are more likely oriented toward the resolution of problems, are more likely to complete alcohol-abuse treatment, and are more likely to recover from a surgical treatment faster and more successfully.

2.2.7 Social Support

The protective factors include so-called **social support** – assistance or support coming from the individual's social environment. Mareš (2002) provides an overview of social-support functions according to their type.



Emotional support – comes from friends and loved ones and allows the individual to talk about his/her feelings and vent his/her worries. It decreases anxiety and worries and supports the individual's self-trust.

Tangible support – the provision of material support or resolution of practical problems, e.g. help with tidying up, repairs in the flat, babysitting, provision of transportation to a physician or to do the shopping, etc.

Information support – the provision of advice, recommendations, information or suggestions on how to resolve problems encourages the individual to manage tasks more efficiently.

Support provided by the social community – induces a feeling of affiliation and belonging in the individual and provides him/her with inclusion in a group of people with whom he/she can spend his/her leisure time, unwind and take his/her mind off stress. This support function includes joint trips, sports activities, visits to cultural facilities, religious ceremonies, etc.

Support by validation – feedback from and comparison with others and their opinions. The individual gets the feeling that what he/she is experiencing is accepted and considered reasonable by other people.

An individual usually welcomes social support, is grateful for it and uses it. However, the need for social support can be perceived differently by the individual and the provider of said support. The person exposed to a stressful situation usually has his/her own ideas about the prospective social support. If others do not provide it to him/her 'according to his/her ideas', he/she protests, gets upset and conflicts arise. If social support does not come at all, one can talk about failed social support.

It is important for everyone to have some social support available and to be able to **recognise, accept** and **use** it. One cannot automatically expect that each person has these capabilities and can use the available social support effectively.

2.2.8 School Environment in Terms of Risk and Protective Factors

The school environment can be considered one of the most important objective life conditions for a child. In the school environment and in his/her class, a pupil must adapt to the material conditions (e.g. type and dimensions of the classroom), physical conditions (e.g. lighting, temperature, noise) and social conditions (pupil-pupil, pupil-teacher, pupil-class and pupil-norm relationships). A child's integration into the social environment of his/her school



and class becomes the essential social-psychological prerequisite of his/her schoolwork (Řezáč, 1998). Unsuccessful adaptation to the school environment can have various consequences with regard to his/her subjectively experienced feeling of life satisfaction and his/her mental and physical health.

In literature the **school environment is more often mentioned as a source of stress**. As the child starts school, the range of stressful situations broadens and there are more sources of stress: teachers, classmates, required activities, required pace, and quality of activities (Čáp and Mareš, 2001).

Emotional stress at school is most often related to (Helus, 2004):

- failure at school,
- unkind attitude of the teachers,
- non-integration into peer relationships in class; the child has a feeling of being an outsider in the class and is permanently ignored, ridiculed or underestimated.

Ideally school can become an environment which has a positive long-term effect on the child and thus becomes one of the **protective factors**. Such a school environment has characteristics that create a **positive school climate** (Mareš, cited in Ježek, 2003): prosocial behaviour of the teachers and pupils, altruism, functional peer learning, quality of friendship, a caring and supportive school climate, and a feeling of safety and certainty. A positive school climate significantly increases the pupil's perception of the quality of school life.



Review Questions

1. What is the relationship between one's health and one's quality of life?
2. Explain the meaning of the term 'salutogenesis'.
3. What are the functions of social support?
4. Is the ability to use and to provide social support given by congenital disposition, developed by social learning, or influenced by both? Substantiate your answer.
5. What situations in school are often sources of stress from a pupil's perspective?



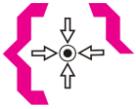
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3 Psychological Aspects of Illness



Objectives

The content of this chapter was designed with the aim of introducing the most important psychological aspects of illness to pedagogical students. In this chapter you will learn about the psychosomatic and biopsychosocial models of illness. You will be able to describe the psychological reactions of a person to an illness and the developmental specifics of children with chronic diseases. You will be able to characterise the upbringing and educational activities of children with illnesses.



Terms to Remember (Key Words)

- psychosomatics
- chronic disease
- progressive disease
- biopsychosocial model
- recurrent disease

3.1 Psychosomatic and Biopsychosocial Models of Illness

Each illness has a biological, psychological and social component, and these three together determine the course of the illness and its treatment.

Discovering the connections between a person's psychological experiences and their reflection in somatic diseases developed in two primary areas in the past century: in **psychoanalysis** (psychoanalysis had a dominant influence on psychosomatics between the 1920s and 1950s) and with respect to the **theory of stress**.

Through **behavioural medicine**, cognitively and behaviourally oriented health psychology asserted itself in the 1980s, following the foundations of the theory of stress and focusing primarily on lifestyle factors with respect to illness.

Tendencies toward the **development of a psychosomatic model** became official in 1939 with the publishing of the first issue of *Psychosomatic Medicine* magazine, which included the mission statement of psychosomatics, the essence of which can be summarised below:



- psychosomatics focuses on a psychological approach to medicine,
- it is interested in the relationship between emotional life and somatic processes,
- it claims that there is no 'logical' distinction between the body and the soul,
- it focuses on finding connections between psychological and physiological processes,
- psychosomatics is a new discipline, but also a component of each medical specialisation.

Psychosomatic models can be divided into specific and non-specific, according to whether they acknowledge the existence of particularly defined psychological agents that can be considered the cause of some somatic diseases (Mohapl, 1992).

Specific psychosomatic models assume that a particular psychological characteristic of an individual inevitably leads to a certain illness. This model was developed primarily in the 1950s:

- Helen F. Dunbar described typical personality profiles for individual groups of illnesses.
- Franz Alexander focused on the connection between various types of intrapsychic conflicts and particular somatic diseases.

Dunbar and Alexander were instrumental in founding systematic psychosomatic research, which they developed at a medical school in Chicago in the United States. They created a solid foundation for psychosomatics, both for further research and for clinical practice. Even contemporary authors keep on returning to them. However, the truth is that the intensity of the impact of psychoanalytical thinking on psychosomatics has significantly decreased.

Non-specific psychosomatic models assume that various influences lead to the origination of an illness, i.e. that in various people different psychological aspects can lead to the same illness. Non-specific models are primarily based on the **behavioural disciplines** and the **theory of stress**.

Therefore, from the psychosomatic point of view, an illness does not originate only from the impairment of a person's normal physiology through infection, injury or internal influences, such as genetic endowment. The



formation and onset of an illness is related to the lifestyle and life conditions under which it prepares itself and appears. A physician should not only focus on somatic symptoms, but on the whole person within the context of his/her particular life. The patient is not treated only with a pharmacological preparation or modern medical technologies, but also by the physician as a person.

Physician and psychoanalyst Michael Balint (1957) focused on the relationship between the physician and the patient beginning in the 1940s. In his perception of illness and treatment, he tried to rid the patient of being passively dependent and of transferring responsibility not only for his/her illness but also his/her life to others or to institutions. He encouraged physicians and patients to have an open dialogue. If physicians want to do their work competently under the conditions of an advanced western society, they must understand not only the somatic, but also the psychological components of the illnesses with which their patients turn to them.

In the 1970s G. L. Engel defined a new term, the so-called **biopsychosocial model**, which replaces the term 'psychosomatics' and is currently generally recognised (Engel, 1977):

'All physiological and mental illnesses contain biological, psychological and social factors which we have to pay attention to if we want our intervention to be effective.'

In the current scientific model, illness is perceived as a **multifactorially** conditioned phenomenon, i.e. various agents contribute simultaneously to the development of an illness.

3.2 Psychosomatic Disorders in Children

In the 20th century there was an effort to classify some diseases as psychosomatic as opposed to other ones that were called somatic. This traditional, strict differentiation between illnesses becomes blurred from the point of view of the biopsychosocial model. Instead, one can distinguish to what extent and how diverse somatic, psychological and social factors contribute to the origination and course of each disorder.

Therefore, the term '**psychosomatic disorders**' is not used for a clearly defined group of illnesses, but is used in cases in which **psychological influences contribute substantially to the cause of somatic problems**. This is more common in some groups of somatic diseases;



in children the psychosomatic model is particularly essential for the following somatic problems (Říčan, Krejčířová et al., 2006):

- seizure diseases, in particular collapses and muscle convulsions without a full loss of consciousness,
- seizure diseases of the respiratory system (bronchial asthma, psychogenic cough),
- impaired thermoregulation (chronic subfebrility and febrile conditions, i.e. frequent and hard-to-explain increased temperature and fever),
- impaired vascular dynamics, in particular migraine headaches,
- impaired gastrointestinal function (non-specific stomach aches),
- impaired excretion without gross neural or organ pathology (enuresis, encopresis, diarrhoea, constipation),
- skin disease, in particular atopic eczema and warts,
- impaired metabolism conditioned by eating disorders (anorexia nervosa, bulimia, obesity).

In children the aforementioned disorders usually have the character of a psychosomatically caused and supported process. However, they also have a somatically pathogenic feature that needs to be mapped, respected and biologically treated. **It is not correct to perceive psychosomatic illnesses as only a psychological issue and downplay the child's problems.**

Some 10% of children who are patients in paediatric practices suffer from psychosomatic disorders, which occur equally in boys and girls.

Stomach aches most frequently affect children between the ages of eight and twelve, with 10–15% of pupils suffering from them. They usually appear in the morning, coinciding time-wise with school time, are usually accompanied by nausea or vomiting, and are often a reaction to the stress experienced at school, before exams, etc.

Headaches are also a very frequent problem in school-age children, with up to 40% of children occasionally suffering from them.

- Chronic headaches affect approximately 5% of school-age children. Most frequently these are tension headaches, with the pain being a



consequence of contracted head and neck muscles, meaning that this is a manifestation of tension as a reaction to stress.

- Children who care very much about their scholastic success usually suffer from headaches. They are performance-oriented, conformist, obedient, ambitious, perfectionist, oversensitive or anxious.
- It is important for parents and teachers to know that it is not that these children use their problems to avoid obligations, but instead that they simply cannot psychologically cope with the stress resulting from the demands placed on them by themselves or their parents. Ambitious parents often place excessive demands on their children with regard to achieving success (Vágnerová, 2004).

The causes of the onset of psychosomatic problems can be seen in the interaction of biopsychosocial factors (Vágnerová 2004):

Biological disposition – one's current physical condition and the tendency toward a certain type of somatic reaction is determined genetically to a large extent, but can also change through experience (regimen, suffered illnesses).

Psychological disposition – determined by the child's personality, his/her tendency toward emotional reactivity and his/her level of resilience against stress.

- People with high self-control and a tendency to **suppress emotions** have a higher tendency to react to stress with somatic manifestations.
- A strong and subjectively important **inner conflict** is a significant cause of the onset of psychosomatic disorders, as the illness is an escape solution on an unconscious level.

Social stressors – in children the most frequent sources of stress are family problems, stress at school and problems in peer relations. In adulthood these are often partner problems and difficulties with social success.

In the **treatment of psychosomatic disorders**, the use of biological means (medication) and psychological means (psychotherapy) is combined. Whether the role of psychotherapy in treating and preventing psychosomatic illnesses is major or supportive depends on the particular composition of factors behind the cause and maintenance of the disorder. It also depends on the damage to an organ and its functioning. As a rule, the respective psychotherapeutic approaches are geared toward the interruption of 'vicious



circles' of the illness, and it is important to recognise which element of the circle is decisive and at the same time influenceable in each particular case. The psychological treatment of a psychosomatically conditioned disorder should at the same time support the healthy development of the child's personality and healthy social interaction (Říčan, Krejčířová et al., 2006).

3.3 Psychological Reactions to a Somatic Disease

Every somatic disease affects a person's psyche: his/her current experiencing, thinking and behaviour.

The **emotional reactions** to a somatic disease may vary (Vágnerová, 2004):

- A serious illness can be perceived as a severe threat that causes **fear** and **anxiety**. These negative emotional experiences are both a reaction to the problems related to the illness and a response to being aware of the threat to one's own future and life.
- The patient suffers from **uncertainty** and does not know exactly what lies ahead. The patient's **worries** have to be listened to and taken seriously; he/she needs to have everything he/she needs to know explained, and one's compassion and support has to be confirmed to him/her.
- A severe chronic disease represents a definite loss of health to which the patient reacts with **sadness** and **mourning**. This is a way to process a loss, and one has to suffer through this experience. This process cannot be sped up and it also makes no sense to suppress the sense of suffering. Only after going through it is the patient able to accept the loss of his/her health and to realistically plan his/her future life taking into account the limitations imposed by the illness.
- Sadness can change into **depression**, and **suicidal tendencies** can appear if a person thinks he/she will never cope with such a loss and that under such circumstances life has lost its meaning.
- Feelings of **helplessness** and **hopelessness** which solidify the conviction of the insolubility of his/her situation may prevail in the patient. If one feels helpless, one falls easily into **apathy** and **resignation** and stops being able to fight the disease. Tiredness and



exhaustion lead to a loss of interest in anything and, in the end, in oneself. A feeling of hopelessness can be a reaction to the total exhaustion of the organism.

- Another emotional reaction, particularly at the beginning of an illness, can be **anger** or **rage**. A person is angry about his/her fate and a situation he/she considers unjust. One vents one's **aggression** on one's environment or on oneself in order to release tension. Aggressiveness is also a manifestation of helplessness and an inability to defend oneself more efficiently.

The rational processing of an illness includes:

1. the initial awareness of one's illness,
2. the need to obtain available information about the illness,
3. consideration of the possibilities of how to resolve one's situation.

The illness represents a complex, stressful situation, and therefore one's rational appraisal is influenced by emotions and there is a higher risk of it being distorted and incorrect. The patient is willing to believe in anything that may bring hope. The appraisal of the cause is often connected with a need to find a culprit, and many times people also blame themselves. Even the interpretation of the course of the illness and the appraisal of the successfulness of the treatment may be incorrect and distorted.

Because of the illness, there is a **change in one's basic psychological needs and values**; the hierarchy of needs and one's current motivation also change:

- Depending on one's health condition and overall exhaustion, the **need for stimulation and new experiences** usually decreases. The patient does not have a great need for new experiences, as he/she does not have enough energy to process them. Stimulus deprivation can occur in patients who have been hospitalised for a long time.
- The patient has the **need to orient him/herself in his/her situation**, to know his/her health condition, to know what will come next, etc.
- There is an increased **need for emotional certainty and safety**.



- The **need for social interaction** may be satisfied with more difficulty, as the patient is more isolated and meets only a limited group of people.
- The **need for self-realisation** also changes due to the illness. The patient gives up his/her original ambitions, as he/she is aware of their being unachievable or because they have lost their earlier value.
- The fulfilment of the **need for an open future** is complicated by a serious illness.

3.4 *Development of a Child with a Chronic Disease*

A **chronic disease** in a child results in severe stress not only for his/her family, but also for the child him/herself. The disease is usually accompanied by pain, treatment procedures and the fear of them, limited movement, separation from the family, isolation from peers, the changed behaviour of the parents as they fear for the child, and feelings of a threat to one's own life (Krejčířová, 1997).

The rational processing of the disease, its causes, course and consequences for future life depends on the developmental level achieved by the child.

- **In children of pre-school age** the rational appraisal of disease is inexact and irrational, as the child cannot understand the essence of his/her disease. He/she has a tendency to look for an unambiguous and comprehensible cause, which many times leads to the idea that the culprit is a certain person or situation, or the child perceives the disease as a punishment for something he/she has done. The thinking of the child is affected by his/her subjective perception of the disease and by how he/she is feeling at any given moment.
- **School-age children** think much more realistically, even though their appraisal of disease is still very much influenced by their experiences at the moment. Their thinking is more logical; the child begins to view the disease as a way an organism functions.
- **In adolescence** he/she already is aware of the fact that everything could be different and begins to understand the possibility of the disease being a future threat (Vágnerová, 2004).

Vágnerová (2004) distinguishes four stages in the **course of the subjective experiencing** of a disease in childhood.



Stage I – First somatic problems – the child does not feel well, can be gloomy and irritated, loses interest in his/her usual activities, and his/her school performance worsens. This stage ends with the identification of a pathological condition; the parents realise that the child is not all right and consult a physician.

Stage II – Disease confirmation and subsequent change in way of life – for the child it is noticeable that the behaviour of the parents and the overall social situation have changed. He/she stops going to school and has to undergo diagnostic and treatment procedures. He/she feels disoriented; based on the parents' reactions he/she is aware of 'something bad going on', but does not know what, as he/she normally does not get any more detailed information.

Stage III – Adaptation to the disease – the child gradually gets used to the change in his/her situation and to the fact that he/she is ill, and learns to live with this restriction.

Stage IV – Additional permanent changes in personality and competences – there are changes in the personality of a child suffering from a chronic disease, as well as long-term fundamental changes in his/her life situation and parental upbringing. The child can be more dependent and less autonomous, and has a different self-valuation. The disease changes the child's lifestyle and restricts his/her opportunities to acquire basic social experience, primarily with regard to his/her peers. It also restricts the possibility of achieving a certain level of performance and of being fully successful at the level of his/her abilities.

In coping with a chronic disease in childhood, one of the most important factors is **parental co-operation** (Krejčířová, 1997):

- the way the parents experience the situation and perceive the disease is transferred to the child,
- one of the most important tasks for the parents is to ensure the child's sufficient motivation to co-operate in the treatment,
- an important condition for good co-operation is the detailed provision of information both to the parents and to the child (as early as pre-school age).

There is a frequent tendency not to talk about the disease with younger children in an effort to protect them from unpleasant facts. The information tends to be put off until adolescence, but this period is



critical in terms of identity formation and the fact of being ill with permanent restrictions toward the future is processed with more difficulties than in the preceding developmental stages.

A chronic disease is often connected with **pain**. Even newborns react to painful stimuli, at first in an undifferentiated manner with diffuse movements of the body and by crying. At around one month, localisation is higher and an obvious anticipatory avoidance of sources of pain appears. Generally it is assumed that the level of pain increases with age (Krejčířová, 1997). The older the child, the wider the possibilities of saying that something hurts and of determining more exactly the intensity of the pain and its location. According to the age of the child, one can apply various psychological techniques for coping with pain, such as muscle relaxation, operant conditioning, bio-feedback, modelling, play therapy, etc. (Mareš, 1997).

3.5 The Sick Child in Terms of Educational Activities

In terms of educational activities, it is necessary to distinguish sick children according to the duration of their disease. **A child with a short-term disease** is fully reintegrated into school education after treatment at home and his/her health condition returns to its original state. Some children are admitted for a short period of time for an acute problem (hernia or appendix surgeries, minor injuries, acute infection). Even after short-term illnesses one has to count on a certain period of convalescence during which the child can have lower performance, is fatigable, etc.

Long-term diseases can be divided into recurrent and chronic. **Recurrent diseases** are those that are repeated at least three times a year. In the interim there are no anatomical or functional changes and the child's health condition is not impaired. Education is complicated primarily by the frequent recurrent absences of the child from school and by physical and psychological weakness. In the interim the child can be overburdened by the necessity to catch up with his/her missed schoolwork.

Chronic diseases are characterised by severe organic or functional changes of the affected organ or system with a long-term course (e.g. asthma, allergy, atopic eczema, diabetes, heart disease). A chronic disease cannot be slowed down, stopped or improved, even with active treatment. With a chronic disease, one can expect consequences in adolescence or adulthood.

There are specific **progressive diseases** during which the health condition deteriorates gradually (progressive muscle dystrophy, oncological



diseases, some cases of cerebral palsies) and as a result school performance deteriorates as well. A child with a progressive disease is under significant psychological strain; the disease has an impact on the functioning of the family and affects the relationship between the parents and the child.

A child with weakened health is in a period of convalescence, has lower resilience toward illnesses, or his/her health condition is threatened as a result of an unsuitable climate or social environment, in particular due to an unsuitable lifestyle and incorrect nutrition. At school, children with weakened health are usually conspicuous by their weaker physique, fatigability, irritability, lack of appetite, sleeplessness and anxiety.

For sick children hospitalised in a medical facility (hospital, children's sanatorium), **special schools** (e.g. a special school at a hospital) are established. These schools provide basic general education to an extent that depends on the child's health condition, his/her treatment regime and the school's material conditions. The didactic work is characterised by the adapted content and method of education and by peculiarities in the organisation of the lessons, as it is usually an incompletely organised school with an ongoing turnover of pupils. After the completion of mandatory school attendance, special schools at a medical facility do not have a duty to educate sick pupils (students). According to their health condition, sick pupils have one to four lessons a day, and the lessons can even be interrupted for a certain period of time. The school's educational activities are fully subject to the treatment regime, for the main purpose of the sick child's stay in the hospital or sanatorium is to be treated and cured (Müller et al., 2004).

The evaluation and assessment of sick pupils is a very responsible and difficult task for the pedagogue at the special school and at the child's proper school. In essence, a sick pupil should be evaluated and assessed for the knowledge and skills shown throughout the lessons like a healthy pupil is. However, in a sick pupil, one must factor in the more difficult health conditions and the increased effort made with his/her weakened health and psychological condition.



Review Questions

1. Explain the basic principles of the biopsychosocial model of illness.
2. Describe a person's psychological reactions to an illness.
3. How does a somatic disease affect a child's development?
4. How does the duration of a disease affect the educational process?





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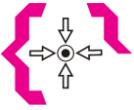
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4 Psychological Issues of a Child with Health Impairment



Objectives

After studying this chapter you will be able to define what health impairment is and to distinguish between primary and secondary impairments. You will learn the respective categories of health impairment. You will be able to describe the psychological changes resulting from health impairment and the developmental specifics of a child with a congenital impairment. You will learn about the issue of psychological adaptations to acquired impairments. You will realise the influence of a child's health impairment on the life of his/her family and on the creation of relationships in the family and on educational attitudes. You will get an overview of the possibilities for educating a child with an impairment and you will be able to describe the advantages and risks of integrating a pupil with an impairment into a normal school.



Terms to Remember (Key Words)

- health impairment
- primary impairment
- secondary impairment
- health disadvantage
- social disadvantage
- pupil with special needs
- integration

4.1 Definition of Health Impairment

Health impairment can be defined as a loss of or damage to a certain organ system. As a result, some standard function or competence is disrupted, restricted or completely missing. From a psychological point of view, it is valid that any impairment will not be manifested only with the disturbed function of one organ system, but that it will affect the development of the whole personality of the affected person. It is important to distinguish between primary and secondary impairments (Vágnerová, 2004).

- **Primary impairment** includes pathological changes that represent a restriction in the development of normal psychological, sensory or motor functions.



- **Secondary impairment** originates as a consequence of various psychosocial factors related to the existence of the primary impairment.

Special education focuses on the upbringing and education of children with health impairment. It distinguishes impairments according to type (Pipeková et al., 1998):

1. **physical**

- a. impaired musculoskeletal system, central and peripheral paralyses, deformation or amputation of extremities
- b. chronic disease, heart disease, allergies, asthma, epilepsy, diabetes

2. **visual** – refraction defects, colour-blindness, nyctalopia, strabismus, amblyopia, dim-sightedness, blindness

3. **auditory** – hearing impairment, deafness, hearing loss

4. **communication disorders** – developmental speech disorders, articulation disorders, speech-flow disorders, etc.

5. **mental disorders** – mental retardation, dementia

6. **behavioural disorders** – asocial and antisocial behaviour

7. **combined, multiple impairment** – two or more impairments

8. **partial impairment** – specific developmental disorders of scholastic skills, minor brain dysfunction, etc.

According to the severity of the impairment, we can distinguish:

- **mild defect** – no immediate threat of disruption of one's relationship with the society,
- **moderate defect** – a threat to social interaction or a social-interaction disorder has already developed,
- **severe defect** – the disorder results in the loss of social interaction.

If the impairment stops being a personal issue and acquires a social dimension, this is reflected in functional and mental performance disorders and disorders in one's relationship with oneself and with one's environment. The



goal of special education is to achieve the maximum level of the affected or disadvantaged individual's personality development and to reach the maximum level of socialisation.

4.2 Psychological Changes Stemming from Congenital Impairment

The **influence of the environment** is important for the development of the individual. As a result of the restrictions imposed by the health impairment, the external environment acts differently than if the child were completely healthy. Due to the impairment, some competences cannot develop in the same way, but within the framework of compensation there will be greater development of other skills. The **personality development** of a child with health impairment depends on his/her acceptance by the parents, on the manner of his/her upbringing, on the amount of contact with other people, and on the possibility of acquiring various social roles. Deviations in the **development of socialisation** belong to the category of secondary impairment, because they depend on the behaviour of the family and the wider society toward the affected child. When a child's upbringing is inadequate, inappropriate dependence on parents, self-insufficiency, egocentrism, feelings of uncertainty and inferiority, etc. may persist in the impaired child (Vágnerová, 2004).

In general one can say that **health impairment changes the course of the child's cognitive, emotional and social development.**

From the viewpoint of Erik Erikson's theory of psychosocial development, the **emotional maturation** of a child with health impairment logically proceeds differently. Each of the eight developmental stages represents a specific developmental conflict between two tendencies, positive and negative. The successful resolution of this conflict is a condition for successful development in the subsequent stages. An individual with health impairment has a more difficult path toward achieving positive tendencies when resolving his/her developmental conflicts.

- In the first stage a child has to acquire **basic trust** in life and defend him/herself against threatening feelings of mistrust. Children suffering from diseases that cause them pain and who are removed from the continuity of motherly care and separated from their family acquire this trust with more difficulty.



- In the next stage it is important to acquire **autonomy**. Health impairment places fundamental obstacles in the way of the achievement of free movement and self-sufficiency, and on the acquisition of independence from the help of others in general.
- During the pre-school years a child with impairment has a more difficult path toward exercising his/her own **initiative** due to the restricted possibilities of free play. Often, after repeated experiences of unsuccessful initiative, he/she becomes anxious and withdrawn. Another possibility, as a result of being spoiled or of a mental deficit, is that he/she has an insufficiently developed awareness of the rules dictating his/her activities, cannot respect borders, and thus has a more difficult time integrating him/herself into peer relationships.
- School-age children with health impairment are able to resist feelings of inferiority only with difficulty, because even with maximum **effort** they cannot achieve the same success and appreciation as their healthy classmates.
- During adolescence the creation of **identity** is essentially threatened – it is more difficult to accept gender roles and body maturation and appearance, and to choose a professional orientation.
- Achieving **intimacy** in young adulthood, fulfilling the need of **generativity** in adulthood, and subjective satisfaction with one's life, so-called **integrity**, in old age are also more difficult.

Knowing Erikson's theory of psychosocial development enables educators (parents and teachers) to provide targeted assistance to the child with regard to creating positive tendencies when resolving development conflicts and overcoming obstacles to their achievement along the way.

A pupil with health impairment can be more mistrustful and more sensitive to disappointment. In such cases one must make an increased effort to create a relationship of trust. We therefore strengthen the child's autonomy, do not do things for him/her that he/she can do him/herself, and do not make decisions about him/her without his/her involvement. We look for possibilities for him/her to exercise his/her initiative and free activity. We appreciate the pupil's efforts and encourage him/her toward outcomes that could strengthen his/her self-confidence. We expand the possibilities for acquiring various social roles that he/she can add to his/her own identity.



4.3 Psychological Adaptation to Acquired Impairment

The reaction to health impairment acquired during one's life, which means a severe emotional trauma for an individual, develops in four stages:

1. **Insufficient information awareness** – the person knows he/she e.g. suffered an injury and is in hospital, but does not know exactly what has happened and what consequences it will have. His/her objective is full recovery; he/she has not been provided enough information about his/her condition.
2. **Comprehension of the traumatising reality** – the person is informed by a physician, or gradually is aware on his/her own, that he/she will probably never fully recover. The reaction to this fact is shock and a tendency to deny reality.
3. **Protest and bargaining** – the person considers life as an impaired individual unacceptable and only gradually reconciles with his/her condition; at the same time, he/she bargains with fate and tries to preserve hope for a better, sometimes even unrealistic result.
4. **Gradual adaptation** – the person learns various compensation methods of movement, self-sufficiency and orientation in the environment. Only in this period do the majority of people with acquired impairment admit to themselves that there has been a permanent and fundamental change in their competences.

A person with acquired impairment has to find new meaning in his/her life, a new goal he/she can strive toward. He/she returns to the society, among friends, but under different circumstances, in a different position. The situation requires the definition of a new identity, an understanding of who he/she is now. To be able to overcome all restrictions, he/she needs to build new self-trust and an acceptable self-concept.

Many well-adapted people with acquired impairment who have coped with this strain have perceived their difficult situation as a challenge. Their problems took on the meaning of an incentive to look for a new solution and were a stimulus for personality development. However, this transition does not always happen, as people can succumb to their troubles and their personality changes in a negative way. Even after a certain period of time, some disabled people do not feel happy; many feel lonely and isolated and suffer from depression and their situation (Vágnerová, 2004).



The main goal of the techniques for coping with a crisis situation resulting from acquired impairment should be the reduction of any feelings of helplessness and the development of a feeling of realistic competence (Mohapl, 1991).

4.4 Influence of a Child's Health Impairment on Family Life

4.4.1 Family Reaction to a Child's Serious Diagnosis

At first the diagnosis causes shock, sadness and anxiety in parents and leads to the rapid development of defence mechanisms. Each family member gradually copes with the fact of the disease in their own individual manner; however, the majority of parents go through a host of emotional reactions in the following stages (Krejčířová, 1997):

1. **Shock**, with irrational thoughts and feelings, with the parents experiencing feelings of derealisation and confusion and having a tendency to react completely inappropriately.
2. **Denial**, manifested by the belief that 'this is not true' or 'there must be some miraculous medication'.
3. **Sadness, anger, anxiety and feelings of guilt**, which are also reflected in an effort to find the culprit, aggressive behaviour, being angry with the whole world and oneself. Furthermore, reactions at this stage also frequently include profound sadness, self-pity, and feelings of guilt in particular which are present in up to 25% of parents.
4. **Balance**, in which there is a decrease in anxiety and depression and an increase in the acceptance of the situation and parental effort to take care of the child and to actively contribute to his/her treatment.
5. **Re-organisation**, in which the situation is accepted by the parents who are coping with the fact of the disease and are looking for an optimum path toward the future. The last stage of re-organisation is not always achieved by all parents, and therefore one has to count on the parents showing an ambivalent relationship toward their child and the entire situation even after a longer period of time (months, even years). If the initial psychological defensive reactions are not overcome, the entire family system's balance will be disrupted and the child will not receive the care and support he/she needs.



4.4.2 Family Adaptation to Caring for a Child with Impaired Health

Ideal family adaptation means the organisation of family life to fulfil not only the needs of the child, but also of all other family members (Krejčířová, 1997). One can expect that the parents of a child with health impairment will have more difficulty preserving a balanced and consistent approach to his/her upbringing. The majority of studies (Langmeier, 1982, cited in Pešová and Šamalík, 2006) hint at the fact that **parents of children with health impairment more often adopt extreme attitudes toward upbringing**, either in the form of hyper-protection or emotional rejection, or alternate between emotional rejection and an effort to make up for it through excessive indulgence.

Hyper-protection – excessive focus on the affected child and his/her protection threaten the child's development, which should be directed toward autonomy. Hyper-protection strengthens the child's feeling of being different from his/her peers and increases his/her anxiety.

Emotional rejection – the parents feel that their child causes them many problems, and irritability and even explicit rejection are reflected in their relationship with the child. They might not be aware of their rejection of the child, and this rejection can be manifested by touchiness, impatience and excessive demands. In many cases this can result in child neglect and child abuse.

Ambivalent attitude – the aforementioned extreme attitudes often mingle and take the form of ambivalence: impatience and hostility are followed by feelings of guilt and an effort to make up for them through warmth and compliance. Sometimes the ambivalent attitude is expressed in different parental expectations – the hyper-protective attitude of the mother contrasts with the rejection or indifference of the father.

4.5 Child with Health Impairment in a Normal School

4.5.1 Possibilities of Educating a Pupil with Health Impairment

For the purposes of the Education Act (561/2004 Coll.), **pupils with special educational needs** in the Czech Republic are divided into three categories according to their diagnoses:

- **health impairment** – mental, physical, visual or hearing impairment, speech disorders, multiple impairment, autism, developmental disorder of scholastic skills, or behavioural disorders,



- **health disadvantage** – weakened health, long-term disease or minor health disorders leading to disorders of scholastic skills and behavioural disorders that require being taken into account during education,
- **social disadvantage** – family environment with low social and cultural status, child threatened with socially pathological phenomena, ordered institutional education or imposed protective education, status of asylum seeker.

These pupils **are entitled to special education**, which can take the form of (Decree 73/2005 Coll.):

1. integration into a normal school,
2. education in a school set up separately for pupils with health impairment.

Health-disadvantaged and socially disadvantaged pupils are educated in normal schools.

For pupils with health impairment, one can choose between integration and education in a special school.

Integration into a normal school can take the form of:

- individual integration,
- group integration (establishment of a special class in a normal school or of a study group within a class).

Pupils with special educational needs are entitled to supportive measures: special methods, forms and guidelines; special textbooks and didactic materials; compensation aids; inclusion of subjects of special-education care; provision of pedagogical-psychological services; services of a teaching assistant; lower number of pupils.

The implementation of the integration of a pupil with health impairment into a normal school imposes specific demands on the teacher, who usually does not have the possibility of close co-operation with experts (speech therapist, psychologist, and physiotherapist) as is the case in special schools. Expert consulting can be found at **school counselling facilities**, which include (Decree 72/2005 Coll.):

- special-education centres



- pedagogical-psychological counselling centres

4.5.2 Pedagogical-Psychological Aspects of Integration into a Normal School

Integration is generally perceived as a dynamic, gradually developing phenomenon in which the co-existence of the impaired and the non-impaired occurs at the level of mutually balanced adaptation. Integration takes place with the affected person's active participation for the duration of his/her life (Michalík, 2000).

Integration entails risks to which the teacher should pay attention. Integration into a normal school represents a stressful situation which might not be managed by the disadvantaged child or his/her teacher or classmates (Vágnerová, 2004):

- In the life of a child with impairment, starting school is an event that is in many cases related to the so-called **first crisis of identity**, as his/her arrival in a group of healthy peers confirms the permanence and constancy of his/her disadvantage.
- **The attitude of the teacher toward the child with impairment** can be different than that toward others. The teacher is aware of the different possibilities of the child with impairment and therefore may have a tendency to lower his/her demands and assess his/her schoolwork more tolerantly, which, in essence, is a manifestation of a hyper-protective attitude. As a result, a child with impairment can develop distorted ideas about his/her abilities and can overestimate him/herself.
- **Healthy classmates** represent a specific reference group for the affected child, from whom he/she is different and who represents insurmountable competition for him/her, at least in certain areas.
- A child with impairment is often forced into the **asymmetric role of a classmate with impairment** who needs to be protected because he/she is ill, and for the same reason he/she is not considered to be completely equal. He/she thus acquires a position on the edge of the class which is related to the higher tolerance of his/her manifestations, but also to his/her lower appraisal.
- At school the child obtains his/her **first significant experience with the manifestations of common attitudes toward people with**



health impairment. The behaviour of classmates can be diverse – considerate, positive and accepting, but also condemning and dismissive. A child with impairment can be overlooked in the class and can be isolated or even actively rejected.

Integration must be viewed in terms of the **degree of benefit for the pupil with impairment.** Integration into school is a process, not a state. Just placing a child with impairment into a normal school does not mean that the integration is complete; it is just the beginning and a pre-requisite for the achievement of functional integration. In terms of the integration benefits for the pupil, the following possibilities exist (Bendová and Zikl, 2011):

- **physical integration** – the pupil is formally integrated, but remains isolated socially; his education does not correspond to his/her needs and possibilities,
- **dysfunctional integration** – the school does not meet the pupil's needs in some component or has a negative effect in some area (e.g. the pupil's self-valuation, subjective feeling of satisfaction, absence of success at school),
- **functional integration** – integration benefits unambiguously exceed any integration negatives,
- **ideal integration** – the situation the school is trying to achieve, because it is always possible to improve and change something in an already functional integration. In the child with impairment, it is suitable to identify the risks and potentials of his/her current situation and to determine the ideal state that the school should strive toward.



Review Questions

1. What extreme attitudes toward upbringing are adopted in some cases by the parents of children with impairment? Try to empathise with their situation and find an explanation for the tendency to develop such attitudes.
2. Describe the stages of psychological adaptation to acquired impairment.
3. Suggest educational methods that could help a child with health impairment achieve the developmental tasks contained in Erik Erikson's theory.



4. Look for arguments in favour of the importance of integrating a child with health impairment into a normal school. On the other hand, also describe the risks and disadvantages of such integration.



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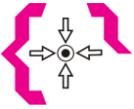
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Decree no. 73/2005 Coll., on the education of children, pupils and students with special educational needs and children, pupils and students who are exceptionally gifted

Act no. 561/2004 Coll., on pre-school, basic, secondary, tertiary professional and other education (the Education Act)



5 Child with a Physical Disability



Objectives

After studying this chapter you will be able to define what a physical disability is and to classify its types. You will get an overview of the differences in the development of a child with a congenital physical disability. You will become aware of the problems that originate as a result of a physical disability acquired during a later stage of development. You will be able to specify the demands related to educating a pupil with a physical disability.



Terms to Remember (Key Words)

- physical disability
- paralysis
- deformation
- malformation
- aesthetic handicap
- somatopaedia

5.1 Definition and Classification of a Physical Disability

A child with a physical disability is a child with a defect of the musculoskeletal system, i.e. the bones, joints, tendons, muscles and vascular supply, as well as with damage to or a disorder of the central nervous system, if manifested by more permanent movement disorders.

According to the time of origination and the basic cause, we distinguish (Müller et al., 2004):

- child with a congenital physical disability,
- child with an acquired physical disability,
 - after an injury,
 - after a disease.

According to the affected body part, we distinguish (Pipeková et al., 1998):

- **central paralyse**s (e.g. cerebral palsy, spinal palsy, spina bifida, multiple sclerosis),



- **peripheral paralyses** (e.g. an injury to an upper or lower extremity can sever or contuse a nerve on the extremity),
- **deformations** (characterised by the incorrect shape of some body part, e.g. scoliosis),
- **malformations** (pathological development of various body parts, most frequently the extremities),
- **amputations** (removal of a part of an extremity as a result of e.g. injury, malignancy, infection-origin sepsis).

5.2 Development of a Child with a Physical Disability

The time when the physical disability occurred is an important factor in the overall development of the child. In this regard we distinguish (Müller et al., 2004):

- child with a congenital physical disability,
- child with a physical disability acquired early,
- child with a physical disability acquired at a later stage of development.

Congenital disabilities and disabilities acquired early usually act as a limiting factor in the overall development of the child, who has never known what a healthy condition is.

A severe physical disability affects the development of all mental functions from the beginning of life, as it limits the child from acquiring all necessary stimuli and experience. A child with impaired mobility is threatened by **increased stimulus risk** and sometimes also by **emotional deprivation** (Vágnerová, 2004):

In the suckling period the development of cognitive processes is underway within the framework of the entire psychomotor development of the child, and this period is labelled as the stage of sensorimotor intelligence.

- **A complex delay in mental development** results from restricted stimulation and contact with the social environment, however, it usually is not a permanent state. As soon as the motor skills improve, there is a simultaneous improvement in mental functions.



- Motor skills affect **the development of the relationship with the mother** and **social competencies**. If the child's facial expression and the mobility of the upper extremities are impaired, he/she does not react to the mother in the usual way, which results in a decline in motherly care and in the restricted stimulation of the child. Somatic deformation increases the probability that the parents will never behave in a standard manner, and decreases the frequency of contact and cuddling.

In the toddler period and during pre-school age it is difficult for a child with limited motor skills to achieve autonomy, and he/she remains dependent on the stimuli from the immediate environment that are provided by his/her carers.

- The natural **separation process** is interrupted; the inability of independent movement and restricted hand mobility affect the parents' attitude and behaviour; the child is perceived as self-insufficient and can be made so even in areas that he/she could manage on his/her own.

The child's difference is more obvious as he/she gets older, and his/her contact with his/her peers cannot develop at an equal, partner-like level. **During school age**, the problems resulting from the limited possibilities of becoming autonomous and from breaking away from the dependence on the family persist as well.

A physical disability acquired at a later stage of development creates problems with dependence as of that period. In older children (mainly in adolescence), a motor disorder causes apathy at first and major affective lability later. As opposed to a disability acquired at an early age, in an originally healthy child a physical disability causes a crisis ('shock from knowledge'). However, in these cases, knowing that one was previously healthy leads the individual to try to conquer the handicap caused by the motor disorder with a more intense effort than that of an individual with a congenital physical disability or with a physical disability acquired early (Müller et al., 2004).

A physical disability represents a major **social disadvantage**; an individual with a disability often causes extreme attitudes in his/her environment (Vágnerová, 2004):

- can be isolated or rejected in the society,
- on the other hand, tends to be protected more often.



Neither of the aforementioned possibilities tends to be acceptable for people with a physical disability, as it functions as a confirmation of their lower social status.

A physical disability is also an **aesthetic handicap**; particularly during adolescence one can become frustrated with the necessity to cope with one's being different.

5.3 Educating a Child with a Physical Disability

Somatopaedia, a discipline of special education, focuses on the upbringing and education of individuals with a physical disability.

The upbringing and education of children with a physical disability follow these basic objectives (Müller et al., 2004):

- providing such conditions to children with a physical disability to receive an education and upbringing equal to the healthy population,
- enabling individuals with a physical disability to work according to their abilities so that they can become full citizens.

Special schools for pupils with a physical disability differ from normal schools in the following ways (Müller et al., 2004):

- adapted work environment,
- low class size with a consistently individual approach,
- didactic technique,
- creation of special-education documentation,
- modification of curriculum content,
- use of special aids and equipment.

When educating a child with a motor disorder it is necessary to respect the changes in his/her motor activity, with special attention paid to the so-called motor routine.

A **motor routine** is an organisation of the child's motor activity in which activities that could worsen his/her health condition are restricted and activities that promote overall motor improvement are deliberately introduced.



According to the health condition, one can distinguish different **degrees of a pupil's motor activity** (Müller et al., 2004):

- he/she can carry out motor activities in the right amount and selection,
- he/she can move outdoors and focus only on simple motor activities, such as games, strolls, etc.,
- he/she can move indoors and focus on activities within the framework of such possibilities,
- he/she can sit and focus on appropriate activities (of a graphical, artistic or practical character),
- he/she has to lie down, but can also carry out simple graphical work to a limited extent and using technical aids,
- he/she has to lie down, but can be educated primarily via visual and auditory stimuli,
- he/she has to lie down at complete rest and cannot be given educational tasks in this condition.

The provision of appropriate complex care for children with a physical disability overlaps into many areas. Education is an integral part of these children's **comprehensive rehabilitation**, and therefore it is necessary for the teacher, in co-operation with other experts, to know the findings and methods from a whole range of disciplines and to apply them in his/her work.

More broadly, rehabilitation is perceived (according to the WHO definition) as the combined and co-ordinated use of medical, social, educational and work-related means in order to train or re-acquire as high a degree of functional ability as possible.

Caring for a pupil with a physical disability, also in a normal school, requires the provision of comprehensive activities, not only of education.

The activities carried out by the teacher are usually based on physiotherapeutic concepts. The pre-requisites for their integration into comprehensive care at school are the knowledge of them among pedagogues, acceptance of the necessity to add them to the activities at school, and at least elementary competence for their practical implementation. The approaches that can be used at school include (Zikl, 2011):



- tactile and vibratory stimulation,
- vestibular and proprioceptive stimulation,
- fitness exercises,
- balance exercises,
- passive exercises,
- forced use,
- breathing exercises,
- relaxation activities.



Review Questions

1. What types of physical disabilities do we distinguish?
2. What impacts does a severe congenital physical disability have on a child's development?
3. What attitudes does an individual with a physical disability usually cause in his/her environment? Try to emphasise with his/her situation and imagine what behaviour by people around you would be acceptable to you.
4. Describe the demands related to the education of a pupil with a physical disability.
5. Explain the term 'comprehensive rehabilitation'.



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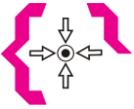
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6 Child with Visual Impairment



Objectives

After studying this chapter you will be able to define visual impairment and classify its types. You will get an idea of the differences in the development of a child with visual impairment. You will be able to specify the demands related to educating a pupil with visual impairment.



Terms to Remember (Key Words)

- dim-sightedness
- residual vision
- blindness
- typhlopaedia
- ophtalmopaedia
- visual hygiene

6.1 Definition and Classification of Visual Impairment

Visual impairment can be defined as the absence of or insufficient quality of visual perception (Müller et al., 2004).

Visual defects can be classified **according to the type of visual impairment** (Pipeková et al., 1998):

- loss of visual acuity (refraction defects),
- impaired peripheral vision (scotoma, tunnel vision),
- oculomotor disorders (strabismus),
- problems processing visual stimuli (cortical blindness),
- colour sensitivity disorders (colour blindness).

According to the degree of visual impairment, we can distinguish dim-sightedness, residual vision, and blindness.

Dim-sightedness is a condition characterised by lower visual acuity in both eyes, even with the aid of glasses; according to the degree, we distinguish minor, moderate and severe dim-sightedness.



Residual vision is determined when one's eyes have reached the lower limits of visual perception. For instance, a person with residual vision can read poster-size type, but spatial orientation using vision is usually impossible.

Blindness is an inability to perceive things visually, even though certain visual perception is preserved (light perception). Accordingly, profound blindness (preserved light perception) and total blindness (complete lack of vision) are distinguished.

6.2 Development of a Child with Visual Impairment

The main differences in the **development of children with congenital visual impairment** are manifested during early age and pre-school age. The process of maturation and learning without the participation of vision is difficult and significantly different from the developmental process of non-impaired children. Therefore, it is particularly important to deliberately stimulate residual vision already in early childhood.

The visual analyser feeds stimuli to the brain during vigilance practically all the time, and thus not only supplies information about the surrounding world, but also activates the CNS. In children with severe visual impairment, the overall **rate of CNS activation is lower** and without the purposeful inducement of activation by tactile, kinaesthetic and other stimuli, the child can give the impression of being apathetic or mentally retarded.

Children with severe visual impairment often **complement the need for stimuli** with their own available means, such as swaying, rocking, hopping and eye-pressing.

It is important not to classify these manifestations negatively as purposeless auto-stimulation or as a consequence of social deprivation. This stimulation appears in children even with demonstrable good care and often lasts until the child is able, based on social learning, to comply with the demands of his/her environment and to control him/herself.

The development of soft motor skills and independent movement in children with severe visual impairment depend on appropriate educational leadership. Neither auditory nor tactile perception has such an effect on the development of motor skills as vision. Sight motivates the child to grasp objects and to move towards visible targets. The psychomotor development of blind children depends to a great extent on their development of the co-ordination of hearing and soft motor skills.



- At first, blind children reach for objects that have touched their hand.
- Only later do they learn to use auditory and movement cues. **Grasping according to an auditory cue** only appears in the last quarter of the first year of age and is an important milestone in the development of the child to discern objects, to grasp objects, and to follow a sound.

Similarly to seeing children, **understanding of object permanence**, **understanding of object relations** and **conceptual development** are important milestones in the **development of thinking** and **speech**. Only if the child is able to overcome his/her dependence on immediate percepts can he/she, to a certain extent, overcome his/her visual impairment.

- The **development of speech in the first year of life** depends on the amount of stimuli coming from one's environment. Even if children with severe visual impairment lack the reinforcement of visual imitation, no significant delay is usually present during this period.
- During further development, **specific differences appear in expressive language**. In children with visual impairment, vocalisation and speech serve not only for communication, but also for understanding the concept of space. Compared to their seeing peers, blind children experiment more with voice, melody and rhythm. It takes them longer to switch to grammatically correct sentence construction. They use words and phrases with distorted content or without understanding their content.
- The number of words a child hears around him/her is linked to visual experience, and a child with visual impairment does not manage to acquire his/her own sensory experience. Blind children often repeat what they have just heard.

Blind children have restricted possibilities when it comes to starting spontaneous non-verbal **communication**. Because eye-to-eye contact is missing, it is harder to understand the child's signals.

For instance, a blind child usually quiets down and subdues his/her activity when his/her mother speaks aloud or is doing some activity close to the child. This can be erroneously interpreted as a lack of interest, yet it is a manifestation of concentration.



It is very important to help the child's parents to gradually learn to understand their child's communication signals and to succeed in using a different system of communication with their child (Pihrtová, 1997).

6.3 Educating a Pupil with Visual Impairment

The discipline of special education that focuses on the issue of the upbringing, education and development of people with visual impairment has several names in the Czech Republic (Pipeková et al., 1998):

- **Typhlopaedia** represents pedagogy for blind people.
- **Ophthalmopaedia** covers the broader issue of people with visual impairment, because apart from blindness there are other categories of defective vision
- **Optopaedia** deals with the development, upbringing and education of people affected by visual disorders.

In English, the following terms are commonly used:

- visual impairment,
- special education for the blind and partially sighted.

When educating **dim-sighted pupils**, one has to protect as well as develop the impaired visual functions. The basic principle is to adhere to the principles of **visual hygiene**, i.e. to create the optimal conditions for visual work through the intensity of light, the adaptation of the workplace, the use of optical corrective aids, reducing the level of strain, etc. (Müller et al., 2004).

At special and normal schools, **blind pupils** need an individual approach from the teachers, more time to fulfil their tasks, the transcription of printed writing into Braille, and a host of special aids.



Review Questions

1. What degrees of visual impairment do we distinguish?
2. Describe the specifics of mental development in children with visual impairment.
3. Name the principles of visual hygiene.
4. Think about the reasons why visual perception is very important for people in our society.



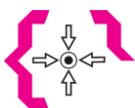


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7 Child with Hearing Impairment



Objectives

After studying this chapter you will be able to define hearing impairment and to classify its types. You will get an overview of the differences in the development of a child with hearing impairment. You will be able to specify the demands for educating a pupil with hearing impairment.



Terms to Remember (Key Words)

- hearing impairment
- deafness
- hearing loss
- pre-lingual impairment
- post-lingual impairment
- deaf education

7.1 Definition and Classification of Hearing Defects

A hearing defect can be (Pipeková et al., 1998):

- **congenital** – hereditary or as a result of negative factors during pre-natal development,
- **acquired** – as a result of complications during childbirth, after infectious diseases in childhood, after head injuries, etc.

According to the severity of the hearing impairment, hearing defects are classified as:

- **hearing impairment**



- **minor** (hearing loss of 20–40 dB)
- **moderate** (loss of 40–70 dB)
- **severe** (loss of 70–90 dB)
- **deafness**
 - **total** – complete loss of hearing
 - **profound** – only with **residual hearing**
- **hearing loss** – a condition in which hearing loss occurs during one's life

7.2 Development of a Child with Hearing Impairment

The secondary consequences of hearing impairment do not depend only on their degree and severity, but also on the time they occurred. The acquisition of language is an important factor (Vágnerová, 2004):

- **pre-lingual** impairment, occurring before the age of three to four, severely impairs a child's overall development,
- **post-lingual** impairment, sustained after the acquisition of language, allows the child to preserve his/her spoken-language abilities.

In a newborn child, the auditory system is already created, but the ability to hear only develops during the entire first year of life during interaction with the environment. Even a non-hearing suckling baby babbles and uses baby talk, but between the 17th and 26th week these manifestations disappear, as the child does not hear his/her voice. A hearing suckling at first reacts to any sudden and loud sounds he/she is startled by. After half a year, the child begins to react to a growing number of quiet sounds and turns his/her head or entire body to find out where the sound is coming from. From the first months of life, the basics of communication are created between the child and his/her parents. At the time when the child begins to put his/her first words together, he/she already has great experience with listening to spoken language. A non-hearing child does not have this experience.

The most serious consequences affect children with a **congenital hearing defect** or with a defect acquired early, for spoken language cannot develop spontaneously. This **impaired speech development** then negatively affects the development of all cognitive processes and socialisation.



The development of **thinking** is based primarily on particular activities (manipulation of objects, observation). The path towards forming general concepts and abstract thinking is more difficult.

Poor vocabulary makes **reading comprehension** more difficult. Studies have shown that graduates from schools for the deaf are on average at the reading level of a hearing child in the third grade of primary school. They have problems with content and grammatical structure (Vymlátilová, 1997).

Hearing provides the non-stop contact of the child with his/her environment and the non-stop reception of information. A non-hearing child is deprived of the possibility of random, unintended **learning**. If he/she is not looking, he/she has no information. He/she misses the continuity of the happenings around him/her, and that has significant consequences on understanding events and anticipating the future.

Limited communication possibilities are negatively reflected in the **socialisation** of the child. A non-hearing child has difficulty understanding the motives for the conduct of other people and finds it hard to orient in interpersonal relations. He/she has fewer opportunities to acquire meaningful social experience, cannot hear the emotional tone of spoken language, and depends on the understanding, awareness and conduct of the persons close to him/her.

When adult non-hearing people talk about their childhood experiences, they find out that they have had similar, often hurtful experiences. In childhood they often did not know what other family members were talking about and felt alone and separated from family life. They had a feeling that the parents preferred to speak more often with their hearing siblings. (Vymlátilová, 1997, p. 90)

The impact of deafness on communication is often the main cause of **emotional and behavioural disorders** in the non-hearing. They occur particularly if the child is repeatedly frustrated because he/she does not experience satisfactory communication with loved ones. Parents also suffer from the lack of communication with their child.

The emotional life of the child is also negatively affected by the fact that he/she, for instance, goes to a boarding school for the hearing impaired and thus lives outside his/her family. **Emotional** and **stimulus deprivation** affects the maturation of the personality and influences family relations. They suffer bilaterally from a lack of jointly experienced everyday joys and worries.



This situation is different in **non-hearing families** in which the parents consider their non-hearing child fully normal, and therefore see no problem in his upbringing. Very soon they establish natural contact with the child through sign language, which allows a strong emotional bond to develop (Vymlátlová, 1997).

7.3 Educating a Child with Hearing Impairment

Deaf education, a discipline of special education, deals with the upbringing and education of a child with hearing impairment.

For the child's education and socialisation, it is important whether or not he/she can **use residual hearing** and can master a certain **system of communication**. The starting point for a child's orientation vis-à-vis residual hearing is he/she being equipped early with hearing aids.

Focusing on residual hearing is important because a high percentage of hearing-impaired children (over 95%) can more or less use it. The effectiveness of this approach is linked to the early detection of a hearing defect at an early age.

The use of residual hearing is closely connected to the **formation of spoken language**. The ability to express oneself through spoken language constitutes the most natural bridging of the communication gap for people with hearing impairment. It is necessary to train the voice through appropriate exercises starting at an early age. Articulation and breathing must be trained. If the voice aspect is not attended to in a timely fashion, voice deformations remain permanent, articulation is inexact, and the rhythm, melody and dynamics of spoken language are impaired. An unnatural voice sounds conspicuous to the social environment, which has negative socialisation consequences for the child. Family members supervised by an expert tend to the development of the child's voice during the early-age and pre-school periods.

For instance, if the child's voice is not forming naturally, his/her mother puts the child's hand on her chest or under her chin and imitates the child's voice. During this incorrect formation, she shakes her head 'no' to say that this is not good. Then she speaks in a natural voice and lets the child feel it. The child uses one hand to perceive the vibrations of his/her mother's voice and lays the other hand on his/her own chest for comparison. A joyous expression



on the mother's face lets the child know when his/her voice formation is correct.

In children with hearing impairment, spoken language is developed content-wise, grammar-wise and articulation-wise. **Dactylology** (fingerspelling) and **lip-reading** (perception of spoken language by sight and its comprehension according to lip movements) are used as auxiliary methods when using spoken language.

Among the **non-verbal methods of communication** used by people with hearing impairment is sign language, which is used particularly by non-hearing people among themselves. **Sign language** has its own syntax and grammar different from spoken language.

When communicating with a person with hearing impairment, one should adhere to the following recommendations (Pipeková et al., 1998):

- Never approach a person with hearing impairment from behind or from the side. Our face has to be well visible. In a dim room, we use artificial light. We face the source of light so that the person with hearing impairment is not dazzled by it.
- Throughout the dialogue, we restrict all other sources of sound (we switch off the radio or TV).
- We establish good personal contact and clarify the way through which the person with hearing impairment can communicate with us.
- With people with hearing impairment, we keep a maximum distance of one metre so that they can partially perceive with their residual hearing. For lip-reading, the maximum distance is four metres.
- If they do not understand, we offer the possibility of repeating, we do not show nervousness, and we do not rush.
- Our articulation must be clear, but not exaggerated. Our speech pace should be slower, but not too slow.
- We make short pauses between sentences. We create shorter sentences and use words that are known to the person with hearing impairment.
- After a certain period of time (15–20 minutes), we take a break, factoring in the significant fatigue from lip-reading.



- The most important thing is to empathise with the situation of people with such impairment.



Review Questions

1. What is the fundamental difference between pre-lingual and post-lingual hearing impairment?
2. Describe the specifics of the development of a child with hearing impairment.
3. What principles should be adhered to when communicating with a person with hearing impairment?



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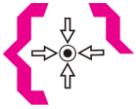
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8 Child with Mental Impairment



Objectives

After studying this chapter you will be able to define mental impairment and classify its types. You will learn about the differences in the development of children with various forms of mental retardation. You will be able to specify the demands related to the education of a pupil with mental impairment.



Terms to Remember (Key Words)

- mental impairment
- mental retardation
- mild mental retardation
- moderate mental retardation
- severe mental retardation
- profound mental retardation
- psychopedics
- Down syndrome

8.1 Mental Impairment

Within the educational practice, **mental impairment** is an umbrella term that **includes practically all pupils whose IQ is below 85**, i.e. individuals with mental retardation (IQ below 70) and individuals with borderline mental retardation (IQ of 70–85). In addition to mental retardation, it also includes the borderline cognitive-social weakening, which puts the affected pupil educated in a normal type of school at a disadvantage (Valenta, Michalík, Lečbych et al., 2012).

8.2 Mental Retardation

Mental retardation represents a congenital impairment of intellectual abilities that manifests itself by an inability to understand one's environment and to adapt to it to the extent required.

There is an inability to achieve an appropriate degree of intellectual development (less than 70% of the norm), even though the affected individual's education was stimulated in an appropriate manner (Vágnerová, 2004).



Mental retardation is a **congenital** and **permanent** condition that continues through adulthood.

Mental impairment is found in approximately 3% of the population; mild mental retardation is most frequent, affecting some 70% of all people with mental impairment.

The cause of mental retardation is **CNS impairment**, which can be caused:

- **by environmental factors** that negatively affect the development of the child during the pre-natal period, during childbirth, or at an early age of up to 1.5 to 2 years:
 - physical (ionising radiation, mechanical foetal damage, lack of oxygen),
 - chemical (medication, alcohol, drugs),
 - biological (viral, microbial).
- **genetically.**

Down syndrome, the most common of all of the known forms of mental retardation, is an example of genetically conditioned impairment. The disease was first described by the English paediatrician John Langdon Down as early as 1866, but the chromosomal origin of the disease was proved only in 1959 when the French researcher Jérôme Lejeune published his findings that these people's karyotype presented an extra chromosome on the 21st pair. Genetically, people with Down syndrome differ from the rest of the population by their cell formation, which includes one extra chromosome, so instead of the common 46 chromosomes in 23 pairs they have 47 chromosomes in each cell, i.e. 22 pairs and three copies of chromosome 21 (Švarcová, 2000).

In terms of impairment severity, several degrees of mental retardation are distinguished. The original names debility, imbecility and idiocy are no longer used in today's expert language and have been replaced by minor, moderate, severe and profound mental retardation.

8.2.1 Mild Mental Retardation

In terms of intelligence, mild mental retardation is within the **IQ range of 50–69**.



The child's overall mental development is delayed beginning in early childhood. At age three, one can already see a one-year delay in development. The delay is manifested primarily in the child's spoken language, social behaviour, level of habits and play, and motor skills (Vágnerová, Šturma and Klíma, 1988).

The characteristics of people with mild mental retardation include:

- In the best-case scenario, adult individuals are able to think at the level of children of middle-school age (11 years); thinking can be logical at the level of individual operations, but they are incapable of abstract thinking.
- Despite their delayed spoken-language development, they can use speech in everyday life and maintain conversation.
- People with mild mental retardation usually achieve complete independence in self-care (eating, bathing, dressing, excretion).
- They are able to learn and to acquire the basics of reading, writing and arithmetic.
- In adulthood they can work, but they need supervision and support.

8.2.2 Moderate Mental Retardation

In terms of intelligence, moderate mental retardation is within the **IQ range of 35–49**.

Early psychomotor development is much delayed, with the first words and the ability to walk appearing up to three to four years later than the norm. Play is routine-like and includes simple tasks, spoken language suffers from agrammatism, vocabulary is deprived of less common terms, and articulation is awkward. The training of common self-care tasks during pre-school age does not achieve the required level (Vágnerová, Šturma and Klíma, 1988).

The characteristics of people with moderate mental retardation include:

- In adulthood, the level of thinking reaches the maximum level of a pre-schooler (6 years of age); thinking is ego-centric, infantile and does not respect logic.
- Memory is mechanical, with a very low capacity, and the acquisition of any skill requires many repetitions.



- Learning is limited to mechanical conditioning and educational progress is limited; people with moderate mental retardation do not acquire basic scholastic knowledge and skills.
- They are educable and can acquire self-care habits and skills; however, they usually do not achieve full independence in this area and require supervision.
- Under leadership they are capable of simple manual work; however, their performance is low in terms of precision and speed.
- In adulthood they do not achieve a fully independent life and require permanent assistance from others.

8.2.3 Severe Mental Retardation

In terms of intelligence, severe mental retardation is within the **IQ range of 20–34**.

From the very beginning there is a marked delay in the child's psychomotor development, with spoken language and walking appearing around the age of six or even later; vocabulary is limited to a low number of expressions that the child uses inexactly, and sometimes the child does not speak at all (Vágnerová, Šturma and Klíma, 1988).

The characteristics of people with severe mental retardation include:

- They think at the level of a toddler and their intellectual abilities do not exceed the level of a two-year-old even in adulthood.
- Learning is significantly limited and requires long-term effort, resulting in mastering basic self-care tasks and fulfilling simple instructions.
- Severe mental retardation often occurs as a combined impairment; there are motor disorders, sensory defects and other defects that indicate damage to the CNS.
- Even in adulthood they are fully dependent on assistance from others.

8.2.4 Profound Mental Retardation

With profound mental retardation the **IQ is 20 or below**. In the majority of cases, profound mental retardation is characterised by:

- combined impairment,



- immobility or significant mobility restrictions,
- negligible or no ability to take care of one's own basic needs,
- full dependence on care by others,
- learning can only be focused on developing the ability to understand and comply with instructions,
- spoken language is not developed,
- cognitive skills are limited to the ability to distinguish known and unknown stimuli and to react to them with pleasure or displeasure.

8.3 Educating a Child with Mental Impairment

Psychopedics is a special-education discipline which focuses on the upbringing and education of children with mental impairment.

There is currently a trend to perceive upbringing and education as an integrated life-long process which includes **all purposeful activities that develop a person's skills** (Švarcová, 2000).

Using this approach, each individual that is able to learn is educable. The task of pedagogy is to find the processes that enable the maximum development of skills, even for children with the most severe degree of mental retardation.

Current trends in caring for people with mental impairment include (Švarcová, 2000):

- **Integration** expresses the society's attitude to people with disabilities. It does not reject them and does not segregate them, but tries instead to create the optimal conditions for their integration into social life.
- **Normalisation** is based on the fact that people with mental impairment have the right to live a 'normal' life like their fellow citizens. This means that they are entitled to live not in an institutional facility but in a family, and can go to school and pursue hobbies, cultural and sports activities.
- **Humanisation** is manifested not only in an attitude that respects people with mental impairment as equal members of the society, but that also respects their rights and human dignity.



Recently the offer of special pre-school and school facilities has been expanded, and there has been an increase in the importance of **special-education centres**, which work on a regular basis and over the long term with the affected child from early age through the completion of school attendance, either in a centre, at school or in the child's family. Care for adults with mental retardation, apart from the family, is offered by day centres and social-care institutions.

The **network of special schools and special school facilities for children with mental impairment** consists of a special kindergarten, a practical primary school, a special primary school, a practical secondary school, and a secondary vocational school. Normal kindergartens, primary and secondary schools can also accept individual pupils and students within the framework of integration or open separate classes for them (Valenta, Michalík, Lečbych et al., 2012).

A **practical primary school** is the most frequented facility for pupils with mental impairment. In this type of school we can also encounter children with mental disorders, scholastic-skills disorders or behavioural disorders. The practical primary school is not significantly different from a normal primary school in its structure, organisation and teaching plans. Its pupils attend it for nine years and the assessment of educational results is expressed by marks, verbal assessments or a combination of both. As opposed to a normal primary school, in this type of school:

- special-education means are used, particularly didactic, diagnostic and therapeutic-formative methods,
- special-education care subjects are added (e.g. individual speech therapy, adapted physical education, sign language),
- pedagogical-psychological services are provided to a larger extent,
- an individual approach is applied, enabled by the lower number of pupils in classes and the provision of a teaching assistant.

A **special primary school** is quite different from a normal school in that it provides education to pupils with a level of intellectual abilities that prevents them from fulfilling the demands of a practical primary school. At this type of school, pupils do not get a basic education, but only the basics of education. Here, an individual approach is used, the lessons are divided into more units, and the main emphasis is placed primarily on the development of communicative, socio-personal and work competences.



The learning ability of children with mental impairment is limited in a variety of ways (Vágnerová, 2004):

- Impaired concentration and memory have an important effect.
- Teaching children with mental impairment is mostly mechanical, based on the creation of associations.
- Acquired information, skills and habits are rigidly fixed; individuals with mental retardation have a problem applying them to new situations.
- Teaching is done at a slower pace, with a need for frequent revision and consolidation.
- Pupils with mental impairment cannot learn and remember purposefully. Remembering is the ability to understand the taught subject matter, to select the basic elements, to find the connections between them, and to integrate them into a certain knowledge set. This is a very complicated activity, even for persons with mild mental impairment.
- The basic lack of thinking in persons with mental retardation – limited or no ability to generalise – manifests itself in their learning by their being unable to internalise rules and general terms. Sometimes they learn these rules by heart, but they do not understand their meaning and cannot apply them correctly. A child with mental impairment remembers more than thinks; thinking is limited to particular situational connections between objects and phenomena, and is poor and unproductive.
- Lower learning effectiveness can be the cause of unnecessary resignation regarding the further development of people with mental retardation. *In many cases, teaching children with mental impairment does not seem effective enough, but its results are very useful in their life, particularly in the field of self-sufficiency. If these people are left without further guidance, they will lose their acquired skills and habits.*
- The motivation for learning depends primarily on the relationship between the person with mental retardation and the teacher or educator, which places demands on the personality of the pedagogue and his/her ability to develop and emotionally warm relationship with pupils with mental impairment.

From the demanding **requirements for a pedagogue educating children with mental retardation** follows the need for good orientation in



didactics, even though it may seem like everyone knows the 'easy' things these children are learning and therefore anyone can teach them. However, the methodological mastering of teaching children with mental retardation how to read, write or count is exceptionally difficult. Practical and special schools have educational programmes available which provide guidelines for the curriculum and the chronology of how the pupils will be taught, and, if needed, also for the creation of an individual educational programme.

The teacher has to use his/her pedagogical skills, and apart from those skills applied in normal schools he/she has to add extraordinary patience, the ability to follow pupils' thought processes, and a high level of empathy.

Usually the teacher or educator has an enormous authority over children with mental impairment, and if he/she is kind to them the children will acknowledge him/her, show their fondness and like him/her very much. Due to their insufficiently developed critical thinking, children with mental retardation are very dependent on the authority of their teacher and are practically helpless against his/her influence, which results in the teacher's high level of responsibility (Švarcová, 2000).



Review Questions

1. What is the difference between mental impairment and mental retardation?
2. Describe the development of a child in terms of the various degrees of mental retardation.
3. What schools usually provide education to children with mental retardation?
4. In what areas is the ability to learn restricted in children with mental impairment?
5. Think about the advantages and disadvantages of integrating a child with mental retardation into a normal school.



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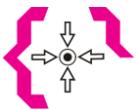
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9 Child with a Specific Developmental Disorder of Scholastic Skills



Objectives

After studying this chapter you will be able to define the basic terms used in special education, to name the causes of specific developmental disorders of scholastic skills (hereinafter 'SDDSS'), to characterise the manifestations of individual learning disorders, and to describe diagnostic techniques. You will learn about learning-disorder therapy and re-education as well as about working at school with children suffering from SDDSS.



Terms to Remember (Key Words)

- ADD
- ADHD
- dyslexia
- dysgraphia
- dyscalculia
- dysmusia
- dysorthography
- dyspixia
- dyspraxia
- etopaedia
- speech therapy
- ODD
- ophtalmopaedia
- psychopedics
- deaf education
- typhlopaedia

9.1 Terms Used in Special Education

SDDSS (SDSS)

Specific developmental disorders of scholastic skills

ICD-10: disorders of scholastic skills

ADHD (Attention Deficit Hyperactivity Disorder)



A specific disorder of behaviour and attention, hyperactivity with impaired attention. It manifests itself with a developmentally inappropriate degree of attention, hyperactivity and impulsivity. (Barkley – with or without aggressiveness)

ADD (Attention Deficit Disorder)

An attention deficit disorder without hyperactivity and impulsivity. It is manifested by impaired effective distribution of attention during any mental activity and a slow work pace.

ODD (Oppositional Defiant Disorder)

A specific disorder consisting of markedly defiant behaviour.

Speech therapy

A special-education discipline that deals with the issues (development, upbringing and education) of people with defects and disorders of the communication process.

Deaf education

A special-education discipline that deals with caring for individuals with varying degrees of defective hearing (hearing impairment, residual hearing, deafness).

Typhlopaedia – ophtalmopaedia

A special-education discipline that deals with the upbringing, education and work integration of people with visual impairment.

Etopaedia

A special-education discipline that deals with the upbringing and education of people with behavioural disorders.

Psychopedics

An interdisciplinary field that deals with people with mental impairment and other mental problems.



9.2 Specific Developmental Disorders of Scholastic Skills (SDDSS)

9.2.1 Causes of SDDSS

Biological, chemical or mechanical factors; combinations of several causes.

The most frequent causes include:

Mechanical brain damage; premature birth (insufficiently developed brain cells); complications during pregnancy, birth or immediately after birth; genetic predisposition; mutation of multiple genes; alcohol and drug use during pregnancy; ecological influences (heavy-metal poisoning, polluted air, water, soil, etc.); ionising or X-ray radiation during pregnancy; radioactivity; food allergy.

Usually an unambiguous cause cannot be completely determined.

9.2.2 Basic Classification and Manifestations of SDDSS

Dyslexia

A scholastic-skills disorder in which there is an impaired ability to learn to read using common educational methods.

The disorder affects the speed, correctness and technique of reading and text comprehension.

For instance, the child deciphers letters, spells or reads hurriedly, making up words or suffixes; confuses letters whose shape (b-d-p) or sound (t-d) is similar, but also completely dissimilar letters; uses double reading and is unable to carry out speech-sound synthesis; does not comprehend what he/she has read (reading quotient).

Dysgraphia

A scholastic-skills disorder in which there is an impaired ability to learn to write using common educational methods.

A disorder that affects the graphical quality of one's written expression (legibility and form).

For instance, the child remembers letter shapes badly and has problems imitating them; often scratches out and rewrites letters; handwriting is messy, too small or too large, poorly legible; the pace of writing is very slow and requires a lot of energy, endurance and time.

Dysorthography



A scholastic-skills disorder in which there is an impaired ability to learn grammatical rules using common educational methods.

It is manifested by an increased number of specific dysorthographic errors, troubles mastering grammar, and problems applying grammatical phenomena.

The child has problems distinguishing short and long vowels, hard and soft syllables (di – dy; ti – ty; ni – ny), and sibilants; does not adhere to the borders of written words; omits or adds letters or syllables.

Dyscalculia

A scholastic-skills disorder in which there is impaired acquisition of mathematical skills using common educational methods.

A disorder that affects the ability to manipulate numbers and carry out mathematical operations and that lowers mathematical imagination and the ability to do geometry.

The child has problems mastering mathematical terms and understanding and mastering mathematical operations; confuses mathematical symbols (+, -, ., :, etc.); mathematical logic is often impaired and the child does not understand basic processes.

Types of dyscalculia:

Practognostic dyscalculia – impaired mathematical manipulation with particular objects or drawn symbols, impaired spatial factor of mathematical skills; the child does not recognise the size of objects and geometric figures; has problems tracing figures and placing figures within space when drawing.

Verbal dyscalculia – problems writing amounts and numbers of objects, operational symbols and mathematical tasks; problems with numerical rows, stating the number of objects, etc.

Lexical dyscalculia – the inability to read mathematical symbols; the child confuses numbers of similar shape (Arabic and Roman), cannot read a multiple-digit number, etc.

Graphical dyscalculia – the inability to write mathematical symbols; the child is unable to write numbers in dictation or transcription, confuses the order of numbers, forgets to write zeros; when writing numbers below each other, the child is incapable of writing them aligned according to the order of digits, etc.

Operational dyscalculia – an impaired ability to carry out mathematical operations, e.g. addition, subtraction, multiplication, division and others; the child confuses calculation operations (addition – subtraction), confuses numerators and denominators and double digits and single digits, has problems solving combined operations, etc.



Ideognostic dyscalculia – an impaired ability to understand mathematical ideas and their relationships. The most severe disorder is the inability to count by one; most frequent is an impaired understanding of numerical series, with troubles also arising when trying to solve mathematical word problems.

Dysmusia

A scholastic-skills disorder in which there is impaired acquisition of musical skills.

For instance, it manifests itself by an impaired ability to recognise rhythm, rhyme, melody, etc.

Dyspixia

A scholastic-skills disorder affecting drawing, consisting mainly of impaired spatial orientation, perception of shapes, figures, etc.

Dyspraxia

A scholastic-skills disorder in which there is impaired co-ordination; this is essentially a sensorimotor dysfunction.

It manifests itself primarily in work activities, in the workshop, when cooking, doing handcrafts, etc. This is manual clumsiness. At school, children with dyspraxia have also problems in physical education. They cannot catch a ball, hit the basket in basketball, hit an opponent when playing dodgeball, hit the ball when playing volleyball, etc. They have problems doing somersaults, walking on a bench, and with some gymnastic exercises.

Non-verbal disorder of scholastic skills

A scholastic-skills disorder in which the development of speech is not impaired and vocabulary is not affected, but the use of spoken language is very insensitive and socially inappropriate. The speed of spoken language is average, but with worse comprehension. The lack of a sense of humour is typical; such affected persons do not understand plays on words and metaphors. The characteristic features of this disorder are problems with spatial orientation (ball games, passing the ball) and social orientation (they do not recognise expressions, gestures, accents).

9.2.3 Diagnosing SDDSS and ADHD



Primary school – pedagogical diagnostics

Level of reading, writing, counting, spoken language, concentration, auditory and visual perception, spatial orientation, determination of left and right, rhythm reproduction, and behavioural fluctuation.

Examination by a paediatrician

Vision, hearing, speech, neurological examination – ruling out of an organic cause.

Pedagogical-psychological counselling centre

Medical history;

An interview with the parents – gaining their trust, the attitude of the parents toward the child, method of upbringing, attentive listening;

An interview with the actual child;

An examination by a psychologist – testing intelligence, skills, memory, personality;

An examination by a special educator – level of reading skills – reading quotient; level of writing – graphical, orthographical and content-wise (copying, transcribing, dictation, essay); examination of mathematical skills – pre-numerical ideas (sorting elements according to size, shape and colour), numerical ideas, structure of a number, mathematical operations, mathematical word problems, numerical series, visual and auditory memory for numbers, orientation in time (hours, days, weeks, months, the seasons); level of auditory perception – auditory differentiation of nonsensical words, recognition of the first and last speech sound in a word, auditory analysis and synthesis (starting at the end of the first year of primary school); level of visual perception – Edfeldt's reversal test (differences between pictures); level of right-left and spatial orientation – orientation in a square, orientation on one's own body, orientation on a sitting person facing the examined child, etc.; speech examination – articulation, vocabulary, expressive skills, etc.; level of soft and gross motor skills – stringing beads, beaded pictures, etc., walking, climbing, jumping, etc.

Diagnosing ADHD

At least six of the following symptoms have to appear often and persist for at least six months:

Pays attention to details or makes mistakes caused by neglect;

Has problems focusing attention;

Acts as if he/she is not listening to what is being said to him/her;



Does not work according to instructions, does not finish work, is surrounded by messiness, does not have his/her things arranged neatly;
Has problems organising his/her tasks and activities;
Postpones the fulfilment of scholastic and domestic tasks that require more demanding thinking;
Allows him/herself be distracted by external stimuli;
Is forgetful in daily activities;
Loses things needed for school or other activities.

At least four of the following symptoms appear often and persist for at least six months at a level incompatible with the child's developmental level:

Shakes hands or feet, wriggles in the chair;
Leaves his/her place in the classroom or gets up when he/she is supposed to remain seated;
Runs around (the room, the table, other children, etc.) at inappropriate times;
Is unable to play calmly or do calmer activities during leisure time;
Often blurts out an answer without having listened to the whole question;
Has problems standing in line, and during games or group activities.
The aforementioned symptoms have to be manifested at home, school and other places, respectively.
If they are not, the cause could be incorrect upbringing in the family, inappropriate methods at school, etc.

9.2.4 Therapeutic Methods (SDDSS)

Re-education – multi-sensory approach (vision, hearing, touching, manipulation with elements and objects).

Compensation – audio recordings; writing in block letters, writing on a computer, copying notes; numerical axis, multiplication charts, etc.

Neuropsychological therapy – specific (focusing on the insufficiently developed hemisphere) and non-specific (developing both hemispheres) stimulation of the hemispheres.

Rehabilitation – adaptation of social relations, restoration of impaired practical abilities and skills, self-realisation of the affected person.

Occupational therapy – co-ordination of soft and gross motor skills.

Integration – into a normal class, dyslexic and equalising classes, 'dys' study room, special 'dys' schools, etc.



Modern technologies – EEG bio-feedback.

Medicinal treatment – nootropic substances, sedatives, etc.

The foundation of any therapy is the co-operation of all of the interested parties, namely the family, the school and the pedagogical-psychological counselling centre.

9.2.5 Basic Methods Both in and Outside School

Respect the style of learning.

Give simple, short tasks that can be fulfilled. Increase the difficulty and extent of the tasks only based on the achieved results.

Emphasise quality fulfilment and completion of tasks (more than the child's behaviour).

Provide only several steps of instructions; communication must be understandable (soliloquy).

Positively strive for desirable behaviour and impose only minor punishment. Frequent feedback is important.

Set clear rules; order and structure are important as is the exact determination of what is expected from the child.

Consistency and insistence on appropriate demands are necessary.

Don't use 'you must' – 'you must not'.

Permanently keep the child in touch with the teacher (educator, parent).

Use creative educational methods.

Less writing, less homework.

Don't discuss the appropriateness of behaviour. The limits and rules are unambiguously set by the adult.

Lead the child toward self-control and self-valuation.

In an appropriate manner, tell the pupil's classmates and friends about the essence of his/her troubles; prevent the child's isolation from others.

Use the STOP technique.

Remain optimistic and maintain strong nerves!

An educational advisor will prepare an individual educational plan for pupils with a more severe specific disorder.

The most frequent types of compensation in secondary school:

Choice of the form of examination – oral or written, but also other alternatives: papers, demonstrations, modelling, etc.



More time for doing homework, tests, written work and other papers, e.g. by 25%.

Use of a computer for writing answers, doing homework, etc.

A facilitator – a person reading the text or questions aloud and writing down the answers – may be present during examinations.

The exam or test questions can be in the form of an audio recording.



Review Questions

1. Explain the terms 'ADHD', 'ADD' and 'ODD'.
2. Which special-education discipline deals with caring for individuals with various degrees of hearing impairment?
3. What are the causes of SDDSS?
4. Describe the manifestations of dyslexia, dysgraphia, dysorthography, dyscalculia and dyspraxia.
5. What is the procedure for diagnosing SDDSS?
6. Name at least seven symptoms of ADHD.
7. Describe at least four therapeutic methods for children with SDDSS.
8. What are the basic methods of working with children with SDDSS (not only) at school?



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10 Selected Behavioural Disorders and the Issue of Bullying



Objectives

After studying this chapter you will be able to classify behavioural disorders and to define and distinguish types of lying, truancy, running away and vagrancy. You will learn about bullying, including its definition, its primary characteristics, the factors contributing to its origination, its main participants, etc. You will learn about the categorisation and developmental stages of bullying, its prevention and methods of resolution, bullying in a dyad, bullying of teachers, and cyberbullying. In this chapter the behavioural disorders that the teacher encounters most frequently in his/her practice are described.



Terms to Remember (Key Words)

- aggression
- aggressor
- antisocial
- asocial
- dissocial
- dyad
- etopaedia
- cyberbullying
- lying
- violence
- victim
- ostracism
- strong personality
- bullying
- wanderings
- vagrancy
- running away
- truancy

10.1 Classification of Behavioural Disorders

Similarly to both criminal behaviour and abnormal behaviour that is not considered illegal, behavioural disorders are considered to be social deviations. They therefore include not just criminality, but also other forms of antisocial behaviour. For instance, in addition to theft, bribery, murder, etc., social deviations also include disturbing the peace at school, truancy, etc.

Even within the framework of etopaedia, this issue is most frequently classified under the term 'sociopathological phenomena'.

In general, behavioural disorders can be defined as non-adjustment to a norm or set of norms respected by the majority of people in a given society.



Only such cases of behaviour by children and adolescents in which the individual understands the meaning of the values and norms of the society, but does not accept them or cannot obey them, can be deemed disorders. These behaviours can have different origins: personal motives, a different set of values, or the inability to control one's behaviour due to one's health condition (e.g. brain disease) or alcohol or drug use.

It is not considered a behavioural disorder if the individual is unable, for various reasons, to understand the meaning of the social norms of a given society (e.g. the mentally retarded or people coming from a different social environment, a different culture where other norms apply).

Every society includes individuals and groups whose behaviour is considered problematic by others. A behavioural disorder can therefore be considered only within a social context. The actual norms are also subject to various circumstances, e.g. it is considered acceptable to chew gum at an open-air rock concert but not at an opera performance, or drinking alcohol is tolerated in the evening but considered problematic behaviour early in the morning.

Almost everyone has been in a situation in their life in which they breached social norms (e.g. came late to a meeting, crossed the street on a red light, did not adhere to the speed limit when driving a car, etc.). When analysing behavioural disorders, one of the problems is the definition of normality and the determination of specific and commonly accepted norms. With criminality, the situation is easier in terms of crime, as there are laws according to which a criminal act is assessed and a certain sanction is imposed.

With common behavioural disorders for which norms are not codified it is sometimes difficult to unambiguously determine what norms the group or society recognises. To understand sociopathological phenomena it is necessary to study the normative order in the various structural levels of the society.

Normative systems can even overlap each other. In some behavioural disorders, several norms, e.g. moral, religious, traditional, legal, etc., can be breached at once.

Each society has a certain unwritten and time-varying tolerance limit. For instance, in terms of alcohol, the limit fluctuates between a strict ban (punished by legal or religious norms) and strong social leniency (a dangerous indifference to alcoholism).

With regard to sociopathological phenomena, one can generally say that it is necessary to perceive a person not only biologically and psychologically, but



also in connection with his/her social conditions and environment, which affect the individual to a significant extent.

There are many theories of the origin of behavioural disorders, and we can roughly divide them into three basic groups according to the cause that has the highest influence on the origin of the deviant behaviour.

One can look for the causes in biological factors (heredity, congenital predisposition, race, etc.), psychological factors (excessive psychological strain, disorders of the personality structure, acquired social behaviour, etc.), or social factors (pathological family structure, influence of the mass media, huge concentration of people in large housing estates, etc.).

For more information, see the section entitled Factors Contributing to the Development of Sociopathological Phenomena.

10.1.1 Dissocial Behavioural Disorders

Some individuals are unable to maintain acceptable social relationships, and this is manifested by inappropriate social behaviour. In these people we often observe a lack of empathy, egocentrism, and an excessive focus on the self and the satisfaction of their own needs.

Dissocial behavioural disorders in childhood and adolescence include, for instance, disturbing the peace at school, defiance, and lack of discipline.

10.1.2 Asocial Behavioural Disorders

A person without a social feeling for and an understanding of the needs of others is considered asocial. Asocial behavioural disorders in childhood and adolescence include, for instance, lying, truancy, running away, wanderings, and some forms of drug addiction.

10.1.3 Antisocial Behavioural Disorders

Activities and behaviour through which an individual harms his/her environment and breaches the law are considered antisocial behavioural disorders.

Antisocial behavioural disorders also include criminality. From a sociological point of view, we can distinguish five types of crime:

1. Index crime – a) violent crimes committed against people; b) property crimes.



2. Professional crime – this category includes crimes committed by professional criminals (committing crimes is their daily job).

3. Organised crime – work of a group of criminals that organises various types of collaboration with other groups of criminals.

4. White-collar crime – various fraudulent machinations, most often involving money and other material goods.

5. Crime without victims – a category of crimes during which there is a voluntary exchange of desired but illegal goods or services among adults (Bartlová, cited in Švarcová, 2010).

10.2 Lying

In a child, lying tends to be a way of escaping an unpleasant situation that he/she cannot resolve in another manner.

Lying can roughly be divided into three basic categories:

1. Outright lying

– Characterised by the intention to use a lie and by the fact that the child is well aware of the untruth of his/her claim. In the majority of cases this is a defence mechanism, with the child trying to avoid problems or gain some advantage. Sometimes the child lies without benefiting from it, just because of having the urge to lie. He/she feels that the lie will be more attractive.

2. Telling tales

– In this case this is not a behavioural disorder, because in a certain way the tale-telling symbolically satisfies the needs of the child that are not being satisfied in reality. For instance, the child vividly describes the beautiful moments spent with grandma, who in reality is no longer alive or does not correspond to the described ideal at all (see Božena Němcová). Sometimes the child tells tales to impress his/her peers, get attention, etc.

3. Destructive lying

– This type of lying deliberately damages another person or other people or is used to gain personal benefit at the expense of others. It cannot be considered an emergency defence and is often connected with other negative manifestations and personality traits, such as egoism, lack of empathy,



aggressiveness, etc. A tendency to lie can sometimes be a permanent personality trait. For instance, psychopathic individuals often resolve their problems by lying.

When assessing children's lies, it is important to find out how often the child lies, to whom he/she lies most often, at what times, in what situations, and primarily why, for what purpose.

10.3 Truancy and Running Away

Running away and truancy can be perceived as a flight reaction. A child usually runs away from an environment that does not suit him/her or even poses a threat to him/her.

Children most frequently run away from home, which is a warning sign of some problem in the family that the child cannot cope with. The family has failed as a source of certainty and safety.

Children also run away from school, and in this case we are talking about truancy. Here as well one should look for a problem that the child does not recognise. It can again be a dysfunctional family, but also problems directly related to his/her school attendance, such as too many demands placed on the child, exclusion from the group of children, bullying, problems in relationships with classmates or a teacher, or avoidance of demanding tasks or some exercises during physical education (the child is afraid of being embarrassed), etc.

Children also run away from educational and other institutional facilities.

There are various forms, manifestations and motivations for running away. In general, we can divide them into two groups:

1. Impulsive running away

– An impulsive reaction to a problematic situation at home or at school. The child runs away from punishment, humiliation or embarrassment. This is a defence against one's degradation. We must understand this type of flight as a warning or a manifestation of desperation and a call for help. This reactive type of flight can be a one-off and after the problem is resolved and the situation is calm, it is not repeated. The child usually wants to return home.

2. Chronic running away



– Planned and prepared in advance. The child usually knows to where he/she will run away (e.g. to grandma's, aunt's, etc.), sometimes even when exactly, and usually does not want to return. Such planned flights are most often carried out by children from disturbed families, and many of these children are physically or mentally abused. Exceptionally, the running away can be related to pathological personality development. When children run away from a children's home or an educational facility, it is usually a reaction to having a feeling of restricted freedom.

10.4 Wanderings

Wanderings are characterised by long-term absence from home. They often follow chronic running away. Again, they tend to be a sign of a dysfunctional family, an absence of support, and an insufficient emotional relationship with family members. The child usually does not care about his/her parents and even rejects them in many cases.

The minimum age of wandering children has gradually been decreasing. Whereas wanderings used to occur in adolescents and older school-age children, even pre-schoolers are starting to wander these days.

A child can wander on his/her own or in a group. To survive, wandering individuals often steal, burgle or live from prostitution. They can also become victims of abuse and in many cases start using drugs or alcohol.

A wandering way of life can become a habit for young people; they consider permanent employment unacceptable and can end up homeless.

Vagrancy is one of the symptoms of a dissocial personality (Vágnerová, 1999).

10.5 Bullying

Aggression (physical or verbal) against an individual who is physically weaker or in a dependent position.

Bullying is any type of behaviour which intends to hurt, threaten, humiliate or intimidate another person or a group of people.

Bullying is a severe, aggressive behavioural disorder occurring in a social environment from early childhood through old age. Shockingly for many people, bullying also appears in nursing homes. This confirms that it is not age-limited.



The Ministry of Education, Youth and Sports' methodical instruction no. 28275/2000-22, on the prevention and resolution of bullying among pupils (students) in school and educational facilities, defines it in the following way:

Bullying is any type of behaviour whose intent is to hurt an individual or to threaten or intimidate another pupil or a group of pupils. It is the targeted and usually repeated use of violence by an individual or a group against an individual or a group of pupils who are unable to, or for various reasons cannot, defend themselves. It includes physical attacks in the form of beating, extortion, robbery or damaging another person's property, and verbal attacks in the form of name-calling, gossip, threats or humiliation. It can also take the form of sexual harassment or sexual abuse. Bullying can also be indirect, such as marked ignoring of a pupil or pupils by a class or a group of classmates. The danger of the effect of bullying lies primarily in its severity and its long-term duration, with life-long consequences on one's mental and physical health being common.

10.5.1 Main Features of Bullying

1. Obvious intent to harm
2. Attacks are repeated
3. Disproportionate power between the aggressor and the victim

E.g. repeated laughing at the victim, humiliation, gossip, bad-mouthing one's family, physical attack (beating), damaging another person's things, etc.

The main characteristics are *self-gain* and *aggression*.

Bullying is never only an issue between individuals; on the contrary, it is a severe disorder of relationships within a group which has succumbed to a kind of 'infection' (virus) from germination to the final stage.

It can originate in a normal environment; in any group there will be children (adults) at the lower end of the popularity scale and children (adults) prone to aggression.

Each child, or even each person, tries to obtain a position within a group that is acceptable for him/her. If he/she does not succeed in an optimum manner, he/she tries to have his/her way in a different manner. The child starts to show off – goofs around, imposes him/herself on the group, or even bribes his/her classmates.



Often, two groups are created in classes, with one considering itself better ('we are the best') and the other considered worse. Many times, a class as a whole turns against an individual it considers 'different'. In this case, the factor of a common 'enemy' enhancing cohesiveness is important. This is a very dangerous and hard-to-detect type of bullying.

Bullying is very dangerous at any age, in particular in children. Its consequences with regard to mental and physical health can be severe, long lasting and even lifelong.

Factors Contributing to the Origin of Bullying

- A demanding situation in a group (in a class) which increases tension. For instance, tension before a test at school is typical, with the aggressor hiding his/her fear and instead causing fear in others.
- Boredom which aggressive individuals try to chase away by thinking up something to do at the expense of the weak; they enjoy abusing the weak and scared.
- Several distinctly aggressive, asocial persons in a group.

10.5.2 Participants in Bullying

Aggressor (aggressors)

The aggressor is often physically fit, likes to show off, acts superior, lacks discipline, is often ruthless, is incapable of empathy, and envies academic results.

He/she usually does not feel guilty for his/her behaviour. In many cases the aggressor him/herself suffers from some suppressed complex.

He/she experiences a feeling of superiority, relishes his/her victims' fear, and continually perfects and escalates the victims' abuse and suffering.

However, the mastermind behind the bullying does not always have to be a physically fit individual with the above-described characteristics. The initiator and the main 'brain' of the violent acts can be a very intelligent individual from a 'good' family, even the top pupil in the class, who is very good at manipulating people. Most frequently he/she uses intimidation and various forms of extortion, but he/she can also control psychologically and emotionally



weaker individuals through various services (cribbing – cheating by copying, providing relief from bullying, etc.) and bribes, including financial ones. In such cases the physically fit individuals are only the executors of violence, and many times, the main participant who is behind all the bullying and is pulling the strings is never discovered. Often, out of fear or false solidarity, the executors take all the blame.

In many cases the aggressor has a narcissistic personality. Narcissism affects approximately 1% of the population. Its basic manifestations include vanity, arrogance, a tendency to react inappropriately, a need to be looked at in awe, a feeling of exceptionality, and haughty behaviour.

Narcissistic personalities like to have fun at the expense of others, have a greater tendency toward bullying, and have unambiguously increased aggressiveness. They are not interested in friendship in its proper sense, and only use other people. They select 'friends' according to the criterion of whether or not they are good for something.

Aggressors can also be psychopathic or socially weaker individuals, and sometimes from high-society families that have no time for the child (emotional deprivation).

Aggressiveness is their main behavioural manifestation, but usually only among friends. At home they usually have a strict upbringing and wouldn't dare try anything. All aggressive individuals have a common denominator in their very low ability or non-ability to empathise.

The aggressor's family usually shows low interest in the child or does not have enough time for the child. Psychological and physical abuse, arguments, family disharmony, and a high tolerance of violence are often present.

The parents of aggressors often have no idea that their child is a bully.

Victim(s)

Until recently we believed that bullying victims were most often individuals who were somehow different from others, e.g. obese, very skinny, too short, abnormally tall, with above-average intelligence, with lower intelligence, with various disabilities, with a different skin colour, differently dressed, etc. It was even confirmed by many studies. Yet all of us (except for monozygotic twins) are somehow different, be it in our looks, character, attitudes and opinions,



moves, gait, etc. Gradually we have come to the conclusion that difference is a mere pretext for bullying.

A quiet, shy, sensitive person, often physically weaker, with low self-confidence, rather withdrawn, and used to conforming to others is a typical victim, but the main factor is that he/she cannot hide his/her fear.

This basic factor is shared by all victims, be they tall, short, obese, slim or completely 'average'.

In addition to the typical victims (see above), children who do not deviate from the 'norm' and about whom we would never say in advance that they could be victims of bullying can also become bullying targets. Only when things are investigated does the aforementioned fear come to the surface. They cannot suppress it and mainly their eyes give them away. One of the more effective forms of prevention or advice for victims, the 'Pink Elephant', is based on this finding (see separate section in this chapter).

The parents of the victims hear about bullying more often than the parents of the aggressors, but their children usually ask them not to intervene.

Strong personality (personalities)

A strong personality in a group is an individual who is not necessarily fit physically, but who is fit personality-wise. Such an individual behaves peacefully, is considerate, can provide support or encouragement to others, offers others his/her knowledge or skills, and inspires confidence. He/she is a child who when witnessing something inappropriate, in this case bullying, intervenes and stands up for the victim – sometimes only verbally, but at other times physically. Very often he/she is beaten him/herself. If he/she is the only one in the group to defend the victim against the aggressor(s), then it depends on the strength of his/her personality how long he/she will continue to defend the victim. Even the strongest personality cannot do this indefinitely on his/her own.

Children with strong personalities usually come from well-functioning families which not only provide the child with basic care, but which also perceive him/her as a full personality. The child has enough love and understanding and knows his/her rights, but also has certain duties and is guided towards responsibility.

In addition to the parents, all educational staff, including teachers, contribute to the strength of a child's personality. A child who only hears criticism and



admonishment will hardly grow up to have a strong personality. Every person, let alone child, wants to be praised, and therefore as far as it is possible and there is a reason for it, give praise; it is a reward that can be given that does not cost us anything. We may not succeed at changing the educational methods of parents, but we can succeed with teachers and other professional educators.

Neutrals – bystanders

Probably the largest part of the group consists of so-called neutrals. This category includes all of the members of the group who have not participated in the bullying-related activities, at least for the time being. These are individuals who prefer not to see or hear anything, because they are usually scared of becoming the next victim. According to the current situation in the class, this group provides either supporters of violence and aggressors or supporters of 'good' and defenders of the victim(s). There are many factors influencing which side they will join: the overall climate in the group (in the class), the proportion of power (aggressors vs. victims supported by strong personalities), the personality traits of neutral individuals and their current psychological and physical condition, etc.

When it comes to tense, crisis situations, some people feel a need to hurt. It is similar when it comes to bullying, but also during family conflicts. Someone makes a person angry, they quarrel, and the person is very upset. Suddenly a third person comes, and instead of saying 'I understand, it will be all right again' or 'Come here, everything will be sorted out, you'll see' or hugging the person as a sign of empathy, the third person says 'Calm down, stop exaggerating' or 'Stop feeling sorry for yourself', etc. What reaction do such words cause in the affected person (victim)? The person gets even more upset, falls down on his/her knees and starts to cry. It is something like showing a bull a red cloth or rubbing salt in a wound. This conduct by the bystander is probably an unconscious reaction with an urge to settle some unfinished business with this person or just an instinctive need to vent anger. However, a strong personality manages to suppress such an urge, many times based on rational reflection, and can provide the victim with assistance and lend him/her a helping hand, even in the form of mere verbal encouragement.



10.5.3 Development Stages of Bullying

Forms of bullying:

a) covert – ostracism

– manifested by social isolation, exclusion of the victim from the group, verbal bullying (gossip, intrigue, jokes, etc.); this is the most common form of bullying (mainly in girls);

b) overt

1. physical violence and humiliation – beating, abuse, leg-tripping, locking in a cellar or a dustbin, etc.

2. mental humiliation and extortion – forcing the victim to serve or to undress, public ridicule, humiliation through inappropriate or unfulfillable tasks, forcing one's obedience, etc.

3. material violence – extortion, requiring financial or other material services, destruction of the victim's property – clothing and other things, tearing up exercise books, cutting one's pullover into pieces, damaging one's shoes, etc.

The victim can either passively endure the humiliating conduct (allows others to call him/her bad names, spit at him/her) or is forced into a degrading activity in favour of the aggressor (gives him/her snacks, carries his/her school bag, ties his/her shoes, writes his/her homework, gets him/her cigarettes, alcohol or food for free, becomes the aggressor's personal servant).

Providing involuntary service to an aggressor is more humiliating than to passively endure any hardship, if the bully is stronger.

Bullying stands no chance within a healthy group with enough strong personalities.

Bullying has certain stages of development:

1. Reconnaissance – the aggressor looks for potential victim(s). This also includes mental aggression, ostracism.

2. Escalation of aggressive attacks – the psychological pressure and ongoing escalation of manipulation may change into physical aggression, and the victim becomes a sort of an outlet for the aggressor. In girls, many times there is no



physical aggression, but the aggressor's attacks have an increasing intensity (gossip, ridicule, humiliation, etc.).

3. Establishment of a core – origination of a group of aggressors who terrorise others.

4. The aggressor's or aggressors' norms are accepted by the majority – the abuse grows into full-scale violence, these norms become the unwritten law, and even moderate pupils behave cruelly.

5. The last stage of bullying = totalitarianism = perfect bullying – the aggressor(s) is (are) uninhibited, norms are accepted by all members of the group, values are completely askew → the best is the one who hurts more; two groups are created: masters vs. slaves, kings vs. subjects, old hands vs. rookies, wolves vs. lambs, superior humans vs. inferior humans, Nazis vs. Jews, etc.

Aggressors use everything that can be abused – e.g. money, intelligence – and enjoy physical brutality.

The first and second stages can be stopped while in progress.

The third stage is decisive – a strong positive group can still be established that would weaken the aggressors' influence; if this fails, the aggressor's group gains even more power and the malignant process can no longer be stopped.

In the fourth stage no opposition can be created against the aggressors.

The fifth stage usually occurs in prison, in military service, in educational facilities, in boarding schools and in secondary schools. It used to be that the fifth stage of bullying was very rare in primary schools, but, unfortunately, it now also occurs there with increasing frequency.

The most dangerous situation occurs when the aggressors' leader is a student from a good family with good academic results.

Bullying occurs more often in classes with children of various ages.

There are no differences when it comes to the children's ethnic composition.

Bullying most often occurs on the playground, in school and in the halls.



10.5.4 Prevention of Bullying

In my opinion, the basis for preventing bullying in school is primarily working with the group (class) right from the start of the bullying activity or following any change, and this work is long-term, or better yet permanent.

This is mainly about the quality of relationships in the group, in which it is most important to support or directly raise strong personalities. As was written earlier, where there are enough strong personalities, bullying stands no chance.

How to do it, though?

Unfortunately, we cannot intervene much into the upbringing in the family, but we can do many things in school. Our current schooling has so far been more or less focused on looking for mistakes. Teachers underline or mark in a different way, mostly in red colour, mistakes on writing assignments and it is as if they do not notice what the pupil wrote correctly. The correct part is never emphasised. It is similar with many teachers during oral examinations, even though they often include a positive assessment if the pupil 'deserves' it. A similar approach has traditionally been used by educators, including parents. The fulfilment of tasks (washing up, tidying one's room, taking the garbage out, etc.) is considered a matter-of-course; many educators do not give praise for these tasks, thinking it is not important. And this is a huge mistake.

How can a child develop a strong personality if his/her mistakes are pointed out all the time and if he/she gets minimum positive praise? How can he/she gain self-confidence? How can he/she respect him/herself and subsequently others? Why is the highest number of 'problematic' children among children with a social or psychosomatic handicap?

Everyone, the child in particular, needs to be praised and feel successful and appreciated.

Therefore: give praise and show appreciation! Of course, not in an exaggerated manner, but whenever it is possible. If we correct a mistake on a written assignment, we should also point out what the child did correctly, what he/she wrote (calculated, measured, depicted, etc.) right.

We should also support politeness, fairness and moral values. We should not forget to trust children and give a second chance even to the 'problematic' ones, and not pin some label on their forehead. Of course, we



always have to be consistent; if the child squanders his/her second chance, the punishment is stronger. Do not forget that we all make mistakes; it is important to learn from them, not just suffer for them.

What are the relationships within the group? Has bullying already occurred? Who are the aggressors and who are the victims? The answers to these questions can be partially uncovered by the teacher using a whole range of sociometric surveys that focus on the detection of social relationships in groups and that allow the determination of the social status of an individual within a group.

10.5.5 Methods of Resolving Bullying

Bullying can be considered a kind of illness and as such should be treated. Therefore, if parents find out that their child is being bullied, they should act as if he/she were ill, i.e. they should start to treat the bullying. I agree with Říčan (1995) that if bullying is not treated, it can have catastrophic consequences for the bullied child.

The child should be approached sensitively and in such a way that the child trusts the adult and believes that they can do something about this phenomenon. Pupils should also have a feeling of trust toward their teacher or educator. Unfortunately, teachers often overlook the initial stages of bullying or do not consider them to be bullying.

The procedure and methods of resolving bullying:

- do not reveal the source of information,
- do not talk about acquired information,
- interview informers,
- interview the affected person (victim),
- look for suitable witnesses,
- carry out individual and confrontational interviews with witnesses (no confrontation of the victims and aggressors!),
- provide protection to the affected person (victim),
- interview the accused person (aggressor),
- should there be more accused persons (aggressors), arrange for a confrontation among them,
- record the results.



According to Říčan (1995), the important thing is to provide protection to the victim. An investigation should not be delayed, but thoroughly prepared. Pöthe (1999, p. 86) also talks about the fact that when trying to resolve bullying, it is possible to induce an atmosphere of compassion with the victim by acting on the feelings of children in the class or in the group.

In some cases of bullying, one can use external pressure or reconciliation. The external-pressure method is applied in the form of a threat – an official reprimand, a worse behaviour mark, a transfer (of the aggressor) to another school, etc. The reconciliation method can be used in the initial stages of bullying when the group has not yet adopted the norms of the aggressors.

Protecting the victim is not always as easy as it might seem. Sometimes it is really enough to delay the aggressor at school to allow the victim to leave. It is also possible to transfer the aggressor to another class, school, etc. However, this is difficult in institutional care facilities. Many times the aggressor is transferred between several facilities in order to protect the victim and at a certain stage another transfer is not possible. It is then up to the supervising teacher to be able to permanently monitor the state and behaviour of the aggressor, the victim, and other children, respectively. This is a demanding job and in some cases also a dangerous one.

In certain circumstances it is suitable to confront the victim and the aggressor. The victim has to be sufficiently prepared and motivated for the confrontation and has to have 100% trust in the person who is in charge of the investigation into the bullying. The reason for this approach is to convince the aggressor that the victim is not afraid to resolve the issue and can stand up to the aggressor at any time; he/she will not be intimidated and will not let him/herself be hurt. Thus, the aggressor loses one of his/her motivations – the victim's fear – and the aggressor's authority among other members of the group may be lessened as well.

10.6 *Bullying in a Dyad*

Bullying in a dyad is certainly not a new phenomenon; it has just not been researched or described much. This is bullying within a pair, between two individuals who are very often in a relationship as friends, buddies, even as lovers or husband and wife.



At school, bullying in a dyad is quite a common phenomenon. It occurs more often with girls, but is also no exception among pairs of boys – buddies.

This type of bullying is more dangerous as it is even harder to detect than the 'classic' type of bullying with more participants. Bullying in a dyad is usually carried out without witnesses, only between the two participants. In addition, the victim in the majority of cases is not even aware of the fact that he/she is being bullied. He/she considers the behaviour of his/her 'friend' to be completely normal. He/she does not admit that he/she might be being used and manipulated.

In bullying in a dyad, the aggressor mainly uses various types of manipulation of the victim, particularly humiliation, emotional blackmail, pointing out their friendship, and threats should the victim disappoint the aggressor – buddy. The aggressor lowers the victim's self-confidence, increases the victim's dependence on the aggressor, and gradually completely controls the victim's independent decision-making. The victim then becomes a slave to the aggressor. The most severe consequence is probably the victim's strong psychological dependence on his/her 'tormentor'.

Blackmailing and humiliating letters are no exception, e.g. 'You are no longer my friend', 'I hate you', 'You have betrayed me', 'You are a stupid cow', 'You will not get away with it', 'I will destroy you', etc., and all these statements can be included in one letter. Next follows the victim's reply in which she makes a tearful apology and promises anything if the aggressor-'friend' forgives her and continues to be friends with her. The aggressor 'graciously' forgives her, but puts even higher pressure on the victim. And so it goes. It also has to be said that the victim has not done anything; everything is just construed to use for further manipulation.

Both participants in bullying in a dyad most often suffer from emotional deprivation. In the case of the aggressor, this is satisfied with control, manipulation, emotional blackmail, and making the other person dependent on him/her. In the case of the victim, this is usually about the need and desire to have a friend, someone close, even at any price.

Both participants often come from so-called good families, but unfortunately there is very often some hidden problem kept secret from the public in such families. This might 'only' be a lack of time to talk with the child, to satisfy his/her emotional needs, but it can also be a more severe disruption in family relationships. Similarly to other problems, sometimes the cause of bullying in a dyad is unknown and inexplicable.



In general, relationships in a pair can be divided into three basic groups:

1. Relationship of *mutual co-operation* – considered the most optimal relationship in a pair, among friends, etc.
2. *Symbiotic* relationship – an alliance of two physically, and many times even mentally, different individuals who accommodate each other's wishes and complement each other.
3. *Parasitic* relationship – a relationship based on the hypothetical superiority of one entity (child) over another who is used, manipulated, etc. This relationship is typical of bullying in a dyad.

10.7 Bullying of Teachers

Currently there is a new phenomenon occurring in our schools which we have not been accustomed to, which we have not known before, and which we were not sufficiently prepared for – an increase in aggression directed against teachers. This is not only a problem in our country, but a problem in many other countries, particularly countries whose citizens have not fully grasped the basic elements of democracy and have somehow confused them with anarchy. The society has done nothing to change their erroneous views or has meted out severe punishment for them without an appropriate explanation.

In a democratic society each individual not only has rights, but also duties stemming from the norms of the society. These norms are legislative (whose breach is punished according to the laws of a given country), social (which are not embedded in law, but express a certain degree of refinement and politeness of each individual and can vary in different countries), and moral (which also cannot be enforced by law, can be different in various countries, and similarly to social norms attest to a person's refinement).

In many developed societies with a rich history, a person is assessed according to social and moral norms. I can mention the English society (culture) as an example.

Why do I mention this under the topic of bullying of teachers? Because democracy vs. anarchy and social and moral norms are closely related to this topic.



In the last century, primarily at the beginning of last century, the position of teacher was very important socially. Teachers belonged among the most important persons in the country and the town alike. The society respected wisdom and educated people. Understandably, schoolchildren also respected a teacher's authority. And it was not because of obsolete pedagogical methods where the teacher had the power to punish a child physically, even though some contemporary experts approve of a mild form of punishment. The social climate was largely responsible.

Various organisations deal with children's and youth rights, which is of course necessary, but on the other hand, the society should also deal with teachers' rights and protection.

Let us bear in mind that if a teacher is not entitled to punish a child in some acceptable way, and if official reprimands and Bs in behaviour are welcomed by the children and therefore no longer serve their purpose, then we are heading towards anarchy in schools. Already today children are entertained by provoking their teacher during a lesson and record everything on their mobile phones. Where will we let this situation go? What teacher will overcome his/her low salary and negligible social prestige and on top of that survive being terrorised by his/her pupils?

We cannot wonder at the fact that the majority of experts are leaving for better conditions, including financial.

Factors contributing to the bullying of teachers

- low social prestige of teachers and educators
- low salary
- incomplete or missing legislation and weak enforcement
- insufficient protection of teachers and educators backed by law
- lack of experts
- minimum possibility of defending oneself against verbal and physical attacks
- imperfect system of sanctions

Possible solutions

- ensure independence from per-student subsidies (the pupil is an important economic element in school)
- increase the powers of teachers and educators
- improve salary and working conditions



- ensure a sufficient number of experts
- increase family responsibility, including amended legislation
- support the social prestige of the pedagogical profession

We should also realise that children interested in getting an education also suffer from the bullying of teachers and various disruptions during lessons. Many times, individuals or small groups succeed in disrupting the course of education even for several lessons.

If we want to have citizens with a quality education, we have to provide quality teachers. Almost every day we entrust our dearest ones – our children – to teachers and educators. Do not let them suffer for the inability of the system to ensure peace and harmony during lessons and for the inability to resolve problematic situations caused by increased anarchy in schools. Let us adhere to the principles of democracy – where one person’s freedom ends, another person’s freedom begins.

Let us not allow our children to learn at school that one can achieve something through power and humiliation.

10.8 Cyberbullying

Internet bullying or cyberbullying is a type of bullying in which modern technologies, particularly electronic ones such as mobile phones, the Internet, e-mails, blogs, etc. are used.

The most common manifestations:

- sending humiliating, offensive or threatening e-mails or text messages;
- creating websites degrading individuals or groups;
- publishing sensitive facts about others on the Internet;
- posing as someone else with the aim of harming him/her (sending fake text messages, e-mails, etc.);
- provoking and recording various humiliating and offensive situations on a mobile phone and the subsequent sending of the recording to the affected person’s acquaintances, or uploading the recording to the Internet, etc.

At school it is not an exception that two classmates agree that one of them will provoke a teacher’s inappropriate reaction during a lesson and the other will



record the whole thing on his/her mobile phone. A similar situation occurred at the primary school in Železný Brod in which the school's headmaster was humiliated and subsequently resigned.

It is primarily the publishing of humiliating material on the Internet which is accessible to a huge number of people that magnifies the victim's trauma. There have been cases in the world where cyberbullying has caused the victim to commit suicide. For instance, Anna Halman, a 14-year-old secondary-school student from Gdansk, committed suicide after her classmates humiliated her, tore off her clothes and acted as if they were raping her. They recorded everything on a mobile phone. The poor girl hanged herself at home.

Compared to 'classic' bullying, cyberbullying has a host of advantages to many individuals. First, one does not need physical strength or a certain social status in the group. This method can essentially be used by anyone, even by those who do not have enough physical strength to terrorise the victim, who do not have any friends with whom they could create a group of aggressors, and who do not have any influence over the group.

On the other hand, cyberbullying can be very dangerous for its perpetrators, as it can lead to detection and unambiguous proof of bullying. In the case of the Polish girl, the recording on the mobile phone was used as a key piece of evidence in the legal procedure against the aggressors, even though its author did not upload it on the Internet and deleted it after having learned of the girl's suicide. The police technicians managed to reconstruct the deleted film.

Many times headmasters and teachers have no idea about bullying at school until some recording surfaces on the Internet.

Cyberbullying is a huge problem in many countries. New acts and security measures are being adopted due to it (e.g. Poland filters access to the Internet on school networks, children are forbidden to use mobile phones at school, and South Korea has adopted broad restrictions regarding the use of the Internet) and some countries have already established special investigative police units to fight cyberbullying. Since 2006 cyberbullying has been a federal crime in the United States. (<http://cs.wikipedia.org>)

This type of bullying has no age limit whatsoever and unfortunately also frequently occurs among adults. In addition to teenagers, the group with the highest occurrence consists of people 20 to 25 years of age.

Bullying through blogs



Its forms:

- publishing aggressive and attacking comments on another person's blog;
- creating blogs and entries on one's own blog that harm an individual;
- creating 'fake blogs', with the readers being under the impression that the blog is written by a victim of bullying; it is suggested to the readers that the victim is the author of the text and material, which he/she would of course never write or publish;
- editing another person's blog to the detriment of the victim, etc.



Review Questions

1. Give at least five examples of asocial behavioural disorders.
2. Describe a destructive lie.
3. What are the primary aspects of running away on impulse? Give an example.
4. What is the difference between running away and vagrancy?
5. Define 'bullying'.
6. Describe the primary features of bullying.
7. State at least three situational aspects that contribute to bullying.
8. Characterise the participants in bullying.
9. Describe the developmental stages of bullying.
10. What are the primary methods used to resolve bullying? State the steps and the main principles.
11. Define 'bullying in a dyad'. State an example.
12. What factors contribute to the bullying of teachers?
13. Give five examples of cyberbullying.



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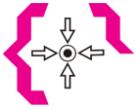
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11 Mental Disorders in Children



Objectives

In this chapter you will learn about the incidence of the most frequent mental disorders in children and you will learn to distinguish problems that require seeking professional help. You will realise the importance of the role of the school in the diagnosis and treatment of mental disorders in children.



Terms to Remember (Key Words)

- mental disorders
- psychodiagnostics
- psychotherapy

11.1 Incidence of Mental Disorders in Children and Criteria for Seeking Professional Help

Sporadic, larger or smaller emotional problems appear in the development of each individual. Less conspicuous and shorter-lasting fluctuations in the child's behaviour and experiencing are usually handled by parents and educators on their own; minor deviations usually spontaneously disappear under positive circumstances.

However, many children have problems of a type or intensity that causes the parents to look for the professional help of a paediatrician, psychologist or psychiatrist. In many cases, parents and teachers can ask themselves whether professional treatment is already unavoidable.

According to the following criteria it is necessary to seek professional help (Langmeier and Krejčířová, 1998):

- when there is a **restriction in some age-appropriate activities** of the child (e.g. a clumsy child starts avoiding games involving movement and a group of children out of fear of ridicule);
- when the deviation starts to **generalise** and affect other developmental areas (e.g. an anxious child avoids social situations and begins to lag behind in the development of appropriate social skills);



- when the deviation **results from serious and persistent environmental deficiencies** (e.g. child neglect).

The decision to seek professional help can be made easier for the teacher by the ability to distinguish his/her pupils' problems. David Fontana (2003) recommends matching the problem with one of the following categories first:

- **A simple problem** can be deemed isolated and can be managed by a one-off measure on which the teacher and the child agree. *The child has a problem with a member of the teaching staff or a school assignment, was unjustly accused of an offence, etc. The task of the teacher is to hear the child out, to ask him/her about the necessary details, to assure the child that it was correct to seek help, and in the end to look for an effective solution to the problem.*
- **A difficult problem** involves the child's personality in a wider context, e.g. the child can be excessively shy, impulsive or suffer from long-term family problems. The characteristic of the problem restricts the possibility of its simple resolution. The teacher cannot rely only on his/her educational intervention, because the solution to the problem requires co-operation with the family and the use of professional help.

The degree of tolerance of the child's developmental deviations and the ability to influence them educationally is different for each parent or teacher. It depends on one's previous experience and the degree of one's own anxiety or subjectively felt need for professional help, while the accessibility of professional services is also important.

All of the aforementioned circumstances, together with diagnostic criteria, influence the detected incidence of mental disorders in children. Therefore, the prevalence stated in the expert literature (Hort, Hrdlička, Kocourková, Malá et al., 2000; Vágnerová, 2004; Říčan, Krejčířová et al., 2006) varies and the percentages of incidence must be viewed only as a guideline:

- **Specific disorders of scholastic skills** can be found in 2–20% of school-age children. According to more conservative estimates, 3% of children in our schools suffer from specific disorders of scholastic skills.
- **Behavioural disorders** occur in 10–15% of children and adolescents.
- The prevalence of **hyperkinetic disorders** is put between 2% and 12%, with the disorder occurring more often in boys than in girls.



- The incidence of phobias is unequal in terms of age categories – certain types of phobias are typical for certain age periods. The most frequent are **specific phobias** (i.e. phobias linked to a specific object or situation) and their prevalence is estimated at 4.5–11.8%. In pre-school age, fears of strangers, darkness, animals, water and thunderstorms are common. At around age nine, fears of blood, injury and dental interventions appear. In adolescence, phobias are connected to social circumstances.
- The prevalence of **depressive disorders** is 0.4–2.5% in children up to 10 years of age and 0.4–8.3% in adolescents (10–18 years of age).
- The risk of **suicide** in depressed children and adolescents is up to twenty times higher than in adults. The frequency of suicides in adolescents has been growing in recent years due to a higher number of psychosocial problems.
- **Separation anxiety disorder**, in its milder form, can appear as early as the beginning of kindergarten or primary school, however, it is most frequent at around age 11 and affects 3.5–5.4% of children.
- **Obsessive-compulsive disorder** belongs among the often hidden disorders which are in some cases detected many years after their onset. The prevalence of the disorder is 1–2% in children and 4% in adolescents. A vulnerable period for the onset of OCD is between 12 and 14 years of age, and another peak of the appearance of the first symptoms is between 20 and 22 years of age.
- **Anorexia nervosa** affects around 0.5–1% of young girls, with the beginning of the illness occurring most frequently between 14 and 15 years of age and with another peak between 17 and 18.
- The prevalence of **bulimia nervosa** is even higher, affecting 1–3% of young girls. In approximately half of the cases, bulimia nervosa is preceded by an episode of anorexia nervosa. The prevalence of subclinical (not fully developed) forms of the disorder is estimated at 8% of adolescent girls.
- Among the **excretion disorders**, enuresis is more common than encopresis. At the age of seven, 7% of children suffer from non-organic enuresis, while the percentage is 1–2% of the population at the age of 14.



- The prevalence of **addictions** is less stable and can change in connection with the accessibility of addictive substances and other social factors. Since 1995 the Czech Republic has been in the leading position in Europe in terms of the widespread use of addictive substances. The fact that the problems caused by addictive substances have been affecting lower age groups is also negative.
- Among **psychosomatic problems, stomach aches** are frequent, coinciding time-wise with school time as a reaction to stress experienced at school and affecting the most children between the ages of eight and twelve; they are prevalent in 10–15% of school-age children. **Headaches** are also a frequent problem for school-age children, with up to 40% suffering from them occasionally and 5% being affected with chronic headaches.

The degree to which some diagnoses are made is a subject of discussion, as it is not easy to determine the border between underestimating a problem and unnecessarily categorising the child's mental manifestations diagnostically.

A typically problematic diagnosis in school-age children is ADHD (Attention Deficit Hyperactivity Disorder); some experts point out the excessive use of this diagnosis in children (most frequently boys) with a more lively temperament (Atkinson, 2000).

Determining a correct diagnosis and naming the problem are the necessary first steps towards a remedy.

11.2 The Role of the School in the Diagnosis and Treatment of Mental Disorders

The question of the possibilities and limits within which a teacher can participate in the resolution of the mental problems of his/her pupil calls for a discussion.

According to Fontana (2003), every teacher is also an educational consultant, which means that the teacher's function includes helping children cope with personal problems. Teachers are distinguished by the degree of importance placed on their consultant role and the extent to which children are willing to confide in them.

It is very probable that during his/her career, the teacher will encounter pupils suffering from a certain type of mental disorder. Every teacher should



have some educational training in psychopathology so that they are able to detect any problematic manifestations in a timely manner, to understand their significance, and **to avoid approaching such pupils in an unprofessional (albeit well-intentioned) manner.**

- *A pupil with a specific phobia of which he is ashamed, and which he is hiding, has undergone a psychological evaluation that did not reveal any other mental disorder. When the class teacher received the written report about the evaluation from the pedagogical-psychological counselling centre, she told him in front of the entire class: 'You see, you are completely normal!'*
- *A teacher 'briefed' on the current problem of anorexia nervosa forced a pupil, who in his opinion was too skinny, to eat her break-time snack in his office under his supervision.*

The determination of a diagnosis of a mental disorder in children should be done by a competent psychologist and/or psychiatrist.

In some aspects of getting to know the pupil, the teacher has an advantage over experts whose diagnosis is based on a one-off evaluation. The teacher is in everyday contact with the child for the entire school year or even more years, has the **opportunity to observe the pupil's emotional reactions and behaviour in natural conditions**, the social interaction and communication of the pupil, his/her roles and relationships, and the manifestations of the same pupil in various situations and under various conditions (Čáp and Mareš, 2001). The teacher's observations of the pupil are quite valuable when diagnosing mental disorders and the teacher's remarks can provide a great deal of information that is otherwise hard to obtain.

- *A second-year class teacher at a secondary school observed a change in the behaviour of one of the students – an increasing problem with concentration, passivity, and slightly worsening academic results. She noticed that for a few weeks the girl had been passively sitting and staring into space during class and not showing any initiative unless called upon. The teacher initiated a meeting with the parents who had not noticed a change in the behaviour of their daughter at home, but based on the information from the teacher paid more attention to the girl and in the end sought professional help: a psychiatrist diagnosed the girl's condition as the initial phase of depression.*



The teacher is not expected to play psychotherapist, a role which belongs only to qualified experts. In addition to the therapy failing, the erroneous application of therapeutic approaches can even be harmful, and therefore practicing psychotherapy in the world and in our country is reserved only for those who have fulfilled the many requirements of qualification.

In many cases, however, **the treatment of a child's mental disorder cannot be practically separated from school life**, especially if it is the context of the school environment that contributes to it or even causes it (e.g. school phobia, anxiety from a negative climate in class, behavioural disorders).

In such cases the optimum solution is to **begin a co-operative effort between the family, the school and the therapist.** Unfortunately and for various reasons, this kind of co-operation often does not occur.



Review Questions

1. In what case is it unavoidable to seek professional help for a child with symptoms of mental problems?
2. What mental disorders occur most frequently in children?
3. What diagnosis is sometimes 'bestowed' in practice on many children with a more lively temperament? Think about the reasons for the excessive use of this diagnosis.
4. Is it within the teacher's competence to determine the diagnosis of a mental disorder in his/her pupil?



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