Interdisciplinary approach to the care of children with mental disabilities and behavioral disorders

(overview essay)

Andrea Prečuchová Štefanovičová

The report is a part of project VEGA 1/0789/14 Determinants and deviations development of school-age children with health disabilities in the somatopathological, psychoeducational, communication and social sphere.

Abstract: *The issue of behavioral disorders of intact children and their upward trend are well known. The discussion about behavioral disorders of children with mental disabilities is less common. Their cause is not a mental disability as such, but it is a separate disorder and therefore we can talk about multiple disabilities. Children with such disabilities need interdisciplinary and special approach, which can help to alleviate and eliminate consequences of disorders. This report is focused on some actual problems of care for children with mental disabilities and behavioral disordes. Here are some characteristics of children with mental disability and some opportunities for further development in order to enhancing scientific knowledge in this area. Our aim is also to present our views on the issue.*

Key words: *Children with mental disability, behavioral disordes, multiple disability, interdisciplinary approach, teamwork*

1 Introduction

At present days there is an increasingly talking where main topics are behavioral disorders as well as problematic behavior of children of all ages. It is very important to remember that even children with intellectual disabilities are children like any others and therefore this phenomenon exists among them too. The behavioral disorder is very often considered as a symptom of mental disability which is not always true. At this case, we can talk about multiple disabilities.

2 A child with mental disabilities and behavioral disorders

In the case of individuals with developmental disabilities and simultaneously with behavioral problems, we can actually talk about the so-called multiple disabilities. As reported Vasek (2006), multiple disabilities at relatively large simplification can sum up into three groups which are symptomatology related:

1. mental disability in combination with other disabilities – this group represents largest group with multiple disabilities,
2. blindly – deafness – is the most severe form of multiple disability,
3. behavioral disorders in combination with another disability or interference.

By Vašek (2006, p. 37–38) "multiple disability (GPC) can be operationally defined as a multifactorial, multicausal and multisymptomatic contingent phenomenon that is the result of collaboration participating disability or impairment. Their interaction and overlapping set up so called 'Synergistic effect', that is new quality of disability which is different from the sum of present disability and disruption."

This phenomenon greatly determines individual functioning of individual compensatory mechanisms. In simplified form, these relations can be expressed as follows:

$$\mathbf{GPC = f(P1, P2, \ldots Pn, Sye, Km)}$$

It follows that the multiple disability (GPC) is a function of interaction participating disability or disturbance (P1, P2, …… Pn), synergy effect (Sye) and compensatory mechanisms (Km).

In the context of behavioral problems at individuals with intellectual disabilities should be noted some common disorders that are manifested by behavioral problems.

Emerson (2008) mentioned a summary of knowledge concerning some of the factors which influence the development of problem behaviors of people with intellectual disabilities:

Gender – generally there is more likely in men and boys to start behaving troublesome than at girls and women.

Age – it seems that the overall extension of problem behavior in a childhood increases with the age and finally reaching a peak in the age group 15–34 years. After that it fades. When comparing the age structure of the total population of people with intellectual disabilities it is evident that the behavioral problems encountered in particular in the group 15–24 years and when comparing the estimated age structure of the population of people with severe mental disabilities, it seems that the wider prevalence is maintained or does not drop until late middle years.

Specific syndromes and disorders – in relation to specific syndromes associated with intellectual disabilities, there has been an increased incidence of certain specific forms of problem behavior.

A specific syndrome includes:

- The incidence of self-destructive behaviors, namely biting into his hands and lips, all people who have Lesch–Nyhan syndrome (Lesch–Nyhan syndrome – an inherited metabolic disorder, which ranks among the disorders of purine metabolism in humans);
- Very high incidence of self-destructive writing after the hands of people with Rett syndrome (Rett syndrome – a neurological disorder that occurs almost exclusively in girls, regardless of their race or nationality, the main feature is apraxia, dyspraxia);
- Higher than expected incidence of various forms of self-destructive behaviors with Cornelia de Lange syndrome (syndrome Cornelia de Lange – a genetic disorder that is visible since the neonatal period, is manifested by specific features in the face and in most cases the presence of mental retardation) and Riley – DAY syndrome (Riley – DAY syndrome – inherited disorder that affects the development and function of nerves throughout the body) and the fragile X syndrome (fragile X syndrome – an inherited genetic disorder caused by a mutation in a gene called FMR1, which lies on the long arm of the X chromosome);
- Greater than expected incidence of hyperkinesis, attention deficit disorders and stereotypes in fragile X syndrome;
- Greater than expected incidence self – harm in people with autistic spectrum disorders;
- High incidence of problem behavior in Prader–Willi syndrome (Prader–Willi syndrome – a condition that affects both genders, this syndrome is a collection of several diseases and their combination, and is the most common genetic cause of obesity);
- The occurrence of problem behavior was recorded in people with epilepsy, and in general, and in relation to specific forms of epilepsy.

Degree of deterioration of intellect – the incidence of aggression, property destruction, self-destructive behaviors and other forms of problem behavior related to the degree of impairment of intellect. It is also likely that we will observe multiple forms of problem behavior at people with more severe intellectual impairment.
Affections – in addition to intellectual disability, which is the emergence of problem behavior overriding impact, may be significant even further hearing and visual disabilities, speech or inability to specific difficulties of comprehension and expression, weaker social skills, a period of disturbed sleep problems and mental health. Especially self – harm is significantly more prevalent among people with severe intellectual disabilities who have significant mobility impairment.
Environment – the occurrence of problem behavior is also influenced by the constraints in terms of residence of the individual. However, it is difficult to interpret the

relationship between the environment and behavioral problems, as research findings may lead to the conclusion that such behavior leads to institutionalization and not vice versa.

In case of problem behavior in individuals with intellectual disabilities must be taken into account that even in the lives of these individuals experiencing severe stressful events with which they have a negative impact. By Ďurecová (In Čadilová et al., 2007) are common, for example:

- Insensitive separation from loved people;
- Loss of important links;
- Restriction or denial of basic human rights (such as the inability to prepare food or drinks for your needs, or leave the area);
- Lack of privacy;
- Download;
- Constant changes in living habits and conditions;
- Institutionalization;
- Lack of control over your life;
- Ambiguity and unpredictability of what is happening around;
- Chronic experience of failure, rejection, puerility;
- Negative interactions and conflicts with the social environment;
- Lack of friends;
- Negative self-concept;
- Traumatic experiences of abuse (a high percentage of people with mental retardation).

The author further states that in practice it is often found that the problematic behavior of the client is automatically treated as a natural feature of mental retardation. Therefore, in the search for explanations of the causes of aggressive or otherwise problematic behavior it is always important to consider whether there are not hidden:

- Somatic health problems of the client;
- Side effects of medication;
- Dysfunction, environment in which there is a deprivation of certain basic needs of the client;
- The inability of the client to communicate their needs in socially acceptable ways;
- A symptom of a particular mental disorder.

Council for Intellectual Disability – Council for the mentally handicapped (2011) also highlights the problematic behavior means that something in human life is wrong. In this context, we can talk about different causes. Some of them are health problems – an individual may be sick or in pain, or a mental health problem. It is therefore important that the physician monitors, and identifies all health problems

that may be causing the problem behavior. Behavior of individuals with intellectual disabilities is a problem if it causes a serious risk to themself or others, and such behavior can have many different causes.

For example, a person with intellectual disabilities:

- Wants something but cannot explain it.
- Is bored.
- Do not like something is happening.
- Feelings of instability of the changes taking place in his life.
- Mourn the loss of a loved one.
- Is in pain.
- Has mental disorder, for example. anxiety or depression.

Currently in Slovakia there are few studies that deal with the behavioral problems and mental illness in individuals with intellectual disabilities.

In the case of behavioral problems Betková (2012) claims that the extreme behavior that violates age appropriate social expectations, therefore, is more serious than occasional children's disobedience, sporadic excesses, milder forms of hyperactivity, emotional swings and so on. According to the authors conduct disorder sometimes linked to emotional disorders or maladjusting and have a wide variability forms. Sometimes it is only a little or not at all linked to specific events (eg in the classroom), games, communication or other interaction. This could be for example. of repeated aggression, restlessness and movement, children often have difficulty in the process of education, to acquire educational skills and it is difficult for them to organize adequate teaching strategies.

3 Hyperkinetic disorder and ADHD

Hyperkinetic disorders are common disorders occurring in childhood and adolescence. The International Classification of Diseases (ICD-10) distinguishes Disturbance of activity and attention and F90.0 Hyperkinetic conduct disorder – F90.1. The classification of the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders, DSM-IV) is a hyperkinetic disorder attention deficit disorder known as ADHD (Attention Deficit Hyperactivity Disorder). European Classification of Diseases ICD-10 requires that ADHD symptoms were present in all three areas (inattention, hyperactivity, impulsivity). The ICD-10 cannot be simultaneous diagnosis of anxiety disorders and mood disorders and their presence exclusion criterion for attention deficit hyperactivity disorder. Classification of the American Psychiatric Diagnostic and Statistical Manual IV. textual revisions (DSM-IV-TR) in ADHD symptoms present and accepts only one symptom area and allows you to

simultaneously diagnose anxiety disorders and mood disorders. DSM-IV-TR, as opposed to the ICD-10 does not define a specific sub-type of behavior disorders on the basis of ADHD, but distinguishes three subtypes: a) with predominance of attention deficit disorders (experienced in 20–30%), b) with a prevalence of hyperactivity – impulsivity (experienced in less than 15%), c) the combined subtype (experienced in 50–75%). According to the DSM-IV-TR may be determined by multiple co-morbid ADHD disorder, which is not possible in the classification ICD-10th In DSM-IVTR blurs the hierarchy disorders. Non-etiological concept of mental illness can sometimes lead to confusion over the nature of disorders such as blurs the distinction between ADHD and a primary or secondary hyperkinetic syndrome. (Šuba, 2009, Tichá, 2008)

3.1 Hypoactivity

A hypoactive child speaks less; is passive, less mobile. Such children are slow, clumsy, speaking little can, last a long time idle. They act as, obedient, but sometimes give the impression of a child with severe disabilities than they actually have. (Betková, 2012)

3.2 Aggression

Aggressiveness according Betková (2012) is any intentional conduct, the motive is open or symbolic form to cause someone or something injustice, harm or pain. In kindergarten disputes arise most often on toys, be it verbal altercation, but which can result in serious attacks such as beatings, shoving, etc. Sugden (2006, cited under Theiner, 2007) recognizes the following five kinds of aggression:

1. impulsive aggression is related to an inability to resist the impulse impelling or temptation, leading to a rapid, unplanned response to internal or external stimuli.
2. Affective aggression is based on affective instability, which means overreaction to negative or frustrating stimuli. Affective aggression often takes place rapidly and appears as impulsive, but differs from previous sharp change in emotional state.
3. Anxiety aggression is associated with anxiety and excessive arousal (hyperarousal). Anxiety is an emotional response to threatening stimuli. However, if excessive, leads to overstimulation and if it exceeds the individual tolerance it can run to misdirected aggression against himself or others, and this aggressive act leads to relief. Typical for children with post-traumatic stress disorder (PTSD) in autism spectrum disorders, neurodevelopmental disorders and mental retardation.

4. Aggressiveness of cognitive disorganization occurs in psychosis, which is impaired perception and judgment. Particularly important is the paranoia that is often trigger of aggressive behavior.
5. Predatory aggression is also referred as cold-blooded or planned. Typically occurs in behavioral disorders.

3.3 Children's disobedience

As reported Betková (2012) when it comes to child disobedience conscious or unconscious sometimes a failure to comply with instructions, orders or prohibitions of parents, teachers, educators, disregard repeated calls for obedience, enforce their own, often educationally undesirable intentions.

Cause rebellious behavior may be (Fisher, 1986, cited under Betková, 2012):
– Incorrect education (vagueness, rigor inconsistency)
– Other harmful influence of the environment (bad pattern, arguments);
– Inborn inclination (inability to adapt)
– Pathological condition (encephalopathic personality disorder, psychopathy).

Most often the child resists around the third year and puberty. The improper upbringing may change physiological rebelliousness in permanent feature of man. Children can grow into rebelliousness affective disorders. (Betková, 2012)

3.4 Oppositional Defiant Disorder

This disorder occurs in children of preschool age. They present strongly defiant, disobedient and provocative behavior and at the same time serious antisocial and aggressive acts do not appear. It is not excluded that it is a type of behavioral disorder that is different from all others in quantity but not in quality.

The basic feature is (according to ICD 10) negativistic, hostile, defiant, provocative and disruptive behavior, which is clearly beyond the scope of normal behavior for a child of the same age and socio-cultural background, and which does not seriously degrade the rights of others.

Present rebelliousness against mature, non-compliance is a psychological torment others. Furthermore, the present irritability – these kids are easy to get angry, because they have a low frustration tolerance. For their mistakes they often blame others. Their defiance has a significant component of provocative, leading to frequent confrontations.

Together with the described symptoms is a disorder characterized by violations of the rights of others, violation of laws, brutality, tyranny and destruction of property.

If these behaviors later in life arise, this is an evolution towards other behavioral deficits. (Theiner, 2007)

4 Overview of some interdisciplinary approaches

For the care of children with any kind of disability, respectively multiple disability, it is extremely important interdisciplinary approach and teamwork. Nowadays, an ever greater effort to enforce such treatment programs that meet these criteria.

Interdisciplinary approach in our view can be understood by team members work independently, meet informally to discuss matters before the actual diagnosis, report writing, or discuss before develop a plan for the child. Parent is considered a collaborator. (Pagliano, 2001)

In the following section of this paper we present some therapeutic interdisciplinary approach applicable in practice when working with children with developmental disabilities and behavioral disorders.

4.1 Program and methodology Hand–Brain ©

Program Hand–Brain © is a new author's methodology by authors A. G. Smolianinov and A. Vančová.

Vančová (2010, S. 158) defines that the methodology is "built on the basis of an interdisciplinary team approach and cooperation, and use complex new, innovative and relatively highly efficient and specific neuropsychophysical, neuropsychoeducational interventions, corrections and therapies. The methodology integrates rehabilitation, correction, stimulation, therapeutic, educational and counseling practices."

Program Background and Methodology Hand–Brain © pursuant Vančová (2010, p. 158) comprises:

- N. Bernštejn theory of evolutionary stages of building movements and physical development sphere,
- Knowledge of human biomechanics,
- Innovative approaches to neuropsychology and neurophysiology with a focus on early and pre-school age,
- Modern approaches of psychophysiology, psychology of learning and applied psychology with an emphasis on feedback theory,
- Adding selected parts of neurotherapy and neurofeedback,
- Holistic application, holistic approach to the notion of the phenomenon of man with disabilities,
- Current special pedagogical theory and educational rehabilitation of communication theory,

– Interdisciplinary approach and team cooperation,
– Us age complex neuropsychophysical, incentive, corrective, educational and counseling practices,
– Attempt to restore anomalous development of a disabled child (individual) within the framework of the existing evolutionary regularities.

Smolianinov and Vančová (2011) point to the work of professionals who deal with biomechanics when writing. This difficult movement involved two ways of working muscle of the that must be made. This has two functions – static and dynamic. In implementing the proper movement of large muscle groups need to fix the position of the entire body in a sitting position, the muscles of the upper limb girdle and arm fixed position throughout the upper limb and form the support for dynamic function and the possibility of carrying out desired hand movements and individual fingers (grip) in mutual coordination. Accuracy and power of movements performed within the fine motor is directly related to the synergetic connections of the muscles with the muscles that make up the support for this movement.

It follows that no physiological involvement of muscles and tendons involved in the backbone of the hands of the forearm (as one of the life stages of infant gross motor skills) and follow each other physiological muscle synergies can be no proper development of fine motor hand with the evolution in terms of grip and thumb opposition fingers.

The authors draw attention to the program, a common problem in the development of fine motor skills of children with CNS damage, in which the biomechanical point of view to see inappropriate training grip, using unsuitable objects. Frequent repetition of the exercise then leads to the creation and consolidation of pathological automatism and pathological synergies, which are very difficult to remove. It is very important to follow the practice of large movement patterns, with security lock kinematic chain. Through the timely development of fine motor skills in children with impaired CNS can effectively stimulate further psychomotor development of children.

4.2 The Portage Model

The Portage Model of education was established as a part of the government program for the development of education for children with delayed development, respectively with disabilities in the United States, Wisconsin. The main idea The Portage Model of education, according to Shearer (1974) home tutorial, directly involving parents in the education of their children. The model is based on the following assumptions:

- Direct involvement of parents in the process leading to the motivation of parents to educate, knowledge and skills to understand the needs of their child,
- Learning takes place at home, so there is no problem of transforming their newly learned skill or behavior from the classroom environment to the home environment,
- Parent has constant contact with the child's behavior, which can lead to a more successful correction of behavior, learning objectives are built taking into account the typical habits of the family, its lifestyle peculiar culture, thus newly acquired behaviors and skills the child has acquired an important functionality for a given environment,
- It is likely that the behavior which has been harvested in a natural environment will be maintained in the long term,
- The involvement in education of the whole family, as a closer social environment, the target becomes easier achievable,
- Acquired knowledge and skills to help parents cope with the problems and at a later age.

The model is aimed at children from birth to six years who had been diagnosed lagging in development, with any type and degree of disability (mental, physical, hearing, visual), impaired communication skills, children with multiple disabilities and behavioral problems. The role of catchment centers (in our conditions could be a center – special educational counseling) is to ensure the availability of disseminating information about the program and search for parents of children with disabilities and delayed development, through collaboration with the pediatrician, neurologist, rehabilitation therapist or other health professional in the field.

The Portage Model consists of five main components:

1. individual educational program (implemented in the domestic environment and includes all development psychomotor development of the child),
2. assess the developmental profile of the child,
3. determine the model of teaching on the basis of the home environment,
4. curriculum with weekly targets,
5. weekly staff meetings to solve problems or diagnosed curricular adaptations.

As a methodological materials for teacher serves the Portage guide early education, which consists of two parts. The first is a set of more than 420 concepts for education and skills training for each area of development. The second part consists of a control record sheet for each sequential skills. The guidance serves as a starting point for planning a curriculum which a teacher individually adapted to the needs of a particular child. During home visits (weekly) teacher educates parents work with the

child for practicing specific skills. The role of the parent is to work with your child to practice their skills throughout the week and record observed changes in child behavior (Shearer, 1975).

The Portage Model of education for children with disabilities has recently become widespread (eg, Canada, Britain, Scandinavia, Japan) and successfully implemented as part of a comprehensive program of early intervention.

4.3 Program HYPO

HYPO is an exercise program for preschool and school age to enhance the visual and auditory memory, concentration of attention in a partial development of perceptual – cognitive functions. The author of the program is dr. Michalová.

- The program is designed for children with attention deficit disorder, deficit hyperactivity disorder, ADD (without hyperactivity or attention deficit disorder only),
- Suitable for children of preschool and school age 5–10 years,
- The focus of the program is in domestic work, working together for a parent with a child,
- Child completes the program for 12 weeks,
- Working at home 15–20 minutes a day,
- 1× per week control and instruction clinic,
- Use is suitable for children with below-average intellect.

HYPO program brings the following results:

- Acceleration of psychomotor speed,
- Calming curves attention,
- Improving of communication between parent and child,
- ability of regular work,
- Improving emotional attunement and access to work,
- Experience success and increase awareness self-worth,
- Elimination of time pressure
- Overall improvement in school work.

(Available online at: http://www.pedagogicka-poradna.cz/pedagogicke-programy/pedagogicky-program-hypo.html, cit. 03. 08. 2014, 01:04)

4.4 Program KUPOZ

KUPOZ program is developing a program created by dr. Kuncová for school age children with a maximum penalty of 12 years. The program is designed for children with ADHD, but also children with slower psychomotor speed, neurotic difficulties, learning disabilities, it is also suitable for children with a marginal degree of mental retardation. The focus of the program is in domestic work, working together for a parent with a child under the guidance of an expert. The program lasts 15 weeks, working out daily 15–20 minutes, 1 to 14 days control. Work program can be run by psychologists or special educators in counseling or in a clinic with a valid certificate (after completing training). KUPOZ delivers similar results as HYPO program.

(Available online at: http://www.kuprog.cz/kupoz.htm, cit. 08. 03. 2014, 12:42)

4.5 Program KUMOT

Program KUMOT aims to practice and develop fine motor and graphomotorical skills.

- The program is designed for children 5–8 years,
- Suitable for children with ADHD, learning disabilities, children shy, socially inept or motor or other difficulties,
- In one group is 6–8 children,
- School and preschool children can be grouped into a common group,
- The entire program consists of 10 sessions, ongoing group 1× a week, 60 minutes each, parents are not participating in the group,
- After completion of the program psychologist/special educator meets with the parents of each child separately to evaluate the submissions and knowledge of the child, including educational conclusions,
- The program can be run by psychologists or special educators.

Results of the work with KUMOT:

- The ability to release, more open communication,
- Better control of impulses, releasing aggression,
- Improving of gross motor skills,
- The ability to express positive feelings, even non-verbal,
- Better control of speech organs,
- More enjoyable child.

(Available online at: http://www.kuprog.cz/kumot.htm, cit. 08 .03. 2014, 01:55)

4.6 School of attention (methodology development and correction of attention in children)

School of attention (methodology development and correction of attention in children) was created by Russian author N. M. Ptylajeva and T. V. Achutina. It is designed for children 5–7 years where at preschool observed or hyperactivity, impulsive act is observed or who are incoherent, or conversely weak, slow, low active, disorganized and scattered. The methodology of forming habits, planning and control is based on work with numeric array.

The aim to work with a number in a series of pre-primary education is to form and consolidate ideas about the amount of children, respectively, fix the relationship between the number and the number, teach a child to operate freely the number and in spirit while working with real objects. The methodology aims to shape and correct habits programming and control (Ptylajeva, Achutina, 2001, quoted in Tichá 2008). The methodology provides a wide range of tasks enabling individualizing approach to the prevention and correction of deficits of attention.

4.7 KUPREV (Precautionary individual program)

Program KUPREV is especially designed for children 4–8 years, according to the needs of the elderly.

- Is successfully used in children with dysphasia, autism, ADHD and other conditions,
- It can be used across the board, even for children with mental disabilities,
- The program provides child orientation in the world,
- Focus is on household chores, working parent with a child under the guidance of an expert,
- Is well usable for children of ethnically mixed marriages,
- The program can be run by psychologists or special educators.

Results of the work with program KUPREV:

- Orientation reinforces a child by a person, place and time, gaining social orientation and information,
- Children who completed the program do not have adjustment problems after entering school,
- Prevention of socio – pathological phenomena,
- Improving communication between parent and child.

(Available online at: http://www.kuprog.cz/kuprev.htm, cit. 03. 08. 2014, 02:08)

4.8 EEG biofeedback

EEG biofeedback is under Bužeková (2001, cited under Tichá, 2008) highly effective method to enhance the activation of the nervous system, particularly the training of attention, self-control, impulsivity and hyperactivity satisfaction, but also improve mental performance. EEG Biofeedback is a method that allows the speed control of electrical activity of the brain. The essence, according to Malá (2000) uses biofeedback to self-regulation of brain activity.

4.9 Filial therapy

Filial therapy is under Štefančiaková (2013) exceptionally prepared and practiced on a client-oriented play therapy. Filial therapy is primarily designed for children aged 3–10, respectively. 12 years. Together with the change of the child, however, there is also a change of a parent.

VanFleet (2011) makes the following therapeutic targets of filial therapy:

A. Therapeutic goals for children:
   - Give children the opportunity to learn and express their feelings fully and constructively,
   - Give children the opportunity to do that hearing,
   - To help children find effective ways of problem solving and effective coping skills,
   - Increase self-confidence and self-esteem of children,
   - Increase the confidence of children towards their parents,
   - Reduce or eliminate maladaptive behaviors and current problems,
   - Help children develop active behavior,
   - Encourage open and cohesive family atmosphere, which contributes to a healthy and balanced development of the child in all spheres: social, emotional, intellectual, behavioral, physical and spiritual.

B. Therapeutic targets for parents:
   - A general increase in parents understanding of the specifics of child development,
   - Increase the understanding among parents and especially their own child,
   - To help parents understand the importance of the game and emotions in the life of their child, as well as in their own,
   - Reduce frustration among parents regarding their child's,
   - To help parents develop skills that are likely to deliver better results in the upbringing of their child,
   - Increase the confidence of parents in their parenting skills,

- Help parents open the door to communication with their child and then help keep this door open,
- To enable parents to work better together as a team,
- Increase parental feelings of warmth and trust towards their children,
- Give parents a safe atmosphere in which are not afraid of problems associated with their children or their parenting.

Based on the research we can talk about the following benefits of filial therapy (Van-Fleet, 2010, cited under Halamíčková, 2013) for children with behavioral problems:
- Low rate of early discontinuation of therapy,
- Significant reduction until complete disappearance of the problems identified,
- Strengthening of parenting knowledge and skills,
- Increasing acceptance and understanding of parents towards their child,
- Reducing parental stress,
- High percentage of parental satisfaction with the outcome of therapy,
- Long-term benefits and sustainability of changes confirmed longitudinal research (after three to five years).

5 Conclusion

The aim of our study was to highlight the need to implement when working with children with intellectual and multiple disabilities therapeutic programs with an interdisciplinary focus. Interdisciplinary approach and teamwork in the modern era should have been obvious, and therefore we present the specifics of some programs, applicable in practice.

6 References

[1] BARTKO, D. et al. 2008. *Demencia Alzheimerovho typu.* [on-line]. In Via practica, 2008, č. 10, s. 398–402. Available: http://solen.sk/index.php?page=pdf_view&pdf_id=3407&magazine_id=1

[2] ČADILOVÁ, V. et al. 2007. *Agrese u lidí s mentální retardací a s autizmem.* 1. vyd. Praha: Portál, 2007. 248 s. ISBN 978-80-7367-319-2

[3] EMERSON, E. 2008. *Problémové chování u lidí s mentální retardací s autismem.* 1. vyd. Praha: Portál, 2008. 168 s. ISBN 978-80-7367-390-1

[4] *Challenging behaviour and health.* NSW Council for Intellectual Disability, 2011. Available: http://www.nswcid.org.au/health/se-health-pages/challenging behaviour-and-health.html

[5] MALÁ, E. 2001. *Hyperkinetické poruchy.* [on-line]. In Psychiatrie pro praxi, 2001, č. 3, s. 12 Available: http://www.psychiatriepropraxi.cz/pdfs/psy/2001/03/06.pdf

[6] *Medzinárodná klasifikácia chorôb. Duševné poruchy a poruchy správania (F00–F99).* Available: http://data.nczisk.sk/old/infozz/mkch/mkch-10/cast0500.pdf

[7] PACLT, I. et al. 2007. *Hyperkinetická porucha a poruchy chování.* Praha: Grada, 2007. 240 s. ISBN 978-80-247-1426-4

[8] PAGLIANO, P. 2001. *Using a multisensory environment.* London: David Fulton Publishers, 2001. ISBN 1-95346-716-2, s. 80–92
[9] SHEARER, D. et al. 1975. *Portage Project Readings.* [online]. Portage: Portage Project readings, 1975. Available: http://www.mncdd.org/parallels2/pdf/70s/75/75-PPR-HEW.pdf ISBN 608-742-5342
[10] SMOLIANINOV, A. G. – VANČOVÁ, A. 2010. *Ruka – Mozg.* Kyjev: Svetoč 2010, 109 s.
[11] SMOLIANINOV, A. G. – VANČOVÁ, A. – HARČARÍKOVÁ, T. 2009. *Komplexná rehabilitácia viacnásobne postihnutých.* In *Komplexná rehabilitácia viacnásobne postihnutých – niektoré nové metodiky a programy.* Bratislava: MABAG 2009, s. 13–29, ISBN 978-80-89113-43-9
[12] ŠUBA, J. 2009. *Nové možnosti liečby ADHD na Slovensku.* [on-line]. In Psychiatria pre prax, 2009, č. 10 (3), s. 116–120. Available: http://www.solen.sk/index.php?page=pdf_view&pdf_id=3819
[13] ŠVARCOVÁ, I. 2011. *Mentální retardace.* 4. vyd. Praha: Portál, 2011. 224 s. ISBN 978-80-7367-889-0
[14] THEINER, P. 2007. *Poruchy chování u dětí a dospívajících.* [on-line]. In Psychiatrie pro praxi, 2007, č. 2, s. 85–87. Available: http://www.solen.cz/pdfs/psy/2007/02/09.pdf
[15] TICHÁ, E. 2008. *Pedagogika jednotlivcov s poruchami správania (Vybrané kapitoly).* Bratislava: Mabag spol. s r.o., 2008. 1. vyd. 94 s. ISBN 978-80-89158-3
[16] VANČOVÁ, A. 2008. *Integrácia a inklúzia osôb s postihnutím, narušením alebo znevýhodnením v kontexte edukácie v komparácii s ich segregáciou.* 1. vyd. Bratislava: Mabag spol. s r. o., 2008. 66 s. ISBN 978-80-89113-48-4
[17] VanFLEET, Risë. *Filial Therapy: What Every Play Therapist Should Know?* In *Play Therapy: Magazine of the British Association of Play Therapists.* [online]. 2011, 65, s. 16–19. Available: http://www.play-therapy.com/images_prof/FT.BAPT.article.pdf. [cit. 17. 7. 2014, 17:21].
[18] VAŠEK, Š. 2006. *Základy špeciálnej pedagogiky.* Bratislava: Sapientia, 2006. 2. vyd. 217 s. ISBN 80-892290-2-6
[19] VÍTKOVÁ, M. 2003. *Integrativní školní (speciální) pedagogika.* Brno: MSD, spol. s. r. o., 2003. 248 s. ISBN 80-214-2359-5
[20] ŽOVINEC, E. 2005. *Dieťa s ADD/ADHD v škole bežného typu*. In *Dieťa so špeciálnymi potrebami v bežnej škole: Zborník príspevkov zo seminára.* Nitra – Hlohovec: PF UKF s. 24–25. ISBN 80-8050-803-8

Internet resorces

American Association on Intellectual and Developmental Disabilities (AAIDD) – www.aaidd.org
Pedagogický program HYPO – http://www.pedagogicka-poradna.cz/pedagogicke-programy/pedagogicky-program-hypo.html
Kuprog CZ – http://www.kuprog.cz/kupoz.htm
Kuprog CZ – http://www.kuprog.cz/kumot.htm
Kuprog CZ – http://www.kuprog.cz/kuprev.htm

(reviewed twice)

PaedDr. Andrea Prečuchová Štefanovičová, PhD.
Pedagogická fakulta, Ústav špeciálnopedagogických štúdií
Račianska 59
813 34 Bratislava
Slovak Republic
precuchovastefanovicova@gmail.com