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У журналі представлено різноманіття психотерапевтичних підходів, модальностей та методик, що пов'язані з психологічним та медичним просторами сучасної психотерапевтичної та консультативної допомоги. Розглянуто теоретичні і практичні питання щодо різних аспектів психотерапевтичного втручання при різних розладах, їх гендерні аспекти, методики психодіагностики, взаємодію психотерапії та культури тощо.

Для психотерапевтів, консультантів, практичних психологів та всіх, хто цікавиться питаннями надання психотерапевтичної допомоги.

В журнале представлено разнообразие психотерапевтических подходов, модальностей и методик, связанных с психологическим и медицинским пространством современной психотерапевтической и консультативной помощи. Рассмотрены теоретические и практические вопросы по различным аспектам психотерапевтического вмешательства при различных расстройствах, их гендерные аспекты, методики психодиагностики, взаимодействия психотерапии и культуры и тому подобное.

Для психотерапевтов, консультантов, практических психологов и всех, кто интересуется вопросами оказания психотерапевтической помощи.

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EXPIRIENTAL GROUNDS OF CLASSIFICATION AND PSYCHOTHERAPY OF THE PERSONALITY DEVELOPMENT PROBLEMS

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The problems of classification of psychological problems, which are particularly acute in the period of rejection of nosological (etiopathogenetic) grounds: normalization of pathological manifestations and tolerance to them are the essence of the cultural mainstream. Given the approach to etiopathogenic classification built on experiential grounds. Four classification axes are considered. The first axis of classification is the types of emotional schemes that are formed in ontogenesis early enough. The scheme includes five components: the actual primary "blocking" experience, the corresponding system of early memories, bodily manifestations (emotions-in-body), corresponding cognitive representations (interpretations) of situation and motivation. In the literature there are attempts at the classification of such schemes, which are called "early non-adaptive schemes" (John Young), however, in this version of the classification confused primary and secondary "blocking" experiences and they are not tied to certain ontogenetic periods and psychotrauma. Therefore, the classification of emotional schemes needs further elaboration. The second axis of classification is the type of personal process, which is determined by the structure of the organization of the psyche. Type of personal process, and they are four (optimal, fragile, dissociative and psychotic), determines the ability of the client to move in psychotherapy. The third axis of classification is the type of organism flow and the level of its actualization. K. Rogers has left the list organismic tendencies. The fourth axis of the classification – the degree of acceptance of the personality of the body flow, that is the depth of self-actualization.

KEYWORDS: classification of psychological problems, emotional scheme, psychotherapeutic process, actualizing tendency.

Existing models for the classification of behavioral, emotional, and social issues focus, as Thomas Achenbach and David Ndetei (Achenbach, Ndetei, 2018, p. 87) point out, on phenotypic characteristics that may be useful for the specification of a disorder by practitioners. These models make it possible to create a conventional space in frame of which the ideas about the types of disorders and their etiology, consequences and results of treatment will be unified and communicated. These authors note that the “lack of knowledge about specific causal connections” (Achenbach, Ndetei, 2018, p. 87) contributes to the creation of a phenomenological classification of disorders, to the description of symptoms and syndromes. In some cases, we meet the nosological orientation of the classification, which describes the etiopathogenesis of the disorder, in most cases, syndromic. These classification models of ICD-10, DSM V, DC: 0-3 are based on the developments of expert committees that modeled diagnostic categories (headings) and criteria. However, in diagnostic categories, especially in children, procedures for assessing behavioral, emotional, and

social problems in different social environments (school, family) are not precisely described and there is a serious inconsistency of data from different informants (teachers, parents and children themselves), which does not allow the doctor to make unambiguous yes/no diagnostic solutions regarding the presence or absence of a diagnostic category. Such symptomatic models are not always convenient in the implementation of medical care, and it seems they seriously weaken nosological positions in psychiatry and neurosology.

The idea of abandoning nosology and the causes of disorders also exists in psychology, primarily in behavioral psychology and psychotherapy, and this idea is reflected in the "aspirin metaphor" - aspirin helps with headaches, but this does not mean that lack of aspirin is a cause of headaches. Thus, the classification of psychological problems can be based on a phenomenological - behavioral - basis.

The antipsychiatric direction also seriously undermines the idea of causation (nosology) and leads to the normalization of a wide range of psychiatric disorders.

Risomal thinking, as a manifestation of postmodernism in culture, generally eliminates clear binary schemes, the difference of cause and effect, center and periphery, top and bottom, important and unimportant, good and bad, and, finally, norm and pathology, etc. As Alexander Dyakov notes (https://www.vshm.science/blog/avkurpatov/921/), the result of this is that "the world has lost its core, but has become not rhizomatic, but a world of consensus". This means that everyone agrees with everyone, including the classification of psychological problems. This, by the way, means that tolerance has come to replace normativity, and what has recently been described as pathology has begun to normalize: homosexuality, transsexualism. In 2016, the Ministry of Health of Ukraine approved a unified clinical protocol of primary, secondary (specialized) and tertiary (highly specialized) medical care for gender dysphoria, which explicitly states that "transsexuals, transgender people and gender-non-conforming individuals *are not inherently sick*. Rather, distress from gender dysphoria, when present, is a problem that can be diagnosed and for which many treatment options are available" (Unified clinical protocol…, 2016, p. 9). If this is not a disease, then why treat it? Gender Identification Disorders (F64), which, for example, include transsexualism, double-role transvestism in the ICD-10 in the ICD-11 project is replaced by a gender mismatch. Mismatch is not a disorder, not a disease. Why am I talking about this? Because the mainstream, associated with normalization and tolerance, leads to the limit that the classification of psychological problems will not be very different from psychiatric ones. This, in my opinion, is the serious danger of losing the psychiatric view itself. And in this sense, there are serious problems of differentiating the psychological problem from the psychiatric one.

The psychological view on the origin of problems can be very different. Today there are many psychologies, and, naturally, many personalities, created by these psychologies. We are based on client-centered psychotherapy, and in its later versions that designated as experimental, or, if more precisely and specifically, as experimental-procedural or emotionally-focused therapy. Joseph Hart (Hart, 1970) identified three phases of client-centered psychotherapy development: 1) the phase of non-direct psychotherapy, 2) the phase of reflexive psychotherapy, and 3) the phase of experimental psychotherapy, where the emphasis is on preverbal, or subverbal client experience. Hart refers to the work of Eugene Gendlin, his concept of felt sense, which reflects the actual pre-modal, subverbal customer experience, where not words, but feelings-in-the body, are important. Moreover, as L. Greenberg and J. Shafran (Greenberg, Safran, 1989) have shown, the ability to reflect on one's own emotional experience is a reliable predictor of psychotherapy success. M. Main (1991) designated this ability as metacognitive.

I will present the main ideas in the form of theses:

1. The topology of the psyche is presented in Figure 1. There are some organismic tendencies (on the OT slide) that are immanent to the personality (the inner circle), and which, like peculiar "irrigation canals" or capillaries, nourish the psyche and revive it. In this sense, the metaphor of psychotherapy, proposed by Joyce McDougall (2007), is "seduction

to live" and not only "understand". What carries such a channel? An organismal tendency or an organismic stream, in which energy and meanings are merged. C. Rogers has no list of such organism tendencies, which is bad for anthropology, but good for psychotherapy. Z. Freud has only one organism tendency, libido, the dynamics of which determine the development and well-being of the individual.

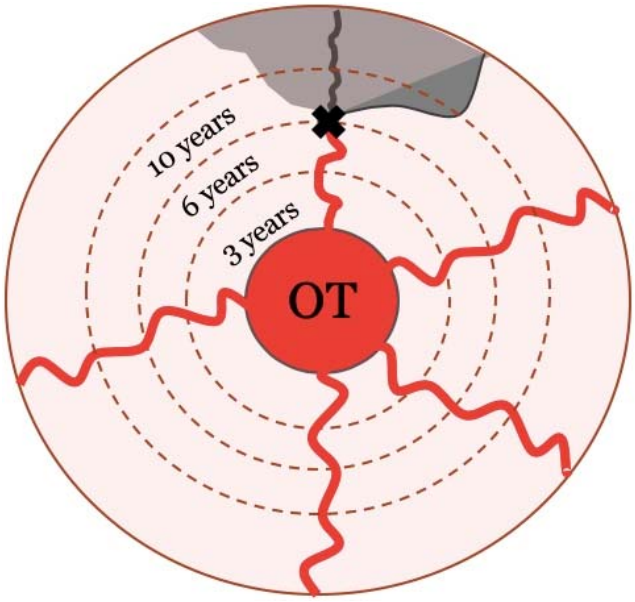

Figure 1. Topological model of psychological space. OT- organismic tendency.

2. Thus, an organismic tendency flows through the capillary, which, as we have said, carries not only vital energy, but also meaning. The meaning is built into it, and it cannot be brought from the outside. The meaning of food in the organismic food stream itself. If it is not, it cannot be brought from the outside.

Otherwise, the meaning is transformed, it becomes the meaning of "love" - "eat for mom, for dad, if you love them, of course"; "Health" – "to eat this, to be healthy?"; "Beauty and visual appeal", etc. The same happens with streams of sexuality, love, affection, separation, etc. The search for meaning outside the organismic stream itself leads to the fact that people are trying to "put" inside meanings, that they take outside themselves. For the time being, it works. Religion can be an external source of information, when it is not embedded in the organismic sacral stream. Rene Girard in the concept of "mimetic desire" presents "external" meaning for the individual sense, induced by another example - a person must steal his desire from another and enter into conflict with him.

The fullness of the capillary determines the energy of this desire, or meaning.

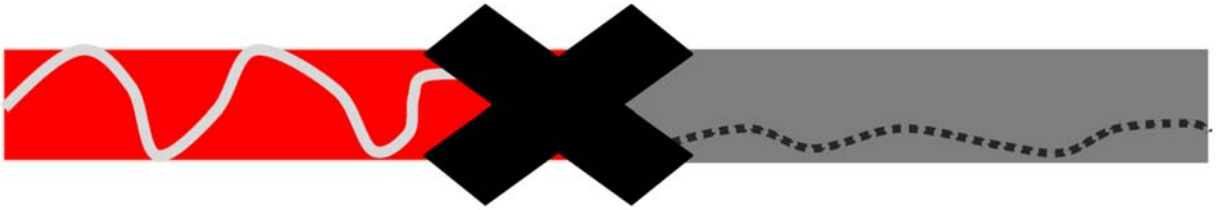

Figure 2. "Blockage" of OT movement in "capillary"

According to B. Nitschke (1998), for Z. Freud it was important to "increase the intensity of the emotional and affective process", i.e. according to our metaphor, - to clean the capillaries from the "mash" plaques, and to ensure the free movement of the organismic stream (OT).

3. The internal "blockage" is a pinched, or fixed affect, which "stuck" in the emotional "capillary",

preventing, like a plaque, the movement of the organismic stream. “Blocking” emotions have a complex structure: the underlying is a poorly conscious primary “blocking” experience (for example, the feeling of “second-rate”, “defectiveness”, “depravity”, “abandonment”, etc.) and “secondary” experiences are superimposed on it. Only by removing the primary links from the structure of the “congestive” experiences, the conglomerate of the “blocking” feelings break down into separate experiences that are ready to move. The low awareness of the primary experience is expressed either by the denial of the presence of some latent experience (there is none), or by the impossibility (difficulty) of calling this experience using the word. This closes the organismic desire itself. If it is alive, the person says, for example, “I want love”; if it overlaps, the statement is different: “I want love,” even further from this desire: “I want to want love”. The farther from the organismic flow, the more the conventions – "I want", "would like", “would like to want”, “would like to want to want”.

If some part of the mental becomes “dead”, for example, love and sexuality, then the quality of “as if” appears in the functioning of the personality (Andryushchenko, 2001):

"I am not given Earthly pleasure
Earthly Peace and Earthly Destiny
I experienced ups and downs
In My striving to become Myself.
But the hour has passed and minutes have flowed.
Aspiring to fill the Void.
But I suffer and love as if
And this state - I live? ".

“As if” (“as though”) life, love, affection, autonomy, etc. become filled with the existential of Emptiness, or Senselessness, or Uselessness, or Second-Grade, etc. The more blocked the flow in the “capillary”, the more it is necessary to compensate reality with fantasy, and desires are replaced by its surrogates – not “I want”, but “I want to want”, and then “I want to want to want”, etc. At a certain stage, when fantasy can no longer cope with the function of replacing reality, it “bursts like a bubble” and Emptiness arises (subdepressive and actually depressive states).

4. Secondary “blocking” emotions have special properties - they: 1) “stuck together” - there is no separate offense, anger, helplessness, etc.; they constitute a holistic conglomerate; 2) resistant to exposure; 3) they do not completely disappear - they only fade, hide, making up potential emotionality, which can be actualized (rather than arise) for the most insignificant reason, i.e. they become potential; 4) somatized - they exist as “things in the body” (A. Yermoshin), as “a lump in the throat”, “balls on the temples”, “a bag on the shoulders”, “failed legs”, etc.; 5) they do not flow - cannot move, change: the offense itself can either be “dried” by rationalization, or defused by cathartic techniques, or the energy of resentment can be shifted to other areas of mental functioning, it is fundamentally difficult to remove it. The only form of movement of “blocking” emotions is a “vicious circle”: for example, resentment → anger → helplessness → resentment, etc. The only possibility to split the stuck together conglomerate of emotions of the “secondary” block consists in extracting the core from it - experiences of primary “blockage”. This is achieved by focusing technique of the client on the experiences of the primary “bockage”. Such focusing is triggers the psychotherapeutic mechanism of “emotional balancing” described by C. Rogers. Primary “blocking” experiences go through the following stages: a) initially, they only "leak" into consciousness; b) they reach the limit; c) they actualize the mechanism of emotional balancing. When the experience of the primary “blockage”, for example, "abandonment", "uselessness" becomes extremely pronounced, it moves, releases the lumen of the capillary, which increases the flow of the organismic tendency. When a mouse is driven into a corner, it becomes decisively wild from fear – it rushes at the offender. Among the many mechanisms of psychotherapeutic change of the client, the mechanism of emotional balancing is the most important and, unfortunately, little noticed even among client-centered therapists. Change does not occur through the "head", not through words (although the mechanism for enhancing maturity is important). It happens when the body changes. Without a change in bodily manifestations, it is

difficult to talk about real organismic changes. The target of therapy, therefore, is emotion-in-the body.

5. The blockade of the organismic tendency is carried out by secondary and primary “blocking” experiences, which, like a concrete slab, overlap it. According to the principle of equipotentiality, the corresponding parts of the body become also "dead".

6. Robert Elliott and Leslie Greenberg introduced the concept of "emotional scheme", which somewhat complicates the understanding of the structural organization of emotional experience, emotional “blockage”. The scheme includes five components:

a) the actual experience, which is a primary emotional “blockage”;

b) a system of early memories that supports this main traumatic experience of the primary “blockage” and, in turn, remains stable under the influence of this experience;

c) bodily manifestation system (for example, “weak legs, hands”, upper body prevailing over bottom, squeezed diaphragm, flattened abdomen, cold kidneys and lower back, psychogenic bladder, “alien” abdomen, feeling of a belt or lining on the abdomen, etc.), which keeps the “blocking” experience in the body;

d) a system of cognitive interpretations, for example, in the primary experience of “abandonment”, interpretation is possible – “Nobody needs me”, “I must be obliging to be interesting”, “I must live by the interests of others to be necessary”, etc.;

e) a motivation system determined by the previous components of the emotional scheme, for example, “I’m afraid to be alone – run to people”, “I'm not going anywhere – anyway, nobody needs me”.

These five components of the emotional scheme are like five nails that hold the slab, under which the organismic, actualizing tendency is constrained. In order to release the organismic tendency, to release it from captivity, it is necessary to remove the slab, and, therefore, to remove all five nails with which it is fixed. Another metaphor: if the riverbed, in which the body flux flows, is blocked, and blocked by all the “bricks” of the emotional scheme, then it is necessary to remove all these “bricks”. And they do not lie separately, but are interconnected in a single network - one such “brick” holds the other. And cleaning the channel is hard work. Here are a few considerations:

a) pure, direct emotion rarely exists - it is, firstly, objectified, and therefore introduced into the symbolism of the objective world (the fear of something is always easier experienced than non-objective anxiety), secondly, the experience is almost always found, like a piece of paper, in an intelligent file. The client’s experience in its pure form is rarely presented: either it is altogether blocked for the client’s awareness, who in a result cannot feel it, or it is distorted. One type of distortion is the intellectualization of an experience in which it is placed in an intellectual shell, like paper in a file. As a result, painful emotions become less traumatic: one thing is to have the concept of one's own loneliness and uselessness, and another is to experience these feelings in a pure form. Emotion in its pure form is difficult to touch, it's like a snow man, yeti – about the existence of which everyone knows, but nobody communicated with him. We cannot pull this emotion over the files -the files we get are empty – emotions fall back, and wrapped in new files. Therefore, the client should be immersed in the traumatic experience in which this emotion is located. If the injury falls on the age of, for example, three years, then we must help the client to remember this experience, but not from the outside, but to enter inside it. We can see through the window of the house next door that the room is dirty. But the knowledge of this does not provide an opportunity to remove this dirt. You need to go there with a broom, cloth and mop, and remove. Trauma memory does not automatically provide immersion in it.

An important means to lead a client into the depth of experience is empathy, but his understanding remains insufficiently articulated, especially since it is rather difficult to immerse in a broken psyche. As noted Bondarenko O.R. (2012, p. 102), “empathic understanding may be limited by the strangeness and obscure forms of experiencing client behavior”. Hence, the psychotherapist is experiencing a shift of focus from emotional (which is understandable when the client’s mind is normal)

to cognitive structures, when the client is at a lower level of mental organization (borderline and psychotic) - "we don't feel into, we'll understand". Various forms of understanding (cognition), replacing the actual empathy arise: "empathic knowledge", "knowing understanding", "sympathetic knowledge" (W.W. Keil, B. Reisel, J. Eckert - cited in 10). As indicated by O.P. Bondarenko (2012, p. 102, 103), the goal of such understanding / knowledge is "to develop approaches at first to incomprehensible forms of experience" when "the world of customer experiences is not sufficiently accessible to direct perception ...".

Thus, **the first approach to the classification, or axis of classification,** of the problems of personality development refers to the classification of emotional patterns that impede the normal development and functioning of the personality.

Jeffrey Young, a representative of cognitive psychology and psychotherapy, introduced the construct "early maladaptive schemes", which includes "ideas of a person about himself, the world and other people, a stable complex of memories, emotions, beliefs and bodily sensations, which was formed in childhood and developed throughout life" (quoted by Galimzyanova and coauthors, 2016). He described 18 early maladaptive schemes, which he grouped into five major categories (domains). Each domain reflects the dissatisfaction of a developmental need.

The first domain reflects, from our point of view, the problems of unmet need for a merger (fusion) and corresponds to the child's age from birth to 1 year of life. These include: abandonment, mistrust (as the expectation of ill-treatment), emotional deprivation, defectiveness (and hence, the eternal experience of shame), social exclusion.

The second domain reflects, from our point of view, variants of violation of the need for autonomy, separation and correlates with the child's age from 1 to 3 years: dependence (helplessness), vulnerability, confusion (or undeveloped identity), unsuccessfulness.

The third domain reflects, from our point of view, disturbed boundaries, but in fact also to some extent indicates problems of separation. These include: grandeur and lack of self-control.

The fourth domain reflects, from our point of view, a violation of the need for self-esteem and self-acceptance, that is, most likely, problems in solving oedipal rivalry (age of the child is 3-5 years old): humility, self-sacrifice, search for approval.

The fifth domain reflects, from our point of view, a violation of the need for the free expression of one's needs and emotions: negativism, suppression of emotions, strict standards (pickiness), punitiveness. In the concept of Jeffrey Yang, on the one hand, primary and secondary "congestive" experiences get confused, for example, obviously secondary, derivatives are "distrust", "social exclusion", "humility", etc., on the other hand, the early maladaptive schemes are presented as types of behavior that are not associated with certain ontogenetic periods of development.

In the concept of ontogenetic development, three periods are distinguished: the 1st (from zero to 1 year) – fusions or merges; the 2nd (from 1 to 3 years) - separation and, the 3rd (from 3 to 5 years) - assimilation of sexuality - for women, the solution to the problem of male rivalry - for men. These periods bear certain threats to development, constitute some psychotraumas associated with dissatisfaction of needs, which are characteristic of these age periods. These are such injuries: for the 1st period - rejection, uselessness; for the 2nd period - depreciation, suppression and formation of learned helplessness; for the 3rd period - asexualization of women and the weakening of male. On the basis of these traumas the corresponding types of characters are formed, which are stable style protective formations that allow to cope with a specific trauma.

In accordance with the type of trauma and characterological type, basic emotional schemes are also formed (Table 1).

This is one of the options for the classification of emotional patterns, corresponding to the characterological style of the personality and determining its behavior. It is necessary to describe these schemes. Two dissertations are being made under our supervision. They are devoted to the influence of early emotional patterns on the formation of post-stress psychological

maladjustment and the influence of emotional patterns on the formation of the lifestyle of students. Work with emotional schemes is important in emotionally focused therapy and is carried out using the focusing technique. From a therapeutic point of view, this means a tactical departure from K. Rogers's therapeutic strategy, namely, the strategy of following, which is expressed by the principle "half a step behind" the client. A new strategy is a customer management strategy.

Table 1

The ratio of ontogenetic periods of development, early traumas, type of character and emotional scheme

Stage of development	Trauma	Character	Scheme
I. Fusion	1. Rejection	Schizoid	?
	2. needlessness	Oral	?
II. Separation	3. Depreciation	Narcist	?
	4. Suppression	Masochistic	?
	5. Forming Learned Helplessness	Symbiotic	?
III. Oedipal	6. Women's asexualization	Hysterical	?
	7. Male weakening	Rigid	?

7. The optimal psychotherapeutic process assumes that if a psychotherapist "calls in" a client, showing participation and empathic understanding, then he will openly go. The psychotherapist needs a little - just "call" the client. The client's optimal movement in psychotherapy is connected with the fact that he quite easily moves from one component of the emotional scheme to another, from one stage of the psychotherapeutic process to another (and Rogers described seven such stages). The client has no "blockage" in such a move, so it's enough to "call" the client - he will hear and go.

The reflective technique proposed by C. Rogers is such a "call" of the client. The optimal process, therefore, involves an organization of the client's psyche, in which all zones are connected, and from one zone (component of the emotional scheme) it is easy for the client to enter another. But there are few such clients, especially recently.

Let me give you some phenomenology of "block" of the psychotherapeutic process (Kocharyan, 2018):

1)"A decrease in the "energy" of the flow — the client initially expresses activity (speed of speech, general activity, emotionality, gesticulation, openness to the psychotherapist, etc.), and then, as if "freezes", he does not have the strength and desire to move deeper, just like also the psychotherapist;

2) the formation of "traps" - the client is happy to discuss some topics (for example, relationships with the mother, childhood), and as soon as the process enters the zone of sexuality, the client stops, is angry, silent. There is a feeling that the client needs to be pulled, and at the same time he rests;

3) loss of some components of the emotional scheme - the client moves exclusively in the intellectual component, or the body component, which makes it difficult to change the entire traumatic pattern;

4) the client, as it is difficult to him to enter the traumatic zone, cannot leave it, showing signs of retraumatization in the process of psychotherapy;

5) high intensity of the client's experiences, blocking the possibility of moving the client into the depth of the problem and their own experiences.

There is a tendency to consider the "bad" process as a manifestation of the client's unwillingness to change. At Rogers, we find that the client is successful in therapy when the pain from therapy is less than the pain from life. In short, if the client does not "go" in psychotherapy, then he did not suffer. At Rogers, we find that the client is successful

in therapy when the pain from therapy is less than the pain from life. In short, if the client does not "go" in psychotherapy, then he did not suffer. And this is a question of the client's personal experience, and not the features of the organization of his psyche. Some authors, for example, Mearns (Mearns, 2008) still point out that something depends on the client. In particular, he attracts the category of "courage" to explain successes in psychotherapy - if the client gets very tense, he will overcome his fear and enter traumatic zones, open up inside himself an organismic tendency. As far as we know, C. Rogers himself did not analyze the reason why some clients easily move from stage to stage, while others "stop", have problems in advancing in psychotherapy. He kept it all down to the client's willingness to move, which was due to the fact that he "suffered". However, Margaret Warner (Warner, 2013) identified several types of client's psychotherapeutic process: *optimal, fragile, dissociative, and psychotic*. In addition, the specified author (Warner, 2013, p. 147) described the structure of the client's ability to procedural experience: 1) the ability to be attentive to the traumatic experience while maintaining a moderate level of emotional involvement in it (when the experiential "I" does not overlap the reflexive, i.e., bifocality is ensured); 2) the ability to regulate (decrease) the level of emotional involvement in traumatic experience; 3) the ability to verbally symbolize their own experiences. These abilities are organized differently in optimal, fragile, dissociative and psychotic processes.

Thus, the peculiarities of the movement of clients in client-centered therapy necessarily lead to the formulation of the question of which structural features of the organization of the psyche determine the turnover / rigidity of the psychotherapeutic process. And, thus, **the second axis of classification** of psychological problems **is the type of personal process.**

8. Let us return to the organismic process, or flow. I said that K. Rogers did not give a classification of these processes. But, I think, for the purposes of building psychological personology, and accordingly classifying personal problems, this should be done. After this, it is logical to diagnose the level of actualization of the personality for each organismic tendency, which, in the end, reveals the level of completeness of the functioning of the personality. In Figure 3 shows a hypothetical profile of the full functioning of the individual.

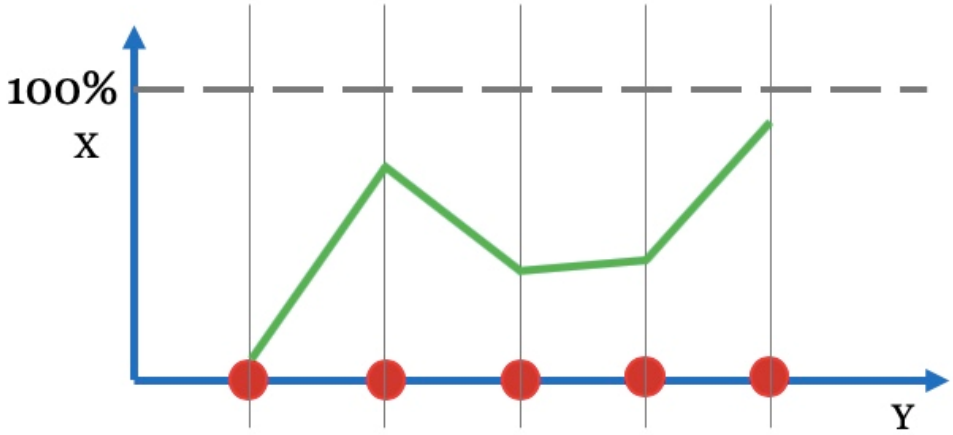

Figure 3. The hypothetical profile of the full functioning of the individual. X axis - level of actualization of the organism tendency; Y axis - types of organism tendency.

Thus, **the third axis of classification of psychological problems** is the classification of the organismic flow, the selection of its types and levels of actualization.

9. And finally, it is necessary to distinguish between actualization and self-actualization. Actualization - reflects the degree of openness of the actualization flow, for example, femininity, sexuality, separation / autonomy, etc., self-actualization reflects how much the individual accepts this flow. Obviously, in the process of psychotherapy, sexuality can open up (I'm not

talking about the physiological function, but about psychosexuality), but it can frighten the personality, it may not be perceived by personality in all areas of functioning. So, the client O., 31, had a dream in which she was in the house with her parents. A young robber rushed into the house, in front of which the mother took the client to the basement, hid her from the robber so that he would not offend her daughter. The client didn't like in the basement, and somehow she broke out alone, without her mother. She was terribly afraid to meet the robber, ran along the houses so that she was not visible. She met her husband, greatly rejoiced, because she felt safe. And suddenly a burglar runs up to her and pulls a glass in the shape of a pear on a long stem and asks: "Is this yours?". To which she replied fearfully: "No." She abandoned her own femininity. Her complaint - tortured obsessive cleaning the anus before leaving the house, so as not to disgrace. This action took daily from forty minutes to an hour. It was extremely painful for her. Natural, organismic sex transformed into anal perserving masturbation.

Thus, **the fourth axis of the classification of the psychological problems of the individual** is the degree of the individual's acceptance of the organismic flow.

Conclusions. Consequently, the experimental bases for the classification of psychological problems of a personality imply 4 classification axes: 1) an emotional scheme; 2) the type of personal process; 3) the type of body flux; 4) the degree of acceptance by the individual of the organismic flow, i.e. depth of self-actualization. Such a classification is inherently causal-oriented.

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ЕКСПІРІЄНТАЛЬНІ ПІДСТАВИ КЛАСИФІКАЦІЇ І ПСИХОТЕРАПІЇ ПРОБЛЕМ РОЗВИТКУ ОСОБИСТОСТІ

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Розглянуто проблеми класифікації психологічних проблем, які особливо загострилися в період відмови від нозологічних (етіопатогенетичних) підстав: нормалізація патологічних проявів і толерантність до них складають суть культурного мейнстріму. Наведено підхід до етіопатогенетичної класифікації, побудованої на експірієнтальних підставах. Розглянуто

чотири класифікаційних осі. Перша вісь класифікації - типи емоційних схем, які досить рано формуються в онтогенезі. Схема включає в себе п'ять компонентів: власне первинне «заторне» переживання, відповідна система ранніх спогадів, тілесні маніфестації (емоції-в-тілі), відповідні когнітивні репрезентації (інтерпретації) ситуації й мотивації. У літературі існують спроби класифікації таких схем, які були названі «ранні дезадаптивні схеми» (Дж. Янг), проте в даному варіанті класифікації плутаються первинні і вторинні «заторні» переживання і вони не прив'язані до певних онтогенетичних періодів і психотравм. Тому класифікація емоційних схем потребує подальшого опрацювання. Друга вісь класифікації - тип особистісного процесу, який визначається структурою організації психіки. Тип особистісного процесу, а їх виділяють чотири (оптимальний, крихкий, дисоціативний і психотичний), визначає здатність клієнта рухатися в психотерапії. Третя вісь класифікації - тип організмічного потоку і рівень його актуалізації. К. Роджерс не залишив переліку організмічних тенденцій. Четверта вісь класифікації - ступінь прийняття особистістю організмічного потоку, тобто глибина самоактуалізації.

КЛЮЧОВІ СЛОВА: класифікація психологічних проблем, емоційна схема, психотерапевтичний процес, актуалізаційна тенденція.

ЭКСПИРИЕНТАЛЬНЫЕ ОСНОВАНИЯ КЛАССИФИКАЦИИ И ПСИХОТЕРАПИИ ПРОБЛЕМ РАЗВИТИЯ ЛИЧНОСТИ

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Рассмотрены проблемы классификации психологических проблем, которые особенно обострились в период отказа от нозологических (этиопатогенетических) оснований: нормализация патологических проявлений и толерантность к ним составляют суть культурного мейнстрима. Приведен подход к этиопатогенетической классификации, построенной на экспириентальных основаниях. Рассмотрены четыре классификационных оси. Первая ось классификации – типы эмоциональных схем, которые формируются в онтогенезе достаточно рано. Схема включает в себя пять компонентов: собственно первичное «заторное» переживание, соответствующая система ранних воспоминаний, телесные манифестации (эмоции-в-теле), соответствующие когнитивные репрезентации (интерпретации) ситуации и мотивации. В литературе существуют попытки классификации таких схем, которые были названы «ранние дезадаптивные схемы» (Дж. Янг), однако в данном варианте классификации путаются первичные и вторичные «заторные» переживания и они не привязаны к определенным онтогенетическим периодам и психотравмам. Поэтому классификация эмоциональных схем нуждается в дальнейшей проработке. Вторая ось классификации – тип личностного процесса, который определяется структурой организации психики. Тип личностного процесса, а их выделяют четыре (оптимальный, хрупкий, диссоциативный и психотический), определяет способность клиента двигаться в психотерапии. Третья ось классификации – тип организмического потока и уровень его актуализации. К. Роджерс не оставил перечня организмических тенденций. Четвертая ось классификации – степень принятия личностью организмического потока, т.е. глубина самоактуализации.

КЛЮЧЕВЫЕ СЛОВА: классификация психологических проблем, эмоциональная схема, психотерапевтический процесс, актуализационная тенденция.

SECTION: PSYCHOLOGICAL COUNSALTING AND PSYCHOTHERAPY
РОЗДІЛ: ПСИХОЛОГІЧНЕ КОНСУЛЬТУВАННЯ ТА ПСИХОТЕРАПІЯ

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"KEY WORDS" AND MEDIATION PRACTICES IN SPECIAL PEDAGOGY

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The topics of this article concern the importance of mediators in education and the inclusion of children in general and, in particular, of those children who have difficulties due to disability, disorders or handicaps. The educator must deal with the individual as a whole and, with the help of the mediators, he must be able to achieve the goals set out in his educational project (or in a relationship of support), taking into consideration the overall needs and strengths of the subject with whom he works, or rather, cooperates. The mediators are defined as a relational resource and as a support to therapeutic, educational and assistance initiatives. They could act as harmonizers and attenuators in particular conditions of stress, suffering and conflict and they could be a valid aid for people with various problems in relationships, communication and with disturbed social behavior. Especially they would support minors, but also those people who have difficulties due to disability, including intellectual disability, and those people who are living critical situations of personal and social vulnerability or suffer an extreme social marginalization. This article highlights the particular importance of mediations and mediators in educational-pedagogical practices in schools and extra-scholastic settings, which are necessary for the growth and learning of children with disabilities. These children must be guaranteed the right to have a complete education in an "ordinary" and not separate, that is inclusive, social path.
KEYWORDS: Illness, Disability, Deficit, Handicap, Stereotypes, Prejudice, Mediations, Mediators, Integration, Inclusion

Deficit, Handicap and Disability: analysis of these terms

In social sciences and in educational sciences in particular, understanding the words in use and understanding their practical, operational meanings is the basis for high quality interventions. It allows not only the action but also the qualitative implementation of the various disciplinary points of view by developing interdisciplinary and inter-institutional cooperation in a network that is renewed according to the highlighted needs and not through bureaucratic and repetitive mechanisms. In this kind of approach, we distinguish and put together different scientific skills, which are necessary to face the complexity of the cases we are dealing with. Terms used in the disability situation are examined, in order to find the meanings and perspectives of our action.

The term Deficit in medical language assumes the meaning of alteration, anomaly, damage in the structures: "reduction of the functional activities of the organism or of certain organs or, in psychopathology, the temporary or permanent weakening of intellectual faculties" (Dizionario della lingua italiana "Treccani"). According to World Health Organization (WHO) we can use the term Impairment that is "any loss or anomaly affecting psychological, physiological or anatomical structures or functions" (Cfr. World Health Organization, 1980). If we analyse the term Handicap we discover that it refers to: "The disadvantaged condition, consequent to an impairment or a disability, which in a certain subject limits or prevents the fulfilment of a social role considered normal in relation to the age, sex, socio-cultural context of the person (Lascioli, 2011, p.17). The meaning of this term seems to derive from the

world of horse racing where, to encourage betting, a disadvantage was imposed on the best horse, such as starting a few meters behind the opponents; the link between handicap and disadvantage would lie in the fact that bets were collected by passing a hat in hand among the bettors, "go cap in hand", or coming from the gesture of putting the hand in the hat, "hand in a cap".

The terms Deficit and Handicap do not have the same meaning in medicine and in the other disciplines since today we have the awareness that the handicap is a social and cultural problem linked mainly to environmental and social factors. The World Health Organization with the second publication of the International Classification of Functioning and Disabilities, ICIDH-2, has first eliminated the negative value of the terms handicap and disability, giving them a more neutral meaning, focusing the attention on the activity rather than on the disability, on the participation and no longer on the handicap itself; ICIDH-2 increases the importance of the role of the Classification as a social model: it includes a list of environmental and contextual factors that influence the functioning and disabilities of people. In 2001 was published the ICF, the International Classification of Functioning, Disability and Health, in which we can clearly see the conceptual transformation of what we have exposed starting from the elimination of the term handicap in favor of the term disability; in the document we can see how this "phenomenon" is considered as the result of actions and characteristics of the environmental and personal factors of the subject in the given life context. We can define this new interpretative model as a "bio-psycho-social paradigm", in which the person is seen as a whole; this model puts on the same level both the aspects concerning the health of the person (the medical model), and the aspects of social participation (the social model), and connects all these aspects in relation to environmental factors. Therefore we will consider that the deficit or the impairment in themselves do not create disabilities, but disability depends on the ways the subject establishes his relationship with the various factors previously exposed in order to create a framework of functioning in a given life context. According with this new interpretative model the role of education and the educational function are also re-evaluated: the aim of educators must be optimizing the environmental and personal factors, so that to ensure that the individual with unfavorable health conditions gets improvements and significant changes on the global functioning; the task of education must be to create development paths suitable for improving the quality of the overall levels of functioning described above, i.e. offering a good level of quality of life.

The Deficit is not the Handicap

On the basis of the use and of the various interpretations in social disciplines, we will further distinguish the terms Deficit and Handicap, which are usually inter-exchanged, but actually refer to different concepts. As already indicated, the Deficit indicates a loss, alteration, anomaly in psychological or physical functions while the Handicap is the disadvantageous condition deriving from impairment: for example, when one hears that a subject has the handicap of "not hearing" because deaf, the damage (the lack of hearing, therefore the Deficit) is considered as a Handicap, which, instead, is given by the sum of personal and environmental factors; in this sense the description of Canevaro helps us: "[…] the deficit is the irreversible difficulty, the limit. It will be useful, instead, and more correct, to focus our attention on the handicap. In situations of disability the irreversible difficulty is accompanied by many elements that make the intervention possible. The same irreversible difficulty can take on a positive connotation if examined with the intention of discovering potential resources" (Canevaro, 1999, p. 5). This is a very important distinction, especially for its interdisciplinary extinctions; in fact, there may be a risk that not only the society, but also the subject may identify himself totally with his Deficit, considering himself as part of a category: the original identity is replaced by the concept of category. Moreover we see how the concept of Handicap concerns the professions of helping relationships and in particular education, in fact it turns out to be the obstacle or the difficulty that the person or the mediator encounters during the educational process to reduce the

asymmetry between being and being able; in this process must emerge the capacity of the educator to deal with an operational pedagogical and/or educational planning from which must be derived precise actions.

Handicap is not disability

This distinction does not want to be in opposition to what was explained above or to what was established in the IFC: we just try to describe the above mentioned concept, that the term Handicap can be considered as part of the educational approach of the Deficit. In particular, the task that this area must carry out is to remove the obstacles, handicaps, which prevent the potential of development present in every subject, because from this action the risk of disability can be reduced; disability, in fact, depends on the quality of life reached by the subject despite the deficit. It should not be linked to the severity of the deficit but to the relationship of the ways in which specific health conditions come into contact with certain environmental, relational and personal factors; therefore in order to discover the cause of the transformation of a serious deficit or pathology into disability, it is necessary to analyze life context and in particular functioning problems, that is the difficulties the person encounters in carrying out a task based on age and needs. In this perspective, which is taken up by the ICF, disability is a problem that concerns the entire social life of the person, it concerns society, and for this reason the deficit health situation should not affect excessively the life of the person himself, we should take into account that the impact on people's functioning levels must be reduced as much as possible, with a consequently increase of their quality of life.

Therefore we now better understand how important education is. The task of education is to create conditions in which the limits do not turn into handicaps, obstacles or disadvantages and do not interfere negatively in the path of human development and living conditions of those with a specific health condition. However, during the analysis of the educational problems of the person, it is necessary to bear in mind the type of handicap, whether it is inherent or induced: the first can be found only in the presence of an actual deficit of the subject since it concerns specific difficulties in the processes of human development; the second, on the other hand, can also be found in subjects without deficits and it is caused by external conditions and it concerns in particular the quality of the relationships that have been created between the subject, the learner and his life context which can affect negatively his personal development, giving several forms of handicap that do not depend precisely on diseases or deficits, but on the lack of significant relationships and educational relationships. Therefore, the distinction between Handicap and Disability is fundamental enhancing relationships of support and educational interventions (also special) and in both interventions the objective is to promote human development paths with incisive proposals for the quality of life of the person.

The Rigidity and Immobility of the Stereotype and the Inclusive Perspective.

"Imperfection has always allowed continuous mutations of that marvelous imperfect mechanism that is the human brain. I believe that imperfection is more genuine characteristic of human nature rather than perfection. [...] Imperfection is a fundamental component of evolution" (Montalcini, 1987).

The extract shown above was taken from "Praise to the imperfection" by Rita Levi-Montalcini, which is significant to give a deep and positive value to what is often mistakenly seen as a limit: imperfection is what often give the motivation to overcome obstacles that seemed insurmountable. Let's take her as an example. Rita Levi-Montalcini was born in Turin and she was Jewish. She had to live a double "imperfection": being a Jewish woman prevented her from exercising in the hospital, due to the racial laws, but this was not an obstacle for her to continue in living her life. She changed her interest in medicine for the research activities, setting up a small home laboratory; at the end of the war she was called to the United States where in 1986 she received the Nobel Prize; this was achieved because Montalcini considered a challenge to overcome what should be considered an imperfection and fragility.

We all were born fragile and fragility does not disappear with age. Fragility is not a characteristic of a particular part of population that does not concern the "normal" part of it: each of us is unique and differs from the other, but often we are deceived into

believing that humanity is formed by two categories: the normal and the abnormal. This distinction actually reassures: "We do not belong to the categories of those who have a disability, a fragility" (Canevaro, 2018, p. 18); perhaps because every encounter that we make reveals us to ourselves, because we see us in the other; but the other has a disability that shows in us a fragility that disturbs us and therefore we try to protect ourselves through mechanisms such as, for example, victimization, pietism or stereotypes. The prison of the stereotype has always represented a marking sign of the disabled person, but this problem can also be experienced by someone who is not disabled, that is, subjects who independently of the actions practiced and lived remain imprisoned in a specific image despite the changes in environmental and social factors. To better explain this aspect, we must now explain the need for belonging: from birth, the child, who is a fragile being and needs care, develops the desire to feel itself as part of the world and of the small context in which it interacts; moreover, it is a way to respond to one's needs and in this way the child find a balance to participation in life. This need is generally not explicitly expressed with this term but we can identify it in the desire that every individual has to have security, to work, to have free time, to play, to meet other people: i.e. to live. Sometimes, however, the need for security can result in the search for what can endanger security itself: for example, those who do not speak the same language, who have different cultural and religious habits, are seen as enemies and this is realized through a mechanism that makes the exception the rule; the danger of expressing the need for belonging in this way is to live it "with a closure inside stereotypes attributed to others and reflected on themselves" (Canevaro, 2016, p. 73). In this expression we find the concepts of "race" and the justification to implement violent behaviors and dynamics that are difficult to control; we can include in this framework, for example, the operation, called T4, carried out by the Nazis on disabled people: it concerned the elimination of disabled people and psychiatric patients to purify the "Aryan race" from "worthless lives"; this acronym therefore allowed the use of any means. To ensure that these stereotyped visions are abandoned, an inclusive perspective must be introduced: it develops the ability to contaminate oneself, to carry out tasks and reach goals with different characteristics; it means not hiding the weak, imperfect part of oneself, not being afraid to mirror oneself in the other, disabled or not. To be able to implement this perspective, an essential element is the assumption of responsibility by the subject: one must value the competent identity that is found in every individual despite their frailties and not for a narcissistic complacency, but to develop and recall the duties of responsibility; the risk that can cause the de-responsibility is the trivialization, that is to attribute a critical element to any situation. One can believe that, being so extended the problem, it is not necessary to look for a solution to reduce the effects. The inclusion is where the connection for a quality of life for all is found, the good practices that do not mean the best but those applicable for all, where the rights of disabled people or those with special needs are found, but without forcing the picture to be completed once for evere.

"When you accept the miracle of who you are and love yourself without conditions, changing the things that need to be changed is much easier. Some aspects that you have always thought of having to change because you considered them your shortcomings, real enemies, in reality they are your faithful servants. It is thanks to them that you are who you are, a unique creature, different from anyone else who came before you or will come after" (Powers, 2014, p. 184).

Mediation - Mediators

The term Competence is of a certain importance in the care, educational and support relationships, and it is also necessary to specify its meaning. "Competence": it is a skill that can organize itself in many different contexts; this organizational capacity that becomes competence is essential as it allows you to be able to face the unexpected without going to hinder the activity but keeping the direction by integrating the unexpected elements in a common perspective.

People who have an educational role and in general a supporting role in psychological, social and pedagogical relationships are considered for their contribution in the creation and in the possible

recovery of dialogue, that it was not possible to start and establish or that does not happen with ourselves, *intra*, and needs to be done with others, *inter*; the mediator must allow us to develop this competence between us and others, in order to regain the *intra* dimension: this is the profound, basic, educational and pedagogical aid competence. This competence is not easy because it needs to use a progressive way of restoring the mastery of the organization, of the discussion, of the economy of thought; through that minimum of autonomy that the subject possesses, a fuller autonomy is reconstructed, therefore through the *inter* the *intra* dimension is regrown and they find again a balance: it is not simple but it is what is required to the educational professions.

The educator and the social professional must proceed carefully in a work of adaptation in order to develop skills and for this they need a project-model, if they want to avoid a dependence on reality and to develop a cooperation that allows exchange relationships; this is essential since without a model there is the risk of being overwhelmed by the events and in some way coordinated by the shortcomings; if this happens we risk being tied to a reality that is flattened on the existing and not easily overcome. The educator and in general the social science professional engaged in a supporting relationship must make it evolve using a model.

With the term "model" we want to indicate a "flexible, elastic structure, but with fixed points. If elasticity and flexibility are exchanged with total informality and improvisation, the risk is that of having a false model" (Canevaro, 2006, p. 25).

In this model we focus our attention on functions, that can be divided in elementary functions and superior functions, the first being the simplest functions of efficiency, such as the physical capacity for survival, perception/action, reactions to the context, simple memory, recognition of persons, etc. From these functions there begins the development of some elements thanks to the capacity of evocation and representation. The superior functions are more complex, they originate the social being with social and non-self-referential knowledge, activities are pragmatic and mental at the same time, i.e. through these functions it is possible to formulate hypotheses, examine the consequences and do hypothetical explorations. One should therefore have the ability to categorize, without closing the possibilities of developing pieces of information, original features, exchanging and reworking them, through argumentative abilities, rationalizations, causal logic patterns. You can define the elementary functions as a base, ground floor, while the superior functions as an overlying floor, and they need a connection, they need "stairs", in order to be always in contact, because life does not work without a base: here you have the "door" to access the room, above are the "windows" from which we can look farther to decide whether it is worth moving and to direct actions. These stairs, these connections, are the mediators, which could also be professional figures who should have the skills of mediation for cooperation. It turns out and it is very important that the mediators try to connect the resources of a community with another one that does not have resources. A good educator and a good professional and therefore a good competence should be able to bring out and become intentional what sometimes happens casually, that is the presence of more mediators. Through the mediators is given the possibility to overcome the tensions and immobility that is generated in the situation of stasis that eliminate the possibility of seeing the various elements that make up reality itself. There should be created a way – a project - which allows to the abilities to become skills, knowing a context, so that a plural reading of the reality is possible and not only a static and immobile one.

For the Mediation it would be necessary to have and to make available, besides the symbolic elements, also the objects, which are linked to answers that serve the child for growth and/or they serve a person in difficulty; the use of objects permits to give motivation to carry out a certain task in an independent way, both from the Educator or the adult of reference and in general from the professional of supporting relationships.

It is therefore essential to recognize the importance of the mediators because it is through them that the suggestions for evolution and change of possible situations arise and these changes can be made by changing the mediators in a scheme of mediator strategies more suited to understanding the

other person and his/her control of the situation. We must constantly have in mind as a guiding idea that the interlocutor is an active subject therefore he/she is able to have as much as possible mastery of his/her pathes; this is one of the hardest form of prejudice against subjects, for example, considered "weak" or with a situation that is called "disability", who are judged without a possibility of control on themselves and on their own development. The mediator is important for this reason.

The educator and the professional of the social activity and supporting relationships should first of all have an interior structure adequate to the educational activity and an approach orientated towards a profound recognition and an effective acceptance of the other: in fact educating does not want to say to assist, to pity or to legitimize the right to be educated; instead, educating means to recognize that even in the other, despite the possible difficulties, humanity itself is present and alive.

The term Mediators concerns people, functions and objects, which give support, facilitation that promote understanding of things and are linked together to provide a path to follow. They should provide a plurality of elements to the subject that understands and connects to a certain reality. They are objects external to the subject and therefore visible from outside the subject itself and for this reason they should represent and be a meeting point between the divergences and the unity that the subject faces to understand and dynamically connect to the realities of knowledge and of their organization.

A mediator should be docile, actor and spectator at the same time, without ever definitively imposing his imprint but always perfectible, he should know how to lead and guide the subject without any feeling of judgment for his/her experimentation so as not to compromise other experiences. These reflections do not want to be a pattern to be followed and implemented, but only aspects to reflect on and internalized in a completely original way; moreover they do not have an order of importance but interact with each other at various times and with various intensities in the educational processes and help reports.

A growing subject is an evolving person who gets into the relationship with people who are already grown up, but should always be aware that they are in permanent transformation. Referring to the thought of Freire and De la Garandeire, the educator is never complete, so the educator is also educating as well as the educator is also an educator, and this does not happen spontaneously, but only through a careful and in-depth work. The educational task is therefore a task of mediation, an educational dynamic in which the educator is a methodological guide that identifies the tools, adapts distant knowledge in order to reorganize them once learned and through this mediation interaction with the educator or the adult, through this process of interaction and social integration the child and / or the person who needs to be "hetero-regulated" becomes "self-regulated". Proceeding in this way one acquires the awareness of being able to follow a path without the need to be totally guided.

What the action of a mediator consists in? "The ability to create a connection between what a subject already has and what the other has". In order to understand the answer, one must start from the proximal development zone formulated by Vygotsky, that is, arrange and test a *mediator suitable* for sensory thresholds that an individual can handle. In this action there are many events of "active education". Active education means to take on new challenges to find effective mediators in perspectives without pre-established limits. Care should be taken when an improvement is achieved in the subject, without idealizing it as therapeutic: music, water, animals, objects and elements of mediation in general are mediators and their productivity consists in being able to place thems alongside other mediators; this aspect is essential because it deals towards the plurality of mediators, who constitute a continuous entrance, a constant process opening in order to continue, to move forward, while the therapeutic aspect risks a closing vision. The characteristics of the mediators must therefore be: *plurality*, that is the construction through them of a shared reality without renouncing to one's own identity; the *security* and the *invitation to risk*, that is to be a point of continuity and interruption, building

a project that also includes the possible unpredictable elements, the unforeseen, that can be used to continue and go further; a *mediator is not scary*, if the mediator is frightening it is necessary to replace it otherwise one runs the risk of being blocked or paralyzed; the *multimodality*, the different ways that are used to realize a design which are suggested by subjective aspects and circumstances; *multimedia*, i.e. different capacities and possibilities of choice, and finally *re-enacting organizational functions*, or the ability to reorganize a project by placing it in a context of life, habitual or not, institutional or family, shared or experienced individually, mental etc.

Being able to reorganize a project, in the course of life, is the most widely used as well as the most useful and intelligent way to solve the problems that we inexorably encounter. Having and building, organizing and engineering a project in any situation we find, are important things for personal life and coexistence (to-live-with), for a better life for ourselves and for the others.

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«КЛЮЧОВІ СЛОВА» ТА МЕДІАЦІЙНА ПРАКТИКА В СПЕЦІАЛЬНІЙ ПЕДАГОГІЦІ

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Тематика статті стосується важливості медіаторів в освіті і інклюзії дітей загалом і, зокрема, тих дітей, які відчувають труднощі через інвалідність, розлади або недостатність. Педагогу слід взаємодіяти з людиною в цілому, і за допомогою медіаторів він повинен бути в змозі досягати поставлених освітніх цілей (або забезпечувати стосунки підтримки), беручи до уваги загальні потреби й сильні сторони суб'єкта, з яким він працює, або, скоріше, співпрацює. Медіатори визначаються як реляційний ресурс і підтримка терапевтичних, освітніх і допоміжних ініціатив. Вони можуть виступати в якості гармонізаторів і аттеньюаторів в конкретних умовах стресу, страждань і конфліктів, і вони можуть надавати дієву допомогу для людей з різними проблемами в міжособистісних стосунках, спілкуванні та з порушеною соціальною поведінкою. Особливе значення вони мають з точки зору підтримки неповнолітніх, а також тих людей, які відчувають труднощі через інвалідність, в тому числі розумову відсталість, і тих людей, які опинилися в кризових ситуаціях, є особистісно або соціально вразливими або піддаються крайньому ступеню соціальної маргіналізації. У статті підкреслюється особливе значення медіації та медіаторів в навчально-педагогічній практиці в школах і позанавчальних умовах, які є необхідними для зростання і навчання дітей з обмеженими можливостями здоров'я. Таким дітям повинно бути гарантовано право на отримання повної освіти за «звичайним», а не окремим, тобто інклюзивним, соціальним шляхом.

КЛЮЧОВІ СЛОВА: хвороба, інвалідність, дефіцит, недостатність, стереотипи, упередження, медіація, медіатори, інтеграція, інклюзія

«КЛЮЧЕВЫЕ СЛОВА» И МЕДИАТИВНАЯ ПРАКТИКА В СПЕЦИАЛЬНОЙ ПЕДАГОГИКЕ

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Тематика статьи касается важности медиаторов в образовании и инклюзии детей в общем и, в частности, тех детей, которые испытывают трудности по причине инвалидности, расстройств или недостаточности. Педагогу следует взаимодействовать с человеком в целом, и с помощью посредников он должен быть в состоянии достигать поставленных образовательных целей (или обеспечивать отношения поддержки), принимая во внимание общие потребности и сильные стороны субъекта, с которым он работает, или, скорее, сотрудничает. Медиаторы определяются как реляционный ресурс и поддержка терапевтических, образовательных и вспомогательных инициатив. Они могут выступать в качестве гармонизаторов и аттенюаторов в конкретных условиях стресса, страданий и конфликтов, и они могут оказывать действенную помощь для людей с различными проблемами в межличностных отношениях, общении и с нарушенным социальным поведением. Особое

значение они имеют с точки зрения поддержки несовершеннолетних, а также тех людей, которые испытывают трудности по причине инвалидности, в том числе умственной отсталости, и тех людей, которые оказались в кризисных ситуациях, являются личностно или социально уязвимыми или подвергаются крайней социальной маргинализации. В этой статье подчеркивается особое значение медиации и медиаторов в учебно-педагогической практике в школах и внеучебных условиях, которые необходимы для роста и обучения детей с ограниченными возможностями здоровья. Таким детям должно быть гарантировано право на получение полного образования по «обычному», а не отдельному, то есть инклюзивному, социальному пути.

КЛЮЧЕВЫЕ СЛОВА: болезнь, инвалидность, дефицит, недостаточность, стереотипы, предубеждение, медиация, медиаторы, интеграция, инклюзия

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COGNITIVE DISORDERS AND THEIR CORRECTION IN CHILDREN WITH EPILEPSY

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The article is devoted to the analysis of literature data on the study of cognitive disorders in children. The issues of the prevalence of these disorders are considered. Ir was noted the fact that the high prevalence of epilepsy in the population, frequent combination with mental retardation and personality changes and the need for long-term therapy anticonvulsant therapy determine the exceptional importance of this problem in pediatric neurology and psychiatry. The issues under consideration are due to the fact that the presence of cognitive disorder is one of the essential aspects in epileptological practice, as well as the fact that neurologists and psychiatrists involved in the treatment of epilepsy in children and adolescents often underestimate these disorders. The article pays attention to the etiological and pathogenetic aspects of the cognitive disorders formation, the dependence of the occurrence of these disorders on the localization of the epileptic focus, on the nature of the seizures and age-related features of the epilepsy course. It is indicated that cognitive disorders in patients with epilepsy is determined by biological and social factors interaction complex. The main points that can explain the cognitive and behavioral problems in children with epilepsy are underlined. Two mechanisms in the violation of the cognitive activity of patients with epilepsy are identified. It is indicated that psychosocial problems for patients often come to the fore, including cases when control over seizures has not been achieved yet. In particular, depression in patients with difficult to control epilepsy affects quality of life more than frequent suizures. In addition, depression can have a significant impact on cognitive function. Complaints on speech functions, memory, attention, thinking disorders that patients can present at the doctor's appointment, are in second place after complaints on seizures. It was also given attention to the views on approaches to the treatment of cognitive disorders. It is indicated, that providing assistance to children with cognitive disorders should have a comprehensive and individual approach, combining non-medicament and medication methods.bThe funds belonging to the group of nootropic drugs, and also directed psychological correction, supported by antiepileptic therapy are applied traditionally for the treatment of cognitive disorders.

KEYWORDS: cognitive disorders, epilepsy in children, correction of cognitive disorders in children.

The problem of cognitive disorders is now very relevant and significant from a medical and social point of view in modern epileptology. There are quite a few publications in the literature concerning to the study of cognitive disorders in the adult population. However, violations of these functions are quite common among children (according to some, about 20% of children and adolescent). Some sources state that among 50 million registered epilepsy patients at least 15 million children. The high prevalence of epilepsy in the population, the frequent combination with mental retardation and personality changes, the need for long-term anticonvulsant therapy determine the exceptional importance of this problem in pediatric neurology and psychiatry. Considering the study of the prevalence of speech and language disorders in children with epilepsy, including reading and writing disorders, 5-20% of children have been diagnosed with these disorders according to some sources.

Availability of cognitive disorders is one of the essential aspects in epileptological practice. At the same time, neurologists and psychiatrists involved in the treatment of epilepsy in children and adolescents, often underestimate these disorders. Ignoring the cognitive disorders that present in patients in the

initial stages of the disease in the future may lead to their deepening condition and complicate treatment. Sometimes, on the contrary, there is a reassessment of existing cognitive disorders in patients with epilepsy, when virtually any behavioral, personal characteristics of patients are associated with others or themselves with the existing disease. It is known that an epileptic attack and antiepileptic drugs (AED) affect on the functioning of the central nervous system, including to higher mental functions (attention, gnosis, memory and thinking).

Currently, there are not enough works in domestic and foreign literature on the study of cognitive function in patients with epilepsy. It is estimated that more than 60% of patients with epilepsy have disorders of intellectual-mental processes. Some authors have shown that more significant cognitive disorder is observed in patients with generalized epileptic seizures compared with patients with partial seizures. There is a view that indicators of cognitive function in patients with remission of seizures are close to those of healthy individuals, statistically and significantly not differ from them, but in another study noted that after achieving stable remission, there is an improvement in cognitive functions, however, none of the examined patients had complete recovery.

A cognitive disorder in patients with epilepsy is determined by the complex interaction of biological and social factors. Scientists have identified five main points that can explain cognitive and behavioural problems in children with epilepsy:

1) structural pathology of the brain,

2) epileptogenic lesion,

3) epilepsy (as the basis of electrophysiological dysfunction),

4) medicines,

5) psychosocial factors.

There are two mechanisms in disorder of the cognitive activity of patients with epilepsy :

1) reducing the degree of action of mental activity by reducing its energy supply level.

2) qualitative changes in intelligence against the background of maintaining its level characteristics, which are caused, apparently, by localization and lateralization of lesion of paroxysmal activity in the brain.

In general, 30-60% of patients with epilepsy have neuropsychiatric problems [Zavadenko N.N., Suvorinova N. Yu., Rumyantseva M.V., 2006, Luria A.R., 1969, 1973]. Psychosocial problems for patients often come to the fore, including cases where control over seizures has not yet been achieved [Luria A.R., 1973], as well as cases of the controlled disease. In particular, depression in patients with severely controlled epilepsy has a greater impact on the quality of life than, saying, frequent seizures. In addition, depression can have a significant impact on cognitive function. Complaints on impaired language functions, memory, attention, thinking, which patients may present during a visit to the doctor, are in second place after complaints of seizures.

There are some differences between cognitive and behavioural functions disorders in childhood and adulthood. In children, epileptic seizures, as well as therapy with antiepileptic drugs (AED), affect on the development of structures of the central nervous system and the formation of higher mental functions (HMF), which ensure the adaptation of the child's body to the environment. This leads to marked changes in the personal sphere and functions that form the basis of cognitive activity (attention, gnosis, memory, thinking). At the same time, the plasticity of mental processes in childhood causes the possibility of compensation for disorders in the directional correction. In addition, children have special conditions - epileptic encephalopathies (early malignant encephalopathies (childhood) and caused by prolonged activity on the electroencephalogram during slow-wave sleep). A long history of the disease, diffuse or gross local lesions of the brain structure and other factors can lead to both intellectual and mental impairments, up to the degree of dementia, and also to severe mental impairments, which are more rigorous to therapy and psychological correction in adults and especially the elderly, [Larrabee GJ, Crook TM].

It should be noted that the development of these disorders is polyetiological [Kyle R., 2003]. The main group of factors is directly related to the disease itself: age of debut (correlates with reading impairment); form of epilepsy, duration, type, duration and frequency of seizures, their

polymorphism (correlated with impaired counting functions); localization of the epileptic lesion and other electroencephalographic features, including the presence of prolonged epileptiform activity during slow-wave sleep (associated with memory, attention disorders, as well as language functions and disorders in the behavioural sphere); the presence of epileptic status in the anamnesis (associated with delayed development of various cognitive functions). Gender differences have been described (boys with difficult-to-detect epilepsy are more likely to have impaired academic performance). Structural anomalies and their localization (especially cortical dysplasia), which are manifested in neuroimaging, and developmental delay may be associated with certain disorders of cognitive function and behaviour. However, the correlation between disorders in the higher mental sphere and the localization of the structural centre, as well as regional epileptiform activity, is not always observed. It is important to take AED in mono or polytherapy. In addition, the disorders described leading to social maladaptation and stigmatization, which in turn have a negative effect on disorders in the higher mental sphere, forming the so-called vicious circle.

A unified classification of disorders in the higher mental sphere in patients with epilepsy has not been developed. In general, there are cognitive disorders and mental disorders. Domestic psychiatrists distinguish mental disorders in relation to the seizure period, including disorders that are a component of the seizures, in addition, allocate paroxysmal and permanent mental disorders in epilepsy [Bawden H.N., Knights R.M., Winogren H.W.]. Epileptic mood disorders include to paroxysmal mental disorders (dysphoria, depressive disorders); twilight darkening of consciousness; epileptic psychoses, - different variants of personality change include to permanent mental disorders. In addition, the concept of epileptic encephalopathies has been widely developed recently, as discussed above [Voronkova K.V., 2002, Voronkova K.V., Pylaeva O.A., 2004].

Up to the XX century it was thought that patients with epilepsy had reduced mental capacity. In the framework of intellectual disorders was considered gross deficiency of the mental-intellectual sphere - mental retardation and epileptic dementia [Dennis M., Wilkinson, M., Koski, L. et al.]. However, in recent decades, it has been shown that the intelligence rate in these patients varies widely, sometimes reaching fairly high values, and only a small number of patients have progressive deterioration in the mental-intellectual sphere. In some patients, there is a total violation of WFP to the degree of epileptic dementia (more often in elderly patients) or diagnosed with mental retardation, mainly in patients with malignant epileptic encephalopathies of early childhood [Dennis M., Wilkinson, M., Koski L. et al., Chapman SB, Saez-Llorens X., McCracken GHJr.]. In turn, epilepsy may be diagnosed in 20% of people with intellectual disabilities, which is associated in most cases with structural disorders of the brain.

A group of epileptic syndromes that pathognomonic with a decline in intelligence is early malignant encephalopathies in children with onset seizures, mainly in the first year of life [Anderson V., Anderson P., Grimwood K., Nolan T.]. In most survivors, intellectual disabilities manifest almost simultaneously with the onset of seizures or are associated with mental retardation, a major symptom of the disease; the development of intellectual disabilities may subsequently become a plateau. Intellectual disorders are noted in patients with such rare diseases as Kozhevnikov - Rasmussen syndrome, progressive forms of epilepsy with myoclonus. Intellectual deficiency, which is noted even in the absence of seizures, may regress as the epileptiform activity is reduced by EEG in children with electrical epileptic slow-wave status . If therapy is not started in time, intellectual disabilities can be sustained. However, it is now convincingly shown that even when therapy is scheduled on time, intellectual deficits may persist in the future [Chandran A., Herbert H., Misurski D., Santosham M.]. It was shown in numerous studies that in children and adults with good attacks control of drug antiepileptic therapy, the prognosis for the intellectual sphere is favorable [Christie D., Viner RM, Knox K. et al., Bedford H., de Louvois J., Halket S. et al.].

Previously, cognitive deficits were also considered as an integral symptom of the clinical picture of epilepsy. It was further shown that not all

patients with epilepsy develop cognitive disorders. Male, the etiology of epilepsy and localization of the lesion of epileptogenesis in the brain, the presence of interectal epileptiform activity, intake of AED, disease course, local structural changes, and continuous spike-wave complexes in the slow wave of things in the brain are associated with the development of cognitive disorders. According to M.G. Harbord, cognitive disorders, and behavioral disorders are 3 times more likely to occur in children with prior intellectual disabilities than in children with normal intelligence.

In general, cognitive disorders, as well as mental disorders, can be transient (ictal or postictal), long-term or permanent (interictal). In addition, we can distinguish partial cognitive disorders, specific (for example, speech impairments in Landau - Kleffner syndrome) and total, as discussed above. It should be added that against the background of antiepileptic therapy, cognitive disorders most often have a dose-dependent transient or prolonged nature, but chronic side effects of AED with permanent, in some cases, progressive disorder of cognitive functions may also develop. In most episodes, transient cognitive disorder is transformed into permanent and even progressive in long-lasting, epilepsy-resistant epilepsy.

The nature of ictal and periectal cognitive disorder is in most cases associated with the localization of the epileptiform activity site on the EEG and with the localization of the structural defect of the brain, and in children such disorders are more pronounced compared to adults. Ictal cognitive disorder may be manifested by speech disorders, memory disorders that differentiate with transient global amnesia and the onset of dementia in elderly patients. Ictal cognitive disorder may be associated with the unconscious status of lesion seizures and absences. Such conditions can be difficult to diagnose especially in elderly patients, in patients with debut epilepsy and with pre-existing disorders of cognitive function. During the status of absences, both mild cognitive decline and marked cognitive impairment may occur. During the status of lession atacks, there are disorders of cognitive functions that correlate with the localization of the cortical dysfunction lesion. Postictal variable cognitive disorder, as a rule, there is a positive dynamics of recovery after seizures. Interctal cognitive disorder in patients with epilepsy is quite variable, and it is impossible to distinguish any specific type of cognitive disorder, as it may depend on the location and nature of brain damage, age of onset of pathology, antiepileptic therapy, and disorders such as depression.

Memory disorder is one of the most cognitive problems that common in patients with epilepsy. Most researchers attribute the occurrence of dysmnestic syndrome with bilateral lesions of the temporal lobes of the brain or specific disorders of the verbal (with left-sided lesions of the temporal lobe) and spatial memory (with right-sided localization of lesions). In recent years, studies have emerged indicating that, more pronounced specific memory disorders occur after surgery on the temporal lobes in difficult-to-epilepsy. Earlier structural pathologies (eg, brain tumors) also show more severe memory disorder. Particularly relevant is the problem of studying cognitive disorder in patients with hippocampal sclerosis or hippocampal lesions due to other etiology. It is assumed that since this structural pathology is a consequence of impaired brain embryogenesis (cortical dysgenesis) or arises as a result of prolonged or serial febrile seizures, due to the plasticity of the brain (especially the child) functionally significant areas are formed in the intact areas of the ipsilateral or contralateral hemisphere. In this regard, patients with hippocampal sclerosis may not have memory disorder. However, the majority of patients with this pathology can be diagnosed with dysmnestic syndrome [Daffner K.R., Mesulam M.M., Scinto L.F., et al.].

Thus, B. Hermann and et al. suggest that temporal lobe epilepsy with the onset in childhood (up to 14 years) causes a significant reduction of brain tissue in the hippocampal area, with the spread to the extracranial areas [Hermann B., Seidenberg M.]. Patients with rolandic epilepsy (with or without seizures) describe minimal behavioral disorders and fine motility that may be associated with focal rolandic adhesions [Bedoin N., Herbillon V., Lamoury I., et al]. The presence of an epileptiform lesion on the side of the dominant

hemisphere can cause linguistic dysfunction [Berroya A.G., Mclntyre J., Webster R., et al.]. There are slight differences in the performance of cognitive tests, mainly on attention and visual-motor coordination, between the examined patients and the children of the control group intellectual or behavioral deficits in neuropsychological testing [Besag F.M.]. In patients, cognitive activity and success may be impaired [Besag F.M., Yung A.W.]. However, it is important to note that many children do not have cognitive deficits for epilepsy, and not all schooling problems are caused by epilepsy or anticonvulsant medication [Herranz J.L., Northcott E., Connolly A.M., Mclntyre J., et al.].

It is well known that the subjective patients' perception of their own disorders in the mystic sphere may be more negative than the objective results of neuropsychological testing. This is related, on the one side, to disorders in the affective-personal sphere, and on the other - to the fact that patients with disorders in the mystic sphere can affect long-term memory, and testing is carried out only at certain short intervals of time. Memory disorders during testing may be more pronounced or manifest de novo if an epileptic seizure has occurred within 24 hours before the study.

Patients with epilepsy may also be disturbed by attention-deficit problems, particularly in the context of attention deficit hyperactivity disorder (ADHD). According to many authors, ADHD is more common in patients with epilepsy than in the general population. Accordingly, these patients are defined by attention deficit. Absence forms of epilepsy can also be accompanied by impaired attention. In general, attention disorders can be observed in patients of both sexes with all forms of epilepsy.

Linguistic disorders in patients with epilepsy are studied less frequently than disorders in the mental sphere. However, they can have serious consequences for patients' social functioning, including training. Moreover, language problems (most often when reading and writing) can occur in patients with epilepsy without impaired intelligence. Most authors attribute the occurrence of disorders in the lingual area to the pathology of the left temporal lobe [Haverkamp F., Honscheid A., Muller-Sinik K.]. Epileptic syndromes with specific speech disorders are described, such as syndrome or aphasia, Landau - Kleffner, in which speech disorders in the form of sensory and then motor aphasia occurring in children with prior normal language development at the age of 4 to 11 years, associated with regional epileptiform activity in the temporal or parietal branches of the EEG. Diagnosis of this syndrome is difficult due to the fact that in some patients' epileptic seizures do not develop. In some patients, seizures, on the contrary, can be preceded by aphatic disorders. In case of speech disorders in patients with epilepsy, correction of antiepileptic therapy may be performed, training with a speech therapist is recommended.

In the frontal parts of the brain, such disorders in the cognitive sphere as difficulty programming actions, decision-making, and strategies, abstract thinking, etc. have appeared mainly in localization of the pathological focus, which generally determines the ability of individuals to live independently and adapt in society. Numerous studies have been carried out regarding the lateralization of the functions discussed in the cortex of the frontal lobes of the brain, including observations [Parisi P., Verro A., Paolino M.C. et al.], which showed that in this aspect, the frontal lobes are the only area of operation without a clear difference of the parties. This may also be due to the high frequency of the phenomenon occurring in the form of electrical discharge at the localization of the epileptogenesis lesion in the frontal lobe from one hemisphere to another. In the following papers, D. Upton et al. reported that the most pronounced abnormalities occur when the pathological process is localized in both hemispheres [Waldier K.D., Hausmann M., Milne B.J., Poulton R.].

Many studies have addressed a wide range of issues related to the identification of global or specific cognitive deficits, behavioral problems, specific patterns of speech lateralization, the relationship between localization of the epileptic focus and the nature of cognitive dysfunctions [Piccirilli M., D'Alessandro P., S'Aarmaandro P., S'Aarmaandro P., al., Croona C., Kihlgren M., Lundberg S. et al.]. In 2000, T.W. Deonna et al. published the results of a long-term prospective study that identified "acquired prolonged reversible

dysfunction" associated with epileptiform EEG activity in children with rolandic epilepsy [Deonna T.]. More than 25% of patients had disabilities, family-related problems related to impulsivity, attention deficit, auditory and / or visual, verbal, or visual-spatial disorders occurring in the interval of two or more months from the onset of the disease, and lasted from 9 to 36 months. The cause of these disorders was centrotemporal spikes that persisted after the cessation of the seizures, sometimes for a very long time that poses a serious problem in addressing the duration of anti-epileptic treatment according to T.W Deonna et al. [Deonna T.W., Roulet E., Fontan D., Marcoz J.P.].

During neuropsychological examinations using computer systems indicated the presence of moderate partial deficits of cognitive function in most patients in our population of children with rolandic epilepsy. Only 29% of children had not deviation from the age limit. In patients with rolandic epilepsy Functions characterizing the quality of analytical and synthetic processes suffered most of all: attention distribution, short-term visual memory, imaginative thinking, rates of psychomotor activity [Balkanska S.V., Kuzenkova L.M., Studenikin V.M., Maslova O.I.].

Patients with rolandic epilepsy, aged 5 to 11 years, identified neuropsychological deficits and found a relationship with the duration and localization of regional epileptiform changes in another prospective study, during 5 years. All children who were supervised after reaching school age, studied in a secondary school. However, in neuropsychological testing, on the moment of applying for the appointment of AED, cognitive function was retained in only 11% of patients, and various dysfunctions were detected in most children. Most patients had a decrease of verbal intelligence in the preservation of nonverbal intelligence, reduced verbal memory, optical-motor coordination and the violation of arbitrary regulation. In more than half of all cases, language disorders such as dyslexia and verbal dyspraxia were identified. Behavioural disorder associated with impulsivity, attention deficit, and hyperactivity was detected in 1/3 of patients. All schoolchildren had a cognitive dysfunction that was not gross and did not significantly affected on the learning of the school program [Ermolenko N.A., Yermakov O.Yu., Buchnev I.A. et al.].

Approaches to cognitive disorders therapy.

Assistance to children with cognitive disorders has a comprehensive and individualized approach, combining non-medication and medication methods. Traditionally, nootropic drugs have been used to treat cognitive disorders. Nootropics - a group of drugs that differ in composition and mechanism of action, but have a number of common properties. As a result of improving of metabolism and interneuronal transmission in the central nervous system (CNS), nootropic drugs improve mental activity, attention, language, activate learning processes (nootropic action); improve memory, ability to reproduce information and translate current information into long-term memory (mnemotropic action); reduce the need of neurons in oxygen during hypoxia (antihypoxic action), and also increase the resistance of the CNS to adverse factors: hypoxia, intoxication and other extreme effects (cerebroprotective and adaptogenic action).

In the therapy of patients with partial and also total deficit of the higher mental sphere, directed psychological correction supported by anti-epileptic therapy plays a significant role.

Choosing methods of psychotherapy correction, the following should be considered:

- nosological diagnosis (level of mental disorders - psychotic, neurotic);
- syndromological qualification;
- the level of mental development of the child;
- the stage of ontogenetic development and the level of pathological response (somato-vegetative, psychomotor, affective, emotional-ideatory);
- type of personality or personality anomaly;
- the level and quality of the individual socialization, the presence of pedagogical neglect, also the conditions of life and of the child upbringing ;
- psychological settings available to the child;
- structural and dynamic characteristics of age psychology;
- existence of age crisis;

Psychotherapy should be directed not only at the child, but also at his(her) environment, at those adults

who are engaged in his(her) education, treatment and training.

Psychotherapy begins with contact with the patient and his or her relatives. Next is preparation for correction, creation of an optimal psycho-hygienic atmosphere, formation of a psychological setting for the implementation of psychotherapeutic recommendations, determination of the mode of life and nutrition.

Then – work on the correction of characterological disorders and the elimination of bad habits, on learning appropriate ways of psychological protection, optimal techniques of stress factors disactualization, conflict situations.

We pay great attention to group psychotherapy (group discussion, pantomime, psycho-gymnastics, projective drawing, music therapy, motion therapy, etc.).

The game methods are equally important. There is a release of emotional tension in the course of the game. This method is used for both correction and diagnosis. Special sets of cards are useful for younger teens.

Role-playing games (role-changing) that normalize the behaviors and reactions indicated to older teens. Homeworks that consolidate the effect of various types of psychotherapy are used to enhance the therapeutic effect.

Thus, the use of methods of psychocorrection and psychotherapy in neurotic and somatoform disorders in childhood is one of the main pathogenetic approaches to the treatment of psychogenic disease, which are most common in childhood.

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КОГНИТИВНЫЕ НАРУШЕНИЯ И ИХ КОРРЕКЦИЯ У ДЕТЕЙ С ЭПИЛЕПСИЕЙ

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Статья посвящена анализу литературных данных, посвященных изучению когнитивных расстройств у детского населения. Рассмотрены вопросы распространенности указанных нарушений. Обращено внимание на то, что высокая распространенность эпилепсии в популяции, частое сочетание с умственной отсталостью и изменениями личности, необходимость длительной антиконвульсантной терапии определяют исключительную значимость данной проблемы в детской неврологии и психиатрии. Рассматриваемые вопросы обусловлены тем, что наличие когнитивных расстройств является одним из неотъемлемых аспектов в эпилептологической практике, а также тем, что неврологи и психиатры, занимающиеся лечением эпилепсии у детей и подростков, нередко эти расстройства недооценивают. В статье обращается внимание на этиологические и патогенетические аспекты формирования когнитивных нарушений, зависимость возникновения этих расстройств от локализации эпилептического очага, характера припадков, возрастных особенностей течения эпилепсии. Указано, что когнитивные нарушения у больных с эпилепсией детерминированы сложным взаимодействием биологических и социальных факторов. Выделены основные моментов, которые могут объяснить когнитивные и поведенческие проблемы у детей при эпилепсии. Выделены два механизма в нарушении познавательной деятельности больных эпилепсией. Указано, что психосоциальные проблемы для пациентов часто выходят на первый план, включая случаи, когда контроль над приступами еще не достигнут. В частности, депрессия у пациентов с трудно контролируемой эпилепсией в большей степени влияет на качество жизни, чем, скажем, частые приступы. Кроме того, депрессия может оказывать значительное воздействие и на когнитивные функции. Жалобы на нарушения речевых функций, памяти, внимания, мышления, которые пациенты могут предъявлять на приеме у врача, находятся на втором месте после жалоб на приступы. Уделено внимание и взглядам на подходы к терапии когнитивных нарушений. Указано, что оказание помощи детям с когнитивными нарушениями должно носить комплексный и индивидуальный подход, объединяя немедикаментозные и медикаментозные методы. Традиционно для лечения когнитивных расстройств применяются средства, относящиеся к группе ноотропных препаратов, а также направленная психологическая коррекция, поддерживаемая антиэпилептической терапией.

КЛЮЧЕВЫЕ СЛОВА: когнитивные нарушения, эпилепсия у детей, коррекция когнитивных нарушений у детей.

КОГНІТИВНІ ПОРУШЕННЯ ТА ЇХ КОРЕКЦІЯ У ДІТЕЙ З ЕПІЛЕПСІЄЮ

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Стаття присвячена аналізу літературних даних, присвячених вивченню когнітивних розладів у дитячого населення. Розглянуто питання поширеності зазначених порушень. Звернуто увагу на те, що висока поширеність епілепсії в популяції, часте поєднання з розумовою відсталістю і змінами особистості, необхідність тривалої антіконвульсантной терапії

визначають виняткову значимість даної проблеми в дитячій неврології і психіатрії. Розглянуті питання обумовлені тим, що наявність когнітивних розладів є одним з невід'ємних аспектів в епілептологическої практиці, а також тим, що неврологи і психіатри, які займаються лікуванням епілепсії у дітей та підлітків, нерідко ці розлади недооцінюють. У статті звертається увага на етіологічні і патогенетичні аспекти формування когнітивних порушень, залежність виникнення цих розладів від локалізації епілептичного вогнища, характеру припадків, вікових особливостей перебігу епілепсії. Зазначено, що когнітивні порушення у хворих з епілепсією детерміновані складною взаємодією біологічних та соціальних факторів. Виділено основні моментів, які можуть пояснити когнітивні і поведінкові проблеми у дітей при епілепсії. Виділено два механізми в порушенні пізнавальної діяльності хворих на епілепсію. Зазначено, що психосоціальні проблеми для пацієнтів часто виходять на перший план, включаючи випадки, коли контроль над нападами ще не досягнуто. Зокрема, депресія у пацієнтів з важко контрольованою епілепсією в більшій мірі впливає на якість життя, ніж, скажімо, часті напади. Крім того, депресія може мати значний вплив і на когнітивні функції. Скарги на порушення мовних функцій, пам'яті, уваги, мислення, які пацієнти можуть пред'являти на прийомі у лікаря, знаходяться на другому місці після скарг на напади. Приділено увагу і поглядам на підходи до терапії когнітивних порушень. Зазначено, що надання допомоги дітям з когнітивними порушеннями повинно носити комплексний і індивідуальний підхід, об'єднуючи немедикаментозні і медикаментозні методи. Традиційно для лікування когнітивних розладів застосовуються засоби, що відносяться до групи ноотропних препаратів, а також спрямована психологічна корекція, підтримувана антиепілептичної терапією.

КЛЮЧОВІ СЛОВА: когнітивні порушення, епілепсія у дітей, корекція когнітивних порушень у дітей

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DYNAMICS OF PSYCHOLOGICAL CHARACTERISTICS OF DRUG ADDICTS IN THE PERIOD OF REHABILITATION FOR UP TO ONE YEAR AND FROM ONE TO FIVE YEARS

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Despite the fact that in Ukraine there are constantly a large number of preventive and corrective measures to prevent and eliminate the phenomenon of drug addiction, statistics show that the problem does not diminish its relevance. Now there is a large number of studies that reveal the personal characteristics of a drug addicts. Many scientists are unanimous that in the period of drug addiction there is a distortion in the personal sphere. However, the features of these distortions at various stages of drug addiction are not fully understood. At the same time, the elimination of psychological dependence on narcotic substances by means of rehabilitation effects is possible only if the knowledge on the psychological characteristics of the addict is taken into account at different stages of the rehabilitation process. The main goal of rehabilitation work is not only the rejection of drugs. This is the development of new value orientations, personal growth in the individual and social sense, the development of human anti-drug resistance properties, the development of responsible choice skills, the formation of the internal locus of control, the formation of a positive life scenario and the availability of internal resources for its implementation. The article analyzes the effect of rehabilitation methods on the personality traits of drug addicts with short-term and long-term rehabilitation. The study included 60 people, of which 30 drug addicts were with a period of rehabilitation up to one year and 30 drug addicts with a period of rehabilitation from one year to five years. The complex of diagnostic tools includes methods for studying the level of aggressiveness, anxiety scales, behavior in a conflict situation, assessing the neuropsychic personality tension, a questionnaire for studying the level of impulsivity, a questionnaire for studying the level of subjective control, a questionnaire for studying well-being, activity, mood. The dynamics of psychological characteristics of drug addicts in the period of rehabilitation up to one year and from one to five years was determined.
KEY WORDS: drug addict, psychological characteristics of drug addicts, rehabilitation.

Problem formulation. Due to date, there is a substantial range of studies that reveal the identity of the drug addict. Continuous preventive-informative methods and a lot of methods of psycho-correction are actively applied across the country in order to prevent and eliminate a phenomenon of drug addiction. At the same time, statistics of detected drug addiction shows that the problem does not decrease its relevance. Many scientists agreed on the fact that during the period of drug addiction there is a distortion in the personal aspect, but the peculiarities of these distortions at different stages of drug addiction are not completely understood. Meanwhile, the elimination of psychological dependence on drug-addictive substances with psycho-correction and rehabilitation influence is possible only with the knowledge of the psychological characteristics of the drug addict at different stages of the rehabilitation process.

Social and economic restructuring of the last 10-15 years have changed the value systems of modern society. Unfortunately, not all of them are positive. Each of us faces with displays of socially negative behavior – aggressions, addictions, unlawful acts etc. Despite the fact that the issue of deviant behavior among adolescents is very traditional, today appears range of new issues, one of which is an effective way of prevention and correction of the problem -

oriented on basic psychological determinants of adolescent tendency to deviations. The purpose of this work is to determine the main factors of deviant behavior of adolescents, its analysis and comprehensive generalization of psycho measures.

Deviant behavior is a social behavior that does not conform to the norms in the society. Deviations in the behavior of children and adolescents are those features and expressions, which not only attract attention but also alarming parents, teachers and society. Deviant behavior is different in content and targeting, can manifest itself in various social deviations: evasion study, theft, vandalism, fights, alcoholism, drug abuse, suicide, etc. These features characterize the behavior not only deviations from the standard of conduct, but also pose potential risks to the subject of behavior, development of his personality, the people around him and society (Belycheva, 1993).

Classify deviant behavior of adolescents as follows:

1. Social deviations of selfish orientation: offenses, behavior relating with the desire to obtain material, money, property benefits.

2. Social deviations aggressive orientation – action against the person (offenses, disorderly conduct, assault, murder, rape).

3. Deviations socio-passive type: the desire to avoid an active lifestyle, to evade civic duties unwillingness to solve personal and social problems (evasion of studying, vagrancy, alcoholism, drug addiction, toxic mania, etc.). Notable among these deviations takes the suicidal behavior (Zmanovskaya, 2003).

Typically, deviations in behavior and social development of children and adolescents can be reduced in two groups: the situational forms of deviations in behavior (temporary signs or reactions caused by certain factors and circumstances: the reactions of refusal, protests, withdrawals, aggressions, etc.) and the resistant forms of deviations in behavior (developed by one or another type due to unfavorable conditions of life and work in general) (Belycheva, 1993).

The objective of the paper. The aim of this paper is to analyze the dynamics of personality traits of a drug addict during rehabilitation process.

The main material research. The research was conducted by the author during 2016-2018 on the basis of NGO "History of Life". The study included 60 people, of which 30 drug addicts were with a period of rehabilitation up to one year and 30 drug addicts with a period of rehabilitation from one year to five years. The age range of the sample of respondents within rehabilitation period was 18-67 years, the gender composition of the sample was 43 women and 17 men.

Diagnostic tools included the following techniques: Buss–Durkee Hostility Inventory, Level of Impulsivity Questionnaire by Losenkova, V.A., the "Evaluation of Neuro-Psychic Stress" technique by Nemchin, T.A., the questionnaire "The Level of Subjective Control" by Bazhina, Ye.F., Golinkina, E.A., Etkind, L.M., Questionnaire "Feeling, Activity, Mood" by Doskin, V.A., Lavrentieva, N.A., Kulia, V.B., and Miroshnikov, M.P., the Spielberger's State Anxiety Inventory modified by Hanina, Yu.L., and Thomas-Kilmann conflict mode questionnaire.

The selected methods meet the requirements of standardization, validity, reliability and relate to the aim of the research and material research. Statistical data processing method: Student's t-criterion is presented in the package of statistical tools IBM SPSS Statistics 20.

The dynamics of psychological characteristic of drug addicts within the period of rehabilitation for up to one year (*group 1*) and from one to five (*group 2*) will be analyzed, starting with a comparison of self-assessment of functional status of addicts. The research was conducted by us using the Questionnaire "Feeling, Activity, Mood" by Doskin, V.A., Lavrentieva, N.A., Kulia, V.B., and Miroshnikov, M.P. With its help, we managed to determine the prevailing states and attitudes of drug addicts in the period of rehabilitation for up to one year and from one to five. The results of the study in a summarized form are presented in the chart below (Figure 1).

According to the chart (Figure 1), the significant increase in the functional states rate of drug addicts is observed, the number of low indicators decreases and the number of mean and high indicators increases within all method scales. So, low levels of

well-being are reduced from 64% to 7%, while average and high rates increase from 13% to 37% and from 23% to 56%.

These differences were established at the level of statistical significance p≤0,001 (t = 3,81), and therefore, the long-term stage of rehabilitation leads to a decrease of apathy, fatigue and exhaustion of drug addicts, and increases sense of momentum, strength recovery and health.

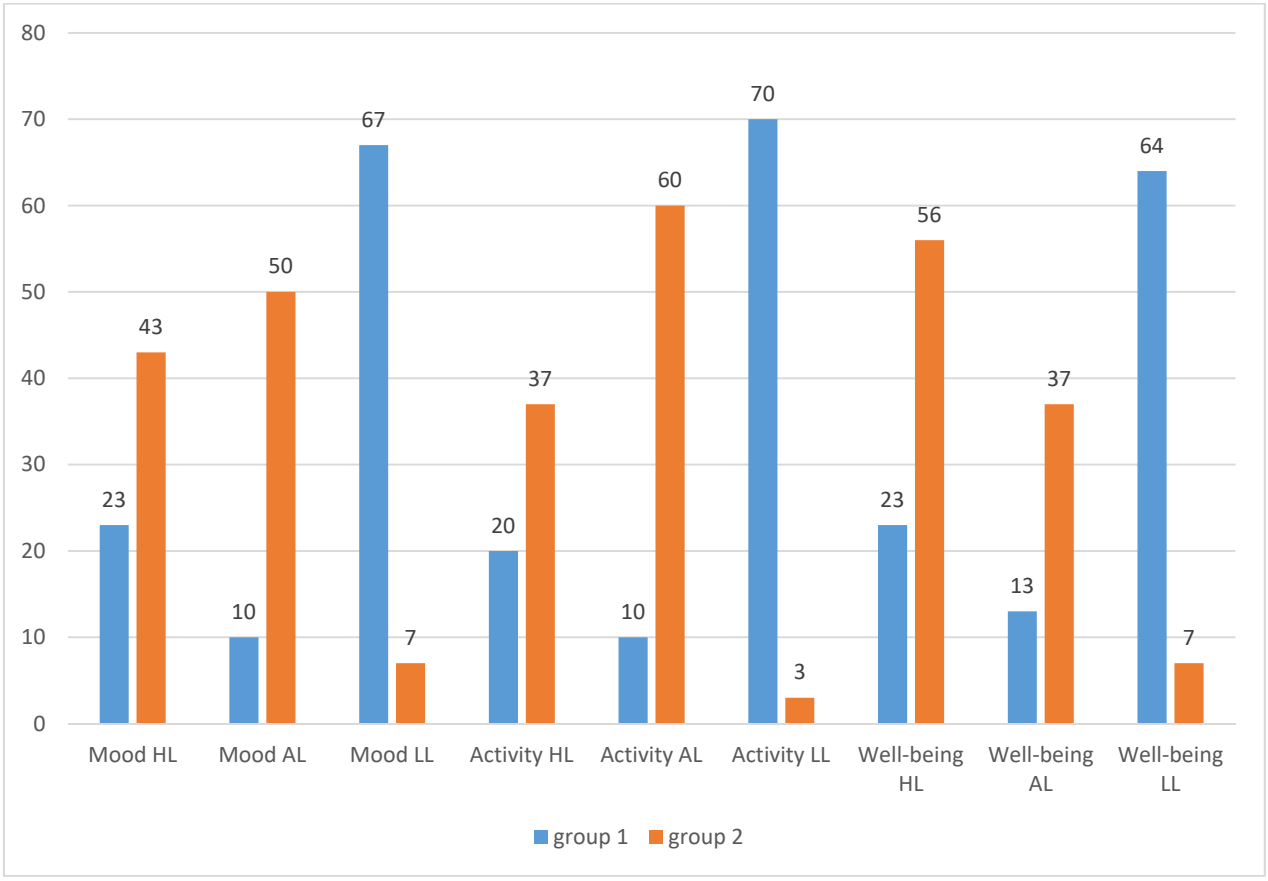

Figure 1. Comparative Chart of Self-assessment rates of functional states of drug addicts in the period of rehabilitation for up to one year and from one to five years (n = 60,%)

Low activity rates are reduced from 70% to 3%, while the average and high rates increase from 10% to 60% and from 20% to 37%. These differences were established at the level of statistical significance p≤ 0.001 (t = 3.85), which indicates an increase in the pace of mental and physical activity, an increase in the concentration and interest of drug addicts within long-term rehabilitation from one to five years.

Low mood rates also decrease from 67% to 7%, while average and high rates increase from 10% to 50% and from 23% to 43%.

These differences were established at the level of statistical significance p≤ 0.001 (t = 3.72), and therefore, the five-year stage of rehabilitation of drug addicts leads to an improvement in the emotional state of the subjects that allows them to adequately perceive the events, people, evaluate their opportunities, hope for the future without being concentrated on past failures.

Thus, all components of the functional state of drug addicts in the period of rehabilitation from one to five years have positive dynamics, what is also a favorable ground for other psychological changes. This data is confirmed by the results of the next study of the nervous-psychic stress of drug addicts during the rehabilitation period, which was carried out by using the technique “Evaluation of Neuro-Psychic Stress" by Nemchin, T.A. The received data is shown in Fig. 2.

According to the chart, drug users in the period of rehabilitation from one to five years have a twofold decrease (from 63% to 30%) and a corresponding increase in the average (from 37% to

60%) and high (from 0% to 10%) rates of neuro-psychological stress. These differences were established at the level of statistical significance p≤0,01 (t = 2,79) indicating a general increase in the quality of productivity of mental activity.

Let's consider the results of the study on the impulsivity of drug addicts in the period of rehabilitation for up to one year and from one to five years obtained by using the Losenkova, V.A. method of determining the level of impulsivity (Fig. 3).

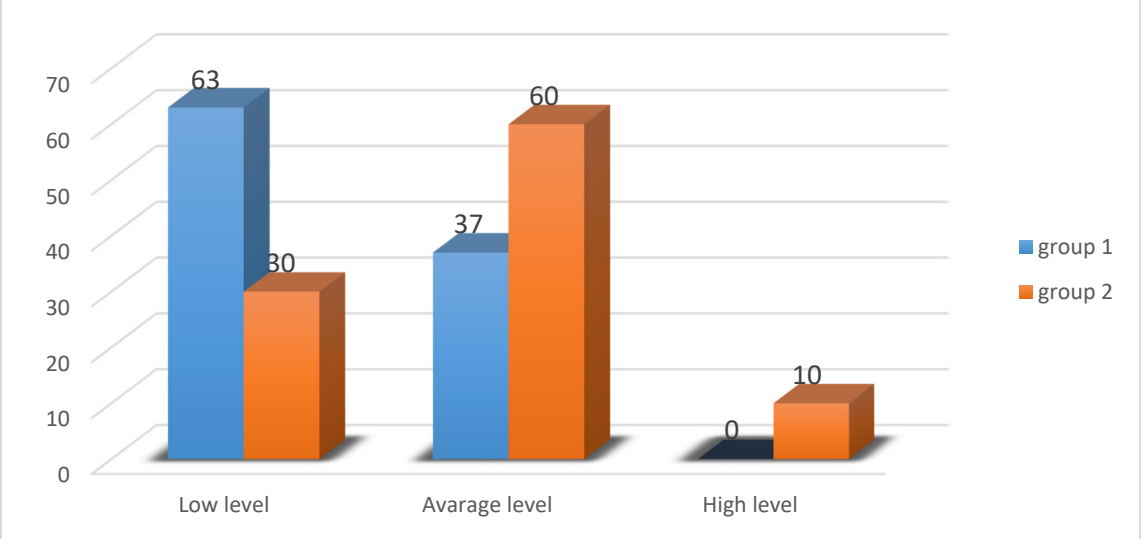

Figure 2. Comparative Chart of nervous-psychic stress rates of drug addicts in the period of rehabilitation for up to one year and from one to five years (n = 60,%)

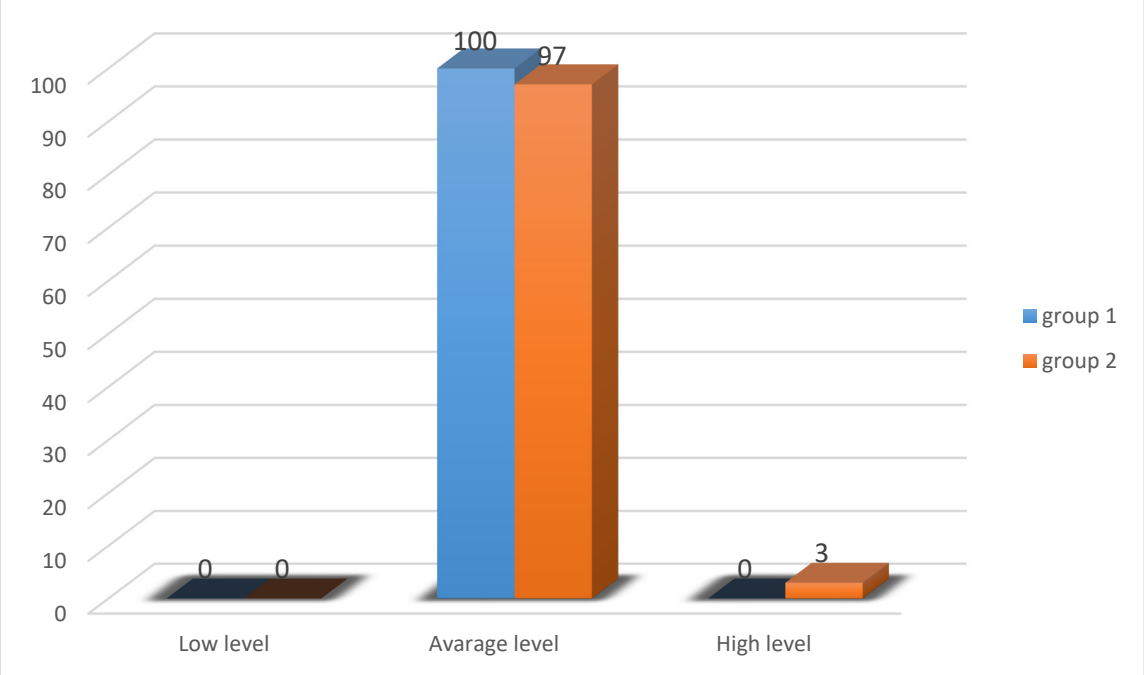

Figure. 3. Comparative Chart of impulsivity rates of drug addicts in the period of rehabilitation for up to one year and from one to five years (n = 60,%)

According to the comparative chart (Figure 3), the results of the study of the impulsivity of drug addicts almost did not change, there was a slight increase in rates, so the average impulsivity rates decrease from 100% to 97%, while the high rates increase from 0% to 3%. There were no statistically significant differences determined. Consequently, the long-term rehabilitation maintains a certain level of equilibrium in the activity and actions of the subjects involved in the study, the balance in life plans determination and perseverance of efforts to achieve them.

Let's consider the results of the study on the anxiety rates of drug addicts in the period of rehabilitation for up to one year and from one to five years obtained by using the Spielberger's State Anxiety Inventory (see Figure 4).

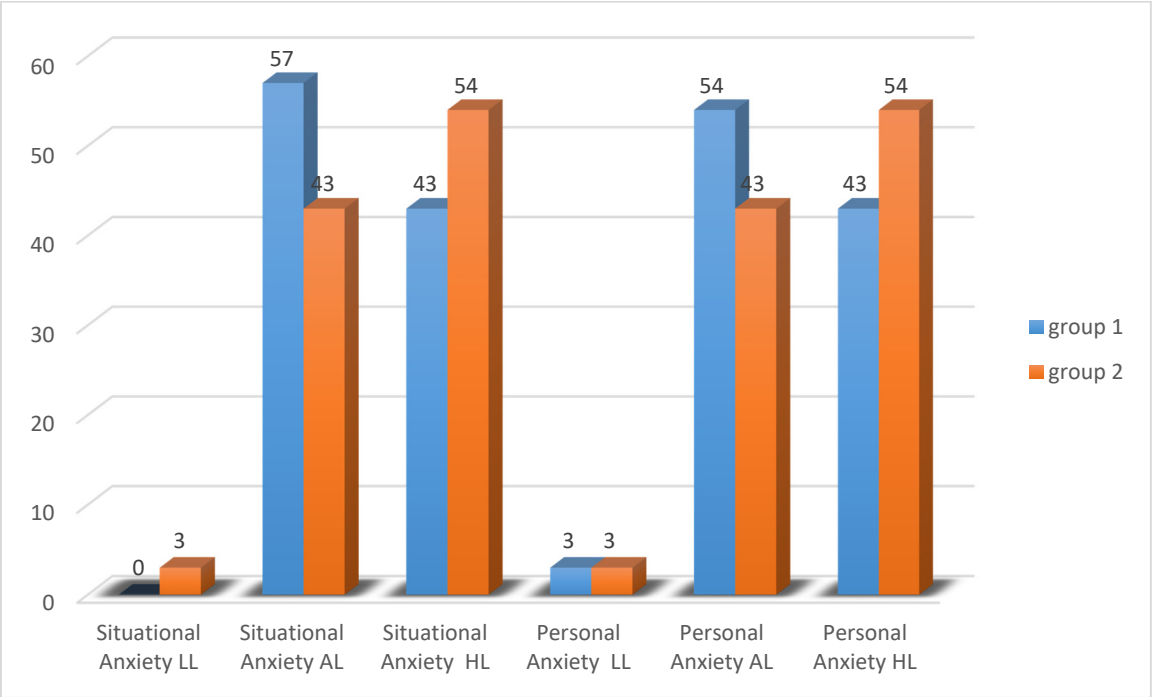

Figure 4. Comparative Chart of anxiety rates of drug addicts in the period of rehabilitation for up to one year and from one to five years (n = 60,%)

The comparative chart (Figure 4) shows that rates of situational and personal anxiety of drug addicts in the period of rehabilitation for up to one year and from one to five years are distributed almost equally. Average rates of situational anxiety decreased from 57% to 43%, and high rates rose from 43% to 54%. Similarly, average personal anxiety rates decreased from 54% to 43%, and high rates rose from 43% to 54%. There were no statistically significant differences determined.

The presence of anxiety as a personality trait is very important, because it determines the behavior of the subject to a large extant, its sufficient level is a natural and mandatory characteristic of the active personality. Every person has his optimal or desirable level of anxiety - so-called useful anxiety. During the period of long-term rehabilitation, drug addicts are aware of a large range of problems and difficulties that were not obvious to them during the active drug use. Therefore, it would be logical to have a higher level of both, situational and personal anxiety in the period of awareness of their problems and acceptance of responsibility for their lives in the present, past and future.

Next let's consider the results of the study on the aggression rates of drug addicts in the rehabilitation period for up to one year and from one to five years obtained by using the Buss–Durkee Hostility Inventory (Figure 5).

The chart shows that aggression rates of drug addicts during the rehabilitation period for up to one year and from one to five years did not change significantly. The rates of Negativism and Resentment grew, while the rate of Guilt fell. Differences in Negativism rates have statistical significance at the level of $p \leq 0.001$ ($t = 3.12$), while Resentment rates have statistical significance at the level of $p \leq 0.001$ ($t = 3.01$). The results can be explained by specific aspects of rehabilitation work including talking about displaced emotions, attraction and resentment, that reduce feelings of guilt and expands life concepts of personality. In general, drug addicts in the period of rehabilitation for up to one year and from one to five years are characterized by distrust, jealousy and hostility towards the outside world demonstrated ranging from passive discontent to an active verbal and physical confrontation.

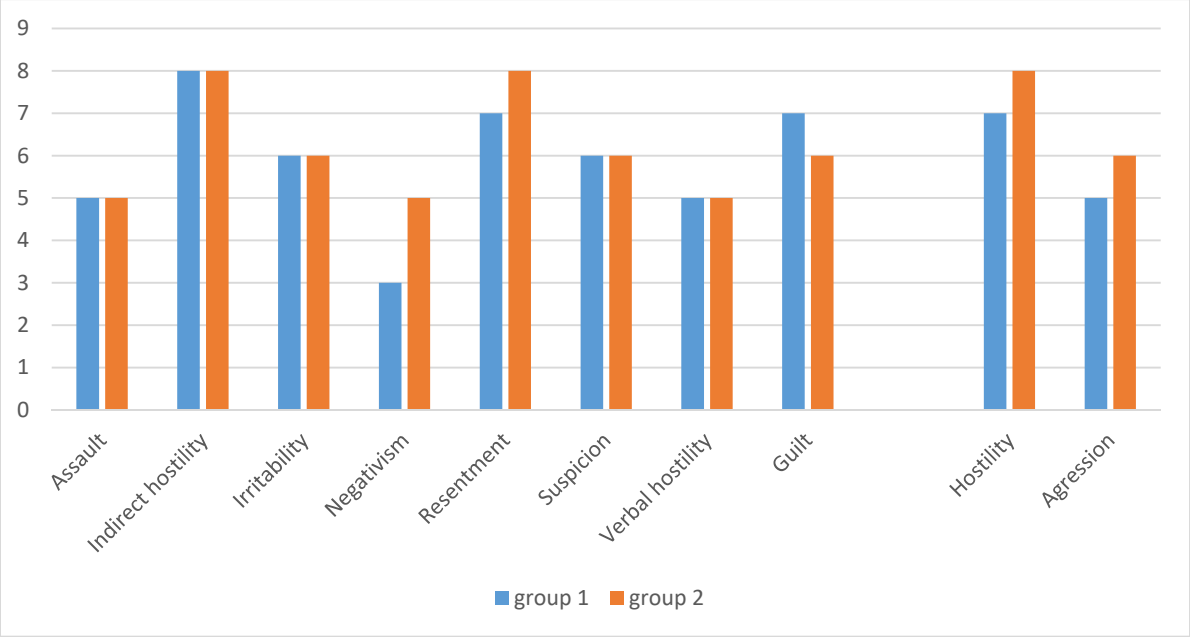

Figure 5. Comparative Chart of aggression rates of drug addicts in the period of rehabilitation for up to one year and from one to five years (n = 60,%)

The determination of the Hostility and Aggression of drug addicts in the period of rehabilitation for up to one year and from one to five years showed an increase in both indicators – a high level of Hostility and above average level of Aggression. Differences in the Hostility rates have statistical significance at the level of $p \leq 0,01$ ($t = 2,65$). Consequently, we can state that they have an affective complex including anger, insult and suspicion. Insomnia is defined as the basis for aggression and increases the probability of impulsive acts of aggression aimed at the surrounding world or itself (autoaggression) by destroying Self with psychoactive substances. Particularly, such a tendency in drug addicts does not disappear, it is only realized and taken under its own control by means of rehabilitation and psycho-correction.

Every individual should have a certain degree of aggression, its absence leads to passivity, conformance, etc. Thus, the process of rehabilitation of drug addicts should include the normative aggression of patients, who should become active subjects of their life, break old patterns and build up qualitatively new ones.

Let's consider the results of the research on the conflict response styles of drug addicts in the rehabilitation period for up to one year and from one to five years obtained by using the Thomas-Kilmann conflict mode questionnaire (Kenneth W. Thomas and Ralph H. Kilmann, 1974) modified by Grishina (Figure 6).

The data shows a decrease in the indicators of the conflict response styles, such as Collaborating from 17% to 3% and Avoiding from 40% to 20%. Differences in the Collaborating indicators have statistical significance at the level of $p \leq 0,01$ ($t = -2,99$). The rates of Competing increased from 20% to 27%, as well as the rates of Compromising - from 17% to 27% and the Accommodating rates - from 6% to 23%. In numerical terms, the most significant is the decrease of Avoiding conflict response style indicators, that had a leading position at the beginning of rehabilitation work. Contrary to this, there is a significant increase in the Accommodating rates that is one of the top three dominant conflict response styles, along with the Competing and Compromising.

The aim of the rehabilitation process is to recover the physical and mental states of an individual to the point where he will be able to rebuild the relationship with society through upgrading a life style. The new identity is based on the positive basic values of the addict, what helps gradually enter into the society and re-socialize. Methods of development are aimed at mobilizing resources and the development of personality by individual's compensatory mechanisms.

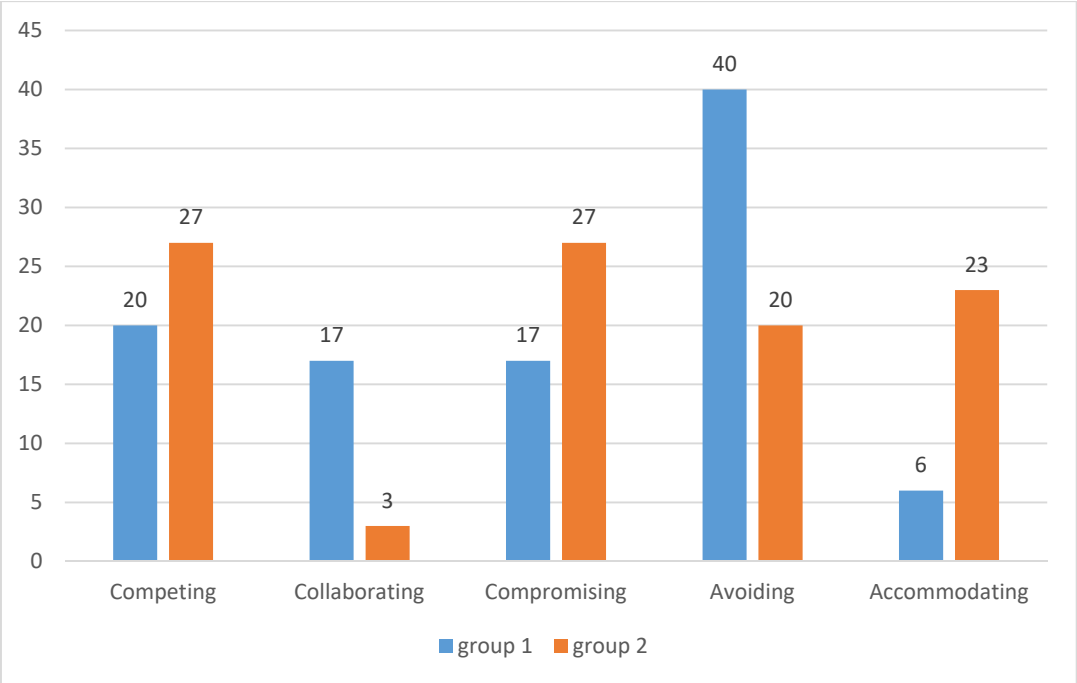

Figure 6. Comparative Chart of the conflict response styles rates of drug addicts in the period of rehabilitation for up to one year and from one to five years (n = 60,%)

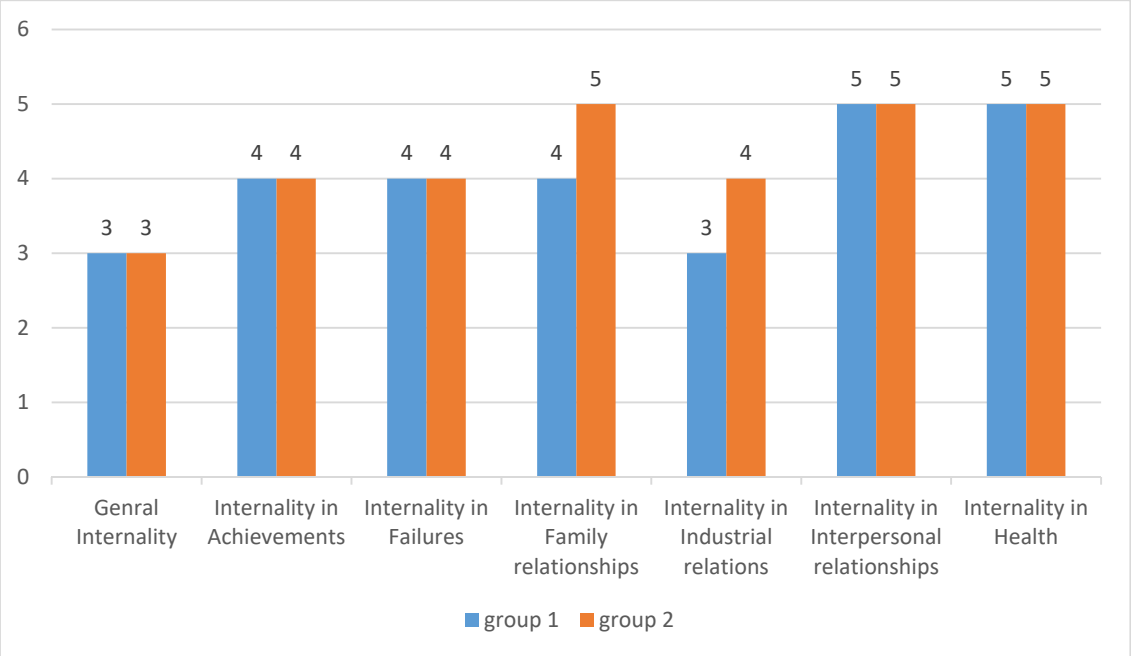

Figure 7. Comparative Chart of the Internality rates of drug addicts of drug addicts in the period of rehabilitation for up to one year and from one to five years (n = 60,%)

Interaction within the framework of rehabilitation is characterized by non-direct, partner-style communication, an appeal to dialogue, understanding, rational-critical analysis, best use of the effects of group and interpersonal interaction. The patient is considered as an active subject with positive changes, what definitely determines the positive changes in the ability to manage conflict situations with a wide range of response styles, in accordance to the significance and objectives of each situation with various positions of opponents during a communication.

Let's also consider the results of the study of the Internality rates of drug addicts in the period of rehabilitation for up to one year and from one to five years obtained by using the questionnaire "The Level of Subjective Control" by Bazhina, Ye.F., Golinkina, E.A., Etkind, L.M. (see Fig. 7).

As we can see, drug addicts in the period of rehabilitation for up to one year and from one to five years show an increase in the Internality in Family relationships and Industrial relations. Differences in the indicators of Internality in Family relationships have statistical significance at the level of $p \leq 0,01$ ($t = 2,44$). This is due to the specific aspects of rehabilitation programs based on universal and family values. The low productivity of an adult leads to the emergence of a psychological crisis and the intention of escaping from reality, also through psychoactive substances. Establishing balance in the family and industrial areas of life becomes a solid foundation for recovery from a life crisis, increasing the feeling of empowerment and the ability to influence and change this world in accordance with own goals and values.

The highest indicators of internality in the period of long-term rehabilitation of drug addicts are the Internality in Family relationships, the Internality in Interpersonal relationships, and Internality in health. These indicators have the boundaries of internality, and therefore, the researchers tend to believe that these aspects of life are influenced by external factors (God, heredity, life circumstances, etc.), and internal (own desires and efforts) factors.

The rest Internality indicators (General Internality, Internality in Achievements, Internality in Failures, and Internality in Industrial relations) are lower, indicating that they are more externalized, and therefore subjects feel less ability to influence their own efforts to achieve the desired results, giving the leading role to a matter of chance, luck-failure, to help of other people, the will of the higher power, etc.

Conclusions. The aim of rehabilitation work is not only a drug refusal, but also the elimination of anti-social behavior, the development of useful skills and abilities, the development of new values sets, in other words a complete change in lifestyle.

The main aim of rehabilitation is to increase personal growth in individual and social aspects, and the main tool for its achievement is the patient's acquisition of integrity. In addition, it involves the development of the properties of anti-drug sustainability of the individual, such as personal identification completion, the formation of skills of responsible choice, the formation of internal locus control, the existence of a positive life scenario, the availability of internal resources for the positive life scenario implementation, elimination of drug use from all possible life aspects of the individual . The deep level of psychotherapy anticipates a direct or indirect reference to the categories of values and sense of social meaning. Therefore, this process is complex and quite conflicting for drug addicts.

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ДИНАМІКА ПСИХОЛОГІЧНИХ ОСОБЛИВОСТЕЙ НАРКОЗАЛЕЖНИХ У ПЕРІОД РЕАБІЛІТАЦІЇ ДО РОКУ ТА ВІД РОКУ ДО П'ЯТИ

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Попри те, що в Україні постійно проводиться велика кількість профілактичних та корекційних заходів з метою попередження та усунення явища наркозалежності, статистика свідчить, що проблема не зменшує своєї актуальності. Наразі існує досить велика кількість досліджень, що розкривають особистість наркозалежного. Багато вчених одностайні в тому, що в період наркозалежності відбувається спотворення в особистісній сфері, однак особливості цих спотворень на різних стадіях наркозалежності до кінця не вивчені. Разом із тим, усунення психологічної залежності від наркотичних речовин засобами реабілітаційного впливу можливе лише за умови врахування знання щодо психологічних особливостей наркозалежного на різних етапах реабілітаційного процесу. Головною метою реабілітаційної роботи є не тільки відмова від наркотиків. Це розвиток нових ціннісних орієнтацій, зростання особистості в індивідуальному і соціальному плані, розвиток властивостей антинаркотичної стійкості особистості, сформованість навичок відповідального вибору, сформованість внутрішнього локусу контролю, наявність позитивного життєвого сценарію та наявність внутрішніх ресурсів для його реалізації. У статті проаналізовано вплив реабілітаційних заходів на особистісні особливості наркозалежних, які знаходяться на короткотривалому та довготривалому етапі реабілітації. Дослідженням було охоплено 60 осіб, з яких 30 наркозалежних з періодом реабілітації до року та 30 наркозалежних з періодом реабілітації з року до 5 років. В комплекс діагностичного інструментарію увійшли методики на дослідження рівня агресивності, шкали тривоги, поведінки в конфліктній ситуації, оцінки нервово-психічної напруги особистості, опитувальник для дослідження рівня імпульсивності, опитувальник для дослідження рівня суб'єктивного контролю, опитувальник для дослідження самопочуття, активності, настрою. Визначено динаміку психологічних особливостей наркозалежних у період реабілітації до року та від року до п'яти.

КЛЮЧОВІ СЛОВА: наркозалежна особа, психологічні особливості наркозалежних, реабілітація.

ДИНАМИКА ПСИХОЛОГИЧЕСКИХ ОСОБЕННОСТЕЙ НАРКОЗАВИСИМЫХ В ПЕРИОД РЕАБИЛИТАЦИИ ДО ГОДА И ОТ ГОДА ДО ПЯТИ

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Несмотря на то, что в Украине постоянно проводится большое количество профилактических и коррекционных мероприятий с целью предупреждения и устранения явления наркозависимости, статистика свидетельствует, что проблема не уменьшает своей актуальности. Сейчас существует достаточно большое количество исследований, раскрывающих личность наркозависимого. Многие ученые единодушны в том, что в период наркозависимости происходит искажение в личностной сфере, однако особенности этих искажений на различных стадиях наркозависимости до конца не изучены. Вместе с тем, устранения психологической зависимости от наркотических веществ средствами реабилитационного воздействия возможно лишь при условии учета знания о психологических особенностях наркозависимого на разных этапах реабилитационного процесса. Главной целью реабилитационной работы является не только отказ от наркотиков. Это развитие новых ценностных ориентаций, рост личности в индивидуальном и социальном плане, развитие свойств антинаркотической устойчивости личности, сформированность навыков ответственного выбора, сформированность внутреннего локуса контроля, наличие положительного жизненного сценария и наличие внутренних ресурсов для его реализации. В статье проанализировано влияние реабилитационных мероприятий на личностные особенности наркозависимых, находящихся на кратковременном и длительном этапе реабилитации. Исследованием было охвачено 60 человек, из которых 30 наркозависимых с периодом реабилитации до года и 30 наркозависимых с периодом реабилитации с года до 5 лет. В комплекс диагностического инструментария вошли методики для исследования уровня агрессивности, шкалы тревоги, поведения в конфликтной ситуации, оценки нервно-психического напряжения личности, опросник для исследования уровня импульсивности, опросник для исследования уровня субъективного контроля, опросник для исследования самочувствия, активности, настроения. Определена динамика психологических особенностей наркозависимых в период реабилитации до года и от года до пяти.

КЛЮЧЕВЫЕ СЛОВА: наркозависимый человек, психологические особенности наркозависимых, реабилитация.

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SPECIFIC LEARNING DISABILITIES

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This article reports the specific disorders and difficulties in school learning settings and its frequent and relevant problems, as outlined in psychological literature and pedagogical sciences. These definitions are recognized and fully contemplated by the Law in several European countries, including Italy, and treatment, educational and relational guidelines are proposed, to be considered in a logic of protection and promotion of the child's well-being (as a children or teen) with its specific learning disability. This document contains a first approach to the subject, aimed to inform and guide for the identification and distinction of this pathologies, which can coexist, and to limit their negative effects, which could compromise the child's growth and development, especially if addressed early. Specific learning disabilities are related to reading, writing and mathematical calculation; it is important that in a school context the operators are (in) formed, in order to face and guarantee every day the realization of student's learning and educational work in general.
KEYWORDS: Specific Learning Disabilities (LD), Dyslexia, Anorthography, Dysgraphia, Dyscalculia, Rehabilitation Treatment, Scholastic Facilitation, Psychomotor Functions, Family School Relationships

Learning disabilities represent a clinical area of interest, where important discoveries has been achieved over the past forty years thanks to numerous contributions both from scientific research and diagnostic investigation techniques.

In 1990 Hammill defined the general characteristics of Learning Disabilities (Hammill, 1990) based on the agreement reached by numerous associations of researchers and field experience: learning disability (LD) refers to a heterogenic group of disorders manifested by significant difficulties in the acquisition and use of listening skills, oral expression, reading, reasoning and mathematics, presumably due to dysfunctions in the central nervous system. Behavioural problems might coexist with learning disabilities, like self-regulation, social perception and social interaction, but those are not considered LD. Learning disability might occur in conjunction with other deficit factors or extrinsic influences (cultural, educational, relational poverty, etc.), but they are not the result of those conditions.

Italian Law 170/2010, recognizes dyslexia, dysgraphia, anorthography and dyscalculia as specific learning disabilities; they manifest themselves in presence of adequate cognitive abilities, in absence of neurological pathologies and sensory deficits, but may constitute a limitation for some activities of daily life. The aims of this law are: to guarantee the right to education, to promote scholastic success even providing adequate support measures (compensatory instruments and dispensatory measures), to guarantee adequate training and to promote the development of the pupil's potential, to reduce relational and emotional discomforts by adopting forms of verification and evaluation appropriate to the training needs of the students, preparing teachers and raising parents' awareness to the problems related to Specific Learning Disabilities, increasing communication and collaboration between families, schools and Health Services during the educational path of the child, to promote early diagnosis and support rehabilitation and, finally, to ensure equal opportunities to develop skills in social and professional field.

Under this law relational and emotional dimension are crucial for improvement and recovery for those who face Learning Disabilities.

Which origin have specific learning disabilities? What they entail?

Learning Disabilities relate to a specific area, such as reading, writing or calculating, although in clinical practice it is more common to encounter association of multiple disorders (for example specific reading disorder, also called dyslexia, and specific of writing). However, these are distinct disorders, each with its own specific appearance and description.

LD have neurobiological origins and refer to a significant impairment in the development of skills related to school development, such as reading

(dyslexia), writing (anorthography and dysgraphia) and mathematical skills (dyscalculia). They have an evolutionary matrix, they aren't acquired but they are inherent in child, they always existed, that's why the child has never acquired certain skills. In Italy Learning Disabilies are called Specific Learning Disorders (Disturbi Specifici dell'Apprendimento, DSA). We talk about "disorder" and not "delay" or "difficulties"; delay and difficulties presuppose a time that is perhaps dilated to arrive to acquiring a competence, disorder means that instead of this competence we cannot get there, as if there were resistance to interventions and the automation of specific abilities (Vio, Tressoldi, Lo Presti, 2012). Even in main manuals diagnostic there is a discrete concordance in proposals' classification of these disorders: *"normal methods of question abilities acquiring are altered already in development starting phases . They aren't a consequence of learning lack opportunities and aren't due to an acquired brain disease. Rather, it is believed that disorders derive from abnormalities in cognitive processing largely related to some type of biological dysfunction "*(ICD-10, 2000).

Dyslexia manifests itself with worse precision and rapidity when reading out loud, therefore it's understood as a specific disturbance in automation of this ability; we can observe both an excessive slowness in reading and a considerable number of errors from a visual, phonological or lexical standpoint. It is observable how, in a dyslexic child, there is not a "lexical warehouse" to recover known words from memory. Dyslexic subjects, during reading, also fix prepositions, articles, conjunctions, etc. and have difficulty in switching lines as if they should always set again the starting point. Diagnosis is possible only at the end of the normal learning process for reading and writing skills, therefore at the end of the second grade of primary school. After the identification of suspected cases, the procedure followed in cases of presumed dyslexia involves a targeted recovery activity, after this the difficulties encountered can be communicated to families that will present an evaluation request to services in charge. The evaluation request is followed by diagnostic procedure, in case the disorder is confirmed a diagnostic certification document will be redacted; families will be obliged to communicate it to the student's schools and they will proceed with the compilation of the Personalized Teaching Plan (Piano Didattico Personalizzato) which will indicate the possible compensatory instruments and the agreed dispensatory measures.

Anorthography refers to a deficit in encryption of orthographic code. This disorder involves phonographic coding skills and orthographic competence. According to the Tressoldi's model (Vio, Tressoldi, Lo Presti, 2012), following Wroting Skills can be identified in:

-phoneme discrimination (ability to distinguish, for example, "form " to "from" or "prin" from "drin")

-phonemic analysis (ability to break down the word into his phonemes for example FAIRY → F-A-I-R-Y),

-graph-phoneme correspondence (write throgh instead of through),

-praxic speed,

-lexicon of words (the storehouse of known and automated words).

Dysgraphia is a deficit in grapheme realization, specifically of a motor nature. Writing is slower and not readable.

On the other hand, **Dyscalculia**, is a issue in the acquisition of automatisms that has to deal with calculation and/or processing numbers. Numerical competences are divided in two circuits: the approximate system (innate and independent of language) which includes subitizing's skills (the **subitizing** term was coined (Kaufman, 1949) and refers to the ability to distinguish quickly and accurately the quantity in a small number, objects or elements), of comparison between numerosity and ability to estimate; the exact system (dependent on language and learned through instruction) which corresponds to the counting and evolves towards the one-to-one correspondence between objects and numbers, stable order, abstraction, cardinality and irrelevance of order. the children learns,one after another, the numeric system and their transcoding, the semantic coding and then access the calculation system which includes operation's signs and their applicative meaning and the stock of arithmetic facts (tables, calculations until ten). Then comes the problem solving, which includes understanding and

solving math problems. So, there are two different profiles of dyscalculia, one is referring to the compromise of approximate system by basic skills, the other one is understood as a deficit of the executive and calculation procedures. Dyscalculia could be diagnosable only at the end of the third grade of primary school, when normal process of learning the calculation skills is finished.

Even if these disorders are related to biological maturation, this doesn't imply that affected children are simply at the lowest end of a normal ctinuum and that they will then regain lost ground over time, but depending from the range of difficulty experienced, the acquisition of the required skills might changing over time, but almost never reach the expected levels for age and/or schooling.

This difficulties occur in the early stages of child's learning, when he must acquire new skills such as reading, writing and calculating while starting from a neuropsychological set-up that does not favour automatic learning of these specific skills. These difficulties can persist marking through adolescence to adulthood.

This occurs also when rehabilitative and educational interventions have been carried out, which are nevertheless decisive to allow, even if slowly, path to improvement and most important, to guarantee appropriate learning conditions and opportunities. Disorders' evolution, in fact, are favoured by intervention's precociousness and adequacy, as well as by compensatory measures taken in the school pathway's context to favour learning.

Two types of actions are distinguished in Learning Disabilities' Treatment:

✓ Rehabilitation treatment, which aims to improve poor performance through specific cognitive training; in the last few years many multimedia software has been developed, being less boring to the children, they favour learning through a playful approach.

✓ School environment's facilitations and aid that serve to support children with Specific Learning Disorders are compensatory tools (technological tools that compensate encountered difficulties) and dispensatory measures (the student is exempted from certain services considered "normal" for example reading aloud or using italics in written texts).

Taking care of child's psychological well-being, his emotional stability, the growth of his self-esteem must always be at the base of every action conceived and acted by whose surround him, parents, teachers, rehabilitators, in order to create a solid and effective relationship framework. Unfortunately, sometimes this does not happen; Anger and repulsion towards reading or any other object of qualification emerges, the feeling of inferiority in comparison with other companions and hate for constant training caused by this sense of inadequacy.

Along the actions addressed to LD, there are actions address these disorders from a cognitive-behavioural point of view and embracing the idea that it is possible to have a positive intervention in a dynamic and amusing way. The basic idea comes from boys with LD transversal observation, especially from the psycho-motor point of view. Often, many of these children demonstrate characteristics (similar to each other) of an absolute lack of mastery of the pre-requisites, which are at the basis of general motor coordination and body schema's structuring. They appear awkward and clumsy and physical performance often falls below the average, as if not all the mechanisms favouring learning had been structured, even on a physical level as well as on a cognitive level. In careful consideration there are many similarities that lead to remembering child's development.

According to Piaget, the stages of cognitive development, in order are: sensorimotor stage, preoperational stage, concrete operation and, finally, formal operation. The phase of the lived and perceived body thus anticipates the phase of abstract operations. Furthermore: "*the whole knowledge construction, from simple to complex forms, non-verbal knowledge through images to verbal literary knowledge, depends on creating maps ability of what happens over time within our body, around our organism, to ours and to our body - one thing after another, which causes something else, repeated until infinity"* (Damasio, 1999).

The structuring of lived body experience anticipates, therefore, all the cognitive abilities that are created subsequently, at a temporal level.

But then, which are the pre-requisites that need to be enabled because they aren't structured in the period of their sensitive phase? Which characteristics can affect reading structuring, writing and calculation skills?

Seven key concepts

The psychomotor functions are defined by the ICF (International Classification of Functioning, Disability and Health, WHO, 2001), (this international classification integrated medical and social prospective of health and illness, indicating the functioning and participation of the person in the various contexts of life) as "specific mental functions controlling lateral dominance, posture, spatial-temporal organization and motor perseverance". Usually they are developed by child's environmental experiences, they produce automatic behaviours with sensory and perceptive integration of the stimuli and allow to perform actions by solid reference points; therefore, they constitute a learning structure and exercise of actions. These functions, in subjects with LD are disturbed due to a dyspraxia which in turn generates a sort of dispersion of cognitive energy: the child spends so much energy performing the actions that all his attention is catalysed towards execution, losing sight of the purpose of the exercise. The motion pre-requisites that are the basis of the success of learning structuring are therefore:

- ✓ Lateralization
- ✓ Spatial orientation
- ✓ Time orientation
- ✓ Proprioception
- ✓ General coordination
- ✓ Oculo-manual coordination
- ✓ Muscle tone

Lateralization is a progressive process that occurs during the child's development. It is thought that specialization or lateral prevalence has wide subjective variability: everyone seems to possess a different lateralized distribution of neuropsychological processes (Geschwind, 1972). Among these there is a motor predominance, whose most obvious expression is manual preference. Being decidedly right-handed or left-handed in motor actions, for example in shooting, aiming, precision throws "is the original reference of every spatial orientation, both motor and graphic; it is the first link in orientations chain of and, if it is poorly consolidated, it will become a disorienting factor for all incoming neuro-perceptive and praxis-motor information" (Spezzi, Barbieri, Lodi, Vecchione, 2015). The occurrence of lateralization gives the learning subject full awareness of the directionality (foundation of writing, from left to right in our case) which in turn is the base for sequentiality and therefore of ordered recognition of the letters that make up words or the order of figures. The lateralization is therefore, a pre-requisite of spatial and temporal orientation.

Spatial orientation development is at the base of all topological conceptuality, of shape recognition, dimensions, directions, above-below, inside-outside, right-left, near-far concepts. All essential skills to be able to access reading, writing, mathematical stacking, recognition and orientation skills of geometric shapes. Recognizing alphabet's letters based on graphic form requires spatial orientation. The letter **A** differs from the letter **V** for the tip's orientation, **p** and **q** are mirrored in "belly" as well as **b** and **d**.

Temporal orientation is expressed in the concepts of sequentiality, temporality and rhythmics. Rhythmic internalization sequence can help the reading process, but it can also create significant interconnections in numerical recognition sequences. The concept of "before" and "after" is the basis of chronological mental creation of sequences; to writing a text temporal organization is required as well as the succession of steps in mathematical resolution problems.

Proprioception is the ability to recognize our own body position in space and mussel's contraction state, regardless of the use of sight. It plays a fundamental role in complex mechanism of motor control. This ability is possible by the presence, in the human body, of kinaesthetic (or proprioceptive) receptors that are sensitive to postures changes and body segments. There are two types of receptors: one measures the variation of muscle's length (neuromuscular spindles) and the other the change in tension and expressed force (Golgi tendon organs). A good proprioceptive ability allows to acquire full

control of all body parts and to deal with increasingly complex motor actions. Proprioception is strongly interconnected with the ability to acquire automatisms.

By **general coordination** we mean the movement selection strategies. These strategies can be automatic or voluntary and are related to two anatomical and functional levels of nervous system. Automatic coordination is the first form of human movement, it automatically triggers at an unconscious level and is expressed in the globality of action. This type of coordination makes possible to create movement patterns that are consolidated through repetition and practice, creating automatisms.

Voluntary coordination is the conscious, desired form of movement and is generated by proprioceptive awareness of kinaesthetic information that the subject reaches through sensory feedback.

Human coordination means knowing how to manage in harmonious way our own strength, speed, mobility, both exteroceptive (coming from outside) and proprioceptive return information to achieve a desired and finalized movement.

Oculo-manual coordination is even finer, and refers to the same principles expressed for general coordination but with an attentive focus on eye-hand correlation. Aiming (using the pen on the sheet), spatiality, writing ability, lining up number in columns and gestures' fluency all depends on the good establishment of this capacity.

"**Muscle tone** is the operative substrate of every praxis: if it's too bland, will produce a soft and subtle motor intervention, unsuitable for various tools uses, typical of a renouncing and poorly convinced attitude; if too intense, the propensity to excess, hyperactivity, difficulty in adapting and listening will increase" (Geschwind, 1972). Very often children with LD show a hypotonic attitude and considerable difficulties in organizing motor gestures; a part of them, on the other hand, is hypertonic and uses excessive energy in their finalized actions, thus facing difficulties in action controlling, greater fatigue, inaccuracies due to rigidity and lack of body control. In both cases, exercises for tone regulation lead to a psycho-physical improvement, limitation of emotional excesses, increase in adaptability, self-control, with a significant repercussion in social interactions and increasing self-esteem.

From these key concepts we can therefore think that their correct acquisition through careful "motor qualification" can contribute in mitigating specific learning disorders. Nothing is taken away from all interventions that have been implemented so far, training at the gym and domestic reinforcement are not substitutes, but are added on top, with the aim of reinforcing their effectiveness.

Training in cooperation with other boys, within a favourable environment, has a high socializing power. Targeted exercises, easy to carry out, leads children to success and this helps to create positive feelings and emotions, like effectiveness and mastery, which lead to a boost in self esteem. A positive self-image contributes in structuring a strong and determined personality, able to react to difficulties encountered in everyday life, in school and in peers' relationships.

Often rehabilitative treatment of LD have a cognitive-behavioural matrix, based on a diagnosis made through performance tests administration and subsequently calibrated training on functions deemed deficient. The focus arises on the kid's incapacity who is further highlighted and where he's asked to continue working on them; this modus operandi sometimes creates considerable frustration, anxiety, anger, up to the point of repulsion towards those activities on which he is asked to continue training. Motor approach widens the action's range of these treatments with the aim of strengthening and amplifying them. It also requires constant application and determination, so that the success of motor qualification must continue also through repetition at home of these exercises, but this constancy also expands in all processes of personal growth, self-determination, exercise of willingness to overcome the difficulty. The playful and informal context makes work enjoyable and pleasant. With good support this is widely possible. In the worst case, when there is no significant improvement, alas, it will be only good gymnastics.

Relational framework importance

"Self-esteem corresponds to the individual consideration that one has of himself" (Galimberti, 1999). This consideration is also developed through unconscious evaluation attributed thought others by itself. Adult must always bear in mind that his behaviour towards the child influences positively or negatively the image that child has of himself. Any important adult, parent or teacher, can never underestimate importance of the given judgment, of implicit or explicit message sendt and repercussions that they could have.

A LD boy faces difficulties that may seem insurmountable to him: structuring of school teaching, test moments and interrogations, confrontation with his classmates, rigidity of some teachers that aren't aware of the real problems, difficulty to keep attention in classroom and on homework, and this can have a very negative influence so much it can lead him into escape, avoidance and defensive behaviours.

At the basis of learning process there is the knowledge on how to perceive, as a parent, this series of problems, knowing how to deal with them together with child without expressing negative judgments, knowing how to reshape expectations of scholastic surrender, becoming aware that their own child, despite having an intelligence in the norm , is weak and must be helped through aspects that common world considers, in previous era, as "normally learned". In pilot project that I've illustrated in its essentiality, parents have an active role in following children's domestic exercises and are invited to play with them. Now, not dwelling on the utility of this project even for adults, I just emphasize how much this practice can lead to consolidation of the relationship between parent and child, where the parent enters the real context of child's experience and child will feel followed, protected and supported. "The communicative dynamics that are activated in true and real game between child and parent have an enormous emotional-communicative strength that allow child and parent to discover and rediscover of each other, to know each other more and more deeply, to trust and to trust the other, sharing and accepting similarities and dissimilarities" (Lodi, Barbieri, Buiani, Seghi, 2014). However, not all parents are able to interact positively; this is where therapist figure comes up as a mediator and facilitator of communication.

Teacher plays an active role, equally significant, into school context. This figure, first, is involved in the learning process; he is responsible for identifying student's strengths and support him in its weaknesses. He is the first source for the recovery of child's skill not learned or only partially learned. Teacher must know problems and know how to intervene; with this statement we not only consider "bureaucratic" preparation in Personalized Teaching Plan's drafting but also scrupulous adherence to what has been set up without prejudice, without passing negative messages that could harm student's self-esteem. A prepared teacher is one who knows how to teach in an inclusive manner, who knows how to prepare manageable lessons for each class member, who creates suitable support material, who knows and knows how to use all the learning channels (visual, auditory and kinaesthetic). A good teacher is also one who knows how to create a constructive relationship with the family, and seeks constructive confrontation with the parents.

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СПЕЦИФІЧНІ РОЗЛАДИ НАВЧАННЯ

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У статті розглянуто специфічні розлади й труднощі в процесі шкільного навчання, а також найбільш часті та актуальні проблеми, що викладено в психологічній літературі й педагогічній науці. Ці визначення визнано і повністю передбачено Законодавством декількох європейських країн, включаючи Італію, та запропоновано рекомендації щодо лікування, освыти й реляційних орієнтирів, які повинні розглядатися в логіці захисту і сприяння благополуччю дитини (як дітей, так і підлітків) зі специфічною нездатністю до навчання. Цей документ містить перший підхід до предмету, спрямованого на інформування й керівництво по виявленню та розмежування цих патологій, які можуть співіснувати, й обмеження їх негативних наслідків, які можуть поставити під загрозу зростання та розвиток дитини, особливо в разі раннього втручання. Конкретні порушення навчання пов'язані з читанням, писемністю й математичним рахуванням. Є важливим, щоб в шкільному контексті оператори були поінформовані для щоденної взаємодії та гарантії реалізації навчальної та виховної роботи учня в цілому.

КЛЮЧОВІ СЛОВА: специфічна нездатність до навчання (НН), дислексія, анортографія, дисграфія, дискалькулия, реабілітаційне лікування, шкільна фасилітація, психомоторні функції, сімейно-шкільні стосунки

СПЕЦИФИЧЕСКИЕ НАРУШЕНИЯ ОБУЧЕНИЯ

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В статье рассмотрены специфические расстройства и трудности в процессе школьного обучения, а также наиболее частые и актуальные проблемы, изложенные в психологической литературе и педагогической науке. Эти определения признаны и полностью предусмотрены Законодательством нескольких европейских стран, включая Италию, и предложены рекомендации по лечению, образованию и реляционным ориентирам, которые должны рассматриваться в логике защиты и содействия благополучию ребенка (как детей, так и подростков) со специфической неспособностью к обучению. Этот документ содержит первый подход к предмету, направленному на информирование и руководство по выявлению и разграничению этих патологий, которые могут сосуществовать, и ограничению их негативных последствий, которые могут поставить под угрозу рост и развитие ребенка, особенно в случае раннего вмешательства. Конкретные нарушения обучения связаны с чтением, письмом и математическим счетом. Представляется важным, чтобы в школьном контексте операторы были информированы для ежедневного взаимодействия и гарантии реализации учебной и воспитательной работы учащегося в целом.

КЛЮЧЕВЫЕ СЛОВА: специфическая неспособность к обучению (НО), дислексия, анортография, дисграфия, дискалькулия, реабилитационное лечение, школьная фасилитация, психомоторные функции, семейно-школьные отношения

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BEYOND MENTAL HEALTH DISORDERS: RISK ASSESSMENT BY USING THE 4th GENERATION OF FORENSIC TOOLS

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The causal relationship between mental health disorders and (violent) recidivism is weak. Beyond mental health disorders, criminogenic factors contribute to the prediction of recidivism. In order to be effective, interventions need to be offense-oriented, i.e. focused on factors that are directly associated to the offense mechanism. To treat mental health disorders while ignoring criminogenic needs is highly ineffective. A risk/needs orientation of the criminal justice system must be emphasized. Therefore, psychiatric treatment will not be sufficient to prevent future criminal behavior. The main approach should be based on explaining the mechanism of the offense to understand the underlying offense dynamic and develop on that basis a well-fitting intervention strategy. FOTRES (Forensic Operationalized Therapy/Risk Evaluation System) is a structured professional judgment (SPJ) tool of the 4th. generation designed to assess recidivism risk and to monitor treatment progress and intervention quality. FOTRES now is already implemented within the Risk-Oriented Enforcement of Sentence (ROES) project in Switzerland. The cost-benefit analysis with the ROES is positive. The tool is widley used also in Germany and Austria.
KEY WORDS: FOTRES, health disorders, risk assessment, criminogenic factors, criminal behavior

Classical risk assessment

A widely used definition of risk assessment has been that given by Kraemer et al. (1997 p. 340) as: *The process of using risk factors to estimate the likelihood (i.e., probability) of an outcome occurring in a population*. The calssical risk assessment involves systematic efforts to estimate and evaluate outcomes (cited by Crighton et al; 2010; 2015). Risk factors are often sub-divided into historical factors (which are unlikely to change) and clinical factors (which may be amenable to change). Legal notions of dangerousness include two distinct concepts as the probability of violence towards others and the severity of that violence (Crighton et al; 2010; 2015). A classical risk-taking model sees exposure to risk as a normal facet of life and places its emphasis on individual rights, abilities, choice and participation. The risk-minimization model by contrast sees risk as something requiring control, therefore targeting those most at risk and stressing notions such as health, danger, control and incapacity. These models are perhaps better seen as a continuum (Crighton et al; 2010; 2015).

Meehl (2006) and his collaborators (e.g. Janus and Meehl (1997)) made a distinction between 'actuarial' (statistical) and clinical prediction. It has been suggested that risk assessment instruments can now be seen as lying on a continuum, with unstructured clinical assessment at one end and structured statistical predictors at the other. Risk instruments can be described in terms of the extent to which they provide a structure to four elements (Crighton et al; 2010; 2015; Goncalves et al., 2017):

- i) The identification of risk factors
- ii) The measurement of risk factors
- iii) The combination of risk factors
- iv) The production of a final risk estimate

There is some evidence to suggest that actuarial and structured clinical approaches may be more

accurate than clinical assessment. The use of a standard list of risk factors is the least structured form of judgment in simply identifying a number of risk factors. Assessments such as, for example, the Historical and Clinical Risk 20 (HCR-20), a widely used assessment of risk of violence, go one step further in defining the list of risk factors and how these risk factors are measured. Assessments such as the Classification of Violence Risk (COVR) and Level of Service Inventory Revised (LSI-R) also determine the way in which risk factors should be combined but allow for clinicians reaching a final risk estimate. The Violence Risk Appraisal Guide (VRAG; SORAG) and Offender Group Reconviction Scale (OGRS) and similar actuarial assessments provide the rules for determining the final risk estimate without input from the assessor. The use of purely actuarial risk assessment instruments to individual cases represents poor practice (Figure 1). The use of clinical judgement drawing from the available empirical evidence base appears more useful and, when competently undertaken, may lead to improved accuracy of assessment (Crighton et al; 2010; 2015; Goncalves et al., 2017).

Figure 1

Different Aspects of Risk Assessment Instruments Relevant to Forensic Practice (taken from Rossegger 2010)

Aspects of instruments	PCL-R (Hare, 1991)	VRAG (Quinsey et al., 2006)	HCR-20 (Webster et al., 1997)	FOTRES (Urbaniok, 2007)	LSI-R (Andrews & Bonta, 2001)
Area of application	Any offender	Violent and sex offender	Mentally disordered violent offender	Any offender	Any offender
Specificity of risk assessed	Unspecific	Violent and sex	Violent	Specific, specified by user	Unspecific
Type of result					
Risk categories	No	Yes	Yes	Yes	Yes
Calibrated reoffending probabilities	No	Yes, within 7 and 10 years	No	No	Yes, within 1 year
Exhaustiveness	Semiexhaustive	Scarce	Semiexhaustive	Exhaustive	Semiexhaustive
Inclusion of dynamic items	Semidynamic	Static	Semidynamic	Dynamic	Dynamic

Note: PCL-R = Psychopathy Checklist–Revised; VRAG = Violence Risk Appraisal Guide; HCR-20 = Historical, Clinical, Risk Management–20; FOTRES = Forensic Operationalized Therapy/Risk Evaluation System; LSI-R = Level of Service Inventory–Revised.

The poor impact of Mental Health Disorders[1]

Already in 1990, Andrews and Bonta have published the Risk-Need-Responsivity (RNR)-approach to emphasize the importance of nonclinical criminogenic needs/factors in risk assessment and risk management strategies. They have promoted the "Central Eight" (antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial peers, family, school/work, leisure/recreation, substance abuse) and established a tool called the "Level of Service/ Case Management Inventory" (Goncalves et al., 2017; Gerth 2018).

There is clearly a strong relationship between mental health disorders and (violent) recidivism

[1] The explanations are mainly based on a work by Goncalves et al., 2017 & Gerth 2018

(Chang et al., 2015). Further, the more diagnoses an offender is affected by the stronger the relationships gets. However, Chang et al. (2015) showed in there longitudinal study of more than 47'000 prisoners that criminogenic factors attenuate this relationship. Only up to 20% (in men) and 40% (in women) of the re-offenses could be attributed to the suffering of a mental health disorder.

Walters et al. found in 2014 (N = 1163) the main effect of serious mental health disorders in predicting future violent behavior vanishes when history of violence is included in the model.

Elbogen et al. found in 2016 (N = 34653) an association between major mental health disorders and subsequent violent behavior but other risk factors (dispositional like anger; situational like acute crisis; disinhibition like substance use) mediated this association. Lund et al. (2013) (N = 349) stated the clinical information has little predictive value when information on previous criminal behavior is included.

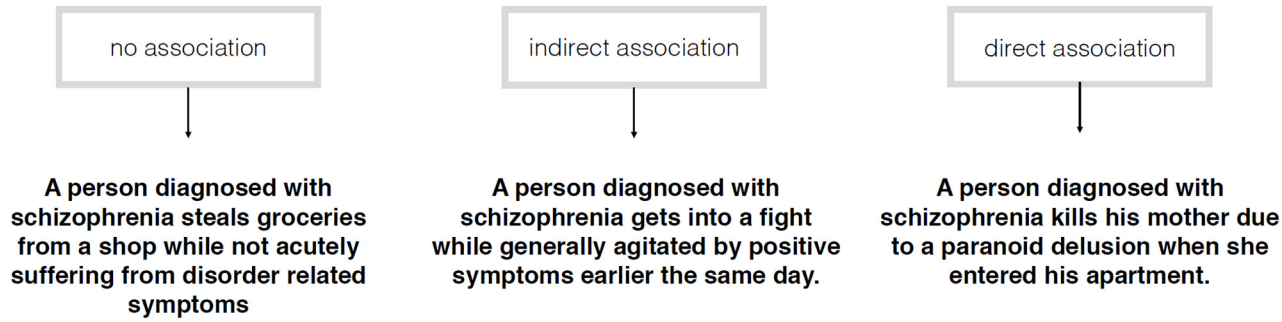
Ten Have et al found in 2014 (N = 6646) that mental health disorders were associated with violence, especially externalizing disorders but after including violent victimization, negative life events and social support most mental disorders lost their significance with the exception of substance use.

Skeem et al in 2014 (N = 221) found both, risk factors unique to serious mental health disorders and general risk factors exist. However, risk factors unique to serious mental health disorders don't add incremental validity upon general risk factors (Figure 1).

Bonta et al. in 2014 (N = 23900, meta analysis) stated that predictors for general and violent recidivism were the same for mentally disordered offenders as for non-mental disordered offenders (i.e. criminal history, antisocial personality, substance abuse, and family dysfunction). Clinical variables were not except for antisocial personalty/psychopathy.

Figure 2.

Continuum of association (Skeem et al., 2014; taken from Gerth 2018)



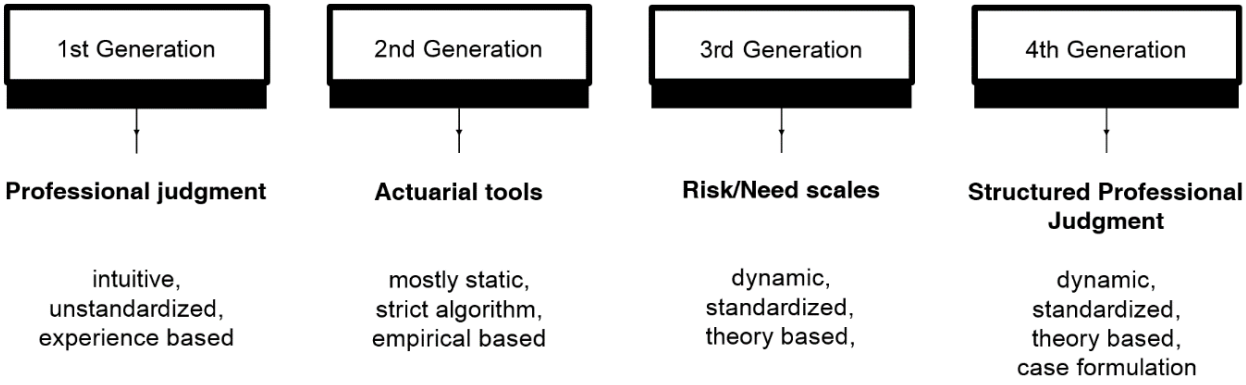
As we`ve seen from this studies and others the causal relationship between mental health disorders and (violent) recidivism is weak. Beyond mental health disorders, criminogenic factors contribute to the prediction of recidivism. In order to be effective, interventions need to be offense-oriented, i.e. focused on factors that are directly associated to the offense mechanism (Figure 2). To treat mental health disorders while ignoring criminogenic needs is highly ineffective. A risk/needs orientation of the criminal justice system must be emphasized (Goncalves et al., 2017; Gerth, 2018).

Assessment strategies/tools of the 4th. Generation

New tools have to explain the mechanism of the offense to understand the underlying offense dynamic and develop well-fitting intervention strategies. They should use operationalized terminology and focus on characteristics, which show proximity and causality to the specific problematic behavior. The chosen risk characteristics should explain the most variance (Figure 3).

Figure 3.

Generations of risk assessment (taken from Gerth 2018)



The motivations for developing and implementing the FOTRES tool (Forensic Operationalized Therapy/Risk Evaluation System; Urbaniok, 2007, 2016) in the Swiss criminal justice system were the limitations of actuarial risk assessment tools, such as the inability to apply group-based recidivism estimates to individual patients. In addition, there were errors in estimating recidivism rates when applied in different jurisdictions, and the inability to incorporate case specific information to modify estimated recidivism rates (Goncalves et al., 2017; Gerth 2018).

FOTRES is now routinely used by many forensic services nationally as well as in Austria and Germany to estimate the recidivism risk of criminal offenders and to document treatment progress (Goncalves et al., 2017, Rossegger et al., 2011; Singh, 2016).

FOTRES therefore is not a statistical system in which an ultimately abstract algorithm constitutes the core of the basic concept. FOTRES is almost the opposite of statistical methods (e.g. Static 99, VRAG etc.). It is above all a diagnostic system that is not primarily focused on diagnosing diseases, but rather on recording and accurately mapping the risk profile of a person in each individual case. It is in that way completely different from all the statistical forecasting tools, which are questionable from the point of view of the rule of law because they are based on statistical relationships but have no causal relation to the individual case. FOTRES has described the individual - and often more favourable - risk profile (Figure 5).

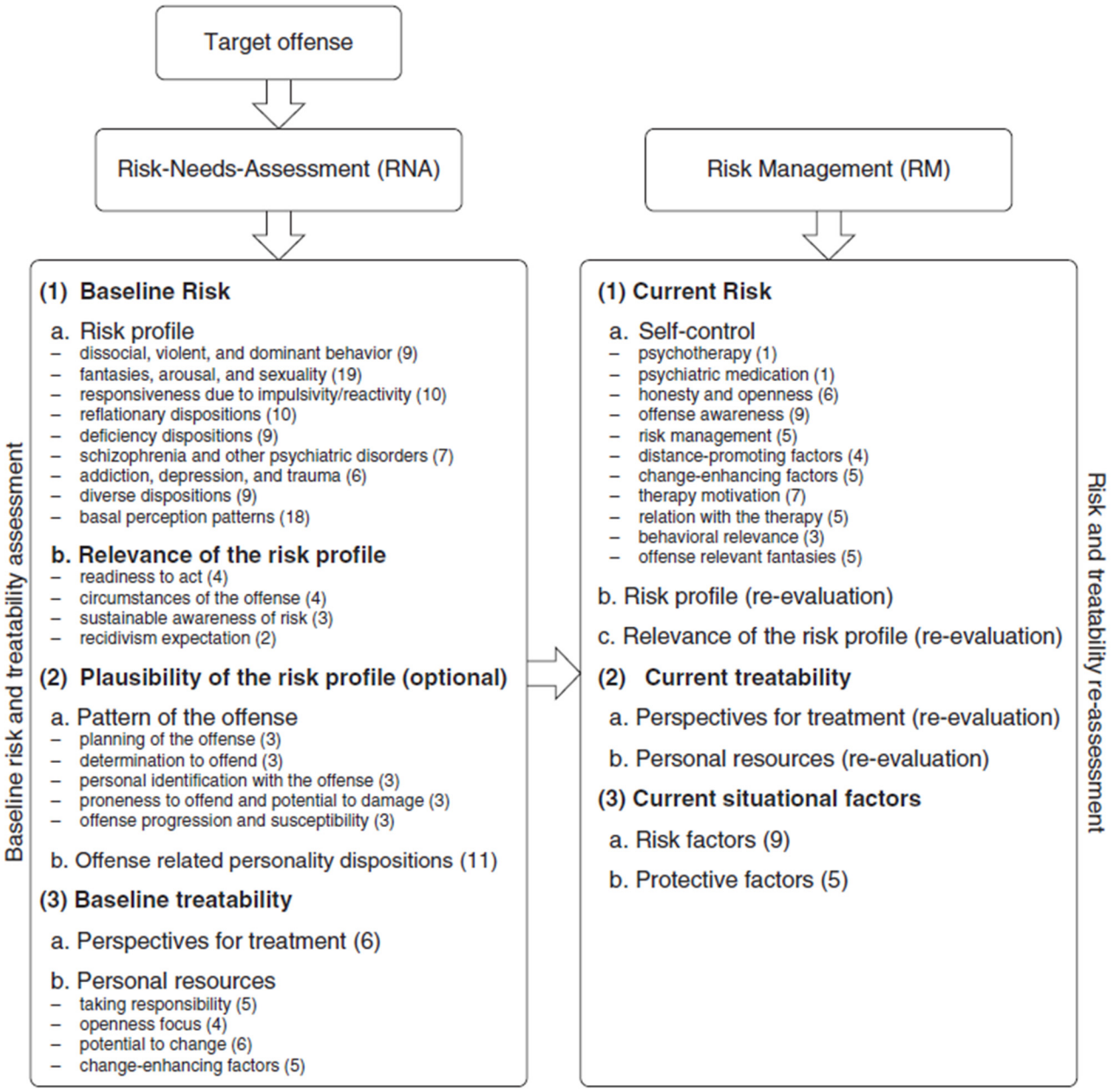
In FOTRES, the risk of reoffending is estimated for a specific offense, which is called the "target offense." Users choose one out of 29 potential target offenses (e.g., violent offense) and then specify the offense within the selected category (e.g., homicide). If an offender committed several different offenses, a separate risk estimate can be derived for each target offense.

The tool consists of two main levels: the Risk-Needs Assessment (RNA) level and the Risk Management (RM) level. Basically, the RNA level estimates the risk of reoffending and the offenders' treatability. Items included in this level explore the offender's personality disposition to committing crimes, specific areas of concern relevant to the offense, and the pattern of the offense itself. The RM level describes the treatment progress and changes in recidivism risk caused by interventions. Items included in this level measure the actual risk reduction achieved through therapy progress, through the implementation of coping strategies, and through the identification and management of offense related personality patterns. Whereas RNA is only assessed once (at the time of the target offense respectively before an intervention of any kind takes place), the RM level is scored periodically whenever the current risk of reoffending needs to be assessed

(Goncalves et al., 2017); Rossegger et al., 2011; Urbaniok, 2016b). A flow diagram illustrating the basic structure of FOTRES v3 is given in Figure 4 (Goncalves et al., 2017; Gerth 2018).

Figure 4.

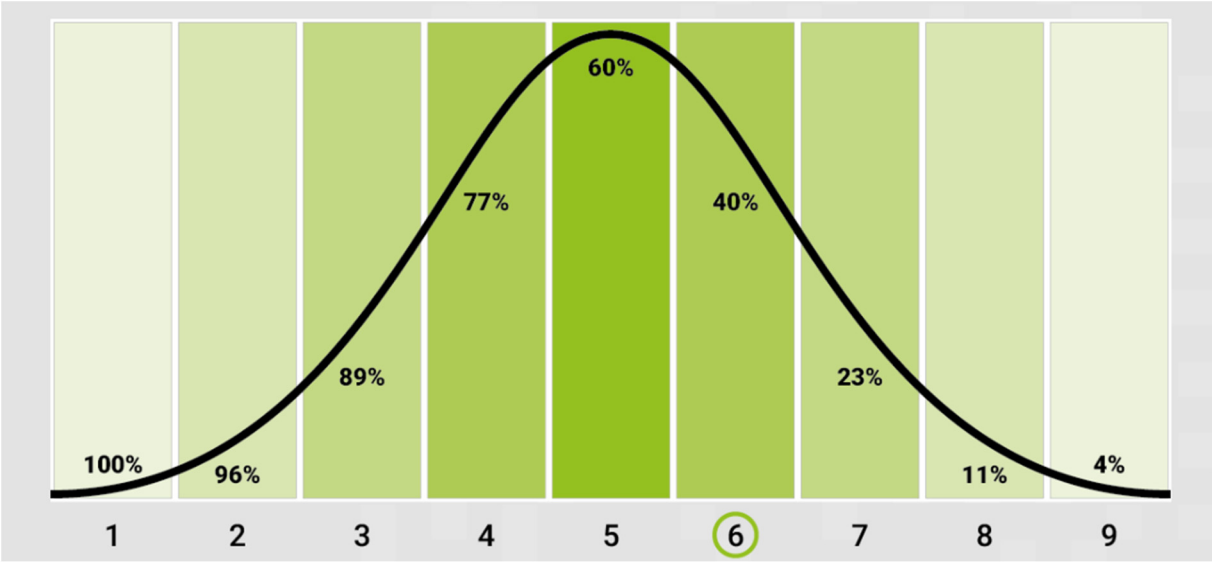
Diagram flow of the FOTRES 3 basic structure. FOTRES 3 = Forensic Operationalized Therapy/ Risk Evaluation System Version 3. The number of items included in each scale is presented in parentheses (taken from Goncalves et al. 2017)



FOTRES is currently in its third version. The tool is constantly being updated online to include more risk characteristics, as found by the clinical experience of the tool developers. Major changes across different FOTRES versions were made to make it more comprehensive and, at the same time, more user friendly. Additionally, the terminology has been simplified and is now more straightforward. For example, "dynamic risk reduction" in FOTRES v2 has been renamed "self-control" in FOTRES v3; "unstable autonomous risk-relevant factors" was renamed "current situational factors"; and "structural risk for recidivism" is now called "baseline risk." (Goncalves et al., 2017; Urbaniok, 2016b).

Figure 5.

Representation of the basis risk (BR) (2.5) on a 9-level FOTRES scale within a stanine distribution (6)



In versions 3, not the diagnoses but symptoms of psychiatric conditions are included as risk characteristics. In addition, for some risk characteristics there is now a distinction between affinity and preference when describing whether a risk characteristic is of a primary nature (e.g., pedophilia as a preference would mean that the offender is interested in children only) or is of a secondary nature (e.g., pedophilia as an affinity would refer to an offender who, besides children, is also interested in adults) (figure 4) (Goncalves et al., 2017; Gerth 2018).

FOTRES has primarily been developed for assessing and managing recidivism risk in violent and sex offenders, although it is not limited to offenses of that nature. Despite including situational risk factors, FOTRES is especially focused on personal risk characteristics and associated treatment needs. In fact, violent crimes committed solely because of a highly specific situation are very rare (e.g., honor crimes). In the case of offenses that are exclusively triggered by the situational context, there are different implications for risk management and, in most cases, ordinary sanctions are sufficient to achieve an adequate outcome. FOTRES was designed for use with offenders of either sex, aged 16 years or older, who have committed any type of crime. The tool can be used in community and institutional settings to assess people, excluding offenders with severe mental health disorders (Goncalves et al., 2017; Gerth 2018). It has been used mostly in Europe (Singh et al., 2014).

The tool estimates the risk of pertinent reoffending, meaning new arrests, charges, or convictions for repeat offenses within the same offense category as the index offense without regard to a specific time frame. It includes static and dynamic items assessing risk factors rooted in the personality of the offender and situational factors that can influence the likelihood of reoffending. As there are general salient personality traits used to describe a person (e.g., authentic, shy, or intelligent), there are also specific personality traits that are directly linked to criminal behavior (e.g., dominance or violence affinity) (Goncalves et al., 2017; Gerth 2018). In FOTRES, these traits are conceptualized as risk characteristics. These risk characteristics are closely related to individual behavior and should not be confounded with psychiatric disorders according to taxonomic classification systems such as the DSM-IV-TR; V (American Psychiatric Association, 2000; 2013) or the ICD-10 (World Health Organization, 1993), even if those can overlap. In FOTRES, risk is always specified as the risk for committing a certain type of crime (Goncalves et al., 2017; Gerth 2018).

This specification is operationalized as the target offense and is made during the first step of the

assessment. The target offense does not necessarily need to correspond with legal classifications. For example, killing a person would be considered a homicide legally but such an offense is sometimes sexually motivated (e.g., sexual murder). Therefore, the selection of the target offense always takes into consideration the motivation of the offender. The risk of committing the target offense must directly result from the characteristics of the offender's risk profile. Recidivism risk is estimated based on an hypothesis regarding the offense mechanism (Goncalves et al., 2017; Gerth 2018).

The offense mechanism is specific to every case and explains the process of how the relevant personal and situational risk characteristics led to the perpetration of the target offense. The goal is not to develop an etiological model about how and why the person became an offender, but rather to develop a model that describes how the risk characteristics interacted and influenced a specific criminal behavior. The offense mechanism hypothesis is therefore very descriptive and close to individual behavior. If case information is collected (file information and personal interview) the administration of FOTRES takes approximately 60 minutes (Goncalves et al., 2017; Gerth 2018).

As in other SPJ tools (structured professional judgment), in FOTRES the evaluator must identify the relevant personal and situational factors that lead up to the offender's criminal behavior from a larger set of available risk characteristics that were developed to reflect the state of the art with respect to scientific knowledge and professional practice. The evaluator then onceptualizes the causal role of these risk characteristics, speculates about possible future behavior, and develops individual case management plans (Goncalves et al., 2017; Gerth 2018).

Validity and Reliability

In a study investigating the predictive validity of the tool with 109 violent and sex offenders released from a prison in Switzerland between 1994 and 1999, and who were followed in the community for an average of nine years, Rossegger et al. (2011) found that both the total score (OR = 1.74, p < .010) and the risk categories (OR = 3.74, p = .010) of FOTRES v2 were significantly associated with repeated offending, and discriminated well between recidivist and non-recidivist (AUC = .81, .76, respectively). Compared with the Psychopathy Checklist-Revised (PCL-R; Hare, 1991), the Violence Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice, & Cormier, 2006), the Historical, Clinical, Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997), and the Level of Service Inventory–Revised (LSI-R; Andrews & Bonta, 2001), FOTRES presented the highest odds ratio (OR) for both the total score and risk categories. Only the PCL-R presented a higher area under the curve (AUC; .84 for the total score). The inter-rater reliability among three raters for 20 cases was good (Kappa > .65; Altman, 1991). In another study, 15 patients from a German forensic psychiatry unit were rated on FOTRES by three independent raters based on the official records of the penitentiary. Keller et al. (2011) found that the intraclass correlation (ICC) for structural risk, the main scale of FOTRES v2, was poor (r = .23; Cicchetti, 1994). For the likelihood of successful treatment scale, the ICC, was fair (r = .53). Both scales included subscales with high and low agreement. Rossegger et al. (2011) found that both the total score (OR = 1.74, p < .010) and the risk categories (OR = 3.74, p = .010) of FOTRES v2 were significantly associated with repeated offending, and discriminated well between recidivist and non-recidivist (AUC = .81, .76, respectively) (Goncalves et al., 2017; Gerth 2018).

Compared with the Psychopathy Checklist-Revised (PCL-R; Hare, 1991), the Violence Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice, & Cormier, 2006), the Historical, Clinical, Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997), and the Level of Service Inventory–Revised (LSI-R; Andrews & Bonta, 2001), FOTRES presented the highest odds ratio (OR) for both the total score and risk categories. Only the PCL-R presented a higher area under the curve (AUC; .84 for the total score). The inter-rater reliability among three raters for 20 cases was good (Kappa > .65; Altman, 1991). That is, the tool has the advantage of being very specific and comprehensive but the rating of the baseline risk may differ substantially across raters. Such problems may be attenuated in the perspectives for treatment part of

the tool, where every item is rated (Goncalves et al., 2017; Gerth 2018).

Urbaniok, Rossegger, and Endrass (2006) conducted a study investigating the assessment of high-risk offenders and the establishment of post-sentence preventive detention for offenders identified as very high risk during imprisonment in Switzerland. The authors identified a total of nine offenders that were released from prison (from 1997 to 2005 in the canton of Zurich) due to legal reasons despite their evident level of dangerousness. The authors evaluated the progress of eight of these released offenders in a follow-up study. They found that these highrisk offenders re-offended with severe violent and sex offenses—seven within a year of their release—resulting in a total of 24 victims being harmed. The authors also found that although incarcerated violent and/or sex offenders frequently score high on risk assessment tools, what distinguished this group of high-risk offenders was the combination of a high recidivism risk with a lack of treatability and unsuccessful attempts at therapy and/or other kinds of coping strategies training. Specifically, all nine offenders had a very high score of 3.5 or 4 in structural risk of recidivism, and very low scores of 0 or .5 in mutability and dynamic risk reduction, as assessed by FOTRES v1 (Urbaniok, 2004). The results of this study showed that at least some categories of very dangerous offenders can be reliably detected with FOTRES (Urbaniok, Rossegger, & Endrass, 2006). Users of FOTRES working in different settings throughout the Swiss cantons have described the tool as very useful in the development and monitoring of risk management plans (Manhart et al., 2014). This indirectly attests to the face validity and clinical utility of the tool (Goncalves et al., 2017; Gerth 2018).

Risk-Oriented Enforcement of Sentence (ROES)

One of the most important developments in prison and sentencing measures in recent years in Switzerland is the Risk-Oriented Enforcement of Sentence (ROES) project, funded by the Federal State and launched jointly in four cantons from 2010 to 2013. The motivations for the project were the critical events and recidivism rates observed during previous years, as well as the obligation to plan the criminal sanctions introduced in 2007 by the PG-CP law, art. 75 CP (Bundesversammlung der Schweizerischen Eidgenossenschaft, 1937). The ROES process includes four steps: (1) screening, (2) assessment, (3) planning, and (4) correctional process. FOTRES is implemented with every violent and sex offender and used in the assessment and planning phases as a standardized risk assessment and case formulation guide, including standardized information on the target offense, personal and situational characteristics related to the offense, and risk management plans. The cost-benefit analysis with the ROES was positive. Since May 2013, following the preliminary evaluation of the ROES project, the canton of Zurich has made it mandatory to use FOTRES to assess high-risk offenders. This was later extended to all German cantons and is planned to be extended to the French cantons as well. It will probably be extended to the entire country at a later stage (Goncalves et al., 2017; Gerth 2018).

Future Directions

FOTRES has been implemented into the forensic practice of different Swiss cantons. It is used in the development of a structured risk-based process, e.g. ROES, that improved the quality and efficiency of the execution of penal sanctions and the work process of the criminal justice system. The tool has been regarded as useful in the assessment, treatment, and follow-up of offenders, as well as in the establishment of a uniform process and terminology across the different entities involved in the criminal justice system of different cantons of Switzerland. The tool is nowadays also widely used in other European countries (Austria; Germany).

Though, FOTRES has proved to be a useful tool for the criminal justice system, especially when used as one tool among a more comprehensive array of risk assessment tools and diagnostic scales, there is limited empirical data available regarding its psychometric properties. However, unlike the reductionism of actuarial scales (which include few items and are mostly of a static nature), SPJ tools attempt to assess the complexity of a case and allow professionals in the field to better understand the offender and thus to better plan suitable treatment interventions (Rossegger et al., 2011). FOTRES can therefore be used for monitoring offender treatment

and for providing information on treatment goals, level of security, recommendations for early release, and therapeutic progress in offense-oriented treatment plans. The complexity of the tool requires considerable effort for translations. Despite this, translations of the tool and the manual into English and French are being made (Goncalves et al., 2017; Gerth 2018). Translations into more languages are planned.

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МЕНТАЛЬНИЙ РОЗЛАД ЗДОРОВ'Я: ОЦІНКА РИЗИКІВ ЗАСТОСУВАННЯ ІНФОРМАЦІЙНИХ ІНСТРУМЕНТІВ ЧЕТВЕРТОГО ПОКОЛІННЯ

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Причинно-наслідковий зв’язок між розладами психічного здоров'я та (насильницьким) рецидивізмом слабкий. Крім порушень психічного здоров'я, криміногенні фактори сприяють прогнозуванню рецидивізму. Для того, щоб бути ефективними, втручання потрібно орієнтувати на правопорушення, тобто орієнтуватись на фактори, що безпосередньо пов'язані з механізмом правопорушення. Лікувати розлади психічного здоров’я, ігноруючи криміногенні потреби, не е ефективним. Психіатричне лікування е недостатнім для запобігання майбутній злочинній поведінці. Основний підхід повинен базуватися на поясненні механізму правопорушення, розуміння динаміки основного правопорушення та розробити на цій основі придатну стратегію втручання. ФОТРЕС (Операціоналізована система терапії / оцінки ризику) - це структурований професійний інструмент судження (SPJ) четвертого. покоління, призначений для оцінки ризику рецидивування та контролю ходу лікування та якість втручання. FOTRES зараз уже впроваджений в рамках проекта забезпечення виконання покарань, орієнтованого на ризик (ROES) у Швейцарії. Аналіз вартості та вигоди з ROES позитивний. Інструмент Відлі використовується також у Німеччині та Австрії.

КЛЮЧОВІ СЛОВА: ФОТРЕС, розлади здоров'я, оцінка ризику, криміногенні фактори, злочинна поведінка

МЕНТАЛЬНОЕ РАССТРОЙСТВО ЗДОРОВЬЯ: ОЦЕНКА РИСКОВ ПРИМЕНЕНИЯ ИНФОРМАЦИОННЫХ ИНСТРУМЕНТОВ ЧЕТВЕРТОГО ПОКОЛЕНИЯ

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Причинно-следственная связь между расстройствами психического здоровья и (насильственным) рецидивизмом слабый. Кроме нарушений психического здоровья, криминогенные факторы способствуют прогнозированию рецидивизма. Для того, чтобы быть эффективными, вмешательство нужно ориентировать на правонарушения, то есть ориентироваться на факторы, непосредственно связанные с механизмом правонарушения. Лечить расстройства психического здоровья, игнорируя криминогенные потребности, не является эффективным. Психиатрическое лечение е недостаточным для предотвращения будущий преступном поведении. Основной подход должен базироваться на объяснении механизма правонарушения, понимание динамики основного правонарушения и разработать на этой основе пригодную стратегию вмешательства. ФОТРЕС (Операционализованная система терапии / оценки риска) - это структурированный профессиональный инструмент суждения (SPJ) четвертого. поколения, предназначенный для оценки риска рецидивирования и контроля хода лечения и качества вмешательства. FOTRES сейчас уже внедрен в рамках проекта обеспечения исполнения наказаний, ориентированного на риск (ROES) в Швейцарии. Анализ стоимости и выгоды с ROES положительный. Инструмент Видли используется также в Германии и Австрии.

КЛЮЧЕВЫЕ СЛОВА: ФОТРЕС, расстройства здоровья, оценка риска, криминогенные факторы, преступное поведение

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THE ROLE OF EMOTIONAL INTELLIGENCE IN SELF-ACTUALIZATION OF PERSONALITY

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The article is aimed to reveal the analysis of the emotional intelligence role in adult age personality self-actualization process. The relevance of emotional intelligence and self-actualization connection study in the context of modern scientific discourses and crisis conditions of society is described. The article summarizes the results of theoretical analysis of the problem of self-actualization. The most significant features of the self-actualization process from the point of view of humanistic psychology are presented. Also, methodological principles and basic aspects of self-actualization understanding in domestic psychology are described according to the methodological principles of the activity approach. The essential features of emotional intelligence of the personality, its structure are determined. It is substantiated that emotional intelligence is connected with the process of individual's self-actualization through realization of the personality in the fullness of his own emotional life, ability to experience peak emotions, emotional sphere content control, etc. The methodological bases of the study, the specifics of the sample and the compared diagnostic groups are described. The empirical data of the person's self-actualization study, its most significant parameters, expressiveness of different aspects of emotional intelligence are analyzed. The obtained empirical data are interpreted in accordance with classical and modern scientific views on the nature of the self-actualization processes and emotional intelligence. The emotional intelligence indicators expressiveness in intra- and interpersonal plane was interpreted in two groups – respondents who receive a second higher education in the specialty "Psychology" and those who aim to self-actualize. The predominance of interpersonal emotional intelligence and its components – understanding other people's emotions and managing other people's emotions – in the sample, which aim at their own self-actualization, is statistically substantiated and substantively analyzed. Also, the tendency towards identification of one's own emotional sphere content, its expression and indicator of emotional intelligence in general was expressed for both groups of the studied. On the basis of empirical data generalization the tendency of self-actualization and emotional intelligence signs combination in of personality's functioning is revealed.

KEY WORDS: self-actualization of the personality, self-actualization factors, time orientation, emotional intelligence, interpersonal and intrapersonal emotional intelligence, emotional intelligence as a factor of self-actualization

Rising of the problem. The question of the personality's self-actualization is one of the most complex and relevant in a modern society. The increased attention to this problem is caused, firstly, by the need to study the system of resources and the process of personal development in the crisis conditions of modern society (multi-vector development and self-realization, expanding consumption values in the absence of vital certainty, lack of individual's confidence in the future due to complex socio-political and economic processes of Ukrainian society, etc. (Sedykh, 2013), and secondly, the lack of a unified and comprehensive understanding of the processes of personality's self-actualization for its psychological support. Particularly actual problem of self-actualization occurs in adulthood, when the personality not only learns and develops, as in childhood and adolescence, but already has certain results of own activities, by which personality can raise the question of the effectiveness of life, it's fullness in meaning, inherent values conformity to the goals that was set at the beginning of the self-actualization process. Particularly important is the problem of the effectiveness of personality's life, the assessment of achieved goals and future perspectives, which reflects the features of self-actualization of the individual.

Also it's important issue of distinguishing the range of self-actualization resources of an adult, among which the important role belongs to the ability to identify own emotions, to recognize the emotions of others and to manage emotional processes. These qualities reflect the emotional intelligence generated in the individual and is a significant component of self-actualized personality.

The aim of this article is to investigate the peculiarities of the emotional intelligence formation of the adults with different ways of self-actualization.

Development of the problem under investigation. The question of personality's self-actualization is one of the fundamental problems of scientific knowledge, because person joins the society, harmoniously and balancedly discloses it through the self-actualization. While personality is realizing the opportunities for the development of his "Self".

The main scientific theories of self-actualization have been developed within the approaches of such scientists as A. Adler, R. Assadjouli, A. Langle, A. Maslow, G. Allport, K. Rogers, V. Frankl, E. Fromm, K. Horney, E. Shostrom, K.G. Jung. A. Maslow, the founder of humanistic psychology, defines self-actualization as the desire of man to actualize what is contained therein as potencies. This tendency can be called the desire to become the person it can become, to reach the peak of its potential (Sedykh, 2016, p. 494]. Self-actualization by the view of E. Fromm is expressed through the notion of "effective orientation" in human life, the true self, which is understood as the installation of the realization of man's inherent opportunities, expedient to use his powers (Starins'ka, 2015). E. Fromm isolated from the five main existential needs of man (in establishing connections, overcoming, the need for roots, identity with themselves, system of views and devotion) enriched scientific ideas about the mechanisms of self-actualization.

The consideration of the problem of self-actualization in the native psychology is associated with the main provisions of the activity approach to the interpretation of the inner world of personality (P.Ya. Halperin, O.M. Leontiev, S.L. Rubinstein, K.O. Abulkhanova-Slavska, B.G. Ananiev, A.V. Brushlinsky, etc.). The basic principles of the activity theory (reflection, objectivity, systematicity, development, determinism, etc.) allowed scientists to re-examine the concepts of foreign humanistic psychology about self-actualization and self-actualization and to reveal the nature of the mechanisms of its development. As observes (Starins'ka, 2015), the theoretical and methodological foundations of the self-actualization study in native psychology led to the understanding of the "self-actualization" phenomenon essence through the categories of "activity", "orientation", "system of relations", "individuality", "subject", "life path"; use for its interpretation of the concepts of "urgent need", "actual ability", "actual and potential characteristics of man".

An important and definitively unresolved issue in this context is the search for resources of self-actualization of the personality. Modern authors consider self-actualization in connection with various psychological phenomena and processes, focusing mainly on studying self-actualization in the context of professional formation, overcoming difficult life situations, realization in family relationships, etc.

Emotional intelligence is an important phenomenon that reflects the personality's ability to establish, maintain and interpret emotional relationships and phenomena, its management. The phenomenon of emotional intelligence is differently explained by scientists, but is mainly associated with cognitive processes, and with the process of individual life realization. That is, the abilities and manifestations that make up the emotional intelligence of the individual are both significant for the process of its self-actualization. Therefore, emotional intelligence is determined as one of the most powerful personality's self-actualization resources, reflecting the accuracy of personality's orientation in the system of emotional phenomena, their identification and guidance.

Emotional intelligence and its components understanding presented in the concepts of emotional intelligence today. First of all, it is a model of Western researchers (J. Meyer, P. Salovey and D. Caruso, R. Bar-On, (Goulman, 2009), K. Petridix and A. Fernham) [1, 4]. It is important to note that

despite the common terminology, scientists somewhat differently determine the essence of the emotional intelligence phenomenon. Given these differences, all existing models can be grouped into three groups: abilities models, characteristics / traits models, mixed models.

In abilities model emotional intelligence is interpreted as an intersection of emotions and cognition, that is, as a cognitive ability. Such a model is described in the theory of emotional and intellectual abilities of J. Mayer, P. Selovey, D. Caruso (Sergienko, 2010). In it, emotional intelligence acts as an ability to reflect on emotions and emotions. Emotions themselves are useful source of information that helps to navigate the social environment. This model explains that people differ in their abilities to process information of an emotional nature and correlate it with what is happening around.

More formally, J. Meyer, P. Selovey, D. Caruso defines emotional intelligence as a set of competences, which includes "the ability to accurately perceive emotions; the ability to access and generate feelings when it favors thinking; the ability to understand information about emotions and to use knowledge about emotions; the ability to manage or regulate both their own emotions and emotions of others in order to promote emotional and intellectual growth and well-being" (Sergienko, 2010).

Summarizing the actual research, we generalize that the role of emotional intelligence in the process of self-actualization of the adult age personality is most clearly and simply demonstrate in characteristics of self-actualized personality, which are allocated by different authors, and included in the scope of its emotional intelligence. In particular, such characteristics of the personality include: mystical and higher experiences (Maslow, 2007); the ability to spontaneous behaviour and expression of feelings, the adoption of aggression as a natural manifestation of human nature (E. Shostrom); openness as an expression of the desire to love and invoke love (V. Shuts); openness of experience, containing emotionality and reflection (S. Maddi and R. Nelson-Jones); spontaneity in deeds and sincerity in expressing their thoughts and feelings (V.V. Stolin); the ability to clearly understand own feelings (K.K. Platonov). Therefore, the ability to clearly express their emotions, their identification of control is a significant characteristic of self-actualizing personality. Accordingly, the issue of studying emotional intelligence as a factor of self-actualization of personality has the considerable importance.

Presentation of the main research material. In the study of the subjects that are differently self-actualized features of emotional intelligence "Diagnostics of personality self-actualization" (A.V. Lazukin's inventory in the adaptation of N.F. Kalina (SAMOAL)) and "Questionnaire of emotional intelligence (EMI)" (D.V. Lucin) are used. The study was conducted on a sample of 75 persons, which included 2 subgroups. The first subgroup includes 45 persons who receive the second higher education in the specialty "Psychology", the second group – 30 persons, who paid attention to their own self-actualization – held courses in psychotherapy, training, practicing spiritual practices, etc. In our opinion, such groups of researched are the most suitable for studying the characteristics of self-actualization, because such representatives are interested in developing their potential, are concerned with this problem.

According to the results of the study, it was found that the majority (87.5%) of the representatives are characterized by an average level of self-actualization (Fig. 1). Such respondents are able to determine their own capabilities, interests and values, and ways of their implementation. However, they often do not have a holistic vision of their own lives or are centered in some of its time intervals – past or future (50%), sometimes not having a sufficient level of spontaneity (25%). This study is characterized, mainly, medium expressed ability to contact (50%) and the need for knowledge and creativity (56.25%).

The smaller part of the sample (12.5%) has a high level of self-actualization. Such respondents self-actualized, are able to find a way to reconcile their desires and opportunities to realize them, satisfied with their own Self. They are able to live successfully today (50%), take on themselves, others and life in general as a gift with all the negative and

positive sides. This representatives has the inherent ability to live in the present, that is, to experience the present moment of life in its entirety, and not simply as a fatal consequence of the past or preparation for the future of "true life". They are able to feel the continuity of the past, present and future, that is, to see their life as a whole. Such attitude, psychological perception of time by respondents testifies to the high level of their self-actualization.

They are independent in their actions, they seek to be guided in their lives by their own goals, convictions, attitudes and principles (50%), which, however, does not mean hostility to others and confrontation with group norms. They are free to choose, are not inclined to external influence, have an internal control locus. For these respondents flexibility of behavior and spontaneity of manifestations of their capabilities, the ability to creative expression and orientation on the knowledge of the new are inherent.

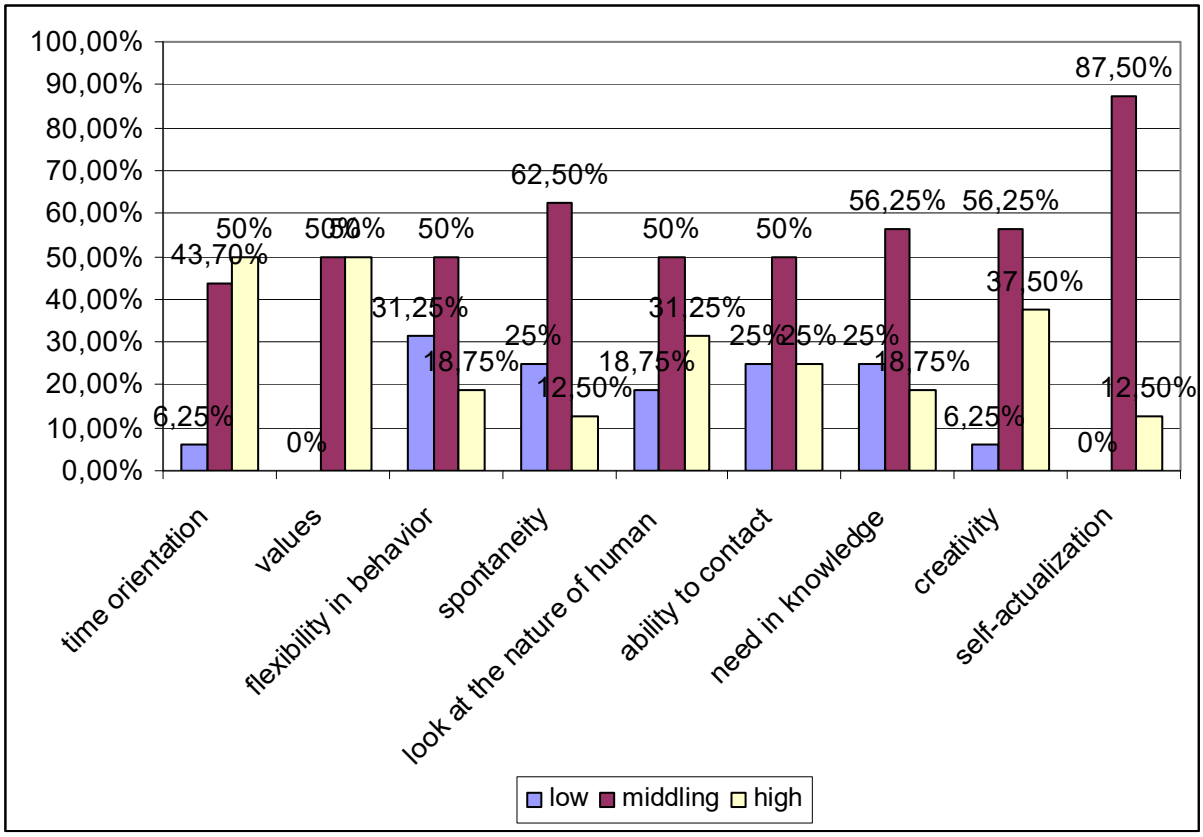

Figure 1. Indicators of self-actualization of the respondents

Analyzing group indicators, we can determine that the most pronounced characteristics of self-actualization of the respondents are time orientation, values, a view of human nature, creativity, flexibility. Thus, 50% of researched people live in the present, realizing their potential in it and not trying to live memories. Also, 50% of the group share the values of self-actualized personality, defined by Maslow, (2007) – kindness, integrity, vitality, justice, order, simplicity, etc. At the same time, 37.5% of the respondents are characterized by expressed at a high level creativity – the ability to create a new, creative combination of previously allocated parts of the problem, etc. For 31.25% of the sample representatives peculiar expressed faith in the nature of human – the confidence that the person is endowed with potential opportunities, able to develop and appropriate attitude to others.

Less expressed self-actualization parameters include flexibility in behavior (31.25% of respondents have low quality levels), need for cognition and spontaneity (25%, respectively).

Consideration of the emotional intelligence data in the two groups we studied is presented in Table 1.

Table 1.

Indicators of emotional intelligence of the sample

Indicators of emotional intelligence	Level		
	low	middling	high
The emotions of others understanding	12,5%	50%	37,5%
Others' emotions managing	12%	44%	44%
Own emotions understanding	25%	31%	44%
Own emotions managing	25%	31%	44%
Expression control	25%	19%	56%
Interpersonal emotional intelligence	19%	44%	37%
Intrapersonal emotional intelligence	25%	19%	56%
Emotions understanding	19%	44%	37%
Emotions managing	25%	12,5%	62,5%
Emotional intelligence	19%	12,5%	68,5%

As shown in Table 2, the two studied groups have rather high levels of emotional intelligence. In particular, most of the respondents (68.5%) are characterized by a high level of emotional intelligence, able to adequately understand their and others' emotions, and effectively manage them. Also, 12.5% of respondents have an average level of emotional intelligence, mostly correctly and adequately understand emotions, manage them, but often they may be wrong or not fully understand the meaning of emotional phenomena, paying more attention to cognitive processes and phenomena. Also, the minority (19%) of the respondents who focus on their own self-actualization, have a low level of emotional intelligence, are unable to correctly identify emotions and effectively manage them in interpersonal interaction and intrapsychic life. Consequently, the self-actualized adults of an adult age, mainly, are characterized by elevated indicators of emotional intelligence.

It has been determined that respondent's intrapersonal emotional intelligence is higher (high level is inherent in 56%) than interpersonal (high level is recorded in 37%). That is, the respondents are better at identifying their own emotions, regulating their course, than understanding the emotional experiences of others, staying with them in emotional resonance. At the same time, the representatives of the sample considerably better control their emotions (a high level of 62.5%) than they understand it (37%). They have developed clear patterns of emotional self-control in accordance with social standards and expectations, which, however, impedes them in the process of self-actualization.

In general, we recorded similar indicators of severity of certain aspects of emotional intelligence in the sample. In particular, 44% of the respondents have a high level of others and their emotions control, understanding the content of their own emotional sphere. Also, 56% of respondents have a high level of control over their own emotional experiences and 37.5% – a high level of understanding of others' emotions. Low levels of certain aspects of emotional intelligence indicators are characteristic for a small proportion of the respondents and range from 12% to 25%.

Thus, the study of both groups is characterized by the predominance of elevated emotional intelligence indicators, especially its regulatory component in the internal intrapersonal aspect.

Also we compare the emotional intelligence indicators among the two subgroups, because we predict that this quality expressiveness level engaged in self-development and students of the second higher education may differ in view of various motivational trends in their self-development or education. These data are presented in Table 2.

Table 2.

Indicators of emotional intelligence of the respondents who receive the second higher education (1st subgroup) and are engaged in self-development (2nd subgroup)

Indicators of emotional intelligence	Subgroup	Level			*t*
		low	middling	high	
The emotions of others understanding	1st	22%	33%	45%	3,310**
	2nd	0%	71%	29%	
Others' emotions managing	1st	22%	33%	45%	2,221*
	2nd	0%	57%	43%	
Own emotions understanding	1st	22%	33%	45%	0,575
	2nd	29%	29%	42%	
Own emotions managing	1st	22%	22%	56%	1,287
	2nd	29%	42%	29%	
Expression control	1st	22%	22%	56%	0,285
	2nd	29%	14%	57%	
Interpersonal emotional intelligence	1st	33%	33%	34%	2,57*
	2nd	0%	57%	43%	
Intrapersonal emotional intelligence	1st	22%	11%	67%	0,889
	2nd	29%	29%	42%	
Emotions understanding	1st	22%	33%	45%	1,357
	2nd	14%	57%	29%	
Emotions managing	1st	22%	22%	56%	0,165
	2nd	29%	0%	71%	
Emotional intelligence	1st	22%	0%	78%	0,757
	2nd	14%	29%	57%	

As shown in Table 2, there is a straight distinction between the two groups of participants in the interpersonal emotional intelligence expression ($t = 2.57$, $p \leq 0.05$) and its components – others' emotions understanding ($t = 3.310$, $p \leq 0.01$) and others' emotions managing ($t = 2{,}221$, $p \leq 0{,}05$). Moreover, according mathematical statistics data, these characteristics are more inherent (by comparison of mean values) to a group of people paying attention to their own self-actualization, despite the fact that the percentage of high-level characteristics of others emotions understanding and managing among the representatives of second higher education group are higher. This can be explained by the prevalence of average and high levels in the group of self-actualized ones, along with a greater dispersion of interest rates in the second highest group. That is, personalities engaged in own self-actualization, characterized by a more pronounced indicator of interpersonal emotional intelligence, the ability to perceive, understand and interpret the emotions of others, and manage them in the process of interpersonal interaction.

According to other indicators of emotional intelligence between the groups of the second higher education and those who engaged in self-actualization, the statistical difference is absent. That is, they equally understand their own emotions at the elevated level, control emotional experiences and their expression, characterized by increased levels of emotional intelligence. Representatives of the sample who receive second higher education have some higher percentage values for managing their emotions and their understanding, which, however, do not have a statistically significant difference.

Conclusions and perspectives of further exploration in this field. The role of emotional intelligence in the process of self-actualization of the

adult's age is attributed to the definite characteristics of self-actualized personality that relate to the sphere of emotional life (higher experiences, the ability to spontaneous behavior and expression of their feelings, the adoption of aggression as a natural manifestation of human nature, openness as an expression of the desire to love and to cause love , emotionality, immediacy in actions and sincerity in expressing their thoughts and feelings, the ability to understand their own feelings).

Empirical data analysis gave us the opportunity to conclude that both group respondents are characterized by high enough indicators of emotional intelligence. In particular, most of the respondents are characterized by a high level of emotional intelligence, capable of an adequate understanding of their and others' emotions, and effective it management. It is determined that for the entire sample the intrapersonal emotional intelligence is mare inherent than interpersonal. That is, personalities engaged in own self-actualization, characterized by a more pronounced indicator of interpersonal emotional intelligence, the ability to perceive, understand and interpret the emotions of others, and manage them in the process of interpersonal interaction.

The prospect of further research is the study of the connection between the process of self-actualization of the person and its peak experiences, which will enable to explore new factors of self-actualization of the individual.

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РОЛЬ ЕМОЦІЙНОГО ІНТЕЛЕКТУ В САМОАКТУАЛІЗАЦІЇ ОСОБИСТОСТІ

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Стаття присвячена аналізу ролі емоційного інтелекту у процесі самоактуалізації особистості дорослого віку. Описано актуальність вивчення зв'язку емоційного інтелекту та самоактуалізації в контексті сучасних наукових дискурсів та кризових умов суспільства. Стаття містить узагальнення результатів теоретичного аналізу проблеми самоактуалізації. Подано найбільш суттєві ознаки процесу самоактуалізації з точки зору гуманістичної психології та описано методологічні засади й основні аспекти розуміння самоактуалізації у вітчизняній психології згідно методологічних принципів діяльнісного підходу. Визначено сутнісні ознаки емоційного інтелекту особистості, його структура. Обґрунтовано, що емоційний інтелект має зв'язок із процесом самоактуалізації особистості через реалізацію особистості у повноті власного емоційного життя, спроможності до переживання пікових емоцій, контролю змісту емоційної сфери, тощо. Описано методичні засади дослідження, специфіку вибірки та порівнюваних діагностичних груп. Проаналізовані емпіричні дані вивчення самоактуалізації досліджуваних, найбільш значимі її параметри, вираженості у досліджуваних різних аспектів емоційного інтелекту. Отримані емпіричні дані інтерпретовано відповідно до класичних та сучасних наукових поглядів на природу процесів самоактуалізації та емоційного інтелекту. Інтерпретовано вираженість показників емоційного інтелекту в інтра- та інтерперсональній площині у двох групах досліджуваних – респондентів, які здобувають другу вищу освіту за спеціальністю «Психологія», і досліджуваних, що мають на меті самоактуалізуватися. Статистично обґрунтоване та змістовно аналізоване переважання міжособистісного емоційного інтелекту та його компонентів – розуміння чужих емоцій і управління чужими емоціями у представників вибірки, що мають на меті власну самоакуталізацію. Також, виявлено загально виражену для обох груп досліджуваних тенденцію до ідентифікації змісту власної емоційної сфери, її експресії та показника емоційного

інтелекту загалом. На основі узагальнення емпіричних даних виявлено тенденцію поєднання ознак самоактуалізації та емоційного інтелекту в функціонуванні особистості.

КЛЮЧОВІ СЛОВА: самоактуалізація особистості, чинники самоактуалізації, орієнтація в часі, емоційний інтелект, міжособистісний та внутрішньоособистісний емоційний інтелект, емоційний інтелект як чинник самоактуалізації

РОЛЬ ЭМОЦИОНАЛЬНОГО ИНТЕЛЛЕКТА В САМОАКТУАЛИЗАЦИИ ЛИЧНОСТИ

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Статья посвящена анализу роли эмоционального интеллекта в процессе самоактуализации личности взрослого возраста. Описаны актуальность изучения связи эмоционального интеллекта и самоактуализации в контексте современных научных дискурсов и в кризисных условиях общества. Статья содержит обобщение результатов теоретического анализа проблемы самоактуализации. Представлены наиболее существенные признаки процесса самоактуализации с точки зрения гуманистической психологии и описаны методологические основы и основные аспекты понимания самоактуализации в отечественной психологии согласно с методологическими принципами деятельностного подхода. Определены сущностные признаки эмоционального интеллекта личности, его структура. Обосновано, что эмоциональный интеллект имеет связь с процессом самоактуализации личности через реализацию личности в полноте собственной эмоциональной жизни, способности к переживанию пиковых эмоций, контроля содержания эмоциональной сферы. Описаны методические основы исследования, специфика выборки и сравниваемых диагностических групп. Проанализированы эмпирические данные изучения самоактуализации испытуемых, наиболее значимые ее параметры, выраженность у испытуемых различных аспектов эмоционального интеллекта. Полученные эмпирические данные интерпретированы в соответствии с классическими и современными научными взглядами на природу процессов самоактуализации и эмоционального интеллекта. Интерпретирована выраженность показателей эмоционального интеллекта в интра- и интерперсональной плоскости в двух группах испытуемых – респондентов, получающих второе высшее образование по специальности «Психология», и испытуемых, имеющих целью самоактуализироваться. Статистически обоснованно и содержательно проанализировано преобладание межличностного эмоционального интеллекта и его компонентов – понимания чужих эмоций и управления чужими эмоциями у представителей выборки, имеющих целью собственную самоакутализацию. Также, обнаружено выраженную для обеих групп испытуемых тенденцию к идентификации содержания собственной эмоциональной сферы, ее экспрессии и показателя эмоционального интеллекта в целом. На основе обобщения эмпирических данных выявлена тенденция сочетания признаков самоактуализации и эмоционального интеллекта в функционировании личности.

КЛЮЧЕВЫЕ СЛОВА: самоактуализация личности, факторы самоактуализации, ориентация во времени, эмоциональный интеллект, межличностный и внутриличностный эмоциональный интеллект, эмоциональный интеллект как фактор самоактуализации

SECTION: SEXOLOGY AND GENDER PSYCHOLOGY
РОЗДІЛ: СЕКСОЛОГІЯ ТА ГЕНДЕРНА ПСИХОЛОГІЯ

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ON THE INFLUENCE OF GENETIC FACTORS ON THE FORMATION OF HOMOSEXUALITY BY DATA OF TWIN STUDIES

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Results of twin studies are presented; these demonstrate that in a number of cases genetic effects can play a role of mild predisposing factors for the development of homosexuality, but the main part in its formation is accounted for by psychological and social factors. The opinion that genetic factors play the only and dominant role in the genesis of homosexuality does not hold water due to the fact that if it were so then their concordance for homosexuality in monozygotic twins would be 100 %, but it is not observed in reality. The studies conducted with the correct selection of examinees revealed 20 % of the concordance for homosexuality in male monozygotic twins and 24 % in female ones (Bailey, J.M., et al. Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample. *J. Pers. Soc. Psychol*. 78(3), 524-536). The use of Holzinger's formula for analyzing the obtained numerical findings demonstrated that in the above case the proportion between heritable and environmental factors for male persons was 0.2 (20 %) versus 0.8 (80 %), for female persons it being 0.15 (15 %) versus 0.85 (85 %). Earlier twin studies (Bailey, J.M., Pillard, R.C. (1991). A genetic study of male sexual orientation. *Arch. Gen. Psychiatry*. 48(12), 1089–1096) revealed that their concordance for homosexuality in siblings (biological brothers, who are not twins) was lower than in adopted brothers (9.2 % versus 11 %), it contradicting to the idea of genetic determination of same-sex attraction. Moreover, attention is also attracted by the fact that dizygotic male twins demonstrated a significantly higher concordance for homosexuality than siblings (22 % versus 9.2 %). But it is known that dizygotic twins, like siblings, have on an average only 50 % of common genes. If there were genetic determination, such differences would not exist; the revealed difference demonstrates environmental effects, since it is evident that family upbringing of dizygotic twins is much more similar. Also it is necessary to pay attention to the fact that the rate of homosexuality in adopted homosexual brothers (11 %) considerably exceeded recent estimations of the part of homosexuals in the general population and was actually equal to the value for siblings, once again convincingly demonstrating a significant role of the environment in the formation of sexual orientation. We should not also ignore the fact that upbringing of monozygotic twins is even more similar than that of dizygotic ones; this phenomenon can cause their larger concordance for homosexuality.

KEY WORDS: homosexuality, formation, twin studies, genetic factors, role.

The authors, who conduct genetic studies of homosexuality, often try to declare it a consequence of the prevailing influence of genes. But in order to make an objective opinion it is necessary to resort to presentation and analysis of the materials which deal with this problem.

Some studies of twins have recorded the concordance rate for homosexuality in monozygotic (monochorial), dizygotic (dichorial) twins and sibs/siblings (biological brothers and sisters, who are not twins) and revealed that the above concordance is higher in monozygotic twins, this fact demonstrating biological predisposition to homosexuality rather than its congenital character. The range of values of this concordance, according to different authors, varies greatly. Next are several examples.

J. M. Bailey and R. C. Pillard (1991), researchers from the Northwestern University and Boston University School of Medicine, published

their findings that revealed in males their concordance for homosexuality in 52 % (29/56) of monozygotic twins, 22 % (12/54) of dizygotic twins, 9.2 % (13/142) of siblings and 11 % (6/57) of adopted brothers.

Discussing the above research it is necessary to point out the methodology of selection of the material that could significantly affect the findings. The authors did not study a random sample of homosexuals, because the cases were involved by means of advertisements in homosexual press. This method was highly dependent upon the readership of such issues and motives of those people who desired to participate in the above studies. This approach could result in distortion of findings: for example, an increased rate of homosexuality for twins because of selectivity in the formation of the group of respondents (Baron, 1993).

Attention is also attracted by the fact that the concordance for homosexuality in siblings was lower than in adopted brothers (9.2 % versus 11 %), it contradicting to the idea of genetic predisposition to same-sex attraction. Moreover, we should consider that dizygotic twins demonstrated a significantly higher concordance for homosexuality than siblings (22 % versus 9.2 %). But it is known that dizygotic twins, like siblings, have on an average only 50 % of common genes. If there were genetic determination, such differences would not exist; the revealed difference demonstrates environmental effects, since it is evident that family upbringing of dizygotic twins is much more similar. Also it is necessary to pay attention to the fact that the rate of homosexuality in adopted homosexual brothers (11 %) considerably exceeded recent estimations of the part of homosexuals in the general population and was actually equal to the value for siblings, once again convincingly demonstrating a significant role of the environment in the formation of sexual orientation (URL: http://overcoming-x.ru..., 2018). We should not also ignore the fact that upbringing of monozygotic twins is even more similar than that of dizygotic ones; this phenomenon can cause their larger concordance for homosexuality.

Determination of the heritability estimate using Holzinger's formula (URL: www.medbio-kgmu.ru..., 2018) demonstrates that the proportion of heritable and environmental factors in the above study was, respectively, 0.38 (38 %) and 0.62 (62 %), it revealing a more pronounced influence of environmental factors.

J.M. Bailey et al. (1993) published results of a similar study among adult females (lesbians and bisexuals). These findings were as follows: the concordance for homosexuality in monozygotic twins was 47.9 % (34/71), in dizygotic ones 16.2 % (6/37), in adopted sisters 5.7 % (2/35).

Some studies show a lower influence of heritable factors. M. King and E. McDonald (1992) examined 46 homosexual males and females, who were twins. The reported level of concordance for homosexuality was 10 % or 25 % for monozygotic twins (depending upon the fact whether bisexuals were taken into consideration together with homosexuals). The levels of coincidence for dizygotic twins were 8 % and 12 % (also with consideration of the above dependence).

If homosexuality were congenital and caused by influence of genetic factors and if environmental (psychological and social) ones did not produce any effect on the formation of sexual orientation, then every monozygotic brother of a homosexual would be only homosexual. It should be emphasized that during explanation of a higher concordance rate for homosexuality in monozygotic twins we should not focus our attention only on a possible influence of genetic factors, since it is not only monozygotic twins but even dizygotic ones too have a similar hormonal environment during their prenatal period of life, when sexual differentiation of the brain takes place. Hence, the influence of hormonal factors in this case should not be ruled out. Neither ignored should be the fact that, as we have emphasized above, the monozygotic twins, who live in the same family, undergo the influence of the same ecological effects of the psychological and social character.

Examination of the twins, who were brought up in different conditions, would undoubtedly demonstrate more clearly the real role of biological (heritable) as well as psychological and social factors in the genesis of homosexuality. But for absolutely obvious reasons it is extremely difficult and actually impossible to conduct such a study with involvement of any significant number of respondents.

Discussing the problem of influence of genetic factors on the formation of homosexuality, R. Hubbard and E. Wald (1997, p. 97) point out the fact that studies of dizygotic twins revealed, as a rough estimate, twice more homosexuals than among other biological brothers (siblings). This result demonstrates influence of the environmental factor on the above twins, since they, as we have already emphasized, do not have more biological similarities between themselves than non-twin brothers (siblings). Moreover, the authors insist that this finding should cover even more monozygotic twins; their acquaintances regard them as "identical" and treat them as identical, and they themselves often feel their similarity or identity.

R. Crooks and K. Baur (2005, p. 246) report that for some time past the methods of selection of examinees, used in studies of homosexuality in twins, have been subjected to criticism. The works of 1990s turned out to be particularly vulnerable, as the examinees were invited with help of advertisements in publications for gays and lesbians or by using their acquaintances. Moreover, from the very beginning the examinees knew that they participated in the study of homosexuality. Therefore it could happen that the twins, who were invited to take part in such a study, took into account the sexual orientation of the other twin, their brother or sister, before deciding to participate in the study. And eventually it could result in higher values of coincidence than those ones that could be obtained for the general population. In this way the above authors unequivocally state that in order to increase the percentage of concordance in homosexuality among twins the homosexuals, who knew about the planned study and its purposes, took a decision about their participation or non-participation in the study with a resultant distortion and possible formation of an unrepresentative sample.

Taking into consideration these critical statements, J. M. Bailey et al. (2000) conducted a new study of twins, whose results were published in 2000. The authors used the Australian National Health and Medical Research Council Twin Registry. All in all 1,538 twin pairs participated in the study: 312 pairs of monozygotic male twins, 182 pairs of fraternal male twins, 688 pairs of monozygotic female twins and 376 fraternal female twins. All the twins, who took part in the study, were chosen randomly, irrespective of data about the other twin, the brother or the sister. The concordance for homosexuality was 20 % in monozygotic male twins and 0 % in dizygotic ones; in representatives of the female gender the above proportion was 24 % versus 10.5 % (Dawood, Bailey, Martin, 2001).

Conspicuous is the fact that with such a correct approach to the study the percentage of the concordance for homosexuality in twins turned out to be much lower than in the studies led by the same author before (Table 1).

The use of Holzinger's formula in analyzing the obtained numerical material demonstrates that in this case the proportion of heritable and environmental factors is 0.2 (20 %) versus 0.8 (80 %) for the male gender and 0.15 (15 %) versus 0.85 (85 %) for the female one. Taking this information into account it is not difficult to make the same conclusion as in the study mentioned, though if we consider the difference in the concordance between monozygotic and dizygotic twins during interpretation of the obtained data we can say about mild inherited predisposition.

Table 1.

The concordance for homosexuality in monozygotic and dizygotic twins of the male and female gender

Concordance for homosexuality in twins	**Monozygotic male twins**	**Dizygotic male twins**	**Monozygotic female twins**	**Dizygotic female twins**
Bailey J. M. and Pillard R. C., 1991	52 %	22 %	–	–
Bailey J. M. et al., 1993	–	–	47.9 %	16.2 %
Bailey J. M et al., 2000	20 %	0 %	24 %	10.5 %

Results of a large-scale and representative study of twins were published in 2002 by sociologists Peter S. Bearman and Hannah Brückner (2002). They used information about teenagers of the 7th-12th grades from the National Longitudinal Study of Adolescent Health (Add Health). Of 18,841 teenagers, 8.7 % reported about their attraction to people of the same sex, 3.1 % informed about romantic relationships with representatives of their gender, and 1.5 % had homosexual intercourses. Lawrence S. Mayer and Paul R. McHugh (2016) point out that P.S. Bearman and H. Brückner (2002) did not find any confirmation for a significant genetic influence on sexual attraction. This influence would be significant if the concordance rate of same-sex attractions were considerably higher in monozygotic twins versus fraternal ones or non-twin brothers. But the revealed coefficients were statistically consistent: the concordance was 6.7 % in monozygotic twins, 7.2 % in fraternal twins and 5.5 % in non-twin brothers (Table 2). The authors came to the following conclusion: "it is more likely that any genetic influence, if present, can only be expressed in specific and circumscribed social structures" (Bearman and Brückner, 2002, p. 1198).

It should be noted that when assessing a number of twin studies we should keep in mind that homosexuality could be detected by sexual behaviour rather than by sexual attraction. Though often these factors correlate, they are not identical. A person can live a sexual life with representatives of the same sex without any sexual attraction to them. As it is known, there is homosexual experimentation of adolescents (when same-sex attraction is absent), homosexual prostitution, etc. Even such a term as "males practicing sex with males" exists, when sexual orientation and sexual identity are not taken into account. On the other hand, a person with same-sex attraction may not have any contacts with people of the same gender.

Table 2.

The concordance of same-sex romantic attraction among different pairs of siblings

Type of pair	All		Males		Females	
	N	%	N	%	N	%
Monozygotic twins	45	6.7	26	7.7	19	5.3
Dizygotic twins	83	7.2	48	4.2	35	11.4
Siblings	183	5.5	89	4.5	94	6.4
Other	216	4.2	110	2.7	106	5.7
All	527	5.3	273	4.0	254	6.7
P (Fisher's exact test)	0.630		0.564		0.651	

When assessing results of the twin method of researches we should keep in mind that it assumes equality among both monozygotic and dizygotic twins. But in real conditions even the twins, who live together, are subjected to different environmental effects with a resultant distortion of the true contribution of heritability and environment to the development of a certain sign. The above fact particularly concerns those signs, which are very sensitive to the influence of environmental factors. The following causes of different influence of the environment on the development of twins are singled out (URL: www.medbio-kgmu.ru...):

- "accentuation of the likeness of monozygotic twins by their acquaintances;
- accentuation of differences of dizygotic twins, for example in succeeding in different kinds of activity; seeking of dizygotic twins to emphasize their dissimilarity;
- conditions of their development can reduce similarity of twins in both monozygotic and dizygotic pairs; as, for example, during their intrauterine development twins are often in unequal conditions:
  - differences in blood supply;
  - uneven compression of the placentas;

- differences in liability for birth injuries, etc."

It is pointed out that differences between twins can increase during their postembryonic development. It may be caused by division of duties between twins during their differentiation on the "leader-subordinate" basis, etc.

Discussing this problem, Lawrence S. Mayer and Paul R. McHugh (2016) nevertheless note: "One needs to bear in mind that identical twins typically have even more similar environments – early attachment experiences, peer relationships, and the like – than fraternal twins or non-twin siblings. Because of their similar appearances and temperaments, for example, identical twins may be more likely than fraternal twins or other siblings to be treated similarly. So some of the higher concordance rates may be attributable to environmental factors rather than genetic factors."

Niklas Långström et al. (2010) published findings of their large-scale study of sexual orientation of twins in Sweden; they analysed data of 3,826 pairs of same-sex monozygotic and fraternal twins (2,320 monozygotic and 1,506 fraternal pairs). Having concluded that sexual orientation appears under the influence of both heritable and environmental factors, the Swedish scientists have stated that "the present results support the notion that the individual-specific environment does indeed influence sexual preference" (Långström, Qazi, Carlström, Lichtenstein, 2010, p. 79). As Mayer and McHugh (2016), who analysed this study, point out the findings received by the above authors demonstrate that we cannot deny the role of the genetic component in the development of homosexual behaviour, but it is the unique environmental factors that play a decisive and maybe dominating role.

It should be noted that in our article we have presented a characteristic of different sample groups, i.e. we are talking about the "group portrait", where the role of genetic factors in the genesis of homosexuality was determined. But it is absolutely obvious that often this is in reference to merely acquired forms of homosexuality, where no role of genetic factors is seen at all. This fact is confirmed by clinical observations.

At the same time, in some cases predisposing biological factors apparently can, if their manifestation is large, particularly when this refers to their combinations, cause development of homosexual orientation even in the absence of any pronounced environmental homosexualizing effects (upbringing, informational influences of a certain kind, etc.).

On the basis of their comprehensive meta-analysis of a large number of studies of homosexuality the American medical researchers Mayer and McHugh, (2016) state the following: "Summarizing the studies of twins, we can say that there is no reliable scientific evidence that sexual orientation is determined by a person's genes. But there is evidence that genes play a role in influencing sexual orientation."

To our mind it would be interesting to conduct a twin study of heterosexuality. I have no doubts that in this case the heritable factor would show itself in an absolutely another way and, apparently, we could state that it plays a large part in the formation of heterosexual orientation because it is in line with the human gender (!).

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О ВЛИЯНИИ ГЕНЕТИЧЕСКИХ ФАКТОРОВ НА ФОРМИРОВАНИЕ ГОМОСЕКСУАЛЬНОСТИ ПО ДАННЫМ БЛИЗНЕЦОВЫХ ИССЛЕДОВАНИЙ

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Приведены результаты близнецовых исследований, которые свидетельствуют о том, что в ряде случаев генетические влияния могут играть роль мягких предрасполагающих факторов в развитии гомосексуальности, но основное значение в ее формировании принадлежит факторам психологическим и социальным. Мнение, что генетические факторы выполняют доминирующую и единственную роль в генезе гомосексуальности, не выдерживает критики в связи с тем, что если бы это было так, то соответствие по гомосексуальности среди однояйцовых близнецов составляло бы 100%, чего на самом деле не наблюдается. Исследования, проведенные с корректным подбором исследуемых, свидетельствуют о 20% конкордантности по гомосексуальности среди однояйцевых близнецов мужского пола и 24% – среди женского (J. M. Bailey и соавт., 2000). Использование формулы Хольцингера при анализе полученного цифрового материала свидетельствует о том, что в данном случае соотношение наследственных и средовых факторов для лиц мужского пола составляет 0,2 (20%) против 0,8 (80%), а для женского – 0,15 (15%) против 0,85 (85%). В более ранних близнецовых исследованиях (J.M. Bailey, R. C. Pillard, 1991) было выявлено, что соответствие по гомосексуальности у сиблингов (родных братьев, но не близнецов) было ниже, чем у приемных братьев (9,2% против 11%), что входит в противоречие с идеей генетической обусловленности однополого влечения. Помимо этого, обращает на себя внимание тот факт, что у дизиготных близнецов мужского пола соответствие по гомосексуальности значительно выше, чем у сиблингов (22% по сравнению с 9,2%). Однако известно, что дизиготные близнецы, также как и сиблинги, имеют в среднем лишь 50% общих генов. Если бы речь шла о генетической детерминации, то таких различий не должно было бы быть, и выявленное отличие свидетельствует о средовых влияниях, так как очевидно, что у двуяйцовых близнецов воспитание в семье будет гораздо более схожим. Также необходимо обратить внимание на тот факт, что частота гомосексуальности у приемных братьев гомосексуалов (11%) намного превышала последние оценки доли гомосексуалов в общей популяции и практически была равна показателю для сиблингов, что в очередной раз убедительно свидетельствуют о значимости роли социальной среды в формировании сексуальной ориентации. Нельзя обойти вниманием и тот факт, что у однояйцовых близнецов воспитание является еще более схожим, чем у двуяйцовых, что может сказываться на их большем соответствии по гомосексуальности.

КЛЮЧЕВЫЕ СЛОВА: гомосексуальность, формирование, близнецовые исследования, генетические факторы, роль.

ПРО ВПЛИВ ГЕНЕТИЧНИХ ФАКТОРІВ НА ФОРМУВАННЯ ГОМОСЕКСУАЛЬНОСТІ ЗА ДАНИМИ БЛИЗНЮКОВИХ ДОСЛІДЖЕНЬ

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Харківська медична академія післядипломної освіти

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Наведено результати близнюкових досліджень, які свідчать про те, що в ряді випадків генетичні впливи можуть грати роль м'яких факторів у розвитку гомосексуальності, але основне значення в її формуванні належить факторам психологічним і соціальним. Думка, що генетичні чинники виконують домінуючу і єдину роль в генезі гомосексуальності, не витримує критики у зв'язку з тим, що якби це було так, то конкордантність за гомосексуальністю серед однояйцевих близнюків становила б 100%, чого насправді не спостерігається. Дослідження, проведені з коректним підбором досліджуваних, свідчать про 20% конкордантність за гомосексуальністю серед однояйцевих близнюків чоловічої статі і 24% – серед жіночої (J. M. Bailey і співавт., 2000). Використання формули Хольцингера при аналізі отриманого цифрового матеріалу свідчить про те, що в даному випадку співвідношення спадкових і середовищних факторів для осіб чоловічої статі становить 0,2 (20%) проти 0,8

(80%), а для жіночої – 0,15 (15%) проти 0,85 (85%). У більш ранніх близнюкових дослідженнях (J. M. Bailey, R. C., Pillard, 1991) було виявлено, що конкордантність за гомосексуальністю у сиблінгів (рідних братів, але не близнюків) була нижче, ніж у прийомних братів (9,2% проти 11%), що входить в протиріччя з ідеєю генетичної обумовленості одностатевого потягу. Крім цього, звертає на себе увагу той факт, що у дизиготних близнюків чоловічої статі конкордантність за гомосексуальністю значно вище, ніж у сиблінгів (22% в порівнянні з 9,2%). Однак відомо, що дизиготні близнюки, також як і сиблінги, мають в середньому лише 50% загальних генів. Якби мова йшла про генетичну детермінацію, то таких відмінностей не повинно було б бути, і виявлена відмінність свідчить про середовищні впливи, так як очевидно, що у двуяйцевих близнюків виховання в сім'ї буде набагато більш схожим. Також необхідно звернути увагу на той факт, що частота гомосексуальності у прийомних братів гомосексуалів (11%) набагато перевищувала останні оцінки частки гомосексуалів в загальній популяції і практично дорівнювала показнику для сиблінгів, що в черговий раз переконливо свідчить про значимість ролі соціального середовища у формуванні сексуальної орієнтації. Не можна обійти увагою і той факт, що у однояйцевих близнюків виховання є ще більш схожим, ніж у двуяйцевих, що може позначатися на їх більшій конкордатності за гомосексуальністю.

КЛЮЧОВІ СЛОВА: гомосексуальність, формування, близнюкові дослідження, генетичні фактори, роль.

ПРАВИЛА ОФОРМЛЕННЯ СТАТЕЙ ДЛЯ ЗБІРНИКА
«Психологічне консультування і психотерапія»

Відповідно до постанови Президії ВАК України №7-05/1 від 15 січня 2003 р. «Про підвищення вимог до фахових видань. Внесених до переліків ВАК України» при підготовці статей до фахового збірника слід дотримуватися таких вимог:

• постановка проблеми у загальному вигляді та її зв'язок з важливими науковими та практичними завданнями;

• аналіз останніх досліджень і публікацій, в яких започатковано розв'язання даної проблеми, на які спирається автор;

• виділення невирішених раніше частин загальної проблеми, котрим присвячується означена стаття;

• формування цілей статті (постановка завдання);

• виклад основного матеріалу дослідження з повним обґрунтуванням отриманих наукових результатів;

• висновки з цього дослідження і перспективи подальших розвідок у цьому напрямі;

• список використаних джерел у транслітерації (література оформляється відповідно до вимог ДАК МОН України

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Наприклад:

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3. Bulan, A.A. (2015). Психоемоційні стани комбатантів в умовах бойових дій [Psychoemotional states of combatants in combat situations], *Aktualni problemi sotsiologiyi, psihologiyi, pedagogiki, 4(29),* 9-12. (in Ukrainian)

Всеукраинская общественная организация «Институт клиент-центрированной и экспириентальной психотерапии» (сокращенно – ИКЭП www.pca.kh.ua) была создана в 2012 году. До этого времени функционировала с 2000 г. Мастер-школа клиент-центрированной психотерапии, созданная доктором психологических наук, профессором Кочаряном Александром Сумеровичем, который получил профессиональную подготовку в области клиент-центрированной психотерапии и консультирования в рамках обучающей программы интернационального института клиент-центрированного подхода (Лугано, Швейцария) и Центра кросс-культурной коммуникации (Дублин, Ирландия) для психологов и психиатров стран Центральной и Восточной Европы (Братислава, Прага) в 1990–1994 гг.

В том же 2012 г. ИКЭП получил статус коллективного члена Всемирной ассоциации человеко-центрированной и экспириентальной психотерапии и консультирования (World Association for Person Centered & Experiential Psychotherapy & Counselling http://www.pce-world.org/).

ИКЭП имеет учебные филиалы в Харькове, Киеве, Хмельницком, Луцке.

Основные формы деятельности ИКЭП:

Научная деятельность: выявление пределов и возможностей клиент-центрированной психотерапии (по нозологии и характерологии), разработка идей процессуальности в психотерапевтическом контакте. Защищены кандидатские и докторские диссертации по проблемам клиент-центрированной психотерапии, созависимых отношений, нарушений ответственного поведения, невротических расстройств, сексуальных и полоролевых нарушений. Изданы монографии: 1) Психотерапия: психологические модели – СПб.: Питер, 2003 – 1 изд., 2007 – 2 изд., 2009 – 3 изд. 2) Основы психотерапии – М.: Алетейя, 1999. 3) Основы психотерапии – К.: Ника-центр, 2001. 4) Психотерапия в особых состояниях сознания. – М.: АСТ, 2000. 5) Психотерапия сексуальных расстройств и супружеских конфликтов. – М.: Медицина, 1994. 6) Личность и половая роль – Х.: Основа, 1996. 7) Психотерапия как невербальная практика – Х.: ХНУ, 2014.; 8) Полоролевая психология – Х.: ХНУ, 2015.

Практическая деятельность (психологическая и психотерапевтическая работа): индивидуальное психологическое консультирование, групповая работа, проведение тематических тренингов.

Формы работы института: краткосрочные и долгосрочные программы, клиентские группы, группы встреч (личностного роста), профессиональное обучение, курсы обучения решению личностных проблем.

Преподавательский и тренерский состав ИКЭП: 1) Кочарян Александр Суренович - профессор, д. психол. н. (член единого профессионального реестра психотерапевтов Европы); 2) Кочарян Гарник Суренович - профессор, д. мед. н.; 3) Жидко Максим Евгеньевич - доцент, к. психол. н. (член единого профессионального реестра психотерапевтов Европы); 3) Кочарян Игорь Александрович - к. психол. н. (член единого профессионального реестра психотерапевтов Европы); 4) Терещенко Надежда Николаевна - доцент, к. психол. н. (официальный преподаватель межрегионального уровня); 5) Долгополова Елена Викторовна (официальный преподаватель межрегионального уровня); 6) Харченко Андрей Александрович (официальный преподаватель межрегионального уровня); 7) Цихоня Валерия Сергеевна - к. психол. н.

В настоящее ИКЭП реализует следующие проекты:

Профессиональная образовательная программа по клиент-центрированной психотерапии (адаптированная к требованиям Европейской Ассоциации Психотерапии). Программа включает в себя три модуля: 1) рефлексия личного опыта; 2) профессиональные знания и навыки; 3) поддержка и сопровождение профессионального опыта. Общее количество часов – 3215. Обучение проводится в закрытой группе (до 20 человек) с меняющимся составом сертифицированных лекторов и тренеров. Подготовка включает в себя лекции, тематические семинары, работу в эмпатической лаборатории и

лаборатории терапевтических ответов. Дополнительно обучающиеся проходят дидактическую индивидуальную психотерапию и участвуют в супервизионных семинарах. Завершение обучения предполагает позитивную рекомендацию тренеров, зачеты по всем тематическим семинарам и практическим занятиям, защиту практического случая (при условии вынесения его на супервизии), а также публичную защиту письменной дипломной работы.

Образовательная программа «Базовый курс психотерапии» («Психотерапевтическая пропедевтика»). Общее количество часов – 216 (из них 96 часов теории и 120 часов – практики). Включает в себя два модуля: 1) опыт самопознания (личный опыт); 2) основные направления психотерапии.

Супервизионная программа в области полимодальной и клиент-центрированной супервизии.

Мастер-класс професора А. С. Кочаряна – «Кухня клиент-центрированной психотерапии» (постоянно действующая открытая группа).

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