

# Psychological Support for Children with Intellectual Disorders in War Conditions

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**Abstract:** *The article reveals the problems of psychological support for children with intellectual disabilities in wartime. As children with intellectual disabilities are one of the most difficult categories of children with special educational needs due to their difficulties in communication, behavior, sensorimotor functioning, environmental orientation, social adaptation and socialization, they become the most vulnerable and need maximum assistance in crisis situations.*

*The empirical research was carried out using the following methods: a conversation was conducted with parents / guardians of children with intellectual disabilities to determine the traumatic events that children experienced during the war, then used a questionnaire "General reactions of children after the war / war events" and the diagnosis of stress disorders in children was carried out with the help of Luscher's abbreviated method of color choices, as well as the projective drawing technique "What scary dreams I have and what I am afraid of during the day". The study involved 26 parents (legal representatives) and 26 children aged 7 to 15 years with intellectual disabilities. Respondents included both local families and internally displaced persons.*

*According to the results of the parents' survey, it was established that virtually all respondent children witnessed and participated in certain traumatic events related to hostilities in our country: children remained in shelters for a long time during air alarms and shelling, experienced severe hunger and cold, felt the fear of their own death, etc. According to the parents, they noted in their children problems with memory, thinking, concentration, social services, frequent mood swings. In fact, the diagnosis of children with intellectual disabilities also revealed high levels of stress disorders and unfavorable emotional states. The article also offers recommendations and areas of psychological support and assistance to children with intellectual disabilities in wartime.*

**Keywords:** *current emotional state; war; children with intellectual disabilities; psychological support and assistance; traumatic situation.*

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## **Introduction**

Today Ukraine is going through quite difficult times. Society has faced incredible trials and social upheavals: full-scale hostilities, the destruction of all state infrastructure, the occupation of territorial communities, internally displaced persons and migrants who have left the country, the extremely difficult state of the economic system and more. All this affected every citizen of our country.

Children, women, and low-mobility groups are increasingly suffering from modern military conflicts. During the war, children, like adults, can often fall victim to various horrific events that traumatize their psyche. They may witness artillery shelling and shootings, experience difficulties in emergency and sudden evacuations, observe the destruction of their hometown or village, or even their homes. Children can spend a long time in difficult conditions in bomb shelters and shelters, see the wounded or dead, torture and murder, mass deaths. They may be injured themselves, suffer heavy losses, see their family members and friends being injured or dying (Zavatskyi et al., 2020).

Such experience can lead to a variety of psychological problems in both normative children and children with special educational needs, in particular children with intellectual disabilities. Among the most characteristic changes they may have irritability, anxiety, sadness, frequent crying, isolation, depressed mood and timidity. Children may be afraid of loud noises, afraid to go outside their home, they find it difficult to concentrate while learning (Andryushchenko, 2000). Some of them may experience a loss of self-control and fear of going insane.

As the nature of wars changes, professionals working with children in war-torn countries try to find new ways to help and focus it narrowly on the most vulnerable. It is now believed that the sooner you help your child cope with the stresses of war, the better he or she will feel and the risk of deep problems in the future will decrease (Smith et al., 2014). If the entire population is involved in the war, often the first task of specialists is to provide assistance to a large number of children as soon as possible and accelerate their recovery.

## **Literature review**

The implementation of an inclusive approach in the economic system, education system of Ukraine and society in general continues to ensure access to quality social and educational services for all children,

including those with special educational needs. In general, over the last 5 years, the number of students in inclusive education has increased 7 times (Nichugovska et al., 2021). Significant progress in the implementation of inclusion for children with intellectual disabilities (Melnichuk, 2019) is due to a set of measures, the key of which is Ukraine's accession to basic international documents (Zasenko & Kolupaeva, 2014), adoption of normative-legal documents that ensure the implementation of organizational-legal and financial mechanisms of its implementation (Verbovsky, 2020), development of theoretical and methodological principles of inclusive education (Horishna et al., 2020), strengthening the institutional and financial capacity of local governments in the development of inclusive education and the realization of the right of children with special educational needs to receive quality education at the place of residence (Belova, 2014). However, due to the beginning of hostilities on the territory of Ukraine and the imposition of martial law, there are changes in the legal framework and humanization of relations in the educational and social space, changes in the educational paradigm, continues to actively search for new directions, technologies, methods of education especially, psychological support for children with special educational needs. Significant attention is paid to children with intellectual disabilities of varying severity, due to the presence of persistent trends towards the spread of new options for combining psychophysical disorders in children against the background of emergencies or in combination with intellectual disabilities (Shevchenko, 2020). This category of children with special educational needs is considered as one of the most difficult for psychological recovery and inclusion in the educational process of educational institutions. This is due to the fact that intellectual disabilities are usually accompanied by disorders of the psyche, speech, communication, behavior, sensorimotor functioning and, as a consequence, there are difficulties in orientation in the environment, social adaptation and socialization (Ilyashenko, 2021). The use of modern diagnostic tools makes it possible not only to detect intellectual disabilities, to determine the degree of their complexity, but also to obtain reliable information for planning forms of current psychological support, as well as psychological, pedagogical and correctional and developmental work. Studies of domestic scientists reveal various aspects of the inclusion of children with intellectual disabilities in the social environment, in particular, the features of their cognitive sphere and psychological and pedagogical support (Horishna & Maichuk, 2021), support for children and their families in times of war and military conflict (Smith et al., 2014), socialization and social and labor adaptation (Yarmola, 2019). At the same time, the analysis of scientific

research shows that modern approaches to providing psychological support to children with intellectual disabilities are extremely relevant, but in the domestic scientific discourse have not received due attention.

## **Methodology**

The empirical study was conducted on the basis of Khmelnytskyi Collegium named after Volodymyr Kozubniak among children with intellectual disabilities and their parents. It was attended by 26 parents / guardians and 26 students, aged 7 to 15, with special educational needs, including 20 students who are local residents and 6 students - internally displaced persons from other cities of Ukraine. Parents and other legal representatives of children orally agreed to participate in the study, which took place outside of school hours, without disclosing personal information about the participants and the results of the study. The solution of the tasks was carried out by using a set of general scientific methods and methods of psychological and pedagogical research. In particular, theoretical methods were used: analysis of scientific literature, comparison of different approaches and concepts, theoretical synthesis, classification, methodological generalization, etc. We also used empirical tools: interviewing parents / guardians to identify traumatic events that children experienced during the war, using the questionnaire "General reactions of children after the war / war events" (among parents and legal representatives of children with special educational needs) (Smith et al., 2014), diagnosis of stress disorders in children using the method of Luscher's color choices (8-color abbreviated version of the technique) and projective technique "What scary dreams I have and what I am afraid of during the day" (Isaeva, 2006). Based on the results of the diagnosis, practical recommendations for parents and specialists working with children with intellectual disabilities in wartime were developed and substantiated.

## **Results and recommendations**

In order to differentiate and understand the psychological characteristics of children with intellectual disabilities, we turned to the interpretation of this concept, the classification of intellectual disabilities. Yes, the American Association on Intellectual and Developmental Disabilities (AAIDD) defines intellectual disabilities as those associated with significant limitations of intellectual functioning and adaptive behavior, which manifests itself in impaired learning, social and practical skills and manifests itself before the age of 18 (Schalock et al., 2009).

The American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders of the 5th revision (DSM-5) considers intellectual disorders as disorders of neuropsychological development and emphasizes their persistent nature and connection with early brain dysfunctions. The main diagnostic features of such disorders are established on the basis of clinical studies and standardized assessment results of inconsistency of intellectual functions (ability to think, abstract thinking, judgment, understanding, learning, problem solving, planning) and adaptive skills (performing everyday activities in educational, social and practical areas in different contexts - at home, in preschool / school / college, in the community, etc.) according to age, gender and socio-cultural expectations (Afanasenko et al., 2021). Disorders in these functions and skills can be manifested not only until the child reaches the age of 18, but throughout the period of personality development (Matson & Issarraras, 2019).

In researches of domestic scientists intellectual disturbances are considered as persistent disturbances of cognitive activity owing to organic defeat of a brain (congenital or acquired) (Chupakhina, 2020). They define them as a group of pathological conditions characterized by a violation of the systemic interaction between intellectual and affective spheres of cognitive activity and manifested in general mental retardation with a dominant intellectual defect and complications in social adaptation (Voytiuk, 2020). Also, intellectual disorders are a set of hereditary, congenital or acquired persistent syndromes of general mental retardation, which are manifested in difficulties in adapting to the social environment (Pryadko & Furman, 2015). Despite the lack of a unified interpretation of this term in the domestic scientific discourse, the key aspects are common: they relate to the fact that such disorders manifest themselves in childhood, negatively affect the development of personality and the ability to act independently (social dysfunction) due to difficulties in perception and understanding new information and mastering new skills (intelligence impairment). According to Schalock et al. (2007), despite the development of terminology used to refer to intellectual disabilities and advances in research, social policy, and clinical practice, the very construct of "intellectual disability" remains virtually unchanged. and includes impaired cognitive function, adaptive behavior, and early onset of these symptoms.

In Ukraine, the diagnostic criteria defined in ICD-11 (WHO, 2021) and the corresponding IQ indicators are used to determine the presence and degree of intellectual disabilities in children:

50-69 - mild degree. The child is capable of self-care, can perform simple work, has personal hygiene skills, but needs help in solving complex problems in learning and daily life, can show signs of social immaturity;

35-49 - moderate degree. The child has a speech delay, there are severe learning difficulties, impaired social interaction. It can perform instructions, simple tasks, but cannot function independently without outside support;

20-34 - severe degree. The child is unable to count and read, has a depleted vocabulary, communicates with gestures, needs constant support throughout life;

below 20 - deep degree. The child may have certain specific skills, but he has a limited understanding of what is happening around him, the understanding of the language is symbolic, he is not able to follow simple instructions and remains dependent on constant outside help.

Accordingly, our study involved children with mild to moderate intellectual disabilities. Thus, the first stage of empirical diagnosis was working with parents of children with special educational needs. In May 2022, a written interview was held with parents and legal representatives to identify the traumatic events that their children have faced since the beginning of the full-scale military events in Ukraine (Smith et al., 2014). Participants were asked to note in writing all the difficulties that children experienced during the war. Thus, table 1 presents the results of this survey.

**Table 1.** Traumatic events that children suffered during the war (according to parents / legal representatives)

<b>№</b>	<b>Event</b>	<b>Children - local residents (20 people),%</b>	<b>Children - internally displaced persons (6 persons),%</b>
1	They are forced to leave their city, town or village	25	100
2	Soldiers or armed men forcibly entered the house	0	66.6
3	The house was shelled	0	33.3
4	Separated from family	30	33.3
5	The parents are separated from each other because of the war	40	83.3
6	A family member went to the front to fight	35	50
7	A family member was wounded	5	33.3

	during the war		
8	A family member died during the war	0	16.6
9	Shooting at a very close distance	0	50
10	Remained in the basement for a long time during an air alert or shelling	100	100
11	Feeling of being very cold	70	100
12	Feeling of being very hungry	45	83.3
13	Seen the wounded	10	66.6
14	Experienced threats	0	33.3
15	Thought would die	85	100

Source: authors own conception

Thus, from the results of this survey, we saw that almost all child respondents (according to their parents) witnessed certain traumatic events related to hostilities in our country. Accordingly, 100% of local children and internally displaced persons remained in shelters for a long time during air strikes or shelling, more than 70% of children experienced severe hunger and cold, 85% thought they would die, and so on.

The next stage of the empirical study was the use of the questionnaire "General reactions of children after the war / military events"(Smith et al., 2014). Parents (legal representatives) of children with intellectual disabilities were asked to note the reactions they observed in their children during the last month. Table 2 presents the results of a survey of parents of local children and internally displaced persons.

**Table 2.** General reactions of children with intellectual disabilities after the war (under parental supervision)

№	Type of reaction / features of behavior	% of children who have this type of reaction
1	Irritability	73
2	Shivering, especially from loud sounds	96.1
3	Fears, timidity	92.3
4	Emotion	88.4
5	Anxiety	84.6
6	He is afraid to go outside, to leave the apartment	38.4
7	Solitude	26.9
8	Depressive disorders	15.3
9	Frequent crying	53.8
10	Easily upset over small things	80.7
11	Does not want to communicate, play with peers	46.1
12	Annoyance, getting angry quickly	76.9

13	Anxiety	84.6
14	Problems with concentration	96.1
15	Sleep disturbances, nightmares	57.6
16	Military themes in games	30.7
17	Reactions of grief	80.7
18	Fear of death of other family members	65.3
19	Loss of interest in daily activities	73
20	Whimsy or a quick change of mood	96.1

Source: authors own conception

The results of the questionnaire showed that more than 96% of children have tremors after loud sounds, problems with concentration, show capriciousness or rapid mood swings. 92.3% of respondents are timid and experience various fears, including fear of the death of other family members. 84.6% feel anxious and anxious, and 88.4% of children are anxious. Thus, we identified a significant frequency of emotional, behavioral changes in children with intellectual disabilities in war.

Next, we diagnosed stress disorders in children using the method of Luscher's color choices, which used an 8-color version of the method (Sobchik, 2007). The purpose of testing was that the subjects, choosing some colors and discarding others, construct seven color series. The set of incentives consists of eight color cards, these are the main colors: red, blue, yellow, green; achromatic: gray, black and mixed: purple, brown. An abbreviated version of the Luscher test includes one main scale, consisting of eight elements and several additional scales. All scales are interconnected and are considered part of one integrated structural scale. The method of color choices proposed by L. Sobchik is an adapted version of the Luscher color test. The method is designed to study the unconscious, deep-seated personality problems, current situation, basic needs, individual style of experience, type of response and the degree of adaptability of the subject. In addition, it allowed to identify the compensatory capabilities of the subjects, to assess the severity of painfully acute traits and clinical manifestations. According to L. Sobchik (Sobchik, 2007) with the help of this technique it is possible to diagnose the leading needs and features of response in everyday situations. Table 3 diagnoses the leading needs of children with intellectual disabilities affected by the war.



**Table 3.** Leading needs of children according to the Luscher method

№	Leading need and general condition	Number of children with dominance, %
1	The need for rest and harmony with others	15.4
2	The need to wait for change	73
3	The need for emotional relaxation and rest	80.7
4	Physical and psychological exhaustion	57.7
5	Subjective lack of strength	30.7
6	Feelings of anxiety, fear of loneliness, the desire to avoid conflict and stress	96.1
7	A state of emotional tension, increased anxiety, the desire to avoid difficulties	100
8	Stress caused by limiting one's independence by external obstacles	65.4
9	Lack of opportunity to realize the need to preserve one's own individuality and the "social niche" that would create a sense of understanding and security	23
10	The need for compassion, a sense of helplessness	92.3
11	Frustrated need for independence	19.2
12	Anger	69.2
13	Despair	38.4
14	Crash, failure and regression	53.8

Source: authors own conception

Thus, the results of the study of the leading needs and general condition of children with intellectual disabilities showed that all respondents (100%) are in a state of emotional tension, have increased anxiety and seek to avoid these difficulties. Thus, 96.1% of respondents experience feelings of anxiety, fear of loneliness and try to avoid conflicts and stress. 24 children (92.3%) need compassion and feel powerless. 80.7% of respondents need rest and emotional relief. More than half of the respondents (57.7%) showed physical and psychological exhaustion. Accordingly, from this we can make a preliminary conclusion that the children at the time of diagnosis were in a difficult psycho-emotional situation and needed immediate intervention to restore their psychological well-being.

The final stage of our diagnosis was the study of fears with the help of drawings What scary dreams I have and what I am afraid of during the day"(Isaeva, 2006). Some children (19.2%) did not draw their fears at all

(explained it for various reasons: "I'm not afraid of anything", "I don't know what to draw", "I can't draw it", "I don't want to draw", "I don't want to think about their fears "). Other participants overcame the barrier of fear in their minds, were able to reflect with strong-willed, purposeful efforts what they try not to think about, what they are afraid of, what hinders them.

After the child drew fear, she was asked certain questions:

1. What did you draw?
2. Is it your fear or some other person's?
3. Why are you afraid of this?

The completion of the diagnosis with the help of projective methods was an exercise, which can be attributed to the correction, the purpose of which was to reduce the degree of manifestation of fears and free the child from their persecution. When the child answered the question about his fear, which was drawn on a piece of paper, the paper was folded so that the picture was no longer visible and placed in a large beautiful box with the words: appeared, put it in this beautiful box, where he will never come out. And instead of this fear, we will give you a gift (candy, stationery, a book, etc.)! ” All the children were satisfied after such an "exchange".

As the results of the diagnosis indicate that children have severe psycho-emotional states, problems that require professional help, we have developed appropriate recommendations for psychological support of children with intellectual disabilities in war. The consequences of a child's mental trauma during a war may depend on how quickly the child receives help after the traumatic event, how well his or her own defense mechanisms work: self-esteem, self-confidence, problem-solving skills, and the belief that he or she can cope. a changed situation from the available emotional support.

The greatest harm can be done to a child by postponing a call for help (Wenger et al., 2006). The injury does not heal on its own, the problem is not solved and goes deeper and deeper. The child seeks to hide it under the protections and strategies by which he tries to cope with the situation. In fact, after the child uses all these mechanisms of protection and overcoming, the problem can "look" better. But it continues to affect the child's character, his dreams, form fears, destroy feelings of trust and plans (Yul & Williams, 2001).

The tasks of psychological support and assistance to children and adolescents with intellectual disabilities who have experienced severe mental trauma are fundamentally different depending on the time of its receipt - immediately after the injury or a few months. At the first stage of psychological support, the work in general can be described as medical-

psychological, at the second - as psychological. This determines the selection of specialists for such work (Mykyteichuk et al., 2022). Consider the main changes in children of different ages who suffered during the war (table 4).

**Table 4.** The main symptoms of psychological trauma in children with intellectual disabilities in wartime (Litvinenko, 2016)

Changes	Age from 4 to 7 years	Age from 8 to 11 years	Age from 12 to 17 years
Physiological	Sleep disorders: frequent awakenings, nightmares, etc. Enuresis, encopresis. Abdominal pain	Sleep disorders. Headaches. Abdominal pain. Nausea. Vomit. Stool disorders. Frequent urination	Sleep disorders. Headaches. tremor. Tiki
Emotional	Generalized fear. Lack of language expressions of concern - refusal to talk, "dumb" questions. Anxieties related to misunderstanding of death, destruction, murder, fantasy of "cure from death"; the expectation that criminals may return, attack. Aggressiveness.	Concern for one's own actions during events: concern for one's responsibility and (or) guilt. Specific fears that are triggered by memories or being alone. Fear of being overwhelmed by one's own experiences. Close attention to the condition of parents, relatives, fear of upsetting them with their worries. Fear and feelings of change caused by their own reactions of grief, fear of fire, loud noise, soldiers and others.	Shame and guilt. Fear of looking abnormal. Thirst for revenge and devising plans for revenge. Acute feeling of loneliness
Cognitive	Cognitive difficulties that manifest themselves in misunderstanding. Attributing mystical properties to memories of	Impaired concentration. Disorders of memory, thinking, speech. Academic learning difficulties	Impaired concentration, inattention. Memory impairment. Understanding your fears, your own vulnerabilities

	trauma. Difficulties in recognizing anxiety		and other emotional reactions
Cognitive	Helplessness and passivity in ordinary matters. Recurrent trauma. Anxious attachment (clinging to adults, unwillingness to be without parents). Regressive symptoms (finger sucking, babbling). Various communication disorders. Problems of adaptation to new institutions	Retellings and reproduction of events (traumatic games), distortion of their picture and obsessive detailing. Taking care of your safety and the safety of others. Disturbed or unstable behavior (for example, usually aggressive or reckless behavior, negativism).	"Disruptions" in illegal, deviant behavior. Dangerous way of life. Self-destructive or risky behavior. Sharp changes in interpersonal relationships.

Immediately after the traumatic event, the main task of psychological support for the affected children and adolescents is rapid relief of acute symptoms that interfere with the normal functioning of the child:

- restoration of normal sleep and nutrition (this creates favorable conditions for the recovery of the central nervous system);
- ensuring a normal level of overall activity and its streamlining;
- overcoming acute phobias, depressive states, acute anxiety, flashback effects;
- correction of gross communication disorders (Havrylkevych et al., 2021).

Removal of these symptoms contributes to the further normalization of the psychological state, intensifies the child's use of coping strategies and protective mechanisms of the psyche. Such tasks are typical of psychological support, which is not aimed at providing deep personal transformations, but at "getting rid of negative feelings, discomfort or depression."

According to the available data, a significant increase in the level of subjective well-being can be achieved in one or two psychotherapeutic sessions. Overcoming or reducing emotional discomfort is also important as a preventative measure that reduces the risk of further development of post-traumatic stress disorder. It is established that in the absence of special

preventive work, this disorder is found in 70% of children and adolescents who have experienced a severe traumatic situation (Andryushchenko, 2000).

Emergency psychological support and assistance to children with intellectual disabilities of primary school age:

1. Establish physical contact with the child - take him in his arms, hug him, shake him in his arms, it gives the child a sense of security.
2. Calm down with the words: "It is all over, I'm with you ...".
3. Take the child away as soon as possible from the place where the traumatic event took place.

Emergency psychological support and assistance to adolescents with intellectual disabilities:

1. Physical contact: touch to the shoulder, hands.
2. If possible, inform the child about what is happening.
3. Opportunity for the teenager to actively participate in solving the situation - to help others, smaller and weaker.
4. Verbal support: "You're great, you helped me a lot (you can help ...)".

The main task of working with the delayed consequences of a traumatic event is to restore the normal social and intra-family functioning of children with intellectual disabilities. It is important to ensure regular attendance at school (school, kindergarten). To restore the normal condition and functioning of children requires special work with the child's immediate environment, with parents and teachers.

Children, as well as adults, in a traumatic situation lose confidence in the world (Zavatskyi et al., 2020). Therefore, the key points of psychological support for a child with intellectual disabilities will be as follows.

1. Gradual restoration of the child's trust, given that she has a pronounced loss of trust in the world.
2. Refusal of standard diagnostic procedures before talking about traumatic events.
3. Creating a reliable environment during psychotherapy.
4. Adequate performance of rituals that help meet the child's need for safety.

For the gradual formation of trust are useful statements of a psychologist, which recognizes the problems experienced by the child. To work effectively with injured children, it is necessary to have a room divided into separate zones, each of which must be provided with the equipment and materials necessary for a certain type of activity:

- role-playing area (house with dolls, toy furniture and utensils; toy garage with a variety of machines and appliances; sets "Hairdresser", "Shop", "Hospital"; soft toys);
- area of constructive activity (sets of handicrafts, building materials and designers of different types);
- sports area (simulators, Swedish wall, mats, dry pool; balls, hula hoops; spring mattress);
- aggression response zone (punching bag and gloves; inflatable swords, hammers and batons);
- area of artistic activity (paints, brushes, water, pencils, pastels, plasticine, white and colored paper);
- water play area (water basin, floating toys, scoops);
- relaxation area (artificial aquarium, music center, mattresses, rugs, pillows, small "magic" accessories - elephants, bells, "dream catchers").

The space should be organized in such a way that the objects that fill it, themselves encourage children to appropriate activity. Toys and materials must be hung on the walls, laid out on the floor, as if left in the middle of an already started activity (Wenger et al., 2006).

During psychological care for children with intellectual disabilities, the diagnosis does not need to be allocated to an independent stage. This is due to the special brightness and obviousness of the symptoms targeted by therapy, as well as the need for emergency care. The assessment of the child's condition is carried out on the basis of observations, conversations, complaints of parents, analysis of reactions to psychological influences, etc. Only in some cases you can use special diagnostic techniques (in particular, the child can be offered some drawing tests).

With younger children, psychological support can be provided using the methods of play therapy, with older children - art therapy. Each lesson with a child should be built on the principle of a wave: first there is a gradual inclusion of the child in the activity, its intensity increases, reaches a certain maximum, which is determined by the psychological state of the child, and then decreases. The lesson ends with a quiet activity, such as drawing or a relaxation session. Before going home, the child can be given a toy, which is a reminder of joint activities with a psychologist and thus helps to consolidate the results of psychological support. Children also need to be offered materials for artistic activities; set homework (which you can not insist on): draw and bring a picture, make and bring a product.

When working with a child, the psychologist must constantly demonstrate a willingness to listen to the story of their behavior in an extreme situation, but never stimulate the actualization of traumatic

experiences, if the child does not want to tell about them. This is due to the fear of disrupting the protective mechanisms of the psyche and may exacerbate the pathogenic effects of a traumatic event. An important component of the psychologist's work is the involvement of parents in therapy (if possible), the restoration of their normal communication with the child (Yul & Williams, 2001).

The child, who first came to the psychologist, must first get acquainted with the room and tell in more detail about toys, objects that are in designated areas. If the child refuses to inspect the room (for example, sits on the carpet and sits for a long time, doing nothing), the psychologist can slowly and unobtrusively offer different activities: bring paper and paints, give a balloon, and so on.

At the beginning of work with a child who has experienced a traumatic event during the war, it is necessary to pay special attention to overcoming sleep disorders, which allows to provide favorable conditions for the recovery of the nervous system (Guillén-Burgos & Gutiérrez-Ruiz, 2018). Various forms of relaxation and control of the rhythm of breathing contribute to the restoration of sleep. One of the options for such control is the task of adjusting the breath to the rhythm, which is directly set by the psychologist (the psychologist counts slowly, and the child takes a breath at each expense). You can set the rhythm by taking the child's hands in their own and slowly, evenly raising (inhaling) and lowering them (exhaling), just as it is done with artificial respiration, but not so sharply. Another control option is to focus the child's breathing (according to the instructions: "Listen to how you breathe, but do not try to do anything with your breathing, do not try to control it"). Due to this, breathing becomes smooth and deeper. Such classes with children (parents can be taught to perform such tasks at home) help not only to restore normal sleep, but also reduce overall tension, help to overcome the state of acute anxiety, typical of a person who has experienced a severe traumatic event.

To restore the general level of activity it is necessary to use forms of work, the choice of which depends on the degree of initial inhibition of the child (Guillén-Burgos & Gutiérrez-Ruiz, 2018). Thus, with a particularly pronounced passivity, the psychologist can offer a variety of simple tasks to choose from: drawing, assembling puzzles or the simplest model from the designer, playing with dolls and more. The psychologist himself should take an active part in the activity, encouraging the slightest manifestations of the child's initiative. If the child refuses all these activities, the specialist should start playing or drawing in front of the child, periodically encouraging him to take part in it. Art therapy plays an important role in restoring overall

activity. Children can paint with gouache on a sheet of wallpaper spread on the floor. Sometimes at the initial stage, the child is more willing to agree to paint with a sponge soaked in paint (technique of "soaking"). You can also use paints for hand painting.

Restoration of activity is an effective way to overcome childhood depression. At the same time, it is often accompanied by the actualization of symptoms, which previously could not be detected precisely because of the general inhibition of the child. There are chaotic, unfocused actions, destructive and aggressive manifestations. In most children, whose activity level was not reduced at the time of treatment, such behavior can be observed simultaneously. To structure and organize the child's activity requires a gradual increase in the number of rules and restrictions (for example: "play - take away the toys"); only then can you move on to another lesson. For children whose condition is characterized by high activity, rules and restrictions can be set from the beginning of psychological support. A significant place must be given to the response to aggression. Children can be offered the following activities: fencing with inflatable swords and batons; punches on a punching bag or cardboard box; puncturing balloons; games with "horror stories" and toys depicting aggressive characters (wolf, crocodile, monster); marching, stamping feet; creating drawings with aggressive content; tearing paper or cardboard.

Care must be taken to ensure that aggression does not go directly to another person. Yes, even during fencing it is allowed to strike with a sword only on another sword, but not on a person. Usually, the reaction of aggression is accompanied by loud sounds, which is also useful in overcoming acusophobia (fear of loud sounds), which is present in most children who have experienced a traumatic situation during the war. Each aggression response session should end with a relaxation session.

In group work, as well as in individual, it is necessary to widely apply various forms of art therapy with tasks that require compliance with certain rules (Litvinenko, 2016). For example, group drawing with the transfer of the brush in a circle: each member of the group collects the paint, draws until the paint on the brush runs out, then washes the brush and passes it to the next participant. In case of mass traumatic situations (explosions, destruction of housing, hostage-taking, stay in basements, shelters) it is necessary to organize large-scale group work with children.

To restore the normal psychological state of the child after the trauma, psychological work with the whole family is of great importance. As a result of the injury, normal child-parent ties are broken, symbiotic or forced-distance relations between the child and parents arise. These two



types of disorders of intra-family communication are often combined with each other: in domestic relationships there is a symbiotic relationship, while emotional contacts are significantly weakened. With the advent of dysfunctional forms of children's behavior, parents feel their incompetence and helplessness and involuntarily contribute to the consolidation of negative stereotypes of behavior in the child.

If both parents and children experienced mental trauma during the war, the pace of recovery of their psychological state differs significantly. Usually children return to normal emotional levels faster due to greater mental flexibility and adaptive capabilities. The condition of parents changes more slowly and prevents the normalization of the mental state of children. Despite the fact that parents are concerned about providing support to their children, insufficient criticism of their own psychological state often forces them to avoid seeking psychological help. In this regard, special attention is paid to involving parents in working on their own psychological problems and difficulties.

It is especially important to work with families in cases where the family structure is disrupted due to the death of a father or mother. At the same time, intra-family ties are sharply disrupted, as the functions of the deceased do not pass to another family member (Andryushchenko, 2000). The most difficult category is male widowers raising young children. Manifestation of daily care for the child is an unusual function for them. Their emotional state can remain very difficult for a long time. This is reinforced by the common stereotype that seeking psychological help humiliates a man and indicates unacceptable weakness. Grandparents, who are not always physically able to perform this role and also experience mental trauma, often take on a heavy burden.

## **Conclusions**

We can now predict quite broadly how children with intellectual disabilities react psychologically to war. After the impact of the atrocities of war, everyone is in danger. When entire communities are at war or in political violence, many children may suffer. Although local and international organizations can treat children after (or during) war, the level of care needed for children can be reduced by acting early to prevent the symptoms that occur first (Zavatskyi et al., 2020).

The results of empirical research show that children with intellectual disabilities, who to varying degrees have become participants or witnesses of the horrors of war, have significant changes in physiological and psycho-emotional states. Almost all respondents show acousophobia, frequent mood

swings, problems with concentration, capricious, angry. Children experience various fears, anxiety and restlessness, and worry a lot. They are in a state of emotional tension for a long time, have increased anxiety and try to avoid these difficulties, feel their own helplessness. The results of projective techniques, response processes and children's stories were dominated by images of destruction and drawings on military themes.

That is why psychological support and assistance to children with intellectual disabilities who have survived an extreme situation should be provided, abandoning the usual treatment of symptoms, and considered as psychological support of the individual, aimed at positive change for integration and development of all levels of functioning. With this in mind, the specialist should keep this in mind.

1. The main and professional function of the psychologist in this work is to help the child in maintaining the existential contradictions that are inevitable in the process of change. To do this, you need to be empathetic and loving, not kind: this is the only way to keep an individual from a completely natural desire to escape from pain.

2. To really help a child you need to know a lot and take into account the degree of his intellectual disability. Necessary knowledge about the features of positive and negative experiences of mental trauma, and about the internal difficulties that may inhibit the restructuring of the child's lifestyle, and the dynamics of experiencing the consequences of an extreme situation.

3. In addition to knowledge, practical skills are also needed - it is important to master psychotechnics, which are the most adequate and effective at different stages of work with victims. It should be borne in mind that the work must be conducted at all levels of personality simultaneously (physical, social, psychological and spiritual).

4. It is important for a psychologist who works with children who have experienced an extreme situation to be in symbiosis with their own feelings that arise in the process of work. After all, a psychologist is inevitably exposed to the influence of his clients, whose condition can be contagious and traumatic.

5. Personal maturity is also required to work with traumatized persons. The psychologist must be mentally stable, reliable. He is called to be aware of his strengths and to soberly assess his own limitations and his human vulnerability.

When providing psychological assistance and support to children with intellectual disabilities who have experienced traumatic extreme situations, the psychologist must remember that their reactions are normal

and that there is no person who would not experience the consequences of crisis or extreme situations. Therefore, the prospects for further research are the development of a program of support and psychological assistance to various categories of children in wartime for students of psychology and its implementation during higher education.

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