Transformations in the Understanding of Specific Learning Disabilities in the Czech Context: A Historical-Comparative Perspective

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This paper traces the historical development of perspectives on specific learning disabilities in the Czech Republic, from the earliest insights in antiquity to the contemporary inclusive trends in education. It captures the evolution from the medical model to the psychological approach and, more recently, to pedagogical interpretations. The paper highlights key figures, legislative milestones, and institutional changes that have influenced the approach to educating pupils with specific learning disabilities. Attention is also given to educational support systems, remedial care, and current challenges in the fields of diagnosis and education. The text demonstrates how societal views on these pupils have evolved and how the system of care has shifted towards individualization, respect, and interdisciplinary collaboration.

Keywords: *specific learning disabilities, history, pupils with specific learning disabilities, support, dyslexia*

Introduction

Specific learning disabilities are not a new phenomenon – their manifestations were observed as early as antiquity and later addressed by prominent educational figures, including Jan Amos Komenský, who recommended adapting teaching to the individual needs of pupils. Currently, specific learning disabilities are viewed as neurodevelopmental differences that affect the ability to read, write, or calculate, while intellectual capacity and motivation for learning remain intact.[1] The contemporary approach to educating pupils with

[1] Snowling, M. J. – Hulme, C. (2012). Annual Research Review: The nature and classification of reading disorders – a commentary on proposals for DSM-5. *Journal of Child Psychology and Psychiatry, 53*/5, pp. 593–607. https://doi.org/10.1111/j.1469-7610.2011.02495.x

specific learning disabilities is influenced by a multidisciplinary perspective that emphasizes the collaboration of teachers, special educators, psychologists, and families. An essential factor in providing effective support is quality diagnostics and subsequent remedial intervention tailored to the pupil's specific needs.[2] Research indicates that the development of reading skills results from the interaction of biological, cognitive, and cultural factors.[3] In the context of international professional literature, dyslexia is also considered a consequence of a deficit in phonological processing, which can be mitigated through appropriate interventions.[4] Today, digital technologies are increasingly included into remedial care – their effective use can enhance the efficiency of teaching and contribute to increasing pupil motivation. Current trends thus focus on using technological tools as a supplement to pedagogical efforts, rather than as a replacement. Overall, the approach to pupils with specific learning disabilities is shifting from a purely deficit-based understanding towards a supportive model grounded in respect, individualization, and early intervention.

The Medical Approach

From the very beginning, the understanding of specific learning disabilities developed alongside advancements in neurology and related disciplines. The discovery of specific learning disabilities is not attributed solely to teachers, as might be expected, but also to medical professionals. Neurologists primarily viewed these disabilities through the lens of the functions of the individual cerebral hemispheres. The issue of specific learning disabilities has always been shaped by the interplay of theoretical and practical knowledge. Medical professionals and psychologists have played a significant role in shaping the historical perspective on this issue.[5]

In the 18th and 19th centuries, discussions centred on the localization of brain functions, where experts sought to determine whether the brain functions as a whole or is composed of regions responsible for specific functions. The shape of the skull roughly corresponds to the shape of the brain, and it was believed that, based on the study of skull contours, one could deduce aspects of personality traits. Attempts were made to localize speech functions to specific areas of the cerebral cortex. At the turn of the 19th and 20th centuries, difficulties in teaching pupils to read were often attributed to poor vision,

[2] Bartoňová, M. (2019). *Speciálně-pedagogická diagnostika a intervence u žáků se specifickými poruchami učení.* Brno: Masarykova univerzita.

[3] McBride, C. (2016). *Children's Literacy Development: A Cross-Cultural Perspective on Learning to Read and Write*. New York: Routledge.

[4] Høien, T. – Lundberg, I. (2019). *Dyslexia: From Theory to Intervention.* New York: Springer.

[5] Bartoňová, M. (2004). *Kapitoly ze specifických poruch učení I: vymezení současné problematiky.* Brno: Masarykova univerzita.

and parents frequently sought help from ophthalmologists. Visual perception problems were considered the main cause of specific learning disabilities until the 1960s. A specific area in the frontal lobe of the left hemisphere was discovered to be responsible for the motor aspects of speech. Damage to this area significantly impaired the ability to articulate, produce speech, and express oneself. Another area at the top of the temporal lobe was found to play an important role in understanding spoken language and in the content of verbal expression. Initially, researchers highlighted the loss or limitation of the ability to speak or understand spoken language as a result of brain damage. However, later findings revealed that brain damage could have subtler consequences, affecting not only spoken language but also written language.[6]

A significant milestone came with the identification of a distinct type of reading disorder that differed from true alexia. Pupils lost the ability to read despite having normal intelligence and intact vision. Subsequently, a developmental form of speech dysfunction was described, which did not manifest in spoken language but in written language, leading to developmental difficulties in acquiring reading and writing skills. Not only the clinical picture and possible origins of the disorder were described, but also therapeutic interventions, including the use of tonal lenses in glasses. However, the efficacy and clarity of these treatments were not conclusively proven. The modern approach to the study of dyslexia viewed the core of the specific reading disorder as rooted in impairments of speech functions. Delays and disorders in the development of speech functions were believed to arise from difficulties in establishing unilateral brain dominance in specific areas, with hereditary factors also being taken into account. Such disorders were thought to respond to specialized training, provided that a precise diagnosis was made and appropriate remedial methods were implemented based on the individual needs of each pupil. Dyslexia, defined as the misinterpretation of perceived symbols, was believed to have origins in imperfect hemispheric lateralization, which disrupted the cooperative functioning of the brain's hemispheres.

The Beginnings of Care for Pupils with Specific Learning Disabilities in the Czech Republic

In the Czech context, the pioneering figure and founder of the field of specific learning disabilities is the distinguished psychiatrist Prof. Dr. Antonín Heveroch. In 1904, he published an article in the teaching journal *Česká škola* titled „O jednostranné neschopnosti naučiti se čísti při znamenité paměti." Using the case of an eleven-year-old girl with average intelligence, Heveroch described reading difficulties that resemble what we now recognize as dyslexia. He viewed this as a one-sided disorder stemming from minor anomalies in the

[6] Matějček, Z. (1972). *Vývojové poruchy čtení.* Praha: Státní pedagogické nakladatelství.

speech areas of the left hemisphere of the cerebral cortex. Unfortunately, as Heveroch himself predicted, research and practical care for these pupils (as was the case internationally) remained largely confined to the medical field for a long time. Heveroch also contributed to the journal *Pedagogické rozhledy* with an article titled „Dítě neposeda“, in which he described a child with mild cerebral dysfunction. The first scientific approach to this issue was later published by Otokar Chlup.[7]

Experimental Research in Healthcare (1950s)

Another significant group that addressed the issue of specific learning disabilities approached it from a psychological perspective. According to this view, the causes of specific reading disabilities are seen as a manifestation of a disrupted emotional relationship with a particular person, stemming from a neurotic foundation. In terms of therapy and support, psychotherapy was introduced. In the Czech context, this issue was addressed by experts from the psychiatric hospital in Dolní Počernice, with psychologist Josef Langmeier (1952) playing a key role in systematically addressing the remediation of specific reading disabilities. Langmeier worked at the children's psychiatric hospital in Havlíčkův Brod.[8] In 1954, this care moved to the children's psychiatric hospital in Dolní Počernice, thanks to Otakar Kučera, who became the head of the psychiatric department there. Pupils with severe reading disabilities, who had experienced academic failure and displayed neurotic difficulties and behavioural anomalies, were admitted. Only after thorough and specialized examinations did it often become clear that the primary cause of their problems was dyslexia. Among the main findings were: before starting remedial education, the root cause of reading disabilities must be identified; optimal learning conditions must be ensured; develop methods tailored to the structure of the language; allow the pupil to reinclude into regular life. [9]

Kučera was one of the first experts to approach the classification of specific learning disabilities based on etiology through his research. He classified specific learning disabilities into three groups: encephalopathic (mild brain dysfunction), hereditary, and mixed.[10]

Since the 1930s, parallel movements have emerged that view the main causes of specific learning disabilities as the result of a multifactorial combination of factors, including health, neurotic, sensory, psychological, motivational, and social aspects.[11]

[7] Chlup, O. (1925). *Výzkum duševních projevů u dětí méně schopných.* Brno: Filosofická fakulta.
[8] Langmeier, J. – Matějček, Z. (1966). *Neprospívající dítě.* Praha: Ústav zdravotní výchovy.
[9] Kučera, O. a kol. (1961). *Psychopatologické projevy při lehkých dětských encefalopatiích.* Praha: Státní zdravotnické nakladatelství.
[10] Černá, M. a kol. (1992). *Lehké mozkové dysfunkce.* Praha: Karolinum.
[11] Pokorná, V. (1997). *Teorie, diagnostika a náprava specifických poruch učení.* Praha: Portál.

The Emergence of Specialized Classes and the Shift into the Education System (1960s)

A different perspective on specific learning disabilities emerged from a theoretical standpoint, particularly in the field of educational practice. Teachers developed special methods for working with pupils, focusing on mastering basic reading, writing, and arithmetic skills. Among Czech authors, Hana Tymichová[12], Olga Balšíková,[13] and A. Fryaufová contributed significantly to the development of specialized tests. In 1962, the first dyslexic (specialized) class was opened in Brno. The establishment of this class was supported by Dr. Vratislav Vrzal,[14] psychologist E. Kloubková, and teacher Věra Reinerová.[15] In 1966, the first book titled „Poruchy čtení a psaní" was published as part of the „Na pomoc učiteli" series, written by Jaroslav Jirásek, Zdeněk Matějček, and Zdeněk Žlab.[16] The inclusion of pupils with dyslexia into the educational system came in 1967, when chief physician Luděk Černý from the children's psychiatric hospital in Dolní Počernice advocated for the creation of seven experimental classes in primary schools in Prague.[17] In Karlovy Vary, under the leadership of Tymichová, a primary school for pupils with dyslexia covering grades 1-5 was established in 1971.

Official Adoption of the Issue in Education (1970s)

On February 20, 1972, the Ministry of Education issued guidelines for the establishment of specialized classes for pupils with specific reading and writing disabilities, as well as for pupils with school adjustment difficulties. By the end of the 1970s, around 1% of pupils attended specialized classes. These classes had smaller groups of pupils, special educators, and adapted grading and classification systems. Remediation took place directly in the educational environment, with individualized speech therapy care. The official adoption of this issue in education was supported by the establishment of educational and psychological counselling centres in the early 1960s. These centres began focusing on diagnostics, interventions within the school environment, training dyslexic assistants, and providing education and methodological guidance.

[12] Tymichová, H. (1985). *Nauč mě číst a psát.* Praha: Státní pedagogické nakladatelství.
[13] Balšíková, O. – Dan, J. (1991). *Náprava čtení a psaní.* Praha: Státní pedagogické nakladatelství.
[14] Vrzal, V. (1969). *Proč vaše dítě neumí číst.* Brno: Krajské ústředí zdravotní výchovy a osvěty.
[15] Reinerová, V. (1981). *Dítě s vývojovou poruchou čtení a psaní na základní škole.* Brno: Krajský pedagogický ústav.
[16] Jirásek, J. – Matějček, Z. – Žlab, Z. (1966). *Poruchy čtení a psaní: vývojová dyslexie.* Praha: Státní pedagogické nakladatelství.
[17] Černý, L. (1983). *Dětské neurózy.* Praha: Ústav zdravotní výchovy.

In the 1970s, a variety of diagnostic materials, instructional guides, aids, and professional texts were created, some of which are still in use today.[18]

Stabilization and a Relatively Unified System (1980s)

During the 1980s, the issue increasingly moved from specialized classes into regular classrooms, with a focus on training primary school teachers. By the early 1990s, a five-tier system of remedial care had been developed and stabilized, which defined the possibilities for educating pupils with specific learning disabilities based on the severity of their disorder: (1) The mildest forms of specific learning disabilities were addressed directly in regular primary school classrooms by the class teacher. For example, the teacher would adapt teaching methods for the pupil with specific learning disabilities, assign additional exercises, and apply basic remedial techniques. (2) Some schools for pupils with specific learning disabilities established so-called mini-dyslexic classes, where pupils with learning disabilities from the same grade were grouped together for Czech language instruction. Other subjects were taught with their regular class. Czech language instruction was led by special educators. Another option was the creation of a so-called dyslexia cabinet or other specific learning disabilities, equipped with special tools and methodological materials. This cabinet was led by a special educator or a trained teacher, who worked with pupils in small groups (two to four pupils). Pupils would attend these sessions instead of certain regular lessons. (3) In cases of more severe disabilities, remedial exercises were carried out by parents under the supervision of a staff member from the educational and psychological counselling centre. (4) The pupil was placed in a specialized class. (5) The most severe cases, requiring complex care, could be hospitalized in children's psychiatric hospitals.[19]

In 1986, a methodological guide for the assessment and classification of pupils with specific learning disabilities was published. In 1989, the World Conference on Dyslexia was held in Prague. Since the second half of the 20th century, dyslexia had become a global issue. Overall, Czechoslovakia was recognized for its well-developed care for pupils with specific learning disabilities.[20]

Professor Zdeněk Matějček is considered a classic figure in the care and support of pupils with specific learning disabilities in our country. This world-renowned child psychologist was a pioneer in the field of specific learning

[18] Šauerová, M. – Špačková, K. – Nechlebová, E. (2012). *Speciální pedagogika v praxi: komplexní péče o děti se SPUCH.* Praha: Grada.

[19] Vašutová, M. (2008). *Děti se specifickými vývojovými poruchami učení a chování a násilí ve školním prostředí.* Ostrava: Ostravská univerzita.

[20] Smečková, G. (2013). *Specifické poruchy školních dovedností - vstup do problematiky.* Olomouc: Univerzita Palackého.

disabilities, deprivation, disorders of intellectual development, and institutional and family care. He dedicated more than 35 years to this field, publishing numerous monographs, scientific papers, and professional publications. He was also the head of the Dyslexia Society in our country. His work is highly regarded not only by experts and teachers but also by parents. For his work, he received the highest accolades. Lili Monatová highlighted research in the field of computer games, which positively influence pupils' speech development. She also focused on preschool education, particularly early intervention.[21]

Politics of Integration (1990s)

After 1989, the care for pupils with specific learning disabilities, as well as for pupils with other disabilities, increasingly emphasized integration. Individual integration in regular classrooms was defined by Decree No. 73/2005 Coll., on education of children, pupils and students with special educational needs and exceptionally gifted children, pupils and students, as the preferred form of education for pupils with disabilities. The goals shifted from the traditional emphasis on knowledge in basic subjects to the development of all aspects of the pupil's personality, with respect for the social needs of the pupil.[22]

The willingness of regular schools to accept pupils with specific learning disabilities into their classrooms and provide them with proper support was encouraged by increased norms. If necessary, an individualized education plan could be developed for the integrated pupil, which was a binding document to ensure the pupil's special educational needs. It included information such as the provision of individual care, educational goals, and a list of compensatory and teaching aids. The individualized education plan was usually created by the class teacher, based on recommendations from a school counselling facility.[23]

In the field of counselling, the trend was to differentiate workplaces according to their area of expertise, leading to the establishment of the Institute for Pedagogical-Psychological Counselling, centres of educational care, special education centres, and the development of school counselling services. The private sector focused on professional care, creating methodological materials, publishing, and producing educational tools and computer programs.[24]

A significant event was the founding of the Czech Dyslexia Society in 1999, which became a member of the International Dyslexia Association in 2000 and the European Dyslexia Association in 2001.

[21] Monatová, L. (1996). *Pojetí speciální pedagogiky z vývojového hlediska.* Brno: Paido.
[22] Michalová, Z. (2001). *Specifické poruchy učení na druhém stupni ZŠ a na školách středních.* Havlíčkův Brod: Tobiáš.
[23] Zelinková, O. (1994). *Poruchy učení.* Praha: Portál.
[24] Selikowitz, M. (2000). *Dyslexie a jiné poruchy učení.* Praha: Grada.

Support for Pupils with Specific Learning Disabilities in the 21st Century

Forms of education and the provision of remedial care were based on recommendations from educational and psychological counselling centre or in collaboration with special education centre and Dys-centre: (1) Individual care provided by the homeroom teacher within regular class – this form of care was applied to milder forms of learning disabilities within the regular primary school class. The teacher was expected to have basic knowledge and skills regarding the issue and to create the best possible conditions for remedial procedures. The pupil could also be integrated into the regular class if the learning disability was more severe and the conditions for integration were met. Integration was recommended for pupils with average or above-average intelligence, who were curious and easily adaptable. (2) Individual care provided by a teacher who has completed a specialized training course – the care was also provided by a special educator. He worked within the primary school classroom, led dyslexia support groups, dyslexia cabinets, and remedial care, while consulting with school counselling facilities. (3) Individual care classes established in primary schools – these classes were attended by pupils throughout the day. They typically focused on Czech language lessons with an emphasis on remedial care, and after these lessons, the pupil would return to their regular class. Remedial care was typically provided by a special educator. (4) Mobile teacher – typically a worker from an educational and psychological counselling centre or a special educational centre, the mobile teacher visited primary schools to provide remedial care during lessons. Remedial care was provided before and after lessons. (5) Specialized classes for pupils with specific learning disabilities – these classes had a reduced number of pupils (12). The lessons were taught by a special educator. These classes were established at primary schools, and for pupils with a diagnosed specific learning disability, an individualized approach was preferred. The designed remedial care took place throughout the entire educational process. Placement of pupils in specialized classes was based on the results of professional assessments and recommendations from the relevant school counselling facility, with the consent of the pupil's legal guardian and the school principal. Education in such a class required teamwork between teachers, school counselling professionals, parents, and pupils. The placement of pupils in smaller groups of peers with the same disability allowed for intensive and continuous special educational care, aimed at helping the pupil overcome their functional impairments in the central nervous system and develop a positive attitude towards education. This form of care was considered more beneficial than integration into a regular class for certain pupils. It was particularly suitable for pupils with average or slightly below-average intellectual abilities, those who were less adaptable, introverted, had neurotic traits, worked at a slower pace, and needed individualized attention. (6) Special schools for pupils with specific learning disabilities – a team of

specialists took care of the pupil, ensuring individualized and, therefore, special care throughout the entire educational process. (7) Child psychiatric hospitals – in the classes at psychiatric hospitals, pupils with severe disabilities were treated and educated. Remedial care was also provided here. These pupils typically had multiple disabilities, and therapeutic care was also provided. (8) Individual and group care in educational and psychological counselling centre, special education centre, and Dys-centre – group care was conducted in the form of educational and stimulation groups or individually guided remedial sessions. Parents were involved in this care, participating in joint group sessions, which also had a significant motivational effect on their children. These groups were organized not only for preschool children but also for primary school pupils.[25]

Current Practices in the Care of Pupils with Specific Learning Disabilities

Another evolving direction contrasts with the neurological approach. In this perspective, educators and psychologists argue that specific learning disabilities do not stem from brain dysfunctions but rather manifest as a reduction in the pupil's abilities. In pupils with reading disabilities, causes for performance failure can be identified that are not neurological. Help and support should therefore focus on changing the methodological approaches within the educational process, as well as altering the home environment.

Another area that continues to evolve is the theory of right-hemispheric or non-verbal learning disabilities. These disabilities are linked to difficulties in spatial perception, poor emotional regulation, and an inability to navigate social relationships. These issues are sometimes associated with impairments in deeper brain structures.[26]

The emphasis on inclusive education for pupils and the shortcomings associated with imprecise diagnostic criteria for pupils with specific learning disabilities contributed to the introduction of the three-tier care model: First level of care (individualized teacher support) assumes that for pupils who are experiencing early learning difficulties, teachers will minimize or eliminate them through immediate intervention. It is essential that teachers are professionally skilled and experienced in reading, writing, and arithmetic instruction. Close collaboration with the family is crucial. Teachers should offer regular consultations to parents, explaining the issues and approaches. The recommended duration of this stage is six months (at least three months), during which the teacher creates a portfolio and conducts educational diagnostics. If no improvement is seen, and the learning disabilities are not minimized, the pupil will be recommended for the second level of care. Second level of care

[25] Bartoňová, M. (2012). *Specifické poruchy učení: text k distančnímu vzdělávání.* Brno: Paido.
[26] Kocurová, M. (2000). *Specifické poruchy učení a chování.* Plzeň: Západočeská univerzita.

(pedagogical support plan) – in the second phase of intervention, the teacher consults the issue with staff from the school counselling workplace (such as a school special educator, school psychologist, or potentially a educational counsellor) or external school counselling facility. They will receive methodological guidance from professionals who visit the school. Based on these consultations, a pedagogical support plan is developed. This intervention is more intensive and should last from three to six months. If no improvement occurs, the pupil is referred for a comprehensive assessment at an educational and psychological counselling centre. Again, cooperation with parents is key. Third level of care (specialized interventions at a professional centre, individualized education plan) – based on the comprehensive pedagogical-psychological diagnostic assessment, the centre determines whether the impairment is severe enough to warrant a formal diagnosis. The pupil will then receive expert intervention in the form of specialized remedial methods and approaches. According to the relevant legislation, inclusion and the creation of an individualized education plan will be recommended for the pupil.[27]

The three-tier care model supports the enhancement of professional competence, skills, and prestige among teachers. It is an operational system that allows for timely and efficient problem-solving and serves as a preventive measure for educational failure. Currently, the preventive-intervention care model is complemented by a system of support measures, as its first level directly mirrors this support system.[28]

The success of educating pupils with specific learning disabilities is contingent upon the creation of an appropriate educational program and the implementation of suitable support measures. It is advisable to use alternative methods for acquiring knowledge and skills when teaching such pupils. Schools may adjust entrance and final exams for pupils with specific learning disabilities. Some degree of tolerance should be applied in evaluation and grading, but it is also important to consider tolerance in areas such as reading, handwriting, expression difficulties, and the use of computers in teaching.[29]

[27] Mertin, V. – Kucharská, A. a kol. (2007). *Integrace žáků se specifickými poruchami učení – od stanovení diagnostických kritérií k poskytování péče všem potřebným žákům.* Praha: Institut pedagogicko-psychologického poradenství České republiky.

[28] Kucharská, A. – Pokorná, D. – Mrázková, J. a kol. (2014). *Třístupňový model péče (3MP) ve školách zapojených v projektu RAMPS-VIP III.* Praha: Národní ústav pro vzdělávání, školské poradenské zařízení a zařízení pro další vzdělávání pedagogických pracovníků.

[29] Michalík, J. – Baslerová, P. – Felcmanová, L. a kol. (2015). *Katalog podpůrných opatření pro žáky s potřebou podpory ve vzdělávání z důvodu zdravotního nebo sociálního znevýhodnění: obecná část.* Olomouc: Univerzita Palackého.

Conclusion

Currently, society is changing its approach and attitude towards pupils with specific learning disabilities. The issue of comprehensive care is being addressed, including for individuals in adulthood. One of the problems related to literacy concerns specific learning disabilities in adults, individuals who are at risk due to limited access to traditional education. While poor reading skills were previously not considered a significant issue and a poor reader was not seen as an exception, modern society is placing strong emphasis on basic education for the entire population. Education is now regarded as a priority and a marker of societal prestige. Persistent learning deficits in individuals with specific learning disabilities bring about numerous challenges, which continue to affect individuals into adulthood. The issue of care and support for pupils with specific learning disabilities is addressed by current legislation and well-developed strategic approaches. In the Czech context, we can observe a significant shift in how specific learning disabilities are perceived and how they are approached in educational practice. Previously, the medical model predominated, which viewed specific learning disabilities primarily as an individual deficit requiring expert diagnosis and specialized methods outside the regular school environment. This model emphasized the identification of the disability rather than the development of the pupil's potential. However, there is now a growing emphasis on a more comprehensive approach, which understands specific learning disabilities in the context of the pupil's broader psychosocial functioning and in connection with the environment in which the pupil is educated.

A significant feature of this transformation is the shift towards a supportive and inclusive educational model. This model does not focus on labelling pupils, but rather on the early identification of their needs and the flexible provision of support measures within the regular school environment. There is an increasing emphasis on interdisciplinary collaboration, where teachers, special educators, school psychologists, and families of the pupils come together. The Czech system is thus beginning to more closely reflect international approaches, which focus on preventing school failure, strengthening the pupil's strengths, and naturally including support into daily teaching practices. From a historical-comparative perspective, this shift represents a transformation in values – from a focus on performance and diagnosis to cultivating a supportive environment that allows all pupils to meaningfully develop.

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