

# Taking Care of Psychomotor Development Delay of a 7 Year-Old Boy in Lubumbashi - Study Carried Out at BalouCenter

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**Abstract:** *This study is about taking care of psychomotor developmental lag of a 7-year-old boy in Lubumbashi, whose field data collection was carried out by KarungiMave Hope whom we thank. It aims to determine factors that can be at the root of this lag in psychomotor development in order to help the patient to integrate into the society and to become independent. The clinical method supported by the interview and clinical observation made it possible to collect the data, the analysis was carried out thanks to the content analysis and finally the thematic analysis served us in the processing of the results. After supportive psychotherapy and psychomotor exercises, we came to the physical, social and behavioural changes and there was autonomy in personal care. The patient has become independent, jovial, he talks and plays with his entourage, jokes, undresses alone and he now has friends. On an emotional level, we have seen recognition of self-image, a smile and good self-esteem.*

**Keywords:** Taking care, Motor development and lag in psychomotor development

## 1. Introduction

Generally speaking, human development is observed during certain well-defined periods of life, it is possible to know how humans develop; why they develop; how and why mental processes, behaviours, performance and skills change (get developed or get lost) during their human life.

For Hotyat (1978), a development is all of the constant progress in the behaviour of the child over a period of time, but this general term covers very diverse transformations: behaviours not yet displayed before; the pace of the efficiency of behaviours and the pace of the progress of an activity. But, it happens to notice the lag of the motor development which besides is observed in the whole world, characterized by the non-acquisition of standards of development at the programmed ages. Psychomotor lag or delay can be global (affecting all types of acquisitions), or concern only one of them.

Henri (1962) believes that child psychology has assumed an increasing importance and influence. Chaix (2008) adds that the evaluation of the psychomotor and psycho-intellectual development of infants and normal children will schematically include the evaluation of motor acquisitions and cognitive capacities of the child while ensuring normal brain growth. It follows from our observations at the Balou / Kimbembe medico-psycho-pedagogical centre, the presence of a child who is 7, but who still cannot walk. This situation is at the root of marginalization and stigmatization of this child by certain parents, neighbours as well as friends of the child's parents. This is why we have understood that there is a problem of psychomotor development, therefore we asked ourselves the following question: what would be the psychotherapies which could make it possible to take care of this child? This question conducts all of our work, the point below attempts to answer it provisionally.

Based on the assumption that the strategy for taking care of psychomotor developmental lag would be the psychomotor

rehabilitation, our goal is to determine psychomotor management in order to improve the state of our participant and that of his family. This work will allow other researchers to deepen or enrich knowledge in the field of clinical psychology and more specifically in psychomotricity.

## 2. Theoretical Foundations

The theoretical foundations of this research relate to the definitions of basic concepts and theories inherent in psychomotor development.

### 2.1 Definitions of basic concepts

Three concepts hold our attention in this study, namely: taking care, motor development and delayed psychomotor development.

#### 2.1.1 Taking care

Taking care is a polysemic term, its use depends on the area in which it is registered. According to Reverso (1967), it is a consideration that a therapist brings to a patient who needs help with their problem for their psychological reintegration and integration. For Jehel & Lopez (2006), it is taking someone, taking care of them, guiding a person who presents psychiatric problems for a decision on their state of health and showing their responsibilities in their problem. As for us, taking care is a help that we bring to a person in the management of a pathological or normal situation, while directing them towards some avenues of solutions in which he himself is an actor to make good arrangements facing their problem.

#### 2.1.2 Motor development

Rigal (2003) says that motor development is the appearance and natural and continuous evolution of the motor functions specific to the species, by interaction between genetic and environmental factors. The development of the physical system in action proposed by Bril & Lebel (1994)

Volume 9 Issue 4, April 2020

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corresponds to the morphological evolution linked in particular to musculoskeletal development and then takes into account the anthropometric characteristics and the mechanical constraints imposed by the body. Dupoux & Melher (1990), admit that motor development is essentially determined by the maturation of the central nervous system and the baby walks when he has to walk, speaks when he has to speak so the environment cannot modify what has been defined by the organism genetic program. Having regard to these definitions, psychomotor development is part of a global development process during the ontogeny of child development which is marked by significant morphological changes. This period of learning to walk also corresponds to the period when growth is the fastest.

### 2.1.3 Lag in psychomotor development

According to Larousse (2011), developmental lag is a time lag in a function or activity that appears in an individual after the time it appeared in other individuals of the same age. Developmental lag or delay is defined as a significant delay (two standard gaps below the average with a standardized tool or its equivalent) in at least two development spheres (Shevel, 2003). For us, any child suffering from retarded psychomotor development is considered to have vulnerability or an overall developmental delay, the child is usually judged to be at risk of experiencing possible problems for their future adaptation.

## 2.2 Explanatory theories of the psychomotor development

The theories mobilized in this study respect the Bio-Pscho-Social model to properly discuss the results relating to the delay in psychomotor development in children. Psychomotor disorders are neuro developmental according to Albaret, which affect the subject's adaptation to their perceptivomotor dimension. Michel (2018) develops the theory that in children, the notion of development is associated with a period of rapid and normalized change with reference to relatively fixed ages. Psychomotor retardation is a problem health situation, which disrupts the development of the subject as well as that of those around them. That's why other researchers like us have done studies on this. Gesell (1946) spoke of the evolution of motor development to psychomotor retardation in walking on children. According to Mulio (2011), there is growing interest worldwide in the analysis of this phenomenon. The study on the growth of children today provides valuable information both on this growth and on the conditions, which can hinder or promote the development of the subject.

Developmental progression goes through successive stages which offer the subject new capacities (notably social, cognitive and sensorimotor) which appear in particular in the clinic of Normal by following evolutionary processes. For Thomas (2004), the child is held in an upright position with one hand placed in the upper thoracic region. We first observe the straightening of the lower limbs and trunk, so that the child supports for a few seconds a large part of the body weight. Thus, the child is slightly forward, and a succession of steps is observed, automatic walking involves a rhythmic contraction of the antigravity muscles triggered by skin contact with the sole of the foot.

### 2.2.1 Biological factors

The concept of maturation is frequently used to describe these changes which are linked to a sequential process programmed at the genetic level (in the sense of the chromosomal genes). Psychologists who consider that development corresponds to a process entirely and strictly determined by biological factors (anchoring of a fixed genotype from the conception strongly marking human destiny) are called maturationists, innatists (preponderant force of the innate) or even preformists.

### 2.2.2 Social factors

Unlike biological factors, social factors are only initiated by the environment, by its own rules and laws (invented by the "socius" during the history of civilization), but also by passing through complex features from each microsocial environment (communities, families, etc.). For Gesell (1949) the environment in which the child grows therefore intervenes only moderately in the unfolding of developmental sequences. We find that in this sense, social factors are not pre-programmed but largely organized by the social world and in particular by life experiences. In Freud's approach (1856), the role of the environment in development becomes preponderant compared to that of maturation. The individual is shaped by their personal experiences and the interpersonal relationships they developed, especially during childhood, a period of intense psychic construction.

### 2.2.3 Psychological or cognitive factors

The changes taking place in thought (representations of the world, of oneself, of the other, etc.), the notion of intelligence, access and deployment of language are examples of developmental factors of a cognitive nature. They directly involve the idea of "cognitive awareness" of oneself and the world.

Cognitive factors are the most open and the least programmed. They are also intimately linked to biological and social factors: without the biological formation of the cortex (made possible by ontogenesis), without stable knowledge or without relative predictability of the environment, cognitive generalization (functional and neurophysiological connections at the cerebral level) cannot develop. According to Harlow & Bowlby (1905), the need for social contact, for attachment to one's mother or to a fellow member appears here to be free of any link with the satisfaction of primary needs (such as food need) and is considered as an innate characteristic of the species.

We emphasize that it is evident that development is placed under the control of biological ontogenesis, more particularly during embryogenesis and at the beginning of life. But it would become less and less channelled, determined, during its successive phases. The cognitive and social factors would take an increasingly important place in the later phases. The variable "age" therefore does not provide the same wealth of information according to the different periods of life. As development progresses, data such as the state of health, intellectual capacities, economic resources and cultural affiliations of the family environment are increasingly essential to grasp the developmental challenges in a subject.

At each age, the child is supposed to develop certain aspects of these cognitive, social and biological aptitudes but also of psychoaffective nature (to its various degrees: management of instinctuality, emotional manifestations, expression of feelings).

Normative events related to age: Walking, access to language, the development of puberty or the rhythms of schooling are all events encountered by each individual of a given culture at the same time in their life and, finally, at a given age. As their name suggests, these events are closely linked to chronological age. They include not only biological benchmarks but also socio-cultural indices. These events are responsible for intra-individual differences (changes in abilities within the same individual) and inter-individual differences (which is the source of differences between individuals, of differences between distinct groups).

Psychomotor development according to Hotyat (1978) is that the orientation of one activity towards functional play, the mobility of one attention and the very least analytical character of one perceptions hinder one's progress towards efficiency. But many of these factors will change quickly between 3 and 7 years. According to Piaget (1896) each stage is characterized by an overall structure, and corresponds to a level of equilibration. They follow one another in the same order for all children, even if the age of access to each stage can vary a little for example under the influence of the environment. The age indicated here should therefore not be considered as an absolute standard, but only as a benchmark. Contrary to what Piaget thought, it is now shown that the progression within a stage can vary depending on children. The transition from one stage to another is due to an important acquisition which will change the child's usual mode of functioning.

#### 1) The sensorimotor stage

From birth to two years (0-2 years). As the name suggests, this stage corresponds to the development and coordination of the baby's sensory and motor capacities. It is characterized by the exercise of sensorimotor actions. The intelligence that will manifest itself at the end of the first year is due to the mobility of the schemes, but it is an intelligence that is still only practical (linked to action). At the end of the second year, the emerging mental representations will allow the child to manipulate in thought and no longer only in action. They will therefore allow internalization of actions.

#### 2) The preoperative period<sup>1</sup>

From 2 to 7-8 years old, this is a preparatory period towards the 3rd stage, but which deserves to be studied in itself, by the importance of the acquisitions of this period in particular those which characterize the semiotic or symbolic function. During this period there is internalization of the action.

#### 3) The concrete operating stage

<sup>1</sup>We keep this word 'period because, for Piaget, a stage is characterized by a set of structure, it is the case of the previous: sensorimotor stage, and of the following: stage of concrete operations. We are here on important evolutive processes, but which present no formal structure of stage.

From 7-8 years old to 11- 12 years old. The growing mobility of the child's mental structures leads him to consider other points of view than their own. He becomes capable of mental operations that are to say of internalized and reversible actions: the child can conceive that to each action performed corresponds an inverse action which allows for example to return to the previous state. He becomes able to understand that a modification of a property of the object does not simultaneously affect all the possible properties of the object, and that certain invariant properties allow to return to the previous state. Mental operations are coordinated into whole systems which are structures (for example logic-mathematical or infra-logical). What differentiates this stage from the following is the fact that the mental operations of children of this age relate to concrete material which serves as the basis for their reasoning, which is therefore still very dependent on the content to which it applies.

#### 4) The formal operating stage

From 11-12 years old to 15-16 years old. The adolescent's handling of mental operations has progressed a lot, in particular because he becomes able to reason, no longer on concrete material as before, but on more abstract material, such as verbal propositions or algebraic signs: he becomes capable of formalization, the form of their reasoning dissociates from the content to which they apply. He thus develops a formal logic and their reasoning becomes hypothetico-deductive (he becomes able to formulate hypotheses and submit them to verification).

These transformations of thought with age occur very gradually, in the incessant dialectic of assimilating and accommodating exchanges between their conceptual thinking and the data of experience, through the succession of phases of imbalance and rebalancing of their thinking. We therefore go through progressive and continuous transformations of intelligence.

### 3. Method

This point is devoted to the presentation of all the steps taken in carrying out this work relating to taking care of psychomotor developmental lag of a 7-year-old boy in Lubumbashi. It is structured as follows: context, participants and measures.

#### 3.1 Context

For Riviere (2000), children's motor activity is a fundamental instrument for conquering their world. This instrument cannot be studied only from a physiological point of view. It must be related to the psychic life of the child. With regard to Thomas, (2004) psychomotor development corresponds to the evolution of psychomotor acquisitions in infants and children. These are particularly numerous from birth to the age of 3. This development depends on many factors such as genetic and environmental factors, the integrity and proper maturation of the nervous system, the quality of sensory and proprioceptive information, and the quality of cognitive and affective development. So the child's story is important to better understand their development and possible disorders. Carric (1999) adds that

in the event of psychomotor retardation, psychomotricity management is generally indicated. Depending on the child's difficulties, the rehabilitation and therapeutic axes may concern psychomotor awakening, sensorimotor exploration, or one of the psychomotor items (praxis, tonic regulation, space, time, etc.). The diagnosis is made from the interview with parents, who find a frequent delay in different stages of motor development: to sit, to crawl, to walk. Signs of examination are obtained by asking the child to jump with both feet together, with one foot, to stand on one leg, to tap with the finger, to tie a lace, to catch a ball ... Confirmation is ensured by a psychomotor assessment. Psychometric tests find "performance" or "non-verbal" scores lower than "verbal" scores. This disturbance can seriously interfere with schooling and activities of daily living.

In the Congolese context, the lag in psychomotor development is a function of socio-economic, family, environmental conditions and the level of education. This is why in Lubumbashi in particular, when we find that a small child does not seem to be in the same phase with the characteristic and habitual skills of other children of their age, at first some people attribute this fact to the occult world. So the victim's family turns to soothsayers, traditional healers, witch doctors, pastors and other servants of God. On the other hand, if the retardation of psychomotor development is perceived as a specific developmental disorder manifested by motor difficulties resulting in clumsiness and inaccuracies or motor slowness, the consultation of health specialists is required.

In this study, we chose the BalouCenter as our investigative environment in which we encountered cases of cerebral palsy. This Center began its activities in 1980, the objective was the upgrading and integration of children living with disabilities in society. In 2000, the Center had the opportunity to be established in Commune Annexe in the Kimbembe District; its capacity has increased from 80 to 140 children.

It is located the north of the city of Lubumbashi, in Commune Annexe, Kimbembe District on Likasi road precisely on Zawadiza Imani Site and pursues the following objectives: Re-education, integration, care, guidance and socialization. Several types of disability exist, among others: cerebral palsy, trisomy 21 or T21, phocomelia, diplegia, hemiplegia, monoplegia, dyslexia, parkinson, microcephaly, macrocephaly, autism, myopathy, hermaphroditism, imbecility, PICA and X fragile syndrome.

### 3.2 Participant

We saw fit to retain a case of treatment at BalouCenter, and only one patient participated in this study. It is a 7-year-old boy who has suffered from psychomotor developmental delay. Our goal is to acquire knowledge of the specific peculiarities concerning him in order to understand his situation of delayed psychomotor development. This will allow us to explain the current situation, in order to undertake a psychomotor re-education which will help him to overcome his traumatic situation following the parameters of the target population.

### 3.3 Measures

We used the clinical method. The clinical interview and clinical observation enabled us to collect data, the analysis of this data was carried out thanks to the content analysis and finally the thematic analysis served us in the processing of the results.

Berthier (2008) believes that the clinical interview is an instrument relating to the procedures used to carry out a particular activity with the know-how required for the mastery of a task or an activity. In practice, we performed 8 sessions in total, each of which was more or less than an hour. These sessions were carried out with the mother of our patient; all of these interviews were carried out at the Balou psycho-pedagogical rehabilitation center. They are distributed as follows: in the first 2 sessions the mother of our participant completely refused to bring up the subject, it was in the 3rd session that she agreed to tell us about the history of the suffering of her child, but suddenly she stopped talking to us and she left crying and the last 4 interviews went normally. So, it is not for us to multiply the interviews without highlighting them with what we already had as data. It is the singularity of the case that is interesting until we have reached saturation. Saturation effect of the interviews: the mother "always" says the same thing, and that brings nothing more.

We used the observation technique to get more information about our patient, every day we observed the patient on arrival, during therapeutic sessions or psychomotor rehabilitation exercises until he left the Center. To build data based on observations, we had a notebook where we used to summarize everything that was seen, heard or listened to about our participant. Regarding the observation, we ensured our permanent presence on the ground.

In fact, we have analyzed the data from the interviews and observations thanks to the content analysis based on precise stages, in particular the organization of the corpus, the breakdown and the interpretation. Also the speeches collected following the interviews carried out with the mother of our patient were completely transcribed then treated by thematic content analysis to highlight all common characteristics of the speech of the subjects interviewed.

Finally we made use of thematic analysis which allows us to identify the themes present in a corpus and then do the analysis. In the thematic analysis to which we have added denominations which are called themes in order to summarize and treat our corpus, we also sometimes speak of sub-themes or categories to refer to the decomposition of certain themes. In short, it is a question of using themes to respond little by little to the question of our problem relating to the delayed psychomotor development of a 7 year old boy, met at the Balou psycho-pedagogical re-education center.

## 4. Results of the Study

In the first moment we present the data of our research, which we analyze by means of thematic analysis finally, we discuss the results on the basis of theories related to



psychomotor development. Therefore, we start with the description of the case.

#### 4.1 Presentation of the case

This point, essentially devoted to the description of the clinical case, is divided into the following two sub-sections: the presentation of the case, the breakdown of data in the form of speeches, the grouping of speech into unity of meaning and the qualification of the contents.

##### 4.1.1 Biographical

This study is carried out on a boy whom we named S.B.B. We use this name which is a pseudonym to designate our patient taking into account ethics, deontology and respect for confidentiality. He is 7 years old and was born in Lubumbashi with 2,500 Kg as weight, living in the Kalubwe district, of Catholic confession, his parents are all alive; but, are divorced, they do not live together, his father is a merchant and his mother still carries out the same work. The patient is a Catholic Christian like his parents. The only son of his family, he studies at the Balou School. He is from the city of Mbuji-Mayi; because, his father is from the province of Kasai Oriental and his mother is from the province of Haut-Katanga.

##### 4.1.2 Analysis and pre-evaluation of the case

The analysis of the case is carried out first by cutting up data in the form of speech, then this speech is grouped into units of meaning. It follows the qualification of the content, the diagnostic hypotheses and the therapeutic proposal, finally the evaluation.

##### a) Division of data in form of speeches

It seems important to us to point out that the speeches that we present to you at this level were gathered during the interviews that we carried out with the mother of our patient.

- 1) Currently he can anticipate the exercises because he already created the automation.
- 2) So we started treating him for meningitis and it still doesn't work.
- 3) So a doctor recommended that we go with the child to the Baloucenter.
- 4) After giving birth my child was doing very well.
- 5) Today my son is 7 years old but he doesn't walk.
- 6) To move the finger.
- 7) It was after three months that this hell started.
- 8) This is what allows him to always be next to another person.
- 9) To cross the arms to say that he agrees with what you ask him.
- 10) And after the medical examinations, the doctors told me that the child suffered from meningitis.
- 11) Here in the center when he is asked to move his hands before his eyes, he was unable to.
- 12) He likes being around adults to help him get around and do other movements.
- 13) He expresses his anger through tears.
- 14) He nods to accept and shakes it to refuse.
- 15) He expresses himself by gestures and not by words
- 16) He couldn't even sit down.
- 17) He enjoys rehabilitation exercises.
- 18) Two months ago my son couldn't even touch his head.

- 19) I was pregnant at the age of 23
- 20) I don't know if it's because we don't live together.
- 21) When he is hungry he cries, if necessary he refuses all that is suggested to him to do in order to express that he is hungry.
- 22) Now it's okay anyway, because he can stand upright while leaning on objects (doors, chairs and sometimes falls).
- 23) But once, to move from one place to another, he did it by the buttocks.
- 24) But I decided to stay at home with my family.
- 25) Even leaning on one thing, he is incapable
- 26) My son seemed to be suffering from malaria
- 27) We found that the child does not evolve like other children.
- 28) Because my parents didn't want this man.
- 29) As for me, I don't like to talk about it.
- 30) His dad doesn't care about him.
- 31) Please, he couldn't even crawl like a baby at his age!
- 32) Everything seemed to work in the very beginning.
- 33) I am convinced that it will eventually work.
- 34) He knows how to greet me with a smile to express his joy.

##### b) Grouping of speeches into unity of meaning

Category A: delay in psychomotor development from a physical and behavioral point of view:

- Walking : 5, 14, 15, 16, 23, 25, 26 and 34
- Recognition of body diagram: 21
- Movement coordination: 1, 6, 9, 12, 17 and 18

Category B: On an emotional and social level:

- Affective deficiency : 23 and 27
- Sociability : 8 13, 20 and 24

##### c) Qualification of content

##### The delay of psychomotor development from physical and behavioural point of view

From a maturationist point of view, from the moment when the upper centers of the brain take over, reflexes are progressively inhibited and three categories of movement must be mastered by the child for optimal adaptation to the environment: axial tonic control, locomotion and grip. At 7 years our patient could easily pedal on a bike without side wheels. He can lace his shoes. He hits a ball for a goal. He buttoned his clothes. His drawings are refined. But we note the opposite of the elements that we have just presented above, our patient could not hold his head; nor to sit, he was not able to do pedalling in space and even make hand movements before his eyes, he was unable to stand up alone; nor crawl, he moves from one place to another by the buttocks. Added to these elements from our observations in the field including the spontaneous motor activity of SBB that is comparable to that of the infant that is to say it is no longer considered the production of random movements and undifferentiated, but like exploring the dynamics of an action which will gradually lead to the discovery of areas of stable behaviour, attractors precisely. We then say that on the physical aspect, SBB presents almost a certain delay in development that we have grouped into three subcategories below: walking, recognition of the body diagram and coordination of movement. Inspired by the theory of

psychomotor development supported by Hotyat (1978) according to which several factors had to evolve rapidly between 3 and 7 years but, we practically have the absence of the orientation of his activities towards functional game, the mobility of his attention and the lack of analytical skills of his perceptions hinder his progress towards efficiency.

**Delayed emotional and social psychomotor development**

We say that at the age of 7, SBB does not have a coherent, rich language which should allow him to communicate better with others and he does not use verbs correctly. He is unable to understand the intentions of others. SBB is not even able to identify with the parent of the same sex and be interested in his way of doing things. SBB is unable to begin to understand, control and overcome his emotions better. He cannot distinguish the concepts high / low, morning / afternoon, nor recognize the right from the left, known colors. Now he has entered the age of curiosity: the age of why and multiple questions and he should have to developed his imagination. During the interviews with the mother, an emotional problem arises due to the fact that the parents do not live together, that is to say that SBB is a child out of wedlock. Piaget (1896) in his theory on psychomotor development, maintains that from 2 to 7-8 years, this is a preparatory period for the next stage, but which deserves to be studied in itself, by the importance of the acquisitions of this period, in particular those which characterize the semiotic or symbolic function. During this period there is internalization of actions.

**4.1.3. Diagnostic hypotheses and psychotherapeutic proposal**

In this part of the work we identify the diagnosis on the basis of the symptomatology. S.B.B. at 7 years old, he has the insufficiencies such as the inability to walk, to speak, to eat alone, to play games inherent in his age, to distinguish colors, to write, etc. This clinical picture shows us that our patient suffers from delayed psychomotor development. To this suffering we offer psychomotor rehabilitation as psychotherapy which we present in more detail in the next point.

**4.1.4 Taking care with Psychomotor re-education**

As the patient has a delay in psychomotor development, we performed the therapy individually. Thus, we have not made a specific **re-education** protocol for an area; but, we rather proposed exercises of different types, which we repeated several times. For this, we proposed the following exercises: the pivot exercises, the posture exercises, the balance exercises, and finally the walking exercises and these are the exercises that allowed us to support our patient well so that he can find well-being.

**First therapeutic session on pivoting exercises, from 22 to 28/01/2019, from 8:30 to 12:30**

At this level, we started to move shapes from the rotating diagrams of the body and limb axis to the winding diagram. It is used by children in the first instance when they turn their back on their stomach. But also, at the second time of the back turn on the stomach. The purpose of this exercise is to support this postural position on the right elbow and the straightening curve of the body axis with the extension of rotation of the lower limb

**Table 1: Exercises of pivoting**

Date	Equipment	Activity	Subactivities	Quality and adaptation	Sequence		
					Frequency	Duration	Interval
01/22/2019	The ball	Pivoting	left and right pivoting	Latency	2 times per week	1h	8:30 am-12:30pm
01/25/2019	The ball	Pivoting	Pivoting from the belly to the back and from the back to the belly	Pretty good	2 times per week	1h	8:30 am-12:30pm
01/28/2019	The ball	Pivoting	Repetitions of all the exercises already performed	Verywell	2 times per week	1h	8:30 am-12:30pm

Regarding the first table, we present in a more synthetic manner the pivoting exercises that we performed with the patient in the context of psychomotricity. The pivoting consists in laying a mat to put the child in safety, that is to say when he falls, he will not be injured. Then we used a large balloon to rotate the child so that he only falls on the back or on the stomach and not on the side. The goal of our exercises is to strengthen the tone of the muscles, but at the very beginning the child refused to do these exercises, it is as soon as he has acquired a taste. These exercises were performed for one hour in the interval from 8h30 to 12h30.

**Second therapeutic session on posture exercises, from 04 to 28/02/2019, from 8:30 to 12:30.**

The posture exercises have the objectives of developing the muscles of the lower limbs. As material, we dug a hole and we put the patient in the standing position there, supporting him with cushions to protect him for at least an hour. And at this level, the child trains to prepare for standing.

**Table 2: Posture Exercises**

Date	Equipment	Activity	Subactivities	Quality and adaptation	S sequence		
					Frequency	Duration	Interval
02/04/2019	Board, hole, cushion and container	Posture	Sitting posture,	Latency	2 times per week	1h	8:30 am-12:30pm
02/02/2019	Board, hole, cushion and container	Posture	Repetitions of all exercises already done.	Pretty good	2 times per week	1h	8:30 am-12:30pm
02/15/2019	Board, hole, cushion and container	Posture	Repetitions of all exercises already done	Verywell	2 times per week	1h	8:30 am-12:30pm

This table number 2 is the continuation of the first, it completes the exercises of psychomotricity in which we

used four types of materials: we have a board, hole, cushion, toys and container. These tools allow the child to have the posture to walk better, to allow him to stand up.

Concretely we proceed in the following way: in the first moment we tie the child to a board with bandages in the standing position this for a whole hour and to distract him we put the toys in front of him. The second way of doing it was to surround the boy with four twenty-liter containers filled with water so that he kept the same position, that is, standing for an hour. And the last way of working is to put the child in a hole which goes up to the level of his thighs by fixing his Achilles tendons to the ground thanks to the cushions.

And in carrying out the exercises we insist more on fixing Achilles tendons to the ground. Regarding the weather, we did these exercises twice a week, for an hour, in the interval of 8 hours 30 minutes and 12 hours 30 minutes. As for the appreciation, it is progressively increasing, namely latency and a very good performance of the exercises.

Third therapeutic session on balance exercises, from 25 to 07/03/2019, from 8:30 a.m. to 12:30 p.m.

At this level, we used different exercises, so that the child can stand in an upright position. First we observe the straightening of the lower limbs and the trunk, so that the child supports for a few minutes a large part of the weight of his body thanks to the balance exercises that we present in the table below:

**Table 3: Balance exercises**

Date	Equipment	Activity	Sub-activities	Quality and adaptation	Sequence		
					Frequency	Duration	Interval
02/25/2019	sheet, mirror, wheelchair and water containers	Balance exercises	Trumpemptying	<b>Latency</b>	2 times per week	1h	8:30 am-12:30pm
02/25/2019	sheet, mirror, wheelchair and water containers	Balance exercises	Trumpemptying	<b>Pretty good</b>	2 times per week	1h	8:30 am-12:30pm
03/07/2019	sheet, mirror, wheelchair and water containers	Repeats all done exercises s .	Trumpemptying	<b>Verywell</b>	2 times per week	1h	8:30 am-12:30pm

Table number 3 shows how we proceeded with balance exercises through which we used the following instruments: a sheet, mirror, wheelchair and water containers. And, these instruments helped our patient to have a mental representation that he is accepted in his social environment, that he is protected and that he is safe. Finally, we forced the patient to put the heels on the ground so that he can have balance. In addition to these elements, there is the trump emptying which consists in transferring water from a bucket to an empty container. We performed these exercises at the same frequency and the same duration as that in table number 2, twice a week, for one hour, in the interval of 8h30 and 12h30 minutes. As for the appreciation, it is progressively increasing, namely latency and a very good performance of the exercises. For illustration purposes, we put an image whose face of our patient is hidden to guarantee the anonymity and confidentiality of the identity of our patient as required by ethics and professional conduct for psychologists.



**Image 1: Balance Exercises**

This picture allows us to explain more about psychomotor exercises. SBB is a standing position for at least an hour performing his exercises. Two other images are listed in the appendices.

**Fourth therapeutic session on of walking exercises from 14 to 28/03/2019, 8:30 12:30.**

For exercises on walking, we aim to see the child slightly walking by himself in a succession of steps and to observe the first automatic walk involves a rhythmic contraction of the antigravity muscles triggered by skin contact of the soil of the foot.

**Table 4: Walking Exercises**

Date	Equipment	Activity	Sub-activities	Quality and adaptation	Sequence		
					Frequency	Duration	Interval
03/14/2019	Bamboo, bag, wall and candy	Walking	Parallel stick	<b>Latency</b>	2 times per week	1h	8:30 am-12:30pm
03/18/2019	Bamboo, bag, wall and candy	Walking	Walk on the wall	<b>Pretty good</b>	2 times per week	1h	8:30 am-12:30pm
03/28/2019	Bamboo, bag, wall and candy	Walking	Repetitions of all exercises already done	<b>Verywell</b>	2 times per week	1h	8:30 am-12:30pm

Table number 4 shows how we applied the walking exercises that the child will practice. We place in parallel two bamboos on the pillars which serve as a support for the

child to walk. And we place the child between the two bamboos and hold his backpack in front of him and we ask him to come and collect.

As for the previous exercises, we performed these exercises at the same frequency and the same duration as that in Table 2, twice a week, for one hour, in the interval of 8h30 and 12h30. As for the appreciation, it is progressively increasing, namely latency and a very good performance of the exercises.

#### 4.1.5. Psychotherapy assessment

To observe the progress on motor development made by our patient, we wanted to present the results in the form of tables, i.e. arithmetic progression tables. Thus, we targeted standing position forms, movement evolution exercises and psychomotor walking exercises. These exercises or these instruments were used as a representative element of reflection of our patient, the level of thought, cognition of disturbed children and their motor and psychic capacities in the restoration of motor and psychomotor evolution, locomotion or even displacement. The notion of displacement or locomotion is a very crucial notion of psychomotor development of children and the retardation of psychomotor development. It allows children to determine their position and their relationship with significant objects, that is to say, the signifier and signified, and with the environment.

The delay in psychomotor development being a pathology due to lesions occurring during the perinatal, postnatal and / or antenatal period, it demobilizes the body, in all forms. If the intervention is not carried out as quickly as possible, a deterioration can be observed or takes place in all aspects of human health. It is in this context that we examined the behavioral modifications recorded after our therapeutic intervention carried out with our subject, This is to say that the change noticed on this subject is clearly visible on almost all aspects of our patient's existence.

The evaluation of the therapeutic strategies applied on our patient based on psychomotor re-education, gives us impressive results going towards relief. We have, therefore, after experimentation, observed the following modifications:

- 1) **On the physical and behavioral level:** autonomy in personal care, he seeks to interact with those around him, he jokes, he undresses alone and he has become independent.
- 2) **On an emotional and social level:** recognition of self-image, a smile, good self-esteem, he now has friends; because, he becomes cheerful, he talks and plays.

The psychomotor management has brought about an important modification in our patient, because the psychomotor re-education has helped SBB to find more or less his psychic and bodily unity often compromised by various handicaps from which he suffers. This gives him self-confidence and the joy of life, the knowledge of his body and its possibilities thanks to the training of the capacities hitherto intact.

#### 4.2. Discussion of results and conclusion

We notice with SBB that his improvement seems even lower because of a relative slowness of his reactions and less precision of his usual movements; certain performances are not yet acquired due to a very limited vigor and a still

incomplete sensorimotor experience. Above all, the orientation of his activities towards functional play, the mobility of his attention and the lack of analytical character of his perceptions hinder his progress towards efficiency.

Certain performances are not yet acquired due to a very limited vigor and a still incomplete sensorimotor experience. These results confirm the theory of Harlow & Bowlby (1905) according to which the need for social contact, attachment to one's mother or to a fellow-member appears here to be free of any link with the satisfaction of primary needs and is considered as an innate characteristic of the species. Sometimes, SBB walks using the soles of the feet and the palms of the hands. Sometimes he moves on the hands and the posterior (the buttocks), either still he walks along a support and finally he walks once he is held by the two hands as it is the case when we place him between two bamboo sticks as we have noted in table N°4 which presents the balance exercises.

The results of this study also corroborate Hotyat's theory (1978) which states that the child comes to repeat an action not for the pleasure that it gives but for the result it provokes. We have noticed that SBB has enjoyed as long as the activities were organized; but at the beginning, he seemed not to be motivated.

These results allow us on one hand to confirm our hypothesis according to which the strategy of managing a retarded motor development in a child would be psychomotor re-education, and on the other hand to achieve our objective in that the management of a psychomotor nature made it possible to improve the condition of our participant and that of his family.

The contribution of this work is to be situated on two levels on one hand because our study has a therapeutic aim, it brings relief to our patient, on the other hand, this study contributes to the advancement of science in the field of clinical psychology. The use of psychomotor therapy that we have proposed has made it possible to observe modifications with a good improvement in the situation of our patient thanks to the exercises performed by him. This shows that managing psychomotor developmental delay can have a good result through psychomotor therapy.

Our study focused on the management of retarded motor development in a 7-year-old boy in Lubumbashi. We formulated the object of study in the following question: what psychotherapies would be able to make it possible to take care of this child? In writing this work, we set ourselves the objective of determining the factors which can be at the root of this retardation of psychomotor development in order to be able to help the patient to integrate into the society and to become independent. To achieve this objective, we used the clinical method which is supported by clinical interview and clinical observation, which allowed us to collect data. The analysis of these data was carried out thanks to the content analysis and finally the thematic analysis served us in the processing of the results.

This methodological device allowed us to understand the level of suffering of our patient through the following



clinical picture: On the physical and behavioral level, there was autonomy in personal care. He has become independent because he becomes jovial, he talks and plays with those around him, he jokes and he gets to undress alone. On the social and emotional level, we have seen recognition of self-image, smile, good self-esteem and he now has friends. The taking care by psychomotor re-education by means of pivoting, posture, balance and walking exercises have helped SBB to regain more or less his mental and bodily unity often compromised by the various handicaps from which he suffers. This tends to give him self-confidence and the joy of living, the knowledge of his body and its possibilities through the training of the capacities remained until then intact.

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