ASPECTS OF PHYSICALLY DEFICIENT CHILDREN'S RELATIONS WITH THE FAMILY AND THE EDUCATIONAL ENVIRONMENT

Ana Maria FURTUNĂ

„St. Andrew's" Children's Centre, Piteşti, Romania

DOI: 10.19062/2247-3173.2017.19.2.13

Abstract: *We start from the hypothesis: Physical deficiency as well as the influence of environmental factors are the triggering factors of the formation and deterioration of self-image.*

Environmental factors: biological factors, unfavorable environmental conditions, unhealthy lifestyles, risk factors related to healthcare. All of these facts contribute to the damaging of self-image.

Objectives:

- *Identification of self-image;*
- *Identification of physical deficiency;*
- *Highlighting a personality profile;*
- *Influence of environmental factors;*

Keywords: *deficiency, children, therapy, counselling, temperaments, personality, family, factor, education.*

1. ANALYSIS AND INTERPRETATION OF DATA

Table 1 - Subjects investigated

Item no.	Name	Sex	Age	Diagnosis	Family	Siblings	Ses	M.R
1.	**A.D**	F	15	Osteochondrodistrophy	COM	1	**Me**	**U**
2.	**C.O**	F	16	Congenital malformation	DI	3	**UA**	**R**
3.	**C.B**	M	13	Inequality of inferior limbs	DI	3	**AA**	**U**
4.	**A.D**	M	15	Neuromuscular dystrophies	COM	-	**UA**	**U**
5.	**A.L**	F	16	Myopathy	COM	1	**Me**	**U**
6.	**B.R**	M	13	Neuromuscular dystrophies	COM	3	**UA**	**U**
7.	**T.D**	M	14	Inequality of inferior limbs	COM	3	**AA**	**U**
8.	**B.V**	M	14	Neuromuscular dystrophies	COM	-	**ME**	**R**
9.	**A.T**	F	16	Congenital luxation	COM	1	**ME**	**U**
10.	**N.S**	M	**12**	Neuromuscular dystrophies	COM	-	**ME**	**R**
11.	**R.D**	M	**15**	Neuromuscular dystrophies	DI	2	**UA**	**U**
12.	**M.F**	M	13	Congenital malformation	COM	-	**ME**	**R**
13.	**F.M**	F	12	Congenital luxation	COM	-	**ME**	**U**
14.	**A.I**	F	13	Neuromuscular dystrophies	COM	2	**AA**	**U**
15.	**C.U**	F	15	Congenital malformation	COM	2	**ME**	**R**
16.	**R.B**	F	12	Congenital luxation	COM	1	**ME**	**R**
17.	**C.I**	F	13	Neuromuscular dystrophies	COM	-	**ME**	**U**
18.	**N.P**	M	14	Congenital malformation	COM	1	**ME**	**R**
19.	**D.I**	M	15	Inequality of inferior limbs	COM	-	**ME**	**R**

Item no.	Name	Sex	Age	Diagnosis	Family	Siblings	Ses	M.R
20.	**L.C**	F	11	Neuromuscular dystrophies	COM	**-**	**ME**	**R**
21.	**A.T**	F	12	Neuromuscular dystrophies	COM	-	**AA**	**U**
22.	**A.A**	M		Congenital luxation	DI	2	**UA**	**U**
23.	**T.A**	F	14	Neuromuscular dystrophies	DI	1	**UA**	**R**
24.	**M.F**	M	16	Congenital luxation	COM	**-**	**UA**	**U**
25.	**R.M.F**	F	14	Congenital malformation	DI	3	**UA**	**R**

LEGEND:
F - female; M - male; COM - compact; DI – dis-harmonic; UA - under average; Me – medium; AA – above average; U - urban; R - rural;

Table 2 - Centralized data of the applied tests

Item no.	Name	PSC	BELOV	HSPQ							
				c	E	D	1	o	Q2	Q3	Q4
1.	A.D	lse	c	-	+	-	+	-	+	+	-
2.	C.O	lse	M	-	-	+	+	+	-	-	+
3.	C.B	lse	F	+	-	+	+	+	-	-	+
4.	A.D	lse	s	-	-	-	-	-	+	+	-
5.	A.L	lse	c	-	+	+	+	+	-	-	+
6.	B.R	lse	M	-	-	+	+	+	-	-	+
7.	T.D	lse	c	-	.	+	+	+	-	-	+
8.	B.V	lse	M		-	. +	+	+	-	-	+
9.	A.T	lse	c	-	+	+	+	+	-	-	+
10.	N.S	lse	c	-	+	-	+	-	+	+	-
11.	R.D	lse	M	-	-	+	+	+	-	-	+
12.	M.F	lse	M			+	+	+	-	-	+
13.	F.M	lse	M	-	-	+	+	+	-	-	+
14.	A.I	lse	M	-	-	+	+	+	-	-	+
15.	C.U	lse	F	+	-	+	+	+	-	-	+
16.	R.B	lse	s	-	-	-	-	.	+	+	.
17.	C.I	lse	M	-	-	+	+	+	-	-	+
18.	N.P	lse	M	-	-	+	+	+	-	-	+
19.	D.I	lse	s	-	-	+	+	+	-	-	+
20.	L.C.	lse	M	-	-	+	+	+	-	-	+
21,	A.T	lse	c	-	+	-	-	-	+	+	-
22.	A.A	lse	c	-	+	+	.+	+	-	-	+
23.	T.A	lse	c	-	+	+	-	+	-	-	+
24.	M.F	lse	F	+	-	+	+	+	-	-	+
25.	RMF	lse	M	-	-	-	+	-	+	+	-

LEGEND:
LSE : Low self-esteem C: choleric M: melancholic F: phlegmatic S: sanguine HSPQ: - FACTORI:C - expansivity – self force; E -submission / dominance; D - excitability; I - realistic / anxious hypochondriac behaviour; Q - adaptation / tendencies towards guilt; Q2 - dependence / independence to a group; Q3 – sense of self; Q4 – energic tension.

Table 3 - Centralized data obtained from the interview with subjects

Item no.	Name	Intr. 1	Intr. 2	Intr. 3	Intr. 4	Intr. 5	Intr. 6	Intr. 7	Intr. 8
1	A.D	3	1	4	4	4	4	1	1
2	C.O	2	2	2	2	2	3	1	2
3	C.B	3	1	4	4	4	4	1	1
4	A.D	3	1	4	2	2	3	3	1
5	A.L	2	3	4	4	4	3	3	1
6	B.R	1	2	2	2	4	1	1	2
7	T.D	2	2	4	4	2	3	3	2
8	B.V	2	3	4	2	4	3	1	1
9	A.T	2	1	4	4	2	3	1	1
10	N.S	1	2	2	2	2	1	3	2
11	R.D	2	2	1	1	1	1	1	2
12	M.F	1	2	1	1	1	1	1	2
13	F.M	3	1	1	1	1	4	1	2
14	A.I	2	3	1	1	1	4	3	1
15	C.U	1	1	4	2	4	3	3	1
16	R.B	2	1	4	4	2	3	1	1
17	C.I	2	1	4	4	4	3	1	1
18	N.P	3	1	4	2	2	3	3	1
19	D.I	2	1	2	2	2	3	3	1
20	L.C	2	2	1	1	1	1	1	1
21	A.T	3	1	4	4	4	3	1	1
22	A.A	2	1	2	2	2	1	3	1
23	T.A	3	1	2	2	2	1	3	1
24	M.F	2	1	4	4	4	1	1	1
25	R.M.F	2	1	4	4	4	3	1	1

2. THE GRAPHICAL PRESENTATION, WHICH IS LATER INCLUDED IN THE QUESTIONNAIRE, HIGHLIGHTS THE DISTRIBUTION OF THE DATA OBTAINED IN THE RESEARCH

This research was carried out on a random, unrepresentative sample of 25 physically deficient subjects attending both normal and mass education, as well as the Special School (mostly, respectively 22 of the subjects studied).

The graphical presentation, which is later included in the questionnaire, highlights the distribution of the data obtained in the research.

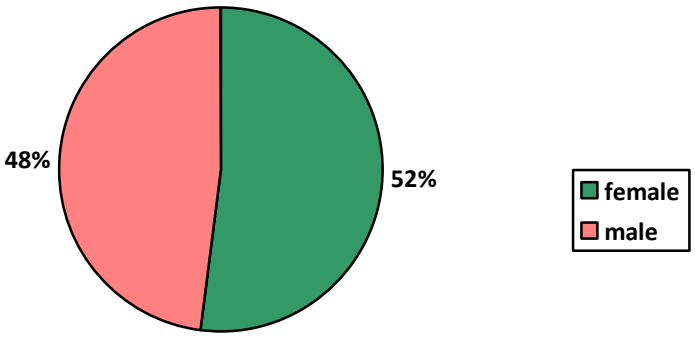


FIG. 1 - The distribution of subjects by gender

In terms of gender distribution, the majority share is held by the female gender, 52%, followed closely by the male gender 48%, the deficiencies not being specific to one gender.

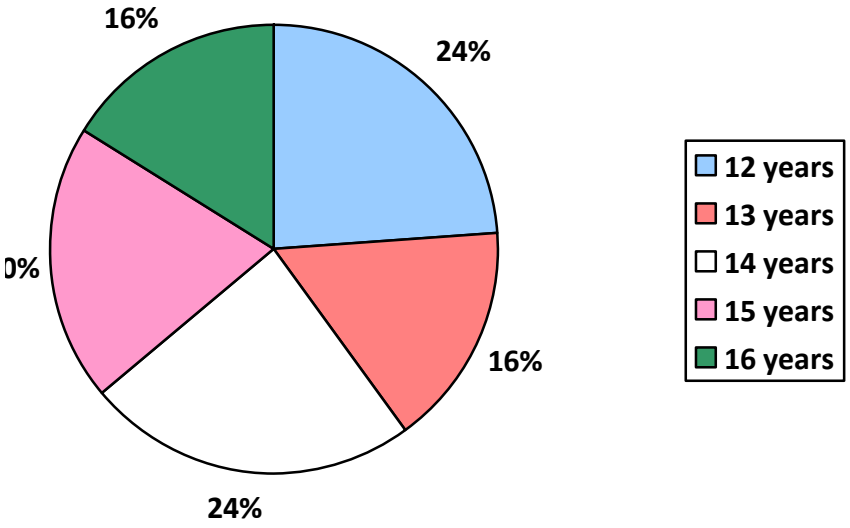


FIG. 2 - The distribution of subjects by age

Distribution by age: 24% 12 years old, 16% 13 years old, 24% 14 years old 20% are 15 years old and 16% are 16 years old.

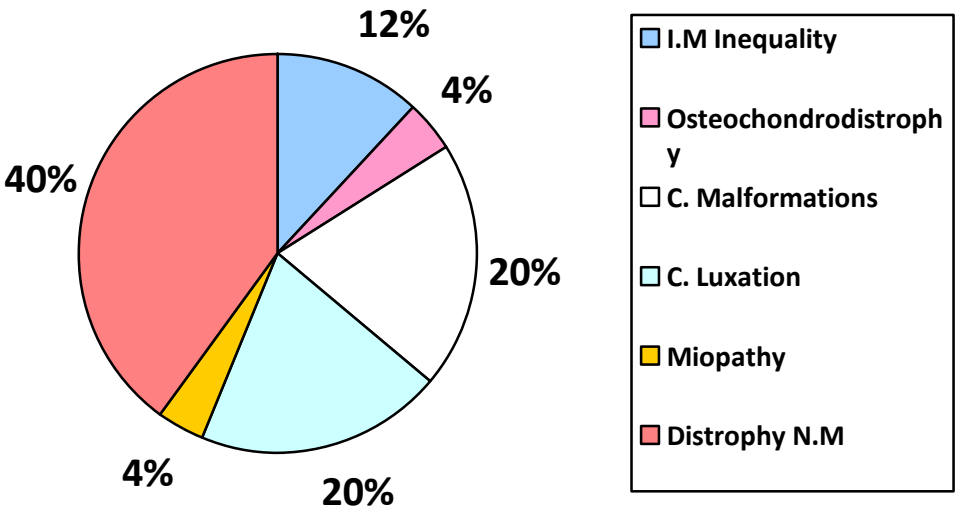


FIG. 3 - The distribution of subjects by diagnosis

Diagnosis based repartition: 40% of subjects have the diagnosis of "neuromuscular disorder", 12% have inferior limb inequalities "integrated in mass education", 4% have osteochondrodistrophy, 20% have DGs. Of Congenital Malformations, 20% have congenital luxations and 4% Myopathy.

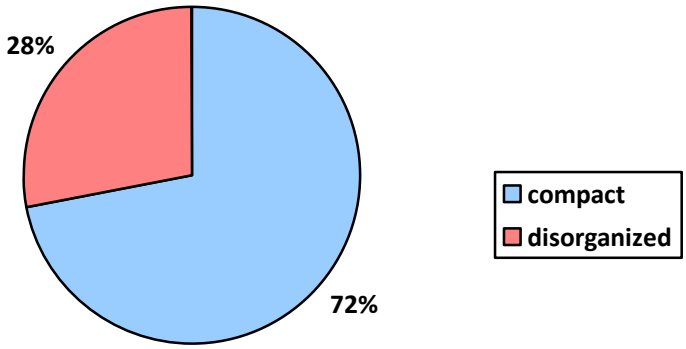


FIG. 4 - The distribution of subjects by family type

We note that 72% of the studied subjects come from compact families and 28% of the subjects are from disorganized families. We can conclude the following: Physical deficiency is not influenced by the type of family, it can occur independently of it.

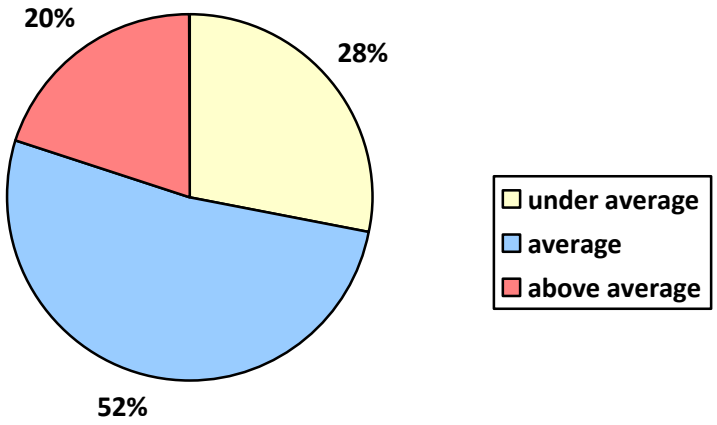
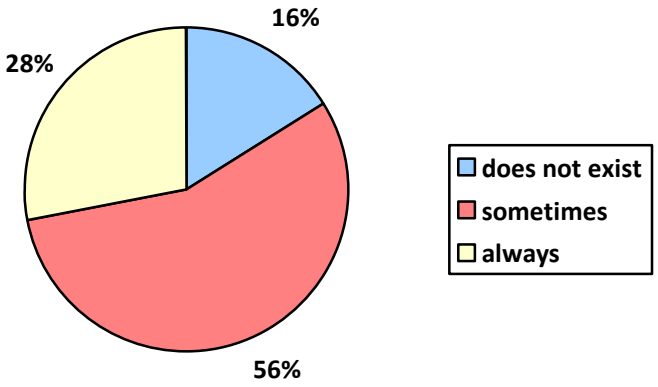


FIG. 5 - The distribution of the economic and social status of the families of the subjects

School performance is one of the factors influencing the (partial) recovery of physical deficiency, and their social integration is the socio-economic status of the family. In this case, most of the children come from families with an average SES, i.e. 52%, and the other percentages are for children from families with SES 20% over average, followed by those with SES under average at 28%.We find that children with lower SES need greater structuring and support to help them succeed in an ordinary classroom. While for those with high SES, self-control and self-direction are more important. In middle-class families, school is more important to learning in both formal and informal programs by contacting frequently the school to ask for information about the children.



Ş

FIG. 6 - Representation of family – school cooperation relationship

After applying the interview, the question about the real collaboration of families with the school, the results are as follows: in 56% of cases the family is specifically interested in the child's evolution only at times. In 28% of cases, the family maintains permanent reports with the school, contributing greatly to the development and integration of the child, 16% of parents do not care about school and the child's evolution. It has been shown that systematic meetings between school staff and pupils' parents can contribute to their progress. It has been found that middle-class families pay more attention to school, to the need for learning.

They frequently contact the school to get information for their children. In the case of parents with low SES, we notice that they prefer to let the children go through school however they can, based on the decisions of others.

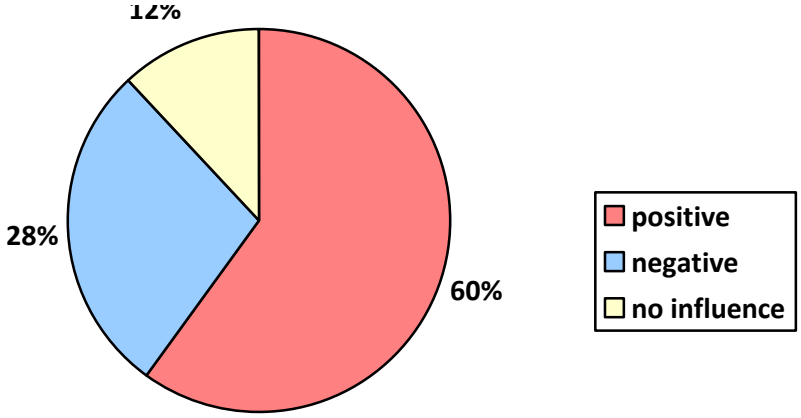


FIG. 7 - Representation of the influence of family on the child's evolution

Family is the most important factor in modelling relationships.

"Family relationships are of major importance in that they frame the image of" the other "and" the self "by the comparison effect, and the ongoing reporting of these images takes place in the process of modelling the relational motivation." (I. Muşu and A. Taflan)

Roger Perron says: "It is likely that parents who focus their attitudes and behaviour on the disability of the child teach them to perceive and define themselves as handicapped."

In our case it has been demonstrated in most situations - 60 / that the family positively influences the evolution of the child. However, in a significant percentage of 28%, families that negatively influence the child's evolution are affected. Specialty literature talks about the family's disintegration as to the evolution of the child, as we have seen before. So intra-family conflicts occupy a very important place in the relational constellation.

These are closely followed by inter-school conflicts. Thus, school becomes more conflicting for the physical deficient than for the normal child.

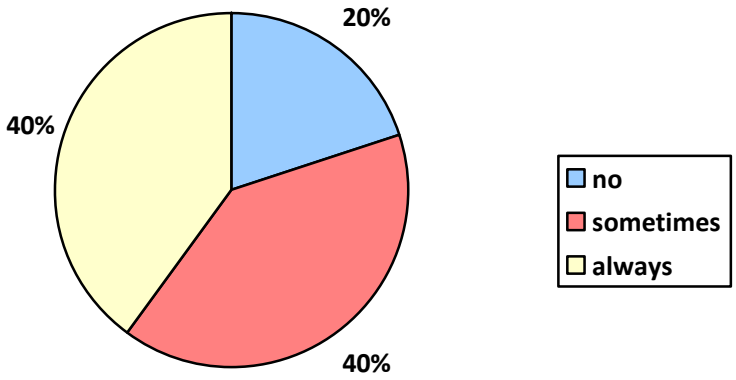


FIG. 8 - The frequency of teacher requests by parents in order to solve educational problems

The information that parents can give to the teacher about the child can be the basis for making the most appropriate decisions when parents are interested in the child's progress and show willingness to collaborate with the school staff.

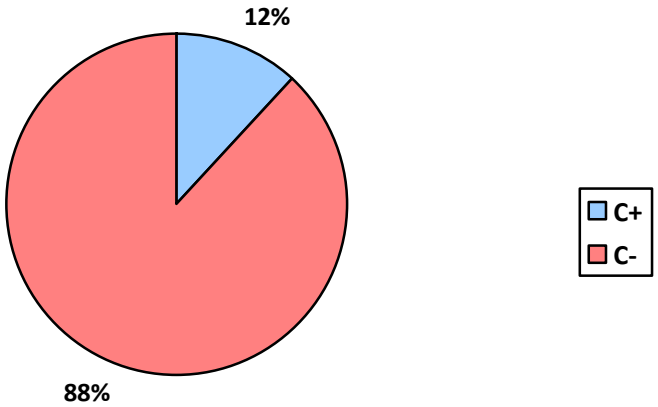


FIG. 9 - Repartition of the subjects depending on the C-HSPQ factor

These children are not satisfied with school and family, slightly contradicted by things and people, hard to keep calm, are unable to follow rules, suffer from digestive and sleep disorders, unmotivated fears.

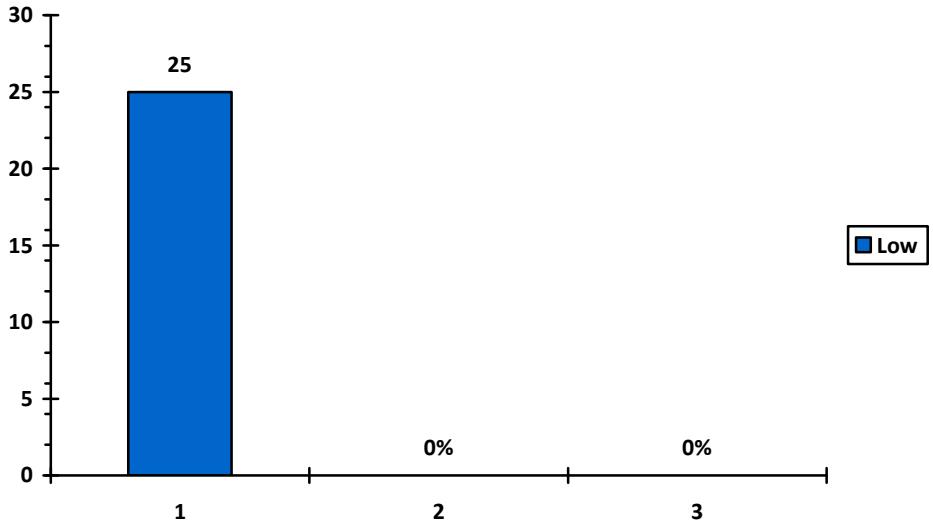


FIG. 10 - Distribution of the subjects according to self-esteem BSP

Both the disease and the influence of environmental factors contribute to the formation and deterioration of self-image.

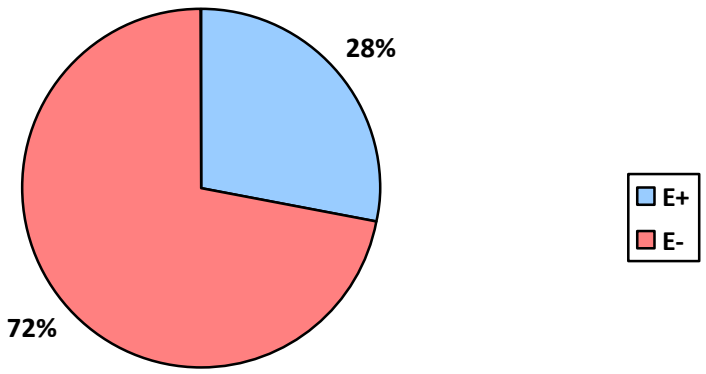


FIG. 11 - Repartition of the subjects depending on the E-HSPQ factor

Factor E highlights subject dominance and respectively submission. Dominance tends to be positively correlated with social status and is higher for recognized leaders than for listening people. Both positions of this dimension raise problems of adaptation. High grades occur in the case of teenager offence-related problems associated with part of the teenager pattern, the low grades being equally pathological because they appear in the traditional neurotic profile. Subjects are characterized by dependence, obedience.

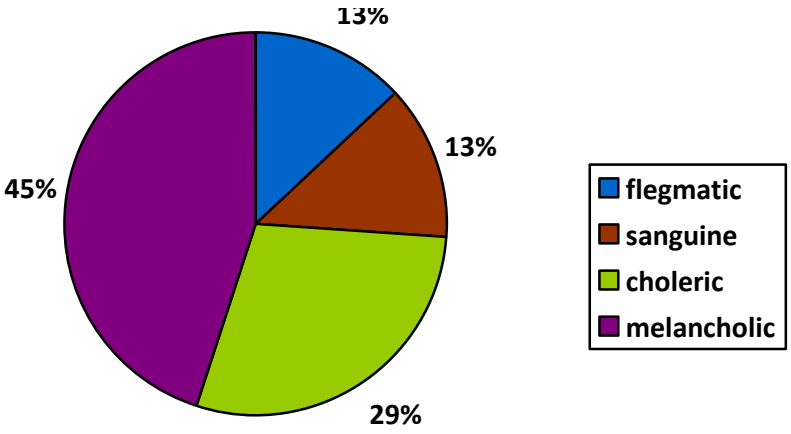


FIG. 12 - Repartition of the subjects depending on temperament type - Belov

Following the Belov test, we noticed that 45% of our subjects belong to melancholic temperament, do not have affective reactions, being introverted and lacking in energy; 29% of choleric temperament, characterized by inequality in manifestations, anxiety, exaggeration in terms of friendship, and hostility; 13% of the blood temperament: sociable, lively, adaptable, etc. and 13% of phlegmatic temperament: people with stable, calm habit, dedicated to an activity.

3. CONCLUSIONS

Following the tests and the interview, we observed the following:

Warmness, anxiety, self-confidence, inferiority complexes find justification in a concrete physical plane.

The physically deficient child is hypersensitive, lacking self-experience, the bodily identity that a healthy person gains through the sense of touch, comfort, movement.

The deficient child is selfish, irritated, we also observe how engagement capacity in activity is reduced by the character, and how illness influences temperament.

The above draws attention to the low self-esteem of all subjects due to physical deficiencies.

We notice that their personality is fragile, with frustration and anxious notes, with internal tensions and conflicts, excessive sensitization, which hinders the relationship with the others as well as social-professional integration.

The issue of disabilities in children must be regarded as complex: from a medical, educational, psychological, professional and social perspective.

REFERENCES

[1] Albu A., Albu C-tin., "*Psycho-pedagogical and medical assistance of the physically impaired child*" (*Asistenţa psihopedagogică şi medicală a copilului deficient fizic*), laşi, Ed. Polirom, 2000;

[2] Albu A., Albu C-tin., Petcu L, "*Family assistance of the person with functional impairment*" (*Asistenţa în familie a persoanei cu deficienţe funcţionale),* laşi, Ed. Polirom, 2002

[3] Alexandrescu I., Blumenfeld S., Volosievici I.,"*The psyche of the pulmonary tuberculosis patient*" (*Psihicul bolnavului de tuberculoză pulmonară*) Ed. Junimea, 1981

[4] Allport G. "*The structure and development of the personality*" (*Structura şi dezvoltarea personalităţii*) Bucureşti EDP.1991

[5] Alexandrescu I., "*Person, Personality, Character*" (*Persoană, Personalitate, Personaj*) Ed. Junimea, 1981
[6] Bălan A., "*Educational counselling*" (*Consiliere educaţională*), Cluj Napoca Ed. Dacia, 2001
[7] Chelcea S., Chelcea A., "*You, Me, Us –Hypothesis certitudes, psychic life*" (*Eu, Tu, Noi - ipoteze certitudini, viaţă psihică*), Bucureşti Ed. Albatros.
[8] Câmpeanu E., Şerban M., Abrudaru M., "*Clinical neurology*" (*Neurologie clinică*)" Cluj Napoca, Ed. Dacia, 1980
[9] Cosmovici A., lacob L., "*School psychology*" (*Psihologie şcolară*), laşi, Ed. Polirom, 2000;
[10] Enăchescu C-tin., "*The artistic expression of the personality*" (*Expresia plastică a personalităţii*), Bucureşti, Ed. Ştiinţifică, 1975
[11] Gorgoş C., "*Human and medical dimensions of the personality*" (*Dimensiuni Umane şi medicale ale personalităţii*), Bucureşti, Ed. Medicală, 1984
[12] Luban B., Plozza "*Psycho-somatic diseases in medical practice*" (*Boli psihosomatice în practica medicală*), Bucureşti, Ed. Medicală, 2000
[13] Mărăscu L. Caraman Verza E." *Defectology problems*" (*Probleme de defectologie*), Bucureşti EDP.
[14] Neamţu C., Gherguţ A., "*Special psycho-pedagogy*" (*Psihopedagogie specială*) laşi, Polirom, 2000
[15] Neveanu P.P., Zlate M., Creţu.T.," *Manual de Psihologie* " (*Psychology Manual*) Bucureşti EDP 1998
[16] Păunescu C-tin., "*Mixed deficiency and organization of the personality*" (*Deficienţa mixtă şi organizarea personalităţii*), Bucureşti, EDP,1977
[17] Păunescu C-tin., "*The deficient child – its knowledge and education*" (*Copilul deficient*) Bucureşti, Ed. Ştiinţa pentru toţi, 1983
[18] Ştefănescu D.O., "*Psychology manual*" (*Manual de psihologie*), Bucureşti, Ed. Humanitas, 2000
[19] Verza EM "*Special psycho-pedagogy*" (*Psihopedagigie specială*) Bucureşti, EDP, 1993
[20] Verza E., "*The educator's guide*" (*Ghidul educatorului*)
[21] Weihs T., "*The special needs child"* (*Copilul cu nevoi speciale*) Bucureşti, ed. Triade
[22] Zlate M., "*The self and personality*" (*Eul şi personalitatea*), Bucureşti, Ed. Trei, 2002
[23] Zlate M., "*The psychology of cognitive mechanisms*" (*Psihologia mecanismelor cognitive*), laşi, Polirom, 1999
[24] Zlate M., "*The bases of psychology*" (*Fundamentele psihologiei*), Bucureşti, ed. Pro Humanitate, 2002