THE CHILD WITH MOTOR DISABILITIES AND HIS RELATIONSHIP WITH THE FAMILY

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Abstract: *Hypothesis: We assume that: personality is influenced by both disease and environmental factors.*

Objectives:

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

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

1. INTRODUCTION

Interfamily relationships have the most importance among all the factors that compete in childhood modelling relationships. We can observe that in the phase of evolution of direct or implicit interventions, personality structuring needs to model personality functionality. In modern psychology, personality is defined especially in affective-social relationships, which shows us that this type of relationship is defining in the evolution and structuring of personality. Within these relationships the motivation of the interpersonal relationships of the modelling affective order is established.

In the majority of cases, modelling factors are impaired and we notice that they become powerful forces due to the existence of relations between "Myself and the world". Emotion and differential forms of affectivity are forms of interpersonal communication and have a mediating value between "Myself and the world" "J. Nutimm says.

"Whatever the concrete form in which it expresses itself, an affective process always highlights a relational-communicational nature and a selective-evolutionary function" (M. Golu), the affectivity of the child being the result of intercommunication. The parties are the first elements of educational value. The language of exchange between the child and the parents, in the beginning stages, is affectivity. The relationship between the formation of levels of socio-emotional integration is directed by the mother-father couple, starting from the authority, to the determination of the feelings, attitudes and anxiological missions. The social psychology of physical deficiencies, highlights the harmful effects of inter-familial relationships of physical deficiencies on deficient behaviour. When in a family group, a physically deficient child appears, causing a traumatic shock so severely that the family often de-compensates. The problems raised by the physically deficient child cause a serious state of anxiety, conflict in parents. It is noticed that the existence of the physical deck creates different situations in the constellation of family relationships.

Cook applied a questionnaire on parents 'attitudes to more types of deficient and normal, the results leading to the determination of parents' emotional attitudes, polarized as follows: liberalism / authority and cold / soul warmth. C. Paunescu's research that led to the same result was expressed in a computationalist language. It is observed that polarization takes place between the attitude of hyperprotectionism (as a form of anxiety and accusation) and rejects (as a form of conflict) what interests are the forms, the meaning of the manifestations of the parents, but especially of the deficient child.

The most common form is hyperprotection. We see serious contrariety caused by familial hyperprotectionism in developing the child's relational motivation. On the one hand, the abolition of the attempts of autonomy, self-denial, and on the other hand expressing the feeling of guilty culpability of the parents through the overworking form, lead to serious conflicts in the motivational sphere. When placed under competitive conditions in game or school relationships, these forms of disorder become operative. By itself, hyperprotection is a powerful conflict of the parent's affective-motivational origin, which is transmitted through the child-modelling influence. C. Paunescu and I. Musu consider that "hyperpotectionism is a form of anger, aggression, and faulty dissatisfaction of the parent. All these elements act through relationships that are established in the family group. Due to the fact that with the appearance of a child with a family deficiency, the attention is absorbed by it, it can also cause problems for the brothers. The very slow progression of some children is as if the mother would grow more infant series. Because this can be exhausting for those involved, the child must be the constant concern of the whole family.

In the first 7 years, the child's participation to a considerable extent in conflicts is observed, without the existence of an open communication. When the parents of the deficient child learn to master the relationship between them and the child, they learn the individual aspect, the efforts of the child being felt as a separate, free child fighting for affirmation, as well as the symbiotic aspect, which makes the child's needs to be their needs. Then the brothers will not only want to help, but they will not face a problem in treating him as an equal, respecting the needs of their brother or sister. Studies show that siblings are important components in the social support network of caregivers in age. Many have emotional support from siblings (Seltzer, 1981). Usually, the most involved is a sister, usually older, who lives close to home. The burden and parental stress is lower, morale and health are better when the brothers get involved.

When the child does not have siblings, the parents of the deficient child have the tendency to organize their lives according to the needs of the child. If the situation is not well managed, it can create an atmosphere that can only enhance the child's problem. The deficient child must always meet the specific needs according to the context, and the sacrifices are inevitable on both sides.

It is noticed that the functional disorder of the family group is transmitted as a tensional-motivational form of the child.

Another way of expressing the reaction to a child in the family is abandonment with its degrees and intensity - from masked abandonment, through a form of complete satisfaction to the material needs of life, to the manifest abandonment, the rejection of the child, the total abandonment. For the child, abandonment is a major form in which the need for human dignity is compounded to profound trauma. `` Family relationships are of major importance in that they frame the image of the other " and " of the self ", by the permanent comparison of these images appearing the process of modelling the relational motivation" (I. Musu and A.Taflan).

“The handicapped appears only correlated with a particular environment”, Andre Berge considers. The child is disabled or not depending on the situation in which it is placed. The family is the first child environment and the starting point, the school, then the adult society.

Paunescu found that `the devalorizing parent devalues himself '. The affective message of the child-parent relationship is very important for the deficient child, who becomes aware of his physical, mental and social deficiency. Between him and his social status, a conflict situation begins. `` He is not sick, but has the status of an invalid, incompatible with normality. His state of illness is fleeting and affects non-specific resonators, the state of social incompetence is a condemnation. "

The research found that mothers of deficient children compared to fathers suffer from stress, several symptoms of restlessness, more pessimism, greater family tension, overburdening, their mental and emotional health is weak, probably due to the roles the parents are taking in the family.

In the family environment, emotional character is the greatest force, but also its weakness. We observe how love easily transforms into hatred, as family members cannot be indifferent to each other. Love is not always disinterested: it can be tyrannical, possessive, detonating. When the least turbulence appears in the emotional balance of parents, the disturbances are much greater in children. Thus, in the relational constellation, intra-family conflicts play a very important role. Close, in terms of intensity, are the school conflicts. For the deficient child, school becomes more conflictual.

When the deficient child does not manage to do things as well as he wants, when failures occur, the family must consider that it was just a mistake, a mistake the child wants to fix.

School is the environment in which the child differentiates his / her feelings and structures his / her personality.

Deficient children who are not in their time in specific therapy activities show more or less strenuous backwardness in the development process. If these children are not rapidly engaged in complex therapy, they also have difficulty in the process of schooling. If they are not registered quickly with educational institutions, there may be a delay in development for various reasons.

A first cause is that they have limited access to information and reduced processing and transmission capacity. Reducing the reduction capacity is another cause of slow development.

Another factor that determines the slow development of the child with deficiencies is the limitation of interpersonal and group relationships with the occurrence of isolation and the appearance of the feeling of inferiority (Radu, 1999).

The disease greatly influences personality. The deficient child becomes irritable, selfish in the sense of taking everything for granted.

Due to the illness, the child may have some reactions considered by the patient as a self-defence system:

• Closing in himself - psychically,

• Refuses contact with other people, can lead to refusal to communicate with the family - socially;

• Installation of the "inferiority complex", shame towards people, thus avoidance or hatred towards others - on the psycho-social plane

In the absence of anomalies, physically impairees are normal in terms of intellectual capabilities.

Due to their exceptional situation and the unfavourable environment, their personality can become fragile with pronounced signs of frustration and anxiety, with conflicts and inner tensions with excessive susceptibility and sensitivities that make it difficult to adapt and relate to others and integrate themselves into socio-professional life.

The integrity of knowledge processes of physically deficient children is relatively similar to normal persons.

Stagnations, progresses and regressions are dependent on the quality of the educational-recuperatory process, but also on the severity, type of handicap, etc. Children with deficiencies can undergo disturbances in the general development process.

2. HISTORY AND OBJECTIVES OF THE RESEARCH

We shall start from the hypothesis that: personality is influenced by both disease and environmental factors.

Objectives:

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

3. SAMPLE

This research was conducted on a random, unrepresentative sample of 25 physically deficient subjects with different diagnoses: inferior limb inequality, osteochondrodistrophy, neuromuscular dystrophies, congenital dislocations, myopathy of congenital malformations attending both the Special School (22 of the subjects studied), as well as the normal mass education.

4. RESEARCH METHODS

In this research, the method of testing and interviewing was used as a research method.

5. METHODOLOGY

We applied the CORPORAL PERCEPTION TEST (PSC), PERSONALITY QUESTIONNAIRE H.S.P.Q. TEENAGERS and BELLOV QUESTIONNAIRE FOR TEMPERAMENT IDENTIFICATION as well as the interview.

6. RECOLUTION AND DATA PROCESSING

Subjects are 11-16 years of age with the following diagnoses: osteochondrodistrophy, congenital dislocations, congenital malformations, neuromuscular dystrophies, inferior limb inequality. We compared the IQ of the rural and urban subjects, comparison by age, comparison between the school environment of the rural and urban students, the distribution of the subjects according to the factors I, C, Q, D, E (HSPQ), the distribution of subjects according to temperament (Belov) and the distribution of subjects according to self-esteem.

6.1 Corporal series performance test (psc)

The PSC questionnaire is developed by psychologist A. Cilnciu and outlines a comprehensive dimension of self-esteem through the reunion of physical and mental components. The author starts from the premises: "We all know that we have physical points of strength or weaknesses, which benefit us or not. The interest for our own body is vital because it is "our better or less good home, the place where our youth, health, or their opposites come from". The PSC questionnaire calls for objective and sincere answers by completing a few identifiers and giving marks that express the degree of satisfaction or dissatisfaction with your body or parts of it. The rating is as follows:

3 - deep dissatisfaction with the indicated part of the body;
2 - high dissatisfaction;
1 - slight dissatisfaction;
0 - indifference;
1 - slight satisfaction;
2 - accentuated satisfaction;
3 - strong satisfaction

6.2 Bellov questionnaire for temperament identification

It is taken from the Compendium of Psychology for Coaches (Epuran and Holdevici, 1980) with an important change: assumptions about the four temperaments have been grouped and placed one after the other (choleric, blood, phlegmatic, melancholic), the responses are collected on columns, in boxes marked with a bullet, so that they can be easily processed later. The subject has the right to assign 2 points for full concordance, zero for discordance, and one for the midpoint, with the final score having greater variability (0-40 points for the twenty sentences assigned to each temperament). This scoring method creates the possibility of statistical data processing to see if there is a standard of averages and deviations of the four temperaments.

6.3 H.S.P.Q personality questionnaire for teenagers

This questionnaire simultaneously measures 14 personality dimensions and addresses children aged 12-17 years. Each factor of the 14 is measured by 10 items. Because there are two parallel forms of test A, B, there is a possible increase in the fidelity of measurements, giving the same subject the two forms and summing up the results.

The 14 personality dimensions are independent and are designated by letters of the alphabet. It can be observed that dimensions such as: A - cyclotymia / schizo - thymia and D - excitability, refer to temperament traits and others such as: E - dominance / obedience or F - expansivity / nonexpansivity are what we can call environment related features - C - the force of the self, represents the level of integration while the factor G - the force of the super self is a measure of what is usually the development of the moral sense. A dimension - aptitude was also included, general intelligence factor B. The following factors provide us with information about:

H-Factor (anxiety, shyness) / parmia (courage, insensitivity);
Factor I - harria (hardness, realism) / premsia (emotional sensitivity);
Factor j - dynamic simplicity / neurasthenic tendency;
Factor O - confident adaptation / guilt tendencies;
Factor Q2 - group dependency / sufficient self;
Factor Q3 - weakness of self-feeling / strength of self-esteem;
Q4 factor - low energy tension / high energy tension;

This test was applied to reveal an individual personality profile according to the established objective.

7. CONCLUSIONS

After applying the tests and the interview, we found that:

Anxiety, guilt, inferiority complexes, lack of self-confidence, find justification in a concrete physical plane. The deficient child is not only hypersensitive, but also lacking the experience of the self, the body identity that a healthy person gains through the sense of touch, comfort, and movement.

The deficient child is irritated, selfish, his character reduces the ability to engage in activity, and the illness influences his temperament.

We noticed that all subjects have a low self-esteem, due to their physical deficiency. Their personality is fragile, with frustration and anxiety, with internal tensions and conflicts, excessive sensitization, which make interaction with people as well as social and professional integration difficult.

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

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