ANXIETY OF CHILDREN WITH INTELLECTUAL DISABILITY

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Abstract: Middle school is characterized by strong emotional reactions, manifested by children at the beginning of the scholar phase or during those school years. The most common reaction that occurs in schoolchildren is anxiety, which is being manifested in different intensities due to children's particularities and the general context of their situation.

Starting from this fact I have conducted a comparative study regarding the manifestation of anxiety on typical children versus atypical children – the ones with disability of intellect.

The research objective is to comparatively study the anxiety level at children, and to find differential psychological approaches that fit the category of child.

Keywords: schoolchildren, disability of intellect, anxiety

Theoretical foundation

Anxiety is a manifestation of fear that leads to an amplification of the state of fear towards any difficult situation. Predescu defines anxiety as "a mental disorder mainly determined by psychotraumatic factors whose symptomatology nucleus is represented by anxious syndrome" (Predescu, 1998 p.8130).

Other authors describe it as a diffuse fear without a well-defined object. Anxiety is defined as a personality disorder exhibited through agitation, fear and unmotivated concern, lacking the factors that provoke them. Anxiety reveals itself as a state of fear due to individual's uncertainty, where the

individual has the impression of an imminent misfortune surrounding him, which cannot be described or removed.

Anxiety problems are followed by physiological phenomena such as: palpitations, precordial embarrassment, hard breathing, sweating etc. As psychopathological symptom, the most common is anxious melancholy, in obsessive and phobic neurosis, in the onset of psychoses or in endocrine and cardiac disorders (Popescu – Neveanu, 1978).

The most adequate definition for this clinical manifestation, anxiety, can be seen in the last edition of The Diagnostic and Statistical Manual of Mental Disorders, where it is presented as "*a pervasive pattern"* of social inhibition with feelings of inadequacy and hypersensitivity to negative assessment that is instituted at the beginning of adulthood (DSM. V, 2016 p. 664).

In order to develop personality, both school children and children with intellect disorder face a fundamental problem which is learning, because only by learning they can acquire knowledge, new behaviours, which in turn will influence the further development of intellectual abilities. In this process there may occur learning barriers that can refer to any obstacle in learning. One of those barriers consists of anxiety. (Druțu, 1995)

One of the key aspects of the learning-development approach at children with disabilities in the perspective of their recovery is referring at the variety of deficits that influence the structure and dynamics of personality and that are ranked in a hierarchy being the result of the damage suffered by the body as a result of the interaction of the individual with the environmental factors (Arcan, Ciumăgeanu,1980).

Specific disorders occurring on different levels / sectors of the personality structure in people with intellectual disabilities particularly affect complex psychic functions such as psychomotricity, language, conscious regulatory mechanisms, self-control.

For this reason, it is necessary to apply early corrective-recovery-compensation measures to anxious reactions to achieve the highest possible level of efficiency and especially to prevent the consolidation of maladaptive behaviours (Coman, S 2001).

When it comes to children with intellectual disabilities, certain elements that come into their personality structure - image and self-esteem are of particular importance and greatly influence their relationships with others as well as their self-acceptance. For many of these children, this component of personality determines a complex set of adaptation and integration problems in the school environment, feelings of inferiority, anxiety, exaggerated nervousness, and behavioural disorders. Another particular phenomenon encountered in children with intellectual disabilities in addition to aspects related to the particularities of cognitive processes is the phenomenon of

"affective avitaminosis". This phenomenon occurs after the child's removal from the family. Affective deficiency can have irreversible effects in the affective, moral, behavioural, and characterial spheres, manifested through apathy, non-involvement in game activities, school activities, reticence towards adults, psychic and emotional insecurity, and diminishing social adaptability (Ciumăgeanu,1990).

Both children with intellectual disabilities and children with disabilities in general feel this state of affective frustration, materialized in strong tension states, by obnoxious psychological and physiological reactions (nocturnal enuresis even at older ages), stereotypical movements of the body, anorexia, depression with crying etc.

The lack of educational and therapeutic interventions in certain situations of frustration can lead to the following behaviours over time: complexities of inferiority (compared to other children in school that have better conditions than theirs), complexes of origin (through embarrassing acceptance of belonging) (isolation and the occurrence of marginalization), the institutionalization syndrome (present in children after a period of time spent in an assistance and protection institution, creates a state of inadequacy in the difficult conditions of life, the lack of resistance to the biological, physical and psychic demands, reaction to fear, fear without immediate object (Vrăşmaş, 2004).

The child in this state cannot predict what can happen at certain times, circumstances that he perceives as generating inconveniences, dangers, and troubles. The anxious reactions encountered in children with intellectual disability are often less intense states being perceived as reactive states. (Verza, Păun, 1998)

Among the negative peculiarities of children with intellectual disabilities we can see the following:

- Inability to lead, make decisions, to self-manage, being largely dependent on adult;
- Unjustified negativity, that is, the tendency to act diametrically opposed even to the logically proven demands;
- Rejection of aid as a result of educational mistakes;
- Suggestibility by accepting any external guidance due to lack of experience, poor manifestations of self-control in concrete or unexpected situations;
- Hostility manifested through indiscipline, fleeing responsibility, desire for isolation;
- Rage outbreaks to the surrounding children, surrounding objects, the tendency to destroy the personal belongings of the surrounding colleagues;
- Apathy states, taciturn, lack of verbal communication, indifference, neglect of duties, restraint from game activities, etc.

- Difficulties of self-control, basic needs related to food procurement, physical comfort, security, which cannot be met by children with special educational needs;

There are some peculiarities that outline the personality of children with special educational needs; a large part of them can be diminished and prevented through comprehensive and accurate educational measures and appropriate therapeutic measures. Decreasing and preventing negative affective states and misbehaviour patterns lead to the creation of a positive, tonic, stimulating and affective climate which allows a balanced structure of the child with deficiency and the modeling of its behaviour (Ionescu, Radu, 2001).

As a conclusion we can state that the process of knowing and analysing the personality of the students with disabilities implies a series of problems related to the types of deficiency and the limits imposed by the gravity of the deficiency, the attitude towards the self and the degree of acceptance of the others around. All this knowledge about children with disabilities is a major challenge for special psychopedagogy.

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Methodology

The current research involves a comparative study of anxiety in 15 pupils (8-10 years - girls and boys) in the state school (Gen. No. 20) and 15 pupils (Captain Ignat Special School) with mild intellectual disability and average, coming from uniparental or biparental families.

Psychological tests of intelligence were applied: The RAVEN Test and the Hamilton Questionnaire to determine the level of anxiety in the two classes of male and female students, of different backgrounds, from different families, with varying degrees of intelligence (IQ), to determine the correlation between anxiety and IQ level in the two categories of pupils - normal class and pupils with mild and moderate intellect deficiency.

Results and discussion

The analysis of the descriptive statistics on the subjects' answers to the two questionnaires resulted in the following: As for age, the youngest participant is 8 years old, the oldest has 10, the mean m = 34,4, with a standard deviation sd = 9 29. Primary environment (mass school, special school) average m = 22.3, with a standard deviation sd = 8.27. Family type (monoparental or biparental).

The Hamilton Anxiety Scale, known as the HAM scale, contains 14 questions. Each question can receive between 0-3 points, the maximum being 21 points. HAM is a screening test and not a diagnostic test.

Anxiety is an average m = 8.14 and the standard deviation sd = 4.481, which shows that the level of anxiety is relatively low, referring to the

pathological standard, so the level of anxiety does not exceed the normal sphere.

Hypothesis 1: There is a significant correlation between IQ - the intelligence and anxiety coefficient. For this we used correlations, the Pearson coefficient. r = 0.871 (**), significantly at a threshold p <0.01, meaning that there is a significant correlation between the level of intelligence and the level of anxiety. In item 1 of the column with the coefficient t and the significance threshold, a coefficient significantly lower than 0.01 was obtained which means that there is a significant difference in anxiety depending on the school of origin and IQ, respectively.

Table 1

Descriptive Statistics

	Mean	**Std. Deviation**	**N**
IQ	79.43	33.424	30
Scor HAM	18.53	7.99	30

Table 2

Correlations

	IQ	**Scor HAM**
IQ	1	.871**
Scor HAM	.871**	1
Sig. (2-tailed)	.000	.000
N	30	30

In order to test the established hypotheses, we conducted a correlation study, which is included in the "Correlations" table. The lower the IQ, the level of anxiety decreases and is non-existent in children with intellectual disabilities at the special school. The higher IQ the anxiety level increases in children in normal school.

In the case of anxious children, upper shy who always seek refuge, who feel frightened in front of everything that is strange, new or unusual, if we want to help them, we must focus our attention on neuro-vegetative symptoms.

We have to convey to them the feeling that we are truly caring for their fate and that we want to be real and active companions for them.

The latent trauma of the anxious child is being afraid of being abandoned. The latent trauma of the hyperactive child is that it does not feel desirable (Vrăşmaş, 2001).

Hypothesis 2: There are differences in the type of family environment and level of anxiety. The level of anxiety is higher in children from the uniparental family type, compared to students coming from biparental families.

To combat these manifestations of the anxious-shy child type, it is necessary to keep the child away from everything that is negative and to intervene on time with appropriate psychotherapeutic methods.

According to a qualitative study carried out in Romania by the Save the Children Organization and launched in October 2010, 20% of children suffer from a mental illness, 3.5% were diagnosed with clinical depression and 13% with separation anxiety disorder, panic attacks. In other words, Romania's levels are 880,709 children with mental health problems and disorders, of which 154,124 children with depression and 572,461 children with anxiety disorders.

The problems of recovering children with a limiting intellect are no less important to society in relation to the problems of recovery of children with mental deficiency, because each case of delay, even initially negligible, without appropriate measures to stimulate development and recovery can lead to gradual worsening, ending "by establishing an enormous difference between a delayed and a normal child, an unbroken distance" (Gherguţ, 2005).

The preoccupation of specialists for the early discovery of the problems of a mentally disabled child, psychophysical factors with recovery potential and evolutionary development is in the priority of psycho-pedagogical and therapeutic objectives of special pedagogy for children with disabilities. Without a detailed picture of the parameters that are trained in forming the autonomy of the mental deficient, as early as possible, we cannot discover the methodological tools that we use in the educational-therapeutic act; they sometimes even destabilize more than they build, from where they conclude that they are deserving of the original purpose. (Popescu, Pleşa, coord. 1998)

Forming the autonomy of the mental deficient is the concurrent work of some specialists with equal possibilities of recovery through the prescriptions, indications and paths applied throughout the educational-rehabilitation process.

Conclusions

Given the following statistical data processing, assumptions were confirmed. The lower the IQ, the level of anxiety decreases and is non-existent in children with intellectual disabilities at the special school. The higher IQ the anxiety level increases in children in normal school.

There are differences in the type of family environment and level of anxiety. The level of anxiety is higher in children from the uniparental family environment type, compared to students coming from biparental families.

Specialists who are involved in studying and organizing educational and recuperative activities after the birth of the deficient child should take up their specific tasks even before birth; this way we could get a reduction of some deficient sides.

The educational-therapeutic program begins with the mother, continuing with the birth of the child and following educational activities from the first day, when it becomes a permanent in the life of the child. This approach must be a conception, a practical action useful to the entire body specialized in the knowledge and design of an educational-therapeutic program throughout the evolution of the child with disabilities.

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