# Attitudestowards children with intellectual disabilities in the primary cycle

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**Abstract:** *Attitude is the expression of man's opinions and experience of certain objects, personal phenomena It is influenced by the person's ancestral experience, relationships with others and the individual value system of each. In childhood the attitude is copied after that of the parents, the critical system and the one of its own values are not sufficiently strutted.*

*The author concludes a study on a group of 50 primary school children about their attitudes towards children with disabilities. The findings show that negative attitudes can be skipped, because there are correct counsellors who change the way children think and understand disability.*

**Keywords:***school children; attitudes; children with disabilities;counselling;*

## 1. Theoretical framework

By attitude is meant a psychic predisposition to act in a characteristic face in different situations. Opinion is the verbal expression of attitude. Defining attitudes is that they refer, both implicitly and explicitly to values, to a well-defined axiological system.

G. W. Allport in 1935 proposes the first definition of the concept of attitude. In his view, attitudes are "the predispositions learned to react with consistency to an object or class of objects in a favourable or unfavourable manner." From this unanimously accepted definition, we note that attitudes are learned, not instinctive, that attitude is a predisposition for manifestation of a certain behaviour, that the responses are oriented positively or negatively and last but not least that attitudes are lasting (apud Thibaut, 2017).

From a psychogenetic point of view, attitudes and character traits are formed and structured in the context of relationships that originally establish between child and adult; during adolescence, a group of equal or co-elderly acquire a particular significance. From the same perspective, the attitudes are formed on the basis of the activities, being a form of generalization of the affective experience of the subject in direct connection with the notions and ideas regarding the interpersonal relations (Lewin, 1964, apud Moldovan 2015, p.186).

Attitudes present a series of features that manifest themselves as invariant properties. include:

-*Valance* refers to the affective dimension of attitudes. An attitude may be favourable or unfavourable, positive or negative to a particular object.

-*Intensity* is the power of the affective component. The more an approach approaches one of the extreme poles of a "favourable-unfavourable" or "positive-negative" bipolar scale, the greater its intensity.

-*Centrality* refers to the position of an attitude in all the elements that characterize an individual: social belonging, values, aptitudes etc.

- *The degree of differentiation* of beliefs is the number of beliefs that are present in attitude. The lower the number of convictions, the more attitude can be changed.

-*Specificity or generality* is the way in which an attitude toward an object or a whole category of objects is oriented. For example, we can develop a negative attitude towards a brand of soft drinks or all brands of soft drinks (Verza and Verza, 2017).

Functions of attitudes are presented differently from author to author, this being especially possible because attitudes are very important in the whole of an individual's psychic life, being directly or indirectly connected with all the processes and components of the personality and interaction between individuals in a social context.

In the literature, attitudes are considered to have four functions:

- *The cognitive function* is accomplished by attitudes formed by the individual experience that hierarchizes and orderings perceptions.
- *Utility function* Attitudes also exert an instrumental or utilitarian function. Attitudes also form a social adaptation function. By doing so, we express attitudes that allow us to receive the approval of others.
- *The function of expressing the value*. attitudes are a means of expressing self, self-reliance and self-development.
- *The self-defense function.* the indi- vidual forms certain attitudes to defend himself from external threats or internal deficiencies (apud Craciun, 2005).

Intellectual disability, one of the major psychiatric dysfunctions, is a concept that is still undefined with precision, involving many aspects of a medical, psychological, pedagogical, sociological and even legal nature. Generally, intellectual disability (synonymous with mental deficiency) means a significant reduction in mental capacities that causes a series of disruptions of responses and adaptation mechanisms of the individual to the conditions of continual change of the environment and to the standards of social cohabitation in a which places the individual in a state of incapacity and inferiority, expressed through a state of disability in relation to the other members of the community to which he belongs (Chircev, 1989).

Intellectual disability is understood as a global deficiency that significantly influences socio-professional adaptation, personal and social competence and autonomy, affecting the whole personality: structure, organization, intellectual development, affective, psychomotric, adaptive-behavioural.

In the United States, the American Association for Intellectual Disability considers that this deficiency exists whenever there is significant intellectual activity significantly below average associated with adaptive limitations in two or more areas: communication, self-care, social networking, community services, situational orientation, health and personal security, knowledge applicable in everyday life (Sima, 1998).

In our country, the first rigorous definition of mental deficiency belongs to Alexandru Roşca (apud Buică, 2004), for whom this abnormality represents a state of restricted potency or a stop in the cerebral development, after which the person reached is unable to mature adapt to its environment, to the requirements of the community, so that it can maintain its existence, without oversight and external support.

Ionescu and Radu (apud Bonchiş, 2000) understand by mental deficiency the type of deficiency determined by a complex of etiological factors with unfavourable action on the brain during the maturation period, having two main consequences: to stop or slow the pace of evolution, especially of the functions cognitive and diminishing social competence.

Bonchiş (2002) states that mental deficiency refers to the phenomenon of organic damage and/ or functional impairment of the central nervous system, with negative consequences on the process of mental maturation, development under different aspects of the individual concerned. Mental Disability is the disadvantage that mental deficiency creates in the context of adaptive and integration relationships of the individual in the social environment to which he / she belongs.

In some specialty circles, a distinction is made between the mental deficiency, which indicates an abnormal level of organization and mental functioning, with direct implications on the organization and structure of the individual and the deficiency of intellect, a term that

denotes the inability of the individual to deal with tasks included in the act of learning, as a consequence of the inadequacy of these tasks, often overloaded in school, to the specific and actual potential of the child. In other words, mental deficiency - which is an impairment of evolution and development due to the pathology of organizing and functioning of psychic structures, differs from the deficiency in the intellect where, even under the conditions of a normal mental organization, the individual cannot exceed certain limits adaptation and learning (Bonchiş, 2004).

Specialty literature uses a number of synonymous terms to describe mental deficiency, of which the most common are: mental retardation, mental retardation, oligophrenia, mental retardation, mental impairment, mental retardation, mental retardation, mental disability, mental debility, behavioural alteration adaptation, alterations in learning/ social skills/ maturity, etc. (Cosmovici, 1999). Due to the fact that these terms, with the exception of the last two, have a blatantly pejorative nature, the specialists have decided in recent years to use the term intellectual disability.

Most of these terms are mostly used in the psychiatric field. In recent years, medical terms, specific to psychiatric, classical and modern nosology, are used less in the field of special psychopedagogy, with strong recommendations from practitioners in this field to abandon medical terminology due to the effects induced by the psychological nose label and negative public perceptions / representations about this category of people (Gherguţ, 2016).

This attitude is of great importance, especially from the point of view of the socio-professional integration of individuals and the removal of the mentalities and prejudices that constitute real barriers to the understanding, acceptance and valorisation of those persons.

To support the theoretical foundation of mental deficiency, specialists have proposed several theories most frequently cited (Vrasmas 2004):

- *Etiological theory:* explains the nature of mental deficiency through the multitude of factors that determine it;
- *Symptomatological theory:* defines mental deficiency by reference only to certain mental processes and phenomena (thinking, intelligence, affectivity, will); Within this theory there were several currents:
    - Seguin (apud Gherguţ, 2016) characterized the mentally deficient as a subject of will;
    - Intellectual currents emphasize mental insufficiency, reduced mental level in defining mental deficiency;
    - Lewin and Vigotsky formulate the dynamic theory of mental debility, integrating mental deficiency into the complex system of mental processes and phenomena, with all the consequences on the development and evolution of the personality of the subject;
- *Theory of specific syndromes:* it is supported by a series of theses, among which we refer to the thesis of heterogeneity, heterogeneity, heterodevelopment, social incompetence, the theory of genetic viscosity, the thesis of inertial cognitive processes, thesis of stiffness of brain structures and others;
- *Psychoanalytic and Psychosocial Theory:* It explains the appearance of mental deficiency as an effect of lack of affectivity (especially of the mother) in the early years of life of the child, favoring the installation of a pronounced inhibition at the level of the thalamus, lacking affective stimuli and leading to a structural-functional failure of the bark due to the suppression of stimulus intake at this level; it is known that through the genetic program in the early years of life, the development of nerve links by increasing the number of synapses is based on a high incidence of cerebral stimuli and the concomitant occurrence of neuronal anatomo-physiological structures responsible for the acquisition of the information (Holdevici , 2000);

- *Integrated theory:* This theory, supported by Paunescu (apud Gherguţ, 2006) explains mental deficiency as a pathology of organization and functioning of mental structures and personality as a whole.

Recovery programs for mentally disabled seek to harness the intellectual and aptitude potential of the mentally disabled child, assuming that any progress made in recovering and developing personal and social autonomy will allow a higher level adaptation and integration in the family and community environment as a condition for normalizing the lives of these categories of people (Dikel, 2015).

Here, we can also mention the Declaration of the UNESCO World Conference on Special Education at Salamanca (1994). This document sets out fundamental changes in the education policies of the signatory states for an inclusive education approach, enabling schools to serve all children and, in particular, those with special educational needs.

The set of rules developed and promoted by the United Nations provides each country with responsibility for ensuring equal opportunities for the education and professionalisation of people with disabilities.

## 2. Research Hypothesis

It has been assumed that a proper counselling of parents and children can change their attitude toward children with disabilities.

## 3. Sample

Two Second Classes of Children from the General School no. 19 Arad, comprising a total of 25 children each participated to the study. In the whole group of 50 children there were 5 children with intellectual disabilities.

## 4. Methodology

A Likert scale of 5 items was built, to which the children had to respond, giving values between 1 and 5, 1 meaning no, never, and 5 very often. The Likert Scale has been applied to children to highlight their attitude towards children with intellectual disabilities that they have as peers. At the same time the Likert scale was also applied to a shoulder of 42 parents of children who accepted to partake in research.

In the experimental phase, counselling was provided from the perspective of the social assistant, both of the children and the parents, to make them understand the disability better and change their attitude towards it. This stage lasted two months.

In the last phase the Likert scale was applied again to see the results obtained in changing the attitude of the children and parents after counselling.

## 5. Results and discussions

Table 1 and Figure 1 give the frequencies of responses to the five items of the Likert scale for children.

Table 1. Children's responses to Likert scale items

| | Items | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| a | Staying with me in the bench | 37 | 5 | 3 | - | - |
| b | Be on my team | 40 | 3 | 2 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| c | Play with him | 39 | 2 | 4 | | |
| d. | Come to the party | 44 | 1 | - | - | - |
| e | Go with him in a trip | 42 | 2 | 1 | - | - |

It is noticed that most of the answers are in the category at all or never. This meant that children do not want to have any connection with disabled children: they also do not want to stay with them in the bank or join their team or play with them and participate in a party or trip. This child respiration attitude can be explained in two ways: on the one hand, it is inherent in age that children do not accept anything that is not similar to what they know is normal and ordinary, and on the other hand their attitude reflects in great attitude, the attitudes they have taken from home, from parents.

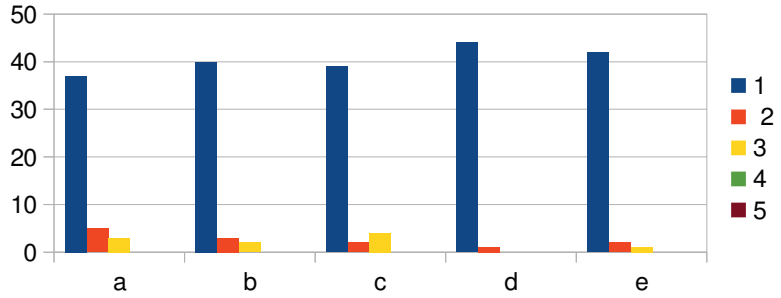


Figure 1.Children's responses to Likert scale items

Even though I feel a kind of sense of mercy towards children with disabilities, it is quickly seduced by the attitude of the other children who also show their rejection towards this category of children. Our task as social assistants is to ensure that the pupils' class will have a good integration of children with disabilities. This makes them accept and quote in various activities by their classmates.

The parents' responses to the Likert scale are illustrated in Table 2 and Figure 2. We mention that of the parental sphere approached only 30 wanted to participate in our research.

Table 2. Parents' answers to the first application of the Likert scale

| | Items | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| a | Staying in the bench with my baby | 12 | 8 | 5 | 4 | 1 |
| b | To be teamed with my child | 9 | 9 | 8 | 3 | 1 |
| c | To play with my baby | 10 | 10 | 4 | 5 | 1 |
| d. | Come to my baby's party | 13 | 7 | 6 | 3 | 1 |
| e | Go on a trip with my baby | 11 | 8 | 5 | 4 | 1 |

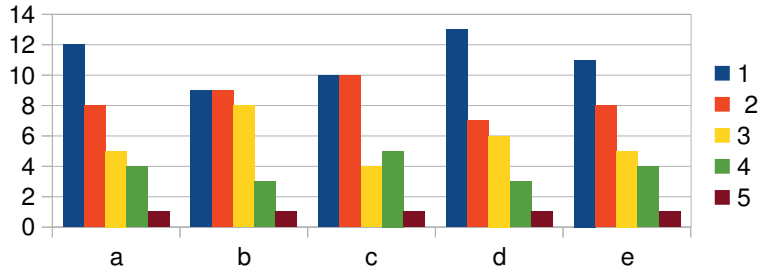


Figure 2. Parents' answers to the first application of the Likert scale

It is found that parents' responses are more diverse than children, but they also dominate the answers on the left of the chart, reflecting the attitudes of rejection of children with disabilities. A single parent agrees to accept unconditionally the presence of children with disabilities. We are no longer surprised by the answers of the children, if the parents' attitudes are those presented in the table and figure above. The children took the attitude of rejection from their parents. Parents, from a misconception of protecting their child, are reluctant to dissuade children with disabilities, so that their children may not be bothered.

The two-month counselling phase followed. With the children, the counselling was done during class hours, and it was explained to them that children with disabilities are just like them, that they feel inferior when they are rejected, that they would like to hear from all their hearts to participate in all activities with the others and even the madrids are invited to a party or on a trip.

Table 3. Children's responses to Likert scale items after counseling

| | Items | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| a | Staying with me in the bench | 2 | 12 | 10 | 6 | 15 |
| b | Be on my team | 3 | 2 | 9 | 12 | 19 |
| c | play with him | 1 | 1 | 10 | 14 | 19 |
| d. | Come to the party | 3 | 5 | 9 | 17 | 11 |
| e | Go with him in a trip | 2 | 2 | 11 | 12 | 18 |

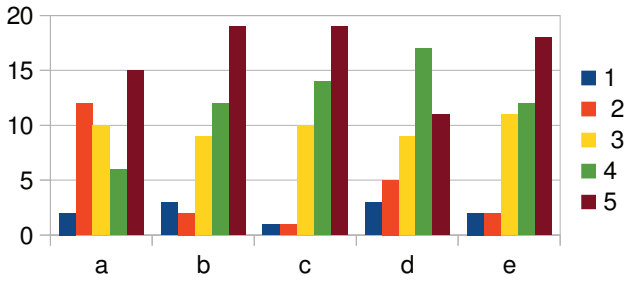


Figure 1. Children's responses to Likert scale items after counseling

With parents, the counselling was done at the end of the hours, when they wanted to take their children from school. Generally, the parents participated in a shoulder of 6 honeymoon sessions during the two months, while with the children 12 sessions were held.At the end of the counselling, after the passing of the two months, both children and parents were again asked to respond to the items of the Likert scale.Children's responses to Likert scale items after counselling are shown in Table 3 and Figure 3.

The table shows an obvious shift of children's responses to the quoted pole number 5 with very often. This means that children have changed their attitudes towards children with disabilities and are trying to get them into their activities. There are still some retirements in terms of accepting children with disabilities at their birthday parties or accepting them as bank colleagues. In addition, the children were receptive to counselling, understood the feelings of discomfort and sadness that children with disabilities are living when they are retired and strive to make them feel as good as possible by including them in their activities during school hours.

For parents, the answers after counselling are presented in Table 4 and Figure 4.

Parents also show an improvement in attitudes towards children with disabilities, though not as spectacular as children. This may be due to the fact that in parents, attitudes are formed for a long time and have become habits that are more difficult to modify. However, the progress made makes us believe that in the future they may also get a proper attitude towards this category of children.

Table 4. Parents' responses after counselling

| | Items | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| a | Staying with me in the bench | 7 | 7 | 4 | 4 | 8 |
| b | Be on my team | 5 | 5 | 4 | 3 | 13 |
| c | play with him | 7 | 10 | 1 | 1 | 11 |
| d. | Come to the party | 8 | 6 | 3 | 3 | 10 |
| e | Go with him in a trip | 6 | 7 | 2 | 3 | 12 |

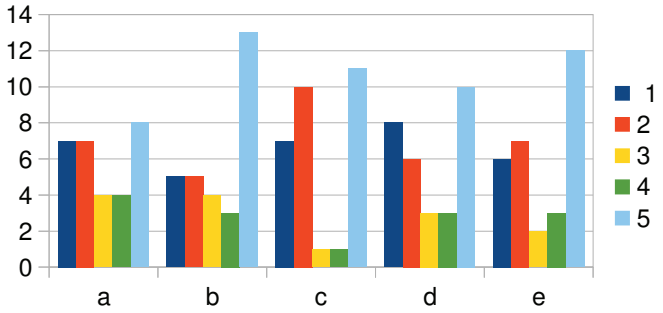


Figure 4. Parents' responses after counselling

## 6. Conclusions

The research has highlighted the fact that both children and parents have a number of negative attitudes towards children with disabilities, attitudes that can be explained by the misunderstanding of their disability and the erroneous interpretation of their need for integration. The social worker, in team with the psychologist and the primary education teacher, must ensure the conditions of maximum integration of these children in the school table. Let's not forget that the collective of the class is a social microgroup that reflects the society later on. That is why the integration of children with disabilities into the classrooms of the students is a prerequisite for their future integration into society. This integration starts as early as possible, because as our rate and research do, children are more likely to change attitudes than adults. A proper counseling for both parents and children can lead to a good integration of children with disabilities and thus to their assimilation into the future society.

**Acknowledgement:** We hereby state that the subjects involved in our research were informed about the voluntary character of participation in this research, about the understanding of information and of that fact that withdrawal from research is possible at any time without negative consequences upon the participant. The research complied with all ethical research standards, the research participants/participants` guardians giving their consent to participate in the research.

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