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# THE WELLBEING OF THE PEOPLE WITH DISABILITIES

## DOCTORAL THESIS
## SUMARRY

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**KEY CONCEPTS**: happiness/wellbeing, people with disability, social exclusion, integration, inclusion, normality/abnormality, personality, self-knowledge, self esteem, attitude, out-siders.

## INTRODUCTION

The objective of this work is to highlight that happiness/wellbeing is essential for a normal life. People with disabilities must have equal opportunities to a fulfilling life. Our attitude towards them contributes to the image in their "social mirror". To live means to choose. Every moment of our life we are confronted with dilemmas, we have to move to the left or to the right, to leave or to remain, life is a game in which we have to appreciate the card we count on. To cry about our potential differences means denying an obvious: life is varied, it is like a play in which roles are different distributed, so everyone might have a place (Jalenques, 2008, p.51).

The wellbeing we call happiness isn't an attribute of reach, beautiful and healthy people. The right to life, equal opportunities, normalization principle, promoted by all international organizations and adopted in every nation constitution, provides the right to a superior quality life, the right of personal self-fulfillment.

Happy people are more sociable and more energetic, likely to do charity, more cooperative and more pleasant by others. The happiness has many positive side effects, leads to experiences based on joy, thanks, love, proud and, on the same time, allows us to improve certain aspects of our own life: energy level, immune system, commitment to work and to our neighbors, mental and physical health. When we become happier, the self respect and self confidence increase. The benefit will be ours and our families, our community, our society in general (Lyubomirsky, 2010, p. 42).

The attitude of others contributes to our wellbeing. Our daily "social mirror" shows us the way we are perceived by others and feeds our wellbeing or, contrary, it is pushing us in the gap of loneliness and suffering.

## CHAPTER 1
## THE HAPPINESS

The first chapter of this work includes 8 sequences: **Happiness as a purpose; Historical perspective; Positive psychology; The concept of happiness; The components of happiness; The ways through happiness; The measuring of happiness; The right to be happy**.

The approach starts from the importance of the word happiness, a word which appears very often in common language. Psychologists dealt decades after decades with unpleasant emotions. Together with neuroscientists they have struggled to find out how fear, anger and depression appear (Klein, 2006, p.6).

In the last half century psychology concerns have focused mainly on mental illness. Measuring instruments schizophrenia, depression and alcoholism have been clarified and formed. Unfortunately, this progress was paid very dearly, because the interest on improving conditions that cause misery decreased the interest to strengthen those who do more than simply correcting their weaknesses. Psychology has neglected, unfortunately, the positive side of life. Every one hundred articles on sadness, there is only one about happiness (idem, p. 25). Appearance of positive psychology, led and named by Martin Seligman, brought some new concepts, applicable to all people, no matter how happy or unhappy they consider themselves. The central idea of positive psychology is that we need to focus on authentic sources of happiness, that give meaning to our life. We should deal in particular those sides of life where we truly excel, that is on our strengths, because in order to continue it is more important to cultivate our capacities than struggle with our weaknesses.

Most articles and treaties on happiness, which gather the experience from the many experiments and observations, call happiness: *subjective well being* (Diener), *subjective welfare* (occurred within 50 years as a social indicator), *quality of life*, *optimal experience* or *flow* (Csikszentmihalyi, 2008), yet the word *happiness* doesn't miss in their titles. Perhaps these synonyms are modern versions of the concept of happiness, born out of the desire of researchers to distinguish a scientific name for a term used too common, it is an analytical gain by differentiating the connotations that the term has in common vocabulary (Bălţătescu, 2009, p. 36). In our view, happiness is the preferred term

considering that this is the most comprehensive and most representative for our purpose and taking into account the fact that the instruments used to measure life satisfaction, happiness in a given time or overall happiness, are based on self-conscious subjects.

Chu Kim-Prieto, Ed Diener, Maya Tamir, Christie Scollon and Marissa Diener (2005), have identified three possible approaches to subjective well-being (SWB), each offering its own conceptualization and a specific way of measuring: *overall assessment of life and its aspects, subjective perception of well-being, experimenting some emotions several times, in a certain period of time*. In their research, they concluded that there is a correlation between subjective wellbeing and the different measurements used, but this correlation, being moderate, it is recommended the use of different instruments, to eliminate any potential errors. They considered wellbeing a concept that consists of four components taking place while influencing each other: *life events and circumstances, emotional reactions to these events, evoking these reactions, overall assessment of life.* The correct evaluation of wellness means to measure all these four components, neglecting of one might lead to wrong results. On his turn Seligman (2007), founding positive psychology in the late 90, gathered around him a number of experts who have joined forces in happiness study: Sonja Lyubomirsky, Ken Sheldon şi David Schkade. They offer us a "happiness formula" (Seligman, 2007, p. 77):

$$\mathbf{F = T + C + V}$$

In this formula **F** represents the degree of lasting happiness, **T** - range of genetic trends, **C** - life circumstances and **V** – factors under volunteer control.

The author highlights the need to distinguish between *momentary happiness* and *lasting happiness*. In terms of concept *range of genetic trends,* introduced into the equation indicating that we inherit a kind of "guide" which guides us to a certain level of happiness or sadness, each of us has a predetermined range of genetic trends, a fixed level of happiness inherited to which we return. Life circumstances can change for the better happiness, but it is a difficult and costly change.

In his book, *Happiness theory*, Jonathan Haidt (2008, p. 128), takes the positivist formula with small changes:

**F = PF + C + V**

The level of happiness that we feel is the sum consisting of the biological fixed point, plus living conditions and voluntary activities.

Permanent anxiety and sadness are risk factors for health that put the stress on the body, this in turn increasing the risk of myocardial or cerebral concussion. Unlike stress pleasant feelings stimulate the immune system, intellectual performance. Happy people are more creative, more sympathetic and more willing to see the good in others, are more involved in the community life, are better negotiators. Each author or book written on happiness is trying to give us the most important "keys" or "steps" to reach its maximum level. If Seligman (2007) suggests three ways to achieve happiness: pleasant life, good life and meaningful life, Csikszentmihalyi (2008) considers the flow - "optimal experience" - a state that helps to build psychological capital that can be used in the subsequent. Lykken (André, 2003, p. 119) proposed a HAP standard (abbreviation word for happiness) suggesting to measure each activity and each moment: Hap many count for a walk in nature, for a meal with friends, work carried out successfully. Two of the dimensions of happiness can be measured: one is purely psychological, subjective feeling of satisfaction with one's own existence ("I am satisfied with my life") and another is an emotional dimension, which depends on the frequency of positive mood ("I feel good often") (André, 2003, p. 123).

Given that we often find around us people with disabilities, we seem to justify the following questions: Is happiness a right for all? And if so, may those who were born with a disability or acquired it at some point, be happy? Are there differences between the chances of individuals who have disabilities and those so called "normal"? Where is the border between disability and "normal"? Are or aren't people with disabilities "normal" persons? What is normality?

## CHAPTER 2
## PEOPLE WITH DISABILITIES

Chapter two has 7 parts: **Conceptual boundaries: deficiency, disability, handicap, person with special needs; Definitions adopted by the World Health Organization; Disability and handicap dimensions; Evaluation and expertise of people with disabilities; Evaluation of children with disabilities for educational and remedial intervention; Features developing of people with disabilities; Segregation – the "normals" attitude against people with disabilities along the history.**

The issue of persons with special needs form a complex semantic field located in a rapidly changing, and at the same time, calls attention to how those terms are used, because they don't reflect the reality all the time and can harm human dignity. Psychopedagogical literature use more terms. Depending on the approach to the issue of people with special needs, these terms can clarify a number of useful semantic demarcations accurate and nuanced understanding of the phenomena under consideration (Ghergut, 2001, p. 12): medical question - impairment, functional aspect - the inability or disability, the social aspect – handicap. Searching for a uniform definition to be both rigorous and not stigmatize, was the subject of concern in recent years. World Health Organization has proposed the usage of three different concepts, used by that time but not in a uniform manner (Manea, 2008, p. 8): infirmity or deficiency (impairment), incapacity or disability, handicap. Based on these distinctions the International Classification of Impairments, Disabilities and Handicaps (ICIDH-1) has developed and was adopted as a working document by the WHO in 1980. ICF is a tool for achieving the rights of persons with disabilities but also a valuable method in the standardization of health states, unification and diagnostic approaches for assessing the health and functionality.

A "measurement" of disability is dependent on two factors: fidelity and validity of the scales and the quality of the medical care (the current status of the diagnosis and prognosis, estimating the trend of evolution). Evaluation and expertise of people with special needs is very important. It is an ongoing and vital process, based on a number of important elements: a certain philosophy of evaluation, coherent and uniform construction of the content evaluation, modern and flexible legislation. When a child with

disability is evaluated, the following correlated areas are assessed: medical evaluation, psychological evaluation, educational evaluation, social assessment. When assessing children is to determine the quality and the operation of the anatomical structures, bodily functions, activities and the participation of the child with disability in social life, taking into account the environment in which he lives, extent or not receiving appropriate services and interventions, including: prosthetics, technical means, care, rehabilitation, education, etc. Evaluation of children with disabilities is a complex process estimating quantitative and qualitative features of development and learning ability of children. It regards to planning and programming personalized service plans and personalized intervention programs.

The concept of development means sequential changes of an organism from birth to death, changes caused by hereditary or environmental factors interacting with education, taking place on several levels (Ghergut, 2005, p. 52): physical development, cognitive development, psychosocial development. "Cognitive architecture" of the human psyche, is allowing an individual to learn from its relationship with the environment or from personal experience.

Specific process development disorders in people with disabilities take place in different levels of personality structure, any deficiency disorders presenting a series of derivatives, more or less pronounced, affecting particularly complex mental functions and processes: psychomotricity, language, regulatory mechanisms of conscious, self-control, etc. (Ghergut, 2005, p. 129). Over time, a person with disability has been addressed differently from epoch to epoch. Deschamps (apud Vrăşmaş, 2001, p. 9), analyzing the attitude of society towards children with disabilities, mentioned four types of reactions: extermination, segregation, granting citizenship reduced, the recognition of equal rights.

## CHAPTER 3
## NORMAL AND " ABNORMAL"

The third chapter includes 3 sequences: **Personality between certainty and assumptions, between scientific and empirical – Normality; The emotions of the**

**people with disabilities; Personality of the person with disabilities. Deafs and hard hearing.**

Common features of personality definitions are highlighted by Perron (apud Dafinoiu, 2002, p. 31): globality, consistency, permanence. The three features points out that personality is a structure, as Allport stressed in 1981: *Personality is the dynamic organization within the individual of those psychophysical systems that determine thought and behavior characteristic*.

Psychology applied the attribute personality to human being in the process of reaching its socio-cultural synthesis to some determinants:

- Relative autonomy in relation to the living environment (capacity for self caring, self managing, maintaining balance and identity);
- Capacity to anticipate and self control;
- Active integration into the community, achieve their own value system;
- Service of activities for the benefit of society;
- Intellectual level high enough to have personal autonomy;
- Awareness of their existence development, awareness of self and world.

The concept of personality can not be reduced to a simple definition, but rather an inventory of numerous attempts to develop a more complex and comprehensive definitions. One can speak about theories of personality rather, a structured set of concepts that make it possible to understand the behavior and development predictions, about testable hypotheses. Of the above mentioned, one can conclude the following: human personality *is the unit and not repeating combination of the psychological traits which characterize stronger and in a greater degree of stability the concrete man and its methods of behavior* (Jurcau and Megieşan, 2001, p. 66).

One can't draw some clear and precise lines between those things that the society we live in distinguish the normal from abnormal. Compliance with the rules of a collectivity, in a given society, on a certain time, may be inconsistent with diversity. This example is about people with disabilities who have always been part of human experience, disability resulting from a complex interaction between the individual and society. Subnormal person, or the person with a disability, is nothing but a real dimension of diversity, without which humanity can't exist, disability being a strong challenge to

diversity. In the consciousness of a disabled person coexist the aspiring to become a normal individual, together with a painful evidence of failure compared to the performance of the “normal” model. Disability awareness is always the balance to be inclined to failure. A conflict arises inside the disabled person's soul between the desire to achieve, to reach the "normality" and the barriers imposed by his disability (Gregory, 2002, p. 13).

The discovery of the disability of his own "uniqueness" in a negative sense, opposites and often leads to feelings of tension. Early on he is forced to make contact with the deficiency, to regard it as something very particularly, shameful, and later the disability becomes the "whip" that other children to hit and humiliate him (Gregory, 2002, p. 14).

People with disabilities, conscious of their handicap, become rebels and try to escape the label pursued there. The road until accepting the condition of disability is much longer than anyone else`s. In deaf’ case, like in any person’s with a disability, he is going through the same difficult stages. In his article, *Dealing with the Feelings*, Mitch Turbin (2004), identifies five stages through which the deaf passes until he accepts his deaf identity: denial, anger, reconciliation, depression, acceptance.

Maria Anca in hers work *Psychology of hearing impaired* (2001), gives an insight into how the lack of hearing affects the normal, harmonious development of the child, as can be seen from what follows. Hearing deficiency leads to limiting language, adversely affecting the assimilation of information through the medium, like organization of memory and adaptive flexibility. Sensory deprivation alters all the psychophysiological buildings of the child’s world. Among the most important functions of the hearing are: *background function, signaling function, heuristic function*. One can speak of a *symbolic function* of hearing too, which is related to the acquisition and development of language and interpersonal communication.

## CHAPTER 4
## SELF – KNOWLEDGE

Chapter 4 includes 6 sequences: **Self-knowledge; Self Esteem; Human development, between general and particular; Self esteem of deaf children – the perspective of hearing researchers; Self esteem of deaf children – the perspective of deaf researchers; Conclusions.**

Effective functioning in the socio-professional is due to correct self-discovery and self-regulation of the person. Self-knowledge and self-acceptance are fundamental variables in optimum function and adaptation to the social environment, in maintaining mental and emotional health. Self is an essential component of personality which is a very complex entity. On the basis of our self is our experience stored in our long term memory, which has maintaining it's scheme relatively stable and this involves organizing the information that people have about themselves, the characteristics, the attributes, the beliefs, the social status, the family status etc., in a word: *who and what are they*? (cf. Ross, 1992, apud Bonchiş and Secui, 2004, p. 261).

Self esteem is one of the basic human psychological needs. The level or the lack of self esteem has an impact on all major aspects of life: thinking, emotions, hopes, values, choices, purposes. Deviation from a balanced self-esteem can lead to psychological problems, which in turn may affect its level, showing that there is a reciprocal relationship between them. It is a fundamental dimension of any human being. It relates to how we evaluate ourselves, how good we consider ourselves compared to our expectations or with others. It's actually an evaluative and affective dimension of self-image (Băban, 2003, p. 72).

The concept of development refers to changes in the body from birth to death, changes due to either biological processes or interaction with the environment. Researchers have tried to establish a standard scale development that would include what is characteristic of each age. Reference to this, have observed that there are children who can not follow every step to set standards and this is due to a deficit or a deprivation or to a family or cultural deprivation order (Băban, 2003, p. 38). Children with disabilities have an unusual development, very hard to relate to a particular "scheme". They are different and "unique" at the same time. Their normal development is hampered due to a

"lagging behind", due to a different rhythm of development, unmistakable and specific. A disability occurred once, leads to a handicap, which, in turn, causes a different disability and the chain continues to deepen the differences between the child and his peer and his recovery is more difficult. Pitfalls that await him are depression, isolation, lack of motivation.

## CHAPTER 5
## A SOCIETY FOR ALL - RELATIONSHIP BETWEEN HANDICAP AND SOCIAL EXCLUSION

Chapter 5 has 6 sequences: **Disability as stigma; Integration; Integrated education; Inclusion, Models and forms of realization of integrated education; Conclusions.**

Social exclusion of disabled people means not only fewer resources, but especially their difficulties or inability to participate effectively in economic, social, political and cultural life, or even alienation and distancing from ordinary society. Education of people with disabilities has been done for a long time especially in segregated forms as special education, separate from the usual. Goffman (1990, p.13) uses the term stigma, referring to an attribute that profoundly discredits, as a reference to a language of relationships, and not a language of attributes. Goffman's analysis focused on three types or categories of stigma: abnormal body (physical deficiencies), individual character defects, negative traits associated with race, nation, religion. Following Goffman, the fundamental effect of the stigma is to reduce the stigmatized person's life chances through discriminatory actions.

Rejection is a very painful experience. To be rejected because of what you are, to have the feeling that people avoid you because of a certain race, nationality, religion, social class or disability, lead to a great destructive pain. Even the rejection by some unknown and unseen person, being in a situation without a concrete stake or the fact to be ignored in any discussion, may cause disruption of self-esteem (André, 2010, p. 235).

Considered at first as a goal of normalization, then as integration and recently as inclusion, joint effort of implementing the educational opportunity for all children, to provide normal living conditions, is applicable and useful in any society, because it can be adapted to any social change. **Integration** means that the relations between

individuals are based on a recognition of their integrity, common values and rights that they possess. The relationship between the individual and society is the base of integration, which works on several levels, from simple to complex (Popovici, 1999, p. 19): physical integration, functional integration, social integration, personal integration, integration in society, organizational integration. The ultimate goal of any integration activity is, in fact, a full inclusion of people with disabilities. To achieve this objective, it is necessary to resolve the social rejection these people experience by society. In order to complete the successful integration of children with special educational needs, it must go through several distinct phases, seeking to ensure optimal conditions for a new form of organization of the school (Ghergut, 2005, p. 273): *awareness, training, decision, transition, evaluation process.* Returning to the awareness, our experience enables us to appreciate that the first representatives of schools, who should be convinced of the need to integrate children with special educational needs, should be the school managers as they have the power to decide, control and support the work in those institutions. In kindergartens and schools, the first place where the child comes in close contact with foreign people and young children nearest age, the teachers have an essential role. Their attitude is extremely important for the child, the way he is accepted, watched, encouraged, or rather rejected, tagged, brutalized, can affect the entire life of the small happiness candidate, it can trace the journey of his life in a desired direction, or conversely, it can condemn him to loneliness and suffering.

## CHAPTER 6
## ATTITUDE

Chapter 6 includes 8 sequences: **Conceptual delimitation; Horizontal and vertical structure of attitudes; Formation of attitudes; Functions of attitudes; Structure of attitudes; Changing attitudes; Stereotype, prejudice and discrimination; Out-siders**.

The need to be together with others shows the fundament of socio-cultural personality. The way we relate to those around us, constantly forces us to rethink our personality. We look around for approval, and we often ended up as others see us. We want to beloved and we love those who love us, or we hate those who reject us. The

opinions, the beliefs and our convictions are always dependent on others, which are for us a benchmark, because it enables us to build our selfimage as close as it is possible to the truth (Chelcea, 1994, p. 57). Our relationships with those around us are accompanied by attitudes. Attitudes and supportive relationships are two sides of the same reality, because the attitudes reveal in the relationships of individual systems, but these are also formed grace them.

The concept of attitude has been first introduced in the German experimental psychology from the early twentieth century, with a different sense from common one, with reference to posture, with the role of attitudes to explain the relationships between stimuls and subject response (Neculau, 2004, p. 127). Most psychologists promoted the idea of three components or sources of attitudes, outlined for the first time by Rosenberg and Hovland (Radu, Iluþã and Matthew, 1994, p. 65): affective component, cognitive component, behavioral or conative component. Attitudes operate like schedules and scenarios, they are saved and stored responses from people, events and situations, being the shortest way to draw us how we respond.

Katz (1960, apud Boza, 2010, p. 20) points out four key functions of attitudes: function of knowledge, adaptation function/utility or instrumental, expressive function, the function of self defense.

Regarding the structure of skills, in the literature there are several models recognized: uni-dimensional model, three-dimensional model, sociocognitiv model, schematic model, the model representation of attitudes, the associative model, associative-integrative model of attitudes and self variable.

*Persuasion refers to changing the attitudes or personal beliefs produced by receiving a message* (Cochinescu, 2008, p. 109), is the process of changing the attitudes of others by arguments, means related to them (Leahey, 2003, apud Cochinescu, 2008, p. 109), the act of communication being intended to modify the individual's mental set (Corneille, 1992, apud Necolau, 2004, p.136).

Studies of stereotypes, prejudice and discrimination can be considered a continuation of discussions about attitudes, they are different facets of inter-group attitudes (Neculau, 2004, p. 262). We can classify intergroup attitudes: *stereotypes* – refers to the cognitive dimension or reporting mainly cognitive to a group or its

representatives; *prejudice* - is the affective dimension; *discrimination* - refers to the behavioral component or behavioral consequences, determined by stereotypes and prejudices. Most times the three concepts are negative connotation. In the research in recent years they have taken more account of the fact that stereotype, prejudice and discrimination can be both negative and positive, sometimes they are even complementary, because discriminating negatively out group members it involves to discriminate positive the members from own group (Neculau, 2004, p. 263). Belonging to a particular race, nationality, religion or another type of such a group may prove a negative, a characteristic attributed to a stigma based on a social level by this membership. "Status out-sider/deviant" born of the labeling, occupies often a central position in the personality system, more precisely in the identity. Because of this appears persistence in deviance, after the principle of the self fulfillment prophecy, where the label becomes part of the self image (Cochinescu, 2008, p. 197).

## CHAPTER 7
## RESEARCH METHODOLOGY

### Objective and hypotheses

Our research started from the idea that people with disabilities have a lower life satisfaction than people without disabilities, their subjective wellbeing was affected by life circumstances. Attitude of others, especially relatives: family members, teachers, peers, prejudices, segregation and finally self-segregation, do nothing but further decrease of the chances of people with disabilities to live a fulfilled life.

Wanting to do something and improve the living circumstances of children which, by changing the attitude of those around, have the chance to grow in a world with fewer prejudices, a world of equal opportunities, to live a normal life, we started with an initial research study in which we investigated the life satisfaction of adults with disabilities, some of them are immobilized in a wheelchair, some deaf. We compared it with that of those "normal" (with no health problems).

Because we believed that the most important intervention, for children with disabilities integrated into mainstream schools, can be done with teachers, we did a second study, based on investigation into teachers' training needs at the county level

(Bihor county), both schools in cities and in villages, involving teachers and measuring their willingness to accept and work with children with disabilities. We proposed in a continuous training program accredited (with credits) by Ministry of Education and Research, a course of *Integration of children with special educational needs in mainstream schools*.

The course aimed primarily the awareness of teachers in mainstream education, to prepare them for a successful integration of children with disabilities, to avoid fundamental mistakes, because they do not know the methods to address to children, the disability-specific strategies, and all these gaps can lead to real tragedies.

Through the experiment with a single subject, we could establish more clearly the causal relationship between the attitude of teachers and school performance, so we conducted a third study, showing the importance of knowing the best strategies to address students, depending on the specifics of their disability.

Given the above, we postulate the following assumptions:

1. ***There are significant differences between life satisfaction of the people with disabilities than those valid.***
2. ***There are significant differences between the degree of self perceived happiness of people with disabilities than among those valid.***
3. ***There are significant differences regarding the acceptance of children with special educational needs by teachers who participated to an intervention program, depending upon the moment of testing.***
4. ***There are significant differences regarding interest in drawing sketches in the background levels and stages of intervention therapists, in the sense to increase its therapeutic intervention phases with individual counseling and positive reinforcement reflected by school results .***

## Subjects and design

In the three research studies were included following subjects:

- **In the first study**: 30 adults with disabilities, 12 of whom were immobilized in a wheelchair (9 women and 3 men) and 18 deaf (8 women and 10 men), and 30 "normal" (no health problems) people (19 women and 11 men);
- **In the second study**: 755 teachers, 459 of urban areas, 296 of rural areas; 205 teachers from kindergarten, 188 teachers in primary school and 362 teachers in secondary school and high school, from Oradea (GPP nr. 42, GPP nr. 53, GPN nr. 1, GPP nr. 22, S08 "Avram Iancu", S08 nr. 16, S08 "Al. Roman"), Beius (four groups of teacher from Beius and surroundings), Salonta (Kindergarten nr.1), Alesd (S08), Stei (S08 "Miron Pompiliu, LIT "Avram Iancu" and surroundings), S08 Ceica, S08 Cociuba Mare, S08 Dobreşti, S08 Balc, GRI Suplacu de Barcău, GRI Popeşti, LIT Bratca.
- The subject of the third study is a teenager girl, aged 17 years, X-grader at the School of Art.

**Design Type:**

The first study design is intergroup cvasiexperimental, for study two, we have a design unifactorial intra group. In the third study, we used an experiment with one single subject, reversible model ABAB. In the first phase (A) of the design, we measured objectively and repeatedly the anxious behavior of the subject of the therapeutic intervention, thus establishing a basic level of behavior under discussion. In the second phase was introduced the therapeutic intervention (B), which consisted of individual counseling and assistance after hours, and assistance during school hours, following that in phase three (A) therapeutic intervention was eliminated and we returned to base level. In the last phase of the design (B) the therapeutic intervention was applied again.

**Instruments and procedure**

In the first study, we used two instruments to measure life satisfaction and momentary happiness:

1. **Life Satisfaction Scale (SSV),** evaluate their overall satisfaction with lives. The scale contains five items, framed in short sentences, subjects' task is to answer each statement by choosing one of the choices presented on a scale of 1-7, where 1 means *strongly against* and 7 *is strongly agree*.
2. **Fordyce's emotions questionnaire**, the questionnaire contains a list of 10 items, of which the participant must choose only one, which best describes the level of happiness perceive .
3. **For the second study**: At the beginning of the course was measured teachers' willingness to accept and work with children with disabilities. This was done by using a short questionnaire in which participants were asked to answer "yes", "no" or "I don't know" at the next question: ***You are a teacher, headmaster of a school. A mother comes to you with the request that her son /daughter who has a disability (hearing, seeing, mobility ...), need to be accepted in your group /class/ school. Do you agree or not?*** The participants were asked to list at least three reasons for the choice they had made. After finishing the course, we reapplied the same short questionnaire to see if the intervention program was effective.
4. **The third study: Single subject experiment:** Intervention period lasted 56 days and each phase lasted 14 days. The drawings made by the subject on its own initiative were counted daily, the results were recorded in scale of observation, which helped us to organize and systematize the results of intervention during the 56 days:

Table 3. *Scale of observation. The number of drawings made by the subject in each of the four phases of the experiment.*

| Day | A Phase | B Phase | A Phase | B Phase |
|---|---|---|---|---|
| 1 | 2 | 4 | 4 | 3 |
| 2 | 0 | 3 | 2 | 4 |
| 3 | 0 | 4 | 2 | 4 |
| 4 | 0 | 5 | 3 | 5 |
| 5 | 1 | 5 | 2 | 4 |
| 6 | 2 | 6 | 1 | 4 |
| 7 | 1 | 7 | 4 | 6 |
| 8 | 2 | 7 | 3 | 4 |
| 9 | 0 | 5 | 3 | 5 |
| 10 | 0 | 5 | 1 | 5 |
| 11 | 0 | 5 | 5 | 5 |
| 12 | 1 | 5 | 5 | 4 |
| 13 | 1 | 6 | 2 | 6 |
| 14 | 1 | 8 | 1 | 6 |
| Total | 11 | 75 | 38 | 65 |

At the same time we followed the anxious behavior of the subject during the execution of drawings, the quality of the drawings, marks obtained at school, and those obtained in individual consultations.

For the intervention phase (B), we worked with a specialist teacher who conducted individual counseling. The intervention lasted for 14 days and the subject was monitored daily during this period. In the next phase of the experiment, the basic level 2 (A), all means of intervention have been withdrawn, and we returned to observe the behavior of the subject. The last phase of the experiment, intervention 2 (B), meant the reintroduction of therapeutic intervention that we have used in the first intervention. We have kept the same structure of the intervention.

## CHAPTER 8
## PRESENTATION AND INTERPRETATION OF DATA

**First study:**
**A) Life satisfaction**

Assuming that postulates: ***There are significant differences between life satisfaction of people with disabilities than those valid***, a statistical comparisons were made between scores obtained by people with disabilities and those scores obtained from "normal." Prior was tested the normality of data distribution for the dependent variable - life satisfaction - based on test Kolmorogorov – Smyrnov:

Table 4. *Testing normality of data distribution for life satisfaction, using test Kolmorogorov – Smyrnov*

| Variable | Life satisfaction |
|---|---|
| Number of subjects: | 60 |
| Kolmogorov-Smyrnov Test: | 1.266 |
| Sig | .081 |

Distribution data for variable *life satisfaction* is normal for the population because calculated p .081 is higher than critical p.

For comparing two groups of subjects - people with disability, valid - was used **T test for independent samples.**

Table 5. *Means and standard deviations for variable life satisfaction at valid and disabled groups*

| | Condition | N | Mean | Standard Deviations | Std. Error Mean |
|---|---|---|---|---|---|
| Life satisfaction | Disabled | 30 | 22.7667 | 3.39049 | .61902 |
| | Valid | 30 | 31.0333 | 1.88430 | .34402 |

It may be noted that, for the condition of disability the mean score is less: 22.76 67 than mean scores for the condition of valid: 31.0333.

Table 6: *t test for comparing life satisfaction scores of people with disability with thoseof valid individuals.*

| T | df | Sig. |
|---|---|---|
| -11.673 | 45.354 | .000 |

For **t (45.354) = -11.673** we achieved a significance level of **sig .000** less than critical sig .01, therefore we reject the null hypothesis and accept the specific hypothesis with risk to fail less than 1%. The research hypothesis is supported, between the two categories of persons there are differences in life satisfaction, people with disabilities are less satisfied with their lives.

In conclusion, we can say that the life satisfaction of persons with disabilities is lower than those valid. This is due to disability, because it implies for deaf and for mobility handicap a restriction of autonomy, an awareness of limits, the presence of peer compassion, networking and communication difficulties, rejection, labeling, the difficulty of finding a job, a life partner, or difficulty of having and raising children.

**B) Degree of momentary happiness**

The second step of the research wants to see if the 30 participants, people with disabilities are considering themselves less happy than 'healthy' participants and starts from the following hypothesis: ***There are significant differences between the degree of self perceived happiness of people with disabilities than among those valid.***

We used the Fordyce of emotions questionnaire, which measures the degree of momentary happiness. Each participant chose only one of the 10 items of the questionnaire (Appendix 2), the one that best describes its average level of happiness. To analyze the degree of happiness perceived differences between the two categories of participants, $\chi 2$ test was used statistically.

Table 7. *Observed frequencies, the expected and standard adjustable residues on disability and normal subjects who chose one of the 10 items.*

| | | | Degree of happiness | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | quite unhappy | somewhat unhappy | slightly unfortunate | neutral | slightly happy | somewhat happy | pretty happy | happy | Total |
| Condition | Valid | Observed frequency | .0 | 0 | 0 | **0** | 4 | 8 | **15** | 3 | 30 |
| | | Expected frequency | .5 | 1.5 | 1.5 | **3.5** | 5.5 | 6.5 | **9.5** | 1.5 | 30.0 |
| | | Total percent | 0% | 0% | 0% | **0%** | 6.7% | 13.3% | **25.0%** | 5.0% | 50% |
| | | Adjusted standardized residues | -1.0 | -1.8 | -1.8 | **-2.8** | -1.0 | .9 | **3.1** | 1.8 | |
| | Disabled | Observed frequency | 1 | 3 | 3 | **7** | 7 | 5 | **4** | 0 | 30 |
| | | Expected frequency | .5 | 1.5 | 1.5 | **3.5** | 5.5 | 6.5 | **9.5** | 1.5 | 30.0 |
| | | Total percent | 1.7% | 5.0% | 5.0% | **11.7%** | 11.7% | 8.3% | **6.7%** | 0.% | 50% |
| | | Adjusted standardized residues | 1.0 | 1.8 | 1.8 | **2.8** | 1.0 | -.9 | **-3.1** | -1.8 | |
| | Total | Observed frequency | 1 | 3 | 3 | **7** | 11 | 13 | **19** | 3 | 60 |
| | | Total percent | 1.7% | 5.0% | 5.0% | **11.7%** | 18.3% | 21.7% | **31.7%** | 5.0% | 100% |

In the table above we can see the observed frequencies, the expected frequencies and adjusted standardized residues for each of the eight items of the questionnaire, take into account (note that the first and last item of the questionnaire: *extremely unhappy* and *extremely happy*, were not selected in the table because they were not elected by anyone), following options expressed by participants in research, disabled and valid people.

To observe significant differences, we follow the individual cells with adjusted standardized residues. The values contained in range (-2, 2) will be considered indicators of significant differences between observed and expected frequencies (Sava, 2004, p. 67):

Table 8. *Significant amount of residue adjusted standardized for Questionnaire Fordyce*

| Response Type: / Condition : | The values of adjusted standardized residues | |
|---|---|---|
| | Neutral | Pretty happy |
| Valid | - 2.8 | 3.1 |
| Disabled | 2.8 | - 3.1 |

In Table 8 one can see two significant differences in subjects' responses to the questionnaire Fordyce. For item Neutral (neither happy nor unhappy) we have the range (-2.8 - 2.8), a positive value to individuals with disabilities, so we can say that there is a significant difference between the number of people with disability who have opted for this answer to the number of valid, which elected him as representative of them. Therefore, unlike normal people, the disabled tend to perceive themselves as being neither happy nor unhappy.

The second item that is relevant to our research is quite happy (I'm in good spirits, I feel good). The range that we have adjusted standardized residue (3.1 - -3.1) shows trend is positive, this time for "normal" people. The results show that there is a significant difference between normal and disabled persons as regards self-perception happy.

Table 9. ***χ2*** *test value.*

| | Value of *quite happy* | d f | Sig. |
|---|---|---|---|
| Coefficient (Pearson) $\chi 2$. | 24.879(a) | 7 | .001 |
| Number of valid cases | 60 | | |

a 10 cells (62.5%) have expected frequencies less than 5.

Minimum expected frequency is .50

The values in the table above confirms, so that analyzing the situation of the normal and disabled participants options on Fordyce questionnaire of emotions, we have $\chi 2$ (df 1) 22.259 with a significance level .000, lower than the critical sig. of .01, so we

can say without risk of mistake less than 1%, that there are significant differences between the degree of happiness perceived of people "normal" to those with disabilities.

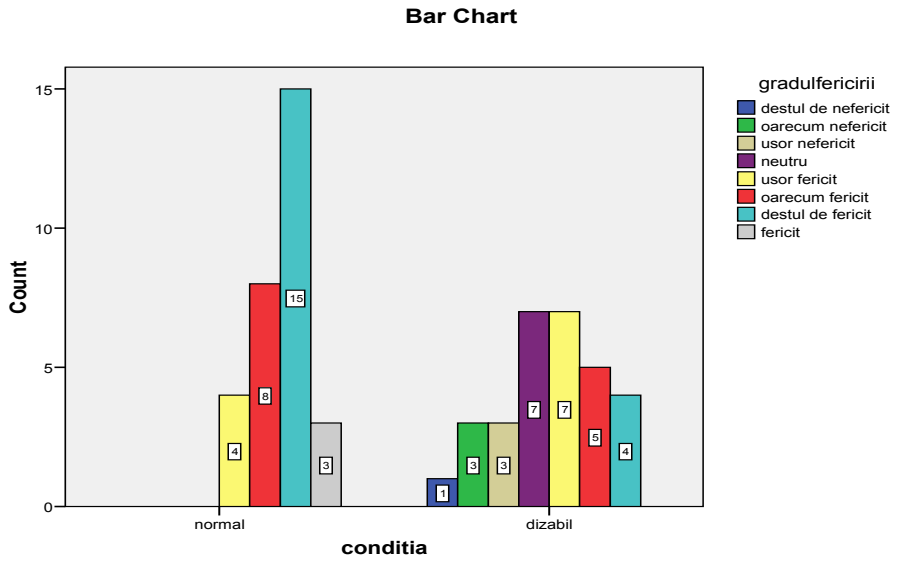


Figure 3. *Graphical representation of the degree of happiness perceived by valid and disabled persons from the responses to the Fordyce questionnaire of emotions.*

**Research limitations of the first study**

Since the first two research hypotheses were tested on the same subjects, who completed both questionnaires, we refer to both moments of research regarding the limitations that we encountered. Given the condition “disabled” of the participants in research, we used only several tools, and those used were selected because they comprise only 5 items, or selecting only one item and that we wanted to be easily applied. The persons concerned were hardly persuaded to complete the questionnaire scale, they are resistant and don’t have confidence in the usefulness of research, they consider it an invasion of private space. With regard to deaf persons, we have been encountered a

number of obstacles due to the fact that in their perception, the items are identical and they don't understand why they answer the same question several times. In most cases an interpreter was needed and each participant took about two hours work. Interpreters were chosen so as to be reliable for deaf people.

Another limit we consider a relatively small number of subjects. If we can apply the instruments to a large number of valid people, we can not say the same for people with disabilities. Given the small circles on which they attend, the mistrust that they have regarding strangers and the small number reported in the normal population, it was difficult to meet the minimum required number of subjects to begin the research.

**The second study - the intervention program on the attitude of teachers from accepting children with special needs of education**

First we wanted to verify the effectiveness of the intervention program. The 755 teachers participating in the program responded with *Yes, No, I do not know* before attending and after graduation the course. For research it was used SPSS, Chi-Square test.

Table 10. *Prime data:*

| Răspunsuri | Inainte de intervenţie | După intervenţie |
|---|---|---|
| **Da** | **306** | **583** |
| **Nu ştiu** | **164** | **75** |
| **Nu** | **285** | **142** |
| **Total** | **755** | **755** |

**The efficiency of the program**

Table 11. *Observed frequencies, expected frequencies, percent and adjusted standardized residues on teachers' responses before and after intervention.*

| | | | Answers | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | I don't know | |
| Moment | Pretest | Observed frequencies | 306 | 285 | 164 | 755 |
| | | Expected frequencies | 422,0 | 213,5 | 119,5 | 755,0 |
| | | Total percent | 20,35 | 18,9% | 10,9% | 50,0% |
| | | Adjusted standardized residues | **- 12** | **8,2** | **6,3** | |
| | Post test | Observed frequencies | 538 | 142 | 75 | 755 |
| | | Expected frequencies | 422,0 | 213,5 | 119,5 | 755,5 |
| | | Total percent | 35,6% | 9,4% | 5,0% | 50,0% |
| | | Adjusted standardized residues | **12,0** | **- 8,2** | **- 6,3** | |
| Total | | Observed frequencies | 844 | 427 | 239 | 1510 |
| | | Total percent | 55,9% | 28,3% | 15,8% | 100% |

In the table above we can follow observed frequencies, expected frequencies, percent and adjusted standardized residues, for 755 teachers participating in our intervention, responses operationalized by *yes, no, I do not know*:

Table 12. Significant adjusted standardized residues

| Response Type: / Moment | adjusted standardized residues values | | |
|---|---|---|---|
| | Yes | No | I don't know |
| Pretest | -12 | 8.2 | 6.3 |
| Post test | 12 | -8.2 | -6.3 |

As it can be seen, the results of intervention are significant, differences between pretest and post test are very high. The biggest difference was obtained for acceptance of responses, which enables us to say that the number of teachers who support children with disabilities increased significantly after participation to the intervention program. This assertion is supported by significant differences in responses obtained at the answers *no* and *I don't know*, where situation was reversed, going from positive to negative values, the number who are undecided or refuse to post-test situation is significantly lower.

Table 13. **χ2** test value.

| | Value | df | Sig. |
|---|---|---|---|
| Coefficient (Pearson) χ2 | 144.805(a) | 2 | .000 |
| Number of valid cases | 1510 | | |

a 0 cells (.0%) have expected frequencies less than 5. Minimum expected frequency is 119.50.

Values in the table above confirms, considering options of the participants to the intervention in pretest and post test situation, we have χ2 with 2 degree of freedom (d f) of 144.805, with a significance level .000 lower than the critical sig. .01, so we can say without risk of mistake less than 1%, that there are significant differences between the number of teachers who agree to work with disabled children before and after the intervention program, and the program is considered efficient.

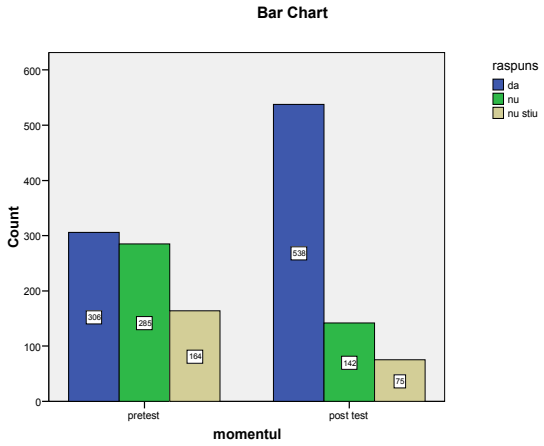

Figure 4. *Graphical representation of the situation of teachers' responses before and after they participated to intervention.*

The results lead us to suggest that this intervention was effective, after intervention program a large number of teachers who were participants reconsidered their position on children with disabilities, became interested to document and inform themselves, they understood the dramatic situation of these integrated children into schools where teachers are unprepared, and don't know the strategies of addressing to them.

Because we saw a difference between the attitude of teachers, who participated in the intervention program, depending on the environment of origin (urban or rural), we thought it would be useful to do further research on relation to the environment from which the teachers were. So we started from the collateral premise that ***there is a significant difference in the response of teachers participating in the intervention in terms of area of origin.*** To check the assumptions we used again **$\chi$2 statistical test**.

**The results observed to teachers from urban: 459 teachers**

First we compared the differences between pretest and post test responses of 459 teachers from urban areas:

Table. 14. *Observed frequencies, expected frequencies and adjusted standardized residues of urban teachers, on pretest and post test.*

| | | The response of teachers from urban area | | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | I don't know | |
| Moment | Pretest | Observed frequencies | 45 | 281 | 133 | 459 |
| | | Expected frequencies | 148.0 | 210.0 | 101.0 | 459.0 |
| | | Total percent | 4.9% | 30.6% | 14.5% | 50.0% |
| | | Adjusted standardized residues | **-14.5** | **9.4** | **5.1** | |
| | Post test | Observed frequencies | 251 | 139 | 69 | 459 |
| | | Expected frequencies | 148.0 | 210.0 | 101.0 | 459.0 |
| | | Total percent | 27.3% | 15.1% | 7.5% | 50.0% |
| | | Adjusted standardized residues | **14.5** | **-9.4** | **5.1** | |
| Total | | Observed frequencies | 296 | 420 | 202 | 918 |
| | | Total percent | 32.2% | 45.8% | 22.0% | 100% |

From the table above we can see observed frequencies, expected frequencies and adjusted standardized residues of urban teachers, before and after the intervention. Thus we make the following findings:

Table 15. *Significant adjusted standardized residues.*

| momentul / tipul de răspuns | Valoarea reziduurilor standardizate ajustate | | |
|---|---|---|---|
| | Da | Nu | Nu ştiu |
| Pretest | - 14.5 | 9.4 | 5.1 |
| Post test | 14.5 | - 9.4 | - 5.1 |

In Table 15 we can see that all three cases confirm the usefulness of the intervention program. So in the cases of acceptance, whether before the course number of teachers in urban areas responding *yes* is quite small compared to expectations, confirmed by the large negative residual value (- 14.5), the post-test situation changes significantly, number of teachers willing to work with children with disabilities has increased greatly, reversing the ratio (14.5).

The situation of denials supports the utility of intervention too. If at first many teachers (281) admit they do not want to work with children with SEN, after intervention the situation improves significantly, the phenomenon of refusal is greatly decreased, this is attested in the cell *No* of adjusted standardized residue, this range showing a significant decrease from 9.4 to - 9.4.

A similar decrease observed with undecided teachers (from 133 to 69), adjusted standardized residues decrease this time by 5.1 to – 5.1.

Table 16. The values of ***χ2***

| | Values | Df | Sig. |
|---|---|---|---|
| (Pearson) χ2 Coefficient | 211.652 (a) | 2 | .000 |
| Number of valid cases | 918 | | |

a 0 cells (0%) have expected frequencies less than 5. Minimum expected frequency is 101.00.

As expected, from the observations above, and from the observation of the table with χ2 test values, we can conclude that the responses of urban teachers involved in the intervention program, implemented in order to raise their awareness from children with special educational needs, before and after program intervention, we have χ2 with 2 degree of freedom (d f) of 211.652, with a significance level .000 lower than the critical sig. .01, so we can say without risk of mistake less than 1%, that the intervention program involving teachers from urban area has been effective.

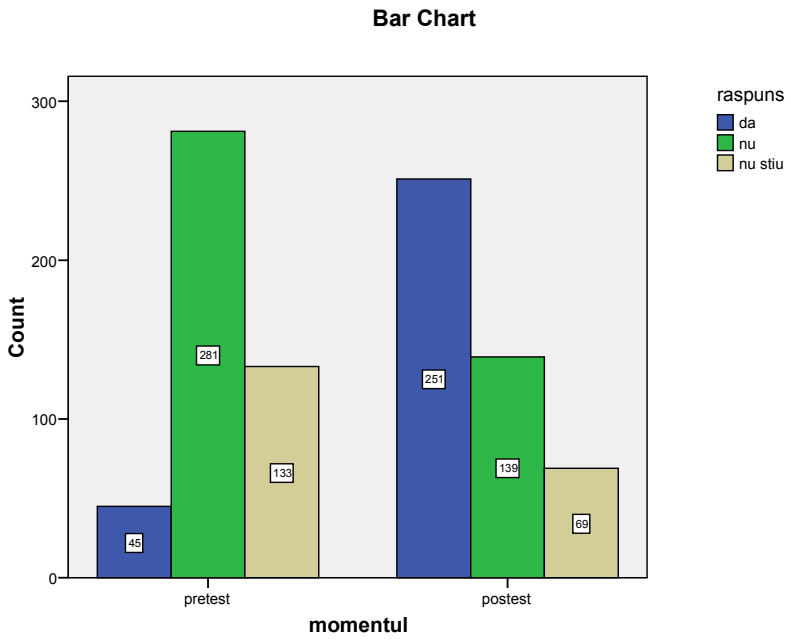


Fig. 5. *Responses of the urban teachers participating in the intervention on pretest and post test phases.*

**The results observed to teachers from rural: 296 teachers**

Table. 17. *Observed frequencies, expected frequencies and adjusted standardized residues of rural teachers, on pretest and post test.*

| | | The response of teachers in rural areas | | | | Total |
|---|---|---|---|---|---|---|
| | | | Yes | No | I don't know | |
| Moment | Pretest | Observed frequencies | 261 | 4 | 31 | 296 |
| | | Expected frequencies | 274.0 | 3.5 | 18.5 | 296.0 |
| | | Total percent | 44.1% | 0.7% | 5.2% | 50.0% |
| | | Adjusted standardized residues | **-4.1** | **.4** | **4.2** | |
| | Post test | Observed frequencies | 287 | 3 | 6 | 296 |
| | | Expected frequencies | 274.0 | 3.5 | 18.5 | 296.0 |
| | | Total percent | 48.5% | 0.5% | 1.0% | 50.0% |
| | | Adjusted standardized residues | **4,1** | **-,4** | **-4,2** | |
| Total | | Observed frequencies | 548 | 7 | 37 | 592 |
| | | Total percent | 92.6% | 1.2% | 6.3% | 100.0% |

From the table 17 we can see observed frequencies, expected frequencies and adjusted standardized residues of urban teachers, before and after the intervention.

Table 18. *Significant frequencies of adjusted standardized residues.*

| response type / moment | Adjusted standardized residues values | | |
|---|---|---|---|
| | Yes | No | I don't know |
| Pretest | - 4.1 | .4 | 4.2 |
| Post test | 4.1 | - .4 | - 4.2 |

From the above table it appears that only two of the three cases confirmed the usefulness of the intervention program. So in the acceptance cases, if before the intervention the number of teachers in rural areas who respond yes was quite high above expectations, confirmed by the negative value of the residue (- 4.1) too, the post-test situation changes significantly, number of teachers willing to work with children with disabilities increased, reversing the ratio (4.1).

In the case of undecided teachers we have also a significant change, their number decreases in favor of accepting. Adjusted standardized residues decrease this time to 4.2 to - 4.2.

In the case of the teachers who have responded *no*, difference is not statistically significant due to small number of participants. However, since their number decreased from 4 to 3 persons, we can say that there was a percentage decrease of 25% in negative responses.

Table 19. *The values of χ2*

| | Values | Df | Sig. |
|---|---|---|---|
| (Pearson) χ2 Coefficient | 18.268 (a) | 2 | .000 |
| Number of valid cases | 592 | | |

a 2 cells (33.3%) have expected frequencies less than 5. minimum expected frequency is 3.50.

Observing table χ2 test values, we can conclude that the responses of teachers in rural areas involved in the intervention program, implemented in order to raise their awareness to children with special educational needs, before and after the intervention, we have χ2 with 2 degree of freedom (d f) of 18.268, with a significance level .000 lower than the critical sig. .01, so we can say without risk of mistake less than 1%, that the intervention program involving teachers from urban area has been effective.

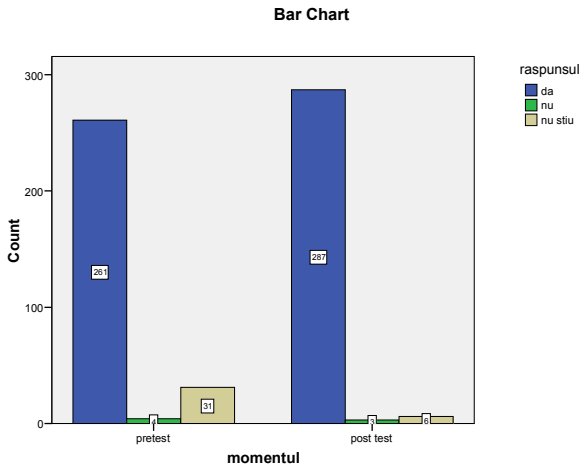


Fig. 6. *Responses of the rural teachers who participated in the intervention program, on the pretest and post test phases.*

As it is seen in figure 6, in rural areas, there is a greater willingness to accept children with SEN from the beginning. We appreciate that in rural areas there is greater awareness, the intervention program requirements are greater on level of documentation and information.

Comparing the differences in rural teachers' responses with those of teachers in urban, we found a greater willingness to accept children with disabilities to those of rural. The reasons leading to this opening are evident:

- *Claims and ambitions of children, parents and even teachers in urban areas are much higher;*
- *In small communities, teachers have a much closer relationship with parents and siblings of children, some of them were once their students, or they are friends or at least known people;*
- *Most rural teachers are people over 45 years, with extensive experience within the department;*
- *Number of pupils in rural areas that make up the classes are smaller, and therefore the time allocated to each child is greater;*

- *City, through its congestion, lack of job stability presents a much higher degree of stress, therefore patience is about to become an "ideal" hard to reach;*
- *Empathy is much more evident to teachers in rural area.*

**The representativeness of the subjects (teachers) depending source environment**

For accuracy of research, we found it a useful perspective on professionals representing teachers. To this purpose we performed chi-square statistically test using the following assessment:

Table 20. *Observed frequencies, expected frequencies and adjusted standardized residues of teachers, on pretest and post test (educators in kindergarten, teachers in primary schools, teachers in secondary schools), depending on the environment of origin.*

| | | | Techers | | | Total |
|---|---|---|---|---|---|---|
| | | | Teachers in kindergarten | Teachers in primary school | Teachers in secondary school | |
| Origin | Urban | Observed frequencies | 157 | 112 | 190 | 459 |
| | | Expected frequencies | 124,6 | 114,3 | 220,1 | 459,0 |
| | | Total percent | 20.8% | 14.8% | 25.2% | 60.8% |
| | | Adjusted standardized residues | **5.4** | -.4 | **-4.5** | |
| | Rural | Observed frequencies | 48 | 76 | 172 | 296 |
| | | Expected frequencies | 80.4 | 73.7 | 141.9 | 296.0 |
| | | Total percent | 6.4% | 10.1% | 22.8% | 39.2% |
| | | Adjusted standardized residues | **-5.4** | .4 | **4.5** | |
| Total | | Observed frequencies | 205 | 188 | 362 | 755 |
| | | Total percent | 27.2% | 24.9% | 47.9% | 100% |

From table 20 we can see observed frequencies, expected frequencies and adjusted standardized residues in the three categories of teachers according to their origin. On the basis of observed frequencies we can determine where these differences are, but to see where the significant differences lies we follow the adjusted standardized residues for each individual cell.

Table 21. *Adjusted standardized residue values*

| FAQ Answers / Origin | Adjusted standardized residue values | | |
|---|---|---|---|
| | Teachers in kindergarten | | Teachers in secondary school |
| Urban | 5.4 | | - 4.5 |
| Rural | - 5.4 | | 4.5 |

In the above table, two of the three cells are important. In the first case, the teachers in kindergarten, we can note that teachers from urban areas are better represented in the sample than those in rural areas (157 vs. 48), so we have a positive value for urban teachers: 5.4 and a negative value for rural teachers. A second box in which we find significant is the teacher of secondary schools values (-4.5, 4.5).

Table 22. ***χ2*** *test values:*

p

| | Value | df | Sig. |
|---|---|---|---|
| (Pearson) χ2 Coefficient | 32.048(a) | 2 | .000 |
| Number of valid cases | 755 | | |

a 0 cells (0%) have expected frequencies less than 5. Minimum expected frequency is 73.71.

From Table 22, we can conclude:

Analyzing the representativeness of the situation of teachers involved in the intervention program, implemented in order to raise the awareness of teachers for children with special educational needs, in urban and rural areas, we have χ2 with 2 degree of freedom (d f) of 32.048 with a significance level .000 lower than the critical

sig. .01, so we can say without risk of mistake less than 1%, that the representativeness of teaching staff on professional category was balanced.

The higher number of teachers in urban areas due to the fact that the number of pupils in urban areas is much higher, and consequently there is a greater number of schools in urban area and a great number of teachers, too. This is reflected in the representation of each of the three categories of teachers:

a) In the group of participants we involved 157 kindergarten teachers from urban and 48 from rural;
b) 112 primary teachers from urban and 76 from rural area;
c) 190 secondary and high school teachers from urban to 172 from rural.

Another explanation for the higher number of teachers in urban areas is the access of these teachers to the training was much easier. Teachers in rural areas had the opportunity to move from the localities where they live to the teachers' training center or to form groups of 20-25 people to justify a request for removal of the trainer in their schools, which was more difficult for small schools.

There were also higher conditions for better courses when they were hold in specially designed and equipped cabinets, with modern equipment and materials, that facilitated the transmission of information. Based on these considerations, trainer's request was teachers to move for the purposes of training, but it was difficult for those who lived at great distances.

However we have seen a greater and seriousness involvement of teachers in rural areas attending the courses which were involved with dedication and have found new means of access to information, communication and networking. Teachers in urban areas tend to go faster, they had the opportunity to attend several training courses on various areas and they aren't equally impressed by the novelty and diversity of these.

**The third study - single subject experiment**

Degree of the basic stability of the experiment was calculated using *tuming point test*, the results are presented in the following table:

Table 23. *The degree of stability of the basic A*

| T calculated | T expectated | P calculated |
|---|---|---|
| **3** | **14** | **.21<.66** |

The string of 14 data recorded in the first phase: 2, 0, 0, 0, 1, **2, 1, 2**, 0, 0, 0, 1, 1, 1, there are two points below the peak, a point below and three turning points. Number of return points expectancy is higher than those calculated which indicates that successive points are connected and there is a certain tendency in the media data variance. This is confirmed by the calculated p value (.21) higher than the critical p (.66), which is likely to find a turning point from three successive observations, 2/3 (.66). We can say that in our experiment the basic features meet the requirements of the degree of stability.

After finishing the intervention we compared the four phases of the experiment, alternative basic phases with the phases of intervention. For statistical data processing we used a simple ANOVA for independent samples, considering repeated measurements of the basic levels and interventions that are data from independent groups of subjects. The decision to use ANOVA for independent samples was taken after checking the normality of data distribution (K-S = 1.138, p calc = .150 > .05).

Table 24. *Statistical indices for the variables involved*

| | M | Σ |
|---|---|---|
| Nivel de bază 1 | .78 | .80 |
| Intervenţie 1 | 5.35 | 1.33 |
| Nivel de bază 2 | 2.71 | 1.38 |
| Intervenţie 2 | 4.64 | .92 |

From the above table, we see that the average of behavior observed (interest in drawing sketches reflected in the number of drawings made on her own initiative), in phases 2 and 4, respectively during interventions, greater than the basic phases, 1 and 3, when the subject was monitored without intervention.

Table 25. *Comparison between the number of observed behaviors manifested in the four experimental phases*

| | **SP** | **Df** | **PM** | **F** | **P calc.** |
|---|---|---|---|---|---|
| **Intergrup** | 177.48 | 3 | 59.16 | 45.47 | .000 |
| **Intragrup** | 67.64 | 52 | 1.30 | | |

Data presented in the table above confirms our expectations and highlight the existence of significant differences {F (3,52) = 45.47, p calc. = .000 < p critic .01}, which shows the growing interest for drawing in intervention phases compared to the basic phases.

Drawing increasing interest can be seen in the quality of executed drawings (Annexes 5-26). Drawings of the first phase of the experiment are clumsy, does not comply with any rule of construction, but those from the first intervention phase shows a remarkable progress and the comprehension of the tasks.

In the third stage we can see a slight knowledge of the technique fixed during the intervention, but without individual support, so that the new details of another kind of drawing enforcement are weak. In the last phase, entering the second intervention, the subject was able to improve his technique so it creates him a psychological comfort, is less anxious, she works much more relaxed and happier. Anxiety during the observations and during the first phase of the experiment was provoked by the uncertainty given by the inability to understand the workload when the teacher addressed globally to whole class, from a too great distance to understand what the teacher says, on the other hand, that there is no manual or other written support from which she could learn necessary information and the subject is very technical, sketches execution are done by some very precise rules, who once learned, provide security and enabled the students to improve their execution, to make up the detail, smoothness and obtain quality of the execution.

During the observation in the base phase (A) the teenager was tense, she was disturbed because she couldn't make her homework alone, she tried several times to make sketches, she erased much of what she drew, she broke the sheets, then became agitated, she told to her parents that she is afraid to go at the sketch class, that the teacher

"does not believe me that I do not know!", she told them she does not understand how to do the drawings, she didn't want to go to school any more and the day before having that class, she didn't find her place, she couldn't sleep, and she repeated that she was afraid of the teacher.

During the classes she was inhibited, she failed to do almost anything, and the teacher, in her turn, threatened and told her that she does not belong to an arts high school, and punished her to do 10 sketches for the future class, without explaining her the technique individually.

Another teacher, from the same school, with whom she had a different subject matter, less technical and whit whom she had a much closer relationship, was chosen for the intervention phase. During the hours of consultation, she listened very carefully, she had the possibility to have a dialogue with the teacher, to require an explanation of specialized terms. She understood the tasks more easily, she was cooperative, relaxed. The first drawings were executed with small errors but from the beginning, the teacher could see that she understood this technique, she complied with rules and proportions. Gradually the drawings became more obvious and quite beautiful. At home she was quieter, she was drawing on her own initiative, from the desire to improve technique and to reduce working time for any draw. If at first she would require an hour for a sketch, to end of the 14-day intervention she could make a sketch in about 5 minutes.

In the third stage, after the withdrawal of the intervention, specialist teacher, the holder of the discipline at school switched to teaching to other sketches, involving drawing a human body in a relaxed position, or sitting, and other technical rules. The student was able to draw body proportions as that fixed during the intervention, but she couldn't understand, without individual support, the new rules of drawing the change center of gravity and body relaxation. She started again to be tense, agitated, to be afraid to go to school, and she asked her parents to find a teacher in order to make classes in private, because she realized how much help she received during the intervention.

Last phase of the experiment, the second intervention, was eagerly anticipated by the students and by her parents, the results were spectacular again. Another part of the success of the intervention was reflected in school grades. In Phase 1, she received two

marks of 5, in the second phase she received 7 and 10, in the third stage she received again 5 and 6, and in the final phase the marks increased again 9 and 10.

The successful of the experiment enables us to say that for the students with disabilities integrated into mainstream education in high schools, it must be some support teachers in order to offer them equal educational opportunities. We also consider that the attitude of the teachers is very important too. Very often the teachers, even if they know that the student has a disability, they don't know how to address them, and they label them from the beginning as incapable, although these children may be very intelligent and with expert support they may achieve even performance.

## CONCLUSIONS

The research started from the idea that people with disabilities have a lower life satisfaction than people without disabilities, their subjective wellbeing is affected by their state of health and by life circumstances. The attitude of others, especially relatives: family members, teachers, peers, the prejudices they are confronted with, segregation and finally self segregation are to fall further the chances of disabled people to live fulfilling life.

Wanting to intervene and improve the living circumstances of children, which, by changing the attitude of those around can grow in a world with fewer prejudices, a world of equal opportunities to live a normal life, we started the research investigating life satisfaction of adults with disabilities. Some of them are immobilized in a wheelchair, some deaf. We compared their life satisfaction with that of those valid (with no health problems).

The results of the research support the hypothesis postulated in the first study, the life satisfaction and the degree of happiness of people with disabilities are lower than those of valid.

The intervention program that we've done has proven to be effective and will be replicated. Teachers, whether urban or rural, have professional and moral obligation to accept and educate children with disabilities. Their attitude is very important for them, for other children of the class, for parents of children with disabilities and parents of other children, too. To be able to achieve such a goal is necessary that the teachers look the

integrating of the children with disability like a professional challenge, an opportunity to self-improve. Without being aware and familiar with all the problems facing the disabled child and his family from his birth, without knowing all the implications of disability, their real limits of possible recoveries, skills and effort required for the child to access, the teacher doesn't have a proper perspective on the task that he is involved so difficult and still generous.

From the research we noticed that awareness and proper information drop resistance to change the teachers and develop their empathy and availability. Significant results due to the increasing number of teachers who agrees to work with children with SEN, lead us to believe that such intervention programs are useful, important and especially necessary right now when there is a great campaigning for massive integration of disabled children in mainstream schools.

The third study, an experiment with a single subject, started from our desire to see the extent to which a disabled child can be helped in learning when receiving a support teacher, the importance of knowledge some particular strategies with approach to child disability by the class teacher, in order to provide truly equal opportunities to education, to exploit the physically and psychologically potential of the child to its true value. The experiment is a clear indication that, when teaching is done in accordance with the child's educational requirements, his work results can be surprising. When the child understands and feels that he is accepted and encouraged, he is more interested and more motivated in school tasks.

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