Physical Motor Deficiency In Adolescence - A Psychological Profile From The Development Perspective

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Abstract: This paper addresses, both theoretically and experimentally, the complex problem of teenagers with physical motor deficiency (PMD). Is presented first the etiology and define the specialty terms regarding physical, motor impairment. In order to outline the psychological profile of teenagers from the perspective of personality development, a methodological investigation was carried out, involving the application of a set of psychological tests with deep resonance within the personality (Woodworth-Mathews / WM Personality Inventory, Introversion-Extraversion-Neurosis / Eysenck Test, Depression-Anxiety Questionnaire / DE-AN). The statistical results obtained in the two groups of teenage girls who participated in the experiment (basic group - teens with PMD and the control group - teens without physical deficiencies) are presented and compared. The interpretation of the obtained results gives us interesting data on the special psychological profile of people with physical deficiency. The elements of novelty and interest were followed. The findings of the investigation highlight the need to seriously address the PMD issue in terms of social integration, psychological counseling for these young people but also to change as far as possible the perception and attitude of society towards physical disability. The experimental analysis presented here is enrolled in a more comprehensive project on teenagehood deficiency, conducted by the author in previous years.

Keywords: adolescence, depression, personality, physical motor deficiency.

1. Introduction

Physical disability is a topic that is still being debated in the field of current research. Whether it is the redefinition of the psychological profile of people with physical deficiencies, or the aspects related to integration are analyzed, the theme of physical disability has a wide range of approaches. To work with such people involves knowledge, protection and the provision of special conditions and help. Any approach in this field will affect both the actual life of people with disabilities and the profile of today's modern society. Tolerance, help and support for people with special needs is the feature of a modern society, marked by humanism and empathy.

2. Etiology and terminological definition

In the multitude of causes directly related to the manifestation of physical disability two major categories are distinguished. An important category is the one that has a direct influence, and addresses the elements of the deficiency and another indirect category, which causes a morphological or functional deficiency. They can affect the whole organism and cause global or total deficiencies, or limit themselves to certain regions, segments or parts of the body and cause segmental or local deficiencies [27]-[8]. Synthesizing the various opinions regarding the etiology of motor deficiencies expressed by specialists [4]-[9]-[16]-[25], some significant conclusions will be high-lighted. From the perspective of causal correlations, can be listed three commonly accepted categories of locomotor deficiencies:

(i). Genetic causes: congenital (hereditary and non-hereditary);
(ii). Deficiencies caused by growth;
(iii). Posttraumatic sequelae.

a. Congenital causes are, in turn, hereditary (primary) or non-hereditary (secondary). Hereditary malformations are the consequence of altering the hereditary base (genotype) and are transmitted from ancestors to descendants following the hereditary laws established by Mendel [12]-[30]. Considered a favoring or predisposing cause, heredity can sometimes be decisive for the child and the future adult. Secondary congenital malformations are determined by the environment-mental factors that act during the intrauterine period. These congenital malformations have also been called phenocopies because they mimic similar genetic disorder, simulating their hereditary transmission. Environmental factors that induce fetal malformations of the fetus can be grouped into physical, chemical factors (atomic and x-ray radiation, drug substances) and hormonal factors (maternal viral diseases: measles, epidemic parotitis, influenza disorders, lack of vitamins). Congenital malformations may also be the cause of secondary ailments through static and dynamic abnormal conditions that do not create a favorable environment for the development of the growing organism [6].

b. Growth impacts. Researchers in this field have defined a new term and implicitly a new chapter in the study of the etiopathogenesis of physical deficiencies: auxology or the science of organism growth. It distinguishes between development (morphological and functional differentiation, materialized in qualitative improvements) and growth, which is a process of quantitative accumulation [15]. Favoring factors for the production of physical handicaps are considered factors that negatively affect the health and normal functioning of the organs, especially during periods of growth and active development of the child.

c. Posttraumatic episodes. A large category of handicaps and infirmities is due to accidents. From the pathophysiological point of view, such sequelae can be classified into disorder caused by trauma directly,
indirect disturbances, disorders due to immobilization (atrophy, decalcification) and treatment disorders. Even though this classification is quite extensive, a number of causes such as metabolic and hormonal disorders, burns and frostbite lesions, myopathies, progressive muscle atrophy, ataxia, etc. should not be omitted.

The specialized literature contains several types of classifications made by various criteria. Thus, after the synthetic classification, which takes into account the degree of functional impairment of the individual, made by Emil Verza [27], there are two main categories of physical disabilities: morphological or structural and functional or of activity. Both categories may be divided, in relation with the extent and depth of the disease, into a global subgroup (general or overall) and a partial subgroup (regional or local). In the subgroup of global morphological deficiencies, they report the following specific features: growth (hyposomia, nanosomes, disharmons, dis propor-tionalities), nutrition, attitude, skin, muscles, the bones, joints and of behavior [3].

3. Psychophysiological consequences of physical deficiency.

An important area in studying the personality of deficient individuals is that of profound analysis of the psychophysiological consequences of the presence of physical dysfunction. Physicians speak of the so-called "subjective symptoms" [4] that a patient suffering from a locomotor system disease can indi ce, which largely reflects the psychological implications of the deficiency (for example: pain, functional impotence, vicious attitude, and deformity or sensitivity disorders). Pain is the most common subjective symptom, which takes on the most diverse aspects as a place of appearance, intensity, characteristics and evolution. The pathophysiological mechanism of pain in locomotor system disorders is complex and largely unknown. In diseases of the locomotor system, is commonly encountered so-called somatic pains conditioned by the excitement of the exteroceptors and proprioceptors, and rarely the so-called visceral pain [13], which refers to the interceptor segment. Functional impotence is a second subjective symptom with important implications in the individual's life. It may be partial or total and may affect a segment of a limb, a limb or several limbs. Functional impotence may be transient or definitive, regressive, stationary or progressive [3]. For example, in the paralyzed form of poliomyelitis, functional impotence is progressive in the acute phase, regressive in the regression phase of paralysis, and stationary in the sequelae phase. The aspect that interests us here is that a prolonged functional impotence changes in a significant proportion the patient's psychological profile, seriously disrupting what Pavlov called the "freedom reflex" [8]. Sensitivity disorders with similar psychological effect are present with subjective disorders in the form of various sensations on the skin, muscles, mucous membranes and nerve trunks (abnormal sensations, numbness, tingling, stings, etc.). The case of the phantom limb is to be placed in a separate category of its own, but its psychological implications are very interesting. It presents a particular form of sensitivity disorders and consists in the false perception of missing body parts [6]. The most common form of "phantom limb" manifestation in invalids who lack of both legs is that of involuntary movements and tingling in the fingers, heels, and extremities. The "Ghost Sensation" becomes clearer the lower the amputation takes place [9]. Muscular hypertrophy is very common. Functionally hypertrophied muscles have a slightly increased tonus, unlike sedentary muscles that are more flaccid. Generally, any condition of the locomotor system triggers antalgic reaction, a greater or lesser degree of muscle contraction, in order to immobilize the segment and avoid the pain caused by a patient's movement. Searching for this antalgic reflex muscle contract has a great practical value. In this respect, it is interesting to study the psychological reverberation of these irritating elements at a subjective level.

4. Experimental investigation

4.1. Proposed hypothesis

The first feature that defines the "human project" is, after Handley Cantril [7], "the need for physical and mental security necessary to protect the already accumulated acquisitions and to provide a platform on which it can then climb step by step" [7]. This is why a close proximity to the people with PMD is an obligation in the field of scientific investigation. Our work hypotheses have started from the possible psychological consistency of physical deficiency: There is a significant link between the presence of motor deficiency and the development of psychic traits and specific behavioral reactions within the personality as PMD:

- affects the aspiration of being and becoming a normal individual;
- modifies the personality traits: increased neurosis, anxiety, feelings of inferiority and depression;
- is associated with pessimism in personal development and poorly outlining the ideal of life.

In his work "On the Structure of Personality" J. Nuttin [14] notes that the feeling of frustration results from an affective-emotional conflict: "sometimes a tension created by a need, a task, or an intention, fails to produce forms of conduct that create or lead to the object itself. Many types of obstacles may occur. It happens that due to a social ban or psychological disability, the necessary action can not be enforced; it is also possible for the individual, trying all means to achieve the goal, fail and be so before the obstacle conceived by his own incompetence or inaptitude; it may eventually happen as an opposition between two incompatible behaviors or motives to push the individual to an object at the same time as removing it. All these forms of internal and external obstacles create frustrations and conflicts" [14]. The first conflict occurs between the desire to adhere to the normal model and the "barriers" that the deficiency imposes. The second one is manifested through the need for relationship and evaluation, the growing need for affection and a strong demand of affective-moral nature. People with physical motor deficiencies constantly experience a deep sense of inferiority. Most of the time, the deficiency and lack of understanding of those around them, complete the frustration of the individual towards emotional and relational satisfactions. There is an example with only one hypostasis: the frustration of not being able to play - and it is enough to understand the inner drama experienced by children with physical deficiencies. However benevolent may be the family or educational institution, it is not enough to give that child a social-moral value in terms of their inner needs. All failures of fulfilment produce in the structures of
the affectivity of these children with deficiencies a psycho-emotional trauma, a kind of wound that is constantly open and painful, hard to bear. This trauma can cause changes in affective mood, changes in central nervous system functioning, neurovegetative and personality changes.

4.2. Investigation tools
In the context of the investigations, the use of both extensive methods and intensive procedures has been imposed, all the more so since there have been pursuing a synthetic look, but also an analytical approach to affective perturbations and compensation deriving from this situation. The experimental research was carried out on a group of 52 pupils aged 15-17, from the Technical College "Ion Holban" of Iași, Romania, presenting different types of motor deficiencies (PMD) and 50 pupils without deficiencies, from "Emil Racovita" High School of Iași (Romania). In order to highlight the correlations between the advanced hypotheses and the experimental data obtained, were used the following set of samples: Woodworth-Mathews Personality Inventory (WM), Introversion Extraversion Neurosis /Eysenck Test, Depression-Anxiety Questionnaire /DE-AN produced by Castello, Comrey and Zunk.

4.3. Psychological Investigation Program
The equalization of the two groups, the experimental group (G1) and the control group (G2), was made based on the following criteria: age (subjects between 15 and 17 years); gender (the groups included girls); social provenience (urban environment). The purpose of the G1 and G2 tests was to see if there are significant differences between personality constants traits of deficient and non-deficient teenagers. The statistical analysis comprised the comparison of the results obtained at the various items of the applied tests.

5. Results and Discussions - Significant Differences
The statistical interpretation of the data obtained from the initial constatative tests reveals key-aspects related to the psychological profile of PMD and non-deficient adolescents, differences that raise the negative effects of FDM. The sample set was first applied to group G1 (with PMD) and then to control group G2 (no deficiencies). Next, is brought to light the significant differences recorded by statistical calculation (Mann Whitney’s significance test) resulting from the comparison of the test data obtained from testing in the experimental group G1 and the G2, the control group. For the Woodworth-Mathew Personality Inventory, the results reflect a net differentiation in the group of girls with PMD, in the sense that are notable strong depressive tendencies, isolation tendencies towards the social environment, and increased emotion due to insecurity, lack of self-confidence and to the over-estimated perception of "normality" standard (Table 1):

As an indicator of psychic fragility, expression of insufficient self-esteem, emotivity \((Z = -4.303, p <0.0001)\) was recorded as significantly greater in the group of teenagers with PMD than the group of teenagers without deficiency and becomes expressive in the overall picture of the personality. The increased sensitivity, the affective mood, changes in central nervous system functioning, neurovegetative and personality changes.

<table>
<thead>
<tr>
<th>Nr. crt</th>
<th>TENDENCIES</th>
<th>Independent samples</th>
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<tbody>
<tr>
<td>1.</td>
<td>EMOTIVE</td>
<td>mG1=54,00 mG2=30,80 Z=-4,303 p&lt;0,0001</td>
</tr>
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<td>2.</td>
<td>PSYCHASTHENIC</td>
<td>mG1=47,60 mG2=32,3 Z=-2,939 p&lt;0,003</td>
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<tr>
<td>3.</td>
<td>SCHIZOID</td>
<td>mG1=48,52 mG2=32,21 Z=-2,511 p&lt;0,012</td>
</tr>
<tr>
<td>4.</td>
<td>PARANOIC</td>
<td>mG1=48,76 mG2=31,73 Z=-3,235 p&lt;0,001</td>
</tr>
<tr>
<td>5.</td>
<td>DEPRESSIVE</td>
<td>mG1=50,53 mG2=28,22 Z=-5,110 p&lt;0,001</td>
</tr>
<tr>
<td>6.</td>
<td>ANTSOCIAL</td>
<td>mG1=13,88 mG2=6,00 Z=-3,270 p&lt;0,001</td>
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</tbody>
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Table 1. Significant differences G1,G2

(Images and tables are not provided in the text, but are required to complete the analysis.)
whole symptomatology can be identified, found in both the onset of neuroses and their manifestation. The presence of a significant difference between the group of normal teenagers and deficient teenagers in this variable indicates that the way of perceiving the deficiency makes the personal attitude of teens with PMD marked by a more or less strong tendency to put obsessive thoughts, fears that sometimes get an existential tone in the center of their ideation. Slow walking, excessive fatigue, seemingly unjustified, disharmonious, "abnormal" aspect, all of which are associated with the thought that they will always be labeled in an embarrassing manner by others, are the sources of crying and endless ruminations on the subject. Fears are storage of more or less conscious mental loads. They are inevitably associated with the fear of pain, the fear of being immobilized (either in the hospital due to surgery, or the irreversible immobilization in the wheelchair), the fear of accidents that can sometimes be very serious. Not often, parents' expectations about the performance of their own child with physical deficiency may adversely affect the child's mental development. The desire to please parents ignites not only psychic states of a conflictual nature but ultimately leads to a feeling of guilt and confusion in the adolescent mind. François Dolto (1988) comments this with an irreconcilable tone: "The teenager begins to understand that things in life are so that you can not survive without leaving yourself imprisoned, incarcerated, enrolled. If you pass the exams you will become a man, they are told and thus cultivates the anxiety that becomes the basis of education, this being the subsequent cause of the large number of comportamental disorders in teenagers" [10]. If these aspects are real for normal adolescents without any physical deficiency, for adolescents with PMD, the fear of failure profoundly marks their personality, sometimes in the form of obsessive thoughts and fears, inevitably exaggerated. Sometimes the fear caused by the possibility of fatal evolution of the disease caused by the deficiency can be an essential element in the general attitude of the subject to their own existence. Not often, the depressed state, the fear of getting into the wheelchair too early is materialized in the inability to fight, to give themselves a chance. Is notable the existence of a significant difference between the two groups regarding the tendency towards isolation (schizoid: $Z = -2.511, p <0.012$), meaning that the desire to isolate from the group is significantly higher in adolescents with PMD, as opposed to the teenage girls with no physical deficiencies. The tendency to avoid contact with other adolescent groups reflects in fact the shame, disappointment, disillusionment with the attitude of others and the refusal to establish continuous, harmonious relations with the group. Running from others is equivalent, psychologically speaking, to retraction itself, to closure in one's own universe, refusal to change, and to becoming more cooperative, more communicative. Loneliness is not only a way to avoid the psychological trauma linked to the curious, offensive or aggressive behavior of others towards them, but at the same time indicates the psychological inability to deal with these situations, to find a solution to them, as a result of which these teens would not be negatively impacted in a psychical sense. The tendency toward isolation acts in practice as a protective mechanism for the sensitized ego, traumatized, unable to find a savior response or a reaction that would lead to success in dealing with others [21]-[22]. In this situation, self-isolation acts as a protection, as a way of no longer being exposed to insults and failures. However, the tendency towards isolation is always accompanied by a refuge in the imaginary, by the tendency to replace real life with the refuge in a universe of fantasies and harmless reveries. Psychiatric doctors such as Cristian Vlad [29] are wondering, though, if this method of protecting the deep self of the individual is not part of a complex defense mechanism, of "sheltering" in the face of conflicting, distorting and causative situations of subsequent destructions of personality. Will we accept, the author inquires, to "awaken" the subject from their innocent reverie, throwing them in a tumultuous and uncomfortable hic et nunc or let them continue their fantasies, risking in some way their adaptation to society? [29] This is still a question without a definitive answer. Often, refusal to participate results in deepening of suffering, accentuating instability and impulsivity. Another significant difference exists in the paranoid trend variable ($Z = -3.235, p <0.001$), being higher in the experimental group relative to the control group. This reflects the difference of attitude towards self and life in general, between the two groups. As far as teenagers with PMD are concerned, their personality is centered on an amplified issue, linked to the very presence of the deficiency. The accentuation of these concerns is crystallized in a rigidity of the whole personality, always centered on ruminatives, obsessive thoughts about the future, whether this future refers to the realization as a personality within society, either as a realization within a family or the impossibility of having children, which constitutes an "aggravating" factor in the emergence of "fixed" attitudes to the opposite sex, for example. These teen girls always have the feeling that in dealing with a boy who is not affected by a physical disability, they would become a burden to him that to which they will practically condemn him to an existence that he will realize later he does not want, while choosing another life partner without physical defect would effectively bypass these issues. Rigidity in thinking and behaving is the result of the inability to overcome oneself, lack of desire and understanding that they could become otherwise, more communicative, more sociable. The fact of oversteering the importance of the physical deficiency makes these girls constantly consider that the others perceive it the same as they do. Without becoming paranoid symptoms, these tendencies reflect rather an over-self-centering on those personal problems, on psychological trauma, and on the physical deficiency, that generates it. Within this variable is also highlighted the presence of ideas of persecution, of chimeric ideas, such as in this case, the idea that their own deficiency is the consequence of the mistakes of the parents (committed "sins") or would be a punishment for an imaginary guilt. In this situation, the feeling of guilt is amplified, marking the whole behavior of adolescents with PMD. Another variable of the Personality Inventory W.M. which is significantly higher in the experimental group compared to the teenage group without deficiencies is the depressive tendency ($Z = -5.110, p <0.001$). Depression, in general, reflects that decrease in the affective tone and mental tension, the causality of which in the experimental group situation is represented by the ruminations on the present and future complications that may occur in the evolution of the physical deficiency, as well as the presence of pessimistic thoughts related to professional achievement, joining the social group or establishing a family [13]-[24]-[28]. Depression is a cumulation of these obsessive ideas, which considerably diminishes age-specific optimism, contributing to shaping a
psychological profile characterized by lack of self-confidence, pessimism, and inability to relate naturally within the group through contractions, anxiety and emotional instability. The mental strength of these teenagers, their psychological balance, is disturbed by the constant presence of thoughts of guilt and self-devaluation, profound reverberations of the acute sense of inferiority. The desire to die is floating somewhere in a horizon of dark thoughts that mark the psyche of these teen girls. Some of them have often expressed the desire to die in our individual discussions, to end up with this life that is not offering them nothing but torment, while other girls have experienced real suicide attempts (by overdose on medicines, for example). In the latter depression has turned into despair, in an existential limit reaction. The state of sadness and the abandonment of enthusiasm, the desire to take courageous actions, derives from the inability to accept their own deficiency, denying it, when, in reality, they are adopting a regressive behavior bypassing the generated psychic conflict in the subconscious and unconscious. On the other hand, the tendency toward depression is also the exaggerated tendency towards self-analysis, to the painful comparison with the others, which are considered “free” to success and performance. The exaggeration of introspection, accompanied by the inevitable scoring and accentuation of the depreciating elements of the personality of adolescents with PMD, leads in time to a dissociation of personality and to the onset of psychological disorders of pathological consistency. To these elements can be added the tendency to transform into suffering any conflict with others, as well as any shortcomings related to a physical incapacity as being specific to teenagers with deficiencies. Without becoming a manic-depressive syndrome associated with suicide attempts, these attempts still reflect a loss - even momentary - of any hope, limiting the self-help, as they give up asking for the support of those closest. From the symptomatology of depression can be also mentioned crying crisis, the motivation of which is usually the painful, long-lasting physical state or / and the failure suffered in the affective relationship, the mistrust in themselves and in others. The accentuation of tendencies towards emotional instability (Z = -1.735, p <0.082), antisocial, aggressive or egocentric tendencies (Z = -3.270, p <0.001) is also reflected in all the significant differences identified in our research. As a direct effect of affective instability, the tendency toward aggression indicates one of the most common ways of compensating affective frustrations, revealing accumulated psychic tensions [20].

Even if aggression is in fact, a defense mechanism, it only deepens the inner crisis, adding to the already existing problems that of the complication of the relations with the others which otherwise could provide means of balancing and emotional restoration of the being. The negative effects of aggressive manifestations in the structure of the personality make this type of reaction often scuppered exactly by the adolescents approaching it. The inability to control this aggressive tendency towards others (whether of a physical or verbal nature) is due to an increased psychic tension accumulated in previous frustrating and conflicting relationships. The conditions of removal from parents, cohabitation in a dormitory of students with a heterogeneous structure (normal and deficient) make the psychological tension of these teenagers progressively accumulate, relative to personal frustrations or with the educational level previously conferred by the family and school [17]. The tendency towards aggressiveness can be encountered not only as heterogression but also as self-aggression, materialized in repeated attempts of suicide. Cannot be neglected the truth that aggressive behavior reveals in fact the affective nature of the impulses that generate it. It is recognized that affection is fundamental in the case of aggressive discharges and involves a morbid action marked by a lacking control of reason. A very important role in shaping aggressive behaviors, in the sense of their control and reduction is the education received, the internalization of social norms, the individual's desire to integrate into the social group. Comparing the results of the two groups (G1-G2) obtained in the Depression-Anxiety questionnaire, there is a significant difference regarding depression (Z = -2.66, p <0.007), meaning that it is much more pronounced in teenagers with PDM compared to those without disabilities (Table 2):

| Table 2. DE-AN Test. Significant differences G1-G2 |
|---------------------------------|------------------|------------------|
|                                | Independent samples | Experiment group G1-Control group G2 |
| DEPRESSION - ANXIETY           |                  |                  |
| Depression                     | mG=50,61         | Z=-2,66          | p<0,007     |
| Introversive-Extraversion       |                  |                  |
| Neurosis                       | mG=53,88         | Z=-3,970         | p<0,001     |

Thus, teenagers in the first group are distinguished by the sadness, anxiety, lack of satisfaction, increased sensitivity and irritability that characterize them as compared to those without any deficiencies that are less affected by some conflicting situations, finding some compensatory solutions easier, adapting to frustrating or devaluing situations. The results of the questionnaire reflect, in the case of PDM adolescents, disappointment, unhappiness, crisis of crying, lack of confidence in the future, poorly outlining the ideal of life. Depression expresses inner feelings of affective nature, deformed in this case, in the sense of diminishing their tone and of their obvious negative content. Thoughts of depreciation, feelings of helplessness, intuition of an intimate and social failure, due to the presence and complex implications of motor deficiency, mark their psychological profile, the tendency to block their own psychic energies and alienation. Thus, depression is strongly correlated with the other variables previously highlighted as significantly more pronounced for the experimental group than the control group, such as emotivity, anxiety, the presence of obsessions and phobias, and isolation tendencies towards the group. Depression throws the individual into the circle of helplessness, connects the individual to the negative source of destructive (or self-destructive) thoughts of devaluation, of depreciation, to the discontent with the world and life in general [18]-[19]-[20]-[21]-[22]. Neurosis (Z = -3,970, p <0,001) in the Introversive-Extraversion test indicates a significant difference between the two groups, being more pronounced in the experimental group compared to the teen group with no deficiencies (Table 2). In the analyzed case, neurosis is that psychic state of instability, very low tolerance to frustration, the inability to maintain a stable balance in behavior being characterized by the disruption of uncontrolled impulses of the subjects. Neurosis also reflects the direct effect of psychological complications generated by
the presence of physical deficiency. Failure in intimate, personal relationships, dissatisfaction, unhappiness, leads to the crystallization of an impulsive, unstable state that generates in time neurotic states, sometimes reaching even a pathological intensity. Neurosis can be correlated with increased anxiety, emotional and antisocial attitudes, aggressivity, and is sometimes dependent on obsessive ideas about the presence and evolution of physical deficiency. In the case under consideration it is an additional psychological tension that profoundly disturbs the personality of teenagers with PMD, leading in time - if they do not get psychological or psychiatric help - to pathological phenomena of destruction of personality, at the onset of manic, obsessive-phobic, depressive syndromes, as well as suicide attempts. Neurotic states are often maintained and stimulated by less sympathetic and empathizing families of heterogeneous groups in which the teenagers live, unable to assimilate them with their qualities and defects, resulting in emotional rejection and trauma. Neurosis is in fact a strong psychic reaction to chronic affective frustration, which only the psychologist can take care of. In conclusion, that the results obtained can be considered to be consistent with the presented significance of the deficiency. They clearly reflect the significant differences in self-perception and others’ perception in the case of deficient and non-deficient teenagers, respectively. It can be said that adolescents with PMD have a different psycho-logical profile in their essential data, compared to that of adolescents without deficiencies. The first ones are strongly marked by the presence of PMD, which poses the problem of the need for the development of compensatory traits, which minimize the negative effects of the physiological, vocational, social limitations that the deficiency creates. Thus, the assumptions that are the starting point of this research are also confirmed. On the one hand, there is a significant link between the presence of motor deficiency and the development of psychic traits and specific behavioral reactions within the personality and, on the other hand, the claim that motor deficiency leads to the development of compensatory tendencies, features, psychic attributes and compensatory behavior is reflected in the data presented in this paper. The statistical analysis revealed significant differences in the various variables of the applied samples, such as: emotivity, the tendency towards isolation and psychastheny, paranoia, depression, the tendency to aggression and the need for compensation, neurosis and anxiety. The mentioned psychological aspects are emphasized in these teen girls with PMD, finally generating a particular psychological profile, expressing the general psychophysiological and social consequences of the presence of motor deficiency.

Conclusions
Based on the analysis of the data obtained in the experimental group, it becomes conclusive that there are some essential features characterizing the personality structure of the subjects with FDM: strong psychostennial tendencies as well as increased emotivity due to the uncertainty, the self distrust due to overvalued perception of the others, the isolation tendency demonstrates the presence of feelings of inferiority, the inability to achieve natural social contacts, the fear of failure, the presence of a strong tendency to compensate unwanted feelings, dissatisfaction with the psychosomatic effects of physical deficiency, the accentuation of psychic states that are on the border with pathology (depression, anxiety, obsessions, phobias, paranoid tendencies, neurosis, aggression). There is a danger of exacerbating them in case of aggravation of conflicting states, which confirms the necessity of minimal psychological intervention in order to avoid their chronicling. In the case of teenagers without deficiencies the factorial analysis indicated the presence of features specific to their characteristic personality structure: strong tendencies towards self-assertion; the need for self-definition, sometimes expressed through retreat from the group, internalization and fantasy, the presence of an increased anxiety whose causes may be related to affirmation of personality within the group or family. Anxiety - and sometimes neurosis - are most often correlated with concerns about subsequent competitions, achieving a degree of training appropriate to the acquisition of a desired profession, the tendency of courageous approach to any situation, whether conflictual or frustrating. Other characteristics include an increased ability to normal adolescent girls to adapt to situations with disruptive effect on personality, the presence of more flexible adaptation mechanisms. The methodological investigation was completed by confirming the proposed assumptions. There is a serious psychological tendency for young people with physical disabilities to develop specific personality traits, and the occurrence of some differences in sensitivity and interpretation of the world and the choice of the ideal of life were statistically recorded in this study. As a result of these findings we can note the need to seriously address the issue of PMD in terms of social integration, psychological assistance and counseling to these young people, but also to change as far as possible, the perception and attitude of society towards physical disability [5]-[25]. Since adolescence represents that stage of development that crystallizes the ideal of life and the personality affective and motivational profile it is necessary to provide young people with a favorable social climate with multiple possibilities to overcome the difficulties of movement as well as of the psychic problems that come from physical impairment caused by a deficiency.

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References


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Marinela Rusu is a psychology researcher graduated at the University "Al. I. Cuza" of Iași, Romania, (1985), and a PhD from 1999, scientific title received at the University "Al. I. Cuza" of Iași. From 1996 until now she was also teaching as associated lecturer at the Faculty of Psychology and Social Assistance at the University "Al. I. Cuza” of Iași.