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SOCIAL SUPPORT OF MENTALLY RETARDED PERSONS

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Annotation. *Purpose:* The aim of this work is to assess the relationship between the environment and mentally retarded persons. *Material and methods:* Information referring to social support of mentally retarded persons is a source material collected on the base of the data included in the Polish and foreign literature. The issues under discussion related to the following problems: social integration of persons with intellectual disabilities in a family and local environment, social functioning of people with mild intellectual disability, social rehabilitation of people with moderate, severe and profound intellectual disability and specific contact with people with disabilities. *Results:* For a person with an intellectual disability, the family is the source of acquisition of basic social skills that give him the opportunity for further development and performing certain social roles in a sense of safety. Full acceptance of the intellectually disabled, may dismiss their sense of shame and fear, and instill the satisfaction of belonging to a social community. *Conclusions:* Full social acceptance of people with intellectual disabilities is the basis for their assimilation and social functioning.
Key words: social, support, integration, interpersonal, relationships, mental, retardation.

Introduction

Persons with mental retardation are considered, along with the ones with mental health problems, to be a social group that is most vulnerable to discrimination and social exclusion [1]. There is, at present, a tendency to popularize behaviors towards integration into society. Therefore, the variety of activities related to the specific intellectual disability should be taken into account when undertaking every action. This aspect of the activities was highlighted in the Declaration of Madrid [2] and in the last Report on monitoring the implementation of the "Standard Rules on the Equalization of Opportunities for Persons with Disabilities, 2000-2002". The Report underlines that these people are rarely "heard" in society. Therefore, their needs are overlooked or ignored when creating programs aimed at improving the situation of people with disabilities [3].

The aim of this work is to assess the relationship between the environment and mentally retarded persons.

Material and Methods

Literature search

Different databases from their inception up to January 2014 were used to conduct a comprehensive electronic search of the literature concerning social support of mentally retarded persons. Due to the use of the Medical subject Headings (MeSH) terms „mentally retarded persons" and „social support", 32 publications were found in PubMed, Ebsco, and Scopus. The remaining 17 were downloaded from the databases belonging to Polish universities.

Definition of mental retardation

Mental retardation can be defined as a *developmental disability that first appears in children under the age of 18. It is defined as an intellectual functioning level (as measured by standard tests for intelligence quotient) that is well below average and significant limitation in daily living skills (adaptive functioning)* [4]. Mental retardation is a condition in which individuals have intellectual functioning that is less than average. It is associated with some degree of impairment in such areas as adaptation in learning, social adjustment, or maturation, or in all three ones [5]. American Association on Mental Retardation (AAMR), possibly the dominant professional organization in the field of intellectual disability, presented the definition of mental retardation in 2002 in its 10th edition of the AAMR reference manual on definition and terminology. According to the definition, **mental retardation** is a disability which is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18 [6]. We can distinguish between three levels of mental retardation:

Level I. Mild mental retardation: concerns approximately 85% of the mentally retarded population. The IQ score of these individuals ranges from 50-75 and they are often able to gain academic skills up to the 6th grade level. They can become quite self-contained and sometimes live independently, with community and social support.

Level II. Moderate mental retardation: about 10% of the mentally retarded population is moderately retarded. Moderate retarded persons have IQ scores ranging from 35-55. They can perform work and elementary activities of daily living with moderate supervision. They usually learn communication skills in childhood. Besides, they can be successful when living and functioning within the community in an environment such as a group home.

Level III. Severe mental retardation: about 3-4% of the mentally retarded population is severely retarded. Severely retarded persons have IQ scores of 20-40. They may acquire elementary self-care skills and some communication skills. Many people with severe retardation can live in a group home [7, 8].

Results

The results are presented in the form of four sub-sections on the following topics: social integration of mentally retarded children in family and local environment, social functioning of persons with mild mental retardation, social

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rehabilitation of people with moderate, severe and profound mental retardation and specificity of a contact with mentally retarded persons

Social integration of mentally retarded persons in family and local environment

The main goal of social integration of disabled people is to create the conditions for their development, learning, work and spending free time in natural social environment [9, 10, 11]. Dykcik [12] treats social integration as a social and educational movement that counteracts segregation and isolation tendencies as well as intolerance and discrimination of disabled persons. She also believes that social integration expresses itself in aiming at creating for disabled persons the opportunities for full or partial inclusion into normal life, an access to all institutions and services that the non-disabled derive benefits. This is expressed in such normalization of all the factors in the environment these people live in, so that their distinctness would be a natural phenomenon and that they would have the right to be different [13, 14]. In the 1960s in Denmark the diversity in society was appreciated as it was claimed that every man has something to offer to the other people, despite the color of the skin, good looks, health or efficiency. Everybody possesses certain dispositions and values and is able to evoke positive changes and trigger good experiences and motivations. Therefore, one should strive to normalize the living environment of such people so that every man could be fulfilled and could contribute to the environment by enriching it with everything they can bring to it [15].

Although the society is heterogeneous, i.e. diverse, everyone is equally important. Thus, the aim of social integration is the normalization of the social situation of the disabled who were isolated in the past, lived on a margin of social life, having a limited access to many institutions and cultural values [16, 17]. The opposite to social integration is social disintegration that in its extreme entails ending relations, social closure, a lack of rules and norms of social coexistence [18].

Social integration of a mentally retarded person within a family and a local community manifests itself mainly in the feeling of a mental and emotional bond with nondisabled persons, and his or her subjectivity in various situations in social life [19]. The family is the main area of the living space for a disabled person [20]. It is considered to have a huge potential for rehabilitation [21]. In a family a disabled child gains a basic knowledge of the world around, acquires the social behavior patterns, and develops basic social skills and habits indispensable for everyday life [22]. Therefore, he or she should be included to the maximum extent in every aspect of family life that all the members participate in. Exclusion or limitation of the mentally retarded person‟s participation in current family affairs can be very painful [23].

Partial integration has been considerably introduced to traditional special education. The idea of social integration has caused great transformations in this educational system:

- opening of the special needs schools and centers to social communities as well as starting close relations with the parents of the children and getting them involved in the revalidation process,
- enabling the children from special needs centers to spend their time often in the family homes in order to reduce their social isolation,
- getting the special needs schools pupils interested in varied forms of activities in a local community and for it in order to emphasize their presence in a positive way [24].

Social functioning of persons with mild mental retardation

Mental retardation (mental handicap) is not treated as a disease but as heterogeneous disorders of a different etiology, clinical picture and course that restrict the implementation of social aspirations. It concerns not only cognitive sphere, but all the spheres of functioning and comprises the holistic man [25]. The development of a person with a mental retardation is subject to the same laws as of the nondisabled. However, due to central nervous system disorders and concurrent diseases, it entails educational and rehabilitating interactions as well as favorable environmental conditions that are more varied and applied for a longer time. Special significance is attributed to the social sphere development in which the capacities of mentally retarded persons are definitely greater than in the intellectual one. Mastering the capacity to function in society is one of the major conditions that enable active life leading to a more complete feedback-based community integration that stimulates their further development [26]. Among the consequences of mental retardation one should also mention the difficulties to achieve social adaptation understood as an adjustment to social life requirements and social maturity, taking and acting out various social roles reliably. Social functioning is associated with temperament, character and intellect. The achieved social functioning aiming at autonomy, self-realization, satisfying quality of life depends on personality, instrumental and interactive factors. The first ones are: self-consciousness, self-acceptance, a sense of self-esteem and confidence. In the sphere of instrumental factors there are: social capacities, coping capacities and capacities to benefit from support. As far as interactive factors are concerned, they include: educative influences of parents and caregivers, active social life and, particularly, special support. They remain strongly correlated [27].

Perceiving a disabled person by society is of crucial significance. A negative image, based on perceiving only limitations, defects, often causes reactions to help out, not to give tasks to the best of a disabled person‟s functional abilities and to treat such a person as an incapable one. It is a negative environmental approach as it entails resignation, unwillingness to do activities, fear, resistance, low self-esteem, defense mechanisms against failure. A positive environmental approach, on the contrary, allows to see functional abilities as well as potential capacities of a mentally retarded person, which gives them a chance to co-participate in social life, teaches how to use the support and is conducive to development. All developmental spheres that constitute a mentally retarded person are closely related and determine an interdisciplinary, multi-sectional rehabilitation process from birth to late adolescence [28, 29, 30, 31, 26, 32].

Most of mildly retarded individualities are potentially able to perform work that requires practical abilities most of all, including unqualified or half qualified physical work. In certain socio-cultural conditions, requiring not big school achievements, mild mental retardation may not be a problem. However, when additionally it is accompanied by recognizable emotional and social immaturity, then observable difficulties occur, that involve meeting marriage and child upbringing requirements as well as adjusting to tradition and cultural expectations. Then, low self-control can be observed. A certain stiffness of behavior, opinions and feelings altogether with increased susceptibility to suggestions is a typical symptom. These individuals represent weak criticism of their surroundings as well as of themselves, although it is often related to functioning in a homogeneous group and the roles that meet social expectations that they are offered and they perform. The tendencies to criminal activity and social maladjustment are often observable in practice and then resocializing treatment is more advisable than revalidation. What must be emphasized is the influence of family and local environment [33, 29].

Therefore, great attention is paid to provide social rehabilitation not only to the disabled, but also their surroundings as it gives them a chance to achieve success that is adequate to potential intellectual abilities of the disabled and to engage them in vocational activity and to perform social roles that meet social expectations. Moreover, it prevents them from shaping negative behavior which is contradictory to accepted norms.

Social rehabilitation of people with moderate, severe and profound mental retardation

Moderate and severe mental retardation is often defined as a profound intellectual disability. However, one should remember that the functioning of the individual with moderate and severe retardation varies widely. Receptor disturbances (for example vision, hearing) and cortex damage, concurrent epilepsy, neurological and physical defects occur more frequently in this population than among people with mild mental retardation. Analyzer impairment causes imprecise reflection of surrounding reality. Sensory and sensory perception disorders are recognizable in perception. In direct contacts attention is attracted by body constitution, the way of looking, delayed reactions, and sometimes inadequate stimulus-responses that manifest themselves in oversensitivity or under sensitivity. They are conscious of the time lapse. They understand the notions: „past", „future". They are interested in their perspectives, although they concern near future. They need support in the process of handling difficult situations. Availing of support forms like physical directing, verbal or emotional imitation is frequently impeded by intellectual limitations on the one hand, and by social environment on the other hand. Mental limitations cause such people to become helpless, passive or excessively impulsive. They are overwhelmed with fear, they have poorly developed interests and low self-esteem or, on the contrary, they are excessively self-important [27, 34]. Familiar environment, ensuring safety, good mood, action provoking and stimulating the very activity through frequent positive reinforcement application, determines efforts of the disabled to solve daily problems by asking for help in even such activities as planning a day, a meal and choosing what clothes to wear. Asking for support is a form of entering into environmental relations and it conditions social skills. Therefore, social competencies are to a high degree dependent on the quality of educational influences. A mentally retarded individual is perceived as being awkward in life and requiring an immediate non-stop care when he or she is excessively focused on, which is characterized by handing such a person out and fulfilling his or her needs as well as avoiding putting him or her in difficult situations.

The coupling of profound neurological disorders, physical defects that handicap the ability to move, for example limb paralysis, various types of paresis, epilepsy, hearing and vision defects occur very often in people with severe mental retardation. They need specialist health and rehabilitation care. Concurrent illnesses can pose a constant life-hazard [35]. Decreased physical immunity, frequent parachute infections, respiratory system diseases, progressive physical and trophic changes for example muscle tensions, spinal deformities, respiratory failure and digestive disorders can contribute to it. Health situation determines the dependence upon caregivers. The complexity of concurrent disabilities triggers extreme functioning difficulties of these individuals in all spheres of life. Hence, severe intellectual disability begins to be defined as profound multiple disability [35]. It is characterized by a highly varied clinical picture. The understanding of simple words and mastering the simplest skills for maintaining personal cleanliness are usually only mentioned as a possible ceiling in classical descriptions of functioning of persons with severe mental retardation. Due to the inability to concentrate and learning different concepts, these individuals have great difficulty in learning many simple acts of self-service. They usually require constant care for basic needs and protection against direct physical danger. They are usually characterized by the simplest emotional reactions as signs of joy or anger, but sometimes they show affection or aversion. They have a deeply distorted capacity to perceive. Focusing their eyes on an object is a great difficulty. People with severe intellectual disability are not in a position to meet all their everyday needs by themselves, most often they are even not able to demand the needs to be fulfilled. They are totally dependent on people who take care of them. Thus, family support plays an extremely important role in the process of rehabilitation of individuals with severe retardation.

Specificity of a contact with mentally retarded persons

Social contacts are very valuable as they enhance the impact of rehabilitation. To make it happen, however, the attitudes of the nondisabled people need to be marked by acceptance, emphatic understanding and creating conditions for a not mentally fully functional person for his or her activity, bringing joy and motivating to act. Behaviors characterized by full acceptance of a child with their successes and failures, enhance activity and joy, self-esteem and also increase responsibility to achieve activity target. This produces a sequence of mutually determined situations, which is the beginning of contact with a mentally retarded person, characterized by acceptance. There is no doubt that it is difficult for the parents to accept mental retardation of their child. They often make irrational attempts to adapt to the situation, which may lead to unrealistic expectations and hopes. Such behavior not only interferes with relations, but

sometimes it increases the symptoms of disability. The reasons for uncontrolled reactions, crying, anger, aggression and self-harm can be identified only through close contact, insightful observations, empathy with experiences, feelings and thoughts and then may be tackled or limited as effectively as possible. In contact with a disabled person one should behave in such a way as to trigger, stimulate and keep being active. Difficulties in establishing social relations with mentally retarded persons require the caregivers to show more initiative but not to impose it. It may happen that a disabled person will take the initiative to make a contact. Then this behavior should be noted and not ignored, but sustained effectively. Stimulating activities need to be adequate to the possibilities and needs of a disabled individual. In such situations a nondisabled person assumes the role of a partner who participates in a given activity. Experiences of revalidation indicate that appropriate stimulations accelerate the development of these people, improve social skills, enable the acquisition of autonomy, a sense of identity and efficacy as well as self-esteem and faith in their abilities. Kościelska [34] claims that psychological development takes place through contact with other people"s psyche. Hence, in her studies she inquired into the problem of „the relationship between various aspects of mental functioning of children with an intellectual disability diagnosis and the nature of their contacts with people?" This research largely related to the studies of the diversity in the functioning of mentally retarded persons and their similarity to the community. It showed that the following social experiences have played an important role in the pathology developmental process of these children:

- high sensitivity to social stimuli,
- special adaptation to poor living conditions,
- developing defense mechanisms that obstruct exploratory activity,
- susceptibility to absorb negative information about the world and themselves.

All the contacts of a mentally retarded person with their immediate and more distant environment are very important. The nondisabled ought to understand that a mentally retarded individual is very sensitive to what the others say and how they behave towards them. This person is sensitive to signals that make them disability-aware. In addition to contacts with adult people, the relations with peers, both the intellectually disabled and nondisabled ones are also important. In peer relationships, a positive or negative self-concept, adequate or inadequate self-esteem, a sense of self-worth or limitations are built. The studies conducted by Strang [36] and Coleman [37] are interesting. They observed that the pupils of educational-caregiving institutions or special needs schools usually create a very positive self-image because they make „downward" social comparisons as in their surroundings they will always find a colleague they will consider as slightly lower. On the contrary, the pupils in mainstream schools usually create a negative image as they can compare themselves only with nondisabled peers and most often the result is unfavorable. For this reason, the authors talk about a beneficial effect of „movable classes" on shaping personality of mentally retarded children and young people (mentally retarded children had some classes separately and some with healthy peers). It was found that both the contacts with the nondisabled and the disabled are conducive to creating not only a positive self-image but also to a great extent an adequate one. The authors suggest that, being with healthy children, the disabled ones learnt to recognize their own distinctness and look at themselves more carefully and critically. Social contact is also determined by the ability to understand the situation the other person is experiencing. One can thus consider empathic skills in mentally retarded persons and also their social inference. One should anticipate that limited empathic skills in these people will be expressed by difficulties in reading the reactions, behaviors, needs and wishes of others, limited readiness to respect requirements and constraints, acceptance of mutuality.

In the process of raising a mentally retarded child, limiting their contacts with peers and adults outside the family is noticeable. The result is that the parents are the only persons the child learns from how to establish social relations, the types of communication and how to perform various activities [19]. Poorly developed social insight hinders the development of social problem-solving skills. Individuals with mental retardation most often use a strategy of requests which they treat as a primitive way of solving problematic situations related to social aspect [38]. Zigler [39], as one of the first researchers, examined the consequences of the environmental social impact on mentally retarded persons. He assumed these people will differ in behavior, depending on the environment they live in. The study covered mentally retarded persons living in a family and social welfare institutions. It showed that the individuals living in institutions are sensitive to a lesser degree than the ones who live in family homes. The author also indicated that greater sensitivity of these people is conducive to the readiness to submit to intellectually nondisabled persons as well as the greater tendency to imitate others. It turns out that the environmental attitude may even lead to the deepening passivity and helplessness of mentally retarded individuals [40]. The environment often acts in accordance with the principle of negative feedback, the greater the failure a disabled person experiences, the stronger demonstration of the surroundings that there is no failure. Such behavior toward mentally retarded people may entail negative consequences such as impeded, distorted understanding of real social situations.

The research on the attitudes of social environment toward mentally retarded persons proves that these individuals often trigger aversion or open hostility in their surroundings [41]. Moreover, in comparison with other groups of disabled people they more seldom gain understanding and acceptance [42]. Ostrowska [43] notes that social attitudes toward mentally retarded persons may be due to the fear of being different, the fear of being dependent and addicted, lack of knowledge and personal experiences, inability to behave in society. The studies on the social image of mentally retarded persons, conducted by Ostrowska [44], found that these people are most often described as weak, timid, nervous, lonely, retreating, insecure, unhappy with life. These features are the elements of a stereotype, a generalized image of these persons in society. The way they are perceived is interchangeably associated with everything that is sad, marked by setbacks in life, and never by successes. They are not the people seen as partners of different life

ventures. Their limitations are always emphasized but their possibilities are hardly ever focused on. The prevailing view is that the development of each person is accompanied by negative experiences. Failures that often occur in life, build the attitude of expecting failure in every new situations. A greater number of failures than successes entails a reduction of a mentally retarded person"s aspirations and leads to action in which achieving the smallest success with no risk of failing is sufficient. In this case, the fear of constant failure develops primitive strategies to cope with various social problems. However, in these strategies there is no reflection and evaluation of effectiveness or usefulness of such action. It becomes rigid and insusceptible to changes [38]. Experiencing too many failures inevitably led to submission, dependency upon the environment and a sense of helplessness. In particular, it may be noticed when undertaking new tasks and entering into new social situations.

One should also mention the studies that showed an increased level of anxiety in mentally retarded persons [45]. It turns out that high and very high anxiety affects more than half of the pupils from special needs schools. That is a fear of lack of acceptance and being rejected. Repeated failures in peer relations trigger prosocial behaviors aiming at endearing themselves and gaining favor. In the course of time, these behaviors become fixed and they determine a major strategy for establishing social relations. However, some of mentally retarded individuals manifest aggression, the others withdraw and avoid social contacts, especially with nondisabled peers. In the lives of people with intellectual disabilities there is constant frustration whose source may be found in irregular relations with the nearest environment, a sense of falling behind the non-disabled in different areas of life, a constant sense of injustice, inability to achieve most of the objectives, being convicted of their lower self-worth.

Knowing the difficulties but also the opportunities for contacts with mentally retarded individuals, we can establish the relations with them more easily. We need to realize that they very often wait for our initiative and sometimes just for being the focus of somebody"s attention.

Discussion

The review of the literature showed that the social integration of mentally retarded people is being done in different environmental circles and different formal and informal structures of social life [46]. The development of a mentally retarded person and a non-disabled one is subject to the same rules. In the process of social rehabilitation, introducing a greater number of more varied and long applied educational and rehabilitation incentives as well as favorable environmental conditions is required due to damage to the central nervous system and comorbid conditions [47]. Special significance is attributed to the social sphere development in which the capacities of mentally retarded persons are definitely greater than in the intellectual sphere. Mastering social functioning skills is one of the main factors enabling an active life along with increasing integration with the environment on the basis of feedback that stimulates further development [48]. The reduction of social distance towards mentally retarded individuals meets a very important need for acceptance, communication, an performing certain social functions. Little acceptance of the intellectually disabled may arise primarily from the low level of knowledge about the specific character of their life and development opportunities [49].

Conclusions

Based on the literature concerning intellectually disabled persons, the following conclusions have been formulated:

1. For a person with an intellectual disability the family is the source of acquisition of basic social skills and plays a significant role for persons who require constant care for basic needs.
2. Mastering the skills of social functioning enables people with mild intellectual disabilities to fulfill social roles and stimulates their further development.
3. Ensuring the safety and the use of positive reinforcement provides a social rehabilitation of people with moderate intellectual disabilities, which determines attempts to seek help in solving everyday problems such as planning the day, meal, choice of clothing.
4. Full acceptance of people with intellectual disabilities may dismiss their sense of shame and fear, and instill in them the natural joy of belonging to a social community.

References

1. Quinn G., Degener T., Bruce A., Burke Ch., Castellino J., Kenna,P., Kilkelly U., & Quinlivan S. *The Current use and future potential of United Nations human rights instruments in the context of disability". In. Human Rights and Disability.* United Nations Press, The United States: New York and Geneva, 2002. 307 p.
2. Okasha A. The Declaration of Madrid and its implementation. An update. *World Psychiatry*, 2003, vol. 2(2), pp. 65-67.
3. Report of the Special Reporters of the Commission for Social Development on Monitoring the Implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities on Third Mandate, 2000-2002. In : *Monitoring the implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, United Nations Document E/CN.5/2002/A, annex, 2002. 100 p.
4. Luckasson R., Coulter D. L., Snell M. F., Spitalnick D. M., & Stark, J. A. *Mental retardation: Definision, slassification, and systems of supports* (9th Edition). AAMR Press, Washington, DC, 1992, 123 p.
5. Wehmayer M. L. Defining Mental Retardation and Ensuring Access to the General Curriculum. *Education and Training in Developmental Disabilities*, 2002, vol. 38(3), 271-282.
6. Luckasson R., Borthwick-Duffy S., Buntinx W. H. E., Coulter D. L., Craig E. M., Reeve A., Schalock R. L., Snell M. E., Spitalnick B. M. & Stark J. A. *Mental retardation: Definition, classification, and systems of supports* (10th Edition). AAMR Press, Washington, DC, 2002, 238 p.

7. Luckasson R., & Spitalnick D. M. Political and programmatic shifts of the 1992 AAMR definition of mental retardation. In V. Bradley, J. W. Ashbaugh, B. C. Blaney, editors, *Creating individual supports for people with developmental disabilities: a mandate for change at many levels*. Paul H. Brookes, Baltimore, 1992, pp. 81-96.
8. MacMillan D. L., Grsham F. M., & Siperstein G. N. Conceptual and psychometric concerns about the 1992 AAMR definition of mental retardation. *American Journal of Mental Retardation*, 1993, vol. 98(3), pp. 325-335.
9. Courtade G., Spooner F., Browder D., & Jimenez B. Seven Reasons to Promote Standards-Based Instruction for Students with Severe Disabilities: A Reply to Ayres, Lowrey, Douglas, & Sievers (2011). *Education and Training in Autism and Developmental Disabilities*, 2012, vol. 47(1), pp. 3-13.
10. French G. *Children's early learning and development*. NNCA Press, Dublin, 2007, 30 p.
11. Liu M. Education and the roles of the State and the market in poverty eradication. In Bas D., editor, *Economic & Social Affairs United Nations Publication*, New York, 2013, pp. 37-54.
12. Dykcik W. *Special education* [Pedagogika specjalna]. UAM Press, Poznań, 2007, 457 p.
13. Bronfenbrenner U. The Ecological systems theory. *Annals of Child Development,* 1989, vol. 6, pp. 87-250.
14. Hanline M. F., & Correa-Torres S. M. Experiences of Preschoolers with Severe Disabilities in an Inclusive Early Education Setting: A Qualitative Study. *Education and Training in Autism and Developmental Disabilities*, 2012, vol. 47(1), pp. 109-121.
15. Giangreco M., & Taylor S. "Scientifically based research" and qualitative inquiry. *Research and Practice for Persons with Severe Disabilities,* 2003, vol. 28, pp. 135–137.
16. Fish M., Stifter C.A., & Belsky J. Conditions of continuity and discontinuity in infant negative emotionality: newborn to five months, *Child Development*, 1991, vol. 62, pp. 1525-1537.
17. Perry B. D. Childhood trauma, the neurology of adaptation and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, 1995, vol.16(4), pp. 271-291.
18. Maciarz A. *Theoretical basics of the disabled children's social integration. From the Theory and Social Integration Studies over the Disabled Children Publishing House*. [Teoretyczne podstawy społecznej integracji dzieci niepełnosprawnych. Z teorii i badań społecznej integracji dzieci niepełnosprawnych]. Impuls Press, Kraków, 1999, 137 p.
19. Green S., Davis, C., Karshmer, E., Marsh, P., & Straight, B. Living stigma: The impact of labeling, stereotyping, separation, status loss, and discrimination in the lives of individuals with disabilities and their families. *Sociological Inquiry,* 2005, vol. 75, pp. 197–215.
20. Wojciechowski F. *Impairment.Family. Adolescence*. [Niepełno-sprawność. Rodzina. Dorastanie]. ŻAK Press, Warsaw, 2007, 389 p.
21. Twardowski A., Obuchowska I., editors. *The situation of the impaired families. A handicapped Child in a Family Publishing House* [Sytuacja rodzin dzieci niepełnosprawnych]. WSiP Press, Warsaw, 2008, 588 p.
22. Kleinert H., Haigh, J., Kearns J., & Kennedy S. Alternate assessments: Lessons learned and roads to be taken. *Exceptional Children,* 2000, vol. 67, pp. 51–66.
23. Ozen A., Batu S., & Birkan B. Teaching Play Skills to Children with Autism through Video Modeling: Small Group Arrangement and Observational Learning. *Education and Training in Autism and Developmental Disabilities*, 2012, vol. 47(1), pp. 84-96.
24. Bogucka J., & Kościelska M., editors. *Upbringing and integrative teaching. New experience* [Wychowanie i nauczanie integracyjne. Nowe doświadczenia]. CMPPP MEN Press, Warsaw, 1998, 223 p.
25. Kościelska M. *Mental impairment and social development* [Upośledzenie umysłowe i rozwój społeczny]. WSiP Press, Warsaw, 1984, 396 p.
26. Głodkowska J. *The diagnosis of the special school pupil* [Poznanie ucznia szkoły specjalne]. WSiP Press, Warsaw, 1999, 295 p.
27. Pilecki J., Pilecka W., & Dykcik W. editors. *The conditions and determinants of the mentally disabled child's autonomy. Society in the Face of the Disabled People Autonomy Publishing House* [Warunki i wyznaczniki autonomii dziecka upośledzonego umysłowo. Społeczeństwo wobec autonomii osób niepełnosprawnych]. Eruditus, Poznań, 1996, 269 p.
28. Bradley V. J., & Bersani H. A. *Quality assurance for individuals with developmental disabilities. It's everybody's business*. Baltimore: Paul H. Brookes, Baltimore, 1990, 189 p.
29. Giryński A. *The assessment of social roles fulfillment by the low-average impaired in the sight of the social distance* [Ocena pełnienia ról społecznych przez młodzież upośledzoną umysłowo w stopniu lekkim]. WSP Press, Kraków, 1991, 174 p.
30. Knoll J. A. *Defining quality in residential services*. In V. J. Bradley & H. A. Bersani, editors, *Quality assurance for individuals with developmental disabilities. It's everybody's business*. Paul H. Brookes, Baltimore, 1990, pp. 235–261.
31. Witkowski T. *To raise the level of the mentally impaired people's social functioning* [By podnieść poziom społecznego funkcjonowania osób z upośledzeniem umysłowym]. UMCS Press, Lublin, 1997, 220 p.
32. Schalock R. L. The new definition of intellectual disability, individual supports, and personal outcomes. *Century* [Siglo Cero], 2009, vol. 40, pp. 22–39.
33. Bartkowicz Z. *The juvenile with a reduced mental capacity in the correctional facility* [Nieletni z obniżoną sprawnością umysłową w zakładzie poprawczym]. UMCS Press, Lublin,1984, 209 p.
34. Kościelska M. *The faces of impairment* [Oblicza upośledzenia]. PWN, Warsaw, 2000, 230 p.

35. Fröhlich A. *At the basis of stimulation. How to stimulate extremely low and multiply handicapped people's development* [Stymulacja u podstaw. Jak stymulować rozwój osób głęboko wielorako niepełnosprawnych]. WSiP Press, Warsaw, 1998, 303 p.
36. Strang L. Social comparison, multiple reference groups and the self-concepts of academically handicapped children before and after mainstreaming. *Journal of Educational Psychology*, 1978, vol. 70, pp. 487-479.
37. Coleman J. M. Self-concept and the mildly handicapped: The role of Social comparisons. *The Journal of Special Education*, 1983, vol. 17(1), pp. 37-45.
38. Pilecki J., Pilecka W., & Baran J. *The upbringing of the children with a reduced mental capacity in a boarding school* [Wychowanie dzieci o obniżonej sprawności umysłowej w internacie]. WSP, Kraków, 1992, 271 p.
39. Zigler E. Research on personality structure in retards. *International Review of Research in Mentally Retardation*, 1966, vol. 1, pp. 77-108.
40. Raber S. M. & Weisz J. R. Teacher feedback to mentally retarded and non retarded children. *American Journal of Mental Deficiency*, 1986, vol. 86, pp. 148-156.
41. Giryński A. *The problem of integration in respect of a social distance* [Problem integracji w świetle dystansu społecznego]. *Problemy Rehabilitacji Społecznej i Zawodowej*, 1993, vol. 4, pp. 37-49.
42. Wheeler D., & Farina A. Dimensions of peril in the stigmatization of menially retardation. *Academic Psychology Bulletin*, 1981, vol. 4, pp. 34-37.
43. Ostrowska A. *The impairment syndrome in Poland. Integrative barriers* [Syndrom niepełnosprawności w Polsce. Bariery integracyjne]. IFiSPAN, Warsaw, 1996, 203 p.
44. Ostrowska A. The integration of children in kindergarten and school [Integracja dzieci niepełnosprawnych w przedszkolu i szkole]. Instytut Filozofii i Socjologii PAN, Warszawa, 1994, 191 p.
45. Piekut-Brodzka D., & Kuczyńska-Kwapisz J. *Special Pedagogy social workers* [Pedagogika specjalna dla pracowników socjalnych]. Academy of Special Education, Warsaw, 2004, 214 p.
46. Park J. H., Faulkner J., & Schaller M. Evolved disease-avoidance processes and contemporary anti-social behavior: Prejudicial attitudes and avoidance of people with physical disabilities. *Journal of Nonverbal Behavior*, 2003, vol. 27(2), pp. 65-87.
47. Curtis V, de Barra M, & Aunger R. Disgust as an adaptive system for disease avoidance behaviour. *Philosophical Transactions of the Royal Society of London B: Biological Sciences*, 2011, vol. 366(1563), pp. 389-401.
48. Kurzban R, & Leary M. R. Evolutionary origins of stigmatization: The functions of social exclusion. *Psychological Bulletin*, 2001, vol. 127(2), pp. 187-208.
49. Yazbeck M., McVilly K., & Parmenter T. Attitudes towards people with intellectual disability: An Australian perspective. *Journal of Disability Policy Studies*, 2004, vol. 15(2), pp. 97-111.

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