

THE ROLE OF THE FAMILY IN THE SOCIAL INTEGRATION OF THE CHILD WITH DISABILITIES

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Abstract: *The role of the family is to support the child with disabilities, so that he develops as a person. The harmonious structure of the family and the involvement of the family in the care and education of the child with disabilities, as well as the social environment, have a positive influence on the quality of life and social integration. The proper involvement of the whole family (nuclear family and extended family) in the care of the child with disabilities, promotes the quality of life and social integration of disabled children. The involvement of all family members in the process of educating children with disabilities brings a valuable resource for the quality of life and social integration. An increased quality of life of children with disabilities and a good social integration are observed especially if the family is harmonious, if the involvement of the family is also high and if, at the same time, the family environment is urban. We generally observe that the results in the ten cases vary, from the perspective of the variables: family structure, degree of care for the disabled child (family involvement in the care and education of the disabled child), social background (rural / urban). Depending on these variables, we expected to identify their influence on the quality of life of the disabled child and on the social integration.*

Keywords: *family; education; social integration; disability.*

Introduction

The family is defined as "a form of human community composed of two or more individuals united by marriage and / or paternal ties realizing, more or less, the biological and / or psychosocial side." (Mitrofan&Ciuperca, 1998, p. 17)

Neagoe (2007) defines the family as a group of people that are united by marriage, blood or adoption, who interact and communicate with each other in their various social roles while creating and maintaining a common culture.

From the first years of life, the family is an important factor in the education and development of the child, with a great impact on his values and behavior. Thus,

The family functions presented by Neagoe (2007) are:

a) *The reproductive function* - an essential function of the family without which the perpetuation of the human species would be impossible;

b) *Economic function* - finds its expression in the community of goods, in an effort to ensure optimal living conditions (food, shelter, clothing, medical care);

c) *The educational function* - represents the totality of information, skills, values, traditions, norms that parents are obliged to pass on to their children.

Batâr (2004), names another function of the family, namely the socialization function, to ensure the behavior that the family and community expect.

More and more studies show that in the case of serious disease at one family member, the entire family system is affected, this is why attention should be given to the family system as a whole, in order to reduce depression, anxiety and to increase the life quality of all those affected (Vintila, Stefanut, Sarbescu, 2019; Gavrilă-Ardelean, 2019) by the complex situation the family is confronted with and which will last for their entire lives. Field literature has already proof of the fact that those involved, the family members, have a reciprocal influence on each other, influencing their psychological wellbeing, as such their psychological wellbeing is crucial (Stefanut, A., Vintila, M., Sarbescu, P., 2020). Consolidating the family system is vital, as exposure to such a high level long-term stress can easily lead to emotional exhaustion at the parents, often finalised through a divorce. Putting a child with special need through such a supplementary challenge, maybe even to be a victim of parental alienation would unnecessarily challenge the psychological wellbeing of the child (Sirbu, A., et al, 2021).

The family has a fundamental role in the education, social integration and medical-psychological recovery of the child with disabilities. The parents should follow all the institutional, educational, medical steps so that the child recovers and integrates socially.

The child with a disability needs support so that he or she can work with other children and be an integral part of the community.

The parenting style is a way of approaching how to raise a child, a characteristic that is constantly manifested in family life. According to Bonchis (2011), the following parental styles are distinguished:

- 1) authoritative parenting;
- 2) authoritarian parenting;
- 3) permissive parenting;
- 4) uninvolved parenting.

Authoritative parenting combines high levels of warmth and control, parents being child-centered. *Authoritarian parenting* transmits a high level of control and a low level of parental warmth. These parents set very strict standards for children's behavior, punishing them excessively.

Permissive parenting - indicates a high level of warmth, these parents will always be focused on the child and will always express a level of acceptance that will be manifested by affection, tolerance and sensitivity, the child being encouraged to express any point of view.

Uninvolved parents show a low degree of support and end up detaching themselves from the child, not getting emotionally involved. Children do not have strict rules, they are not offered support. (Bonchis, 2011)

The role of the parent in educating the child will be paramount. Developing harmonious relationships and respecting the basic needs of the child, the unconditional involvement of the family, the efforts they make in educating and raising the child with disabilities are long-term gains for members of this family (Gavrilă-Ardelean, Gavrilă-Ardelean, 2017). Quality relationships with children are based on positive communication. (Trancă & Neagoe, 2018)

Social integration is a process of assimilation and incorporation of the individual in social systems (group, family, collective, society) according to social requirements. While there are many factors that influence the process of social integration one of them can be represented by mass media. Having the capacity to influence different types of people through its diverse communication channels and means (Coman et al., 2018, p.41), by sharing positive information about children with disabilities, mass media could facilitate their

integration process. Even more, since certain communication channels such as television, are thought to have the capacity to act like replacements for people's day to day activities or experiences (Coman, 2010, p.51), interactions between people are mediated by such means of communication, and thus, because people do not come in contact very often with children with disabilities, their perception about them may be influenced less by their personal experiences with such children and more by mass media (Gavrila-Ardelean, 2016).

Until the establishment of democracy in Romania, people with disabilities were kept away from the eyes of the world in special centers and it was not known how they were cared for, or were "hidden" by their own family. They had no rights or facilities (Otovescu, 2009).

The psychopedagogy of integration has been imposed for the need to respect the fundamental human rights, the right to equal education for all children, taking into account their personal requirements. Thus, it was considered necessary to abandon the segregation and isolation of students with disabilities in special schools because they formed an insufficiently adapted individual in terms of integration into society due to social behavior. Special educational needs -SEN - refer to the educational requirements of certain categories of persons, requirements consequent to dysfunctions or deficiencies of a sensory, psychomotor, physiological intellectual nature or as a result of psycho-affective, socio-economic or other conditions, the absence of the family environment, precarious living conditions that place the student in a state of difficulty compared to other children. (Ungureanu, 2000). Currently, according to national law, ensuring the observance of the rights of persons with disabilities lies mainly with the local public administration authorities where the disabled person resides or resides and, in the alternative, with the central public administration authorities, civil society and the family or representative, legal status of the disabled person (Otovescu, 2009).

The integration of a person into a community aims to provide a set of skills that allow acceptance among the members of that community, as "social adaptation is the process by which a person or a group of people becomes able to live in a new social environment, adjusting their behavior to the requirements of the new environment" (Gherguț, 2018, p. 91). Thus, the integration process is a complex action that determines the development through the factors carrying spiritual, moral values, school, public institutions, cultural, family and belong to a social group. Counseling parents to actively interact with their children is essential as this can help overcome the difficulties in socialization, which these children are often confronted with (Goian, C., 2019). Using an adequate language in the family frame, but also between parents and specialists may enhance the well-being of the family system and of the child (Goian, C., 2010). Also, spending time with the children, actively interacting with them and stimulating them through socializing activities, encouraging them to spend time with other children, prevent excessive use of gadgets can help prevent these children to get even more withdrawn from the rest of the society (Vintila, M., Tudorel, O., Goian, C., Barbat, C., 2018; Tudorel, O., Vintila, M., Vlaicu, L., Balauta, D., Goian, C., Rusu, A., 2018).

The skills and abilities that are needed in adaptation and social integration are the results of a continuous learning in various situations in the life of the child. Children with special educational needs will benefit from educational programs that will ensure their recovery as a first step, and facilitate their integration and adaptation in society. (Gilbert, 2000) Thus, taking into consideration a previous study which showed that "people who live far from the center of a city have access to a wider range of public services than people who live closer to the city center" (Rezeanu et al, 2016, p.13), in the case of children with disabilities, access to schools or institutions which offer educational programs that could help them recover or live a better life, can also be influenced by the area in which those children live in.

It is important to help the child with disabilities to become as independent as possible. A positive attitude from the family helps him to develop his communication and integration skills. A fundamental factor in the early education of children with special needs is that the first actions for development are performed in the family. (Stan, 2016)

When it comes to children with disabilities, professionals should fight against stigmatization, lack of knowledge and lack of support for the children and their families. (Stoia et al., 2020)

Materials and methods

The aim of the research is to identify the social and family aspects that help the social integration of the child with disabilities, respectively for a better quality of life.

The research aimed (1) to identify the impact that the family structure has on social integration, and the quality of life of the child with disabilities; (2) to identify the degree of family involvement in the care, recovery and education of the child with disabilities, for a better quality of life and for social integration; and (3) to identify the impact of the family social environment (urban or rural) for the social integration of the child with disabilities, reflected in a better quality of life.

In the present research, 10 cases were analyzed. The analyzed cases took into account a major criterion, all respondents have in care a child with disabilities, for which they are legal representatives. Some of the subjects work as personal assistants for the child with severe disabilities. Some subjects have other children, without special educational requirements, in addition to the child with disabilities. Other subjects are parents of only one child - the one with disabilities. Five subjects live in urban areas, in Timiș County and five subjects live in Caraș County, in rural areas

The present research is descriptive, so it has a qualitative interpretation of the results. The assessment tool used in the study was the interview, which aims to identify aspects of the family that promote the quality of life of children with disabilities, recovery and social integration. For the rating on the family structure and the degree of family involvement in the care of the child with disabilities, a three-point scale from 1 to 3 points was used (1 point = minimum / 2 points = moderate / 3 points = maximum). Regarding the social environment of origin, 1 point was awarded for the rural environment / 2 points for the urban environment.

The variables were set according to the proposed objectives:

- a) *Family structure* (marital status of the subjects, number of children in the family, number of family members who constantly care for the child with disabilities, presence or absence of both parents in the domestic environment of the child with disabilities);
- b) *The degree family involvement in the care*, recovery and education of the child with disabilities;
- c) *The social environment* (urban / rural) in which the subject and the child with disabilities live.

Results

10 adults, of which 7 women and 3 men, aged between 35 and 50 years took part in this study, and they were selected according to a major criterion: they all care for a child with disabilities, for whom they are legal representatives. 50% live in urban areas, respectively 50% live in rural areas.

Table 1. Participants' socio-demographic data.

Respondents	Age	Social environment	Marital Status	Biological children	Relationship with the	Child age /	Child situation	Child educational
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					child	sex	(disability)	status
T.S. (female)	49	Urban	Living with a partner	No	Asistent maternal profesionist	17 / M	Sensory disabilities (moderate level, with a degree of average disability)	11th grade (without the need for an adapted curriculum)
M.D. (female)	35	Rural	Married	1	reprezentant legal	9 / F	Neuromotor disabilities (severe level, with severe disability)	Unregisterd
R.C. (male)	41	Urban	Divorced	1	Parent	14 / M	Cognitive disabilities (moderate level, with severe disability)	8th grade (without the need for an adapted curriculum)
V.T. (male)	48	Rural	Divorced	2	Parent	17 / M	Cognitive disabilities (severe level, with severe disability, with personal assistant)	He has not attended any form of education since the age of 14
D.V. (female)	44	Urban	Married	1	Parent	17 / M	Mental disability (moderate level, with severe disability)	11th grade (without the need for an adapted curriculum)
M.G. (female)	36	Urban	Divorced	3	Parent and personal assistant	10 / F	Mental disability (severe level, with severe disability)	1st grade
W.O. (female)	42	Urban	Married	1	Parent and personal assistant	10 / M	Mental disability (moderate level, with severe disability)	3rd grade
I.C. (female)	38	Rural	Married	2	Parent	14 / M	Mental disability (moderate	7th grade

L.U. (female)	46	Rural	Married	3	Parent	9 / M	level, with severe disability) Moderate level, with severe disability	2nd grade
G.O. (male)	50	Rural	Widower	3	Parent	12 / F	Moderate level, with severe disability	6th grade

Family structure of the child with disabilities

Case 1 - T.S., woman, 49 years old: A single-parent family (T.S. is unmarried); T.S. is a professional foster carer for a child with a disability, who was abandoned at 6 months. As this family is considered vulnerable, a minimum score of 1 point was awarded for the family structure.

Case 2 - M.D., woman, 35 years old: A biological family, in which both parents are present in the family, Mrs. M.D. she is married, has only one child, which is disabled and has a good support network from close relatives. In this situation we have a family with a harmonious structure, giving the maximum score of 3 points.

Case 3 - R.C., male, 41 years old: Single-parent family, in which the father, is the sole provider of the family, is divorced and raises his only child with a disability (a child who was abandoned by his mother). This family is vulnerable, so we gave the minimum score of 1 point.

Case 4 - V.T., male, 48 years old: A single-parent family; the father is divorced – the mother left the family, he has two children in his care, one of whom is disabled. Even though V.T. receives help from the paternal grandmother for the child with a disability, this family is still vulnerable, so the minimum score of 1 point was awarded.

Case 5 - D.V., woman, 44 years old: The family is biological and both parents are present in the family. D.V. she is married, has one child, who has a disability. The family has a good network of support from close relatives. The maximum score of 3 points was awarded.

Case 6 - M.G., woman, 36 years old: In the single-parent family, M.G. she is the mother of three children, one of whom has a disability, raises the children alone and has no support from the biological father or close relatives. It is a vulnerable family, and the score awarded is 1 point.

Case 7 - W.O., woman, 42 years old: Biological family, structured, both parents being present in everyday life. Mrs. W.O. has a child with disabilities; the family lives in the city and the parents are involved and respond to the needs of the child. Close relatives are involved in raising the child and the family climate is warm. Relationships are harmonious; the child has a high level of socialization and has a good quality of life. For the balanced family structure, 3 points were awarded.

Case 8 - C.L., woman, 38 years old: Mrs. C.L. she is married, has two children (one with a disability) and lives in a rural area. The climate in the family is not very harmonious, there are some dissensions between family members. Close relatives are not constantly involved in supporting the family. The child with disabilities has a moderate level of socialization and a poor quality of life, due to family tensions. For the family structure, given the existing problems, 2 points were awarded.

Case 9 - L.U., woman, 46 years old: Mrs. L.U. she is married, has three children (one with a disability) and lives in a rural area. Family relationships are slightly distant, relatives are rarely involved in supporting the nuclear family to raise a child with disabilities. The quality of life is not very high, the child does not receive enough attention for recovery / education and leaves the house very little, has no friends, does not play with other children of similar age. For the family structure, given that it is rarely visited and there is no consensus in educating children, 2 points were awarded.

Case 10 - G.O., male, 50 years old: A single-parent family in which the father is currently single, widowed). Mr. G.O. has three children (one with a disability). G.O. does not have a stable income (lives from one day to the next from social benefits) and does not receive help from relatives. The level of vulnerability is very high, being given for the family structure the minimum score of 1 point.

Results on the degree of care for the child with disabilities

Case 1 - TS, woman, 49 years old: Mrs. TS, unmarried, professional foster carer for a child with a disability, takes care of this child alone, but receives support from her own family, from the partner she lives with and from the General Directorate of Social Work and Child Protection. For the degree of care of the disabled child and the involvement of the family, the average score of 2 points was given.

Case 2 - M.D., woman, 35 years old: Mrs. M.D., married, takes care of the disabled child together with her husband, receiving support from close relatives. For the degree of care of the disabled child and the involvement of the family, the maximum score of 3 points was awarded.

Case 3 - R.C., male, 41 years old: Mr. R.C., divorced, the only provider of the family, raises his disabled child alone, being only partially supported by close relatives. For the degree of care of the disabled child and the involvement of the family, the average score of 2 points was given.

Case 4 - V.T., male, 48 years old: Mr. V.T., divorced, having two children, one of whom is disabled; receives help only from the paternal grandmother for the disabled child. For the degree of care of the disabled child and the involvement of the family, the minimum score of 1 point was given.

Case 5 - D.V., woman, 44 years old: Mrs. D.V., married, together with her husband care for the only child, who has a disability, receiving only partial support from close relatives (because the grandparents live far away). For the degree of care of the disabled child and the involvement of the family, the average score of 2 points was given.

Case 6 - M.G., woman, 36 years old: Mrs. M.G., mother of three children, one of whom has a disability, raises children alone and has no support for the child with a disability, neither from her ex-husband nor from close relatives. For the degree of care of the disabled child and the involvement of the family, the minimum score of 1 point was given.

Case 7 - W.O., female, 42: Mrs. W.O. she is married, the mother of an only child with disabilities; has a good support network in the extended family; maternal and paternal grandparents are contributing to the support of the family and the education of the disabled child (there are no major conflicts between family members); For the involvement of the whole family in the process of recovery and socialization of the disabled child, which promotes the quality of life and the social integration, 3 points were awarded.

Case 8 - C.L., woman, 38 years old: Mrs. C.L. she is married, has two children (one with disabilities) and lives in a village; due to the tensions between the family members, the two children are a little neglected, the disabled child being withdrawn; the other members of the family, from the extended family, do not visit much, rarely taking care of the child with disabilities. For the moderate involvement of the family in the care and education of the

disabled child, which affects the quality of life and the level of social integration, 2 points were awarded.

Case 9 - L.U., woman, 46 years old: Mrs. L.U. is married, has three children (one of whom is disabled), the family lives in a village; the family is insufficiently involved in the process of caring for and recovery of the disabled child; children are rarely taken out of the home; the disabled child has little social contact, does not participate in social events; relatives are rarely invited home, children do not go to grandparents / aunts; the extended family is rather indifferent to the needs of the child with disabilities. For the moderate involvement of the family in the care and education of the disabled child, which mainly affects the poor socialization of the child, 2 points were awarded.

Case 10 - G.O., male, 50 years old: Mr. G.O., single, widowed, with three children in care, one of whom is disabled, lives in a village; does not receive help from close relatives; for the child with a disability, the extended family is not involved at all. For the low degree of care of the disabled child and for the poor involvement of the family in the care and education of the disabled child, which obviously influences the quality of life and social integration, the minimum score of 1 point was given.

Results on the social environment of the child with disabilities

Case 1 - T.S., woman, 49 years old: Mrs. T.S., together with the disabled child, lives in an urban environment, the disabled child being integrated at the special school and attends recovery services adequate to his needs. For the positive influence of the urban environment on the integration and quality of life of the child with a disability, 2 points were awarded.

Case 2 - M.D., woman, 35 years old: Mrs. M.D., together with her husband and their disabled child, lives in a rural area, where the child does not benefit from recovery services adapted to his needs, the potential of the disabled child being minimized. For the less positive influence of the rural environment on the integration and quality of life of the child with disability, 1 point was awarded.

Case 3 - R.C., male, 41 years old: Mr. R.C., together with the disabled child, lives in an urban environment, the disabled child being integrated in the special school and attending recovery services appropriate to his needs. For the positive influence of the urban environment on the integration and quality of life of the child, 2 points were awarded.

Case 4 - V.T., male, 48 years old: Mr. V.T. together with his two children, one of whom has a disability, lives in a rural area. The child with a disability does not benefit from recovery services adapted to his needs, his potential being undervalued. For the less positive influence of the rural environment on the integration and quality of life of the disabled child, 1 point was awarded.

Case 5 - D.V., woman, 44 years old: Mrs. D.V., together with her husband and their disabled child, lives in an urban environment, where the disabled child is integrated in the special school and attends recovery services appropriate to his needs. For the positive influence of the urban environment on the integration and quality of life of the child with disability, 2 points were awarded.

Case 6 - M.G., woman, 36 years old: Mrs. M.G., together with her three children, one of whom has a disability, lives in an urban area, where the disabled child is integrated in the special school and attends recovery services appropriate to his needs. For the positive influence of the urban environment on the integration and quality of life of the child with a disability, 2 points were awarded.

Case 7 - W.O., woman, 42 years old: Mrs. W.O., together with her only child, who has a disability, lives in an urban environment, where the disabled child is integrated in the special school and attends recovery services appropriate to his needs. For the positive

influence of the urban environment on the integration and quality of life of the child with disability, 2 points were awarded.

Case 8 - CL, woman, 38 years old: Mrs. CL, together with her husband and two children (one of whom has a disability), lives in a rural area, where the child does not benefit from recovery services adapted to his needs, the potential of the disabled child being minimized. For the less positive influence of the rural environment on the integration and quality of life of the child with disability, 2 points were awarded.

Case 9 - LU, woman, 46 years old: Mrs. LU, together with her husband and three children (one of whom is disabled), lives in a rural area, where the child does not receive recovery services, although she would need them, the potential of the child is thus not valued. The rural environment disadvantages the social integration of the child (1 point), and the family climate ensures the child a moderate quality of life (2 points).

Case 10 - G.O., male, 50 years old: Mr. G.O., along with his three children, one of whom has a disability, lives in rural areas. The child with a disability does not have recovery services according to his needs, his potential being much neglected. For the unfavorable influence of the rural environment on the poor social integration and on the poor quality of life of the disabled child, we awarded 1 point (Annex 10).

Discussion

Next, we will discuss some important aspects, following the interpretation of the results.

Family structure: For the variable "Family structure", we have the following results: for case 1 T.S., woman, 49 years old (unbalanced structure); for case 2 M.D., woman, 35 years old (balanced structure); for case 3 R.C., male, 41 years old (unbalanced structure); for case 4 V.T., male, 48 years old (unbalanced structure); for case 5 D.V., woman, 44 years old (balanced structure); for case 6 M.G., woman, 36 years old (unbalanced structure); for case 7 W.O., woman, 42 years old (balanced structure); case 8 C.L., woman, 38 years old (partially balanced family structure); case 9 L.U., woman, 46 years old (family structure partially balanced); case 10, G.O., male, 50 years old (unbalanced structure). We consider that an unbalanced and vulnerable family structure negatively influences the integration of the child with disabilities and his quality of life.

Degree of care for the child with disabilities in the family: three subjects had a weak involvement of the family in the care of the disabled child (subject 4-V.T., 6-M.G. and 10-G.O.), five subjects had a moderate involvement of the family (subject 1 -T.S., 3-R.C., subject 5-D.V., 8-C.L. and 9-L.U.). Two other subjects had a good involvement of the family in the care of the disabled child (subject 2-M.D and 7-W.O.). We believe that those children with disabilities who have more support from their family, in the process of development in the environment, are socially integrated in a better way and have a better quality of life.

Urban background: For the variable "Origin", we have the following results: five of the subjects live with the child with a disability in the urban environment, where he benefits from recovery services, appropriate to personal needs, adapted to the special educational requirements; the other five subjects live with the disabled child in rural areas, where the disabled child does not benefit from recovery services, adapted to particular needs. We consider that those children with disabilities who live in urban areas, benefit from more offers of social services, have a better socialization, are better socially integrated and have a better quality of life.

Regarding the theoretical framework, previous studies on the quality of life of children with disabilities, their social integration, as well as the role of the family, are in agreement with the results obtained in this research.

Reporting the results obtained for the purpose of the research, the proposed objectives and the hypotheses, we consider that the purpose and objectives have been met and the hypotheses have been validated.

The main conclusions of this study are the following: the harmonious structure of the family and the involvement of the family in the care and education of children with disabilities, as well as the urban social environment, have a positive influence on the quality of life and social integration of children with disabilities. These conclusions are in line with the purpose of the research and the results obtained in the ten case studies.

We identified some limitations of the research, namely: the case studies led to results that cannot be generalized, given the small number of subjects; at the same time, the interview had some shortcomings: it did not cover a wider range of information, which could have been related to the research topic; it was also difficult to rate the subjects' responses to the interview, given the qualitative approach of the research.

Proposals: taking into account the theoretical framework for this research, the results of the case studies outlined above and the experience gained in professional and personal terms, we believe that the research can be continued: it can address a larger number of subjects, can analyze the correlation between the variables and can the interview with parents who have a child with a disability can be improved.

Conclusions

In the first hypothesis of the research we assumed that, if the family structure is balanced, then the social integration and the quality of life of the child with disabilities are better.

The results of the study were as follows: Three children with disabilities were obviously favored by a harmonious family structure, two other children with disabilities did not have such a chance, having a vulnerable family with a tense climate. Five other children with disabilities had a vulnerable family with an unbalanced structure. The integration of the child with disability proved difficult, and his quality of life was low, especially in case 4 (the subject's family 4-V.T) and in case 10 (the subject's family G.O.). In contrast, in case 5 (the subject's family 5 D.V.) and in case 7 (the subject's family W.O.), the balance and stability in the family decisively favored the quality of life and social integration of the child. Similarly, in case 2 (the subject's family 2-M.D.), the quality of life of the disabled child was particularly favored by the balanced structure of the family and the unity of the extended family members. The harmonious, balanced structure of the family positively influences the development of children with disabilities, their quality of life and their integration into the community. Thus, hypothesis I is confirmed.

In the second hypothesis of the research we assumed that the higher the degree of care of the child with disabilities from his family, the better the quality of life and social integration.

The results of the study were as follows: Two children with disabilities had a family with a very good contribution in their care and education. Another five children have sufficiently involved parents in the process of raising them, but the other members of the extended family contribute in part to the care of the disabled child. Three children with disabilities are disadvantaged in this respect, having little attention from family members.

Conclusion 2: The good involvement of the whole family (nuclear family and extended family) in the care of the child with disabilities, promotes the quality of life and

social integration of disabled children. The involvement of all family members in the process of educating children with disabilities brings a valuable resource for the quality of life and social integration of these children. Thus, hypothesis II is confirmed.

In the third hypothesis of the research we assumed that, if the social environment of origin is urban, then the quality of life and social integration of the child with disabilities are better.

The results of the study were as follows: Five children with disabilities were favored by the social environment, living in urban areas. Another five children with disabilities were disadvantaged in this respect, living in rural areas, being deprived of educational opportunities and socializing.

Conclusion 3: The urban environment favors in some respects the quality of life and social integration of children with disabilities, having an important role in providing social opportunities for the recovery and development of these children. Thus, hypothesis III is confirmed.

We generally observe that the results in the ten cases vary, from the perspective of the variables: family structure, degree of care for the disabled child (family involvement in the care and education of the disabled child), social background (rural / urban). Depending on these variables, we expected to identify their influence on the quality of life of the disabled child and on the social integration.

Conclusion 4 - An increased quality of life of children with disabilities and a good social integration is observed especially if the family is harmonious, if the involvement of the family in the care of the disabled child is also high and if, at the same time, the family environment is urban.

Conclusion 5: We consider that this study is useful and applicable, so that it can be shared in the professional environment of social workers, for a better quality of life of children and their better social integration. Thus, NGOs, which are privately funded, have the opportunity and flexibility to carry out programs of recovery and socialization activities, addressed to children with disabilities and their families, especially in rural areas. Thus, the results of this study can be used as resources by social workers, who can improve their social services, in the following directions:

- parent counseling programs / systemic family therapy / support groups for families of children with disabilities (to improve the relationship between family members and the child with disabilities);
- programs focused on the educational training of families with children with disabilities;
- recovery programs for children with disabilities in rural areas, respectively socialization activities for disabled children and their families;
- arranging public spaces that favor the socialization of disabled children in natural social environments;
- mobile multidisciplinary team to go to the family home - through privately funded projects.

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