PSY 307
Psychological Aspects of Disability

Ibadan Distance Learning Centre Series

PSY 307
Psychological Aspects of Disability

By
Keyna Chimenka Abiahu
Department of Psychology
University of Ibadan

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Vice-Chancellor's Message

I congratulate you on being part of the historic evolution of our Centre for External Studies into a Distance Learning Centre. The reinvigorated Centre, is building on a solid tradition of nearly twenty years of service to the Nigerian community in providing higher education to those who had hitherto been unable to benefit from it.

Distance Learning requires an environment in which learners themselves actively participate in constructing their own knowledge. They need to be able to access and interpret existing knowledge and in the process, become autonomous learners.

Consequently, our major goal is to provide full multi media mode of teaching/learning in which you will use not only print but also video, audio and electronic learning materials.

To this end, we have run two intensive workshops to produce a fresh batch of course materials in order to increase substantially the number of texts available to you. The authors made great efforts to include the latest information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly. It is our hope that you will put them to the best use.

Professor Olufemi A. Bamiro, FNSE
Vice-Chancellor

Foreword

The University of Ibadan Distance Learning Programme has a vision of providing lifelong education for Nigerian citizens who for a variety of reasons have opted for the Distance Learning mode. In this way, it aims at democratizing education by ensuring access and equity.

The U.I. experience in Distance Learning dates back to 1988 when the Centre for External Studies was established to cater mainly for upgrading the knowledge and skills of NCE teachers to a Bachelors degree in Education. Since then, it has gathered considerable experience in preparing and producing course materials for its programmes. The recent expansion of the programme cover Agriculture and the need to review the existing materials have necessitated an accelerated process of course materials production. To this end, one major workshop was held in December 2006 which have resulted in a substantial increase in the number of course materials. The writing of the courses by a team of experts and rigorous peer review have ensured the maintenance of the University's high standards. The approach is not only to emphasize cognitive knowledge but also skills and humane values which are at the core of education, even in an ICT age.

The materials have had the input of experienced editors and illustrators who have ensured that they are accurate, current and learner friendly. They are specially written with distance learners in mind, since such people can often feel isolated from the community of learners. Adequate supplementary reading materials as well as other information sources are suggested in the course materials.

The Distance Learning Centre also envisages that regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks will find these books very useful. We are therefore delighted to present these new titles to both our Distance Learning students and the University's regular students. We are confident that the books will be an invaluable resource to them.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.

Professor Francis O. Egbokhare
Director

General Introduction and Course Objectives

This course material is written to prepare the students in order to acquire the skills needed for thorough understanding of disability. Psychology, being the scientific study of human and animal behaviour, by inference, is needed for full grasp of the knowledge of disability. Hence, the course is specifically designed to achieve the following:

1. to introduce you to the background knowledge and understanding of disability;
2. to expose you to the meaning of disability in terms of etiology, causes, diagnoses and subtypes. To have knowledge of disability models and understanding of their implications;
3. to have a clear understanding of how psychology and disability are related or different, and acquire the knowledge necessary to identify various types of disability; and
4. to have knowledge of the diagnostic criteria and functional limitations of the disabilities and develop the awareness of the psychological effects, impact and manifestations in the disabled children, adults and family

At the end of the course, you should be able to make a critical analysis of the basic concepts of disability. You should also be able to discuss the meanings of disability, and apply the knowledge of functional limitations to rehabilitation counselling practice.

LECTURE ONE

Towards the Definition of Disability

Introduction

This lecture is to provide you with alternative definitions of disability and explanations of the major models of disability. Disability is perceived and interpreted differently by professionals. This exercise is therefore meant for you to know the emphasis of authors and other fundamentals of psychological aspect of disability.

Objectives

At the end of the lecture, you should be able to:

1. define and explain what disability is all about; and
2. explain the models of disability as used by psychological researchers.

Pre-Test

1. What is disability?
2. Provide three explanations of disability before you commence reading.

CONTENT

There are several ways of defining disability. To be considered disabled under either ADA or 504, a person must have a physical or mental impairment that substantially limits a major life activity, or has a record of such impairment. The DDA definition is the perhaps the most obvious, which explains disability as: a physical or mental impairment that has a

long-term, substantial, adverse effect on the ability to perform day-to-day activities.

The Disability Discrimination Act (1992) defines disability as:

1. total or partial loss of a person's bodily or mental functions
2. total or partial loss of a part of the body
3. the presence in the body of organisms causing disease or illness
4. the malfunction, malformation or disfigurement of a part of a person's body
5. a disorder or malfunction that results in a person learning differently from a person without the disorder or malfunction
6. a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgement, or that results in disturbed behaviour.

But the above is by no means the only definition.

The two most widely used definitions are the medical and the social model (the social model, being the one most disabled people themselves, generally, prefer as this emphasizes the social restrictions that can prevent disabled people from having an equal opportunity to take part fully in all aspect of life).

The Medical Model

Under the medical model, disability is defined with reference to what is 'wrong' with the person: how they are thought to differ from the 'norm' that is accepted by society as a whole. 'Disability' and 'impairment' become interchangeable and are used to describe the 'medical' condition that someone is said to have.

The World Health Organization (WHO) composed this definition of disability in early 1980s. This definition defines impairment, disability and handicap as follows.

IMPAIRMENT – loss or abnormality in structure or function;

DISABILITY – Inability to perform an activity within the normal range for a human being, because of impairment

HANDCAP – Inability to carry out normal social roles because of an impairment or disability. These definitions were initially designed for the convenience of medical personnel. They reinforce the misconception that disability is allied to ill health and that disabled people need the care and attention of the medical profession. These definitions also put the responsibility for functional inability with the disabled person and imply that the answers to solving the persons that arise from living with a disability lie with the medical profession.

The Social Model

The social model looks at the way in which the lives of disabled people are affected by the barriers that society imposes. Having a disability certainly implies that there are some functional limitations that have been caused by an illness, accident or medical condition. In some situations, the limitation is accommodated, i.e. person with hearing loss may use a hearing aid to improve or restore his/her hearing; short sightedness can be corrected by wearing glasses or contact lenses, etc. Day to day activities may be more difficult for a disabled person because of pain, difficulty in moving, communicating, or because of a learning disability, but accepting and accommodating society would significantly reduce the effects of disability. If the social and environmental barriers were eliminated, disabled people would have a more realistic opportunity of living equally alongside non-disabled people.

Alternatively, disability however, is clearly viewed as the disadvantage, restriction on activity and involvement caused by an approach by society (or parts of it), which takes little or no account of people with impairments and their needs, and thus excludes them from mainstream activity.

The social model of disability locates the problems faced by disabled people externally - in the way that organisations, for example, produce information that is not readily accessible to a section of society; in the travel infrastructure that does not make adequate (or any) provision for alternative forms of mobility. So, under the social model approach, the individual is not prevented from reading a magazine by their blindness, but by the lack of readily available alternative formats.

The individual is not prevented from travelling by their use of a wheelchair, but by the lack of facilities at stations, on trains in buses etc,

to accommodate his needs. And, it is the lack of these accessible options that 'disables' the individual.

The social model locates the blame for the barriers facing people with impairments clearly with those who erect the barriers.

The most common barriers are:

1. prejudice and stereotyping
2. inflexible organisational procedures and practices
3. inaccessible information; inaccessible buildings
4. inaccessible transport systems.

Disability can result from accident, illness, congenital or genetic disorders. There are many different kinds of disability—physical, intellectual or mental health related. A disability may be visible or hidden, may be permanent or temporary and may have a minimal or substantial impact on a person's abilities. A disability may affect mobility, ability to learn, or ability to communicate easily.

Although some people are born with disability, many people who currently have a disability may have spent much of their lives without disability. For example, people who have acquired their disability through a workplace incident or car accident, or people who may have acquired a disability as they age. The only thing that distinguishes a person with disability is that he may be unable to do certain things in the same way that most people in the mainstream of society do them without some form of adaptation or alterations to assist him overcome the effects of his disability.

Summary

In this lecture, the concept of disability has been approached from different perspectives. We have learnt that the way we (and others) understand disability can have a fundamental effect on what we are prepared to do, and why, in overcoming the difficulties that disabled people face on a day-to-day basis. It can also have a determining influence on our language when we talk about disability or impairment.

Post-Test

1. How can our knowledge of psychology enhance our understanding of disability?
2. What were the two major models of disability?

References

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Wood, P. (1980). *International Classification of Impairments, Diseases, and Handicaps*. Geneva: World Health Organization.

LECTURE TWO

The Categories of Disability

Introduction

This lecture is designed to educate you on the various categories of disability. We will discuss these categories, and how they differ from one another.

Objectives

At the end of this lecture, you should be able to:

1. explain the different categories of disability; and
2. discuss each type of disability with examples.

Pre-Test

1. List the categories of disability you know.
2. Explain any three of the disability types mentioned.

CONTENT

Visual Disability

Disorders in the structure and function of the eye as evidenced by at least one of the following: (a) visual acuity of 20/70 or les in the better eye after the best possible correction, (b) a peripheral field so constricted that it affects one's ability to function in an educational setting, (c) a progressive loss of vision that may affect one's ability to function in an educational setting. Examples include, but are not limited to, cataracts, glaucoma, nystagmus, retinal detachment, retinitis pigmentosa and strabismus.

Physical Disability

Conditions that impact the musculoskeletal, connective tissue or neuromuscular system are physical disability conditions, which may require an adaptation to one's school environment or curriculum. Examples include, but are not limited to, cerebral palsy, absence of some body member, clubfoot, nerve damage, cardiovascular aneurysm (CVA), head injury and spinal cord injury, arthritis and rheumatism, interacranial hemorrhage, multiple sclerosis, Parkinson's disease, and muscular dystrophy.

Hearing Auditory Disability

Hearing auditory disability occurs when there is a hearing loss of 30 decibels or greater, pure tone average of 500, 1000, 2000 Hz, unaided, in the better ear. Examples include, but are not limited to, conductive hearing impairment or deafness, high or low tone hearing loss or deafness and acoustic trauma haring loss or deafness.

Specific Learning Disabilities

This is a disorder in one or more of the basic psychological or neurological processes involved in understanding or in using spoken or written language. Disorders may be manifested in listening, thinking, reading, writing, and spelling or performing arithmetic calculations. Examples include, but are not limited to, dyslexia, dysgraphia, dysphasia and dyscalculia. Such disorders do not include learning problems due primarily to visual, hearing or motor handicaps; mental retardation; emotional disturbance, or an environmental deprivation.

Speech Disability

Speech disability refers to disorders of language, articulation, fluency or voice that interfere with communication pre-academic or academic learning, vocational training or social adjustment. Examples include, but are not limited to, cleft lip and/or palate with speech impairment, stammering, stuttering, laryngectomy and aphasia.

Mobility and Dexterity Impairment

Mobility impairments range in severity from limitations on stamina to paralysis. Some mobility impairments are cause by condition present at birth while others are the result of illness or physical injury.

Quadriplegia and Paraplegia

Quadriplegia is the paralysis of the extremities of the trunk, is caused by a neck injury; students with quadriplegia have limited or no use of their arms and hands while Paraplegia on the other hand refers to paralysis of the lower extremities and the lower trunk, is caused by an injury to the mid-back; students with paraplegia have full movement of their arms and hands.

Other Disabilities

Not limited to the conditions listed below

Mental, Psychological or Personality Disorders

This refers to any emotional or behavioural neurosis that has or could create an unstable condition in the individual's actions.

Cardiovascular and Circulatory Conditions

These conditions include, but are not limited to, congenital heart disease, rheumatic fever and chronic rheumatic heart diseases, arteriosclerotic and degenerative heart disease, and other conditions of the circulatory system.

Blood Serum Disorders

These refer to all forms of Hemophilia, sickle cell anemia, HIV/AIDS and disorders where the cause is unknown.

Respiratory Disorders

These include tuberculosis of the respiratory system, cystic fibrosis, emphysema, pneumoconiosis and asbestosis, bronchiectasis, chronic bronchitis and sinusitis, and other disease of the respiratory system.

Attention deficit Hyperactivity Disorder (ADHD/ADD)

Attention Deficit Hyperactivity disorder is a neurological condition that affects learning and behaviour. Students may be easily distracted, impulsive, hyperactive, and inconsistent.

Other Chronic Health Conditions

Other conditions that require administrative or academic adjustment such as class schedules, parking and court adjustments, and do not fit into any of the above categories may also qualify.

Summary

In this lecture, we have learnt the categories of disability and noted that disability may be aberration on visual, auditory, physical, learning, speech and other disorders of respiratory and blood circulation.

Post –Test

1. Differentiate among the categories of disability identified above.
2. Briefly explain five of the categories with examples.
3. Differentiate between Quadriplegia and Attention Deficit Hyperactivity disorder.

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LECTURE THREE

What is Impairment?

Introduction

In this lecture, the focus will be on definitions and explanations of impairment as concept. This lecture will also briefly illustrate the different types of impairment and how they differ from one another.

Objectives

At the end of this lecture, you should be able to:

1. define and discuss the meaning of impairment as a disability; and
2. explain the difference between disability and impairment.

Pre-Test

1. What is impairment?
2. How is impairment a disability?

CONTENT

The World Health Organisation (WHO) composed this definition of impairment in early 1980s as loss or abnormality in structure or function. The subsequent effects of an illness, accident or medical condition upon the way a person functions can be divided into two main categories: visible and invisible impairment.

A visible impairment is one that can be seen, for example, a wheelchair user has an obvious physical impairment. Consequently, many people associated disability with using a wheelchair when in fact wheelchair users make up only a small percentage of the disabled

population. There are many other forms of visible and invisible impairments and some examples are listed below. They should not be considered in isolation; a person with advanced diabetes, for example, may have a visual impairment and mobility difficulties due to slow circulation and loss of sensation.

Types of Impairment

Physical impairment – This denotes difficulty in moving or using all or part of the body. The upper limbs may be restricted making it difficult to reach, grasp and manipulate objects; or there may be mobility impairment often caused by partial or complete loss of function in the legs, but conditions that affect balance or loss of sensation can also result in mobility difficulties. A person with mobility impairment may not necessarily be dependent on a wheelchair; he/she may still be ambulant, but may find walking difficult.

Sensory Impairment – Indicates that there is a loss of hearing or sight.

Learning disability – Suggests that a person has difficulty learning in the commonly accepted way, or at the same pace as his/her peers. It does not mean that he/she cannot learn; often-different approaches to learning will help people with a learning disability to understand.

Communication difficulties – Our main forms of communication are by using speech, gestures and the written words. A communication difficulty may arise, for example, when there are difficulties articulating the muscles used for speech or when there are disturbances to the speech area in the brain. We often use gestures to support what we are saying. Therefore, anyone with a condition that affects their muscles control will have difficulty forming natural gestures.

Mental illness – This includes illnesses that result in disorders of mood, perception and motivation, and also conditions that affect the actual brain tissue, giving rise to memory loss or disorientation, as found in Alzheimer disease. It is an illness with symptoms that affect the way a person thinks, feels and acts. Mental illness can affect anyone, regardless of background, age, level of education or professional experience. The exact cause of mental illness is rarely understood. However, it is generally accepted that a combination of biological and environmental factors create a

vulnerability for some people that results in mental illness developing. People may develop symptoms in response to stress, trauma, social change, drugs or alcohol. Stress is the factor most likely to have an impact on mental health. Therefore, a supportive and aware workplace can ensure better health for everyone. If treated, mental illness can be successfully managed and people can live full and productive lives. Mental illnesses include depression, bipolar disorder, schizophrenia, anxiety and personality disorders.

Hidden disability – a number of conditions affect the human body without there being any outward sign of impairment. Conditions such as heart disease, respiratory disorders and epilepsy may affect the ability of a person to function effectively in particular situations or at certain time. Understanding mental illness

Summary

In this lecture, we have learnt that impairment is loss or abnormality in structure or function. We equally noted that the subsequent effects of impairment might be visible or invisible. The exercise also exposed you to the knowledge of the types of different and what they are all about.

Post-Test

1. Highlight the different types of impairment, and explain with examples.
2. Is impairment a disability? If yes, how?

References

American Psychiatric Association. (1994) *The Diagnostic and Statistical Manual of Mental Disorders*: DSM-IV. Washington, DC. Australian Bureau of Statistics 2000.

Jablensky, (2000) *1999 National Survey of Mental Health and Well being*. Commonwealth of Australia. Mental Illness.

LECTURE FOUR

The Barriers to Ability

Introduction

In this lecture, we will examine the different barriers to ability with special reference to environment, the structure of the society, access to information and attitudinal barriers. The cultural and social influences of disability will also be examined to determine whether and to what extent our lives will be affected by disability.

Objectives

At the end of this lecture, you should be able to:

1. explain what is meant by barriers to ability;
2. make a distinction between cultural and social influences; and
3. identify and provide explanations on different barriers of ability.

Pre-Test

1. What are the distinguishing features of cultural and social influences of disability?
2. What do you understand by barriers to ability?

CONTENT

Disabled people argue that if attitude towards them, the way physical environments are designed and the way society is organised were changed, then the effect of their impairments would be minimised, giving them a fairer chance of equality. What can be changed and how?

The environment - both the internal and external environment can be changed to give better access and improved facilities for disabled people. New public buildings should be designed to meet the requirements of the Building Regulations 1991. Approved Documents which set out guidelines on entrances; internal space for example doorways and corridors; access to other floor within a building; WC facilities etc. existing buildings should be adapted wherever possible. Outside, consideration of the needs of disabled people would include, for example, incorporating dropped kerbs at crossings; providing tactile pavement for build and partially sighted people; locating street furniture in places where they are not going to be an obstruction, and highlighting them by using colour contrast; including parking spaces that are close to amenities and that are wider to allow wheelchair access, providing public toilets that are wheelchair accessible. Good and considerate design is of benefit to al people, not just those with disabilities.

The structure of our society, to a certain extent, society dictates how we run our lives. We have rules, protocols and procedures that are based on tradition and are very rarely questioned. We conform because we do not want to be different but, sometime, these traditional values make it difficult for disabled people to fit in. For example, in the work setting, a company may have strict guidelines on how the working week is structured – the day may have start at 8.30am with a briefing season, making it difficult for a disabled person who needs extra time in the morning to get dressed and to the office – to attend. But, if the employer introduced flexi-time and scheduled meeting for the middle of the working day, the disabled person would not have any difficult attending.

Access to information – we rely on written material for academic studies and in our day to day lives to tell us what time the buses are running and how our kitchen appliances operate. This information is only useful to people who can read and/or understand what they are reading. To help people with disabilities, information should be available in plain English, large print and Braille and on audiocassette or through a speech synthesizer. People who are unable to hear spoken words should have access to a sign language interpreter or subtitles if the information is on screen.

Attitudinal barrier – many people have pre-conceived ideas about what disabled people are like probably because they had little contact with them in the past. This can lead to patronising attitudes of intolerance

because they have not recognised that a disabled person may (though no fault of their own) take longer to do something or get tired more easily. People may automatically adopt a discriminatory attitude by making a incorrect assumption that a disabled person would not be as capable as a non-disabled person.

Cultural and Social Influences

What will influence whether and to what extent our lives will be affected by disability? The causes of disability are very diverse and will affect people of all social and cultural backgrounds, but there are some factors that will make us more vulnerable to the causes. For examples:

Where we live in the world – example Polio and TB are still rife in some developing countries where healthcare provision is inadequate and vaccination programmes have not been fully established.

Income – low income families are more likely to live in home that are poorly heated, have a less nutritious diet etc, leading to a higher susceptibility to some illnesses

Lifestyle – the way we live our lives has a direct influence on our health and well being, Stress, smoking, lack of exercise, recklessness are just a few ways that we put ourselves at risk;

Generic Vulnerability – our body make up may determine whether we are susceptible to a particular illnesses or disease. The environment we live in and our financial circumstances will affect how we manage our disability. People who are better off financially are more able to pay for home adaptations and buy in care should they need it. They have choices that disabled people on low incomes do not have. People who have acquired a disability later in life are more likely to have invested for a secure future, while those who are born with a disability may not have education and employment opportunities offered to heir non-disabled counterparts, and are therefore more likely to be dependent on state benefits and social housing. Some cultures have a greater commitment to family so that, rightly or wrongly, the immediate and extended family can be relied upon to offer support to the disabled family member. Other cultures have customs that may make life easier or more difficult for disabled people. For example, the way we prepare and eat our food, the clothes we wear, the way we manage personal tasks.

Summary

In this lecture, we have focused on different barrier of ability and also examined various cultural and social influences of disability. In this exercise, we noted that some cultures have a greater commitment to family so that, rightly or wrongly, the immediate and extended family can be relied upon to offer support to the disabled family member.

Post - Test

1. What is the uniqueness of barriers in the explanation of disability?
2. What are the cultural and social influences of disability?

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LECTURE FIVE

The Disability Discrimination Act

Introduction

The aim of this lecture is to introduce you to the Disability Discrimination Act (DDA), which was introduced in 1995. The 1995 and 2005 Acts have introduced and exerted laws aimed at ending discrimination against disabled people (with disability defined as: A physical mental impairment which has a substantial long term effect on a person's ability to carry out day-to-day activities) and have given disabled people new rights in relation to the discussion highlights below.

Objectives

At the end of the lecture, you should be able to:

1. discuss what the Disability Discrimination Act (DDA) meant; and
2. highlight and explain the new rights of the disabled people.

Pre-Test

1. What is Disability Discrimination Act?
2. Explain the different forms of rights associated with Disability Discrimination Act.

CONTENT

The DDA approaches disability in a strange and unique way. The key part of the definition follows a medical approach, as it is all about what a person is unable to do.

However, many of the additional provisions, within the definition, seem to realize that people can face discrimination (the legal term for barriers) without needing to be 'impaired' to any great degree. For example, it allows for coverage of those with progressive conditions before the adverse effect on day-to-day activities becomes substantial and protects people living with HIV, MS or cancer from the point of diagnosis. In its wider operation, the DDA seems to recognise the need to overcome barriers and that the responsibility for these barriers is external to the disabled person. This is why there are requirements within the Act for 'reasonable adjustments' to be made.

The Disability Discrimination Act (DDA) was introduced in 1995 after persistent lobbying by disabled people and their representative organisations for comprehensive anti-discrimination legislation. The 1995 act has been amended by the disability Discrimination Act 2005, which received Royal Assent in April 2005. The 1995 and 2005 Acts have introduced and exerted laws aimed at ending discrimination against disabled people (with disability defined as: A physical mental impairment which has a substantial long term effect on a person's ability to carry out day-to-day activities) and gave disabled people new rights in relation to:

1. Access to goods, facilities and services – all organisations that provide goods, services or facilities to the general public (excluding transport and education which are dealt with elsewhere in the Act) must offer a service to disabled people equal to that offered to non-disabled people. It is unlawful to refuse to serve or provide a second rate service to people because they are disabled. Service providers may need to make alterations to the way they provide a service; and they may also be required to adapt their premises to improve physical access to their service;
2. Buying or renting land or property – it is against the law to treat a disabled person less favourably when he/she is buying or renting land or property such as a house, flat or business premises. For example, it is unlawful to charge a disabled person a higher deposit on rented accommodation; or to refuse him/her accommodation on the grounds of disability, perhaps making pre-judgments on the suitability of the accommodation or the ability of the disabled person to pay.

3. Employment – the Acts make it unlawful for an employment with 15 or more employees (originally 20; to be reduced to one from 2004) to discriminate against disabled employees or job applicants. If the physical features of the work premises or the working arrangements are preventing a disabled person gaining or staying in employment, then the employer must take reasonable steps to alleviate these barriers. The employer may be required to obtain special equipment or to adapt existing equipment to enable a disabled person to do all or parts of his/her job that would otherwise be impossible or unreasonably difficult. Assistance with his disability is likely to be available under the access to work scheme from the employment service.
4. Education – the DDA builds upon existing legislation that specifically relates to education, in which education providers have a duty to provide mainstream placements for disabled children, subject to the wishes of their parents, providing the placement is appropriate to the needs of the child; does not conflict with the interests of other children in the school and it is an efficient use of resources. Schools must include in their annual reports their arrangements for admitting disabled pupils; the way they will ensure that disabled pupils will be treated equally; and facilities they provide to enable disabled pupils to access the education they are offering. Further and higher education establishments are required to publish disability statements that include for example, the facilities that they have for disabled students. (For details of the Special Educational Needs and Disability Act) which has brought education more fully into the scope of the DDA, contact the Council for Disabled Children of Skill (National Bureau for Disabled Students).
5. Transport –access to transport infrastructures such as stations covered by the access to goods and services part of the DDA. For the transport vehicles themselves, the DDA gives the Government powers to make accessibility regulations to make them accessible to disabled people. For example, all new rail vehicles entering service since 1999, and all new buses and coaches since 2000, have had to comply with accessibility regulations, as do all new taxies. From 2005, all new buses and coaches must be wheelchair accessible. The DDA set up two independent statutory bodies (the

National Disability Council and the Northern Ireland Disability Council) to advise the Government about disability issues and on the implementation of the Act. In April 2000, the National Disability Council was replaced by the Disability Rights Commission (Equality Commission in Northern Ireland). The work of the Commission includes working towards eliminating disability discrimination and promoting equal opportunities, providing advice and information, preparing codes of practice, investigating claims of discrimination and ensuring compliance with the law, and advising the Government on desired legislative changes.

Summary

In this lecture, we have discussed the major related rights to Disability Discrimination Act (DDA) and the concept of DDA itself.

Post – Test

1. Explain different forms of Disability Discrimination Act (DDA) rights.
2. Briefly illustrate your understanding of (DDA)

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American Psychiatric Association. (1994). *The Diagnostic and Statistical Manual of Mental Disorders*: *DSM-IV*. Washington, DC.

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LECTURE SIX

Mental Retardation

Introduction

In this lecture, our focus is on mental retardation. We shall examine the basic definition according to the DSM-IV-TR, the common characteristics accompanied with mental retardation, the levels involved in mental retardation and finally the major etiology of metal retardation.

Objectives

At the end of this lecture, you should be able to:

1. define and explain what mental retardation is;
2. outline and explain the causes and levels of mental retardation; and
3. explain the etiology of mental retardation.

Pre- Test

1. What do you understand mental retardation?
2. What are the likely causes of mental retardation?

CONTENT

Mental retardation is categorised by DSM-IV-TR as one of the disorders usually first diagnosed in infancy, childhood, or adolescence. It is not considered a cognitive disorder but effects cognitive functioning. The definition of DSM-IV-TR includes the following criteria:

1. Significant sub-average intellectual functioning (ordinarily interpreted as an IQ score o 70 or less on an individually administered IQ test).
2. Concurrent deficiencies in adapting behaviour (social and daily living skills, degree of independence lower than would be expected by age or cultural group).
3. Onset before age eighteen (subaverage intellectual functioning arising after age eighteen is typically categorised as dementia).

Common characteristics that accompany mental retardation are dependency, passivity, low self –esteem, low tolerance of frustration, depression, and self-injurious behaviour (APA, 2000). Relative to the general population, persons with metal retardation are much more likely to suffer from psychiatric problems. The more severe levels of mental retardation are associated with speech difficulties, neurological disorders, cerebral palsy, and vision and hearing problems. Individuals with autism may also exhibit cognitive deficits, but mental retardation has been distinguished from autism or various mental and perceptual tasks.

Levels of Retardation

DSM-IV-TR specifies four different levels of mental retardation, which are based only on IQ score ranges, as measured on the revised Wechsler scales.

- Mild (IQ scores 50-55 to 70),
- Moderate (IQ score 35-40 to 50-55),
- Severe (IQ core 20-25 to 35-40), and profound (IQ score below 20 or 25).

Social and vocational skills and degree of adaptability may vary greatly within each category. It should be noted that the American Association on Mental Retardation (AAMR), unlike the American Psychiatric Association and DSM-IV-TR, does not use a classification of mental retardation based on levels of intellectual functioning as revealed in IQ scores. Instead, AAMR considers limitations in both the intellectual and adaptive skills of the individual. Adaptive skills include those required in communication, self-care, social interactions, health and safety, work

and leisure. Furthermore, the skills are placed in the context of one's culture and community. Mental retardation is diagnosed only if low intelligence is accompanied by impaired adaptive functioning. Low intelligence alone, or deficits in adaptive behaviours alone, does not result in a diagnosis of mental retardation according to AAMR.

Although DSM-IV-TR and AAMR use intellectual and adaptive functioning as criteria in the diagnosis of mental retardation, AAMR focuses more on adaptive functioning, and it specifies the type and nature of psychosocial supports needed in adaptive functioning.

Etiology of Mental Retardation

Mental retardation is thought to be produced y environmental factors (such as poor living conditions), biological factors, or some combination of the two. The etiology is dependent to some extent on the level f mental retardation. Mild retardation is generally idiopathic (having no known cause) and familial, whereas severe retardation is typically related to genetic factors or to brain damage.

Environmental factors – certain features of the environment may contribute to retardation. Among these are the absence of stimulating factors or situations, a lack of attention and reinforcement from parents or significant others, and chronic stress and frustration. In addition, poverty, lack of adequate health care, poor nutrition, and inadequate education place children at a disadvantage. A lower socio-economic status generally implies a lower mean group IQ scores.

Genetic factors – Genetic factors in mental retardation include genetic variations and genetic abnormalities. Mental retardation caused by normal genetic variation simply reflects the fact that in a normal distribution of traits, some individuals will fall in the upper range and some in the lower. Researchers have suggested that the normal range of intelligence lies between the IQ scores of 50 and 150, and that some individuals simply lie on the lower end of this normal range. No organic or physiological anomaly associated with mental retardation is usually found in this type of retardation. Most people classified with mild retardation have normal health, appearance, and physical abilities.

The most common inherited form of mental retardation that is caused by genetic anomalies is called the fragile X syndrome because an abnormal gene is present on the bottom end of the X chromosome. Although impairment in functioning varies among those with inherited forms of mental retardation, many affected persons have severe deficits. Those with profound retardation (about 1 to 2 percent of those with the disorder) may be so intellectually deficient that they require constant and total care and supervision. Many also have significant sensori-motor impairment and are confined to a bed or wheelchair by the congenital defects that produced the retardation. Even with teaching, there is minimal, if any, acquisition of self-help skills among these individuals. Their mortality rate during childhood is extremely high, with more than one-half dying before age twenty. Associated physical problems such as neuro-muscular disorders, impairment of vision or hearing, and seizures may coexist.

Down syndrome is a condition produced by the presence of an extra chromosome (trisomy 21, an autosomal, or nonsex, chromosome) and resulting in mental retardation and distinctive physical characteristics. Down syndrome is an example of a chromosomal disorder. It may occur as often as once in every thousand live births. About 10 percent of children with severe or moderate retardation show the genetic anomaly. The well known physical characteristics of Down syndrome are short incurving fingers, short broad hands, slanted eyes, furrowed protruding tongue, flat and broad face, harsh voice, and incomplete or delayed sexual development. Some Down syndrome children receive cosmetics surgery to make their physical appearance more clearly and to eat more normally. The procedure is intended to enable Down syndrome people to fit in as much as possible with their peers to enhance their social interactions and communication abilities.

People with Down syndrome who live past age forty are at high risk for developing Alzheimer's diseases. This is because the gene responsible for the amyloid plaques and neurofibrillary tangles found in Alzheimer's disease is located on chromosome 21, indicating a possible relationship between Down syndrome and Alzheimer's disease. People who have Down syndrome show a greater intellectual decline after the age of thirty-five than do other individuals with mental retardation. Congenital heart abnormalities are also common in people with surgical procedures have improved the possibility of surviving these heart defects and have resulted in both a longer life expectancy and a healthier life.

Parental detection of Down syndrome is possible through amniocentesis, a screening procedure in which a hollow needle is inserted through the pregnant woman's abdominal wall and the amniotic fluid is withdrawn from the fetal sac. This procedure is performed during the fourteenth or fifteenth week of pregnancy. The fetal cells from the fluid are cultivated and, within three weeks, can be tested to determine whether Down syndrome is present. This procedure involves some risk for both mother and fetus, so it is employed only when the chance of finding Down syndrome is high as, for example, with women older than age thirty- five. Remember, however, that the greater percentage of babies with Down syndrome is born to younger mothers, and yet testing for Down syndrome through amniocentesis occurs primarily among older women.

A procedure that allows earlier detection of Down syndrome is chorionic villus sampling. Tests are made of cells on the hair-like projections (villi) on the sac that surrounds the fetus and can be performed after the ninth week of pregnancy. Other, less common genetic anomalies such as Turner's syndrome, klinefelter's syndrome, phenylketonuria (PKU), Tay-Sachs disease, and cretinism can also produce mental retardation.

Non-genetic Biological Factors

Mental retardation may be caused by a variety of environmental mishaps during the prenatal (from conception to birth), prenatal (during the birth process), or postnatal (after birth) period.

Prenatal period - During the prenatal period, the developing organism is susceptible to viruses and infections (such as German measles), drugs, radiation, poor nutrition, and other non-genetic influences. Increasing attention is being focused on the problem of mental deficits related to alcoholic consumption during pregnancy. Some children born to alcoholic mothers have fetal alcohol syndrome (FAS), a group of congenital physical and mental defects including small body size and microcephaly, an anomaly whose most distinguishing feature is an unusually small brain. Such children are generally mildly retarded, but many are either moderately retarded or of average intelligence. Those with normal intelligence seem to have significant academic and intentional difficulties, however, as well as a history of hyperactivity and behavioural deficits.

Smoking and poor nutrition may increase the likelihood that as alcoholic mother will have FAS offspring. Available information suggests that one case of FAS occurs in each 750 live births, which places alcohol among the most common causes of retardation for which an etiology can be determined. Among the different ethnic groups in the United States, the rate of FAS is especially high among American Indians.

Prenatal period - During the prenatal period, mental retardation can result from birth trauma, pre-maturity, or asphyxiation. After birth or during the postnatal period, head injuries, infections, tumors, malnutrition, and ingesting toxic substances, such as lead can cause brain damage and consequent mental retardation. Compared with prenatal factors, however, these hazards account for only a small proportion of organically caused mental retardation.

The most common birth condition associated with mental retardation is pre-maturity and low birth weight. Although mot premature infants develop normally, approximately 20 percent show signs of neurological problems reflected in learning disabilities and mental retardation. In a study of more than 53,000 U.S women and their children, researchers found that low birth weights were generally associated with low IQ scores. The average IQ score of children who had birth weights between 26 ounces and 52.5 ounces was 86, whereas those with birth weights between 122 ounces and 140 ounces had an average IQ score of 105.

Postnatal period - Although most types of mental retardation now have decreasing incidence rates, mental retardation owing to postnatal causes is on the increase. For example, direct trauma to the head produces hemorrhaging and tearing of the brain tissue, often as the result of an injury sustained in an automobile accident or from child abuse. Depending on the definition of child abuse, estimates of the number of the cases of child abuse per year range from 35,000 to 1.9 million. Of this group, large percentages are subjected to violent abuse that could cause serious injury. Other postnatal causes include brain infections, neurological disease, toxic exposure, and even extreme malnutrition.

Summary

In this lecture, we have discussed what mental retardation is, and the likely causes. Specifically, we comprehensively examined the etiology of mental retardation though environmental factors, genetic factors and non-genetic factors. Finally, we looked into the various patterns of non-genetic factors such as prenatal, prenatal, and postnatal.

Post – Test

1. Highlight and explain the three major etiology of mental retardation;
2. Define mental retardation in terms of causes and the levels involved.

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LECTURE SEVEN

Programmes for People with Mental Retardation

Introduction

This lecture focuses on the programmes for people with mental retardation. In the course of this lecture, we shall expose the major programmes, which the mentally retarded highly need to improve their day-to-day activities. The highlights include early intervention, employment programmes, living arrangements and education of family members.

Objectives

At the end of this lecture, you should be able to:

1. identify the programmes needed for people with mental retardation; and
2. explain the programmes for people with retardation.

Pre-Test

1. What are the programmes for people with mental retardation?
2. Outline and describe each type of the programmes.
3. What measures could be used to prevent mental retardation?

CONTENT

Early intervention

Programmes such as Head Start have not produced dramatic increases in intellectual ability among at-risk children (those from low-income families). But long-term follow-up studies have found that they do produce positive results. Children who participated in early intervention programmes were found to perform better in school than non-participants, and the difference between the two groups continued to widen until the twelfth grade. In addition, a greater proportion of the participants in early intervention finished high school, which no doubt helped them obtain and hold better jobs. The programmes also positively influenced the families of participants. They rated the programmes as personally helpful, spent more time working with their children on school tasks, and perceived their children as becoming happier and healthier

Employment Programmes

People with mental retardation can achieve more than was previously thought. The parents of one teenage boy, for example, were told that he would always be childlike and that the only job he would ever be fit for was stringing beads. Another person with moderate retardation, who spent most of his time staring at his hands and rubbing his face, also appeared to have a dismal future. Both of these men now have paying jobs, one as a janitor and the other as dishwasher. Programmes designed to help people with mental retardation learn occupational skills are largely responsible for the improved outcomes of these men and others like them. Gains made in social and vocational skills appear to be maintained or increased in follow-up studies.

Living Arrangement

Institutionalisation of people with mental retardation is declining, as more individuals are placed in-group homes or in situations in which they can live independently or semi-independently within the community. They idea is to provide the “least restrictive environment” that is consistent with their condition and that will give them the opportunity to develop more fully. Although the implication seems to be that institutions are bad places, they do not have uniformly negative effects. Nor do group homes always provide positive experiences. What seem to be most important are

programme goals; programmes that promote social interaction and the development of competence have positive effects on the residents of either institutions or group homes.

Nontraditional group arrangements, in which a small number of people live together in a home, sharing meals and chores, provide increased opportunity for social interactions. These "normalised" living arrangements were found to produce benefits such as increased adaptive functioning, improved language development, and socialization. Many of these positive behaviours, however, were already part of the residents 'repertoires; what they need are systematic programmes that will teach them additional living skills. Merely moving people with mental retardation from one environment to another does not by itself guarantee that they will be taught the skills hey need. Nonetheless, properly planned and supported deinstitutionalisation does provide these individuals an opportunity to experience a more normal" life. Finally, it should be noted that living arrangements, environmental supports, and interventions should be tailored to the type of retardation and severity of limitations found among the individuals.

As mentioned earlier, parents and family members often serve as caregivers for a significant period of time. When this occurs, the family members may need education and training in dealing with someone who has mental retardation. Overcoming myths about the disorder, finding out how to deal with the affected family members, identifying supports and resources, and handling emotional problems (e.g., anxiety, guilty, and anger) within the family are important tasks for caregivers.

Can mental retardation be prevented?

During the past 30 years, significant advances in research have prevented many cases of mental retardation. For example, every year in the United States, advanced research have prevented:

1. 250 cases of mental retardation due to phenylketonuria (PKU) by newborn screening and dietary treatment;
2. 1000 cases of mental retardation due to congenital hypothyroidism thanks to newborn screening and thyroid hormone replacement therapy;
3. 1000 cases of mental retardation by use of anti-Rh immune gobulin to prevent Rh disease and severe jaundice in newborn infants;

4. 5,000 cases of mental retardation caused by Hib diseases by using the Hib vaccine;
5. 4000 cases of mental retardation due to measles encephalitis thanks to measles vaccine; and untold numbers of cases of mental retardation prevented by rubella vaccine

Other interventions have reduced the occurrence of mental retardation. Removing lead from the environment reduces brain damage in children. Preventive interventions such as child safety sets and bicycle helmets reduce head trauma. Early intervention programmes with high-risk infants and children have shown remarkable results in reducing the predicted incidence of subnormal, intellectual functioning.

Finally, early comprehensive prenatal care and preventive measures prior to and during pregnancy increase a woman's chances of preventing mental retardation. Pediatric Aids is being reduced by AZT treatment of the mother during pregnancy, and dietary supplementation with folic acid reduces the risk of neural tube defects.

Research continues on new ways to prevent mental retardation. During research on the development and function of the nervous system, a wide variety of fetal treatments, and gene therapy have been designed to correct the abnormality produced by defective genes.

Summary

In this lecture, we clearly defined the main programmes for people with mental retardation. In the course of the lecture too, we have examined the programmes and how they directly and indirectly reduced mental retardation.

Post – Test

Demonstrate your idea on the programmes for people with mental retardation, and the contribution towards reducing mental retardation

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LECTURE EIGHT

Learning Disabilities

Introduction

In this lecture, you will be exposed to the concept of learning disability, causes and diagnoses, as well as the discrepancy issue involved and the subtypes. Learning Disability is not a specific term; it is a category containing many specific disabilities, all of which cause learning to be difficult. The following definition of "learning disability" is used for legislative, financial, and educational purposes only.

The term 'learning disability' means a disorder in one or more of the basic processes involved in understanding spoken or written language. It may show up as a problem in listening, thinking, speaking, reading, writing, or spelling or in a person's ability to do math, despite at least average intelligence. The term does not include children who have learning problems, which are primarily the result of visual, hearing, or physical handicaps, or mental retardation, or emotional disturbance, or of environmental, cultural, or economic disadvantage.

Objectives

At the end of this lecture, you should be able to:

1. define learning disability;
2. describe its symptoms, causes and subtypes; and
3. explain the discrepancy issues involved in learning disability.

Pre-Test

1. Define learning disability;
2. What are the causes of learning disability?
3. List and descried the subtypes of learning disability.

CONTENT

Definition of Learning Disabilities

Despite federal regulations, the definition of learning disabilities is controversial. The U.S. government defines a specific learning disability as a disorder in one or more of the basic psychological processes involved in understanding or use of spoken or written language, which may be manifest as an inability to listen, think, speak, read, write, spell, or do mathematic calculations. While the definition could include the conditions of perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia, it is not applicable to students whose learning problems are the result of visual, hearing, or motor handicaps, mental retardation, emotional disturbance, or environmental/cultural disadvantage. The major premise is that a significant discrepancy exists between the child's potential and her actual level of academic or language skills.

Each state, however, may determine cutoffs for discrepancies or definitions of processing disorders, leading to variability among states and even differences among districts within a given state. The definition and diagnosis of an LD vary, depending on whether the purpose is to qualify for services or to clinically identify the reason for a child's poor academic performance. In the former, measurement of intelligence and levels of achievement is employed; in the latter, administration of IQ and achievement is extended to include evaluation of attention, memory, and neuropsychological function. Moreover, the age of identification varies, depending on the type of LD; some may not be apparent early because academic skills in areas affected by the LD have not yet been challenged.

The psychiatric definition of LDs (as found in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*) differs considerably from both federal and state classification systems, adding further to the ambiguity. Learning disabilities are presumed to be due to central nervous system dysfunction, and occur across the lifespan. They reportedly occur more in males,

although research in the late 1990s by Sally Shaywitz has disputed this contention.

Official Definition of Learning Disabilities adopted by the Learning Disabilities Association of Canada on January 30, 2002, states that "Learning Disabilities" refer to a number of disorders which may affect the acquisition, organisation, retention, understanding or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning. As such, learning disabilities are distinct from global intellectual deficiency.

Learning disabilities result from impairments in one or more processes related to perceiving, thinking, remembering or learning. These include, but are not limited to, language processing; phonological processing; visual spatial processing; processing speed; memory and attention, and executive functions (e.g. planning and decision-making).

Learning disabilities range in severity and may interfere with the acquisition and use of one or more of the following:

1. oral language (e.g. listening, speaking, understanding);
2. reading (e.g. decoding, phonetic knowledge, word recognition, comprehension);
3. written language (e.g. spelling and written expression); and
4. mathematics (e.g. computation, problem solving).

Learning disabilities may also involve difficulties with organisational skills, social perception, social interaction and perspective taking. Learning disabilities are lifelong. The way in which they are expressed may vary over an individual's lifetime, depending on the interaction between the demands of the environment and the individual's strengths and needs. Learning disabilities are suggested by unexpected academic under-achievement or achievement which is maintained only by unusually high levels of effort and support.

For success, individuals with learning disabilities require early identification and timely specialised assessments and interventions involving home, school, community and workplace settings. The interventions need to be appropriate for each individual's learning disability sub-type and, at a minimum, include the provision of:

1. specific skill instruction;
2. accommodations;
3. compensatory strategies; and
4. self-advocacy skills.

Learning Disabilities - Causes and Diagnosis

With regard to causes, research extends to family, genetic, and neuro-anatomic bases, with most work being done in language and reading disabilities. There appears to be heritability in language and reading LDs, with similar LDs being found in 35 percent to 45 percent of first-degree relatives. Also, identical twins are more likely to have similar LDs than fraternal twins. Chromosomes 6 and 15 have been implicated frequently as possible genetic causes of LDs. Neuro-imaging techniques, such as functional magnetic resonance imaging; have documented differences among dyslexic and nonreading-disabled individuals. Studies have found that in individuals with dyslexia, certain areas of the brain are different from those in individuals without dyslexia. Nonetheless, there are no neuro-anatomic or neuro-electric diagnostic tests that identify LDs in the brain. Although LDs are found more frequently in children subject to brain insult (such as premature birth and asphyxia), many children display LDs without any identifiable cause.

Learning Disabilities - The Discrepancy Issue

The "discrepancy issue" has been established as the primary criterion for identifying children with LDs. Unfortunately, discrepancy formulae are controversial, potentially inaccurate, and inappropriate for detecting cognitive deficits. There are three types of discrepancy formulae.

With an aptitude-achievement discrepancy, a disparity exists between a child's intellectual ability (as measured by an intelligence test) and his actual level of academic achievement (measured by an achievement test). Certain LDs (e.g., a short-term memory problem or central processing dysfunction), however, may also affect a child's performance on IQ tests, thereby reducing the discrepancy between aptitude and achievement. This discrepancy model is useful from third grade onward, and certain disabilities (such as fine motor dyspraxia, retrieval memory dys-function,

and organization problems) often are not detected. Children with the most severe LDs frequently have the smallest discrepancy.

An intracognitive discrepancy (a disturbance in basic psychological processes) occurs in children who have a specific type of cognitive dysfunction such as a deficit in auditory processing, short-term memory, or visual processing. This type of LD is difficult to operationalise, but is useful in identifying pre-school and primary-age children who have learning problems.

An intra-achievement discrepancy reflects divergence or inconsistency in educational achievement performances. This could occur between academic areas (such as reading versus mathematics) or within an academic area (such as a marked difference between reading decoding and reading comprehension).

Regression models, which attempt to correct the problems inherent in discrepancy comparisons, are used in many states. Here a statistical relationship between IQ and achievement is considered, allowing for equal probability of identification of an LD across IQ levels, thereby potentially enhancing identification rates. Research in the 1990s, however, failed to demonstrate valid differences on school-related measures between poorly achieving groups of students with an IQ/achievement discrepancy and those with poor school performance and no discrepancy.

Learning Disabilities - Learning Disability Subtypes

There are many different sub-types of learning disabilities. Byron Rourke, writing in 1993, reported three major groupings: (1) reading/spelling, (2) arithmetic, and (3) reading/spelling/arithmetic. Larry Silver, also writing in 1993, suggested a model that includes input disabilities (visual/perceptual, auditory/perceptual, and sensory integrative), integrative disabilities (sequencing, abstraction, and organization), memory disabilities, and output disabilities (language and motor). Reading/spelling disabilities are by far the most prevalent form, with such disabilities estimated to comprise from 5 percent up to 17 percent of the child and adolescent population. Estimates for the occurrence of disorders of written expression range from 2 percent to 8 percent. Although *learning disabilities, such as dyslexia, can be caused by premature birth or asphyxia at a younger age, in other cases, the direct cause of a learning disability is not known.* (Ellen B. Senisi/Photo Researchers, Inc.) The

prevalence of arithmetic LDs ranges from 1 percent to 6 percent, it is not clear whether weak mathematics performance is due to the quality of instruction or an actual LD.

Nonverbal LDs are often overlooked, occur less frequently than reading disorders, and are characterised by problems in arithmetic computation, graphomotor skills, reading comprehension, math reasoning, science, complex concept formation, visual memory, and social-behavioural skills; these are often found in children with white-matter disorders, and are assumed to be more right-hemisphere-based. As of the late 1990s, a classification schema (based on reading disability/dyslexia research) was applied to all achievement domains included in federal and state definitions of LD. Three major types of LDs were identified: specific language impairment, specific reading disability/dyslexia, and specific math disability.

The area of greatest knowledge is reading disorders. These falls into two main groupings: phonological (dysphonetic) and orthographic (dyseidetic). The former is more prevalent and is characterised by deficits in decoding and word analysis, with guesses made based on the initial letter of the word and mis-spellings being phonetically inaccurate. Shaywitz wrote in 1998 that a deficit in basic phonemic awareness (inability to segment phonemes [the smallest unit of sound] into phonological units) is the underlying cause in virtually all cases of dyslexia. The orthographic reading disability sub-type involves an inability to develop a memory for the whole word (gestalt), with visuo-spatial reversals occurring (e.g., "was" read as "saw") and misspellings being phonetically accurate. There is also a mixed reading disorder, which consists of characteristics found in both types of deficit. The major new finding is that reading disabilities are more strongly associated with auditory rather than visual deficits.

Summary

In this lecture, we have examined learning disability, the causes, diagnoses and sub-types. Specifically, we defined the concepts and also discussed them comprehensively for easy understanding.

Post – Test

1. With your knowledge of learning disability, discuss the cause, and the subtypes.
2. How can you diagnose a person with learning disability?

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LECTURE NINE

Dyslexia as a Specific Learning Disability

Introduction

This lecture focuses on dyslexia. This is another form of disability, though, a specific learning disability. The lecture will provide you with alternative definitions of dyslexia and explanations on each of them. The causes of dyslexia would also be explained, likewise Phonemic Awareness, and Phonological Processing and Phonics.

Objectives

At the end of this lecture, you should be able to:

1. explain what dyslexia is all about;
2. identify various causes of dyslexia; and
3. establish understanding between phonemic awareness, and phonological processing and phonics.

Pre-Test

1. What is dyslexia?
2. What are the causes of dyslexia?
3. How can you diagnose a person with dyslexia?

CONTENT

Historical Perspective

Before the National Institutes of Health began their research in the 1980's, the only definition of dyslexia was an exclusionary one. If a child's difficulty with reading could not be explained by low intelligence, poor

eyesight, poor hearing, inadequate educational opportunities, or any other problem, then the child must be dyslexic. That definition was not satisfactory to parents, teachers, or researchers. So here are three different definitions in use today.

Simple Definition - Dyslexia is an inherited condition that makes it extremely difficult to read, write, and spell in your native language—despite at least average intelligence

Revised definition from the International Dyslexia Association - Dyslexia is a neurologically based, often familial, disorder, which interferes with the acquisition and processing of language. Varying in degrees of severity, it is manifested by difficulties in receptive and expressive language, including phonological processing, in reading, writing, spelling, handwriting, and sometimes in arithmetic.

Dyslexia is not the result of lack of motivation, sensory impairment, inadequate instructional or environmental opportunities, or other limiting conditions, but may occur together with these conditions. Although dyslexia is lifetime disorder, individuals with dyslexia frequently respond successfully to timely and appropriate intervention.

Research definition used by the National Institutes of Health - Dyslexia is a specific learning disability that is neurological in origin. It is characterized by difficulties with accurate and/or fluent word recognition, and by poor spelling and decoding abilities. These difficulties typically result from a deficit in the phonological component of language that is often unexpected in relation to other cognitive abilities and the provision of effective classroom instruction. Secondary consequences may include problems in reading comprehension and reduced reading experience that can impede growth of vocabulary and background knowledge.

Dyslexia (pronounced: dis-**lek**-see-ah) is a type of **learning disability**. A person with a learning disability has trouble processing words or numbers. There are several kinds of learning disabilities; dyslexia is the term used when people have difficulty learning to read, even though they are smart enough and are motivated to learn. The word dyslexia comes from two Greek words: **dys**, which means abnormal or impaired, and **lexis**, which

refers to language or words. Dyslexia is not a disease. It's a condition that you are born with, and it often runs in families. People with dyslexia are not stupid or lazy. Most have average or above-average intelligence, and they work very hard to overcome their learning problems

Cause of Dyslexia

Dyslexia is an inherited condition. Researchers have determined that a gene on the short arm of chromosome #6 is responsible for dyslexia. That gene is dominant, making dyslexia highly heritable. It definitely runs in families. Dyslexia results from a neurological difference; that is, a brain difference. People with dyslexia have a larger right-hemisphere in their brains than those of normal readers. That may be one reason people with dyslexia often have significant strengths in areas controlled by the right-side of the brain, such as artistic athletic, and mechanical gifts; 3-D visualization ability; musical talent; creative problem solving skills; and intuitive people skills. In addition to unique brain architecture, people with dyslexia have unusual "wiring". Neurons are found in unusual places in the brain, and are not as neatly ordered as in non-dyslexic brains. In addition to unique brain architecture and unusual wiring, studies have shown that people with dyslexia do not use the same part of their brain when reading as other people. Regular readers consistently use the same part of their brain when they read. People with dyslexia do not use that part of their brain, and there appears to be no consistent part used among dyslexic readers. It is therefore assumed that people with dyslexia are not using the most efficient part of their brain when they read. A different part of their brain has taken over that function.

Phonemic Awareness

Quotes from prominent NIH researchers: "The lack of phonemic awareness is the most powerful determinant of the likelihood of failure to learn to read." "Phonemic awareness is more highly related to learning to read . . . than tests of general intelligence, reading readiness, and listening comprehension." "Phonemic awareness is the most important core and causal factor separating normal and disabled readers."NIH research has repeatedly demonstrated that lack of phonemic awareness is the root cause of reading failure. **Phonemes** are the smallest unit of spoken language, not written language. Children who lack phonemic awareness are unable to

distinguish or manipulate sounds within spoken words or syllables. They would be unable to do the following tasks:

1. **Phoneme Segmentation**: what sounds do you hear in the word *hot*? What's the last sound in the word *map*?
2. **Phoneme Deletion**: what word would be left if the /k/ sound were taken away from *cat*?
3. **Phoneme Matching**: do *pen* and *pipe* start with the same sound?
4. **Phoneme Counting**: how many sounds do you hear in the word *cake*?
5. **Phoneme Substitution**: what word would you have if you changed the /h/ in *hot* to /p/?
6. **Blending**: what word would you have if you put these sounds together? /s/ /a/ /t/
7. **Rhyming**: tell me as many words as you can that rhyme with the word *eat*.

If a child lacks phonemic awareness, they will have difficulty learning the relationship between letters and the sounds they represent in words, as well as applying those letter/sound correspondences to help them "sound out" unknown words. So children who perform poorly on phonemic awareness tasks via oral language in kindergarten are very likely to experience difficulties acquiring the early word reading skills that provide the foundation for growth of reading ability throughout elementary school. Phonemic awareness skills can and must be directly and explicitly taught to children who lack this awareness.

Phonological Processing and Phonics

Phonemic awareness must exist or be explicitly and directly taught before phonics instruction begins. Otherwise, the phonics instruction will not make sense to the dyslexic child.

Phonological processing refers to understanding of sounds used in our language, ranging from big chunks of sound (words), to smaller chunks (syllables) and eventually to phonemic awareness (every sound within a syllable). Both phonemic awareness and phonological processing are auditory processing skills. Therefore, they can (and should) be taught before letters are introduced. The goal of teaching phonics is to link the

individual sounds to letters, and to make that process fluent and automatic, for both reading and spelling. In other words, phonics teaches students symbol-to-sound and sound-to-symbol. But for phonics to work, a student must first have solid phonological processing and phonemic awareness.

Summary

In this lecture, we have discussed the concept of dyslexia. In this wise, we first defined the subject matter, described each type of the phenomenon and also discussed the causes, phonemic awareness, phonological processing and phonics.

Post – Test

1. Briefly examine the concept dyslexia.
2. Draw a distinction between phonemic awareness, phonological processing and phonics.
3. Define phoneme with examples.

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LECTURE TEN

What is Autism?

Introduction

This lecture is designed to make you understand the concept of autism, in terms of its general constitution. Again, the common signs of autism, the causes, diagnoses, treatment and the role played in inheritance are equally examined.

Objectives

At the end of this lecture, you should be able to:

1. define autism;
2. discuss common signs of autism; and
3. state the causes of autism.

Pre-Test

1. What is autism?
2. What are the common signs of autisms?

CONTENT

Autism (sometimes called “classical autism”) is the most common condition in a group of developmental disorders known as the autism spectrum disorders (ASDs). Autism is characterised by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests. Other ASDs include Asperger syndrome, Rett syndrome, childhood disintegrative disorder, and pervasive developmental disorder not

otherwise specified (usually referred to as PDD-NOS). Experts estimate that three to six children out of every 1,000 will have autism. Males are four times more likely to have autism than females.

Some Common Signs of Autism

There are three distinctive behaviours that characterise autism.

1. Difficulties with social interaction - being unaware of what's socially appropriate, finding chatting or small talk difficult and not socialising much (people with autism find it very difficult to develop friendships and relate to others)
2. Problems with verbal and non-verbal communication such as understanding gestures, body language, facial expressions and tone of voice, making it difficult to empathize with people's feelings.
3. Imagination impairments - such as not enjoying or taking part in role-play games

The hallmark feature of autism is impaired social interaction. Parents are usually the first to notice symptoms of autism in their child. As early as infancy, a baby with autism may be unresponsive to people or focus intently on one item to the exclusion of others for a long time. A child with autism may appear to develop normally and then withdraw and become indifferent to social engagement.

Children with autism may fail to respond to their name and often avoid eye contact with other people. They have difficulty interpreting what others are thinking or feeling because they can't understand social cues, such as tone of voice or facial expressions, and don't watch other people's faces for clues about appropriate behaviour. They lack empathy.

Many children with autism engage in repetitive movements such as rocking and twirling, or in self-abusive behaviour such as biting or head-banging. They also tend to start speaking later than other children and may refer to themselves by name instead of "I" or "me." Children with autism don't know how to play interactively with other children. Some speak in a sing-song voice about a narrow range of favorite topics, with little regard for the interests of the person to whom they are speaking.

Many children with autism have a reduced sensitivity to pain, but are abnormally sensitive to sound, touch, or other forms of sensory

stimulation. These unusual reactions may contribute to behavioural symptoms such as a resistance to being cuddled or hugged.

Children with autism appear to have a higher than normal risk for certain co-existing conditions, including fragile X syndrome (which causes mental retardation), tuberous sclerosis (in which tumors grow on the brain), epileptic seizures, Tourette syndrome, learning disabilities, and attention deficit disorder. For reasons that are still unclear, about 20 to 30 percent of children with autism develop epilepsy by the time they reach adulthood. While people with schizophrenia may show some autistic-like behaviour, their symptoms usually do not appear until the late teens or early adulthood. Most people with schizophrenia also have hallucinations and delusions, which are not found in autism.

Diagnoses

Autism varies widely in its severity and symptoms and may go unrecognised, especially in mildly affected children or when masked by more debilitating handicaps. Doctors rely on a core group of behaviours to alert them to the possibility of a diagnosis of autism. These behaviors are:

1. Impaired ability to make friends with peers
2. Impaired ability to initiate or sustain a conversation with others
3. Absence or impairment of imaginative and social play
4. Stereotyped, repetitive, or unusual use of language
5. Restricted patterns of interest that are abnormal in intensity or focus
6. Preoccupation with certain objects or subjects
7. Inflexible adherence to specific routines or rituals

Doctors will often use a questionnaire or other screening instrument to gather information about a child's development and behavior. Some screening instruments rely solely on parent observations; others rely on a combination of parent and doctor observations. If screening instruments indicate the possibility of autism, doctors will ask for a more comprehensive evaluation.

Autism is a complex disorder. A comprehensive evaluation requires a multidisciplinary team including a psychologist, neurologist, psychiatrist, speech therapist, and other professionals who diagnose children with

ASDs. The team members will conduct a thorough neurological assessment and in-depth cognitive and language testing. Because hearing problems can cause behaviours that could be mistaken for autism, children with delayed speech development should also have their hearing tested. After a thorough evaluation, the team usually meets with parents to explain the results of the evaluation and present the diagnosis.

Children with some symptoms of autism, but not enough to be diagnosed with classical autism are often diagnosed with PDD-NOS. Children with autistic behaviours but well-developed language skills are often diagnosed with Asperger syndrome. Children who develop normally and then suddenly deteriorate between the ages of 3 to 10 years and show marked autistic behaviors may be diagnosed with childhood disintegrative disorder. Girls with autistic symptoms may be suffering from Rett syndrome, a sex-linked genetic disorder characterised by social withdrawal, regressed language skills, and hand wringing.

Causes of Autism

Scientists aren't certain about what causes autism, but it's likely that both genetics and environment play a role. Researchers have identified a number of genes associated with the disorder. Studies of people with autism have found irregularities in several regions of the brain. Other studies suggest that people with autism have abnormal levels of serotonin or other neurotransmitters in the brain. These abnormalities suggest that autism could result from the disruption of normal brain development early in fetal development caused by defects in genes that control brain growth and that regulate how neurons communicate with each other. While these findings are intriguing, they are preliminary and require further study. The theory that parental practices are responsible for autism has now been disproved. In February 2009, a special federal court ruled that there was no proven link between certain early childhood vaccines and autism that developed in three children.

The Role of Inheritance on Autism

Recent studies strongly suggest that some people have a genetic predisposition to autism. In families with one autistic child, the risk of having a second child with the disorder is approximately 5 percent, or one in 20. This is greater than the risk for the general population.

Researchers are looking for clues about which genes contribute to this increased susceptibility. In some cases, parents and other relatives of an autistic child show mild impairments in social and communicative skills or engage in repetitive behaviors. Evidence also suggests that some emotional disorders, such as manic depression, occur more frequently than average in the families of people with autism.

For many children, symptoms of autism improve with treatment and with age. Some children with autism grow up to lead normal or near-normal lives. Children, whose language skills regress early in life, usually before the age of 3, appear to be at risk of developing epilepsy or seizure-like brain activity. During adolescence, some children with autism may become depressed or experience behavioural problems. Parents of these children should be ready to adjust treatment for their child as needed.

Treatment of Autism

There is no cure for autism. Therapies and behavioural interventions are designed to remedy specific symptoms and can bring about substantial improvement. The ideal treatment plan coordinates therapies and interventions that target the core symptoms of autism: impaired social interaction, problems with verbal and nonverbal communication, and obsessive or repetitive routines and interests. Most professionals agree that the earlier the intervention, the better.

1. **Educational/behavioral interventions**: Therapists use highly structured and intensive skill-oriented training sessions to help children develop social and language skills. Family counseling for the parents and siblings of children with autism often helps families cope with the particular challenges of living with an autistic child.
2. **Medications**: Doctors often prescribe an antidepressant medication to handle symptoms of anxiety, depression, or obsessive-compulsive disorder. Anti-psychotic medications are used to treat severe behavioural problems. Seizures can be treated with one or more of the anti-convulsant drugs. Stimulant drugs, such as those used for children with attention deficit disorder (ADD), are sometimes used effectively to help decrease impulsivity and hyperactivity.

3. **Other therapies**: There are a number of controversial therapies or interventions available for autistic children, but few, if any, are supported by scientific studies. Parents should use caution before adopting any of these treatments.

Summary

In this lecture, we have discussed what autism is all about. In the course of the lecture also, a clear distinction was made to achieve full grasp of autism.

Post – Test

1. What is autism?
2. What causes autism?
3. How can you diagnose an autistic person?

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LECTURE ELEVEN

Defining Rehabilitation

Introduction

The aim of this lecture is to introduce you to the concept of rehabilitation, as well as to help you to understand the principles of rehabilitation. This knowledge will help you to differentiate between the principles of rehabilitation and its objectives

Objectives

At the end of this lecture, you should be able to:

1. clearly define rehabilitation; and
2. discuss some principle of rehabilitation.

Pre-Test

1. What is rehabilitation?
2. Briefly examine some principles of rehabilitation.

CONTENT

Charlotte Green Schwartz considered a number of current statements variously identifying rehabilitation.

1. As the services, techniques, or organisation of efforts to bring about functional restoration of a patient (disabled);
2. As the process by which handicapped persons improve and develop their personal equipment and capacities for satisfactory living within their environment;

3. As the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable;
4. As human adjustment of the whole personality;
5. As rein integration of the individual into the community;
6. As the restoration of creative ability and definition of rehabilitation, are so generalised that it is difficult to use them in programme planning and development.

In 1959, Bertram Black, a pioneer in Sheltered Workshop services for the mentally ill and for many years the director of the ALTRO Workshop in New York City, describes rehabilitation as aimed at returning the handicapped person to as much usefulness in society as his remaining capacities will allow.

Douglas Bennett, an English Psychiatrist long concerned with rehabilitation, subscribes to a definition he attributes to Frank Cooksey.

Rehabilitation is the process of enabling a handicapped person to make the best possible use of his residual capacities in as normal a social context as possible.

Somewhat earlier, Bennett, Wing and John Denham, formulated a definition of rehabilitation, as it applies in the industrial rehabilitation of long-stay Schizophrenic patients. They refer to rehabilitation as any activity, which aims at preventing or reducing secondary handicaps, or at developing compensatory mechanism for irreducible primary or secondary handicaps.

One of the best discussions of rehabilitation, which was encountered, is a report of the proceedings of a conference on psychological research and rehabilitation, sponsored by the American Psychological Association (APA). Lofquist posits that, whatever definition of rehabilitation a particular person or group favours, perhaps all would agree that;

1. Rehabilitation is concerned with practical problems in the lives of individuals;
2. It is concerned with past, present, and future individual behaviour, and with assisting an individual to find an optimal balance of these which will permit living as well as possible within the handicaps imposed by disability and within the potential development

described by the individual's particular balance sheet of plus and minus ability, aptitude, interest and personality factors; and

3. It involves active inter-professional participation in planning with and for the individual.

On the basis of the presently available observable definition of rehabilitation psychology and conceptual empirical findings, it is worthwhile to draw our attention to the principles, which Schwartz identified among a number of rehabilitation experts. These principles would help to guard disabled wards or persons with disabilities in our institutions, homes and our hospitals. These are given below:

Principles of Rehabilitation

Based on the present available observable definitions of rehabilitation and empirical findings, it is worthwhile to draw our attention to the principles of rehabilitation process. Schwartz identified among number of rehabilitation efforts that would help us to sustain rehabilitation measures in our institutions, home and hospitals.

1. Patient and encouragement of their health status.
2. Encouragement of the patient to accept as much responsibility as he can handle at present, giving him as much freedom and room for spontaneity as he can manage, though at the same time providing him protection from his own impulses and a feeling of security by a firm, tactful, consistent, and reliable response from the staff members.
3. Those who are attempting to bring about the rehabilitation of the client/patient must determine his existing ability and then develop experiences, which fit it.
4. There appears to be general agreement that in order to work effectively with clients patients, personnel must accept presently functioning level of the client.
5. Alertness to the patient's needs and attempts to fulfill these needs, with attitude of giving without demanding any return that is, not using the patient to fill the staff member's need.
6. Affection and intimacy, personal interest, concern, empathy, and understanding.

7. The object of participation with the patient is to move him from the level at which he functions to the next level of functioning.
8. Respect for and acceptance of the patient and his present way of functioning (including his lack of fitness).
9. Approval, re-assurance, and support for what the patient is able to do at the moment.
10. An interpersonal relationship of warmth and trust must be ensured so as to enhance/increase his sense of competence.
11. Desensitisation, this would help individuals to lose their fear of uncertainty or situations.
12. Attempts to understand the meaning of the patient's behaviour.

Summary

In this lecture, the concept of rehabilitation has been examined. We learnt that the way we (and others) understand rehabilitation can have a fundamental effect on what we are prepared to do, and why, in overcoming the difficulties that disabled people face on a day-to-day basis. The principles of rehabilitation were also examined.

Post – Test

1. What are principles guarding rehabilitation?
2. In your own understanding, explain the concept rehabilitation.

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LECTURE TWELVE

Objectives of Rehabilitation

Introduction

The aim of this lecture is to introduce you to objectives of rehabilitation, their symptoms as well as classification. The lecture will also help you to differentiate between simple deviance and maladaptive behaviour deviance from maladaptive behaviour.

Objectives

At the end of this lecture, you should be able to:

1. explain the objectives of rehabilitations; and
2. discuss the types of rehabilitative assistance you know.

Pre-Test

1. Discuss the objectives of rehabilitation as an intervention programme.
2. List and discuss the processes involved in rehabilitation.

CONTENT

Institution/Clinic based

The process involves the client, caregiver and the professional. The professionals such as occupational, speech and physiotherapist working in rehabilitation are based at a hospital, clinic or institution and offer hands-on therapy to clients on a daily basis. Individual and group therapy approaches involve a wide variety of activities. Home visits are only done when necessary. A multi-professional team approach is optional.

Community Based

The process involves the community, the client, the caregiver and the professional. Community members and clients with disabilities are encouraged to participate in the rehabilitation process. They are encouraged to initiate their own projects and programmes and to take ownership of, and sustain the rehabilitation project and programmes already established. This in turn aims to empower people with disabilities to live their lives optionally and independently within the community and their immediate homes.

Rehabilitation Programme

This varies in different centres. Some centre may set up this with the aim of developing an intersectional, multi-professional and integrated rehabilitation programme within a community, service providers, government and the academic field. Through such collaboration, the aim is to provide effective community and clinic based services. Others may be in form of studying the individual, social and cultural process, through which diseases, illness, health and disablement will be defined, explained and managed by the centre.

Using Halley Stott Clinic in the Kwadedangendlale area of South Africa and health Service Committee of Neuro-psychology as a case study, we shall state the objectives of the rehabilitation centres as an intervention programme.

Objectives of Rehabilitation as an Intervention Programme

- ***To examine and explain the patterns and distribution of diseases (biomedical taxonomies), sickness (social and cultural classifications) and illness (personal beliefs and understanding).***

Rehabilitation investigates how the relationship between diseases, sickness and illness affects the achievement of desired health status. In particular, it also studies the role of both formal and informal health care in this process, as well as the social, cultural and psychological factors, which may condition them. Intervention programme may also engage in researching, establishing and developing appropriate quantitative and qualitative methods through which information on disease, illness, sickness, health and disablement can be gathered, stored and analysed.

- ***To initiate intersectional collaboration in the implementation of the rehabilitation programme.***

This collaboration would involve the leadership of community members, service providers, and government sectors such as transport, labour, education, housing, agriculture, welfare and public workers etc and academic representatives. With this, the disabled will know that there is ability in every disability because the functions of the different sectors will bring out the zeal from the disabled and thus make them feel that they are useful in the community.

This is done because there are two major problems which disabled face in society. These are the attitude type and the access type

The attitude aspect involves the general perception of the disabled in the society and that of the government, individual etc. This is in form of discriminations, abandonment. They are only being patronised (by coming into their aid e.g. giving them arms which is very wrong)

The access aspect talks about the denial of their basic rights, for example education, training, etc. Even physical access e.g. transportation, public services are denied of them etc. Therefore, with the intersectional collaboration, the disabled won't feel these basic problems.

To educate and empower caregivers of children with disabilities

In achieving this, the centre has to handle and stimulate their children appropriately and effectively, encouraging community disability awareness and to initiate income generating projects and the development of the committee. This will enable children from the fundamental stage in their life to put the negative perception of disability and the disabled out of their mind early enough.

To encourage adults with disabilities to initiate the development of their own support group and income generating projects within the community

This objective may be achieved by allowing adults to go into production, for example, shoe making (which can be done by the physically disabled adults). With this income can be generated from the project done by the disabled adults.

To develop a database of people with disabilities in the society through the collection of data at each health post and clinic in the area.

This is possible because the staff of rehabilitation centres collaborate with colleagues in other disciplines, (particularly health service) organizations. Colleagues been collaborated with medical disciplines such as neurology, obstetrics and gynecology, radiology

To establish the rehabilitation centre as a base for a complete rehabilitation team.

In so doing, the aim is to provide individual as well as group assessments, interventions, follow-ups and referrals for daily clients, train and educate caregivers and community members in skills relating to disability intervention, community development and rehabilitation programme development. There is also some training for the provision of capacity building opportunities for students from varied institutions and backgrounds. Thus helps to develop the centre as a resource for further research projects and interventions and finally provide assistive devices and surgical appliances.

A particular focus of rehabilitation centre's work has been to examine the ways in which individuals and group of people in local settings understand and explain the ideas of health, diseases, sickness, illness and disablement, as well as how they behave and practice in relation to those ideas.

By setting such research in the context of broader and often quantitative analyses of more general data, profound and usually insightful findings of major policy relevance often result. With the availability of this, the disabled are let to know that language "deformity is not enormity" and also allow the abled to understand that "equality can only be through participation"

Neuropsychological rehabilitation and stimulation.

This objective is based on patients who have brain-behaviours. The rehabilitation centre provides therapeutic intervention which is needed by the patient to optimise recovery of impaired cognitive functions (attention, , memory et) and to facilitate the development of compensatory strategies.

It also provides treatment for emotional, behavioural disorder associated with the actual lesion in order to facilitate the patient's adaptation process and also maintains the patient's autonomy for as long as possible.

Summary

In this lecture, the major objectives of rehabilitation were the focus. The processes needed to encourage the disabled to participate in rehabilitation were highlighted and discussed.

Post – Test

1. What are the objectives of rehabilitation as an intervention programme?
2. How can people with disabilities live their lives optionally and independently?
3. List and discuss the processes involved in rehabilitation.

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LECTURE THIRTEEN

Theories of Disability in Health Practice and research

Introduction

You will be exposed to the theories of disability and the use in health practice and research. Each of the theories will be explained based on the emphasis or role to cure and to maintain the "normal" functioning of individuals and of society.

Objectives

At the end of this lecture, you should be able to:

1. discuss theories of disability in health practice and research; and
2. comment on some ethical socio-cultural issues involved in positivist disability research.

Pre-Test

1. What is the central claim of the social model of disability?
2. Examine the weaknesses of positivism in disability research.

CONTENT

The Experience of Disability

Over the past 20 years, writings by disabled people have transformed our understanding of the real nature of disability. They move beyond the personal limitations that impaired individuals may face, to social restrictions imposed by an unthinking society. Disability is understood as a

social and political issue rather than a medical one, and this leads to critical questioning of medical interventions: attempts to cure impairments or to restore "normal" bodily functioning. Instead, social and political solutions are sought, to challenge disabling discrimination.

This radically different view is called the social model of disability, or social oppression theory. While respecting the value of scientifically based medical research, this approach calls for more research based on social theories of disability if research is to improve the quality of disabled people's lives. Definitions are central to understanding theories of impairment and disability. In 1986, Disabled Peoples International made a clear distinction: impairment is the functional limitation within the individual caused by physical, mental or sensory impairment; disability is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others because of physical and social barriers.

This schema accepts that some illnesses have disabling consequences and disabled people at times are ill; it may be entirely appropriate for doctors to treat illnesses of all kinds, such as bronchitis or ulcers. Yet it questions why, for example, doctors should decide about access to welfare services such as education or disability living allowance. Theories of impairment, disability, and illness influence which aspects of disabled people's lives require health treatment, or policy developments, or political action, as sometimes-radical alternatives.

Positivism and Disability Research

Health research about impairment and disability is dominated by positivist theories. It focuses on searches for cures, means of reducing impairments, or assessments of clinical interventions and users' methods such as controlled trials, random statistical samples, and structured questionnaires. Even when researching disability (in the sense given above), positivist research tends to use the World Health Organization's classification, now being revised at the insistence of disabled people, which is difficult if not impossible to apply in research terms and yields few useful data.

Disabled people are beginning to influence scientific research. This influence poses difficulties for positivist research in questioning one of its bedrocks: the notion of objectivity. Although positivist researchers accept that subjectivity can be studied objectively, they resist involving subjects

for fear of bias. However, scientific researchers often use the words "suffering" and "victim" as if they are accurate descriptions and not untested, biased assumptions which many disabled people do not experience. In contrast, social constructionism sees experience and subjectivity as central to the research process, and critical theory sees disabling barriers as a key research issue. Though these theories pose intellectual challenges, almost all funding goes to positivist research.

Interventions to Normalise Impairments

Impairment	Intervention	Alternatives
Deafness	Cochlear implants	Sign language teaching in schools
Cerebral palsy	Conductive education	Barrier removal
Achondroplasia	Limb lengthening	Barrier removal, awareness raising
Down's syndrome	Cosmetic surgery	Awareness raising
Congenital conditions	Genetic screening	Legislation for equal opportunities

The influence of implicit and explicit positivism on the Department of Health which, it seems, has discovered the "user," is shown in a recent report: "The NHS is attaching increasing importance to seeking out and acting upon the views of its users on the coverage and delivery of the services it provides. The programme has spent £3.9 million on 30 projects; all are located in universities or the health service. Despite consumer views being the second named priority for selecting research proposals, disabled people have not been involved. None of their organizations have received funding, and no projects could be said to be based on the social model of disability they are all based on positivist theories.

Social Approaches within Positivism

Positivist social medicine recognizes the social context to impairment as well as disability, and it examines environments as well as individuals.

Hence public health measures concerned with sanitation, poverty, health education, and the like have proved extremely effective in preventing rather than curing a range of impairments, such as tuberculosis, polio, rickets, and river blindness.

Prevention of impairments is complicated, however, by prenatal screening to prevent conditions such as Down's syndrome, cystic fibrosis, or Huntington's chorea, and by research into genetic engineering. Leaving aside the efficacy of such interventions, they pose profound ethical, social, and cultural issues for us all. "Life and death decisions are vested in the hands of people who have very little understanding of the reality of disabled people's lives." With the lack of systematic evidence, why should doctors assume, for example, that life with Down's syndrome is not worth living?

Social approaches to disability within positivism classify and count disabled people. Although some support this work, others question the accuracy of the data and say that they yield few significant changes for disabled people.

Recent research, attempting to combine theories, and scientific measures of the extent of disabling barriers with disabled people's own experiences of the extent and nature of those barriers, involves disabled people in designing, collecting and analysing the data. Its success remains to be seen.

Functionalist Theory and Disability

Influential functionalists emphasise medicine's role to cure and to maintain the "normal" functioning of individuals and of society. In this model, the "sick role" involves being compliant and wanting to get well. This can make people with incurable conditions, including disabled people who are classified as sick, seem to be deviant. The link between disability and social deviance that functionalists make influences health care and research and supports the continued dominance of professionally controlled health and welfare services for disabled people. Thus, under current welfare arrangements, more than 70% of spending goes on the salaries of professionals working with disabled people. Only recently has this been reduced through the funding of independent living schemes controlled by disabled people. A variant of functionalism, normalisation theory, underlies some programmes that claim to enable devalued people

to lead culturally valued lives. An example of this controversial approach is cosmetic surgery for people with Down's syndrome.

Functionalism confuses impairment and disability with the sick role. By failing to recognise that disabled people do not necessarily have "something wrong with them," it simply reproduces discriminatory norms and values instead of addressing the cultural and economic forces that precipitate them. The crucial problem is that disabled people, regardless of the type or severity of their impairment, are not a homogeneous group that can be accommodated easily within a society that takes little account of their individual or collective needs. As with the whole population, disabled people differ widely in terms of ethnic backgrounds, sexual orientations, ages, abilities, religious beliefs, wealth, access to work, and so on. Clearly, their situation cannot be understood or, indeed, transformed by any policy based on narrow theories of conventional normality or uniformity.

Social Constructionism

This theoretical approach is centrally concerned with meaning. It shows the crucial importance of learning from disabled people's experience to understand meanings of disability. For example, blindness differs according to the economic and cultural contexts. A classic study in the United States showed that blindness was experienced as loss requiring counseling; in Sweden, it is regarded as a problem requiring support services; in Britain it is taken as a technical issue requiring aids and equipment, and in Italy it is taken as the need to seek consolation or even salvation through the Catholic Church.

Anthropologists and historians show how different societies produce certain types of disease, impairment, and disability. Disability can be produced by "the disability business." In modern America, industrialisation, the subsequent growth of the human service sector, and the more recent politicisation of "disability rights" by the American disabled people's movement have transformed "disability" and "rehabilitation" into a multimillion-dollar enterprise. Disability becomes a commodity and a source of income for doctors, lawyers, rehabilitation professionals, and disability activists.

These examples treat disability as a shared experience, in contrast with conventional individualistic interpretations. Yet each fails to address key structural factors. Consequently, disabled people tend to be treated as

an abstract, somehow distinct from the rest of the human race, and the crucial question of the causes of disability is fudged rather than clarified. For example, how is disability physically based but socially constructed by the disabling environment?

Postmodernism

Postmodernism sees society in terms of fragmented and complex social structures in which social class has less importance, and other sources of social difference (including sex, ethnicity, sexuality, and disability) having more importance. Postmodernists call into question many of the certainties of earlier eras, creating multiple meanings for practically everything.

This theory has, as yet, had little impact on health research about disability. However, a study on concepts of a healthy body, so central to government health promotion, is beginning to show how these concepts can, in themselves, be disabling, unrealistic, and oppressive. "Health promotion is working against popular culture, attempting to construct a view of health that is not privately held." In other words, to have impairment is not necessarily unhealthy; disabled people are not actually ill, and confusion between impairment and illness fails to deal with complex meanings in the postmodern world.

Critical Theory

Critical theory covers similar ground to the other theories discussed here, but it sees disabled people's problems explicitly as the product of an unequal society. It ties the solutions to social action and change. Notions of disability as social oppression mean that prejudice and discrimination disable and restrict people's lives much more than impairments do. So, for example, the problem with public transport is not the inability of some people to walk but that buses are not designed to take wheelchairs. Such a problem can be "cured" by spending money, not by surgical intervention, assistive computer technology, or rehabilitation.

Ideologies perpetuate practical barriers and exclusions. As long as disability is assumed to be an individual matter of personal tragedy or heroic triumph over difficulty, disabled people are excluded from society. Ordinary education, employment, buildings, public transport, and other things which most people can take for granted remain largely closed to disabled people, or at least they present obstacles which each person has to

tackle individually. By emphasizing deficiency and dependency, doctors tend to reinforce these ideologies.

The impact of this critical theorizing on health care and research has tended to be indirect. It has raised political awareness, helped with the collective empowerment of disabled people, and publicized disabled people's critical views on health care. It has criticized the medical control exerted over many disabled people's lives, such as repeated and unnecessary visits to clinics for impairments that do not change and are not illnesses in need of treatment. Finally, it suggests a more appropriate societal framework for providing health services for disabled people.

Conclusion

Implicit and explicit social theorising, coupled with disabled people's insistence that their voices be heard, has begun to change understandings of the nature of impairment and disability. The new understandings pose key questions for health care and research if they are going to provide an appropriate knowledge base for both medical and social progress.

Summary

In this lecture, we have focused on different theories of disability; more so, examined various psychological theories postulated to explain disability as it applies the meaning of disability and disabled peoples' problem.

Post - Test

1. Briefly demonstrate the application of disability theories in health practice and research.
2. Who should be in control of the research process?
3. What is the most appropriate method for undertaking disability research?

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