ELECTIVE II:
REHABILITATION PSYCHOLOGY
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Rehabilitation psychology is a specific field of psychology which deals with the rehabilitation of people with disabilities who have difficulty in dealing with everyday life. Since disabilities can be myriad, its identification and preferably early intervention is important so that it is easier for the person to adjust with the assessment and its results. These problems may be physical or emotional in nature and it becomes imperative for certain people with disabilities to get help professional help. The problems might be chronic or acute and acquired or congenital.

The study of rehabilitation psychology then requires an understanding of the historical perspectives, the professional competencies of the rehabilitation psychologists, the basic principles of assessment and therapy, the concepts of personality traits and disorders, the nature, and approach of intervention.

This book, *Elective II: Rehabilitation Psychology*, is written with the distance learning student in mind. It is presented in a user-friendly format using a clear, lucid language. Each unit contains an Introduction and a list of Objectives to prepare the student for what to expect in the text. At the end of each unit are a Summary and a list of Key Words, to aid in recollection of concepts learnt. All units contain Self-Assessment Questions and Exercises, and strategically placed Check Your Progress questions so the student can keep track of what has been discussed.
1.0 INTRODUCTION
Rehabilitation psychology is defined as the study and application of psychological principles on behalf of persons who have disability due to illness or injury. Rehabilitation psychologists, often within teams, assess and treat cognitive, emotional, and functional difficulties. They help people to overcome barriers to participation in life activities.

Rehabilitation psychologists are involved in practice and research with the broad goal of fostering independence and opportunity for people with disabilities. Rehabilitation psychology serves people across the lifespan affected by any injury or chronic condition that leads to disability.

In this unit, the meaning and scope of rehabilitation psychology has been discussed. The methods, functions and features of rehabilitation psychology have been highlighted. The unit will also provide an in-depth knowledge about the development of various acts related to rehabilitation psychology.

1.1 OBJECTIVES
After going through this unit, you will be able to:
- Discuss the meaning and scope of rehabilitation psychology
- Identify the methods and functions of rehabilitation psychology
NOTES

1.2 REHABILITATION PSYCHOLOGY: DEFINITION AND SCOPE

We will in this section discuss the meaning, scope and methods and functions of rehabilitation psychology.

Definition

According to renowned psychologists, Maki and Riggars (2004), the term ‘rehabilitation’ refers to an integrated program of interventions that empower individuals with disabilities and chronic health conditions to achieve ‘personally fulfilling, socially meaningful and functionally effective interaction’ in their daily context.

Rehabilitation psychology is a specialty area within psychology that focuses on the study and application of psychological knowledge on individuals with disability and chronic health conditions with an aim of maximizing health and welfare, improving quality of life and social participation across lifespan. It aims at helping individuals achieve an optimal level of physical, psychological and interpersonal functioning. In other words, rehabilitation psychology can be seen as an important part of treating and preventing chronic health problems. It also involves practice, research and advocacy which aim at promoting independence and opportunity for people with disabilities.

Rehabilitation psychologists are trained and specialized to engage in a broad range of activities including clinical practice, consultation, program development, research, teaching and training, administration, development of public policy and advocacy related to people with disability and chronic health conditions. As a result, rehabilitation psychology services are spread across variety of settings including in acute care hospitals and medical centers, inpatient and outpatient physical rehabilitation unit, nursing homes and assisted living centers, and specialty clinic (for example, vision loss and low vision, cerebral palsy, multiple sclerosis, or deafness). Some of these facilities are operated privately while others are aided by the government (such as for war veterans).

American Psychological Association defined rehabilitation psychology as, ‘rehabilitation psychology is the study and application of psychological principles on behalf of persons with physical, sensory, cognitive, developmental or emotional disabilities.’
Scope of Rehabilitation Psychology

The scope and application of rehabilitation psychologist is wide, as rehabilitation psychologist address various domains of one's everyday functioning, as per the World Health Organization (WHO)'s International Classification of Functioning, Disability and Health (ICF). Some of these are as follows:

- Assessment of an individual's physical, personal, psychological, cognitive, and behavioural factors and followed by developing an intervention plan accordingly.
- Assessment of an individual's neuro-cognitive status, sensory difficulties, mood and emotions, desired level of independence and interdependence, mobility and freedom of movement, self-esteem and self-determination, behavioural control and coping skills, individual's capabilities and quality of life to understand the client's perspective efficiently.
- It assesses the influence of culture, ethnicity, language, gender, age, developmental level, sexual orientation, geographical location, socioeconomic status and assumptions of difficulty on attitudes and the services which are given to the client.
- It explores the environmental barriers in participation and performance in day to day activities including accommodations and adaptation in the existing social structure.
- It includes research and teaching of psychology students and other health trainees about the requirements of people with special needs. It also focuses on development of policies for health promotion, and advocacy for persons with disabilities and chronic health conditions.
- It provides services within existing networks of biological, psychological, social, environmental, and political environments such as attorneys, courts, government agencies, educational institutions, corporate facilities, or insurance companies.

1.2.1 Methods and Functions of Rehabilitation Psychology

Just like their varied functions, a rehabilitation psychologist undertakes multiple tasks and uses the following methods:

- Administration of standardized and non-standardized tests to assess cognitive and psychological functioning of the client, and use of behavioural observation and interviewing skills to get detailed information about the client.
- Evaluation and treatment of both individual and family members for improving coping and adaptation skills in both the client and the family members.
- Providing individual and group intervention by using counseling and psychotherapy, cognitive remediation, behavioural management and enhancing use of assistive technology for enhancing day to day functioning of the client.
Functions of Rehabilitation Psychologist

A rehabilitation psychologist performs several functions. Some being specific and some being general functions in general. The functions are enlisted as follows:

- He or she focuses on improving functioning and quality of life of persons with special needs by restoring patient’s physical functions and modifying the patient’s physical and social environment.
- Rehabilitation psychology involves case management which includes obtaining written reports regarding client’s progress, developing rapport with physicians and other rehabilitation health professionals and caseload management-which refers to the ability to manage a number of clients, within a given amount of time and provide optimum services.
- It focuses on providing a community based rehabilitation service activities for integration and equalizing of opportunities in all aspects of the society.
- It involves vocational counseling and consultation which include services such as job development and placement, career counseling, vocational planning and assessment.

Some Unique Functions of Rehabilitation Psychologist

There are some unique functions which a rehabilitation psychologist performs:

- Identification of co-morbidities in the client which can affect his or her functioning.
- Use of efficient assessment tools for developing effective intervention strategies.
- Identifying client’s strengths and abilities and developing on it and also identifying the risk factors which need to be taken into consideration while providing an intervention.
- The psychologist should also take into consideration cost and availability of resources for the client.

Rehabilitation psychologist serves a wider range of population which includes:

- Individuals with brain injuries
- Individuals with spinal cord injuries
- Geriatric population
- Individuals with neuromuscular disorder
- Individual with chronic pain disorder
- People with medical condition such as:
  a) Cancer
  b) Multiple sclerosis
  c) Developmental disorder
d) Psychiatric disability
e) Substance abuse
f) Deafness or hearing loss
g) Intellectual disability
h) Blindness and vision loss
i) Impairment by educational or other disadvantages

Therefore, rehabilitation psychologist addresses behavioural and mental health issues faced by individuals affected by injury or any chronic condition that can lead to disability across lifespan. It includes issues such as:

- Emotional coping, mental and psychological status.
- Behaviour that promotes positive adaptation to disability.
- Minor adjustment issues as well as severe psychopathology.

Check Your Progress

1. What is the main aim of rehabilitation psychology?
2. How has American Psychological Association defined rehabilitation psychology?

1.3 HISTORICAL PERSPECTIVES IN REHABILITATION PSYCHOLOGY

Amongst the first charitable organization which contributed to the field of rehabilitation psychology were hospitals. Hospitals were established by the Church during the early Middle Ages, to provide care to the sick and disabled who had no families to care for them. The needs of persons with disability were first addressed by the Red Cross, The National Tuberculosis Foundation, Goodwill Industries and the Easter Seal Society, during the nineteenth and twentieth century. These efforts were sustained by ethics such as charity and the expectation of the recipient was to be humble and grateful towards their benefactors. Governmental organizations were set up during the beginning of the nineteenth century for people who had special needs, mental retardation, illness and children.

Vocational rehabilitation began in the United States with the Act to Provide for Vocational Rehabilitation of Persons Disabled in Industry or otherwise and their return to Civil Employment (1920) that further expanded the role of the Federal Board of Vocational Education, that included the civilians as well as veterans and which helped the state-federal partnership in funding vocational rehabilitation efforts. The definition of disability emphasized the return to work as a goal, from the very beginning. Persons disabled the statute defined as ‘any person by reason of a defect or infirmity whether congenital or acquired by accident, injury or disease is,
or may be expected to be, totally or partially incapacitated for remunerative occupation. The primary mission of the agency of each state is to help people with special needs reach their potential for employment or independent living.

Period of growth has been stimulated by war, which has led to growth in rehabilitation psychology as a result of the increased need to care for large numbers of disabled veterans returning from war. Following the Civil War, efforts to care for the American veterans took place. Several agencies, in 1921, were consolidated into the Veterans Bureau, which later became the Veterans Administration and now the Department of Veterans Affairs. This agency played an important role in developing clinical psychology as a profession and in placing psychologists in rehabilitation settings.

Chief of vocational counseling in the VA, Robert Waldrop was one of the founding members of Division 22 and the NCPAD, its forerunner. In both the fields of clinical and counseling psychology as well as the field of rehabilitation psychology, the role of the VA system has been immense and fundamental. Professional psychology would be considerably smaller as a field, without training and employment opportunities.

The National Council on the Psychological Aspects of Disability (NCPAD) marked the organizational beginning of Division 22. Psychologists, Jane Shover and Phyllis convened this group, who between 1949 and 1951, called psychologists working with persons with disabilities at several American Psychological Association (APA) annual meetings. During this year, the group formally organized as a special interest group within the APA. By the next year, it had become The National Council on the Psychological Aspects of Physical Disability (NCPAPD), which remained the name until 1956 when largely for the sake of convenience it was shortened to its original name. The change of name reflects the tension between those whose work was primarily with physical disabilities and those who saw rehabilitation in a broader perspective that included mental disabilities. Through Division 12 (Society of Clinical Psychology) those interested in the physical disabilities had adequate outlets and they wanted to emphasize on the situation of those with physical conditions. The early role of NCPAD during the annual meetings of the APA was primarily as a focus of activity, but with the course of time there was a greater perceived need for organizational structure to manage the business between annual meetings. The members of NCPAD were ambivalent about making the next step, seeking divisional status within the APA, despite its growth. The results of the vote by the membership in 1955 was only 7 votes were in favour of divisional status, 29 votes were in favour of continuing as a special interest group and 13 votes were in favour of affiliating with another division (15 in favor of a proposal to affiliate with Division 17, Counseling Psychology). At the end of 1957, at the time of becoming a division, a similar vote was 38 in favour, 16 against seeking divisional status. But at the same time, 155 out of 180 members of NCPAD signed a petition for division status. It was recommended by the APA board of directors, to grant divisional status to the Council of Representatives, who then
voted at the APA annual meeting in August 1958 and thus, Division 22 was officially born.

The history of the evolution of its professional identity, in American Psychology, can be traced by looking at conferences which were usually sponsored by APA, which were held to discuss the concerns and articulate the emerging consensus within a field. For example, in 1949, the historic Boulder conference marks the beginning of modern clinical psychology; in 1951, the Northwestern conference marks the beginning of modern Counseling Psychology.

In a conference held in Princeton, New Jersey, February 3 to 7, 1958 on the role of psychology and psychologists in rehabilitation, the origin of rehabilitation psychology was defined. APA and the US Department of Health, Education and Welfare, were the co-sponsors of the conference. Beatrice Wright (1959) recorded the proceedings of the Princeton Conference and it was published by the APA as ‘Psychology and Rehabilitation’. This is an excellent reflection of the thoughts at the time concerning the professionalization of rehabilitation psychology and helps us to understand the goals, viewpoints and methods of this emerging specialty.

The two of the important topics discussed were, the scope and nature of rehabilitation. The main issue was the degree to which rehabilitation should include mental disorders or remain focused on physical disorders. The tension concerning the name of the National Council reflects this debate.

The multidisciplinary character of rehabilitation resulted in the debate on the scope of rehabilitation. As a medical specialty emerged rehabilitation medicine or psychiatry, at the same time. The role of physical therapists, nurses, and social workers, among others was also important. More than most professional’s specialties, rehabilitation psychology involved extensive day to day contact with other professionals from a very wide range of training with very different vantage points on the problems of disability. In the proceeding, an entire chapter was devoted to ‘Inter-professional Relations’. It was noted by psychologist, Wright that rehabilitation ‘is not the sole province of any one profession. It is rather an expression of a system of values and attitudes toward the person with a disability and his or her place in society.’ A key value was a belief that ‘purposeful activity’ should replace the idleness of mere ‘convalescence’.

Vocational focus was another major characteristic of rehabilitation psychology. Work was recognized as a major source of income and psychological independence, although the overall adjustment of a person at an individual level and in other social roles such as family life was a major concern. To provide vocational rehabilitation services to disabled veterans and non-veterans, there were statutory mandates. Vocational counselors and psychologists were brought into the forefront of rehabilitation by agencies that were created to fulfill these mandates. A common ancestor to both Division 17 and 22 is the vocational guidance movement which was stimulated by the returning veterans of World War I. In the year 1958, the concept of vocational rehabilitation had been broadened to include
During the same time period, it was noted that a program of ‘independent living’ would be established by the pending legislation, if passed and thus, heralding changes that were to play larger roles in the field of rehabilitation in later decades.

The discussion also included the roles and functions of psychology in a rehabilitation setting. It was noted that an equal percentage of participants were based in academia and in ‘institutions for the handicapped.’

At the conference, a large number of people were present who trained the clinicians as well as the clinicians themselves. The highest in frequency was administration and consultation activities (all at 73.2 per cent), testing and evaluation was next 68.5 per cent, followed by counseling and psychotherapy at 67.5 per cent, teaching and research was at 65.6 per cent and 61.0 per cent respectively. Improving public attitudes toward disability, which was the next frequent activity, dropped to 47.1 per cent and others trailed off after that. It was recognized that the clients who reflected a spectrum of adjustment and who also addressed their needs, required going beyond the ‘consulting room’ attitude and the emphasis which is put on psychopathology which was seen to be more focused on the mental health.

Finally, the training of rehabilitation psychologists was discussed. The doctoral level of training was seen as the most appropriate, followed by the earlier decisions in clinical and counseling psychology. With the consensus within professional psychology, the broad outline of curriculum, including practicum and internship experiences, was consistent. The discussion further included the needed coursework to acquaint the student with the particular issues regarding disability. Psychological aspects of disability (82 per cent), Medical information (58 per cent), Community relations (51 per cent) and Social Work orientation (32 per cent) were the needs that were highlighted and the frequency of their endorsement by participants in the conference.

It was also pointed out that it was necessary to cover ‘somatopsychology’, a term which was earlier coined by researchers to describe the study of impact of physique and visible disability on psychological functioning.

Another conference sponsored by the Office of Vocational Rehabilitation (OVR) was held at Clark University, a year after the Princeton Conference. As starting points, a more formal set of presentations and papers were used. The paper which aimed at guiding the direction of research efforts was considered the most interesting paper and was sponsored by the OVR as the major federal granting agency. The prevalence of ‘one-shoot’ investigations was noted by psychologist, Myerson and he urged more sustained programs of research by individual investigation. Fortunately, this goal has been met by a growing number of people who author multiple studies having a coherent focus during their careers in rehabilitation psychology. More outlets for research were another need which had been observed. The outgrowth of this goal was, Division 22. Myerson’s call for more ‘comprehensive theories of illness, disability and rehabilitation’ was another
salient point. He observed after reviewing the extant theories that an integrated theory would have to integrate facts about the person, the disability, the social setting, the rehabilitation process itself and the ‘flexibility or amenability to change of each characteristic’.

The three founding members of Division 22 conducted one of the pioneering studies on the psychological aspects of disability. Psychologists, Dembo, Leviton and Wright sought out veterans and others who had lost limbs in the war or were otherwise visibly different. These veterans were then interviewed and sometimes significant others concerning their adaptation to the changes in physical appearance and function and the reactions of others to their visible disability. Somatopsychology was a term which was coined by Dembo and her colleagues, which refers to the ways in which apparent and obvious physical difference has a psychosocial impact on self and others. Throughout the history of rehabilitation psychology, this social-psychological framework has been a major theme.

During this period another important work has summarized the history of literature on psychological adjustment to physical disability. Kurt Lewin, a German-American psychologist played an important role in the psychology and social psychology of disability. The holistic interaction between the individual and the environment was emphasized by his field theory approach to psychology, a concept which was of great relevance to studying how the visible physical differences of amputees led to changed reactions of self and others.

The Lewinian emphasis on the person-environment interaction is reflected in several ways. The individual disability is understood in terms of the impact that the disability has on that individual himself or herself and that individual’s opportunity to integrate into the community at large.

In this early period, another significant development was the close association between rehabilitation psychologists and Division 17. The distinguishing features of counseling psychology have been its emphasis on working with people who are psychologically normal and who are undergoing significant life-stage transitions. Rehabilitation psychology and counseling psychology share an emphasis on the vocational role and its importance in not only economic but psychological independence.

Like counseling psychology, rehabilitation psychology has also been more sensitive to the differences between normalcy and pathology. The field has attempted to identify what factors influence an individual who has a disability to react in an adaptive or maladaptive manner to the circumstances imposed by his or her situation.

The emphasis on ‘functional capacities’ is one of the most important contributions from a rehabilitation view. The goal of returning people to a maximal degree of prior function has resulted in a focus on describing, measuring, and enhancing what the person can actually do. ‘Independent living’ has forced rehabilitation psychologists to structure their relationships with clients around much more pragmatic goals.
Rehabilitation psychology emerged as a distinct specialty within professional psychology by the 1960’s. This year included the intensifying struggle for civil rights and racial justice as well as President Lyndon Johnson’s Great Society and the beginning of the Medicare program as a means of providing health care to elderly and disabled individuals.

Psychologist, William Gellman’s (1966) comments at the annual APA meeting reflected the many social changes underway at that time. In particular, he saw significant changes for persons with disability in the labor force, changes that would ‘devaluate or eliminate the economic potential of groups with limited education or training’. He also urged that rehabilitation increasingly adopt preventive and maintenance objectives.

A disability rights movement gained momentum, in the 1970’s, with an emphasis on the psychological issue of normalization and the social challenge against paternalism. This led to the passage of the Rehabilitation Act of 1973. Empowerment is the ethic behind this movement. This movement viewed the people as socially disadvantaged by physical and psychological barriers and changing those environmental features is the major goal.

The Americans with Disabilities Act (ADA) in 1990, was an important development for persons with disabilities.

The NCPAD published a newsletter, which kept division members up to date on organizational matters, as well as the Bulletin, which presented more formal scientific and scholarly articles. The first editor of the Bulletin was Lee Myerson. He recognized the need to further improve the quality of the journal and the research contained in it if the division was to truly emerge as an important source of knowledge and assistance to practitioners. The editorship has now been passed to Bruce Caplan, and the American Psychological Association is currently the publisher. Two papers addressed both poverty and the impact of race and ethnicity on rehabilitation and reflecting the growing sensitivity to minority group issues were published during the same time.

One particular paper dealt with the social psychology of the rehabilitation process itself in the form of a study on professional-client relations in a rehabilitation hospital. The role of self help groups in the rehabilitation process was provided by Wright (1971) in his earliest discussions.

By 1978, the division had matured enough to begin honoring its members who had distinguished themselves through research or service. James Garrett was the first recipient of the Distinguished Service Award for research contribution. He was a key person in arranging sponsorship of the early conferences defining the field of rehabilitation psychology. One of the early handbooks on the psychological aspects of disability was also edited by him.

Tamara Dembo and Beatrice Wright, who were part of the early Lewinian tradition in rehabilitation psychology, were the other members to receive this award.
Dembo focused her attention on the importance of practical considerations of actual life problems and advocated actively involving the persons with disability in the rehabilitation process. Wright has contributed to social psychology and has extensively written in the field of rehabilitation psychology.

Psychologist, Wilber Fordyce pioneered behavioural approaches to chronic pain and has contributed more than 20 articles expanding on this theme. Nancy Kerr and Lee Myerson are the two main recipients of the Distinguished Service Award; they collaborated on articles concerning the importance of independence for persons with disability and research methodologies for rehabilitation.

Numerous papers on aspects of rehabilitation of persons with mental retardation and sensory disabilities were contributed by Myerson. George Wright was the recipient of the Distinguished Service Award 1988. He wrote extensively on the topic of the competencies of rehabilitation professional and how to train and enhance them.

To honor a senior colleague who had a distinguished career in research in rehabilitation psychology, the Roger Baker Award was initiated in 1988. The first recipient of this award was Brian Bolton. He has contributed and collaborated on more than 120 articles, books, and chapters in the field of rehabilitation.

Recipient of the 1989 Baker Award was William Anthony, who had published nearly 80 articles in the field of psychosocial rehabilitation of mental disabilities. Originally, the field of rehabilitation distinguished itself from the rest of clinical psychology by emphasizing a specific population, persons with physical disability. The combination of techniques and values from one context and which is applied on the other has been termed ‘psychosocial rehabilitation’.

For his long career interest in attitudes toward disability was received by Bob Yunker in 1991. The Attitudes toward Persons with Disability Scale (ATDP) was developed by him, which has been among the most widely used instruments in assessing such attitudes.

Marcus Fuhrer along with Margaret Nosek, were the recipients of the Barker, who were the 1995 winner of the Garret award, took up the theme of independence for persons with disabilities. Significant advances were made in medical technology and the refinement of urban emergency treatment centers in the 1980’s. An increase in number of people surviving serious head injury, stroke, or other acute and often neurological conditions, was the result of these two developments.

The interests of many rehabilitation psychologists became increasingly focused toward the specialty of neuropsychology, with the advent of ‘neuropsychological rehabilitation’, which is the use of psychological principles and techniques to address the needs of persons with neurological disabilities. Neuropsychology began primarily as an aid to diagnosis and much work has been done by members of both Division 22 and Division 41 to enhance the use of psychological assessment data to diagnose brain damage.
Primarily, neuropsychology began as an aid to diagnosis and much work has been done by members of both Division 22 and Division 14 to enhance the use of psychological assessment data to diagnose brain damage. Relationship between the environment and the patient has been one of the themes of neuropsychological rehabilitation. More emphasis was given on the correlation between test performance and the presence or localization of a lesion, by classical neuropsychology.

With Dembo, Wright and Barker began the tradition of the awareness of the importance of the ecological relationship between person and environment. The founding members of the division were involved in working with children, but in 1987, a special interest group was created for psychologists involved in pediatric rehabilitation. An effective vehicle in bringing new members into the division as well as providing a forum for networking and sharing ideas was a pediatric social hour at the annual APA convention.

Pediatric rehabilitation has been but one of several special interest groups that have emerged as the field of rehabilitation psychology has grown in complexity and specialization.

In the 1970’s and 1980’s there was a dramatic growth in rehabilitation and its diversification into subspecialties including but not limited to psycho-social rehabilitation of the chronically mentally ill, neurorehabilitation of traumatic head injury and stroke survivors.

The beginning of the current era can be pinpointed in the series of articles in the June 1990 issue of American Psychologist highlighting rehabilitation. A large number of individuals are both surviving into old age, where disabling conditions are more common and surviving the disabilities and chronic conditions that had earlier resulted in death; has improved in part because of the American population and the improvement of health care.

Under the Medicare as heralding a new era of possibilities, psychologist Frank and his colleagues saw the recent inclusion of psychologists as independent providers. In the last decade managed care organizations have had a growing influence in reimbursement for services in rehabilitation psychology, as they have for many other areas of professional psychology. Medicare and Medicaid are some government benefit programs which have begun to encourage beneficiaries to use health maintenance organization (HMO’S) and other types of managed care.

Rehabilitation Psychologists felt the impact of private credentials bodies, in addition to managed care, with which all psychologists who are health care providers have to deal with.

The major private credentialing body in this specialty area is the Commission for Accreditation of Rehabilitation Facilities and its standard mandating inclusion
The accreditation standards promulgated by the CARF, has been one of the major source for the increased job market for rehabilitation psychologists. This particular requirement was eliminated by a proposed revision of CARF standards in 1996.

An agreement was made by the executive board of the division, which was to offer a diplomat in rehabilitation psychology through the American Board of Professional Psychology (ABPP). In 1977, the first diplomats in rehabilitation psychology were awarded.

Primarily all health care is rooted in a medical model, for better or worse and that invariably implies a diagnostic system. For most of the health care concerns, psychology uses the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association 1994). The chronic problems resulting in disability and requiring rehabilitation is covered by the International Classification of Impairments, Handicaps and Disabilities (ICIDH), which come under the WHO (1980).

Impairment refers to the medical condition itself on the other hand; disability refers to ‘any restriction or lack of ability to perform an activity within what is considered normal for a human being.’ Handicap refers to the disadvantages encountered by individuals because of impairment or handicap and reflects the interaction between the physical level, the functional capacity level and the level of social structures, support and attitudes.

The passage of the Americans with Disabilities Act (ADA, 1990), has been a major milestone in the movement for civil rights of persons with disabilities. Rehabilitation psychologists have been actively involved in providing testimony for passage of this legislation, as well as being involved after its passage in providing interpretative services to business and community groups regarding disabilities.

In pediatric rehabilitation, the division has developed special interest sections. There are special centers for deafness as well. To bring together interests in rehabilitation, wellness, psycho-spirituality, and alternative healing, new committees on integrated health and living have been added. The division has also moved into the computer era, with a website through the American Psychological Association (APA) and a list for server for rapid communication of notices via the Internet.

A strategic planning committee was set up to formulate a long-term vision for the future, in response to the growing complexity of the field and the organization. On professional psychology in general and rehabilitation in particular, the impact of managed care and health care cost containment continues.

Though the U.S. Supreme Court has now begun to limit the scope of the legislation, the impact of ADA continues to be significant. Human beings still transform what might be considered tragic and even catastrophic the onset of a
disabling medical condition, like the phoenix that was once the graphic logo of the division. To live fuller lives with access to all benefits of society, rehabilitation psychologists continue to aid persons with disabilities. The health of the division in this new century seems to look good, as it continues to provide a focus of psychology, disability and rehabilitation.

### 1.4 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Rehabilitation psychology is a specialty area within psychology that focuses on the study and application of psychological knowledge on individuals with disability and chronic health conditions with an aim of maximizing health and welfare, improving quality of life and social participation across lifespan.

2. American Psychological Association defined rehabilitation psychology as, “rehabilitation psychology is the study and application of psychological principles on behalf of persons with physical, sensory, cognitive, developmental or emotional disabilities.”

3. Vocational focus was one of the major characteristic of rehabilitation psychology. Work was recognized as a major source of income and psychological independence, although the overall adjustment of a person at an individual level and in other social roles such as family life was a major concern.

4. Somatopsychology refers to the study of impact of physique and visible disability on psychological functioning.

### 1.5 SUMMARY

- Rehabilitation psychology is a specialty area within psychology that focuses on the study and application of psychological knowledge on individuals with disability and chronic health conditions with an aim of maximizing health and welfare, improving quality of life and social participation across lifespan.

- Rehabilitation psychology can be seen as an important part of treating and preventing chronic health problems.

- The scope and application of rehabilitation psychologist is wide, as rehabilitation psychologist address various domains of one’s everyday functioning, as per the World Health Organization (WHO)’s International Classification of functioning, Disability and Health (ICF).
A rehabilitation psychologist performs several functions. Some being specific and some being general functions in general.

Rehabilitation psychologist addresses behavioural and mental health issues faced by individuals affected by injury or any chronic condition that can lead to disability across lifespan.

Amongst the first charitable organization which contributed to the field of rehabilitation psychology were hospitals.

Vocational rehabilitation began in the United States with the Act to Provide for Vocational Rehabilitation of Persons Disabled in Industry or otherwise and their return to Civil Employment (1920) that further expanded the role of the Federal Board of Vocational Education.

The National Council on the Psychological Aspects of Disability (NCPAD) marked the organizational beginning of Division 22.

The individual disability is understood in terms of the impact that the disability has on that individual himself or herself and that individual’s opportunity to integrate into the community at large.

‘Independent living’ has forced rehabilitation psychologists to structure their relationships with clients around much more pragmatic goals.

Primarily, neuropsychology began as an aid to diagnosis and much work has been done by members of both Division 22 and Division 14 to enhance the use of psychological assessment data to diagnose brain damage.

Pediatric rehabilitation has been but one of several special interest groups that have emerged as the field of rehabilitation psychology has grown in complexity and specialization.

In pediatric rehabilitation, the division has developed special interest sections. There are special centers for deafness as well.

The health of the division in this new century seems to look good, as it continues to provide a focus of psychology, disability and rehabilitation.

### 1.6 KEY WORDS

- **Disability**: It refers to any restriction or lack of ability to perform an activity within what is considered normal for a human being.

- **Handicap**: It refers to the disadvantages encountered by individuals because of impairment or handicap and reflects the interaction between the physical level, the functional capacity level and the level of social structures, support and attitudes.

- **Neuropsychology**: It refers to a form of psychology which aims to enhance the use of psychological assessment data to diagnose brain damage.
• Rehabilitation: It refers to an integrated program of interventions that empower individuals with disabilities and chronic health conditions to achieve ‘personally fulfilling, socially meaningful and functionally effective interaction’ in their daily context.

1.7 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short Answer Questions

1. What are the main objectives of rehabilitation psychology?
2. How are rehabilitation psychologists trained?
3. What are the methods of rehabilitation psychology?
4. Write a short note on the unique features of rehabilitation psychologist.
5. What was the main objective of Kurt Lewin’s field theory?
7. How is impairment different from disability?

Long Answer Questions

1. Discuss the role of veteran administration especially during the time of Civil War.
2. Explain the mission of The National Council on the Psychological Aspects of Physical Disability (NCPAPD).
3. Analyse in detail the scope of rehabilitation psychology.
4. Discuss the main functions of rehabilitation psychologist.
5. What are the issues resolved by a rehabilitation psychologist? Explain in detail.

1.8 FURTHER READINGS


UNIT 2  COMPETENCIES OF REHABILITATION PSYCHOLOGISTS

Structure
2.0 Introduction
2.1 Objectives
2.2 Professional Competencies of Rehabilitation Psychologists
  2.2.1 Nature of Work Settings of Rehabilitation Psychologist
2.3 Designing and Implementing Training Programs for Rehabilitation Psychologists
2.4 Answers to Check Your Progress Questions
2.5 Summary
2.6 Key Words
2.7 Self Assessment Questions and Answers
2.8 Further Readings

2.0 INTRODUCTION

Rehabilitation psychology is defined as a specialty area within professional psychology which helps an individual with an injury or illness which may be chronic, congenital or traumatic including the family. It helps people in achieving optimal physical, psychological and interpersonal functioning. The main objective of rehabilitation psychology is the provision of services consistent with the level of impairment, disability and handicap relative to the personal preferences, needs and resources of an individual with a disability.

Rehabilitation psychologist comprises of interdisciplinary teamwork as a condition of practice and services within a network of biological, psychological, social, environmental and political considerations in order to achieve optimal rehabilitation goals.

In this unit, the competencies of rehabilitation psychologists have been discussed. The importance of setting in rehabilitation psychology and training programs used by psychologists to help individuals has been explained. The unit will also explain the important aspects related to rehabilitation therapy.

2.1 OBJECTIVES

After going through this unit, you will be able to:

- Identify the two main professional competencies of rehabilitation psychology
- Discuss the components of core and professional competencies
2.2 PROFESSIONAL COMPETENCIES OF REHABILITATION PSYCHOLOGISTS

The profession of rehabilitation psychology is grounded in human rights, the value of work, the importance of community integration and understanding the strengths and weakness of the client. Thus, certain core competencies are essential to bring about a positive and an efficient change in an individual’s life.

There are two main types of competencies and are as follows:

1. Foundational or core competencies: Foundational or core competencies focus on the basic skills or knowledge that is essential for providing effective and efficient services to clients. It caters to basic assumptions and principles of rehabilitation and the basic knowledge and skills that each rehabilitation psychologist must carry irrespective of the set up he or she later specializes or chooses to work in.

2. Professional competencies: Professional competencies are deemed to be a skill or knowledge required being able to provide effective rehabilitation services in specific areas of rehabilitation. For instance, the skills needed to deal with a person having special needs or one with hearing or speech impairment are very different from the skills needed to rehabilitated and integrate a mentally ill person back into society.

We will in the following section discuss the components of the main type of competencies.

Core Competencies

The core competencies consist of the following skills:

- **Psychosocial foundations of behaviour:** An understanding of nature and the needs of the individual, at all developmental levels, from a psychological and sociological perspective.

- **Knowledge of disability and disadvantages:** An understanding of the causes of disability, the resultant conditions and the impact of disability on individual functioning in social, educational and vocational environment.

- **Case and caseload management:** An understanding of the importance of case management and caseload management to provide effective rehabilitation services by ensuring that the levels management exercised with individual cases and caseloads is effective and efficient.
• **Legal and policy aspects of disability, disadvantages, and rehabilitation:** An understanding of the legislation that impacts upon the provision of health, welfare and rehabilitation services for persons who are disadvantaged or who have disabilities.

• **Research and evaluation:** An understanding of research in the rehabilitation field and appropriate evaluation of rehabilitation services to design effective programs and a capacity to integrate current research literature into clinical practice, and other functional competency domains.

• **Individual and cultural diversity:** Awareness and sensitivity and skills in working professionally with diverse individuals, groups, and communities who represent various cultural and personal backgrounds and characteristics defined broadly in APA policy.

**Professional Competencies**

The professional competencies include the following skills:

• **Assessment:** The psychologists should be able to conduct assessment and diagnosis of problems of the client, understand the capabilities and issues associated with individuals, groups or organizations.

• **Vocational assessment:** An understanding of vocational assessment strategies including the essential areas to be assessed and utilizing the data to generate realistic vocational options with the clients.

• **Consultation:** The ability to provide expert guidance or professional assistance in response to client’s needs or goals.

• **Supervision:** Supervision and training in different professional services recommended to or provided to the client.

• **Management and administration:** Manage delivery of services catering to the needs of the client and ability to manage different chain of programs associated with the client.

In addition to competencies, a rehabilitation psychologist also possesses a specific set of personal qualities such as:

• An interest in and empathetic understanding of people

• A belief in and a capacity to empower people and promote self-management

• Problem solving and strategy formation skills

• Objectivity

• Flexibility and a positive attitude to change

• Creativity and innovation

• A result focused approach

• Perseverance and resilience
Competencies of Rehabilitation Psychologists

• A well-developed social conscience
• Effective written and oral communication skills

2.2.1 Nature of Work Settings of Rehabilitation Psychologist

Settings refer to the places/facilities where rehabilitation services are delivered. Rehabilitation settings include:

- **Hospital/centers settings:** For example, general hospitals, rehabilitation wards within general hospitals, specialized rehabilitation hospitals and centers. In such set ups, rehabilitation psychologist serves a wider range of populations such as individuals with brain injuries, individuals with spinal cord injuries, geriatric population, individuals with neuromuscular disorder, individual with chronic pain disorder and people with medical and psychiatric conditions such as cancer, multiple sclerosis, developmental disorder, psychiatric disability, substance abuse, deafness or hearing loss, intellectual disability, blindness and vision loss and impairment by educational or other disadvantages.

- **Other institutional settings:** For example, nursing homes, respite care centers (short term stay for elderly or disabled people) and military residential settings. People with severe disabilities require extensive and intensive long term care focusing on their activities of daily living and enhancing their functional independence as far as possible. Some clients with such disabilities fail to reach a state of normal living and continue to need assistance throughout their life.

- **Community based settings:** For example single or multi-professional practices (office or clinic), homes, schools, and workplaces. Rehabilitation psychologist’s work in different set ups and caters to a wide variety of people. At school, they are involved with children with physical and mental disabilities such as ADHD, learning disability, autism spectrum disorder, hearing impaired, cerebral policy and polio at homes, they are involved in the care of bed-ridden or severe ill (medical or and psychiatric) population. At work places, they aim to help disabled people work effectively and lead a life of dignity.

Models of service delivery or the ways in which rehabilitation services/measures can be delivered include the following:

- **Inpatient:** If the patient recovers to the point that they no longer need the level of care provided by hospital but they are still not capable of living unassisted they are sent to an inpatient rehabilitation facility.

- **Outpatient (day rehabilitation, half way homes):** Once the patient has recovered enough to go home from either the hospital or the inpatient rehabilitation facility, they are often given some amount of outpatient rehabilitation specific areas of impairment.
- **Outreach:** It includes in-reach, mobile and tele-rehabilitation.
- **Home-based rehabilitation services:** It is set up was for special needs of special population such as geriatric population.

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<th>Check Your Progress</th>
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<td>1. State the premise of foundational or core competencies.</td>
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<td>2. What is vocational assessment?</td>
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### 2.3 DESIGNING AND IMPLEMENTING TRAINING PROGRAMS FOR REHABILITATION PSYCHOLOGISTS

Several designing and training programs for rehabilitation psychologists have been designed by eminent psychologists. The training programs for rehabilitation psychologist strive to develop competencies as applied to the specialized populations, problems, and procedures in the six core areas of:

1. **Assessment:** The assessment estimates the client’s skills and supports the context of the environment in which the client chooses to live, learn, socialize, and work. The assessment contains three components: an overall rehabilitation goal, a functional assessment and a resource assessment.

2. **Intervention:** There are different types of intervention modalities that are actively followed such as psycho-therapeutics, vocational training, special education and CBT.

3. **Consultation:** Rehabilitation psychologists are consulted by different populations so that they can be better habilitated.

4. **Research and evaluation:** An understanding of research in the rehabilitation field and appropriate evaluation of rehabilitation services to design effective programs and a capacity to integrate current research literature into clinical practice, and other functional competency domains is required.

5. **Supervision and teaching:** It includes research and teaching of psychology students and other health trainees about the requirements of people with special needs. It also focuses on development of policies for health promotion, and advocacy for persons with disabilities and chronic health conditions.

6. **Management and administration:** Some understanding of management and administration is also required as rehabilitation psychologists also work in different hospitals and work place settings.

   Training program in rehabilitation psychology consists of a planned, structured, cumulative and logically-sequenced program of didactic and experiential education and training activities for individuals who wish to seek an expertise in this field.
Rehabilitation psychologists help individuals recover from illness, injury, surgery, stroke, cardiac events or other medical issues and regain functional abilities and independence lost due to these events. Rehabilitation psychologists work to meet the following objectives:

- Prevention of the loss of function
- Slowing the rate of loss of function
- Improvement or restoration of function
- Compensation for loss of function
- Maintenance of current function

In addition, there are seven areas of rehabilitation where rehabilitation psychologists actively work.

- **Physical**: The physical type of rehabilitation therapy works to improve movement dysfunction. Therapists work with patients to restore movement, strength, stability and/or functional ability and reduce pain via targeted exercise and a range of other treatment methods.

- **Occupational**: The occupational aspect of rehabilitation therapy focuses on restoring an individual’s ability to perform necessary daily activities. This may mean working to improve fine motor skills, restore balance, or assist patients in learning how to increase their functional ability via use of adaptive equipment, among other potential treatment options.

- **Respiratory**: This form of rehabilitation therapy works to help patients who have breathing disorders or difficulties decrease respiratory distress, maintain open airways and, when necessary, learn how to use inhalers and supplemental oxygen properly.

- **Cognitive**: It is also commonly called cognitive-behaviour rehabilitation, this type of therapy works with patients to improve learning, attention, memory, thinking and reasoning skills and other cognitive deficits.

- **Vocational**: The vocational aspect of rehabilitation therapy is geared towards preparing individuals to return to work after an injury, illness, or medical event.

- **Hearing and speech**: The hearing and speech of rehabilitation therapy is used to address difficulties with speech, communication and/or swallowing.

- **Mental illness**: It aims at helping mentally ill patients to get rehabilitated back into the society so that they can lead a more functional, independent life and with respect and dignity.
Check Your Progress
3. What are the different types of intervention modalities?
4. What is the occupational aspect of rehabilitation therapy?

2.4 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Foundational or core competencies focus on the basic skills or knowledge that is essential for providing effective and efficient services to clients.
2. Vocational assessment is an understanding of vocational assessment strategies including the essential areas to be assessed and utilizing the data to generate realistic vocational options with the clients.
3. There are different types of intervention modalities that are activity followed such as psycho-therapeutics, vocational training, special education and CBT.
4. The occupational aspect of rehabilitation therapy focuses on restoring an individual’s ability to perform necessary daily activities. This may mean working to improve fine motor skills, restore balance, or assist patients in learning how to increase their functional ability via use of adaptive equipment, among other potential treatment options.

2.5 SUMMARY

- The profession of rehabilitation psychology is grounded in human rights, the value of work, the importance of community integration and understanding the strengths and weakness of the client.
- Foundational or core competencies focus on the basic skills or knowledge that is essential for providing effective and efficient services to clients.
- Professional competencies are deemed to be a skill or knowledge required being able to provide effective rehabilitation services in specific areas of rehabilitation.
- The psychologists should be able to conduct assessment and diagnosis of problems of the client, understand the capabilities and issues associated with individuals, groups or organizations.
- People with severe disabilities require extensive and intensive long term care focusing on their activities of daily living and enhancing their functional independence as far as possible.
- Several designing and training programs for rehabilitation psychologists have been designed by eminent psychologists.
The training programs for rehabilitation psychologists strive to develop competencies as applied to the specialized populations, problems, and procedures in the six core areas.

- The assessment estimates the client’s skills and supports the context of the environment in which the client chooses to live, learn, socialize, and work.
- There are different types of intervention modalities that are activity followed such as psycho-therapeutics, vocational training, special education and CBT.
- An understanding of research in the rehabilitation field and appropriate evaluation of rehabilitation services to design effective programs and a capacity to integrate current research literature into clinical practice, and other functional competency domains is important.
- Training program in rehabilitation psychology consists of a planned, structured, cumulative and logically-sequenced program of didactic and experiential education and training activities for individuals who wish to seek an expertise in this field.
- Rehabilitation psychologists help individuals recover from illness, injury, surgery, stroke, cardiac events or other medical issues and regain functional abilities and independence lost due to these events.
- Therapists work with patients to restore movement, strength, stability and/or functional ability and reduce pain via targeted exercise and a range of other treatment methods.
- The respiratory aspect of rehabilitation therapy aid patients who have breathing disorders or difficulties, this form of rehabilitation therapy works to help them decrease respiratory distress, maintain open airways and, when necessary, learn how to use inhalers and supplemental oxygen properly.
- The vocational aspect of rehabilitation therapy is geared towards preparing individuals to return to work after an injury, illness, or medical event.

### 2.6 KEY WORDS

- **Consultation**: It refers to the ability to provide expert guidance or professional assistance in response to client’s needs or goals.
- **Occupational rehabilitation therapy**: It refers to an aspect of rehabilitation therapy which focuses on restoring an individual’s ability to perform necessary daily activities.
- **Physical rehabilitation therapy**: It refers to an aspect of rehabilitation therapy which works to improve movement dysfunction.
- **Settings**: It refers to the places/facilities where rehabilitation services are delivered.
2.7 SELF ASSESSMENT QUESTIONS AND ANSWERS

Short Answer Questions
1. What are the two main competencies of rehabilitation psychology?
2. How are rehabilitation services measured?
3. What are the main qualities of a rehabilitation psychologist?
4. State the premise of physical type of rehabilitation therapy.
5. What are the objectives of rehabilitation psychology?

Long Answer Questions
1. Discuss the main components of core competencies.
2. Explain the skills required in professional competencies.
3. What are the main rehabilitation settings? Describe in detail.
4. Interpret the six core areas of training programs.
5. Explain in detail any two aspects of rehabilitation therapy.

2.8 FURTHER READINGS

UNIT 3  PSYCHOLOGICAL REHABILITATION AND INTERVENTION

Structure

3.0 Introduction
3.1 Objectives
3.2 Psychological Rehabilitation: Definition and Basic Principles
   3.2.1 Assessment, Diagnosis and Intervention
3.3 Intervention
   3.3.1 Psychoanalytical Therapy
   3.3.2 Client Centered Therapy or Humanistic Therapy
   3.3.3 Cognitive Behaviour Therapy
   3.3.4 Rational Emotive Therapy
   3.3.5 Supportive Therapy
   3.3.6 Augmentative Therapy
   3.3.7 Behaviour Therapy
3.4 Answers to Check Your Progress Questions
3.5 Summary
3.6 Key Words
3.7 Self Assessment Questions and Exercises
3.8 Further Readings

3.0 INTRODUCTION

Psychological rehabilitation helps disabled individuals to develop emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support. The main objective of psychological rehabilitation is to help individuals who have special needs so that they can lead a happy and confident life.

Psychological rehabilitation intervention can be used in cases of mental disorders, harmful addictions and in wellness programs. It is a key to psychosocial and social integration difficulties that usually people undergo. These interventions give support in their daily lifestyles in the most independent and decent manner. The main aim of this type of intervention is to focus on personal and social skills and lay a guideline for the affected people and their families.

In this unit, the principles of rehabilitation psychology and its various instruments have been discussed. The various intervention programs and their theories have been explained in detail. The unit will also provide an in-depth knowledge about the assumptions and techniques related to the theories.
3.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the twelve principles of rehabilitation psychology
- Explain the process of psychiatric rehabilitation psychology and its instruments
- Analyse the aim of psychoanalytical theory
- Interpret the assumptions of client centred therapy or humanistic therapy
- Explain the objectives and techniques of cognitive behaviour therapy
- Discuss the theory of causation and change in Rational Emotive Behaviour Therapy (REBT)
- Identify the aims of supportive and augmentative therapy
- Examine the assumptions of behaviour therapy

3.2 PSYCHOLOGICAL REHABILITATION: DEFINITION AND BASIC PRINCIPLES

As you have learnt before, rehabilitation psychology is defined as the study and application of psychological principles on behalf of persons with physical, sensory, cognitive, developmental or emotional disabilities.

According to Psychiatric Rehabilitation Association (PRA) there are 12 principles and values which are enlisted as follows:

1. Principle 1: It states that psychiatric rehabilitation practitioners believe that all individuals have the capacity for learning and for growth by instilling hope and respect.
2. Principle 2: It states that the practitioners try to make sure that they provide the clients with services which are culturally relevant as it’s a central to recovery.
3. Principle 3: It states that practitioners and client should engage in a mutual decision-making process and should be provided with necessary information which the client is entitled to know.
4. Principle 4: It states that a practitioner builds on the individual’s strengths and capabilities.
5. Principle 5: It states that psychiatric rehabilitation practices are person-centered which are designed to address the unique needs of the client with regard to their values, hopes and aspirations.
6. Principle 6: It says that rehabilitation practices gives support to full integration of the client in recovery and facilitate them to exercise their citizenship rights.
as well as help them to accept the responsibilities and explore opportunities which come when being a part of a community.

7. Principle 7: It states that practitioners promote self-determination and empowerment and have the right to make their own decisions.

8. Principle 8: It states that the practices assist the development of personal support networks like within a community, peer support, and self-and mutual help groups.

9. Principle 9: It states that the rehabilitation practices attempt to help clients improve the quality of all aspects of their lives.

10. Principle 10: It states that rehabilitation practices promote health and well-being and also promote clients to carry out individualized wellness procedure.

11. Principle 11: It emphasis on evidence based, promising, and emerging best practices that generate outcomes congruent with personal recovery.

12. Principle 12: It states that the services must be readily available to all individuals whenever they require them which should also well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices.

3.2.1 Assessment, Diagnosis and Intervention

The first phase of psychiatric rehabilitation process is psychiatric rehabilitation assessment which varies greatly in terms of its formality, specificity, and documentation. In general, the practice of psychiatric rehabilitation involves consumers figuring out the residential, vocational, educational, and social goals which they want to achieve and facilitating them to attain and build up skills and supports they require to accomplish their goals. The purpose of these assessment is to describe the client’s skills and the environmental resources with respect to their impact on the client’s overall rehabilitation goals on the basis of the client and his/her significant other’s perspective and objective evaluation.

The assessment estimates the client’s skills and supports the context of the environment in which the client chooses to live, learn, socialize, and work. The overall rehabilitation goal identifies specific environments in which the client chooses to live, learn, socialize; and work during the next 6 to 18 months which the client currently is in and in which the client wants to stay; or the environment may be one the client desires to move to within the next year or two. After the environment goal has been determined, assessment instruments may then be used to balance the interview process to help the client understand what skills and supports need to be developed to maximize their success and satisfaction in the chosen goal. The overall rehabilitation goal is established during a series of interviews with the client, in which the client’s satisfaction and dissatisfaction with the current environment and choice of future environment is explored. The rehabilitation goal is vital to the assessment because the hope of its achievement motivates the client to engage in the assessment; goal focuses the practitioner and client on those skills and supports that are relevant to success.
Psychiatric assessment typically begins with a series of interviews with the client; two principles guide the assessment interview. First, the practitioner tries to maximize the involvement of the client through the process of interview. Then, the collected information is recorded in a way that maximizes the client’s understanding of the assessment results. Involving the client facilitates active participation by him/her which in turn increases the their ownership of the rehabilitation assessment.

The practitioner needs to work at connecting with the client if the client does not participate in the interview using the practitioner’s skills. A structured assessment instrument can be used to complement the rehabilitation assessment interview. An instrument is used to save time, money, and/or effort while providing the same information that would otherwise be obtained through the interview or direct observation. The benefit of using a test in psychiatric rehabilitation assessment is that a ‘good’ test is the one which is valid and reliable and provides standardization, which is important if the objective of assessment is to compare two clients with each other, to certain norms, or to themselves at different points in time. In this fashion, tests can provide assessment information that could simply be estimated from an interview for example, IQ, aptitude scores, interest profiles. Psychiatric assessment skills allow the practitioner to carry out a truly personalized and comprehensive assessment. Without a skilled practitioner, assessment can revert to a simple checklist of client functioning, seemingly independent of the client’s preferred goals and the specific requirements of the client’s own environment. The practitioner must select the instrument most appropriate to the specific client assessment situation, from the several instruments available which should be clear, brief, environmentally specific, and skills-and/or resources-oriented.

Symptom/Diagnostic Instruments

The preponderance of the assessment literature for people with psychiatric disabilities is in the area of psychiatric symptoms and diagnosis. According to the Diagnostic and Statistical Manual, 4th ed., the Structured Clinical Interview for DSM-IV (SCID) is a structured interview intended to improve the accuracy and reliability of psychiatric diagnosis (First, Gibbon, Spitzer & Williams; 1997). The Brief Psychiatric Rating Scale (BPRS) which is an 18-item rating scale measures severity of symptoms completed after conducting a semi-structured interview with the client (Overall & Gorham, 1962). The Symptom Checklist-90-R (SCL-90-R) is a 90-item self-report inventory designed to measure psychological symptomatic distress (Derogatis, 1994). It is designed to function as both a short screening instrument and as an outcome measure of psychological distress. The Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein & Opler, 1987), the Scale for the Assessment of Positive Symptoms (SAPS; Andreasen, 1984), the Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1983), and the Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978), are four other instruments used to make distinctions between specific syndromes or patterns of symptoms.
Health Status

In the past few years, assessment of health status and needs has increased with people with psychiatric disabilities. The significant problem with this population that often goes unrecognized and untreated is physical health (Skriner & Hutchinson, 1994). Most health measures have been validated on general populations, and a few have included populations of people with psychiatric disorders. The MOS 36-Item Short Form Health Survey (SF-36) was developed as a brief version of the Rand Medical Outcomes Study on the effect of various health care structures on the health status of people with chronic conditions (Ware & Sherbourne, 1992; Ware, Snow, Kosinski, & Gandek, 1993). It can be administered as a brief interview or self-report instrument and measures physical, emotional, social, and mental health functioning. The Sickness Impact Profile (SIP) is a behavioural measure of dysfunction connected to illness (Bergner, Bobbit, Carter, & Gilson, 1981). The SIP contains three major dimensions: independent categories (for example, eating, recreation, work), physical (for example, mobility, body care, movement), and psychosocial (for example, social interaction, emotional behaviour, communication). The Quality of Well Being scale (QWB) was designed to measure the impact of health programs on the health status of different groups of people (Kaplan, Bush, & Berry, 1976). The International Classification of Functioning and Disability (1999) (formerly the International Classification of Impairments, Disabilities and Handicaps) (ICIDH-2) developed by the World Health Organization is a classification system of body structures and functions, activities and behaviours, and participation in roles in society based on WHO’s model of the disablement process, intended to be a universal system categorizing both strengths and limitations caused by medical conditions for use in research and clinical work across cultures in the world and is currently in the process of testing and field trials.

Global Functioning/Status Measures

Webster (1990) defined functioning as activities or performance, ‘a natural or proper action for which a person, office, thing or organization is fitted or employed’. An assessment of functioning may focus on global functioning or specific evaluation of skills and behaviours. Global measures might stress on performance in particular roles (for example, spouse, worker), performance in particular domains (social, emotional, psychological), or status (employment, educational, residential) to indicate functioning. At times, global functioning instruments also include measures of symptoms. Global measures focus on the outcome of functioning (for example, has been employed full time, is married, and has friends) while skill assessments focus on specific sets of behaviours (for example, initiating conversations, expressing feelings, budgeting money). Functional assessment in psychiatric rehabilitation involves the latter. However, measures of global functioning are often used in outcome assessment approaches. Most of the measures of global functioning include both symptoms and general functioning. The Behaviour and Symptom Identification
Scale (BASIS-32) a 32-item self-report measure includes items related to symptoms and role functioning (Eisen, Dill, & Grob, 1994). Respondents rate the degree of difficulty with each item. It contains five subscales: relation to self and others, daily living and role functioning, depression and anxiety, impulsive and addictive behaviour, and psychosis. The Global Assessment of Functioning Scale (GAF) (is a clinician-rated, single-item measure that was included as a measure of Axis V in the DSM-III-R and revised for DSM-IV (APA, 1994; Goldman, Skodol, & Lave, 1992). The clinician assigns a number on a continuum from 0 to 100, which represents the person’s overall functioning in psychological, social, and occupational domains, using behavioural descriptors to assign a rating. The disability rating Form is a 5-item scale that focuses specifically on the areas of functioning affected in people with psychiatric disabilities that are used by the Social Security Administration to define disability (Hoyle, Nietzel, Guthrie, Baker-Prewitt, & Heine, 1992). It is a brief instrument with each item rated on a 5-point scale of severity of disability and duration of disability, each area completed by a clinician who knows the person well with ratings in the following five areas: activities of daily living, social functioning, concentration and task performance, adaptation to change, and impulse control. Another brief measure is the Role Functioning Scale (RFS) that includes four single-item scales evaluating the functioning in the areas of working/productivity, independent living and self-care, immediate social network relationships, and extended social network relationships (Goodman, Sewell, Cooley, & Leavitt, 1993). Each item is rated on a 7-point scale from minimal to optimal functioning, with behavioural descriptions of each rating. The Multnomah Community Ability Scale is a 17-item clinician-rated scale (Barker, Barron, McFarland, & Bigelow 1994). Each item is rated on a 5-point scale representing ability to disability, domains include those related to symptoms and health, activities of daily living (for example, managing money), social competence (for example, social interest, social network), and behavioural problems (for example, impulse control, substance abuse).

The Life Skills Profile (LSP) is a 39-item, 5-scale instrument developed to measure function and disability in adults with schizophrenia (Rosen, Hadzi-Pavlovic, & Parker, 1989), completed by someone who knows the person well. Items are not based on symptoms but on behaviours and problems associated with schizophrenia. Each item is rated on a 1 to 4 scale on the basis of the amount of difficulty the person has on the item. The five sub-scales are self-care, non-turbulence, social contact, communication, and responsibility. The emphasis is on limitations or difficulties in functioning, not on performance of specific skills. The Slaton Westphal Functional Assessment Inventory (SWFA) is a new 77-item instrument, developed to be used by clinicians in assessing levels of functioning on nine sub scales: adaptation to mental illness, substance abuse, basic needs, finances, social relations/support system, recreation/leisure, employment/education, physical health, and institutional placement (Slaton & Westphal, 1999). Items are rated on a 6-point frequency scale (from never to always) with descriptive anchors. In
addition, review of specific items for their relationship to residential or community skills versus domains of functioning is needed to evaluate the measure’s usefulness as a skills-oriented assessment instrument.

Skills Oriented Instruments

The initial impetus for development of instruments with a functional focus was, in part, the establishment of the Community Support Program of the National Institute of Mental Health (Stroul, 1984; Turner & Ten Hoor, 1978), developed for use with persons with psychiatric disabilities. The following is a description of instruments assessing skills related to particular environments—the residential, social, vocational, or educational environments.

Residential/Community Environments

Many states develop their own forms for measuring the functional levels of their clients in Community Support Program; these forms often include rating of client skills. The CSS-100 (New York State Office of Mental Health, 1979) was used by many community support systems. Similarly, the Multi-Function Needs Assessment (Angelini, Potthof, & Goldblatt, 1980) used in Rhode Island and Connecticut included assessment of functioning (self-care, household skills, personal appearance), psychiatric symptoms, and current use of services and has been revised (Weiner & Michaels, 1987) and used in a Hawaii state hospital (Weiner, 1993). Other forms have been used in New Jersey (New Jersey Division of Mental Health and Hospitals, 1979) and Michigan (Cornhill Associates, 1980).

The Katz Adjustment Scale (Katz & Lyerly, 1963) was developed many years before the community support program but is still in use in a variety of settings. The wide use of this scale is most likely the result of the significant data available on reliability, validity, sensitivity, and norms, additionally, as materials for use in training staff to administer the scale (Weissman, 1975). Though many items measure psychiatric symptoms (for example, has trouble sleeping, attempts suicide, talks to himself or herself) and behavioural excesses (for example, has periods when he or she cannot stop moving, has temper tantrums), this scale constitutes items measuring community adjustment skills. Skills assessed consist of physical skills (for example, helps with household chores), emotional/interpersonal skills (for example, gets along with neighbors), and intellectual skills (for example, helps with the family budgeting). The skills are often out forth positively (i.e., ‘the client does this’) and are rated on a frequency scale (i.e., ‘is not doing, is doing some, is doing regularly’). The measurement provides a picture of skill strengths and skill deficits.

The Independent Living Skills Survey (ILSS) is a clinician-rated or self-administered inventory of activities of daily living (Wallace, Kochanowicz, & Wallace, 1985). Items are rated on the frequency of occurrence of the behaviour and the degree of behavioural problem during the past month (Wallace, 1986). This scale does not include socio-emotional or interpersonal skills. Another detailed
scale is the Community Competence Scale, which is a 128-item, semi-structured interview that includes 18 subscales (Searight, Oliver, & Grisso, 1983), in which most items require the person being interviewed to perform a task or provide factual information, while the remaining items require a response requiring judgment or reasoning. Subscales cover such factors as managing money, caring for medical needs, proper diet, social adjustment, and judgment.

The St. Louis Inventory of Community Living Skills is a more recent instrument designed to focus on discrete community living skills, used to evaluate rehabilitation programs, to specify a residential placement, or to measure the impact of skills training interventions (Evenson & Boyd, 1993). It is a 15-item instrument rated on a 7-point scale from few or no skills to very adequate skills and each item is given descriptors, or anchors, and raters are instructed to rate behaviours that they observe, not potential ability. Items cover skills in personal care/physical skills (personal hygiene, grooming, dress skills, self-care, health practices, meal preparation, clothing maintenance), social skills (communication, sexuality, leisure activities, use of resources), and intellectual skills (handling money, handling time, safety, problem solving). Fritz & Evenson, 1999 stated that it seems effective in differentiating between people in three levels of residential care compared with other measures of global functioning. The Katz Adjustment Scale (Katz & Lyerly, 1963) developed many years before the Community Support Program is still in use in a variety of settings. The wide use of this scale is most likely the result of the significant data available on reliability, validity, sensitivity, and norms, as well as materials for use in training staff to administer the scale (Weissman, 1975). Although many items measure psychiatric symptoms and behavioural excesses, the scale consists of items measuring community adjustment skills. Skills assessed include physical skills, emotional/interpersonal skills and intellectual skills.

Social Environment

Many of the measures were developed to examine the effects of behaviour therapy interventions used to increase the social skills of people with severe psychiatric disabilities. The Social Performance Survey Schedule (SPSS) is a 100-item self-report inventory that can also be completed by significant others (Lowe & Cautella, 1978), the items are rated on how frequently the person demonstrates the positive or negative behaviours in question. Another self-report inventory is the Rathus Assertiveness Schedule (RAS; Rathus, 1973). The RAS is a 30-item measure designed to assess assertiveness which rated on a 6-point scale on the extent to which the item is true for the individual. Although originally developed on a non-psychiatric group of people who were participating in assertiveness training, the measure appears to be a reliable and valid measure of assertiveness skills. There are several role-play tests that assess social skills. One is the Interpersonal Behaviour Role Playing Test (IBRT; Goldsmith & McFall, 1975). The respondent views 2S tape-recorded simulated interpersonal situations and is asked to role-play a response to the situation. Responses are then rated on a scale of 0 to 2, with the highest score representing those who met the minimum standard for competence.
in that situation, these situations were drawn from the Interpersonal Situation Inventory (Goldsmith & McFall, 1975), which is a self-report version of this test in which respondents rate themselves on a 5-point scale of how comfortable and competent they feel in the situation described. The Simulated Social Interaction Test (SSIT) is a role-play test of social skills in dealing with eight simulated anxiety-provoking situations (Curran, 1982). In which a narrator describes a situation, and a confederate delivers a prompt, to which the individual responds. Trained raters then score the responses on social skill competence. The Assessment of Interpersonal Problem Solving Skills (AIPSS) is a videotaped role-play test of social skills in which an individual is shown a series of interpersonal problem vignettes and is asked to identify the problem, describe a solution, and role-play that solution, which a trained rater then rates the various components or subscales of the receiving, processing, and sending skills model of social skills developed by Wallace (Donahoe, Carter, Bloem, Hirsch, Laasi, & Wallace, 1990). The Social Problem Solving Assessment Battery (SPSAB) is a battery that incorporates a role-play test to measure social skill and problem-solving ability (Sayers, Bellack, Wade, Bennett, & Fong, 1995). The intent of the measure is to evaluate the skills that enable individuals to identify social problems, generate response alternatives, evaluate the effectiveness of responses, and carry out effective interactions. One key feature of this tool was the contribution of family members, providers, and people with schizophrenia in identifying the problem situations. The battery contains three assessments: a Role-Play Test (RPT), a Response Generation Test (RGT), and a Response Evaluation Test (RET). The RPT consists of six role plays that involve a confederate and are videotaped, RGT includes six videotaped interactions between two individuals who have a conflict or problem, and the individual attempts to identify the problems and propose solutions, and RET consists of 12 audio taped interactions, both effective and ineffective, that the individual rates on a 5-point scale of effective to ineffective.

**Vocational (Work) Environment**

The Standardized Assessment of Work Behaviour (Griffiths, 1973, 1975, 1977; Watts, 1978) assesses a broad range of skills (for example, uses tools/equipment, communicates spontaneously, grasps instructions quickly) measures vocational skills of clients with psychiatric disabilities. Items are rated on a continuum from skill strength (for example, looks for more work) to skill deficit (for example, waits to be given work). The Functional Assessment Inventory (Crewe & Athelstan, 1984) focuses exclusively on functional limitations which consist of seven major functional dimensions which assess: adaptive behaviour, motor functioning, cognition, physical condition vision, and vocational qualifications. Some items look at strengths, but these are considered ‘moderator variables’, they are meant to account for positive attributes or abilities that appear to override limitations. The Situational Assessment: Scales to Assess Work Adjustment and Interpersonal Skills (Rogers, Hursh, Kielhofner, & Spaniol, 1990; Rogers, Sciarappa, & Anthony, 1991), the instrument contains two separate scales consisting of 21 work adjustment
skills and 14 interpersonal skills. Each item is rated on a behaviourally anchored rating scale based on observation of the person in a preferred work environment. The job Performance Evaluation Form (Schulteis & Bond, 1993), an adaptation of the Thresholds Monthly Work Evaluation Form (Bond & Friedmeyer, 1987) is a 25-item checklist of items in four categories: work readiness (for example, attendance, grooming), work attitudes (for example, accepts responsibility, flexibility), interpersonal relations (for example, cooperation and rapport with coworkers), and work quality and performance (for example, follows directions, accuracy). Each item is rated on a 3-point scale of needs improvement, meets expectations, or highly satisfactory. The Work Behaviour Inventory (WBI) a 36-item work performance assessment instrument specifically designed for people with severe mental illness (Bryson, Bell, Lysaker, & Zito, 1997), measure is used in observing the person in a real work situation and consists of five sub-scales: work habits, work quality, personal presentation, cooperativeness, and social skills. Items are rated on a 5-point scale from consistently inferior to consistently superior. Although most items are behavioural in nature (i.e., accepts constructive criticism, takes initiative when work is available), there are a few items that require some judgment (i.e., does not appear overly distant or aloof, seems comfortable when approached by others) or describe what the person should not do (i.e., refrains from inappropriate joking, does not become overexcited or aggressive).

Educational (School/Training) Environment

Less focus is given on the skills needed by students to succeed in educational settings, such as skills in note-taking, test taking, using campus resources, and connecting with other students. The ERIC database revealed a few measures of study habits that are not commonly circulated and have little reliability or validity data available. The Student Skills in Educational Settings (Walsh, Sharee, & Sullivan, 1989) is one of the checklists developed specifically for students with psychiatric disabilities receiving supported education services. It can be used with students to identify their skill strengths and deficits, even though it’s unpublished. Skills are assorted into four groups: environmental skills (i.e., commuting to campus, using administrative services, applying for financial aid), academic skills (i.e., using college resources, preparing for tests, in class participation), emotional skills (i.e., managing emotions, responding to feedback), and social skills (i.e., meeting new people, participating in on-campus groups). Despite no reliability or validity data are available; it is one of the instruments developed specifically for students with psychiatric disabilities.

Resources Oriented Instruments

The Multi-Function Needs Assessment (Angelini et al., 1980) consists of 'Current Services Profile', which lists services received during the previous month and the approximate amount of service (in hours per week) received. Even though no indication of the needed services that are not being received is included, the Current Services Profile does list a broad range of resources: people (for example, a friendly visitor),
places (for example, a child daycare center program), things (for example, prosthetics, medication), and activities (for example, recreational therapy). The Services-Utilization and Need Assessment (State of Alabama Department of Mental Health Services, 1984), another community support program instrument, lists service needs, service provider (i.e., if service need is being met), and barrier to service (if service need is unmet). Types of resources assessed includes people (for example, crisis service provider, advocate), places (for example, nutrition center), things (for example, transportation, medication), and activities (for example, training, planned recreational activity). Although reliability and validity data are not yet available, ongoing studies suggest the instrument is favorable in both areas. More recently, the needs and resources assessment interview (Corrigan, Buican, & McCracken, 1995) or self-report instrument combines identification of needs in specific domains of functioning with a review of the resources required to meet the identified needs. Individuals are also asked to rate their satisfaction with functioning in each of the domains, as well as to rate the importance of the need. The domains includes housing, physical health teeth, mental health, income and finances, education, job status, friends, family leisure time, spiritual life, legal problems, and drug-related problems. Camberwell Assessment of Needs is a similar instrument; it is a structured interview that focuses on 22 areas of functioning (Phelan, Slade, Thornicroft, et al., 1995). Needs are identified by asking about difficulties in each area, individual is also asked about how much help is received from friends and relatives, as well as service providers. The last section outlines the type of assistance needed as identified from the individual’s perspective, and a care plan is developed. One instrument that attempts to capture both social support and social networks is the Triangle Social Network/Social Support Protocol (Estroff, Illingworth, Lachiotte, & Schwartz, 1992), consists of instrumental support (i.e., food, money, shelter) and relational or affective support, measured by the quality of relationships. Social network includes the number and type of people in the network, amount of contact, and length of relationship. The Pattison Psychosocial Kinship Inventory (Pattison, De Francisco, Wood, Frazier, & Crowder, 197S) offers a systematic method for assessing the social system of an individual, in the area of social supports.

A psychiatric rehabilitation practitioner must have good interpersonal skills and requires being able to develop a trust-based relationship with the client, and assessments are not instrument dominated. The practitioner must be capable of involving clients in a psychiatric rehabilitation assessment process that the clients themselves understand. Although increasing numbers of psychiatric assessment instruments are focusing on skill and resource assessments as opposed to a symptom and pathological focus, these instruments are still limited in their clinical application. The most evident limitation is the lack of environmental specificity. Existing instruments, because of their need to be standardized, provide information relevant to general environments rather than specific environments (for example, a general work setting rather than a specific job site). To be used effectively, any assessment instrument must be integrated into the broader context of psychiatric rehabilitation, a process and partnership that is driven by the client’s goal.
Check Your Progress
1. What is the first phase of psychiatric rehabilitation process?
2. How are needs identified?
3. What is Pattison Psychosocial Kinship Inventory?

3.3 INTERVENTION

In this section we will discuss the theories related to the field of psychological rehabilitation.

3.3.1 Psychoanalytical Therapy

The psychoanalytical theory refers to a theory of personality and mental disorders. The term also denotes the procedure adopted by Sigmund Freud, the founder of psychoanalysis, to understand the functioning of mind and it is also widely used as a therapeutic modality. Psychoanalysis literally means the breaking down of the psyche into its constituent elements and their dynamic processes.

Psychoanalysis emerged as a direct outgrowth of the treatment of neurotic patients using hypnosis. When in his medical practice, Freud did not receive much success in treating hysterical patients with hypnosis; he came up with the method of catharsis, which required the patients to talk about their problems in conscious awareness. Soon, Breuer and Freud came to an understanding that symptoms represent repressed ideas that had not reached consciousness. These repressed ideas often manifest in an individual in the form of symptoms.

Freud gave up the hypnotic cathartic method on realizing that the events recalled during hypnosis could be revoked by patients in states of consciousness when these clients were prompted using leading questions by the therapist. Based on this premise, Freud developed a strategy which required the patients to lie on a couch with eyes closed and to concentrate on a particular symptom with the objective of recalling past memories, which later shaped the method of free association. The method of free association requires the patient to express freely whatever comes to his mind irrespective of whether it appears irrelevant, unpleasant, or trivial to the client.

With the new emphasis on recalling repressed memories into the conscious state, Freud observed that the same forces that led to repression interfered with the disclosure of the unconscious material during free association (resistance).

In addition, when Freud saw that the effects of hypnosis were transitory, he postulated that the therapeutic relationship was more essential than any techniques in bringing about the desired change and this gave way to the development of the psychoanalytical concept of transference.
The method of psychoanalysis is based on the following premise:

- It views human beings as struggling against their intra-psychic conflicts.
- These intra-psychic conflicts usually consist of inner, unknown desires and urges, largely libidinal and aggressive in nature, which an individual continually defends against by repressing them thus making them inaccessible to the conscious self.
- Mental phenomena result from a continual interaction of opposing forces.
- Human behaviour and motivations are changing at all times and this forms the basis for conflict and resistance, which tend to precipitate psychopathology.
- Mental phenomena reveal themselves at different levels ranging from the unconscious mind to the preconscious mind and, finally, to the conscious mind.
- The expression and integration of repressed wishes, desires and conflicts at the conscious level is likely to bring relief from the symptoms.
- Human beings have a tendency to pervasively avoid painful feelings or experiences by keeping unpleasant thoughts, wishes, and desires away from conscious awareness.
- Unresolved conflicts at various stages of development can also lead to pathology.

Based on the mentioned assumptions, the psychoanalytical method focuses on analyzing, interpreting and managing an individual’s transference and resistance. Transference refers to phenomena in which patients consistently projects his intense personal unresolved childhood feelings toward the analyst during psychoanalysis, whereas, resistance refers to any attempt that prevents the repressed or forbidden materials to become conscious. At any point in therapy, the transference can be transformed into resistance. Transference can be positive or negative in nature.

Positive transference refers to the expression of good feelings such as love, trust, admiration, respect, sympathy, and so on towards the analyst, that can act as a motivating force for the client to bring about the necessary change. On the other end, negative transference refers to equally intense bad feelings such as anger, hostility, mistrust, rebelliousness, and so on towards the analyst. In negative transference, the patient tends to undervalue the analyst in ways that are quite similar to the way the client feels towards his parents or other authority figures in the past. Both types of transference should be interpreted as they can impede the therapy process. Intense positive transference may take the form of resistance in which the patient avoids too much probing into his or her unresolved conflicts.

During the therapeutic process, the patient may psychologically regress to the earliest stages of development which is marked by the presence of unresolved
conflicts thus, providing a platform where these conflicts could now be resolved in the therapeutic process (known as transference neurosis).

Psychoanalysis also aims to confront, understand and resolve the various defense mechanisms used by the patient with the purpose of preventing anxiety evoking information out of consciousness.

Resistance refers to all the forces that prevent unconscious repressed memories to become conscious in the process of therapy. A client may show resistance to the transference, thereby preventing the development of a transference neurosis or may show transference resistance, in which the transference itself may take the form of resistance.

Freud further stated that resistance can be conscious or unconscious and can be produced by the ego, the id, or the superego. Conscious resistance occurs when the client deliberately withholds information from the analyst. Such resistance is transient and is usually rectified by pointing it out to the patient. Unconscious resistance, however, is more resilient and arises as a defense against uncovering repressed material.

Resistance can take multiple forms like an absolute silence of the client, or the unproductive over-talkativeness on the part of the client or avoidance of painful or emotion-laden topics or coming late for the session or missing sessions and or delaying or forgetting to pay one’s bill.

In psychoanalysis, the first task of the analyst is to manage resistances, which involves dealing with the various defense mechanisms adopted by the client before the repressed material can be dealt with. In psychoanalysis, the therapist makes a note of how the patient resists, what is being resisted, and the reasons for the same.

Another obstacle to analytical progress may be the analyst’s own strong reactions to the patient, or counter-transference, which can inappropriately enter the treatment if the analyst is not sufficiently aware of his or her personal feelings. Counter-transference refers to the analyst’s unconscious emotional needs, wishes, and conflicts that are evoked by the patient and have the potential of negatively influencing the analyst’s objective judgment and reason.

Counter-transference may arise when the therapist identifies with some concrete aspect of the patient’s personality or it may involve more general ingrained pathological patterns of his or her own behaviour, that the therapist is not consciously himself aware off. That is why psychoanalysis stresses that the therapist must undergo his or her analysis as a training requisite.

Counter-transference may manifest itself in multiple ways like providing special consideration for an attractive client or making an unavailable hour available or in failing to remember the changed appointment hour of an uninteresting client. Some of the common warning signs of counter-transference in analysis include experiencing uneasy feelings during or after sessions with certain patients; persistently
feeling drowsy or actually falling asleep during sessions; coming late for his session or extending sessions; making special financial arrangements; wishing to help the patient outside the session; dreaming about one’s patients or continuously thinking about them in one’s leisure time; acting in ways to win the client’s approval and wanting, or not wanting, the patient to terminate.

In psychoanalysis, a collaborative, rational and a trusting therapeutic alliance is essential, which focuses on forming an alliance with the patient using which the therapist helps the patient to distinguish between realistic, healthy, and appropriate behaviour and distorted, neurotic, and inappropriate behaviour. He or she also helps them to differentiate between fantasy and reality and is able to monitor the patient’s regression and irrationality. He or she also enables the patient to receive and comprehend the therapist’s communications rationally, to review and assess interpretations reasonably, to participate cooperatively and responsibly, and, to integrate the insights that are gathered in treatment.

Once a therapeutic relationship has been established, the therapist makes use of the techniques of confrontation, clarification, interpretation and working through to help the client to resolve the underlying, forbidden repressed conflicts.

Confrontation involves asking the client to face a particular event that he has been inappropriately avoiding. Clarification helps the client to differentiate important aspects from the unimportant ones and tries to elaborating on them. Interpretation involves making the client aware of the repressed conflicts based on the information the client brought to his consciousness during the therapy. Through interpretation, the therapist tries to attribute an underlying meaning or cause to the events in question. Working through involves providing repetitive progressive, and elaborated exploration of interpretations by the therapist to the client till he or she has been able to adequately integrate the repressed material in his consciousness.

The interpretive process makes use of the material revealed by the method of free association, dreams, slips of the tongue, and mislaying of objects. In psychoanalysis, the therapist should take into consideration when and how an interpretation should be delivered to the client. Interpretations are hypotheses that the client eventually accepts or rejects and hence may be modified in the light of new information.

Psychoanalysis also involves the interpretation of dreams. Freud regarded dreams as a royal road to the unconscious. Dreams seem to act as a wish-fulfillment of underlying instinctual repressed conflicts.

It is best suited for client having good ego functioning; who are highly motivated; who are capable of forming and maintaining a trusted therapeutic relationship; who are psychologically minded and show capacity for developing insight. It is best suited for the management of anxiety and depressive disorders.

It is usually not the treatment of choice when dealing with psychotic disorders, personality disorders (for example, narcissistic, paranoid, antisocial), sexual disorders and substance abuse disorders. Infantile demands, poor impulse control, an inability
to tolerate frustration, impaired social judgment, and the physical concomitants of
substance abuse severely limit benefits of psychoanalysis.

Psychoanalysis has been criticized for being a time consuming, expensive,
long term therapy; lacking scientific support; for being subjective, deterministic
and mechanistic in nature; and for laying over emphasis on the development of the
insight. The validity and reliability of various psychoanalytical concepts like oedipal
complex, id, ego and superego etc has been questioned. It has also been criticized
for being unduly restricted to a diagnostically, socioeconomically, or intellectually
advantaged patient population.

3.3.2 Client Centered Therapy or Humanistic Therapy

Client centred therapy or humanistic therapy, developed in 1940 by an American
Psychologist, Carl Rogers, is a passive, non-directive therapy which largely deals
with listening, understanding, and reflecting what the therapist perceived the patient
felt. The therapy is based on the following assumptions:

- Human beings have the potential to understand and solve their own problems
  and are reservoirs of limitless inner powers.
- Human beings have an inherent tendency to grow and to take steps towards
  self-actualization.
- In order to resolve their problems, human beings should become aware of
  the things that are going on inside them.
- And an empathetic, non-judgmental, warm and accepting relationship
  between the client and the therapist is essential for the self-actualization of
  the clients to occur.

Rogers believed that each individual perceives reality differently by attaching
his own meaning to events. Hence, what is important is not the event but the way
the client perceived it. He further stated that an individual’s self-concept consists
of his perception of his own characteristics, his relationship with others and the
value he attaches to these perceptions. Each individual has a true self and an ideal
self. The discrepancy between the two selves is likely to create anxiety and forms
the basis for development of pathology. To do away with anxiety human beings
often tend to deny the presence of unacceptable aspects of their self.

The therapy focuses on building a warm and accepting therapeutic
relationship between the client and the therapist, in which the client feels relaxed
and is able to admit his unacceptable parts of the self. The presence of genuineness,
empathy and unconditional positive regard on the part of the therapist is essential
for the building up of such a relationship. Genuineness refers to the ability of the
therapist to be present as a person having genuine interest in the client. Unconditional
positive regard refers to the therapist conveying to the client that he or she accepts
him or her, the way he or she is without judging or evaluating him or her. Empathy
refers to the skill of the therapist to understand the client’s problems as if they
were his or her own without forgetting the as if quality and then being able to
communicate his understandings to the client. When these three conditions are met, the client tends to feel relaxed and understood and continues to become aware of his unacceptable parts of self which he or she had been denying from long. He or she is then able to accept and integrate these aspects with the rest of his or her self-concept.

The therapy aims at integrating these unacceptable parts with the objective of enhancing the individual’s functioning. Integration of these parts is likely to make the individual come out of his denial and conflicts and to become more accepting and tolerant of self and others.

In humanistic psychotherapy, the therapeutic relationship is seen to play a key role in which the therapist tries to actively and empathetically clarify what the patient feels. The therapist tends to restate and reflect what according to him or her, the client may be feeling. The acceptance and the empathy provided by the therapist are in itself therapeutic in nature.

The therapist in humanistic therapy is not concerned about the interpreting the client’s unconscious motivations or conflicts but only attempts to reflect what the client feels. Instead of interpreting the client’s resistance towards acknowledging his or her disowned parts of the self, the therapist focuses on overcoming the resistance by consistently accepting and valuing the client and by empathetically reflecting the feelings of the client. The therapy does not follow the medical model of illness and does not believe in placing individuals into distinct diagnostic categories.

The humanistic therapy is chosen when the clients feel that their organized self-structures are unable to meet their demands of the reality; or when they see discrepancy within themselves and or see that are not able to control their behaviours.

Humanistic therapy has been reported to be useful with children and adults, and in dealing with neurotic problems, situational problems, speech difficulties, psychosomatic problems (for example, allergies), and, to some extent, psychosis. It has been practiced with individuals and groups, and its principles have been applied in industry, education and child rearing.

3.3.3 Cognitive Behaviour Therapy

Cognitive behaviour therapy was pioneered by the works of psychologist, Aaron Beck. It refers to the application of any techniques that aims to modify faulty patterns of thinking and to replace them with more adaptive and healthy patterns of thinking. The emergence of cognitive therapy can be seen both as a reaction to the dissatisfaction with the mechanistic, psychoanalytical approach with its excessive emphasis on the childhood histories, sexuality, unconscious processes, development of insight and the need for long term therapy and as a development within behaviour therapy. The acceptance of the role of cognitive variables in behaviour theory and therapy has been quite slow and grudgingly given as cognitive variables were not amenable to direct observation, measurement and manipulation. It was the works of Bandura on vicarious learning, the concept of self-efficacy and Mischel’s work
on delay of gratification which emphasized the role of cognitive variables and led to their inclusion in behavioural theory and therapy.

It is an active, directive, time limited, problem focused, collaborative therapy which is based on the following assumptions:

- Cognition, feelings and behaviour affect each other.
- Cognition, feeling and behaviour share a reciprocal cause-and-effect relationship.
- Individuals have both innate and acquired tendencies to think, feel and behave both rationally and irrationally.
- Individuals are self-talking, self-evaluating and self-sustaining beings who develop behavioural and emotional difficulties when they mistake simple preferences for dire needs.
- Individuals have strong tendencies to escalate their desires and preferences into diagnostic ‘shoulds’, ‘musts’ and ‘oughts’ which create dysfunctional and disruptive behaviours and feelings.
- Desired changes in ones feelings and behaviour can be achieved by bringing changes in the cognition.

Cognitive therapy is based on the Beck’s theory which states that negative beliefs and logical errors in thinking acquired during the developmental period become the substance of schemata that predispose individual’s to experience emotional problems. Hence, the way an individual structures his reality determines the way he or she is likely to feel. Beck came up with the depressive schema according to which depressed individuals view themselves, their world and their future in a negative manner.

Beck further proposed that individuals are likely to exhibit systematic distortions in their patterns of thinking known as cognitive distortions. Various cognitive distortions are as follows:

- **All-or-none thinking:** In it the individual engages in dichotomous thinking, placing experiences in one of the two opposite categories.
- **Overgeneralization:** It refers to drawing sweeping inferences from a single incident.
- **Discounting positives:** It refers to regarding good and positive things as unimportant.
- **Jumping to conclusions:** It refers to focusing on one aspect of situation in trying to understand the whole of it.
- **Mind reading:** It refers to believing that one knows what the other person is thinking in the absence of any significant evidence.
- **Fortune telling:** It refers to the belief that the one knows what the future holds while ignoring all other possibilities.

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**NOTES**

Psychological Rehabilitation and Intervention
• **Magnifying or minimizing**: It refers to overemphasizing the importance of negative events and underemphasizing the importance of positive things.

• **Emotional reasoning**: It refers to believing that a particular thing is true as it feels like true.

• **Making should statements**: It refers to telling oneself that one should have done or should have not done something, when it is more accurate to say that one would like to do the preferred thing.

• **Labeling**: It refers to assigning a label to an event or a person and then seeing that event or the person in the light of the meaning the label carries.

• **Inappropriate blaming**: It refers to ignoring the role played by others in bringing about a negative consequence and blaming self for it.

• **Selective abstraction**: It refers to selectively picking one event from a series of event that support one’s negative thinking.

• **Catastrophizing**: It refers to exaggerating the negative consequences of an event.

• **Personalization**: It refers to attributing an event to oneself when in reality that event has nothing to do with the individual.

Cognitive therapy lays lot of importance on the active collaborative relationship between the client and the therapist, which regards the client as an expert of his or her experiences and to actively participate in therapy taking over lot of responsibility in bringing about the positive change within himself or herself.

The therapy process requires teaching the client the basic principles underlying therapy. It requires the clients to learn to monitor his automatic thoughts; recognize the relationship between cognition, affect and behaviour; learn to test the validity of automatic thoughts; to substitute more realistic cognitions for unrealistic thoughts; and learn to identify and alter the underlying assumptions or beliefs that predispose individuals to engage in faulty thinking patterns.

To achieve its goal of helping client to attain realistic adaptive cognition, it makes use of various techniques as follows:

• **Socratic dialogue**: It challenges the client’s faulty cognitions by using open-ended questions which are adapted according to the client’s respective problem. These questions focus on identifying the evidence for and against the belief; exploring alternative interpretations of the event or situation; and looking at real implications if the belief is correct.

• **Downward arrow technique**: It refers to the use of series of ‘if-then’ questions in which each answer calls for another question. The questions aim at probing the meaning an individual attaches to a belief with the objective to arriving at the underlying cognitive distortion.
• **Specifying automatic thoughts**: In it the clients are asked to specify automatic thoughts using a Dysfunctional Thought Record (DTR). DTR requires an individual to record situations, beliefs, emotional consequences and the alternative more rational responses to the belief. DTR is used both for the purpose of assessment and management, as it helps the therapist and the client to identify various irrational maladaptive thoughts and then to generate more rational corresponding thoughts.

• **Disputing**: The technique of disputing requires the individual to detect one’s beliefs and thoughts; discriminate between rational and irrational thoughts and then debate irrational thoughts by looking for evidences in favor and against the irrational thought and eventually replacing them with more rational thoughts.

An integral component of cognitive therapy is the assignment of homework to the clients at the end of each session. Homeworks are designed in a way that they provide opportunities to the client to face and test their irrational thoughts and to eventually adopt more effective functional thoughts and thus bring about the desired behavioral change. Often home works are based on the material developed in the previous session. The therapist and the client review homework and collaborate to see how the benefits of the therapy can be enhanced for the client.

In the beginning of every new session, the therapist takes a feedback from the client about the prior session looking into the difficulties the client faced, the goals he accomplished, the reasons behind the problems faced by him and about the concerns the client may have about the issues discussed in the prior meeting.

The therapy eventually focuses on imparting the necessary skills to the client that aims to make the client his own therapist. The therapy is terminated as the client becomes more and more equipped. The termination of the therapy is planned. Commonly the frequency of sessions tapers off to once in every two weeks or once a month.

Cognitive therapy has been empirically found to be effective in the management of various clinical conditions such as major depression, bipolar disorder, generalized anxiety disorder, panic disorder, social phobia, and somatoform disorders; substance abuse; anger; chronic pain; relationship discord; anorexia, bulimia, and body dysmorphic disorder; a variety of childhood disorders, as well as schizophrenia. Cognitive therapy has been used with all age groups, ranging from children to elderly populations.

### 3.3.4 Rational Emotive Therapy

Albert Ellis, an American psychologist in 1950 proposed a popular type of therapy called Rational Emotive Behaviour Therapy, which is widely known as REBT. The main tenet of REBT is to identify and modify irrational beliefs and negative thought patterns that cause distortions in emotions and behaviour.
Upon identifying these unhealthy patterns, the client with the professional guidance of the therapist, develops strategies to substitute negative thought patterns with rational ones.

REBT works quite effectively, particularly for clients dealing with multiple issues, including:

- Anxiety
- Depression
- Addictive behaviours
- Overwhelming feelings of anger, guilt or rage
- Phobias
- Procrastination
- Eating disorders
- Aggression
- Sleep problems

Theory of Causation

REBT is more than just a set of techniques. It entails a comprehensive understanding of human behaviour and its complexities. The ‘biopsychosocial’ model to explain causation – i.e., human emotions and behaviour are influenced by the interaction of biological, psychological and social factors. The fundamental premise of REBT is that human emotions and behaviours are the results of the core beliefs that individuals uphold, believe or assume to be true. This understanding correlates to other cognitive-behavioural theories. Simply put, it is the perception of situations individuals face – and not the situations themselves- that dictates how they approach it emotively and behaviourally.

However, REBT also argues that an individual’s genetic or biological predispositions largely influence their reactions to situations, emotively and behaviourally. This is important to keep in mind as it serves as a reminder that there are certain limitations to the extent that an individual can modify existing thought and behaviour patterns. Hence, it is important to keep in mind that, both a biological endowment or inheritance and learning throughout life have a two-fold effect on an individual’s core belief system.

The role of cognition in Ellis’s theory can be best understood through the ‘ABC’ framework. In this framework:

- ‘A’ represents a life-real event or experience and the individual’s personal ‘inferences or interpretations’ of the event.
- ‘B’ represents the ‘evaluative’ beliefs that follow these inferences.
- ‘C’ represents the emotions and behaviours that arise as a result of those ‘evaluative’ beliefs.
To illustrate the ‘ABC’ model, here is an example of an ‘emotional episode’ encountered by an individual prone to misinterpreting the actions of others, largely attributed to an existing depressive state of mind.

A. 1. Activating Event (What happened)
   ‘My friend passed me on the street without acknowledging me.’

A. 2. Inferences about what happened
   ‘He’s ignoring me. I’m certain now that he doesn’t like me.’

B. Beliefs about A (Evaluation of A)
   ‘I’m not accepted as a friend. So I must be worthless as a person.’

C. Reaction
   • Emotions: Depressed
   • Behaviour: Avoids people generally

It is important to note here that ‘A’ alone does not cause ‘C’. Instead, ‘A triggered B’ and B, in turn, caused ‘C.’ Keeping this point in mind is important to understand that ABC episodes do not stand alone – they take place in a chain reaction – often with ‘C’ becoming the ‘A’ of another episode.

To grow aware of this unhealthy cycle of thought and emotional reactions, one can apply conscious effort to observe and understand how one usually tends to react to life’s events. For instance, the individual in the above example, realizing their tendency to avoid others, could assume that he or she is ‘generally weak and disliked’, further engaging in a negative pattern of self-incrimination.

Theory of Change

REBT asserts that change can occur at different levels. For instance, you are anxious because you are certain that a significant person in your life does not like or approve of you. At a superficial level, you can alter our body chemistry to help you feel better by exercising, making dietary changes or taking medication. Or you could alter the situation by avoiding making contact with this particular person. Additionally, you could also change the inferences you’ve made of the situation by convincing yourself intellectually that this person will not disapprove of you. This helps reduce your anxiety.

For an individual to go move beyond merely feeling better to actually getting better, i.e., to obtain a meaningful and lasting level of change, one must engage in actively modifying the existing core beliefs that creates difficulties for him or her in an array of situations.

Using the example given above, it is important to understand that instead of trying to convince oneself that the person does not dislike or disapprove of them, it might be better to accept it and simultaneously, restructure the underlying core belief that one must have the approval of others at all costs. REBT therapists firmly believe that while superficial change might be a more viable or realistic
option for some clients, efforts must be employed to instill fundamental change in thought and behaviour. To help the client achieve such longstanding change, REBT utilizes a wide range of strategies to restructure fault patterns in cognition, emotions and behaviour.

What is Irrational Thinking?

We have seen how our thoughts impact our feelings. But what types of thinking are highly problematic for human beings?

One way to label a belief as ‘irrational’ is to ascertain whether or not:

- It blocks or prohibits a person from successfully achieving a goal.
- It gives rise to extreme, distressful and persistent negative thoughts that leads to one feeling ‘incapacitated’.
- It makes one want to harm oneself, others and one’s own life, in general.
- It causes distortion in reality (i.e., a faulty interpretation of an event that isn’t supported by factual evidence).
- It contains illogical ways of evaluating oneself, the world and others (cognition distortions such as awfulizing, demandingness, discomfort-intolerance and people rating).

When talking to clients, we often refer to beliefs as ‘self-defeating’ rather than ‘irrational’ in order to emphasize that one of the main reasons for why we tend to replace a certain belief is because of the negative feelings it evokes in us.

Two Types of Disturbance

REBT affirms that human beings ‘defeat or disturb’ themselves in two key ways:

- By irrationally evaluating the ‘self’ (ego disturbance).
- By irrationally evaluating the factors that influence their emotional or physical comfort (discomfort disturbance).

The three levels of thinking human beings engage in are:

1. **Inferences:** In everyday life, events and certain circumstances give rise to ‘drawing inferences’ about ‘what is going on’, i.e., we make assumptions about what we think has happened, is happening or will happen. Inferences are ‘statements of fact’, according to an individual, i.e., he or she thinks designs the facts, based more on individual perception than actual reality. In REBT, little time is dedicated to understanding a client’s inferences – they are considered to be significant only in the context of insight that they provide about an individual’s evaluative thinking.

2. **Evaluations:** In REBT, we move beyond the ‘facts’ to evaluate them in terms of the meaning they carry. Evaluations are sometimes conscious and sometimes bereft of awareness. Irrational evaluations overlap with the four types of distorted beliefs listed earlier: demandingness, awfulizing, discomfort-intolerance and self/other rating. An example of misguided evaluation of a
situation would be: ‘I need her to love me because if she doesn’t, it would prove that I am worthy of being loved by anyone.’

3. Core beliefs: A person’s inferences and evaluations are largely determined by underlying general core beliefs. An example of a general core belief would be: ‘I must have someone who loves me unconditionally for me to be worthy as a person.’

3.3.5 Supportive Therapy

Supportive psychotherapy is a form of therapy used to help clients deal with their emotional distress and life problems. Therapists engage in comforting, advising, encouraging, reassuring and mostly listening attentively and sympathetically. The counseling session offers a safe space wherein the client can emotionally vent, freely express themselves and be themselves without the pressures of their lives outside therapy. Clients are duly informed by the therapist about their illness and get psycho-educated on how best to effectively manage and adjust to it.

Over the course of the treatment, the therapist might have to intercede or present the client on his or her behalf with various figures of authority such as schools, social agencies and parents, if the need occurs strongly.

The therapist’s responsibilities might include, in some cases, having to appropriately explain his client’s behaviour to others and vice versa. The client might have to be educated about the unspoken but key rules that govern or dictate all social and interpersonal interaction. The client is often encouraged by his or her therapist to expand his/her interests in the world by making new friends and engaging in productive activities such as going to school or taking up a job. Partaking in sports or hobbies is widely encouraged as both activities are highly positive and constructive on multiple levels. Hence, to an extent, the therapist comes to serve as a ‘role model’ for desired and appropriate behaviour. By doing so, the therapist offers the client a clear and healthy perspective of how life ought to be led. Hence, in summary, supportive psychotherapy is a deliberate attempt to offer assistance to the client on how to effectively deal with the different kinds of problems that are causing their emotional illness.

Insight psychotherapy is a relatively expensive or prestigious treatment conducted by very few highly trained professionals. It is commonly conducted by therapists invested in helping the client to successfully overcome their difficulties. Both these types of psychotherapies use different methods.

Insight psychotherapy entails interpreting the following:

- Resistance
- Dreams
- Defense mechanism
- Transference reactions to the therapist
- Specific prescriptions for particular anxiety
The process of insight psychotherapy is relatively more prolonged than supportive psychotherapy. The supportive therapist on the other hand, deals rather superficially perhaps, but more immediately with the daily events that occur in the client’s life. The therapist doesn’t attempt to interpret the client’s unconscious but instead simply tries to appeal to it. The therapist takes into consideration not just the client’s own thoughts and feelings about the problem at hand but also explores further by interacting with the client’s family, friends and significant others. While supportive psychotherapy occurs over a short period of time, it is nonetheless intensive in nature.

The indications for both supportive and insight psychotherapy also slightly differ. A client recommended for insight therapy is usually intelligent, motivated, has relative emotional intactness, is relatively financially sound and is able to afford the cost in time and money, given that insight psychotherapy is rather prolonged. The client begins therapy with an adequate level of insight that is crucial to the process of therapy.

On the other hand, the patient for whom supportive therapy is recommended is likely to be financially weaker, low in capability, sicker and at times even psychotic, i.e., possesses a lower ability to tolerate the anxiety of perceiving himself/herself objectively; but this is not a hard and fast rule.

One does not have to be sick to any particular degree or possess a disability in order to benefit from supportive psychotherapy. Clients with varied problems and intensities of problems can benefit from supportive psychotherapy – depressed, schizophrenic, sexually disturbed, neurotic, suffering from a chronic illness. He or she does not even necessarily need to have any special social or intellectual qualification or impairment to qualify to supportive psychotherapy.

Finally, the therapist’s approach to therapy should be taken into consideration. A therapist tailor makes his or her approach to the client depending on whether or not the client requires insight or supportive psychotherapy. In the case of insight psychotherapy, the therapist takes extra precaution before suggesting any intervention to the client or before offering advice, in order to avoid influencing the free flow of the client’s thoughts, feelings, attitudes and remarks. In summary, he adheres to using anonymity.

But on the other hand, in the case of supportive therapy, the therapist is highly active and involved at every step of the therapy. Advice from the therapist might be necessary as the client’s highly disturbed or impaired condition warrantes it in order to help him or her deal with the day to day problems in his life. The therapist speaks openly and freely. A healthy level of self-disclosure might be used if the need to reassure the client of how the therapist feels about him or her arises. He might disclose certain details about his own life in order to demonstrate a point to the client.

But these distinctions blur in practice, as is usually the case in psychiatry. For instance, when a client in insight psychotherapy requires urgent support or
active intervention from the therapist, he or she would indulge in appropriate self-disclosure or offer advice.

3.3.6 Augmentative Therapy

Immuno-augmentative therapy is also known as Immune Augmentation Therapy—was developed by psychologist, Lawrence Burton. According to him, it could control all forms of cancer by restoring natural immune defenses. He claimed to accomplish this by injecting daily injections of processed human blood products that are designed to stimulate the patient’s immune system to attack cancer cells. However, experts concluded that the substances he claimed to use cannot be produced by these procedures and do not exist in the human body. Burton did not publish any detailed experimental evidence for IAT. Moreover, during the mid-1980s, several of Burton’s patients were reported to have developed serious infections following IAT. Thus, there is no logical reason to believe that Burton was honest or that IAT was or is effective.

Burton claimed to have discovered a ‘tumor induction factor’ (TIF) and a naturally occurring TIF inhibitor in fruit flies. Later, in New York, he reported finding the same inhibitor system in mice and concluded that all mammals have it. However, Burton’s research was questioned at Cal Tech after someone discovered that the control fruit flies in his experiments had no injection scars, while their experimental animals did. Burton’s supervisor, biology professor Herschel K. Mitchell, PhD concluded that Burton’s results were ‘meaningless’.

Despite Mitchell’s rejection, Burton applied his theory to the treatment of humans. In the mid-1970s, Dr. Burton established the Immunological Researching Foundation in Great Neck, New York, and filed an investigational new drug application for IAT with the Food and Drug Administration (FDA). However, because Dr. Burton did not provide the experimental evidence for IAT that the FDA requested, the application was not approved. In 1977, Dr. Burton relocated to the Commonwealth of the Bahamas, established The Immunology Researching Centre, and began using IAT to treat persons with cancer.

Burton claimed that his treatment ‘augments the patient’s own immune system’. He postulated that cancers develop because of a breakdown in the immune system and that IAT restores the body’s natural defenses.

According to the brochure, Burton’s laboratory made daily or twice-daily assessments of the levels and proportions of ‘tumor complement’, ‘tumor antibody’, ‘deblocking protein’ and ‘blocking proteins’. The patient was then given daily injections of ‘tumor complement factor’ obtained from the serum of persons with cancer and ‘deblocking protein factor’ and ‘tumor antibody’ obtained from the serum of persons without cancer. Burton determined the dosages after analyzing these data with a computer program that he developed. The brochure also stated:

Each therapeutic IAT intervention is prescribed with the most recent assessment of: (1) the status of the native immune system; (2) the status of tumor
activity; (3) the effects of the most recent therapy; and (4) the accumulated effects of all previous therapy and response.

After the patient was considered stabilized, a computer readout was prepared for a daily program of injections administered at home.

Burton did not claim that IAT products attacked cancers directly. Therefore, if there is any failure it would not be attributed to his treatment but to unresponsiveness of the patient’s immune system due to damage by prior treatment or advanced disease. He advised patients undergoing IAT to stop other therapies ‘so as not to confuse other data’. The brochure stated that Burton did not claim ‘cure’ but did claim that many patients ‘prosper’ by becoming symptom-free and resuming their normal life activities.

The Immunology Researching Center brochure also suggested that double-blind experimentation would be immoral because it would deprive half the patients of active treatment.

In 1978, representatives of the Bahamian Ministry of Health and the Pan American Health Organization (one of whom was a National Cancer Institute official) visited the facility and reviewed 49 charts that the center’s staff considered to represent encouraging results. The report concluded that there was no objective evidence that IAT was beneficial and recommended that the facility be closed. Another IAT facility licensed by Burton was opened in 1987 in Frankfort, West Germany. A third one, the Immune Therapy Clinic, opened in 1989 in Playas, Mexico, with a promotional office in nearby San Ysidro, California (a suburb of San Diego).

In the mid-1980s, the safety of all products derived from human blood, including IAT, came under questioning as the scientific community learned about the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). In 1985, at the request of the families of two patients who had returned to the United States from Dr. Burton’s clinic, a Washington state blood bank examined 18 sealed IAT specimens. All of the samples tested positive for hepatitis B; some of the samples were positive for HIV. These findings were confirmed by subsequent analyses by the Centers for Disease Control and Prevention (CDC), the National Cancer Institute (NCT), and independent laboratories.

In July 1985, at the request of the Bahamian Ministry of Health, representatives from the CDC and the Pan American Health Organization (PAHO) visited the Immunology Researching Centre to investigate the manufacturing process used for IAT. The CDC and PAHO concluded that the manufacture of IAT represented a serious health hazard, and the Bahamian Government closed the clinic. The clinic reopened in March 1986 after Dr. Burton agreed to follow certain quality control procedures, including screening blood sources for HIV and hepatitis B and conducting standard blood donor screening and collection practices. In July 1986, the FDA issued an import ban prohibiting anyone from bringing IAT into the United States. This ban is still in effect.
In 1991, after an extensive investigation, the American Cancer Society issued a position paper warning that it had 'found no evidence that IAT was safe or resulted in objective benefit in the treatment of cancer.'

3.3.7 Behaviour Therapy

The term ‘behaviour’ includes both overt (observable) and covert (non-observable) responses. The roots of behaviourism go back to the nineteenth and early twentieth century, beginning with the works of psychologist, Watson. Watson advocated the study of only observable behaviour using objective methods. Pavlov further showed a relationship between learning and psychopathology in humans. In addition to Pavlov’s works, Thorndike’s and Skinner’s concepts of operant conditioning demonstrated that behaviour is a function of its consequences involving the manipulation of reinforcement and punishment. Social learning theory later introduced the concept of cognitive control and reciprocal determinism to behaviour therapy by emphasizing the prominent role played by vicarious, symbolic and self-regulatory processes. It stated that the relationship between external stimuli and overt behaviour is mediated by cognitive processes.

All the mentioned contributions eventually shaped behaviour therapy. Behaviour therapy involves changing the maladaptive and self-defeating actions and responses of the patients to reduce dysfunction and to increase well-being and quality of life. It makes use of behaviour analysis as a way of both assessing and identifying the target behaviours that need to be changed and as a way of modifying antecedents or consequences to bring about the desired behaviour change. It makes use of principles of learning for the replacing maladaptive behaviours of an individual with more adaptive ones. It largely focuses on overt behaviours and their environmental influences. It is based on the following assumptions:

- It is the situational, rather than mental events that ultimately control an individual’s behaviour
- An individual’s behaviour can be observed, monitored and altered.
- Human beings are largely passive, inactive beings, and
- Human beings are both the producer and the product of the environment
- Both adaptive and mal-adaptive behaviours are learnt.
- Learning principles can be used to modify maladaptive behaviours

Behaviour therapy rejects the classical trait theory. Clear, specific, well-defined goals in objective measurable terms are key aspects of the therapeutic process. The general goal in behaviour therapy is to create new conditions for learning. The goals are set in the beginning of the therapy in agreement with the client. The therapy involves continued assessment to ascertain the extent to which the goals have been met. In behaviour therapy assessment and treatment occurs together. The method of treatment is usually adapted to the client’s problems. It focuses on the current problems faced by the client and avoids dwelling deeply.
into the presumed causes underlying the maladaptive behaviour. It tends to concentrate on the challenges currently faced by the client and is less concerned with his or her childhood histories. Behaviour therapists lay lot of emphasis on obtaining empirical support for their various techniques.

The different techniques that are usually employed by the behavioural therapists in the management of the client’s problems are as follows:

- **Reinforcement**: Reinforcement aims to increase the occurrence of a particular behaviour in future when that behaviour (known as the operant behaviour) is consistently followed by consequences (also known as reinforcer). It can be of two types—positive reinforcement and negative reinforcement. In positive reinforcement it is the addition of a stimulus or an increase in the intensity of a stimulus that strengthens behaviour. Whereas in negative reinforcement, it is the removal of a stimulus or a decrease in the intensity of a stimulus that strengthens behaviour.

  For reinforcement to be more effective the target behaviour should be reinforced immediately and consistently; the reinforcer should of sufficient intensity and should appear reinforcing to the individual.

  Extinction involves the removal of a reinforcer so that the reinforced behaviour stops occurring. The removal of a reinforcer may be followed by a sudden increase in the frequency, duration, or intensity of the behaviour before it decreases and ultimately stops. This phenomenon is known as extinction burst. During extinction burst novel behaviours, emotional responses and aggressive behaviour may occur.

  Extinction is resistant to intermittent reinforcement, i.e., when a behaviour is continuously reinforced, it decreases rapidly once the reinforcement is terminated, but when a behaviour is intermittently reinforced, it often decreases more gradually once the reinforcement is terminated.

- **Punishment**: Punishment aims to decrease the occurrence of a particular behaviour in future when that behaviour is consistently followed by consequences (also known as punisher). It can be of two types—positive punishment and negative punishment. In positive punishment, it is the presentation of an aversive stimulus that weakens behaviour. On the other hand, in negative reinforcement it is the removal of a reinforcing stimulus that weakens behaviour. For punishment to be effective, it should be presented immediately and consistently; it should of sufficient intensity; it should appear punishing to the individual and should be seen as justified by the individual.

- **Shaping**: Shaping is a procedure which is used in the acquisition of a new behaviour. It involves reinforcing every successive approximations of a target behaviour and non-reinforcement of all other behaviours until the person exhibit the target behaviour.

- **Chaining**: Chaining is used to help individuals acquire a complex behaviour consisting of many component behaviours that occur together in a sequence
(called as a behavioural chain). To accomplish this goal the complex behaviour is broken down into its various components (a process known as task analysis). Then using the process of chaining, which involves the use of prompting and fading strategies, the individuals are taught the complex task. Various chaining procedures that can be used are backward chaining (which involves teaching the last step in the behaviour chain first followed by teaching each previous behaviour in the chain), forward chaining (which involves teaching the first step in the behaviour chain first followed by teaching each subsequent behaviour in the chain), total task presentation (which involves performing all the steps of the behaviour chain together in one go using prompts), written task analysis (which involves using written descriptions of each step of the behavioural chain as prompts), picture prompts: (which involves using pictures of each step of the behavioural chain as prompts), Self-instructions (which involves giving oneself verbal prompts for each step of the behavioural chain).

- **Behavioural skills training procedures**: It focuses on helping individuals to learn various skills like communication skill, problem solving skill and social skills through the use of the procedures of modeling, instructions, rehearsal, and feedback. Modeling involves demonstration of the behaviour to be learnt by the therapist which is then imitated by the client. In live modeling, the therapist demonstrates the appropriate behaviour in the appropriate situation, whereas in symbolic modeling, the correct behaviour is demonstrated using audio-visual aids.

  For modeling to be effective, the correct behaviour modeled by the therapist should be met with a successful outcome; the learner should be able to identify with the model; the complexity of the modeled behaviour should match the developmental level of the learner; the learner should pay attention to the modeled behaviour; the learner should imitate the behaviour soon after observing the model and the modeled behaviour should be repeated as often as possible till the learner is able to imitate the modeled behaviour correctly at least a few number of times.

- **Instruction**: Instruction involves adequate description of the appropriate behaviour that the learner desires to learn. For instructions to be effective they should be clear and specific describing exactly the behaviour that the learner is expected to learn. The instructions should also match the cognitive level of the learner; should be delivered by a credible source; should be immediately rehearsed by the learner and should be repeated till the therapist is certain that the learner has heard the instructions correctly.

- **Rehearsal**: Rehearsal refers to the opportunity the learner gets to practice the modeled and instructed behaviour. For rehearsal to be effective, it should be carried out in the proper context; should result in a successful outcome; should always be followed by corrective feedback and it should be rehearsed until it is demonstrated correctly at least a few times by the learner.
• Feedback: Feedback involves providing information about how well the individual formed the target skill or behaviour that was modeled and instructed to and rehearsed by him. For feedback to be effective it should be given immediately after the behaviour; should always involve praise for some aspect of the behaviour; the praise should be descriptive; should be worded in positive terms and should provide corrective feedback on one aspect of the performance at a time.

• Time out: Time out involves the loss of access to a positively reinforcing environment as a consequence of engaging in an inappropriate behaviour. It can be exclusionary (here the individual is taken away from the setting in which the problem behaviour occurred and is taken to another setting) or non-exclusionary (here, the individual remains in the same setting but is denied access to positive reinforcers) in nature.

• Response cost: Response cost refers to the removal of a specified amount of a reinforcer as a consequence of engaging in the problem behaviour. It aims to decrease the probability of occurrence of problem behaviour in future.

• Habit reversal training: Habit reversal training is often used to treat nervous habits like nail-biting, hair-pulling; motor tics and stuttering. It involves awareness training (in which the individual is made aware of the various behaviours involved in the habit; about when the habit occurs or is about to occur); competing response training (involves teaching a behaviour incompatible with the habit behaviour); social support (where the client’s family members are instructed to prompt the client to use the competing response when the habit occurs; to appreciate the client for not engaging in the habit and for using the competing response successfully); and motivation procedures (in which the therapist reviews with the client how embarrassing or inconvenient he might have felt when these habit behaviours occur in a variety of situations; with the objective of increasing the client’s motivation to stop engaging in habit behaviours).

• Token economy: Token economy involves increasing the occurrence of target behaviour by providing tokens as conditioned reinforcers, which can later be exchanged for desired objects or activities as per a predetermined rate of exchange and the reinforcement schedule.

• Behavioural contract: Behavioural contract refers to a written agreement between two parties in which one (one-party contract) or both parties (two-party contract) agree to bring about a change in their behaviour by engaging in the corresponding appropriate behaviour; non-engagement of which shall be followed by predetermined consequences.

From the huge myriad of these techniques, the choice of the technique depends on the problem at hand and on the various factors precipitating and maintaining the problem behaviour. Behaviour therapy has been found to be quite
effective in the management of various problems such as depression, obesity, drug abuse, temper tantrums, phobias and anxiety.

However, behaviour therapy has been criticized on the pretext that it treats symptoms rather than causes; it may change behaviour but fails to change the underlying feelings; it lays less emphasis on the importance of therapeutic relationship; it involves control and manipulation by the therapist and does not provide insight. It does not fully answer the question that why an individual behaves the way he does? It has also been criticized for not taking into account the major role played by cognitive factors in determining one’s behaviour.

Over the last few years the field of behaviour therapy has undergone significant development. One such development has been the acceptance of the role played by cognitive variables in influencing an individual’s behaviour. In fact, their acceptance has bridged the gap between behaviour change and attitude change, thus giving way to the emergence of cognitive behaviour therapy.

**Check Your Progress**

4. What is the aim of psychoanalysis?
5. State the premise of client centred therapy.
6. What is an integral component of cognitive therapy?
7. What is the main tenet of Rational Emotive Behaviour Therapy (REBT)?
8. What are the three levels of human thinking?

### 3.4 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The first phase of psychiatric rehabilitation process is psychiatric rehabilitation assessment which varies greatly in terms of its formality, specificity, and documentation.
2. Needs are identified by asking about difficulties in each area, individual is also asked about how much help is received from friends and relatives, as well as service providers.
3. The Pattison Psychosocial Kinship Inventory offers a systematic method for assessing the social system of an individual, in the area of social supports.
4. Psychoanalysis aims to confront, understand and resolve the various defense mechanisms used by the patient with the purpose of preventing anxiety evoking information out of consciousness.
5. Client centred therapy is a passive, non-directive therapy which largely deals with listening, understanding, and reflecting what the therapist perceived the patient felt.
6. An integral component of cognitive therapy is the assignment of homework to the clients at the end of each session.

7. The main tenet of Rational Emotive Behaviour Therapy (REBT) is to identify and modify irrational beliefs and negative thought patterns that cause distortions in emotions and behaviour.

8. The three levels of human thinking are as follows:
   a) Inferences
   b) Evaluations
   c) Core beliefs

### 3.5 SUMMARY

- Rehabilitation psychology is defined as the study and application of psychological principles on behalf of persons with physical, sensory, cognitive, developmental or emotional disabilities.

- The first phase of psychiatric rehabilitation process is psychiatric rehabilitation assessment which varies greatly in terms of its formality, specificity, and documentation.

- The assessment estimates the client’s skills and supports the context of the environment in which the client chooses to live, learn, socialize, and work.

- The psychoanalytical theory refers to a theory of personality and mental disorders. The term also denotes the procedure adopted by Sigmund Freud, the founder of psychoanalysis, to understand the functioning of mind and it is also widely used as a therapeutic modality.

- Psychoanalysis emerged as a direct outgrowth of the treatment of neurotic patients using hypnosis.

- The preponderance of the assessment literature for people with psychiatric disabilities is in the area of psychiatric symptoms and diagnosis.

- Psychoanalysis also aims to confront, understand and resolve the various defense mechanisms used by the patient with the purpose of preventing anxiety evoking information out of consciousness.

- Client-centred therapy or humanistic therapy, developed in 1940 by an American Psychologist, Carl Rogers, is a passive, non-directive therapy which largely deals with listening, understanding, and reflecting what the therapist perceived the patient felt.

- Cognitive therapy is based on the Beck’s theory which states that negative beliefs and logical errors in thinking acquired during the developmental period become the substance of schemata that predispose individual’s to experience emotional problems.
The main tenet of REBT is to identify and modify irrational beliefs and negative thought patterns that cause distortions in emotions and behaviour.

Supportive psychotherapy is a form of therapy used to help clients deal with their emotional distress and life problems.

Immuno-augmentative therapy is also known as Immune Augmentation Therapy—was developed by psychologist, Lawrence Burton. According to him, it could control all forms of cancer by restoring natural immune defenses.

Insight psychotherapy is a relatively expensive or prestigious treatment conducted by very few highly trained professionals.

Extinction involves the removal of a reinforcer so that the reinforced behaviour stops occurring.

The removal of a reinforcer may be followed by a sudden increase in the frequency, duration, or intensity of the behaviour before it decreases and ultimately stops. This phenomenon is known as extinction burst.

Habit reversal training is often used to treat nervous habits like nail-biting, hair-pulling; motor tics and stuttering.

Behaviour therapy rejects the classical trait theory. Clear, specific, well-defined goals in objective measurable terms are key aspects of the therapeutic process.

Behaviour therapy has been criticized on the pretext that it treats symptoms rather than causes; it may change behaviour but fails to change the underlying feelings; it lays less emphasis on the importance of therapeutic relationship; it involves control and manipulation by the therapist and does not provide insight.

3.6 KEY WORDS

Counter-transference: It refers to the analyst’s unconscious emotional needs, wishes, and conflicts that are evoked by the patient and have the potential of negatively influencing the analyst’s objective judgment and reason.

Negative transference: It refers to equally intense bad feelings such as anger, hostility, mistrust, rebelliousness, and so on towards the analyst.

Positive transference: It refers to the expression of good feelings such as love, trust, admiration, respect, sympathy, and so on towards the analyst, that can act as a motivating force for the client to bring about the necessary change.

Resistance: It refers to all the forces that prevent unconscious repressed memories to become conscious in the process of therapy.
3.7 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short Answer Questions
1. What are the main principles of rehabilitation psychology?
2. How is positive transference different from negative transference?
3. What are the three main dimensions of sickness impact profile?
4. How does counter-transference arise?
5. What are the various techniques of cognitive behaviour therapy?
6. State the fundamental premise of REBT
7. What are the characteristics of a good psychiatric rehabilitation practitioner?

Long Answer Questions
1. What are the instruments used by psychologists to assess client’s assessment situation? Discuss in detail.
2. Discuss the method of psychoanalysis.
3. Identify the assumptions related to humanistic theory.
4. Analyse the various cognitive disorders.
5. Discuss the theory of causation.
6. What are the techniques used by behavioural therapists? Explain in detail.

3.8 FURTHER READINGS

UNIT 4 REHABILITATION OF PERSONS WITH DISABILITIES

4.0 INTRODUCTION

Rehabilitation for people with disabilities is a process which is aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Rehabilitation helps in providing people with disability a need to attain independence and self-determination.

Personality is defined as the combination of characteristics which form an individual’s distinctive character. Personality disorder refers to a way of thinking, feeling and behaving which differs from the expectations of the culture, thus, causes distress or problems functioning.

In this unit, the four main forms of impairment, meaning of personality and its types have been discussed. The forms of personality disorder and the Five Factor Model (FFM) of personality have been explained. The unit will also highlight the role of psychologist in rehabilitation disability.

4.1 OBJECTIVES

After going through this unit, you will be able to:

- Identify the four main areas of impairment
- Discuss the meaning and types of personality
- Explain the different forms of personality disorder
4.2 LIFESPAN DEVELOPMENT OF PERSONS WITH DISABILITIES

Human development is the study of how people change and grow throughout their lives. When the normal development of the person is hampered, he or she is at a risk of developing a particular type of impairment, which can impact certain areas of life such as language, mobility, learning, self-help and independent living.

There are four major areas of impairment:

1. **Learning impairments**: Learning impairment affects person’s ability to acquire, process and use of spoken, written or nonverbal information, difficulties in planning, memory, reasoning, problem solving and perceptual skills.

2. **Motor impairments**: Motor impairments affects disability of the bones, joint or muscles leading to substantial restriction of the movements of the limbs or a usual form of cerebral palsy. Other common conditions giving raise to locomotor disability includes amputation, injuries of head and spine, fractures and muscular dystrophy.

3. **Sensory impairments**: Sensory impairments affect hearing and eye sight of individuals. Blindness can either be total absence of sight or issues in visual acuity. Hearing impairment can take place either due to damage of hair cells in the cochlea or problem in the process of conduction (in outer or middle ear). Each will vary in degree and in type but all will impact on development in some form or another.

4. **Developmental disability**: Developmental disability is a diverse group of chronic conditions that are due to mental or physical impairments that arise before adulthood. It can impact certain areas of life such as language, mobility, learning, self-help and independent living. It includes disorders such as mental retardation, autism and ADHD.

4.2.1 **Personality**

American psychologists Randy Larsen and David Buss define personality as a 'stable, organized collection of psychological traits and mechanisms in the human being that influences his or her interactions with and modifications to the psychological, social and physical environment surrounding them.'

Personality development is a process of enhancing one’s personality. The focus of personality development sessions is to guide an individual on how he/she can develop his/her personality.
Types of Personality

The following are the main types of personality:

- **Duty fulfiller**: Such individuals uphold their roles and fulfill responsibilities with utmost seriousness and diligence.
- **Mechanic**: Such individuals are inclined towards working with machinery like airplanes, motorcycles, cars and so on.
- **Nurturer**: Such individuals are intrinsically inclined towards taking up roles that involve nurturing and caring for others. They tend to place the happiness and needs of others before their very own. They have a positive approach to life and believe in the goodness of others.
- **Artist**: Artists have an eye for natural beauty and creativity. Such individuals believe in living for the moment and put off worrying about the future. They are extremely cool headed and do not get into unnecessary fights and troubles. They draw great satisfaction from creating things using their imagination, ability to envision and think unconventionally.
- **Protector**: A very few people have this personality trait, making it a very rare one. They are highly systematic and hardworking. Their thinking style is irrational and pessimistic. They do not easily trust others.
- **Idealist**: Such individuals uphold a strong sense of ethics and values. They look for opportunities to help others and draw happiness from doing so.
- **Scientist**: Such individuals work by strategically planning. They have keen observation skills and tend to constantly gather information and upgrade their existing knowledge. Scientists are extremely intelligent people who have a very sharp analytical mind.
- **Doer**: Such individuals believe in quick actions and immediate results. They take thrill in risks and fulfill tasks assigned to them very quickly.
- **Guardian**: Such individuals are perfectionists who ensure that things constantly run smoothly. They are mature and their work is dictated by a clear set of standards.
- **Performer**: Such individuals strive hard to gain the attention of others and enjoy being the center of attention. They are fun loving in nature and look for excitement.
- **Inspirer**: Inspirers are talented individuals and often act as a role model for others. They have great social skills and get along very well with people.
- **Giver**: Individuals with “The Giver” personality type enjoy being in the company of others and not being alone.
- **Executive**: Such individuals are natural leaders. They enjoy challenges and are adept at decision making.
Determinants of Personality

The following are the main determinants of personality:

Nature vs. Nurture

- The development of personality, according to an English philosopher, John Locke (1632-1704) and his followers, was purely a question of ‘nurture’ or education. The newborn child, like a clean slate (‘tabula rasa’), could be molded or shaped the way educators wanted it to be.
- Genevan composer, writer and philosopher, Jean-Jacques Rousseau (1712-1778), on the contrary claimed that heredity has the most profound influence on personality, abetting that the innate goodness in human beings could not be ignored. The development of a child, according to him, follows an inner, biological time table and parents cannot influence it.
- Research on identical twins growing up in different environments, has shown that they different from each other in certain characteristics owing to the influence of their respective environments. Hence, it confirms that characteristic is (partly) learned too.

Role of Culture on Personality

Apart from the immediate environment, factors such as culture, type of education or schooling, also influences the development of one’s personality. It is important to take into consideration the influence of individualistic and collectivistic culture on the overall personality development.

Individualist cultures encourage the development of personal qualities such as self-confidence, independence and assertiveness; in collectivistic cultures this is particularly true of qualities such as friendliness, modesty and loyalty and adherence to social norms.

The majority of personality researchers support the five factor theory of personality, which describes five broad personality dimensions of human personality. They are extraversion, agreeableness, conscientiousness, neuroticism and openness.

Check Your Progress

1. What are the five main dimensions of personality?
2. What is personality development?

4.3 PERSONALITY DISORDERS AND ILLNESSES

The term ‘personality’ refers to enduring qualities of an individual that are shown in his ways of behaving in a wide variety of circumstances. It is a deeply ingrained pattern of behaviour that includes modes of perception, relating to and thinking
about oneself and the surrounding environment. This pattern of behaviour seems to be different in each individual as different individuals have their own way of perceiving, thinking and behaving in different situation and circumstances.

Personality traits are defined as normal, prominent aspects of personality. However, personality disorders result when these personality traits become abnormal, i.e., become inflexible and maladaptive and cause significant social or occupational impairment or significant distress.

Abnormal personality traits are usually ‘ego-syntonic’ which means that they do not necessarily cause significant distress to the patient. That is why individual’s having personality disorder does not usually seek psychiatric help unless other psychiatric symptoms co-exist. Personal distress may occur in some personality disorders.

According to ICD-10, the term personality disorder refers to conditions not directly attributable to gross brain damage or disease, or to another psychiatric disorder meeting the following criteria:

- Markedly disharmonious attitudes and behaviour, involving usually several areas of functioning, for example, affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others.
- The abnormal behaviour pattern is enduring, of long standing, and not limited to episodes of mental illness.
- The abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations.
- The mentioned manifestations always appear during childhood or adolescence and continue into adulthood.
- The disorder leads to considerable personal distress but this may only become apparent late in its course.
- The disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

Personality disorder is a common and chronic disorder. Its prevalence is estimated between 10 and 20 per cent in the general population. Many instances of violent and non-violent crime and a large percentage of the prison population are associated with underlying personality disorder. These individuals have chronic impairments in their ability to work and to love; tend to be less educated, drug dependent, single, and unemployed; and tend to have marital difficulties.

Different types of personality disorders are discussed in the following section.

- Paranoid personality disorder: Individuals having paranoid personality disorder are suspicious, mistrustful, resentful, jealous, and sensitive and bear grudges, and have self-important ideas. These individuals tend to suspect actions of other people and are constantly on the look-out for attempts by others to deceive them or play tricks on them. As a result,
other people find them difficult and unreasonable. They do not make friends easily and avoid involvement in groups. They appear secretive, devious and self-sufficient to a fault. They doubt the loyalty of other people and do not trust them.

- **Schizoid personality disorder**: These individuals are seen to be emotionally cold, aloof, detached, introspective and prone to fantasy. They are unable to express either tender feelings or anger. They show little interest in sexual relationships. In extreme cases, these individuals appear cold and callous. They show little concern for the opinions of other people. They do not feel comfortable in intimate relationships and prefer solitary activities over group activities. They usually remain unmarried. They show greater interest in intellectual matters than in people. They have a complex inner world of fantasy often devoid of emotional content. They lack a sense of enjoyment, have little sense of humor, and take little pleasure in activities that most people enjoy. They appear insensitive to social norms and conventions.

- **Schizotypal personality disorder**: These individuals are seen to be socially anxious, experience cognitive and perceptual distortions, show oddities of speech, make inappropriate affective responses and behave eccentrically. They tend to feel anxious in the company of others and have difficulty in making relationships. These individuals lack friends and feel different from other people and do not fit in. Cognitive and perceptual distortions include ideas of reference, suspicious ideas, odd beliefs, magical thinking and unusual perceptual experiences. These individuals at times show oddities of speech in the form of unusual constructions, words and phrases, vagueness and tendency to digress. They make inappropriate affective responses and appear odd, stiff and constricted in their emotions. Their behaviors seem eccentric. They seem to show odd mannerism, disregard conventions and their social behavior seems awkward. These individuals may have unusual choice of clothing. These individuals show obsessive ruminations without inner resistance, often with dysmorpho-phobic, sexual or aggressive content. Occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations, and delusion-like ideas, usually occurring without external provocation may be present.

- **Antisocial personality disorder**: These individuals appear to be callous, irritable and impulsive people who seem to lack guilt or remorse and tend to avoid responsibilities. These individuals are irresponsible and depart from social norms. Their relationships are shallow and largely transient in nature. They tend to lack concern for the feelings of the other and their sexual activity is without tender feelings. These individuals may inflict cruel or degrading acts on other individuals. They do not
obey rules and may get into problems with the law. They are often involved in violent offenses and their offenses typically begin in adolescence. These individuals lack goals, do not plan ahead and typically have an unstable work record marked by frequent dismissals. They tend to get easily provoked, irritable and angry and in anger they may end up assaulting the individual in a quite violent way. They lack guilt or remorse and often fail to learn from their adverse experiences, and also fail to change their behaviour in response to punishment. They tend to blame others for their faults and try to rationalize their failures. They are also deceitful and irresponsible about finances. Their abnormal behaviour is made worse by the presence of drug abuse and alcohol.

- **Narcissistic personality disorder**: It is characterized by a grandiose sense of self importance in these individuals. They tend to be boastful and pretentious. They tend to be occupied with fantasies of unlimited illness, power, beauty or intellectual brilliance. They believe themselves to be special and expect others to admire them and should offer special services and favors to them. They feel entitled to the best and seek to associate with people of high status. They tend to exploit others and do not empathize with or show concern for their feelings. They envy the possessions and achievements of the others and expect that others would envy them in the same way. They are arrogant and behave in patronizing or condescending ways.

- **Histrionic personality disorder**: These individuals are self dramatizing in nature. Their self-dramatization may extend to emotional blackmail, angry scenes and demonstrative suicidal attempts. These individuals are suggestible and are easily influenced by others, especially, by figures of authority. They follow the tastes and opinions of others and adopt the latest fads and fashions. They seek attention and excitement and crave new experiences, get easily bored, and have short-lived enthusiasm. They have a shallow labile effect and display their emotions in a dramatic manner and may exhaust the others with tantrums of rage and unrestrained expectations of despair. There is little depth in their emotional outpourings and recover quickly and are surprised that other people have not forgotten the scenes as quickly as they have.

- **Borderline personality disorder**: The hallmarks of borderline personality disorder are pervasive and excessive instability of affects, self-image, and interpersonal relationships, as well as marked impulsivity. These individuals are seen to engage in frantic efforts to avoid real or imagined abandonment; have unstable and intense interpersonal relationships alternating between idealization and devaluation; have markedly and persistently unstable self-image or sense of self characterized by chronic feelings of emptiness. They may at times show
a tendency to undermine self when they are close to realizing a goal. These individuals tend to show marked reactivity of mood and instability of affect. They tend to engage in recurrent suicidal behaviours, gestures, threats, or self-mutilating behaviours. These individuals may show inappropriately intense anger and may experience difficulty in controlling anger. In them stress-related, transient paranoid ideation or dissociative symptoms are common. These individuals may feel more secure with non-human objects (pets and inanimate objects) than in interpersonal relationships. Impairment is frequent and severe and includes frequent job losses, interrupted education, and broken marriages.

- **Avoidant personality disorder**: Individuals with this disorder are persistently tensed, feel insecure and lack self-esteem. They feel socially inferior, unappealing and socially inept. They appear preoccupied with the possibility of rejection, disapproval or criticism and worry that they will be embarrassed or ridiculed. They are cautious about new experiences and avoid involvement with unfamiliar people. They are timid in the face of everyday hazards and avoid risk. They do not feel comfortable in company and tend to avoid social activities.

- **Dependent personality disorder**: These individuals allow others to take responsibility for important decisions in their life. They appear weak-willed and unduly compliant with the wishes of others. They are unwilling to make direct demands on other people, but instead do it indirectly by appearing unable to help themselves. They lack vigor and feel that they will be unable to care for themselves and fear that may have to do so.

- **Obsessive compulsive personality disorder**: It is also known as anankastic personality disorder. The term 'anankastic' was given by psychologist, Kahn (1928) to avoid the false implication that this type of personality as directly linked to Obsessive compulsive disorder. These people are preoccupied with details, rules, order and schedules. They have inhibiting perfectionism that makes ordinary work a burden and leaves the person immersed in trivial detail. They lack imagination and fail to take advantage of opportunities.

Personality disorders or its onset are caused by several factors:

- Genetic predisposition
- Verbal abuse by parents or colleagues
- Your relationships with your peers
- Childhood trauma
- High sensitivity (sound, smell, emotions)

Some personality traits are connected to neurotic personality traits and five illnesses namely, headaches, asthma, arthritis, peptic ulcers and heart disease.
Personality Traits

The Five Factor Model or FFM was initially proposed by Costa & McCrae in the year 1992, describes the relation between an individual's personality and behaviour.

The five personality traits of an individual are as follows:

1. **Openness to experience**: Individuals who score high on openness to experience are generally very active and creative. They are open to new learnings, skill sets and experiences. They are broadminded and modern in their outlook compared to individuals who are conservative, reluctant to changes and take a traditional approach to life.

2. **Conscientiousness**: Individuals who score high on conscientiousness tend to let their consciousness solely dictate their actions. They are highly methodical, organized, self-disciplined and cautious. They do not take decisions in haste and seek perfection in everything they do. They are proactive and goal oriented. They strive hard to accomplish goals and objectives strictly adhering to deadlines.

3. **Extraversion and Introversion**: Carl Jung popularized both the terms - Extraversion and Introversion.
   a) **Extraversion**: Individuals who score high on extraversion take great interest in what is happening around them, love interacting with people and are generally talkative. They enjoy being the center of attraction of parties and social gatherings. They desire the company of others.
   b) **Introversion**: Individuals who score low on extroversion, on the other hand, are seldom interested in what external events. They prefer to stay back at home rather than going out to spend time with friends. They are hardly seen partaking in large social gatherings. They do not have a large social circle and rely only on a few trusted friends.

4. **Agreeableness**: Agreeableness is a personality trait which enables individuals to be adjusting in almost all situations. Such individuals do not crib and have a positive attitude towards change. Individuals who score high on agreeableness are friendly, kind-hearted, helpful and accommodating. But on the other hand, those who score low on agreeableness are unfriendly and struggle to get along with others.

5. **Neuroticism**: Individuals who are neurotic are prone to high rates of anxiety, anger, envy, guilt and so on. They are often in a state of depression and that comes in the way of them being able to enjoy life. They tend to focus on the negative sides of life and find struggle to cope with stress.
Nature of Work Setting of Rehabilitation Psychologist

When planning interventions and recommending services, rehabilitation psychologists involve the rehabilitation team and consider the network of an individual’s environments (for example, familial, social, cultural, physical, service availability, and political) and the means of addressing barriers in these areas.

They might work in a number of different health facilities. This can include hospitals, physical therapy centers, long-term care centers, drug and alcohol rehabilitation centers, psychiatric hospitals, and mental health clinics. They help improve quality of life or help individuals adjust after a major illness or accident. They may work with physical therapists and teachers to improve health and learning outcomes.

Check Your Progress

3. Why are abnormal personality traits “ego-syntonic”?
4. What are the factors which cause personality disorders?

4.4 PSYCHOLOGICAL PROBLEM AND COPING STYLE

The main purpose of the study related to coping mechanism was to investigate the relationship between a parent’s coping mechanisms (confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem solving, and positive reappraisal) on his or her mental health or distress (depression).
Role of Psychologist in Disability Rehabilitation

The following are the main areas in which a psychologist works:

- Rehabilitation psychologists study and work with individuals with disabilities and chronic health conditions to help them overcome challenges and improve their quality of life.
- Rehabilitation psychologists support individuals as they cope with the mental and physical challenges their conditions present. They often teach their patients how to adapt and make lifestyle choices that promote good health.
- Intervening to reduce stress in the lives of vulnerable individuals, thus reducing the risk of mental illness and preventing rehospitalization. Psychologists can do this by teaching stress management skills (for example, to identify stressors, manage stress, and solve problems), environmental management skills, and the social skills necessary to build their social networks.
- Researching the effects and managements of stress.
- Developing and applying measures to assess both the stress experienced by individuals and the internal and external resources available to cope with that stress.
- Rehabilitation psychologists are concerned with all of the factors in people’s lives that contribute to their wellness and recovery, from the support they receive from family and friends to the relationships they have with their team of treatment providers.
- Rehabilitation psychologists assist individuals who have disabilities and chronic illnesses; the disability may be congenital or acquired — for example, an accident or stroke.
- Psychologists provide psychotherapy and administer assessments.
- It is also work at the societal level to make the lives of the disabled better.
- Psychologists treat might be physical, such as addiction or chronic pain.
- Psychologists might work in a number of different health facilities. This can include hospitals, physical therapy centers, long-term care centers, drug and alcohol rehabilitation centers, psychiatric hospitals, and mental health clinics.

Rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Rehabilitation provides disabled people with the tools they need to attain independence and self-determination.

Rehabilitation psychologists support individuals as they cope with the mental and physical challenges their conditions present. They often teach their patients how to adapt and make lifestyle choices that promote good health.
Rehabilitation psychologists are concerned with all of the factors in people’s lives that contribute to their wellness and recovery, from the support they receive from family and friends to the relationships they have with their team of treatment providers.

Check Your Progress

5. State any one advantage of rehabilitation psychology.
6. What are the various areas in which rehabilitation psychologists work?

4.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The five main dimensions of human personality are extraversion, agreeableness, conscientiousness, neuroticism and openness.
2. Personality development is a process of enhancing one’s personality. The focus of personality development sessions is to guide an individual on how he/she can develop his/her personality.
3. Abnormal personality traits are ‘ego-syntonic’ as they do not necessarily cause significant distress to the patient. That is why individual’s having personality disorder does not usually seek psychiatric help unless other psychiatric symptoms co-exist.
4. The factors which cause personality disorders are as follows:
   a) Genetic predisposition
   b) Verbal abuse by parents or colleagues
   c) Your relationships with your peers
   d) Childhood trauma
   e) High sensitivity (sound, smell, emotions)
5. Rehabilitation provides people with special needs the tools which help them to attain independence and self-determination.
6. Rehabilitation psychologists work in a number of areas of different health facilities. This can include hospitals, physical therapy centers, long-term care centers, drug and alcohol rehabilitation centers, psychiatric hospitals, and mental health clinics.

4.6 SUMMARY

- Human development is the study of how people change and grow throughout their lives. When the normal development of the person is hampered, he or she is at a risk of developing a particular type of impairment.
- Learning impairment affects person’s ability to acquire, process and use of spoken, written or nonverbal information, difficulties in planning, memory, reasoning, problem solving and perceptual skills.
- Motor impairments affect disability of the bones, joint or muscles leading to substantial restriction of the movements of the limbs or a usual form of cerebral palsy.
- Sensory impairments affect hearing and eye sight of individuals. Blindness can either be total absence of sight or issues in visual acuity.
- Hearing impairment can take place either due to damage of hair cells in the cochlea or problem in the process of conduction (in outer or middle ear).
- Personality development is a process of enhancing one’s personality. The focus of personality development sessions is to guide an individual on how he/she can develop his/her personality.
- Apart from the immediate environment, factors such as culture, type of education or schooling, also influences the development of one’s personality.
- The majority of personality researchers support the five factor theory of personality which are extraversion, agreeableness, conscientiousness, neuroticism and openness.
- The term ‘personality’ refers to enduring qualities of an individual that are shown in his ways of behaving in a wide variety of circumstances.
- Personality traits are defined as normal, prominent aspects of personality. However, personality disorders result when these personality traits become abnormal.
- Abnormal personality traits are usually ‘ego-syntonic’ which means that they do not necessarily cause significant distress to the patient.
- Personality disorder is a common and chronic disorder. Its prevalence is estimated between 10 and 20 per cent in the general population.
- Many instances of violent and non-violent crime and a large percentage of the prison population are associated with underlying personality disorder.
- Individuals having paranoid personality disorder are suspicious, mistrustful, resentful, jealous, and sensitive and bear grudges, and have self-important ideas.
- Cognitive and perceptual distortions include ideas of reference, suspicious ideas, odd beliefs, magical thinking and unusual perceptual experiences.
- Narcissistic personality disorder is characterized by a grandiose sense of self-importance in these individuals.
- The hallmarks of borderline personality disorder are pervasive and excessive instability of affects, self-image, and interpersonal relationships, as well as marked impulsivity.
- The term ‘anankastic’ was given by psychologist, Kahn (1928) to avoid the false implication that this type of personality as directly linked to Obsessive compulsive disorder.
- The Five Factor Model or FFM was initially proposed by Costa & McCrae in the year 1992, describes the relation between an individual’s personality and behaviour.
- When planning interventions and recommending services, rehabilitation psychologists involve the rehabilitation team and consider the network of an individual’s environments and the means of addressing barriers in these areas.
- Rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels.
- Rehabilitation psychologists are concerned with all of the factors in people’s lives that contribute to their wellness and recovery, from the support they receive from family and friends to the relationships they have with their team of treatment providers.

### 4.7 KEY WORDS

- **Human development**: It refers to the study of how people change and grow throughout their lives.
- **Motor impairments**: It refers to a type of impairment which affect disability of the bones, joint or muscles leading to substantial restriction of the movements of the limbs or a usual form of cerebral palsy.
- **Personality**: It refers to enduring qualities of an individual that are shown in his ways of behaving in a wide variety of circumstances.
- **Sensory impairments**: It refers to a type of impairment which affects hearing and eye sight of individuals. Blindness can either be total absence of sight or issues in visual acuity.

### 4.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

**Short Answer Questions**

1. What are the main areas of impairment?
2. Write a short note on the determinants of personality.
3. What are the various criteria related to personality disorder?
4. How is extraversion different from introversion?
5. Why is personality disorder considered as a chronic disorder?

Long Answer Questions

1. Explain the main types of personality.
2. What are the main types of personality disorders? Discuss any three in detail.
3. Describe the five factor model of personality.
4. Discuss the role of psychologist in disability rehabilitation.
5. Examine the significance of personality development sessions.

4.9 FURTHER READINGS

UNIT 5  REHABILITATION PROCESS IN VARIOUS AREAS

Structure

5.0 Introduction
5.1 Objectives
5.2 Family and Marital Rehabilitation
  5.2.1 Socio Economic Rehabilitation for Persons with Disabilities
  5.2.2 Addiction Rehabilitation
5.3 Vocational Rehabilitation
  5.3.1 Community Based Rehabilitation Program for People with Disability
5.4 Disaster Rehabilitation and Reconstruction
  5.4.1 Guiding Principles of Rehabilitation and Reconstruction
5.5 Answers to Check Your Progress Questions
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5.0  INTRODUCTION

Relationships, marriage and family are at the core of every society. Families are recognized as an important source of support and security. They can provide safe and stable environments which nurture the growth and development of each member.

For instance, Addiction is a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence. People with addiction (severe substance use disorder) have an intense focus on using a certain substance(s), such as alcohol or drugs, to the point that it takes over their life. Vocational rehabilitation (VR) is defined as a set of services which are offered to individuals with special needs.

Rehabilitation is defined as an action which is taken in the aftermath of a disaster to enable basic services to resume functioning, assist victims’ self-help efforts to repair physical damage and community facilities and provide support for the psychological and social well being of the survivors.

In this unit, the meaning of family and marital rehabilitation has been explained. The social and economic aspects of rehabilitation and the steps involved in the
rehabilitation of addiction management have been discussed. The unit will also provide an in-depth knowledge of vocational rehabilitation, disaster rehabilitation and reconstruction and its principles.

5.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the concept of family and marital rehabilitation
- Identify the social and economic aspects of rehabilitation
- Explain the process of management and rehabilitation of addiction
- Identify the types of rehab facilities
- Describe the meaning of vocational rehabilitation and its services
- Examine the significance of community based rehabilitation program
- Analyse the concept of disaster rehabilitation and reconstruction
- Identify the main principles of rehabilitation and reconstruction

5.2 FAMILY AND MARITAL REHABILITATION

Psychologists argue that all human problems are essentially relational and so family therapy is appropriate in all instances. Families are unique social systems where the membership is based on combinations of biological, legal, affection, geographic and historical ties. Furthermore, while family members fulfill certain roles, which entail specific definable tasks such as the provision of food and shelter, it is the relationship within families which are primary and irreplaceable. With single-parenthood, divorce, separation and remarriage as a part of society, a narrow and traditional definition of the family is no longer useful. It is more expedient to think of a person’s family as a network of people in an individual’s immediate psychosocial field.

Severing all family connections is never possible. Family problems will challenge every kind of family at some point of time. The problems can result from behavioural and mental health issues in the family or from specific stressful events. Common family problems include:

- Financial issues
- Grief
- Substance abuse
- Behavioural issues and academic concerns in children and adolescents
- Mental health concerns
- Separation, divorce, or blended family adjustments
- Chronic illness
Marriage and family therapists may offer to see the family as a group in each session, or individual sessions maybe provided to supplement the group sessions. Most types of family therapy fall under the umbrella of family systems therapy, though there are a number of treatment modalities suitable to addressing family concerns.

5.2.1 Socio Economic Rehabilitation for Persons with Disabilities

In this section we will discuss the social and economic aspects of rehabilitation.

Social Aspects of Rehabilitation

The social aspects of rehabilitation include the following:

- Ensuring the follow-up of victims, assessing their needs and resources and giving support, encouragement and guidance.
- Keeping in contact with concerned authorities and community agencies for co-ordination purposes, through a specially designated person.
- Helping arrange for the resumption of children schooling, in co-operation with the proper authorities, if there is a prolonged shelter operation.
- Planning or continuing activities that will contribute to the rehabilitation effort, such as: recreational programmes, special programmes for the elderly and the disabled (for example, day centres)

Economic Aspects of Rehabilitation

The economic aspects of rehabilitation include the following:

- Target those individuals and families whose economic security has been most threatened by the disaster.
- Replace household economic assets lost in the disaster, such as tools, seeds, agricultural animals.
- Where old economic activities cannot be restored National Societies should consider programmes to stimulate the growth of new activities which will be directly accessible by the most vulnerable.

5.2.2 Addiction Rehabilitation

From pre-historic times, mankind has been using various substances to reduce physical pain or to alter states of consciousness. By now several intoxicants have been discovered that are known to affect the central nervous system (CNS), relieving physical and mental anguish or producing euphoria. Despite the often devastating consequences of taking such substances into the body, their initial effects are usually pleasing. This is a major factor perhaps at the root of substance abuse.

These problem substances or drugs that can alter one’s psychological state or mental functioning either occasionally or regularly are known as psychoactive drugs. Drug is defined by World Health Organization (WHO) as any substance
that when taken into the living organism, may modify one or more of its functions. The diagnostic classification of addictive or psychoactive substance-related disorders is divided into two major categories:

1. **Psychoactive substance:** It comprises of induced organic mental disorders and syndromes, which are those conditions that involve organic impairment resulting from the ingestion of psychoactive substances, such as alcohol abuse dementia disorder involving amnesia, formerly known as Korsakoff’s syndrome. These conditions stem from toxicity or physiological changes in the brain due to vitamin deficiency.

2. **Psychoactive substance abuse:** It comprises of abuse and substance-dependence disorders; focuses on the maladaptive behaviours resulting from regular and consistent use of a substance.

In the following section, we will discuss the meaning of terms such as intoxication, abuse, dependence and addiction.

- **Intoxication:** It is seen as a transient syndrome due to recent substance ingestion that produces clinically significant psychological and physical impairment. These changes disappear when the substance is eliminated from the body. The nature of the psychological changes varies with the person as well as the drug.

- **Psychoactive substance abuse:** It generally involves a pathological use of substance resulting in potentially hazardous behaviour (such as driving while intoxicated), or in continued use despite a persistent social, psychological, occupational, or health problems. This is a maladaptive pattern of substance use that leads to clinically significant impairment or distress.

- **Psychoactive substance dependence:** It involves more severe forms of substance-use disorders and usually involves a marked physiological need for increasing amounts of a substance to achieve the desired effects. Two terms that are closely associated with dependence are tolerance and withdrawal.

  (i) **Tolerance:** It is defined by either of the following:

  (a) There is a need for markedly increased amounts of the substance to achieve desired effect.

  (b) There is a substantially diminished effect with continued use of the same amount of the substance.

  (ii) **Withdrawal:** It is shown by either of the following problems:

  (a) The individual shows the characteristic withdrawal syndrome for the substance.

  (b) The same or closely related substance is taken to relieve or avoid withdrawal symptoms.
Addiction: It is defined as a state in which the drug use has altered the body’s chemistry to the point where its ‘normal state’ was the drugged state, so that the body required the drug to feel normal.

The two main psychoactive substance disorders are alcoholism and drug addiction. In everyday clinical practice, one will usually find that in many cases drugs are not used individually. Some drug users like to combine effects, a common combination being marijuana and alcohol. Other drug users switch repeatedly from one drug to another. Identification of the psychoactive substance used may be made on the basis of the following aspects:

- Self-report data
- Objective analysis of specimens of urine and blood
- Other evidence such as presence of drug samples, in the patient’s possession, clinical signs and symptoms, or reports from informed third parties

It is always advisable to seek corroboration from more than one source of evidence relating to substance abuse. Objective analyses provide the most compelling evidence of present or recent use, though these data have limitations with regard to past use and current levels of use.

Substance abuse affects not only the user, but everyone else in their life including their spouses, children and other family members. Substance abuse often causes one to neglect their family, job and other responsibilities. It can also cause financial problems in a household, as the abuser may use money to buy drugs instead of paying bills. Some of the common drugs leading to addiction are amphetamine, caffeine, cannabis, cocaine, hallucinogens, opioid, phencyclidine, sedatives and hypnotics.

Management and Rehabilitation of Addiction

Rehabilitation is an integral part of multimodal treatment of alcohol and drug dependence. The addiction rehabilitation process involves four key steps—intake, detoxification, rehabilitation and ongoing recovery.

We will discuss these steps in detail in the following section.

1. Intake: Intake consists of a comprehensive evaluation, which is then used to create an individualized treatment plan. Before starting any method of treatment, it is important to follow the following steps:
   - Ruling out or diagnosing any physical disorder
   - Ruling out or diagnosing any psychiatric disorder
   - Assessment of the client’s motivation for treatment
   - Assessment of social support system
   - Assessment of personality characteristics of the patients
   - Current and past social, interpersonal and occupational functioning
Intake is defined as the process which determines whether a particular rehab center is a good fit for an individual or not. This is a stage to ask the questions to the center that are most important to you. Some diagnostic tests or screenings helps to determine the most tailor-made plan for an individual and chart out a treatment plan. The center will likely be interested in knowing the severity of one’s addiction, personal drug use history, family history of addiction, and even financial arrangements for treatment.

Early detection of excessive consumption of alcohol and alcohol misuse is important, because treatment of established cases is difficult, particularly when dependence is present.

2. Detoxification: The aim of detoxification is the symptomatic management of the emergent withdrawal symptoms. The drugs are used in a standard protocol with dosage steadily decreasing every day before being stopped, usually on the tenth day. In case of alcohol, the drugs of choice are benzodiazepines such as clorazepate and diazepam. In addition, vitamins should be administered.

3. Rehabilitation: It involves extensive therapy, which aims to rectify drug-seeking behaviours. After the detoxification step is over, there are several methods to choose from, for further management. Over the years, research has shown that when pharmacotherapy is used together with psychotherapy, the results are often better and stable. Some of the most widely used methods are as follows:

- **Individual therapy:** In individual therapy, patients often do some inner work by identifying when they began using the substance and why they started abusing it. Patients receive strategies on how they can direct their time to focus on getting involved in new hobbies or interests. Time management skills are taught to allow patients to better use their time so they have less opportunity to think about relapse. Patients learn to identify drug use triggers and how to deal with these triggering situations when they come up. If patients have a plan for various tempting situations, they are more likely to put their plan into action and avoid relapse.

- **Cognitive behaviour therapy:** It focuses on psycho-education and the improvement of social and interpersonal skills, stress management skills, impulse regulation skills and conflict management skills as these relate to alcohol and drug misuse. It involves identifying various triggers that cause an individual to drink excessively, disputing the underlying irrational thoughts and cognitive distortions and eventually helping them to plan and rehearse new methods of coping with these situations or triggers. It lays lot of emphasis on relapse prevention. It also involves the use of various techniques ranging from covert sensitization,
Rehabilitation Process in Various Areas

**NOTES**

- **Self-Instructional Material**

- Relaxation techniques, assertiveness training, self-control skills, positive reinforcement and aversive techniques.

- **Pharmacological treatment:** They are often used to help in maintenance of abstinence. Some of the commonly used pharmacological agents are disulfiram, acamprosate, naltrexone and antidepressants.

- **Group therapy:** The addiction rehabilitation process usually includes group therapy. These group sessions allow those recovering from addiction to interact with others who are in the same situation. It is often helpful for recovering individuals to know that they are not alone in their struggles. Similarly, others in the group find solace when these individuals share their own stories of addiction and recovery. This sense of community support is integral to the recovery process.

  - The aim of group therapy is to enable patients to observe their problems mirrored by others who also engage in substance use and to work out better ways of coping with their problems. Regular meetings are attended by about 10 patients and one or more members of the staff. In this process, they gain confidence and members of the group jointly strive to reorganize their lives without alcohol or drugs.

- **Family therapy:** Many addiction rehabilitation facilities offer family therapy as part of their program. Addiction is far-reaching, affecting many people — not just the one individual with the addiction. Family members are often those who are most deeply affected by their loved one’s addiction and they are an important component of the recovery process for that person.

  - A family addiction intervention is also the gateway to healing the relationships of the family members that may have been damaged during the time of the addiction. This intervention will not only inspire the addict towards the path of healing, but also inspires the family to use their love and support to heal all relationships and effects that drugs and alcohol have caused.

- **Marital therapy:** Besides the substance abuser, the spouse or partner of the abuser is often the one who is affected the greatest. This is because substance abuse and relationships do not go well together. Substance abuse often causes one to neglect their family, job and other responsibilities. It can also cause financial problems in a household, as the abuser uses money to buy drugs instead of paying bills.

  - When drug or alcohol use continues to cause problems in a marriage, treatment is needed before the problem gets out of hand and the marriage results in divorce.
4. **Ongoing Recovery**: The entire process of recovery is based on the following 13 key principals of addiction treatment and rehabilitation. According to the National Institute on Drug Abuse, there are a number of key principles which have to be considered when starting a drug or alcohol treatment program. These principles are as follows:

- Not only your behaviour is affected by addiction but also your brain is affected.
- For successful outcomes treating addiction as early as possible is important.
- You do not have to go in voluntarily for treatment in order for it to be effective. Many individuals are compelled to go to rehab by the court system, their place of employment, or family or friends — and they are still able to achieve recovery once they go through the program.
- There is no one-size-fits-all solution to treatment. Different treatments and facilities work more effectively for different people.
- All areas of your life is addressed holistically by effective treatment and not just your substance abuse or addiction.
- Mental health conditions are often linked to drug addiction and should also be evaluated and addressed in your treatment.
- Any coexisting infectious diseases such as HIV, hepatitis, and tuberculosis, should also be assessed by treatment programs.
- In order to effectively overcome your addiction you must commit enough time to treatment.
- Physical detox is important but is only the first stage of treatment. Long-term behavioural change usually requires a process of behavioural therapy and ongoing support.
- The most common form of treatment is behavioural therapy, which may involve some combination of group, family, and individual therapy.
- Pharmaceutical treatment is often necessary in conjunction with therapy.
- Throughout the course of treatment good treatment programs will monitor you for any possible relapses.
- Treatment plans should be continually revised to meet your changing needs and circumstances.

With any disease, family involvement and support is paramount in the treatment and healing processes. Just as a cancer patient needs love and support from their family while undergoing treatment, so needs an addict that is beginning the addiction treatment process.

Even after the drug and alcohol detox, addiction treatment program, and aftercare, families often need continued support for the many questions they may have going forward. Likewise, the recovering addict may run into troubles with...
Rehabilitation Process in Various Areas

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Family counseling, and marital counseling services is available-to, and recommended for our recovering patients and their families.

All treatments believe that in order for an addict to truly heal, and continue their sobriety, the family members of the addicted individual should be actively participating in the road to recovery, not only as support during drug detox and drug addiction treatment, but in order to better understand the necessary tools to keep a recovering addict in sobriety and away from the temptations of relapse.

Family support is provided by explicit structuring of services which includes:

- Early engagement
- Meeting cultural needs
- Keeping families together
- Actively listening
- Active involvement
- Education
- Skills training
- Support for community re-integration

Types of Rehab Facilities

Rehab treatment programs may offer inpatient services, outpatient services and some combination of both service types. However, regardless of whether one chooses inpatient addiction treatment or outpatient care, the intake process will be nearly the same and conducted by a counselor at the facility. We will now take a look at these treatments in brief.

- **Inpatient Treatment**: Inpatient treatment programs remove those struggling with addiction from their old ways of life and place them into a treatment facility that offers 24/7 care from staff personnel. This inpatient care helps to eliminate stress by removing the individual from temptation and the ability to relapse both during detox and during rehab. Inpatient or residential treatment is frequently, the recommended treatment type for individuals who either have long-standing addictions or coexisting medical or mental health conditions (known as dual diagnosis).

- **Outpatient Treatment**: Outpatient programs are very similar to inpatient programs, with the exception that one is permitted to return home each night after treatment. If an individual has significant work or familial obligations such as caring for children or elderly parent, outpatient care allows you to maintain some of those responsibilities. Outpatient care is a good option for those with more mild or short-lived addictions. It may be a less optimal choice for those with serious, long-term addictions or for those with dual diagnosis conditions.
In some rehab programs, family members are welcomed to participate in family therapy sessions. During these sessions, family members can discuss pain caused by their loved one’s addiction and their desire to see that person live a healthy life. Family therapy can help to resolve issues so the family can serve as a pillar of support once their loved one leaves the rehabilitation facility.

Check Your Progress
1. What are the two main psychoactive substance disorders?
2. State the aim of detoxification.
3. What are the steps involved in the process of addiction rehabilitation?

5.3 VOCATIONAL REHABILITATION

Vocational rehabilitation (VR) is a process which enables a person with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome these barriers to accessing, maintaining, or returning to employment or other useful occupation.

Vocational rehabilitation services provide individualized coordination of counseling, career planning, training, support services, and job placement appropriate to the employment and life goals of persons with disabilities.

Vocational rehabilitation consists basically of imparting practical courses through which one gains skills and experience directly linked to a career in future. It helps students to be skilled and in turn, offers better employment opportunities. These trainings are parallel to the other conventional courses of study such as B. Sc., M. Sc.

Many vocational rehabilitation services are subject to financial eligibility. VR services include:

- Counseling and guidance
- Interest and aptitude testing
- Job placement assistance
- Diagnostic evaluations
- College or vocational training
- Assistive and/or rehabilitation technology
- School to work
- Employer consultation
- Communication access services (ASL interpreters, oral transliterators, Communication Access Real-time Translation (CART)}
Rehabilitation Process in Various Areas

Vocational rehabilitation services prepare qualified applicants to achieve a lifestyle of independence and integration within their workplace, family and local community. This transition is achieved through work evaluation and job readiness services, job counseling services, and medical and therapeutic services. For individuals with psychiatric disabilities, situational assessments are generally used to evaluate vocational skills and potential.

To facilitate the process of vocational rehabilitation, the following techniques are used:

- Assessment, appraisal, program evaluation, and research.
- Goal setting and intervention planning.
- Provision of health advice and promotion, in support of returning to work.
- Support for self-management of health conditions.
- Making adjustments to the medical and psychological impact of a disability.
- Case management, referral, and service co-ordination.
- Psychosocial interventions.
- Career counseling, job analysis, job development, and placement services.
- Functional and work capacity evaluations.

According to a National Sample Survey Organization (NSSO), two types of vocational trainings are available in India:

- **Formal vocational training**: It follows a structured training program and leads to certificates, diplomas or degrees, recognized by State/Central Government, Public Sector and other reputed concerns.
- **Non-formal vocational training**: It helps in acquiring some marketable expertise, which enables a person to carry out her/his ancestral trade or occupation. In a way through such non-formal vocational training, a person receives vocational training through ‘hereditary’ sources. Often ‘non-formal’ vocational trainings are also received through ‘other sources’. In such cases training received by a person to pursue a vocation, is not ancestral and is different from the trade or occupation of his/her ancestors.

According to National Sample Survey Organization (NSSO), there are different types of Institutions for vocational training. Different institutions which impart vocational training can be classified into four categories: (i) Government, (ii) Local body, (iii) Private aided, (iv) Private unaided. According to a NSSO report vocational training is received by only 10 per cent of people aged between
15-29 years. Out of this only 2 per cent receive formal training, while non-formal training constitutes the remaining 8 per cent. Out of the formal training received by that particular age group only 3 per cent are employed. Most sought after field of training is computer related training. Only 20 per cent of formal vocational training is received from ITI/ITCs. In India, technical education and vocational training system follows patterns such as graduate, post graduate, engineer and technologists through training colleges, diploma from polytechnics and certificate level training in ITIs through formal apprenticeships.

The Vocational Training in India is imparted by mainly two types of bodies:

- Public Industrial Training Institutes (ITIs)
- Private owned Industrial Training Centres (ITCs)

The Indian Government has invested a lot for the development of skills through ITIs. The DGE&T generally regulates these ITIs and ITCs at national level and implements policies for vocational training. Some of the principal training schemes are as follows:

- The Craftsmen Training Scheme (CTS)
- Apprenticeship Training Scheme (ATS)

A number of vocational training institutes are being run by private training providers. The formal training system of India starts at Grade 8 and above. National Council for Vocational Training (NCVT) is an advisory body, was set up by the Government of India in the year 1956. The National Council is chaired by the Minister of Labour, with members from different Central and State Government Departments, Employers and Workers organizations, Professional and Learned Bodies, All India Council for Technical Education, Scheduled castes and Scheduled tribes and All India Women’s Organization.

State Councils for Vocational Training at the State level and Trade Committees have been established to assist the NCVT. The main mandate of the NCVT, according to DGE&T, is to establish and award National Trade Certificates in engineering, non-engineering, building, textile, leather trades and such other trades which are brought within its scope by the Government of India. It also prescribes standards in respect of syllabi, equipment, scales of accommodation, duration of courses and methods of training. It also conducts tests in various trade courses and lays down standards of proficiency required for passing the examination leading to the award of National Trade Certificate.

The main objective of which is to generate employment; the other objective of producing saleable products; and the wider objective of creating self-reliance amongst the people and building up of strong rural community spirit.

To ensure better and effective vocational training, National Skill Standards (NSS) were set up and they perform the following functions:
Rehabilitation Process in Various Areas

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- NSS are set up primarily to specify the minimum skill and knowledge requirements that the workers are expected to possess in specific occupational areas.
- Used as a tool for unifying all training programmes, training standards and training material.
- A national skill testing and certification system can be established.
- Acceptable means of assessing the competency of skilled manpower.
- Mobility and opportunities in terms of employment and promotion with in the country and abroad.
- NSS for 107 trades under CTS & 153 trades for ATS are developed and in force.

Vocational training is intended specifically to provide students with job skills. Most vocational training programs prepare students for hands-on work rather than academic work, and are generally geared toward one career type. Vocational training is generally shorter in duration than an academic education. Trade schools, community colleges and career colleges are all examples of institutions that provide vocational training.

A vocational rehabilitation psychologist should possess the following characteristics:

- With sincere conviction the vocational rehabilitation psychologist should believe that each client has abilities and will be useful in the world of occupation.
- The vocational rehabilitation psychologist should have the conviction that the client had to be helped to take up responsibility of using the information about vocations and himself that he has been helped to acquire.
- The client should be helped to develop insight into him-self in reference to the occupations.
- The client should he helped to develop skills of self-guidance.
- The vocational rehabilitation psychologist should refrain from directing and dominating the process of guidance.

Vocational rehabilitation is a process which enables people with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome barriers to accessing, maintaining, or returning to employment or other useful occupation. Vocational rehabilitation services provide individualized coordination of counselling, career planning, training, support services, and job placement appropriate to the employment and life goals of persons with disabilities.
Vocational Rehabilitation (VR) training is a federal and state funded program that works with people who have physical or mental disabilities to prepare for, gain or retain employment. VR is committed to helping people with disabilities find meaningful careers.

5.3.1 Community Based Rehabilitation Program for People with Disability

To help people with disabilities is the aim of community-based rehabilitation (CBR) and by establishing community-based medical integration, equalization of opportunities, and physical therapy (physiotherapy) rehabilitation programs for the disabled. One of the strengths of CBR programs is that they can be made available in rural areas, with limited infrastructure, as program leadership is not restricted to professionals in healthcare, educational, physiotherapy, Occupational therapy vocational or social services. Instead the people with disabilities themselves, their families and communities, as well as appropriate professionals, are involved in CBR programs. Through the combined efforts of people with disabilities, CBR is implemented, their families and communities, and relevant government and non-government health, education, vocational, social and other services. These programs and services are different from state to state but may include:

- Vocational counseling, guidance and referral services and vocational rehabilitation counselors, help you choose your work goals, help you plan your program of services by talking with you to see what your skills and interests are.
- Assessments determine your eligibility and vocational rehabilitation needs. Assessments such as career assessments and functional vocational evaluation will help to find more about your interests, skills and abilities.
- Physical and mental rehabilitation services such as help with getting eyeglasses, visual services, and treatment for mental health, or speech therapy.
- For students who are deaf, interpreter services are provided.
- For students who are blind, reader services are provided.
- Transportation related to other vocational rehabilitation services; in some instances you will get pay for the cost of transportation while you are taking part in other vocational rehabilitation programs.
- While receiving certain vocational rehabilitation services, maintenance for additional costs incurred.
- Programs and classes that teach job skills such as vocational and other training, including on-the-job training.
- Supported employment services include job coaching; these services will be provided to you for as long as you need them to help you keep the job.
Rehabilitation Process in Various Areas

NOTES

- Job placement services help you improve job seeking and job-keeping skills such as job development, job placement assistance, and job maintenance.

- Workplace personal assistant services will be provided to the individual (WPAS) such as a work task-related assistant, a reader, an interpreter, help with lifting or reaching work-related items, a personal care assistant, or a travel assistant. Services such as training for managing, supervising, and directing your personal assistance services are also included in it.

- Rehabilitation technology services and devices, one will receive assistive technology, special devices or accommodations to do the job, including enlarged print, TDD, or raising a desk for a wheelchair.

- Independent living programs are organized to assess your independent living needs and identify barriers to employment, to make adjustments to your home to help you better manage tasks and work more efficiently.

- Students with disabilities transition from school to work are provided services.

  From a wide range of disciplines, grassroots community leaders, advocates, and professionally trained individuals can practice community-based rehabilitation. Those include occupational therapists, physical therapists, rehabilitation counselors, developmental therapists, community psychologists, social workers, nurses, public health professionals, and physicians specializing in physical medicine and rehabilitation.

  Internationally, the community-based rehabilitation movement began with two World Health Organization (WHO) initiatives of the 1970s and ’80s: (1) the primary health care (PHC) campaign Health for All by the Year 2000, introduced in 1978, and (2) the community-based rehabilitation movement that emerged, in part, from the PHC campaign.

Practice of Community-Based Rehabilitation

Along a continuum the practice of community-based rehabilitation varies ranging from institutional medical-treatment approaches to community-integrated participatory approaches. Biomechanical approaches to rehabilitation may be included in medical treatment, including manipulating the body or teaching and assisting patients with movement and daily living skills. Medical approaches are criticized by disability rights activists and those scholars, researchers, and practitioners who support a more consumer-centred or participatory approach to rehabilitation.

Check Your Progress

4. Define vocational rehabilitation.

5. What are the two main types of vocational training available in India?
5.4 DISASTER REHABILITATION AND RECONSTRUCTION

Disaster rehabilitation refers to intermediate term activities to assist disaster stricken populations to return to a state of viability. In both man-made and natural disaster situations, the impacts can be mitigated to a large extent through adequate planning and preparedness. Negative impacts of man-made disasters can be managed, if social, ecological and economic consequences of our actions are considered and development decisions made accordingly. On the other hand, while we can be adequately prepared for a natural disaster, we cannot totally eliminate its impacts.

The aim of the reconstruction phase is to restore the living conditions of disaster-stricken communities. The SDC’s humanitarian experts help the victims overcome the effects of war or natural disasters through lasting improvements that lead to better housing, infrastructure and income-generating opportunities.

Rehabilitation and reconstruction operations are integral to disaster recovery. A direct contact between disaster response and long term development is provided by them. The two activities, however, do not have similar connotation. Rehabilitation involves restoring local services related to the provision of immediate needs. It implies a systematic return to pre-disaster status. It refers to actions taken in the aftermath of a disaster to enable basic services to resume functioning, assist victims’ self-help efforts to repair physical damage, restore community facilities, revive economic activities and provide support for the psychological and social well-being of the survivors. It focuses on enabling the affected population to resume more or less normal patterns of life. It may be considered as a transitional phase between immediate relief and major long-term development.

Reconstruction, on the other hand, represents long-term development assistance, which could help people in the affected areas to rebuild their lives and meet their present and future needs. It takes into account reduction of future disaster risks. Rehabilitation may not necessarily restore the damaged structures and resources in their previous form or location. It may include the replacement of temporary arrangements established as part of emergency response or the upgradation of infrastructure and systems from pre-disaster status.

A comprehensive rehabilitation and reconstruction or a broad recovery plan should take into consideration both physical and non-physical requirements of the communities. Failing to address long term recovery could have adverse consequences. The following can be the main types of consequences:

- It may simply result in large investment in infrastructure without the necessary inputs to help the victims to become psychologically fit, socially ready and economically self-sufficient.
- The necessary links between physical, social and psychological recovery may be ignored.
There are several factors that need to be taken into view while designing a long-term disaster recovery plan entailing rehabilitation and reconstruction. These are economic, social, political and cultural.

5.4.1 Guiding Principles of Rehabilitation and Reconstruction

In order to meet its objectives, rehabilitation and reconstruction programme needs to draw upon certain guiding principles. We can infer from our previous Sections some of the guiding principles that are part and parcel of an effective approach towards long-term disaster recovery. The broad priorities in a situation of disaster rehabilitation are:

- Provision of emergency relief to be operationalized by the way of mobilizing human and material resources on a war footing, comprising food security, construction of temporary shelters and other basic needs
- Rehabilitation of all the displaced people, restoration of basic and alternative means of livelihood along with community-based infrastructure and institutions;
- Initiation of long-term development interventions, which would lead to sustainable community-based actions (Medury and Dhameja, 2005).

Reconstruction to Rehabilitation

An important entry point for the rehabilitation process is formed by the reconstruction of shelter and community infrastructure.

To restore and upgrade local habitat a reconstruction program is the first step. It introduces improved systems of building, sets up basic building element supply, and builds up the skills and management capacity of families, local agencies and village artisans in a restricted area and sets up local information and knowledge systems.

A holistic view of “habitat” that links the process of housing with the capacity to make and exercise informed choices related to construction of the building, habitat improvement and economic betterment is the larger goal.

Re-establishing people’s lives through rehabilitation efforts involves the following aspects:

- Moving up the ladder from house to habitat to livelihood.
- Local awareness creation including training for all so that people gain control over the housing process.
- Capacity building and linking to enterprises-livelihood support.
- Devising livelihood interventions in the farm and non-farm sectors based on new economic opportunities to create economic surpluses (that can be directed to responsive housing).
- Creating a basis for community access to institutional housing finance.
### 5.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The two main psychoactive substance disorders are alcoholism and drug addiction.
2. The aim of detoxification is the symptomatic management of the emergent withdrawal symptoms.
3. The addiction rehabilitation process involves four key steps—intake, detoxification, rehabilitation and ongoing recovery.
4. Vocational rehabilitation is a process which enables people with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome barriers to accessing, maintaining, or returning to employment or other useful occupation.
5. According to a National Sample Survey Organization (NSSO), two types of vocational trainings are available in India:
   - Formal vocational training: It follows a structured training program and leads to certificates, diplomas or degrees, recognized by State/ Central Government, Public Sector and other reputed concerns.
   - Non-formal vocational training: It helps in acquiring some marketable expertise, which enables a person to carry out her/his ancestral trade or occupation.
6. The aim of the reconstruction phase is to restore the living conditions of disaster-stricken communities. The SDC’s humanitarian experts help the victims overcome the effects of war or natural disasters through lasting improvements that lead to better housing, infrastructure and income-generating opportunities.
7. Rehabilitation refers to actions taken in the aftermath of a disaster to enable basic services to resume functioning, assist victims’ self-help efforts to repair physical damage, restore community facilities, revive economic activities and provide support for the psychological and social well-being of the survivors.
5.6 SUMMARY

- Psychologists argue that all human problems are essentially relational and so family therapy is appropriate in all instances.
- Family problems will challenge every kind of family at some point of time. The problems can result from behavioural and mental health issues in the family or from specific stressful events.
- Drug is defined by World Health Organization (WHO) as any substance that when taken into the living organism, may modify one or more of its functions.
- The two main psychoactive substance disorders are alcoholism and drug addiction. In everyday clinical practice, one will usually find that in many cases drugs are not used individually.
- Substance abuse affects not only the user, but everyone else in their life including their spouses, children and other family members.
- Rehabilitation is an integral part of multimodal treatment of alcohol and drug dependence. The addiction rehabilitation process involves four key steps—intake, detoxification, rehabilitation and ongoing recovery.
- The aim of detoxification is the symptomatic management of the emergent withdrawal symptoms.
- In individual therapy, patients often do some inner work by identifying when they began using the substance and why they started abusing it.
- The addiction rehabilitation process usually includes group therapy. These group sessions allow those recovering from addiction to interact with others who are in the same situation.
- The entire process of recovery is based on the 13 key principals of addiction treatment and rehabilitation.
- Rehab treatment programs may offer inpatient services, outpatient services and some combination of both service types.
- Inpatient treatment programs remove those struggling with addiction from their old ways of life and place them into a treatment facility that offers 24/7 care from staff personnel.
- Outpatient programs are very similar to inpatient programs, with the exception that one is permitted to return home each night after treatment.
- Vocational rehabilitation (VR) is a process which enables a person with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome these barriers to accessing, maintaining, or returning to employment or other useful occupation.
Vocational rehabilitation services prepare qualified applicants to achieve a lifestyle of independence and integration within their workplace, family and local community.

Vocational training is intended specifically to provide students with job skills. Most vocational training programs prepare students for hands-on work rather than academic work, and are generally geared toward one career type.

Vocational rehabilitation services provide individualized coordination of counselling, career planning, training, support services, and job placement appropriate to the employment and life goals of persons with disabilities.

To help people with disabilities is the aim of community-based rehabilitation (CBR) and by establishing community-based medical integration, equalization of opportunities, and physical therapy (physiotherapy) rehabilitation programs for the disabled.

Along a continuum the practice of community-based rehabilitation varies ranging from institutional medical-treatment approaches to community-integrated participatory approaches.

A comprehensive rehabilitation and reconstruction or a broad recovery plan should take into consideration both physical and non-physical requirements of the communities.

### 5.7 KEY WORDS

- **Addiction**: It is defined as a state in which the drug use has altered the body’s chemistry to the point, where its ‘normal state’ was the drugged state, so that the body required the drug to feel normal.

- **Cognitive behaviour therapy**: It refers to a therapy which focuses on psycho-education and the improvement of social and interpersonal skills, stress management skills, impulse regulation skills and conflict management skills as these relate to alcohol and drug misuse. It

- **Disaster rehabilitation**: It refers to intermediate term activities to assist disaster stricken populations to return to a state of viability.

- **Vocational rehabilitation (VR)**: It refers to a process which enables a person with functional, psychological, developmental, cognitive, and emotional disabilities or impairments or health disabilities to overcome these barriers to accessing, maintaining, or returning to employment or other useful occupation.
5.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

NOTES

Short Answer Questions
1. What are the common family problems?
2. How is addictive disorder classified?
3. List the types of rehab facilities.
4. What is psychoactive substance abuse?
5. List the characteristics of a vocational rehabilitation psychologist.
6. What are some of the most common rehabilitation methods?
7. How is reconstruction different from rehabilitation?
8. What are the various types of vocational rehabilitation services?

Long Answer Questions
1. Discuss the social and economic aspects of rehabilitation.
3. Analyse the principles of ongoing recovery.
4. Interpret the techniques used in vocational rehabilitation.
5. Discuss the main functions of National Skill Standards (NSS).

5.9 FURTHER READINGS

UNIT 6  DISABILITIES

Structure
6.0 Introduction
6.1 Objectives
6.2 Disability: Concept and Definition
   6.2.1 Classification of Various Disabilities: Their Incidence and Prevalence
6.3 Types of Disabilities
6.4 Etiological Factors for Disabilities
   6.4.1 Etiological Factors for Chromosomal Aberrations
6.4.2 Prevention of Disabilities
6.5 Answers to Check Your Progress Questions
6.6 Summary
6.7 Key Words
6.8 Self Assessment Questions and Exercises
6.9 Further Readings

6.0 INTRODUCTION
Disabilities, as per the WHO, is an umbrella term, covering impairments, activity limitations, and participation restrictions. Disabilities can be physical including trouble hearing, moving around, etc.

Another type of disability is learning disability, a term used to describe a range of academic difficulties. Dyslexia, a reading disability, is one example. Psychologists can help individuals with all kinds of disabilities. While some interventions focus on teaching stress management and other coping skills, others focus on the disability itself. As per the world Disabilities Report- 2011, individuals with disabilities comprise of 5% to 8% of Indian population.

In this unit, the meaning of disability, its forms and its factors have been discussed. The various forms of impairment and their characteristics have been explained in detail. The genetic and chromosomal factors have been highlighted. The unit will also discuss the etiological factors for disabilities and steps which can prevent disabilities.

6.1 OBJECTIVES
After going through this unit, you will be able to:

- Discuss the meaning of disability
- Explain the forms of disability
- Analyse the factors which affect disability outcomes
- Interpret the symptoms of autism
• Describe the various forms of impairment and their characteristic
• Identify the etiological factors for disabilities and genetic and chromosomal factors
• Analyse the steps related to prevention of disabilities

6.2 DISABILITY: CONCEPT AND DEFINITION

A disability is an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. It substantially affects a person’s life activities and may be present from birth or occur during a person’s lifetime.

According to the Americans with Disabilities Act (ADA), an individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities.

Medical authority certifies someone with disability when he or she suffers from not less than 40 per cent of any disability. While reading about disability, one often comes across several terms such as impairment, handicap and rehabilitation which are often used synonymously with it. The term ‘impairment’ refers to missing or defective body part, an amputated limb, and paralysis after polio, restricted pulmonary capacity, diabetes, nearsightedness, mental retardation, limited hearing capacity, facial disfigurement or other abnormal condition.

A disability becomes a handicap when it interferes with doing what is expected at a particular time in one’s life. However, the term ‘rehabilitation’ refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric or social functional levels.

Therefore, disability refers to a physical, mental, cognitive, or developmental condition that impairs, interferes with, or limits a person’s ability to engage in certain tasks or actions or participate in typical daily activities and interactions. It can be a permanent injury, illness, or physical or mental condition that tends to restrict the way that someone can live their life.

6.2.1 Classification of Various Disabilities: Their Incidence and Prevalence

Disability has been classified in various ways, based on the degree of impairment, the area affected and the role played by physical and environmental factors.

Classifications of disability on the basis of degree of impairment are as follows:

• **Temporary total disability**: Period in which the affected person is totally unable to work. During this period he may receive orthopedic, auditory or speech, ophthalmologist or any other medical treatment
Temporary partial disability: Period when recovery has reached the stage of improvements so that person may begin some kind of gainful occupation.

Permanent disability: Permanent damage or loss of use of some part /parts of the body after the stage of maximum improvement has been reached and the condition is stationary.

The classification also recognizes the role of physical and social environmental factors in affecting disability outcomes. These outcomes are discussed in the following section.

1. Learning disability (LD): Learning disability is a disorder related to processing information that leads to difficulties in reading, writing, and computing; the most common disability, accounting for half of all students receiving special education. Over these years there has been no single definition of Learning disability, as it has been defined in multiple ways by different people. As per the National Joint Committee for Learning Disabilities (NJCLD, 1981), ‘Learning Disability refers to a heterogeneous group of disorders manifested by significant difficulties in acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual, presumed to be due to central nervous dysfunction, and may occur throughout one’s life. Problems in or concerns with self-regulatory behaviours, social perception and social interaction may exist with learning disabilities but do not by themselves constitute a learning disability. Although learning disabilities may occur concomitantly with other handicapping conditions (for example, sensory impairment, mental retardation, serious emotional disturbance) or with extrinsic influences (such as cultural differences, insufficient or inappropriate instruction), they are not the result of those conditions or influences.” In short one can say that a child has learning disability if:

- He or she has a significantly greater difficulty in learning than the majority of children of his or her age.
- His or her grades are two levels below the grades of children of his or her age.

LD has been broadly classified into the following categories:

- **Dyslexia:** Dyslexia is a type of reading disability. The word ‘dyslexia’ comes from ‘dys’ means ‘difficulty’ and ‘lexia’ means ‘words’. The combination of which implies ‘difficulty with words’. It is one type of learning disability that affects a person’s ability to read. This difficulty in converting written material to speech and spoken words to writing are the essential characteristics of dyslexia. Dyslexia mainly affects the development of literacy and language related skills. Children having dyslexia have poor spellings, poor reading skills, and limited vocabulary.
and have difficulty comprehending text. The incidence of dyslexia in primary school children in India has been reported to be around 2-18 per cent.

- **Dysgraphia**: The word ‘Dysgraphia’ basically means difficulty expressing thoughts in writing. It is a learning disability that affects writing abilities. Dysgraphia is characterized by illegible handwriting with letters wrongly sized or spaced incorrectly. Words are frequently misspelled even though the child may be able to read words correctly. It can manifest itself as difficulties with poor handwriting, spellings, poor keyboard skills and inability to engage in fine motor movements. The prevalence of dysgraphia in school going children in India has been reported to be around 14 per cent.

  Children with dysgraphia tend to write the wrong word when trying to put together thoughts on paper and tend to confuse similar sounding letter such as p, q, b, d and lack basic spelling skills. They tend to write wrong or misspelled words despite methodical instructions or make inappropriately sized and spaced letters. They may also lack co-ordination and may find other fine motor tasks such as tying shoes difficult. However, all their fine motor skills are not affected.

- **Dyscalculia**: Dyscalculia refers to difficulty with counting or mathematics. Dyscalculia affects about 5-8 per cent of the school going population.

- **Dyspraxia**: Dyspraxia refers to a delay or disorder of the planning and/or execution of complex movements. In dyspraxia a marked impairment in the development of motor co-ordination is seen which tends to significantly interfere with academic achievement or activities of daily living. It is understood to be an immaturity of parts of the motor cortex (area of the brain) that prevents message from being properly transmitted to the body. It may be associated with problems of language, perception and thought.

2. **Speech or language impairment**: Speech or language impairment is a disorder related to accurately producing the sounds of language or meaningfully using language to communicate. Speech impairment is characterized by difficulty in articulation of words. Examples include stuttering or problems producing particular sounds.

Language impairment is a specific impairment in understanding and sharing thoughts and ideas, i.e. a disorder that involves the processing of linguistic information. Problems that may be experienced can involve the form of language, including grammar, morphology, syntax; and the functional aspects of language, including semantics and pragmatics.

Speech and language skills develop in childhood according to fairly well-defined milestones. Parents and other care givers may become
concerned if a child’s language seems noticeably behind (or different from) the language of same-aged peers.

3. Mental Retardation (MR): Mental retardation is also referred to as an intellectual disability, is a cognitive impairment which include significant limitations in intellectual ability and adaptive behaviour; this disability occurs in a range of severity.

Mental retardation is defined as a condition of significantly sub-average intellectual functioning with an IQ of approximately 70 or below, with concurrent deficits or impairments in present adaptive functioning in at least two of the following skill areas (communication, self-care, home-living, social or interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety) with an onset before the age of 18.

Mental retardation is further sub-divided into four categories:

a) Mild Mental Retardation (IQ = 55 to 70)
   - It constitutes the largest group of people with mental retardation (nearly 85%)
   - These individuals appear similar to non-retarded individuals but show some deficits in their adaptive functioning.
   - They can achieve academic skills up to a sixth grade level or higher.
   - They can be trained into vocational skills and can do a structured job with little assistance.
   - At times, they appear slow and may need help in negotiating life’s problems and tasks.

b) Moderate Mental Retardation (IQ = 40 to 55)
   - It is seen in approximately 10 percent of the mentally retarded population.
   - These individuals show comparatively more impairment in their cognitive and adaptive functioning.
   - They can achieve academic skills up to a second to third grade level.
   - They can be trained into vocational skills so some extent and may require more extensive supervision on the job and may work in sheltered workshops or other more segregated settings.
   - They may need supportive services to live and work in their local communities throughout their life.

c) Severe Mental Retardation (IQ = 25 to 40)
   - It occurs in approximately 3 to 4 percent of the population of people with mental retardation. These individuals usually have one or more organic causes for their delay.
Disabilities

- Many of them have concurrent motor, ambulatory, and neurological problems, in addition to poorly developed communication skills.
- Most of them require close supervision and specialized care throughout their lives.
- Some individuals learn to perform very simple tasks or routines that facilitate their self-care.

d) Profound Mental Retardation (IQ of 25 and below)
- It affects relatively few individuals (1 to 2 percent)
- Many of them involve pervasive deficits in cognitive, motor, and communicative functioning. Impairments in sensory-motor functioning are often seen from early childhood
- Most individuals require extensive training to complete even the most rudimentary aspects of self-care, such as eating and toileting.
- Often organic causes are seen to underlie profound mental retardation.
- Most individuals require total supervision and care throughout life.

4. Emotional disturbance (ED): Emotional disturbance involves significant problems in the social emotional area to a degree that learning in negatively affected.

5. Autism: Autism is also referred to as Autism spectrum disorder is a disorder characterized by extraordinary difficulty in social responsiveness; this disability occurs in many different forms and may be mild or significant. Autism is known as a complex developmental disability.

Autism is a pervasive developmental disorder marked by the presence of abnormal and impaired development before the age of 3 years. The degree of severity in children varies from mild to moderate to severe in children. The onset of autism is almost always before age 3 and parents typically are concerned between the ages of 12 and 18 months as language fails to develop. There is known to be a higher incidence of autism in boys compared to girls. One should never hurry to make the diagnosis of autism.

Symptoms of Autism

To make a diagnosis of autism, three cardinal symptoms are a must, namely—marked and sustained impairment in social interactions, deviance in communication and restricted or stereotyped patterns of behaviour and interest. Other associated symptoms include the following:

- **Difficulties in communication:** Inability to communicate in full sentences; monotonic or more robot-like intonation; delay in or lack of development of spoken language; marked impairment in the ability to initiate or sustain
conversation with others; sand repetitive use of language or idiosyncratic language; inappropriate use of language such as word salad, echolalia and pronoun reversal.

- **Emotions:** Difficulty expressing emotions; lacking emotional reciprocity; not hugging or kissing family members on their own; sudden mood changes, such as laughing or crying, or giggling to self for no apparent reason.

  Intense anxiety in social situations in high functioning individuals and depression in adolescence may be seen, which may result from their negative social experiences over the years and their partial insight into their condition, knowing that they are different from others without fully understanding their own contribution to the rejecting or otherwise isolating reactions of their peers.

- **Stereotypical behaviours:** Inappropriate play with toys, repetitive stereotypical play, preoccupation with spinning objects, such as spending long periods watching a ceiling fan rotate; lack of varied spontaneous make-believe play or social imitative play appropriate to the developmental level; interest in a repetitive activity—such as, collecting strings and using them for self-stimulation, memorizing numbers, or repeating certain words or phrases.

- **Eye contact:** Poor eye-contact; making it for few seconds and not maintaining it; seeing from the corner of the eye.

- **Social reciprocity:** Failure to develop appropriate relationships with peers; showing little or no interest in peers; lack of awareness of strangers; preferring to stay aloof; being in their own world.

- **Inappropriate body movements:** It includes movements such as posturing, tapping, body rocking, finger wringing, body twirling, which a child usually engages in as a source of pleasure or self-soothing. These movements often decrease in adolescence and adulthood and in those with higher intellectual functioning. Some children with autism may copy other people’s motor movements (echopraxia) without necessarily learning the purpose of that movement; which is, to some extent, the motor equivalent of echolalia.

- **Imitation:** Inability to imitate simple or complex verbal and motor stimuli.

- **Rigidity in behaviour:** It includes behaviours such as following fixed routine or routes for travelling; insisting on wearing a particular dress always; or eating from a particular bowl.

- **Inappropriate behaviours:** It includes behaviour such as eating perfumes, soap, powder, smelling objects; lacking fear of dog or traffic; acute sensitivity to sounds (hyperacusis), for example, covering ears when hearing a dog bark or the noise of a vacuum cleaner; being oblivious to loud noise or people calling them but being fascinated by the faint ticking of a wristwatch or the sound of crumpling paper; getting distressed by presence of bright
Disabilities

• Intellectual and cognitive functioning: Retardation in intellectual functioning; presence of special talents or abilities, which are in contrast with the child's overall deficits in cognitive functioning, such as special ability in decoding letters (hyperlexia) and numbers (although lacking comprehension of what is read); memorizing lists or trivial information, calendar calculation, visual–spatial skills such as drawing, musical skills involving a perfect pitch or playing a piece of music after hearing it only once.

In fact, 70 per cent of children with autism are mentally retarded and nearly 10 percent of individuals with autism exhibit a specific skill. The typical profile on psychological testing is marked by significant deficits in abstract reasoning, verbal concept formation, and integration skills, and on tasks requiring a degree of social understanding.

• Over-activity: Presence of over-activity especially in the preschool years; lack of curiosity in the environment and passivity, or hypo-activity. Both hyper- and hypo-activity may alternate in the same child in different settings or in relation to different activities.

• Sleep and Appetite: Presence of erratic sleep patterns with recurrent awakening at night for long periods; presence of eating disturbances such as aversion to certain foods because of their texture, color, or smell, or insistence on eating a very limited choice of foods and refusal to try new foods; eating inedible substances known as pica may pose a range of safety issues, including the risk of lead toxicity.

• Self-Injury and Aggression: Presence of self-injurious behaviours, such as, biting hands or wrists or banging heads (for this helmets or other protective devices may have to be used); picking out skin; pulling out hair; banging chests, or hitting self; decreased sense of danger; increased impulsivity; frequent temper tantrums, particularly in reaction to demands placed (for example, to comply with a task), changes in routine, or otherwise unexpected events; increased frustration.

• Physical Characteristics: Mostly, young children with autism are often described as attractive and do not exhibit any forms of stigmata but some may show minor physical anomalies such as ear malformations. However, physical attractiveness may diminish in adolescence and adulthood, as the various disabilities and unusual behaviours have an impact on physical appearance.
• **Differential disorders:** It is important to differentiate autism from pervasive developmental disorders such as Asperger’s syndrome, Rett’s syndrome, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified.

### Table 6.1 Various Forms of Differential Disorders and their Characteristics

<table>
<thead>
<tr>
<th>Features</th>
<th>Autism Disorder</th>
<th>Asperger’s Syndrome</th>
<th>Rett’s Syndrome</th>
<th>Childhood Disintegrative Disorder</th>
<th>Pervasive Developmental Disorder Not Otherwise Specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at which it gets diagnosed</td>
<td>0-36 months</td>
<td>Usually more than 36 months</td>
<td>Between 9 to 36 months</td>
<td>More than 24 months</td>
<td>Variable</td>
</tr>
<tr>
<td>Sex ratio</td>
<td>More prevalent in males than females</td>
<td>More prevalent in males than females</td>
<td>Usually seen in females</td>
<td>More prevalent in males than females</td>
<td>More prevalent in males than females</td>
</tr>
<tr>
<td>Social skills</td>
<td>Very poor</td>
<td>Very poor</td>
<td>Poor with age</td>
<td>Very poor</td>
<td>Variable</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Usually poor</td>
<td>Fair</td>
<td>Poor</td>
<td>Fair</td>
<td>Fair to good</td>
</tr>
<tr>
<td>Family history of similar problems</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Not usually</td>
<td>Not usually</td>
<td>No</td>
</tr>
<tr>
<td>Potential of recovery</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Head growth decelerates</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>IQ range</td>
<td>Severe MR to normal</td>
<td>Mild MR to normal</td>
<td>Severe MR</td>
<td>Severe MR</td>
<td>Severe MR to normal</td>
</tr>
<tr>
<td>Outcome</td>
<td>Poor to fair</td>
<td>Poor to good</td>
<td>Very poor</td>
<td>Very poor</td>
<td>Fair to Good</td>
</tr>
</tbody>
</table>

### Check Your Progress

1. What is disability?
2. What are the three cardinal symptoms of autism?

### 6.3 TYPES OF DISABILITIES

You have already learnt about some classification of disabilities, in this section, we will recapitulate the idea along with studying some more types of disabilities.

1. **Hearing impairment:** Deaf, hard of hearing (DIM) involves a partial or complete loss of hearing. The term ‘deaf’ refers to an individual who has severe to profound hearing loss. But the term ‘deafened’ describes an individual who has acquired a hearing loss in adulthood. ‘Hard of hearing’ describes an individual who uses their residual hearing and speech to communicate.

2. **Mobility and physical impairment:** It includes people with varying types of physical disabilities including—upper limb(s) disability, lower limb(s) disability, manual dexterity, disability in co-ordination with different organs of the body. Disability in mobility can be either an in-born or acquired with age problem. It could also be the effect of a disease. People who have a broken bone also fall into this category of disability.

3. **Visual impairment:** It involves a partial or complete loss of vision. ‘Legally blind’ describes an individual who has 10 per cent or less of normal vision.
Only 10 per cent of people with a visual disability are actually totally blind. The other 90 per cent are described as having a ‘visual impairment’. Common causes of vision loss include:

- Cataracts (cloudy vision – treatable)
- Diabetes (progressive blindness)
- Glaucoma (loss of peripheral vision)
- Macular Degeneration (blurred central vision)
- Retinal Detachment (loss of vision)
- Retinitis Pigmentosa (progressive blindness)

4. **Deaf-blindness**: It is a simultaneous significant hearing loss and significant vision loss. It thus, refers to an individual who has both a sight and hearing loss.

5. **Blindness**: It refers to a condition where a person suffers from any of the following conditions namely, total absence of sight or visual acuity not exceeding 6/60 or 20/200 in the better eye with correcting lenses; or limitation of the field vision subtending an angle of 20 degree or worse.

6. **Person with low vision**: A person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device.

7. **Cerebral palsy**: A group of non-progressive conditions characterized by abnormal motor control posture resulting from brain insult or injuries occurring in the pre-natal, neo-natal or infant period of development.

8. **Leprosy cured person**: Any person who has been cured of leprosy but is suffering from loss of sensation in hands or feet as well as loss of sensation and paresis in the eye-lid but with no manifest deformity; manifest deformity and paresis but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity; extreme physical deformity as well as advanced age which prevents him from undertaking any gainful occupation.

9. **Locomotor disability**: Disability of the bones, joint or muscles leading to substantial restriction of the movement of the limbs or a usual form of cerebral palsy. Some common conditions giving raise to locomotor disability could be poliomyelitis, cerebral palsy, and amputation, injuries of spine, head, soft tissues, fractures and muscular dystrophies.

10. **Multiple disabilities**: It involves a simultaneous presence of two or more disabilities such that none can be identified as the primary disability; the most common example is the occurrence of mental retardation and physical disabilities.
‘Multiple disabilities’ means concomitant impairments (such as mental retardation, blindness, and orthopedic impairment), the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments.

Children with multiple disabilities (MD) will typically share deficits in five distinct areas of development: intellectual functioning, adaptive skills, motor skills, sensory functioning, and communication skills.

The roots of MD are many and varied. Cerebral palsy is caused by damage to the developing brain. Other conditions may be caused by chromosomal abnormalities, difficulties associated with premature birth, difficulties after birth. Fetal alcohol syndrome may be a cause. Infections, injuries, and genetic disorders may also factor into MD. Often there’s no known reason for a child’s multiple disabilities.

11. **Orthopedic impairment (OI):** It involves a significant physical limitation that impairs the ability to move or complete motor activities.

12. **Traumatic brain injury (TBI):** It is a medical condition denoting a serious brain injury that occurs as a result of accident or injury; the impact of this disability varies widely but may affect learning, behaviour, social skills, and language.

13. **Other health impairment (OHI):** It involves a disease or health disorder so significant that it negatively affects learning; examples include cancer, sickle-cell anemia, and diabetes.

14. **Organic brain disorders:** The three most commonly known organic mental disorders are delirium, dementia, and organic amnestic syndrome. These are mainly characterized by the presence of impairment in cognition such as in memory, language or attention.

a) **Delirium:** It is the most common organic disorder seen in clinical practice. It is characterized by global impairment in consciousness, resulting in reduced level of aler ness, attention and perception of the environment. It is defined by the acute onset of fluctuating cognitive impairment and a disturbance of consciousness with reduced ability to attend. It is frequently associated with abnormalities in perception, thought, psychomotor activities and disturbances in the sleep–wake cycle. Speech, perceptual and thought disturbances like slurring of speech, incoherence, dysarthria, fleeting delusions (often persecutory), ideas of reference, slow and muddled thinking, experiences of depersonalization and derealization may also be present. These individuals appear most commonly disoriented in time, then in place and rarely in person. It is also associated with cognitive and functional decline. Anxiety, depression, and emotional liability is common. Patient may be frightened or perplexed.
Disabilities

b) Dementia: It is a syndrome caused due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, and orientation, and comprehension, calculation, learning capacity, language and judgment. It is marked by the presence of severe intellectual deterioration. It is defined as a progressive impairment of cognitive functions occurring in clear consciousness (that is, in the absence of delirium).

c) Organic Amnesic Syndrome: It is characterized by impairments of memory due to an underlying organic cause; absence of disturbance of consciousness and attention and absence of disturbance of global intellectual function, abstract thinking or personality. Its key feature is the inability of the individual to learn and later recall new information.

15. Developmental delay (DD): It is a non-specific disability category that states may choose to use as an alternative to specific disability labels for identifying students up to age 9 needing special education.

16. Mental illness disabilities: Just like physical disabilities mental illness disabilities can take many forms. But most of the mental illnesses can be treated if correctly and timely identified and intervened. Various mental illnesses are generally classified into the following categories:

- Psychotic illnesses: Of all the major psychiatric syndromes, schizophrenia are the most difficult to define and describe as over the past 100 years, many widely divergent concepts of schizophrenia have been held in different countries and by different psychiatrists. Also, schizophrenic patients differ from one another more than do patients with other disorders. Thus, schizophrenia is considered to be a heterogeneous disorder. The symptoms of schizophrenic patients involve disturbances in several major areas such as thought, perception, and attention; motor behaviour, affect or emotion and life functioning. The various symptoms are broadly classified into two categories: positive symptoms and negative symptoms. Based on the differing clinical pictures, schizophrenia has been categorized into the following subtypes:

  i. Schizophrenia: It is the most common type of Schizophrenia. It is characterized by the presence of very stable, often paranoid delusions usually accompanied by hallucinations (often auditory in nature) and perceptual disturbances. Disturbances of affect, volition and speech and catatonic symptoms are not prominent. Affect is usually less blunted than in other types of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness and suspicion. Negative symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture.
ii. **Hebephrenic schizophrenia:** It is characterized by the presence of irresponsible and unpredictable behaviour, often accompanied by giggling or self-absorbed smiling and the tendency to remain solitary. The behaviour seems to be empty of purpose and feeling. Grimaces and mannerisms are common. The speech is often rambling and incoherent in nature. Presence of superficial and manneristic preoccupation with religion, philosophy and abstract themes may add to the listener’s difficulty in following the trail of thoughts. Affective changes are predominant with mood being largely shallow and inappropriate. Delusions and hallucinations are usually fleeting and fragmentary in nature. The individual’s thought is largely disorganized. Hypochondriacal complaints are common. Disturbance of affect, thought and volition are usually predominant. Hallucinations and delusions may be present but are not predominant.

iii. **Catatonic schizophrenia:** In it psychomotor activity disturbances are predominant and they may alternate between extremes such as hyperkinesias and stupor; automatic obedience and negativism. Constrained attitudes and postures may be maintained for long periods. Episodes of violent excitement may also take place. These catatonic symptoms may be combined with dream-like (oneiroid) state with vivid scenic hallucinations.

iv. **Undifferentiated schizophrenia:** It refers to conditions meeting the general diagnostic criteria for schizophrenia but not conforming to any of the above subtypes or exhibiting the features of more than one of them without a clear predominance of a particular set of diagnostic characteristics.

v. **Post-schizophrenic depression:** It refers to the presence of depressive episode, which may be prolonged, arising in the aftermath of a schizophrenic illness. The diagnosis should be made only if the patient has had a schizophrenic illness meeting the diagnostic criteria of schizophrenia within the last 12 months. Some schizophrenic symptoms must be still present but no longer dominate the clinical picture.

vi. **Residual schizophrenia:** It is a chronic stage in the development of schizophrenic disorder in which there has been a clear progression from an early stage, (where general criteria of schizophrenia was made) to a later stage characterized by long term, though not necessarily reversible negative symptoms.

- **Simple schizophrenia:** It is an uncommon disorder in which there is an insidious but progressive development of negative symptoms, inability to meet the demands of the society and decline in the total performance.
Delusions and hallucinations are not evident, and the disorder is less obviously psychotic than the other subtypes. The characteristic negative features of residual schizophrenia develop without being preceded by delusions, hallucination or any overt psychotic symptoms. In individuals suffering from simple schizophrenia, significant changes in personal behaviour are manifested as marked loss of interest, idleness and social withdrawal over a period of at least one year.

- **Delusional disorder:** It refers to disorders with persistent, well-systematized, non-bizarre delusion that is not due to any other mental disorder. It is characterized by the presence of persistent delusions of persecution, grandeur, jealousy, somatic delusions and erotomanic delusions in the absence of significant or persistent hallucinations, organic mental disorders, schizophrenia and mood disorders. These individuals usually carry on a near normal social and occupational life without arousing suspicion regarding the delusional disorder. It is only when the area of delusions is probed or confronted that the personality disorganization is evident. It is a disorder with usually a relatively stable and chronic course.

- **Induced delusional disorder:** It refers to a condition in which an individual having a close relationship with another person who already has an established delusional system ends up developing a similar delusional system. The delusions are nearly always persecutory. Sometimes more than two people are involved, but this is exceedingly rare. Over 90 per cent or more of reported cases are numbers of the same family. Usually there is a dominant partner with fixed delusions who appear to induce similar delusions in a dependent or suggestible partner, sometimes after initial resistance. Generally the two have lived together for a long time in close intimacy, often in isolation from the outside world. The condition runs a chronic course. It is usually necessary to advice separation of the affected people.

17. **Mood disorders:** Emotions are largely described by terms like affect and mood. Affect refers to short-lived emotional responses to an idea or an event. Mood refers to sustained and pervasive emotional response which colors the whole psychic life. In mood disorders, the fundamental disturbance is a change in mood, usually to depression (with or without associated anxiety) or to elation (mania or hypomania).

18. **The depressive episode:** It is characterized by the presence of sad mood, loss of interest and enjoyment, decreased energy, increased fatigability, multiple physical symptoms (such as heaviness of head, vague body aches), diminished activity, reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt, feelings of worthlessness, helplessness and hopelessness, pessimistic thinking, ideas of self-harm or suicide, disturbed sleep and appetite.
A duration of at least 2 weeks is usually required for diagnosis, but shorter periods may be reasonable if symptoms are usually severe and of rapid onset. It is likely to occur more frequently in women than men. The life time prevalence rate of depressive episodes is about 8 per cent.

19. **The manic episode**: It is characterized by the presence of elated mood, increased activity, self-important ideas, decreased sleep, increased appetite, increased irritability, excessive spending, reckless decision making, increased libido and flight of ideas. These individuals may start many activities, but leave them unfinished as new one catches their attention. Sometimes their persistent over activity leads to physical exhaustion. Rarely, a manic patient can go into a stuporous state known as manic stupor. Manic episodes are equally likely to occur in men and women. The life time prevalence rate of manic episodes is 0.8 per cent to 1 per cent.

20. **Bipolar affective disorder**: It is characterized by repeated (at least two) episodes of mania or hypomania and depression. Inter-episodic remissions are present and recovery is usually complete between the episodes. It is equally likely to be present in both men and women. Patients having only manic episodes are also classified as bipolar affective disorder.

21. **Recurrent depressive disorder**: It is characterized by the presence of repeated episodes of depression (mild, moderate or severe) without any history of independent episodes of mood elevation and over activity that fulfills the criteria of mania. However, brief episodes of hypomania may be there often after the depressive episode, which can sometimes get apparently precipitated by treatment of a depression. Recovery is usually complete between episodes, but a minority of patients may develop a persistent depression, mainly in old age. Individual episodes of any severity are often precipitated by stressful life events. It is twice as common in women as men. The age of onset and the severity, duration and frequency of the episodes of depression are all highly variable.

22. **Anxiety disorder**: Anxiety can be seen as a distinct symptom in several psychiatric disorders and physical illnesses or can exist as a disorder by itself. Anxiety disorders are described as abnormal states in which the most striking features are mental and physical symptoms of anxiety, occurring in the absence of organic brain disease or other psychiatric disorder. In it the anxiety seems to be the most severe and prominent symptom. Anxiety disorders have an unrealistic irrational fear or anxiety of a disabling intensity at its core.

The various symptoms of anxiety are fearful anticipation, irritability, sensitivity to noise, restlessness, poor concentration, worrying thoughts, dry mouth, epigastric discomfort, frequent or loose motions, constriction in the chest, difficulty inhaling, palpitation, awareness of missed beats, frequent or urgent micturition, failure of erection, menstrual discomfort, amenorrhea, tremors,
Anxiety disorders can be broadly categorized into the following categories:

- **Panic anxiety disorder**: It is characterized as recurrent sudden intense attacks of anxiety in which physical symptoms predominate and usually reach their peak in less than a minute and are accompanied by fear of serious consequences such as heart attack, losing control or death. These attacks are not restricted to any particular situation or set of circumstances and are hence unpredictable. Individual attacks usually last for minutes only though sometimes longer but the frequency is quite variable.

- **Phobic anxiety disorder**: A phobia is a persistent or a disproportionate fear of a specific event or situation which otherwise poses little or no danger to the individual. In a phobic anxiety disorder, anxiety is evoked only or predominantly by certain well-defined situations (for example, crowded places) or objects (for example, spiders) or natural phenomenon (for example thunder), which are not regarded as dangerous in nature and are external to the individual. The individual tends to avoid such feared situations and objects and experiences anticipatory anxiety whenever there is a possibility of encountering these circumstances and objects. The anxiety is not relieved by the knowledge that other people do not regard the situation as dangerous or threatening. Phobic anxiety often co-exists with Depression. Most phobic disorders other than social phobias are common in women than in men and among adolescents and young adults than in older people.

- **Generalized anxiety disorder**: Generalized anxiety disorder (GAD) is characterized by a chronic persistent worry about a number of events and activities. The worry is not restricted to, or markedly increased in any particular set of circumstances. The major areas of worry are health, work, money, and family (Barlow, 1988). GAD is also known as free-floating anxiety because it is not hooked to any specific object or event or situation.

- **Obsessive compulsive disorder**: Diagnostically Obsessive Compulsive Disorder is defined by the occurrence of unwanted and intrusive obsessive thoughts or distressing images, usually followed by compulsive behaviour designed to neutralize these obsessive thoughts and images or to prevent some dreaded event or situation. Obsessions are intrusive and recurring thoughts and images that come unbidden to the mind and appear irrational and uncontrollable to the individual experiencing them. Obsessions may also take various forms like extreme doubting, procrastination and indecision which strongly interferes with one’s normal functioning. Compulsions involve repetitive behaviour (for example, hand washing and checking) or mental acts (for example,
praying, counting) that the person feels driven to perform in response to an obsession to reduce distress or prevent a dreaded event or situation. A true compulsion is viewed by the person as somehow foreign to his or her personality. Stern and Cobb (1978), for example, found that 78 per cent of a sample of compulsives viewed their rituals as silly or absurd.

23. **Post-traumatic stress disorder:** The post-traumatic stress disorder (PTSD) refers to an intense, prolonged and sometimes delayed reaction to an intensely stressful event like natural disaster, war, rape and or serious assaults. It’s essential features are hyper-arousal, re-experiencing of aspects of the stressful events and avoidance of reminders. The common symptoms seen in PTSD are persistent anxiety, irritability, insomnia, poor concentration, difficulty in recalling stressful events at will, intense intrusive imagery in the form of ‘flash backs’, recurrent distressing dreams, avoidance of reminders of the events, detachment, inability to feel emotions (numbness) and diminished interest in activities. Maladaptive coping responses may occur, including persistent aggressive behaviour, the excessive use of alcohol or drugs and deliberate self harm. Depressive symptoms, feelings of guilt, dissociative symptoms and depersonalization may also be present in PTSD.

24. **Somatoform disorder:** They are characterized by the presence of physical symptoms suggesting a physical disorder without any organic basis and the symptoms are linked to psychological factors or conflicts. These individuals are seen to make persistent requests for medical investigations in spite of repeated negative findings and reassurance by doctors that the symptoms have no physical basis. Even when the onset and continuation of the symptoms bear a clear relationship with unpleasant life events or with difficulties or conflicts, the patient usually resists attempts to discuss the possibility of psychological causation. In these disorders there is often a degree of attention-seeking behaviour. The somatoform disorders can be broadly categorized into:

- **Somatization disorder:** It is characterized by multiple, recurrent and frequently changing physical or somatic complaints (gastrointestinal, cardiovascular, neurogenital and skin or pain symptoms) of long duration (for several years), beginning before the age of 30. Most patients have long and complicated history of contact with primary and specialist medical services, during which many negative and fruitless operations may have been carried out. Sexual and menstrual complaints are also common. The disorder is chronic and fluctuating in nature and leads to impairment or disruption of social, interpersonal and family behaviour. Dependence and abuse of medication, marked depression and anxiety are frequently present. The disorder is twice as common in women as in men.
Disabilities

Notes

- **Undifferentiated somatoform disorder**: it is characterized by the presence of unexplained physical symptoms, lasting at least 6 months which are below the threshold for a diagnosis of somatization disorder. In it, the forceful and dramatic manner of complaints may be lacking, or they may be few in number or the associated impairment of social and family functioning may be totally absent. It has a substantially high prevalence.

- **Hypochondriacal disorder**: It is characterized by preoccupation with a fear or belief of having a serious and progressive illness or disease based on the individual’s interpretation of physical signs of sensations as evidence of physical illness. Normal or commonplace sensations are often interpreted by the patient as abnormal and distressing in nature and the attention is usually focused on only one or two organs or systems of the body. Often the results of the physical examination are negative. Yet the fear of having or the belief that one has a disease persists despite medical reassurance. The symptoms should be present at least for 6 months. The disorder is seen to be equally present in men and women.

- **Somatoform autonomic dysfunction**: In it the symptoms are presented by the patient as if they were due to a physical disorder of a system or organ that is largely or completely under autonomic innervations and control of the cardiovascular, gastrointestinal, respiratory or genitourinary system. Symptoms are usually of two types-objective signs of autonomic arousal such as palpitations, sweating, flushing or tremor and subjective, non-specific symptoms such as sensations of fleeting pains, burning, heaviness and tightness. In many patients but not all, psychological stress or current difficulties and problems appear to be related to the disorder.

- **Persistent somatoform pain disorder**: In it the predominant symptom is pain which chronic in nature and is of sufficient severity to cause distress or impairment of functioning. No organic pathology or path physiological mechanism is found to account for the pain in these patients. The pain is usually seen to occur in association with emotional conflict or psychosocial problems.

25. **Dissociative disorder**: Dissociative experiences are a part of normal experiences, both in relation to highly stressful or traumatic experience, and in a variety of trance, possession or other states which may be considered as normal, even admired, in many parts of the world. The essential feature of dissociative disorder is a disruption of the usually integrated functions of unconsciousness, memory, identity or perception of the environment. The common theme shared by dissociative or conversion disorder is a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations and control of bodily movements; in the absence of any evidence of a physical disorder. The dissociative disorders can be broadly categorized into:
• **Dissociative amnesia:** It involves a loss of personal information usually after some traumatic event like divorce, natural disaster, death of a loved one etc. Here the information is not completely lost but cannot be recalled for some period of time, ranging from several months to few months. The extent and completeness of the amnesia often varies from day to day and between investigations. Complete and generalized amnesia is rare.

• **Fugue:** In it amnesia is extensive. The individual often leaves home and settle in a new city with a new name, job, even personality characteristics following a traumatic event. During the period of Fugue individuals appears normal to observers. His self care is maintained. The individual may travel to places that are previously known to him or have some emotional significance for him. It is relatively brief and sudden. On termination, there is no memory for events that took place during fugue. The shift to another city is often purposeful travel involving little social contact. The life time prevalence rate is 0.2% (Ross et al, 1991).

• **Dissociative identity disorder:** In it the patient manifests two or more complete systems of personality, each system having its own stable unique emotional and thought process. Usually there is one host personality and others are subordinate personalities, which differ markedly from the host. Behaviours and needs inhibited by the host are often displayed liberally by subordinate personality. The transition from one personality to the other may take place over a period ranging from few minutes to years although shorter durations are more common. One alter may have no memory of the other alters. Alter may involve a non-human species but the most common alter are often of the child and of the opposite sex. It should be chronic (long lasting) and severe (causing marked impairment) and not temporary under the influence of some drug.

• **Trance and possession disorder:** It is characterized by a temporary loss of the sense of personal identity and a full awareness of the person’s surroundings. It is an involuntary state of trance not accepted by the person’s culture as a normal part of a collective cultural or religious practice and that causes clinically significant distress of functional impairment. Some cases resemble DID with the person acting as if taken over by another personality for a brief period of time. When the condition is induced by religious rituals, the person may feel taken over by a deity or spirit. The affected person may repeatedly perform the same movement or adopt postures or repeat utterance.

26. **Eating disorders:** With the rapid emphasis on looks, physique and zero size popularized by media, more and more eating disorders are being seen in clinical practice. In one study it was estimated that the general practitioner encounters nearly 45 per cent of anorexia nervosa and 12 per cent of bulimia nervosa.
Eating disorders are disorders of eating behaviour deriving primarily from an overvaluation of the desirability of weight loss that result in functional medical, psychological, and social impairment. Eating disorders are usually characterized into two main categories:

- **Anorexia nervosa**: It is an eating disorder characterized by very low weight (defined as being 15 per cent below the standard weight or body mass index, BMI being 17.5 or below); an extreme concern about weight and shape characterized by an intense fear of gaining weight and becoming fat; a strong desire to be thin and in women, amenorrhea. It is a deliberate weight loss induced and or sustained by the patient. The disorder occurs most commonly in adolescent girls and young women, but adolescent boys and young men may be affected more rarely, as may children approaching puberty and older women up to the menopause.

- **Bulimia Nervosa**: It is an eating disorder characterized by an irresistible urge to overeat, extreme measures undertaken by the patient to control body weight and overvalued ideas concerning one’s body shape and weight. The episodes of uncontrolled excessive eating are known as binges.

Bulimia nervosa can take two forms—the purging type and the non-purging type. In the purging type, the individual tries to control his or her weight by the use of self-induced vomiting, laxatives and diuretics. However, in the non-purging type, the individual tries to control his or her weight by using methods like excessive exercise, fasting etc. individuals suffering from bulimia nervosa usually have normal weight, are often females and these females usually report of having normal menses.

**Check Your Progress**

3. State the difference between the terms, ‘deaf’ and ‘deafened’.
4. What are the common causes of visual impairment?
5. How is dementia caused?
6. What is the characteristic of bipolar affective disorder?

**6.4 ETIOLOGICAL FACTORS FOR DISABILITIES**

Developmental disabilities can occur singly or concurrently in one person. They might involve a cognitive or sensory difficulty, social or communications/language-related problem, a motor impairment, adaptive delay or some combination of these.

The term ‘etiology’ refers to causing or contributing to the cause of a disease or condition. Disabilities can be caused by several pre-natal, natal etiologic factor and postnatal factors, chromosomal aberrations and genetic errors. Various
Disabilities

causes underlying disabilities according to the timing of the brain insult can be classified, respectively, as pre-natal, peri-natal, and postnatal. The types of risk factors are explained in the following section.

1. Pre-natal risk factors: It includes chronic maternal illness, certain maternal infections, nutritional deficiencies, pre-conventional factors, exposure to toxins, maternal chronic illness, and maternal nutritional deficiencies.

2. Peri-natal risk factors: It includes the following:
   a) Pregnancy-related complications: In countries where pre-natal and obstetrical care is difficult to access, chronic maternal disease and pregnancy-related complications often go undetected. Conditions which, left untreated, may contribute to premature birth and or developmental delay include:
   b) Gestational diabetes: It is associated with macrosomia, and risk of birth injury, hypoglycemia in the infant and later gestational stillbirth.
   c) Hypertensive disorders: It can cause serious, long-term disabilities, have a higher incidence in developing countries. Pre-eclampsia and eclampsia are associated with placental insufficiency and preterm delivery.
   d) Multi-gestational pregnancies: Such pregnancies have a higher rate of obstetrical complications during the pregnancy and at time of delivery.
   e) Birth trauma: It is associated with macrosomia, maternal obesity, breech presentation, operative vaginal delivery, small maternal size and maternal pelvic anomalies. Serious birth trauma (for example, intracranial hemorrhage) is uncommon but can cause developmental disabilities. Most, but not all, neurological injuries to peripheral nerves (for example, brachial plexus injuries) resolve over time.
   f) Peri-natal infections: Infection exposure during pregnancy or at time of birth (such as HIV, cytomegalovirus (CMV), toxoplasmosis, rubella, syphilis).

3. Post-natal factors: Lack of access to quality care during pregnancy, delivery and soon after birth can significantly, adversely affect outcomes for both mother and child, including contributing to developmental disabilities.

   The lack of maternal and child health care is a significant problem in developing countries.

   Often as a rule than an exception, various etiological factors together seem to underlies various disabilities. For instance, cerebral palsy is very diverse and
Disabilities

multifactorial. The causes are congenital, genetic, inflammatory, infectious, anoxic, traumatic, and metabolic. The injury to the developing brain may be pre-natal, natal, or postnatal. Cerebral Palsy (CP) may result from one or more etiologies and can occur at any stage from before conception to infancy, with the actual cause difficult to determine in all cases.

Genetic and Chromosomal Factors

Pre-conceptional causes of developmental disability relate predominantly to genetic disorders or malformation syndromes. Genetic disorders are the most commonly identified causal factor for intellectual and other disabilities, and include single gene disorders, multifactorial and polygenic disorders, and chromosomal abnormalities. Genetic disorders associated with developmental delay include aneuploidies and inborn errors of metabolism. Consanguinity increases the prevalence of rare genetic disorders and significantly increases the risk for intellectual disability and serious birth anomalies, especially in first cousins. Some ethnic communities (Ashkenazi Jews) have a higher prevalence of rare genetic mutations and congenital anomalies affecting development.

Causes of intellectual disability can be divided into the following categories:

- Chromosomal abnormalities (30 per cent)
- Central nervous system malformations (10 per cent to 15 per cent)
- Multiple congenital anomalies syndromes (4 per cent to 5 per cent)
- Metabolic (3 per cent to 5 per cent)
- Acquired (15 per cent to 20 per cent)
- Unknown (25 per cent to 38 per cent)

6.4.1 Etiological Factors for Chromosomal Aberrations

A chromosome abnormality, disorder, anomaly, aberration, or mutation is a missing, extra, or irregular portion of chromosomal DNA. It can be from a typical number of chromosomes or a structural abnormality in one or more chromosomes. A chromosome anomaly may be detected or confirmed in this manner.

Chromosome abnormalities usually happen as a result of an error in cell division. Meiosis is the name used to describe the cell division that the egg and sperm undergo when they are developing. Normally, meiosis causes a halving of chromosome material, so that each parent gives 23 chromosomes to a pregnancy.

Chromosomal aberrations are of 4 major types: (a) deletion (b) duplication (c) inversion and (d) translocation.

Etiology of chromosome abnormalities is pretty variable. The most often reason is mistake which occurs during the cell division. It is connected with wrong development of the sperm or ovum (female reproduction cell). We recognize two types of cell division – mitosis and meiosis. Other causes are the maternal age and the influence of the environmental.
Chromosome abnormalities are usually fatal. Each second first-trimester abortion is caused by them. Children who survive and get born suffer from very serious mental and physical problems. The screening for chromosome abnormalities is very important. The cytogeneticists use the karyotype testing.

Chromosomal abnormalities usually occur during the process of cell division. There are two main types of the cell division. The first one is the meiosis. It is the process of division of reproduction cells. The result is a cell with 23 chromosomes (it is haploid). Fetus gets 23 chromosomes from the mother and 23 chromosomes from the father. Cells of fetus are already diploid (2N).

The second type of cell division is the mitosis. It occurs in all non-reproductive cells. It is a form of duplication of the genetic information, followed by the halving of material. The parent cell has 92 chromosomes (4N); two subsidiary cells have 46 chromosomes each (2N). Mitosis starts immediately after fertilization and continues thought whole life. When mistake occurs, the chromosomes may not be equal. Problems in mitosis lead to the mosaicism more often.

Influence of the Environment

It is very hard to tell how important the impact of environmental factors is as one cannot find any significant differences between parents with child with a chromosome abnormality and parents with healthy child. They have usually very similar lifestyle or habits. But there are still some dangerous influences – X-rays, medication or food. Most of them have a cumulative character.

6.4.2 Prevention of Disabilities

Since presence of any form of disability, disables one from leading a completely healthy life, hence all attempts should be made to prevent disabilities as far as possible. Although disabilities cannot be completely prevented but the following steps if taken can be very helpful in this regard:

- Genetic assessment of aspiring couples should be undertaken.
- Maternal serum assessment can be done.
- Amniotic fluid examination is quite helpful in this regard.
- Exposure to different infections can be prevented such as MMR.
- Folate and iron supplements during pregnancy can be taken.
- Maternal ultra sounds at regular intervals at the advice of the doctor should be undertaken.
- Intra uterine surgeries can be done to correct deformities.
- Nutritional support is a must.
- New born screening, diagnosis and treatment or earliest possible rehabilitation is strongly recommended.
- Earliest possible enrollment in family, community rehab systems is advised.
- Proper care and management at all levels needs to be done. For example,
Good eye care starts with simple preventive non-medical interventions such as eye examination, washing the face regularly with clean water and soap, eating healthy foods high in vitamin A, and protecting the eye from dryness, sun glare and accidental injury.

- Self-care practices should be engaged in. From washing the affected limb or foot with water to passive stretching hands and performing exercises.
- Training in self-care can be given. Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.
- Early identification and accurate assessments can go a far way in this endeavor. There is good potential for disability measurement instruments to be used across different NTDs. This is particularly true for aspects like visual impairment, anxiety and depression, activity limitations, restrictions in social participation and stigma and discrimination. An NTD Morbidity and Disability (NMD) Toolkit has been compiled to use this potential.

**Check Your Progress**

7. What are the four main types of chromosomal aberrations?

8. What are pre-natal risk factors of disability?

### 6.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Disability refers to a physical, mental, cognitive, or developmental condition that impairs, interferes with, or limits a person’s ability to engage in certain tasks or actions or participate in typical daily activities and interactions.

2. The three cardinal symptoms of autism are marked and sustained impairment in social interactions, deviance in communication and restricted or stereotyped patterns of behaviour and interest.

3. ‘Deaf’ refers to an individual who has severe to profound hearing loss. On the other hand, ‘deafened’ describes an individual who has acquired a hearing loss in adulthood.

4. The common causes of visual impairment are as follows:
   a) Cataracts (cloudy vision – treatable)
   b) Diabetes (progressive blindness)
   c) Glaucoma (loss of peripheral vision)
   d) Macular Degeneration (blurred central vision)
   e) Retinal Detachment (loss of vision)
   f) Retinitis Pigmentosa (progressive blindness)
5. Dementia is a syndrome caused due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, and orientation, and comprehension, calculation, learning capacity, language and judgment. It is marked by the presence of severe intellectual deterioration.

6. Bipolar affective disorder is characterized by repeated (at least two) episodes of mania or hypomania and depression. Inter-episodic remissions are present and recovery is usually complete between the episodes.

7. Chromosomal aberrations are of 4 major types: (a) Deletion (b) duplication (c) inversion and (d) translocation.

8. Pre-natal risk factors of disabilities include chronic maternal illness, certain maternal infections, nutritional deficiencies, pre-conventional factors, exposure to toxins, maternal chronic illness, and maternal nutritional deficiencies.

6.6 SUMMARY

- A disability is an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these.
- Medical authority certifies someone with disability when he or she suffers from not less than 40 per cent of any disability.
- Disability has been classified in various ways, based on the degree of impairment, the area affected and the role played by physical and environmental factors.
- Learning disability is a disorder related to processing information that leads to difficulties in reading, writing, and computing; the most common disability, accounting for half of all students receiving special education.
- Speech or language impairment is a disorder related to accurately producing the sounds of language or meaningfully using language to communicate.
- Mental retardation is also referred to as an intellectual disability, is a cognitive impairment which include significant limitations in intellectual ability and adaptive behaviour; this disability occurs in a range of severity.
- Autism is also referred to as Autism spectrum disorder is a disorder characterized by extraordinary difficulty in social responsiveness; this disability occurs in many different forms and may be mild or significant.
- A person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device.
• Disability of the bones, joint or muscles leading to substantial restriction of the movement of the limbs or a usual form of cerebral palsy is a characteristic of locomotor disability.

• ‘Multiple disabilities’ means concomitant impairments (such as mental retardation, blindness, mental retardation-orthopedic impairment), the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments.

• Just like physical disabilities, mental illness disabilities can take many forms. But most of the mental illnesses can be treated if correctly and timely identified and intervened.

• Anxiety can be seen as a distinct symptom in several psychiatric disorders and physical illnesses or can exist as a disorder by itself.

• The post-traumatic stress disorder (PTSD) refers to an intense, prolonged and sometimes delayed reaction to an intensely stressful event like natural disaster, war, rape and or serious assaults.

• The essential feature of dissociative disorder is a disruption of the usually integrated functions of unconsciousness, memory, identity or perception of the environment.

• Developmental disabilities can occur singly or concurrently in one person. They might involve a cognitive or sensory difficulty, social or communications/language-related problem, a motor impairment, adaptive delay or some combination of these.

• Disabilities can be caused by several pre-natal, natal etiologic factor and postnatal factors, chromosomal aberrations and genetic errors.

• Various causes underlying disabilities according to the timing of the brain insult can be classified, respectively, as pre-natal, peri-natal, and postnatal.

• Pre-conceptional causes of developmental disability relate predominantly to genetic disorders or malformation syndromes.

6.7 KEY WORDS

• Delusional disorder: It refers to disorders with persistent, well-systematized, non-bizarre delusion that is not due to any other mental disorder.

• Disability: It refers to an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these.

• Learning disability: It refers to a disorder related to processing information that leads to difficulties in reading, writing, and computing; the most common disability, accounting for half of all students receiving special education.
• **Rehabilitation**: It refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric or social functional levels.

### 6.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

#### Short Answer Questions

1. How has WHO defined disability?
2. What are the main forms of learning disability?
3. How is disability classified according to the degree of impairment?
4. What are the problems faced by an individual in language impairment?
5. What are the types of organic brain disorders?
6. How is schizophrenia categorized?
7. What are the steps related to prevention of disabilities?

#### Long Answer Questions

1. Discuss the physical and social environmental factors which affect disability outcomes.
2. What is mental retardation? Explain its various categories.
3. Analyse the symptoms of autism.
4. Discuss in detail any five types of impairment.
5. How is anxiety disorder categorized? Explain in detail.
6. Describe the significance of genetic and chromosomal factors.

### 6.9 FURTHER READINGS


UNIT 7  NATURE AND SCOPE OF REHABILITATION PSYCHOLOGY

Structure
7.0 Introduction
7.1 Objectives
7.2 Rehabilitation Psychology: An Introduction
7.3 History and Philosophy of Disability Rehabilitation
  7.3.1 Goals and Objectives of Rehabilitation
7.4 Answers to Check Your Progress Questions
7.5 Summary
7.6 Key Words
7.7 Self Assessment Questions and Exercises
7.8 Further Readings

7.0 INTRODUCTION

Rehabilitation is defined as an integrated program of interventions that empower individuals with disabilities and chronic health conditions to achieve ‘personally fulfilling, socially meaningful, and functionally effective interaction’ in their day-to-day life.

Rehabilitation psychology is an aspect of treatment which aims at helping an individual return to an optimal level of functioning and to achieve his or her life goals. It is brought about by providing medical, psychological and social input.

In this unit, the meaning, scope, methods and functions of rehabilitation psychology have been discussed. The historical perspective of rehabilitation psychology and the concept of disability rehabilitation with reference to its history and philosophical perspective have been explained. The unit will also highlight the objectives of rehabilitation and training methods of a rehabilitation psychologist. Bear in mind that some of the topics have already been discussed in Unit 1.

7.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the meaning and applications of rehabilitation psychology
- Explain the development of rehabilitation psychology as a form of psychology
- Analyse the functions of a rehabilitation psychologist
7.2 REHABILITATION PSYCHOLOGY: AN INTRODUCTION

As you have learnt in the earlier units, Rehabilitation is defined as an integrated program of interventions which empower individuals with disabilities and chronic health conditions. Rehabilitation psychology is defined as the study of psychological principles on behalf of individuals who have special needs.

Historical Perspective

From a historical perspective, rehabilitation psychology can be seen as a field that is interested in studying and dealing with problems of physical and mental impairments and is committed to deal with these people to enable them lead a healthy, fuller and a more meaningful life.

Both from the inside and outside the profession, psychologists, have been viewed as mental health professionals. As the older mind-body dualism gives way to a more holistic integration of the physical and psychological aspects of life, rehabilitation psychology is gaining increasing interest and relevancy.

From the early part of the century, the involvement of American Psychologists with problems of physical illness and disability increased. Training programs for aphasic patients at Mc Lean Hospital were instituted by Ivory Franz (1847-1933), an American psychologist. Some pioneered early work on brain-behaviour relationships (Reisman, 1991). Franz emphasised, in his APA presidential address, that the psychological effects of brain damage need not be permanent.

The emergence of rehabilitation psychology took place between the two world wars. It was noted by psychologist, Oberman (1965) that there were at least 3 streams that fed into the development of vocational rehabilitation, and by implication, rehabilitation in general. The role of one of the stream is private charitable organizations and agencies, another is the development of the state-federal partnership for vocational rehabilitation and another is the federal effort to provide for the needs of veterans with disabilities.

Two events that had a great impact on the growth of the field of rehabilitation psychology were a set of domestic programs that were launched by Democratic President Lyndon B. Johnson in 1964-65 and the establishment of the Rehabilitation Act of 1973.

Way back during the time of WWII, the role of rehabilitation psychologists was not as clearly defined as it is today. At that point, rehabilitation psychologists used to cater largely to both the educational and vocational needs of disabled veterans of the war. One of their major role was to restore physical and mental
nature and scope of rehabilitation psychology

As mentioned in Unit 1, in 1958, American Psychological Association (APA) established the division of rehabilitation psychology as an organization for psychologists concerned with the psychological and social consequences of disability but it got implemented only in August 2015 when, the APA Council of Representatives approved Rehabilitation Psychology as an area of professional psychological practice which had a distinguishing feature of aiding to specified problems in a particular population. Since its genesis, there have been some major developments in the field of rehabilitation psychology. We have already discussed these developments in the previous units of the book; however, let us recapitulate it in the following section.

- In 1994 Division 22 of APA (established in 1958) which focused on Rehabilitation psychology along with Professional Issues Committee was given more importance and a leadership role and Division 22 in the same year organized APA Conference on Health Care Reform.
- In 1995, establishment of The American Board of Rehabilitation Psychology (ABPP) occurred.
- In 1996, Division 22 played an important role in developing the APA Interdivisional Health Care Committee whose purpose is to establish a common agenda for promoting the professional, educational, and scientific goals of health care psychology.
- In 2010, establishment of the Foundation for Rehabilitation Psychology occurred.

Over the years, people with physical and mental disabilities have witnessed a wide variety of attitude, some more welcoming and the others less welcoming, in terms of social expectations and participation. Social stigma, lack of knowledge and discrimination has, in the past and to some degree in the present too, left people with disability with few employment opportunities. In order to bring about a shift in the attitude and develop more acceptance towards people with disability, a comprehensive civil rights law called The Americans with Disabilities Act (ADA), was established that prohibits, discrimination on the basis of disability and provides protection in the areas of employment and public services to such people.

Scope and Methods

We will in the following section discuss the scope, method and functions of rehabilitation psychology.

Scope

The scope and application of rehabilitation psychologist is wide, as rehabilitation psychologist address various domains of one’s everyday functioning, as per the
WHO’s International Classification of Functioning, Disability and Health (ICF). Some of these are assessment of individual’s neurocognitive status, individual’s cognitive, behavioural, physical and personal factors, and influence of culture, gender, language and ethnicity on an individual and so on. It also comprises of methods related to the teaching of psychology and various training programs related to health promotion.

Methods

A rehabilitation psychologist uses various methods to perform his or her own tasks. We have already discussed these methods in detail in our previous units. Let us take a brief look at the various methods used by a rehabilitation psychologist:

- Administration of standardized and non-standardized tests
- Evaluation and treatment of both individual and family members
- Providing Individual and group intervention by using counseling and psychotherapy, cognitive remediation, behavioral management and enhancing use of assistive technology for enhancing the day to day functioning of the client.

Functions

A rehabilitation psychologist performs several functions. The following are its main functions:

- He or she provides a holistic development to the client by working on his or her biological, psychological, social, environmental and even political environment of the client to assist the client through optimal rehabilitation goals via intervention, therapeutic support, education, consultation with other specializations, and advocacy.
- He or she provides clinical guidance and counseling services to both the individual in need as well as his or her family, primary caregivers and other significant people in the individual’s social life and community to help the patient achieve optimal physical, psychological and interpersonal functioning.
- Rehabilitation psychology involves rehabilitation program development which includes educating the public, developing policies for injury prevention and health promotion, advocacy for persons with disabilities and chronic health conditions, research and teaching of psychology students and other health trainees about the requirements of people with special needs.

As already mentioned in earlier units, another important function or key role of rehabilitation psychologist is to conduct research in the following areas:

- Development of new services patterns
- Short term counseling approaches and methods
- Construction of evaluation instruments
7.3 HISTORY AND PHILOSOPHY OF DISABILITY REHABILITATION

A general notion of ‘disability’, encompassing specific disabilities such as blindness and paralysis, was apparently not recognized before the late 19th century, when the emerging concepts of statistical and biological normality yielded corresponding notions of deviation. Even well into the next century, what is now called ‘disability’ was grouped with ‘moral degeneracy’ and criminality as falling on the lower tail of a normal distribution of valued social traits (Davis 2010). One should not expect to find philosophical or other writing on ‘disability’ any earlier than the 20th century, as opposed to writing on specific disabilities.

Philosophical interest before the 1800s was largely in sensory disabilities, and largely in sight—a natural subject for British and other empiricists. Sensory disabilities presented, and appeared to provide answers to, questions about the role and relationship of different senses in acquiring knowledge of the external world. The ‘Molyneux’ problem, perhaps the most discussed disability topic in 17th- and 18th-century philosophy, concerned the relationship of sight to touch and the epistemic priority of the two senses (Degenaar and Lokhorst 2011). This debate was epistemological; it did not concern the lives of people who lacked sight for various periods of time and then acquired it. Similarly, although Immanuel Kant, a German philosopher did not directly address the moral status of humans with cognitive disabilities that preclude the active exercise of rationality, one scholar argues against the prevailing assumptions that Kant’s empirical theories commit him to the position that all human beings have the same basic moral status (Kain...
Diderot’s letters on blindness and deafness may have been the only major Enlightenment philosophical works to address disabilities in a broader context (Margo et al. 2013).

The ideas that are believed to be at the core of everyday thinking are analysed and assessed by philosophers. They often do this by testing commonplace views against counterexamples involving anomalous or uncommon kinds of cases, and then by revising those views accordingly.

Furthermore, views biased towards the typical or normal instance are unlikely to be general enough to resolve fundamental philosophical questions. By identifying and correcting such biases, thinking clearly about disability can advance philosophy as a whole. Both the neutrality and the generality of philosophical views are ensured by it.

Exploring whether theories of empirical knowledge equally embrace both blind and seeing knower’s, or theories about democratic dialogue extend equally to deaf and hearing participants, or theories of feminist value reflect the experiences of women with and without disabilities equally well, helps establish their adequacy as theories.

Considering what individuals without sight understand about visual properties is a familiar philosophical device for distinguishing *a priori* from empirical aspects of knowledge. For example, direct observation plays in an important role in our understanding of the world and the extent to which understanding the meanings of visual terms is independent of experiencing the properties to which they refer, philosophers ask whether those there is same meaning of those visual terms when used by congenitally blind instead of sighted individuals.

From the perspective of disability physical or cognitive limitations are not absences of talent, but instead are constraints upon the ways in which talents are exercised. Social arrangements that offer equivalent prospects of success to people of similar talent and ambition provide fair equality of opportunity. Fair equality of opportunity requires that regardless of whether their functional modes are normal or anomalous, people with similar talents should enjoy equitable access to the necessary social conditions for realizing their talents.

It is argued by several philosophers that giving justice, the preeminent moral role disregards the realities of disability and especially of the dependency associated with it. Psychologist, Susan Wendell thinks feminist ethics that stress care more than justice, and interdependence rather than autonomy, give disabled people a better role. Wendell urges, disabled people will be free to acknowledge their limitations, dependencies, and other real differences, within the embrace of an ethics of care.

The principle of rooting one’s identity in the reality of one’s body is embodiment. It is argued by the Feminists that cultural practice interprets embodiment; for instance, in many societies women’s bodies have functioned as
objects that are possessed and controlled by men. Similarly, it is experienced by people with disabilities disproportionately, as themselves being the physical objects of other people’s abuse and control.

Philosophical studies of disability differ in at least two ways, from how this subject is pursued in most other academic fields. The first is the fact that the philosophy of disability has not been spun off as a sub-speciality but instead is being integrated into whatever discussions of central philosophical issues invite challenges to normalizing assumptions.

As an article of faith disability studies takes the social model of disability, according to which disadvantage is purely a social and never a biological consequence of impairment. The philosophical study of disability keeps this as an open question, unlike disability studies. Most philosophers would agree with Richard Hull’s notion that our concept of disability should reflect both the reality of impairment and the reality of social discrimination. Clearly, applying philosophical rigor and insight to weigh the ways these realities are related grows ever more important. Thinking about our personal and cultural response to disability becomes ever more pressing as we face the social policy implications of our blossoming capacity for biological intervention, for the demand to refine and elevate, as well as a burgeoning population of frail elderly people and disabled people.

7.3.1 Goals and Objectives of Rehabilitation

Rehabilitation psychology is a specialty area within psychology that focuses on the study and application of psychological knowledge on individuals with disability and chronic health conditions with an aim of maximizing health and welfare, improving quality of life and social participation across lifespan. It aims at helping individuals achieve an optimal level of physical, psychological and interpersonal functioning. In order words, rehabilitation psychology can be seen as an important part of treating and preventing chronic and disabling health problems. It also involves practice, research and advocacy with a broader goal of promoting independence and opportunity for people with disabilities.

The following are the main objectives of rehabilitation:

- Develop services for meeting psychological and social needs
- Improve social, emotional relationships between handicapped
- Enlarge free movement in the physical and social environments of the disabled and deprived.
- Study the social and psychological network of rehabilitation services centers with regards to disability and the laws and regulations.
- Goals need to be achievable and based on regular patient assessment of physical and non-physical consequences of the critical illness throughout their recovery.
To meet these objectives and goals, rehabilitation psychologists require intensive and extensive training in the following areas:

- Unique aspects of rehabilitation psychology
- Psychological assessment of persons with disability
- Impact of the environment on the people who are disabled
- Intervention and remediation procedures
- Rehabilitation practices and management strategies

Rehabilitation psychologists can be trained in the several ways. The following are the main ways in which they can be trained:

- In-service training
- Formal academic generic courses
- Short term courses
- Continuing education

Check Your Progress

3. What are the two ways in which philosophical studies of disability differ?
4. State the aim of rehabilitation psychology.

7.4 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. There are two events that had led to the growth in the field of rehabilitation psychology—a set of domestic programs that were launched by Democratic President Lyndon B. Johnson in 1964-65 and the establishment of the Rehabilitation Act of 1973.

2. The scope and application of rehabilitation psychologist is wide, as rehabilitation psychologist address various domains of one’s everyday functioning. Some of these are assessment of individual’s neurocognitive status, individual’s cognitive, behavioural, physical and personal factors, and influence of culture, gender, language and ethnicity on an individual.

3. Philosophical studies of disability differ in at least two ways. The first is the fact that the philosophy of disability has not been spun off as a sub-speciality; secondly it is being integrated into whatever discussions of central philosophical issues invite challenges to normalizing assumptions.

4. Rehabilitation psychology aims at helping individuals achieve an optimal level of physical, psychological and interpersonal functioning.
Rehabilitation is defined as an integrated program of interventions which empower individuals with disabilities and chronic health conditions.

Rehabilitation psychology is defined as the study of psychological principles on behalf of individuals who have special needs.

From a historical perspective, rehabilitation psychology can be seen as a field that is interested in studying and dealing with problems of physical and mental impairments and is committed to deal with these people to enable them lead a healthy, fuller and a more meaningful life.

As the older mind-body dualism gives way to a more holistic integration of the physical and psychological aspects of life, rehabilitation psychology is gaining increasing interest and relevancy.

Training programs for aphasic patients at McLean Hospital were instituted by Ivory Franz (1847-1933), an American psychologist.

The emergence of rehabilitation psychology took place between the two world wars. It was noted by psychologist, Oberman (1965) that there were at least 3 streams that fed into the development of vocational rehabilitation, and by implication, rehabilitation in general.

Way back during the time of WWII, the role of rehabilitation psychologists was not as clearly defined as it is today.

In 1958, American Psychological Association (APA) established the division of rehabilitation psychology as an organization for psychologists concerned with the psychological and social consequences of disability but it got implemented only in August 2015.

The scope and application of rehabilitation psychologist is wide, as rehabilitation psychologist address various domains of one’s everyday functioning, as per the WHO’s International Classification of functioning, Disability and Health (ICF).

Rehabilitation psychology involves rehabilitation program development which includes educating the public, developing policies for injury prevention and health promotion, advocacy for persons with disabilities and chronic health conditions, research and teaching of psychology students and other health trainees about the requirements of people with special needs.

A general notion of ‘disability’, encompassing specific disabilities such as blindness and paralysis, was apparently not recognized before the late 19th century, when the emerging concepts of statistical and biological normality yielded corresponding notions of deviation.

Social arrangements that offer equivalent prospects of success to people of similar talent and ambition provide fair equality of opportunity.
The principle of rooting one’s identity in the reality of one’s body is embodiment. It is argued by the Feminists that cultural practice interprets embodiment; for instance, in many societies women’s bodies have functioned as objects that are possessed and controlled by men.

Rehabilitation psychology is a specialty area within psychology that focuses on the study and application of psychological knowledge on individuals with disability and chronic health conditions with an aim of maximizing health and welfare, improving quality of life and social participation across lifespan.

7.6 KEY WORDS

- Rehabilitation: It refers to an integrated program of interventions which empower individuals with disabilities and chronic health conditions.
- Rehabilitation psychology: It refers to the study of psychological principles on behalf of individuals who have special needs.
- The Americans with Disabilities Act (ADA): It refers to an Act that prohibits discrimination on the basis of disability and provides protection in the areas of employment and public services to such people.
- The Rehabilitation Act: It refers to an Act which prohibits discrimination on the basis of disability in programs conducted by federal agencies, in programs receiving federal financial assistance, in federal employment and in the employment practices of federal contractors.

7.7 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short Answer Questions

1. How is rehabilitation psychology defined from a historical perspective?
2. What was the major role of psychologists during the World War II?
3. What are the methods used by a rehabilitation psychologist?
4. List the areas in which a rehabilitation psychologist carries his or her research.
5. What are the various ways in which rehabilitation psychologist can be trained?

Long Answer Questions

1. Explain the efforts taken by American Psychological Association (APA) in the field of rehabilitation psychology.
2. Discuss the development of rehabilitation psychology.
3. Explain the philosophical viewpoint of disability rehabilitation.
4. Analyse the goals and objectives of rehabilitation.

5. What are the areas in which rehabilitation psychologist require training? Discuss.

7.8 FURTHER READINGS


Multidisciplinary approaches to rehabilitation

UNIT 8 MULTIDISCIPLINARY APPROACHES TO REHABILITATION

Structure
8.0 Introduction
8.1 Objectives
8.2 Introduction to Multidisciplinary Rehabilitation
8.2.1 Biological Model
8.2.2 The Medical Approach or the Medical Model: Disability as a Disease
8.2.3 Psychological Model
8.2.4 Educational Model
8.2.5 Social Model
8.3 Answers to Check Your Progress Questions
8.4 Summary
8.5 Key Words
8.6 Self Assessment Questions and Exercises
8.7 Further Readings

8.0 INTRODUCTION

Multidisciplinary rehabilitation is used to explain a course of treatment which focuses on maximizing functional abilities and aims to promote physical and mental health. It can concentrate on the physical or cognitive aspects of recovery from an illness, disease, condition or injury.

The psychological approaches guide an individual to progress through the stages of disability and help them to resolve any difficulties they may experience along the way.

In this unit, the meaning of multidisciplinary rehabilitation and various approaches related to it are discussed. The psychological approaches to disability and various therapy associated with are explained. The unit will also describe the social model of disability along with its limitations.
8.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the meaning of multidisciplinary rehabilitation
- Analyse the biological approaches of disability
- Identify the characteristics of the medical model of disability
- Explain the assumptions of biopsychosocial model
- Analyse the psychological approaches to disability
- Interpret the basic assumptions of behavioural cognitive and humanistic therapy
- Discuss the various teaching strategies
- Explain the social model of disability

8.2 INTRODUCTION TO MULTIDISCIPLINARY REHABILITATION

Multidisciplinary rehabilitation is a term used to describe a course of treatment which maximizes physical and mental health functional abilities. It focuses on the physical or cognitive aspects of recovery from an illness, disease, condition or injury.

Approaches to disability refer to tools used for defining impairment and, ultimately, for providing a basis upon which government and society can devise strategies for meeting the needs of disabled people. They are often doubted as it is thought they do not reflect a real world, are often incomplete and encourage narrow thinking, and seldom offer detailed guidance for action. However, they are a useful framework in which to gain an understanding of disability issues, and also of the perspective held by those creating and applying the models.

Since approaches to disability are essentially devised by people about other people, they provide an insight into the attitudes, conceptions and prejudices of the former and how they impact on the latter. From this, they reveal the ways in which our society provides or limits access to work, goods, services, economic influence and political power for people with disabilities.

8.2.1 Biological Model

Biological approaches target body’s mechanisms that control the central nervous system, endocrine system, and metabolism. Biological approaches assume that various disabilities result from underlying biological causes, such as structural abnormalities in the brain, biochemical processes, and genetics.
Biological treatments attempt to alter brain functioning with chemical or physical interventions, including drugs that act directly on the brain and body, surgery, and electroconvulsive therapy. They are usually conducted by psychiatrists, physicians, and surgeons. Biological treatments, also known as biomedical therapies.

The various types of biomedical therapies are:

- **Psychopharmacology**: Therapy that incorporates drugs and chemicals; includes three major types of drugs: anti-psychotic, anti-depressant, and anti-anxiety.
- **Biomedical Psychosurgery**: To ease various disabilities Surgical procedures are done.
- **Electroconvulsive Therapy (ECT)**: To alter the brain’s chemical and electrical activity a brief electrical current applied to a patient’s temples.

### 8.2.2 The Medical Approach or the Medical Model: Disability as a Disease

Due to significant advances in the field of science, the medical (or biomedical) model of disability began to gradually replace the moral and/or religious model from the mid-1800s onwards. The medical model or illness approach assumes that disability is caused by disease or trauma and its resolution or solution is intervention provided and controlled by professionals. Disability is perceived as deviation from normality and the role of persons with disability is to accept the care determined by and imposed by health professionals who are considered the experts. In this model, disability is considered as residing within the individual. Psychologist, Olkin (1999) outlines the basic characteristics of the medical model of disability:

- Disability is seen as a medical problem that resides in the individual.
- It is a defect in or failure of a bodily system and as such is inherently abnormal and pathological.
- The goals of intervention are cure, amelioration of the physical condition to the greatest extent possible, and rehabilitation (i.e., the adjustment of the person with the disability to the condition and to the environment).
- Persons with disabilities are expected to avail themselves of the variety of services offered to them and to spend time in the role of patient or learner being helped by trained professionals.

According to the medical model, PWDs deviate from what is normal. Terms such as ‘invalid’, ‘cripple’, ‘spastic’, ‘handicapped’ and ‘retarded’ are all derived from the medical model (Creamer 2009:22). This approach to disability reinforces the notion that PWDs are not comparable with their able-bodied counterparts. Medical professionals who subscribe to the medical model tend to treat people as problems to be solved, often failing to take into account the various aspects related to the person’s life as a whole (Thomas & Woods 2003:15).
Psychologists, Kasser and Lytle (2005:11) highlight the medical model’s exclusive focus on the limitation(s) associated with a person’s disability, which essentially (disregards) environments that might intensify or adversely affect a person’s functional abilities’. Accordingly, the medical model tends to regard the person with disability as the one who needs to change or be fixed, not the conditions that might be contributing to the person’s disability (Kasser & Lytle 2005:11).

For medical professionals who adhere to the medical model of disability, PWDs should play the ‘sick role’ properly if they desire to receive continued help and support. However, Llewellyn, Agu and Mercer (2008:256) highlight the shortcomings of the medical model’s ‘sick role’ approach, especially in relation to the fact that many chronically ill or disabled people do not consider themselves as sick. Furthermore, the ‘sick role’ approach fails to take account of the vital distinction between impairment and sickness. As Llewellyn et al. (2008:256) note, ‘Many disabled people are not sick, but have ongoing impairments that do not present as daily health problems’.

### 8.2.3 Psychological Model

The psychological model is similar to the medical model, except that mental pathology is seen as the main cause of disability—with or without physical pathology. Disability management involves psychological assessment and counseling to modify inappropriate illness perception, beliefs, attitudes and behaviour.

### Biopsychosocial Model

The biopsychosocial approach or model of disability assumes disability as arising from a combination of factors at the physical, emotional and environmental levels. This approach or model addresses issues that interact to affect the ability of the individual to maintain as high a level of health and wellbeing as possible and to function within society and takes the focus beyond the individual. This approach is consistent with the WHO’s revised definitions of disability. It recognizes that disabilities are often due to illness or injury and does not dismiss the importance of the impact of biological, emotional and environmental issues on health, well-being, and function in society.

An individual’s injury treatment is influenced by emotional, behavioural, and situational factors. Psychosocial factors, in relation to patients’ experience of pain, may explain why some patients are unable to make a full recovery. The World Health Organization’s (WHO), International Classification of Function, Disability and Health (ICF) recognizes pain as a subjective experience and have suggested healthcare professionals shift from treating in a biomedical perspective to a biopsychosocial perspective. The biopsychosocial model recognizes the biological factors pertaining to the disease, injury, or condition, as well as the psychological factors (i.e., thoughts, feelings, and behaviours) and social factors (for example,
socio-demographics and social support) that contribute to the patient’s pain and rehabilitation experience that could not otherwise be explained by the biomedical model.

Critiques of this model have suggested that the disabling condition, rather than the person and the experience of the person with a disability, is the defining construct of the bio psychosocial model.

Psychological approaches target the learned faulty behaviours and habits, along with damaging words, and thoughts that are essential for daily living. Psychological approaches assume that many disorders result from mental, behavioural, and social factors, such as personal experiences, traumas, conflicts, and environmental conditions.

Psychological treatments attempt to change behaviours, thoughts, and thought processes and thus improve functioning. They are usually practiced by clinical psychologists, psychiatrists, social workers and counselors. Psychological treatments include four types of psychotherapy.

1. **Psychodynamic Therapy**

Psychodynamic therapy approach assumes that problems are symptoms of unresolved traumas and conflicts. It focuses on inner, often unconscious motivations as well as attempts to resolve conflicts between personal needs and social requirements. According to psychodynamic approach, people can work through problems and can reach an effective solution by making more conscious the relationships between overt problems and the unresolved, internal conflicts that caused them.

2. **Behavioural Therapy**

Behavioural therapy view assumes that problems are the result of learned, self-defeating behaviours.

It focuses on observable behaviour and conditions that sustain unhealthy behaviour. According to behaviourist approach, people can learn healthy behaviours by applying the principles of conditioning and reinforcement.

3. **Cognitive Therapy**

Cognitive therapy view problems as the result of what we think (cognitive content) and how we think (cognitive process), including distorted view of situations and self, faulty reasoning, and poor problem solving. It focuses on thoughts and thought processes that cause problematic emotions and behaviours. According this perspective, people can learn healthy, realistic ways of thinking about life experiences by reconfiguring damaging thinking patterns.
4. Existential/Humanistic Therapy

Humanistic therapy view problems as the result of issues related to difficulties in daily life, especially a lack of both meaningful relationships and significant goals. It focuses on different ways to unite mind and body, that is, the whole person, and thus, release the potential for greater levels of performance and greater richness of experience. According to this perspective, people can develop their individuality and learn how to realize their full potential by examining experiences in current life situations.

8.2.4 Educational Model

In order to achieve learning outcome, teachers/parents/ CBR workers generally use tool called Teaching Learning Material (TLM). It is a well designed tool for the child’s needs and not merely a set of teacher made or purchased material.

The teacher assess at what level the child is and what activities within the level he/she wants to give. Once the assessment is done, the teacher looks for appropriate teaching learning materials so that the teaching becomes effective and goal oriented.

Teaching Strategies

The route towards successful results is in implementing the right strategy for children with deaf-blindness. Right strategies focus on a child for meeting his/her specific needs focusing on his/her holistic development (total development as a whole). Following points would help you identify effective teaching strategies and techniques for deaf blind child:

- Help the learner communicate and understand different communication modes.
- Use residual hearing and the residual vision.
- Encourage the use of touch since hands may be the link to everything and everybody.
- Give plenty of time for reactions and decisions.
- Build a strong relationship/bond with the student.
- Develop a positive self-esteem among students.
- React to the learner’s actions and communication attempts every time they happen.
- Give immediate feedback to their actions, including reinforcement.
- Use functional activities that can be learned in the natural routines of the day.
- Plan activities and experiences so they involve the learner at every step, from start to finish of an activity.
• Let the students know who is in the room, when they enter and leave if they are not able to see. Even if they can see a person enter, they may not be able to identify who that person is.

• Incorporate communication in all areas of the Individualized Educational Programme.

• Be calm.

8.2.5 Social Model

The social model of disability developed in reaction to the limitations of the medical model of disability inspired by the activism of the British disability movement in the 1960s and the 1970s, (D’Alessio 2011:44). The social model of disability has emerged from research conducted largely by people who have disabilities (Swain, Finkelstein, French and Oliver, 1993). This model assumes that a person with a disability may function differently from some other people, and his problems do not entirely result from the nature of disability rather from the unfounded stereotypes and prejudices toward those with disabilities (Funk, 1987). Such attitudes can reinforce incompetence and poor health that may limit social, vocational and recreational participation. As the person who has a disability recognizes and acknowledges the numerous barriers erected by society, feelings of hopelessness, passivity, or depression may merge and these may be interpreted by outsiders as a lack of adjustment and motivation.

A social model of disability sees the problem as rooted within society. Rather than attempting to fix or change the person with the disability, the focus should be on the removal or reforming of environmental and social barriers to full physical, social, career, and religious participation (French, 1993).

The idea of total societal accommodation to the presence of disability is not a new one. According to psychologist, Nora Groce, residents of Martha’s Vineyard from the 17th to the early 20th century used social and linguistic adaptations. The island population contained a huge number of people with a hereditary form of profound deafness. Most of the people who can hear living in the island became bilingual in sign and in verbal language to be able to communicate effectively. Because people with and without hearing impairments were able to communicate, neither group the hearing ones nor deaf were regarded as being handicapped (Scheer and Groce, 1998).

In the field of disability research, most writers today recognize that the problems and barriers are not in the individual who has a disability but in the environment or society that erects barriers to participation. The social model of disability requires that society address barriers to inclusion rather than spending money on segregation of population (Finkelstein, 1991).

This model has been criticized because it ignores or dismisses disease or injury as part of the picture, although such factors and their consequences may...
have a major role in the life of a person with a disability and may require intervention by health care providers at times. People with disabilities are encouraged to see any problems they encounter as emerging from barriers and negative attitudes of others in their social environment.

### Check Your Progress

1. What is the main objective of multidisciplinary rehabilitation?
2. State the premise of the psychological model of disability.
3. What is the main assumption of psychological approaches?
4. Why is the social model of disability criticized?

### 8.3 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The main objective of multidisciplinary rehabilitation is to focus on the physical or cognitive aspects of recovery from an illness, disease, condition or injury.

2. The psychological model of disability is similar to the medical model, except that mental pathology is seen as the main cause of disability—with or without physical pathology.

3. The main assumption of psychological approaches is that many disorders result from mental, behavioural, and social factors, such as personal experiences, traumas, conflicts, and environmental conditions.

4. The social model of disability has been criticized because it ignores or dismisses disease or injury as part of the picture, although such factors and their consequences may have a major role in the life of a person with a disability and may require intervention by health care providers at times. People with disabilities are encouraged to see any problems they encounter as emerging from barriers and negative attitudes of others in their social environment.

### 8.4 SUMMARY

- Multidisciplinary rehabilitation is a term used to describe a course of treatment which maximizes physical and mental health functional abilities.
- Approaches to disability refer to tools used for defining impairment and, ultimately, for providing a basis upon which government and society can devise strategies for meeting the needs of disabled people.
• Since approaches to disability are essentially devised by people about other people, they provide an insight into the attitudes, conceptions and prejudices of the former and how they impact on the latter.

• Biological approaches target body’s mechanisms that control the central nervous system, endocrine system, and metabolism.

• Biological approaches assume that various disabilities result from underlying biological causes, such as structural abnormalities in the brain, biochemical processes, and genetics.

• Biological treatments attempt to alter brain functioning with chemical or physical interventions, including drugs that act directly on the brain and body, surgery, and electroconvulsive therapy.

• Due to significant advances in the field of science, the medical (or biomedical) model of disability began to gradually replace the moral and/or religious model from the mid-1800s onwards.

• The medical model or illness approach assumes that disability is caused by disease or trauma and its resolution or solution is intervention provided and controlled by professionals.

• The psychological model is similar to the medical model, except that mental pathology is seen as the main cause of disability—with or without physical pathology.

• Disability management involves psychological assessment and counseling to modify inappropriate illness perception, beliefs, attitudes and behaviour.

• The biopsychosocial approach or model of disability assumes disability as arising from a combination of factors at the physical, emotional and environmental levels.

• The World Health Organization’s (WHO), International Classification of Function, Disability and Health (ICF) recognizes pain as a subjective experience and have suggested healthcare professionals shift from treating in a biomedical perspective to a bio psychosocial perspective.

• Psychological treatments attempt to change behaviours, thoughts, and thought processes and thus improve functioning.

• Psychodynamic therapy approach assumes that problems are symptoms of unresolved traumas and conflicts.

• Behavioural therapy view assumes that problems are the result of learned, self-defeating behaviours.

• Cognitive therapy view problems as the result of what we think (cognitive content) and how we think (cognitive process), including distorted view of situations and self, faulty reasoning, and poor problem solving.
Humanistic therapy view problems as the result of issues related to difficulties in daily life, especially a lack of both meaningful relationships and significant goals.

In order to achieve learning outcome, teachers/parents/CBR workers generally use a tool called Teaching Learning Material (TLM). It is a well-designed tool for the child's needs and not merely a set of teacher-made or purchased material.

A social model of disability sees the problem as rooted within society. Rather than attempting to fix or change the person with the disability, the focus should be on the removal or reforming of environmental and social barriers to full physical, social, career, and religious participation.

8.5 KEY WORDS

- **Approaches to disability**: It refers to tools used for defining impairment and, ultimately, for providing a basis upon which government and society can devise strategies for meeting the needs of disabled people.

- **Humanistic therapy**: It refers to a therapy which view problems as the result of issues related to difficulties in daily life, especially a lack of both meaningful relationships and significant goals.

- **Multidisciplinary rehabilitation**: It refers to a term used to describe a course of treatment which maximizes physical and mental health functional abilities.

- **Psychological treatments**: It refers to a form of treatment which attempt to change behaviours, thoughts, and thought processes and thus, improve functioning.

8.6 SELF ASSESSMENT QUESTIONS AND EXERCISES

**Short Answer Questions**

1. What are the types of biomedical therapy?
2. State the premise of disability management.
3. Write a short note on biopsychosocial model.
4. What is psychodynamic therapy?
5. State the main objective of humanistic therapy.
Long Answer Questions

1. Discuss the biological model of disability and its assumptions.
2. Explain the characteristics of the medical model of disability.
3. Why is biopsychosocial model criticized? Describe in detail.
4. Interpret the benefits of the Teaching Learning Material (TLM).
5. What is the social model of disability? Discuss.

8.7 FURTHER READINGS


UNIT 9 PSYCHOLOGICAL INTERVENTION

9.0 INTRODUCTION
Psychoanalysis is a set of theories and therapeutic techniques related to the study of the unconscious mind. Psychoanalysis was founded by Sigmund Freud. He believed that people could be cured by making conscious their unconscious thoughts and motivations, thus gaining insight. The aim of psychoanalysis therapy is to release repressed emotions and which make the unconscious conscious.

In this unit, the ranges of development in human beings and the concept of psychoanalytical psychotherapy have been discussed. The learning theories and strategies have been analysed. The unit will also explain the various strategies used to develop communication skills.

9.1 OBJECTIVES
After going through this unit, you will be able to:

- Discuss the concept of planning intervention
- Analyse the assumptions of psychoanalytical psychotherapy
- Identify the various learning theories and strategies
- Discuss the ways in which planning and learning situations are designed
- Explain the strategies used by psychologists to develop communication skills
9.2 PLANNING INTERVENTION

In USA, Individuals with Disabilities Education Improvement Act (IDEA 2004) provides eligible children, starting at age 3, the right to special education services in public schools. Part B of IDEA is for pre-school children aged between 3 to 5, which addresses assessment, individualized programs, and placements. Part C of the same law also provides special education services to infants and toddlers in some states. IDEA diagnoses specific disability categories such as orthopedic and other health impairments, specific learning disabilities, autism, blindness and deafness, and mental retardation. Each state defines disability in terms of health, learning, and developmental problems that can be addressed by special education. To be eligible for special education services, a child must have a disability that meets the state’s definition for at least one of the IDEA categories and must also need special services. For understanding the planning process for early interventions for psychological rehabilitation, we are taking up the provisions of the IDEA Act in this section as an example. In India, the Rights of Persons with Disabilities Bill contains there rights as a separate chapter on prevention and early intervention.

When should Caregivers make Referrals?

All young children are growing and learning new things with each day. We expect to see changes in what very young children know and are able to do from one week to the next. For this reason, identification of disabilities involves comparisons between each child and his or her peers, as well as monitoring changes in growth and development over time. Caregivers need to be familiar with expected ranges of development in order to know when a child might be showing signs of a significant delay or disability.

Birth to 12 Months

Newborn infants have a small collection of simple behaviors such as looking, sucking, turning eyes and heads, waving arms and legs, cooing, and crying. Infants should be referred for evaluation if, by their first birthdays, they do not:

- Develop consistent sleep/wake patterns and routines.
- Calm when familiar caregivers hold, cuddle, and talk soothingly.
- Move with symmetry, balance, and coordination in increasingly upright postures such as sitting, crawling, walking.
- Chew and swallow a variety of solid foods.
- Use sounds and gestures to communicate; combine consonant and vowel sounds to make words.
As children grow, they typically have learned the basic skills necessary for independent movement, communication, and social interaction. Referrals for special services may be appropriate for 3-year-olds who do not:

- Use motor skills in play (running, climbing, and jumping).
- Use fingers and hands to draw, build block structures and play with small toys.
- Play near and with peers; begin pretend play.
- Continue to increase vocabulary and combine words into increasingly longer sentences.
- Use eating utensils, undress and dress themselves, use the toilet.
- Learn simple concepts (hot/cold; up/down; in/out; big/little).
- Match a variety of actions to appropriate objects in play (hugging stuffed toys, turning pages of books, putting hat on head, stacking blocks).

To become adept at communicating, moving about, socializing, and learning new information during the preschool years, children combine and coordinate a number of fundamental skills. Referrals maybe in order for 6-year-olds who do not:

- Participate in groups; attend to adult leading groups of children.
- Engage in cooperative and imaginative play with peers.
- Ask and answer simple questions; consistently use full sentences.
- Use balanced and coordinated motor skills in physical play.
- Show understanding of print concepts (‘reading’, signs, logos, familiar books; ‘writing’ notes, lists, labels).
- Demonstrate beginning knowledge of letters and numbers.
- Eat, dress, and toilet.

In order to receive services under IDEA legislation, it is important to identify developmental delays and disabilities in early childhood because young children must be determined eligible to receive.
evaluating key skills in each of the major areas of development: physical, cognitive, communication, social–emotional, and adaptive. Results of screening assessments indicate which children seem to be developing as expected, and also identify those for whom a comprehensive assessment is needed to determine if there are significant delays or disabilities. The Right of PWD Act calls for survey, investigation and research, assistance of PHC workers, promotion of screening of at-risk children, awareness campaigns and measures for pre, peri, and post natal care in reference to prevention and early detection of disabilities.

**Comprehensive Evaluation and Services**

A comprehensive evaluation is conducted to determine the nature and severity of the problem and establish a child’s eligibility for special services, if screening results indicate a potential disability. They include a very careful and detailed assessment of the skills a child has in each area of development, and are often conducted by a multidisciplinary team of professionals.

**Birth to 3 Services**

Once a child qualifies under Part C of IDEA, further assessment focuses on identifying the functional skills that very young children need to participate in daily routines and family life, such as eating, sleeping, moving about, interacting, and playing. These assessments are usually carried out by therapists, psychologists, and early interventionists, and parents are considered important members of the assessment teams. The team also discusses family priorities, concerns, and resources for the child being assessed. An Individualized Family Service Plan (IFSP) combines family priorities with child assessment results to determine unique and relevant outcomes for each family. Early intervention services for infants and toddlers with special needs, including eligibility evaluations, are provided by school districts in some states, and by health and human service in ‘natural environments’ such as children’s homes, or other places where families participate with infants and toddlers without disabilities.

**Pre-school Services, Ages 3 to 5**

It is the responsibility of local school districts to provide preschool special education services, including comprehensive evaluations. A multidisciplinary team of professionals conducts evaluation of children aged 3 to 5. The evaluation team may include therapists, psychologists, and educators who participate in a detailed assessment. All the assessment results are combined to determine if the child meets eligibility requirements and needs special education. If the child is eligible, an Individualized Education Program (IEP) is designed that contains goals and objectives for each child.

In India, WHO’s ‘Ten Question Plus’ Screening instrument, and ‘Developmental Milestones’ and the three screening schedules by National Institute for the Mentally Handicapped is usually followed.
The Role of Parents and Teachers

Specialized instruction and therapies are important components of special education but, first and foremost, young children thrive in settings with familiar adults who know them and provide loving care. Thus, parents and other caregivers of children with suspected or identified disabilities must find confidence in the following guidelines:

- Make referrals if you have a persistent concern about children in your care. Early identification of disabilities gives positive outcomes.
- Share what you know about individual children with the evaluation team.
- Make sure that a disability diagnosis does not change the child in any fundamental way, but it may change how you think about the child. Remember, the child is still the same child.
- Continue to participate with the child in familiar caregiving routines and activities.
- Keep the child involved in neighborhood and community-based services if at all possible.
- Work with special services personnel to embed IEP and IFSP goals, objectives, and outcomes into ongoing routines and activities at home and in preschool classrooms.
- Learn about a lot of new information, acronyms, agencies, personnel, and teaching strategies. Many parents and early educators become experts about the disabilities of their own children.
- Realize that referral, assessment, eligibility evaluation, and diagnosis can be a very emotional process for parents. Early educators provide an invaluable service to parents by listening, being involved in the process and offering personal support when parents need it.

9.2.1 Psychoanalytic Approach

Psychoanalysis was founded by Sigmund Freud (1856-1939). Freud believed that people could be cured by making conscious their unconscious thoughts and motivations, thus gaining insight. The aim of psychoanalysis therapy is to release repressed emotions and experiences, i.e., make the unconscious conscious.

The title ‘Psychoanalytic Interventions’ sums up the aim of the series, which is to bring together the academic and clinical worlds of psychoanalysis in works that are compelling, lucid, and accessible to a wide range of readers.

Psychoanalytical Psychotherapy

To some extent as a response to the above mentioned criticism, psychoanalytical psychotherapy came into emergence. It is based on the fundamental dynamic formulations and techniques of psychoanalysis but it is broader in scope. It makes
use of a variety of techniques ranging from expressive insight-oriented, interpretive
techniques to more supportive relationship-oriented techniques.

In it, the therapist decides to what extent he will use or manage transference
and the extent to which he would interpret, foster or suppress it. Unlike
psychoanalysis, it focuses on the present rather than the past. It makes use of both
here-and-now interpretations and interpretations that trace patient’s behaviour
and feelings back to their origins in early infancy and childhood. The therapy is of
relatively less duration and does not make use of the couch. Instead in it the patient
and the therapist sit face to face to prevent regression.

The psychoanalytical psychotherapy deals with selected problems or highly
focused conflict. In it, though the numbers of sessions are often decided in the
beginning but the course of therapy can be altered as the patient’s needs and goals
change. It rarely makes use of the free-association method, except when the
therapist wishes to gain access to fantasy material or dreams to know more about
an underlying issue.

Its primary goals are to increase the patient’s self-awareness, resolve some
of the specific conflicts, undo resistances and to deal with preconscious or conscious
derivatives of conflicts as they became manifest in present interactions. It largely
aims at symptom relief and focuses on clarifying recent dynamic maladaptive
patterns.

The therapeutic process involves establishment of a therapeutic alliance and
early recognition and interpretation of negative transference. In it only limited or
controlled regression is encouraged, and positive transference is used largely
unexplored, unless they interfere with the therapeutic progress. Here the therapist
relatively plays a more active role. The techniques of clarification and interpretation
are still used, but are altered both qualitatively and quantitatively.

The therapist makes use of clarification much more than the technique of
interpretation to achieve the goals of the therapy. Unlike psychoanalysis, it makes
use of adjunctive treatment, like psychotropic drugs, to relieve acute symptoms of
anxiety or depression so that analytical exploration can then be adequately
undertaken. Other treatments such as hospitalization, rehabilitative therapies, or
family therapy may also be used if necessary.

Psychoanalytical psychotherapy has become a desirable and widely
applicable form of treatment over psychoanalysis because of the following reasons:

- The psychiatric patients are usually seen to lack sufficient ego strength;
  are often deficient in the cognitive resources necessary for the
  achievement of deep insight; are usually not very motivated and sometimes
  there problems can be too pressing, thus making lengthy treatments
  unsuitable.

- Often patients are unable to continue long term treatments because of
  financial reasons.
Psychoanalytical psychotherapy is regarded as the treatment of choice for neurotic disorders, narcissistic personality disorder, borderline personality disorder and non-psychotic character disorders. It is best suited for individuals having fairly well integrated egos and for individuals who are psychologically minded, have capacity for introspection and are self-motivated, and are able to tolerate doses of frustration without disintegrating.

### Check Your Progress

1. Why is comprehensive evaluation conducted?
2. What are the techniques used in psychoanalytical psychotherapy?

### 9.3 LEARNING THEORIES AND STRATEGIES

In the following sections, you will learn about learning theories and strategies, planning and designing, therapeutic strategies in cases of psychological intervention through different examples disabilities.

The approach to education of individuals who are deaf or blind has changed significantly since the rubella epidemic occurred in the United States and Western Europe in the early 1960s. Through the collaboration and sharing of knowledge from many countries, successful methodologies to teach individuals who are deaf or blind have increased rapidly since the time of the Rubella outbreak. This knowledge has successfully been disseminated to many educators around the world.

#### Principles of Educational Programming for Deaf or Blind Child

- Early identification of sensory deficits helps in providing optimal opportunities for individuals with deaf/blindness.
- For a student who has deaf/blindness, communication is the cornerstone of an educational plan.
- Educational placements should be selected on the basis of individual abilities and needs.
- Age of onset of sensory impairments, amount of auditory and visual impairments, mode of communication, cognition, and existence of additional disabilities are major factors in determining the appropriate educational settings.
- Teachers with specific training are necessary to provide optimal integrated programming for students with dual sensory impairments.
- A functional program is integrated into community life and is based on real life situations. It must include opportunities to develop communication, social, recreational and leisure skills including pre-vocational/vocational training, transition planning, self-help, domestic skills, orientation and independence within all environments.
For a successful educational program for a student with deaf/blindness integration of appropriate and related support services are necessary.

Various specialists may contribute towards assessment, direct instruction, or consultation for the group.

**Instructional Strategies**

With this approach, the specific skills or difficulties of students with Autism Spectrum Disorder (ASD) can be addressed by employing a variety of methods to differentiate (or vary) the following:

- **The content:** The depth or breadth of the information or skills to be taught.
- **The processes:** The instructional approaches used with the student, as well as the materials used to deliver or explain the content.
- **The products of the learning situation:** What the end product will be or look like. This product may be tangible (a worksheet, project, composition), a skill that has been acquired, or knowledge that has been gained.

To determine the most effective strategies for students in a learning situation, it is necessary to consider the learning goals for the students.

**Tips for Teachers**

Teachers must consider adaptations to the curriculum, instruction, or expectations that may be required according to a student’s readiness, interests, and learning profile. Differentiation involves an ongoing process of monitoring student response to the differentiated strategies and evaluating student progress on a regular basis. Strategies that are found to be effective for a student during one activity may be less effective over time or during another activity. The level and type of differentiation will need to be varied according to the student’s response and progress.

**Visual Supports**

The most widely recommended strategies for teaching students with ASD is the use of visual supports. The use of visual supports is one of, as they usually process visual information more efficiently and effectively than information that is presented verbally. Some students may require extra time to process verbal language and understand the message.

Visual images help students to understand information as they provide a source that can be referred to as often as necessary and for the length of time that is required in order to process the content of the information.

For a visual aid to be successful, they must match the student’s level of comprehension. Some students need very basic, concrete visual objects while others understand and respond to more abstract symbols or written language. The primary goal of using visuals is to help a student understand or convey information. These are two effective methods of visual support:

- **Visual images**
- **Visual supports**
1. **Passive modeling (Biederman et al., 1998):** Students are able to see what is expected in a task by being provided with visual examples and demonstrations of how tasks are performed. Instructional language is reduced as much as possible.

2. **Video modeling (Bellini & Akullian, 2007):** Further to and building on the concept of passive modeling, video modeling provides the students with a video example of how tasks are performed and task sequences. This format allows the student to watch the instructional sequence over and over.

Both passive modeling and video modeling are viable tools in terms of practice. Visual supports are usually simple and inexpensive. They will be most effective for a student with ASD if they are used consistently and across various settings.

### 9.3.1 Planning and Designing Learning Situations

#### Structured Learning Environment

A predictable environment is necessary for better functioning of children. A structured learning environment to know what is expected of them in specific situations, to assist them in anticipating what comes next, and to learn and generalize a variety of skills is necessary for students with ASD.

It is also important to structure the physical environment so that it is organized with ‘a place for everything and everything in its place’. The student’s seating arrangement needs to be consistent and in a location that affords as few distractions or exposure to sensory irritants as possible. The environmental scans are important so that the student will access (for example, the gym, library, music room) to determine what elements may have an impact on the student’s ability to participate effectively. Appropriate accommodations can then be made to the environment.

#### Applied Behaviour Analysis (ABA)

For students with Autism Spectrum Disorders (ASD), incorporating Methods of Applied Behaviour Analysis (ABA) into Programs is an effective approach to understanding and changing behaviour, and teaching new skills. ABA uses methods based on scientific models of learning and behaviour to build useful repertoires and reduce problematic ones. In this approach, the behaviour(s) to be changed are clearly defined and recorded, and the antecedents and reinforcers that might be maintaining an undesirable behaviour, or that could be used to help develop alternative or new behaviours, are analysed. Interventions based on principles of learning and behaviour are then designed and implemented to develop appropriate behaviours. Progress is assessed and the program is altered if necessary (adapted from Perry, A. & Condillac, R., 2003).

ABA can be used with students of every age as an instructional approach. It can be applied in a variety of situations, and it can be employed for very limited and specific purposes such as the development or reduction of single behaviours.
or sets of behaviours. ABA can be adjusted according to the individual needs of each student, and may be applied to developing academic skills or behaviours related to social skills, communication, or self-care.

**Modelling**

A form of prompting is modelling. It tells students what is expected in a task by having students see the task being performed through a visual example. It can also help the student see the sequence of steps in the task. For example, the student learns the actions to a song by first watching a demonstration by an adult.

**Reinforcement**

Through the use of reinforcement the target behaviour is encouraged. It is usually provided after the target behaviour to increase the likelihood that the behaviour will reoccur. Reinforcers can be:

- Tangible (such as stickers)
- Activity-based (the student is able to participate in preferred activity)
- Social (praise or thumbs up sign)

Reinforcement can be provided for displaying positive behaviours – to encourage these behaviours to continue—or for refraining from or reducing the occurrence of negative behaviours. It can be something provided (such as praise) or something removed (such as a non-preferred activity being removed when the student asks appropriately). It is important to gradually change reinforcers from others to more natural reinforcers, such as the satisfaction of completing a task in order to encourage students to be as independent as possible.

**Task Analysis**

Breaking tasks down into smaller, teachable steps is referred to as Task analysis. In this method, the goals for each step are established, and task performance can then be taught according to these steps. Each sub-task is taught and reinforced in sequence. In many cases, students may have difficulty only with one step within the larger task, rather than with the task overall. It is important to write subtasks in terms of what the student will do and to record interventions or prompting that are required for students to complete the subtasks.

**Forward Chaining**

In this method, steps within a task are identified through task analysis, and then the focus shifts to teach the first step or subtask that the student has not mastered, and then assist the student with the rest of the task. As the student masters the first subtask, then focus instruction on the next step that the student has not mastered, continuing until the student can complete all of the subtasks. For example, in learning to print his or her name, focus the student on learning to print the first letter, and print the rest of letters for the student.
Backward Chaining

In backward chaining, it is the last step or subtask that is focused on first that a student has not mastered. This provides the student with immediate reinforcement through successful completion of the task. Once this skill is mastered, the focus moves to the next-to-last subtask. For example, a student learning to remove outdoor clothing might initially focus on learning to hang his or her coat on a coat hook after being assisted with other steps. Next, the student would learn to take off his or her coat, and then hang it on the hook.

Discrete Trial Training (DTT)

Like task analysis, DTT involves analysing skills and breaking large tasks into steps or subtasks (or discrete skills). Here, subtasks are usually taught sequentially, and each subtask is mastered before learning the next skill. DTT consists of four steps:

1. The student is given a brief instruction or question (stimulus) that is designed to produce a specific response. If necessary, the instruction is followed by a prompt.
2. The student responds.
3. If the response is as expected, the student receives reinforcement such as praise. If the response is not as expected, the response is ignored or corrected or the student is prompted to provide the expected response.
4. Data are recorded. Subsequent trials or instructions are then given.

Shaping

Shaping aims to change behaviour gradually and systematically through the use of reinforcements. Here, approximations of the desired behaviour are reinforced until the target behaviour is achieved.

Teaching Students with ASD

The learning profiles for students with ASD are diverse and one specific method or program will not be appropriate for all students with ASD.

Literacy Skills

Reading

Many students with ASD have strong visual skills and are often more successful in learning to read through a whole word sight recognition approach than through a more traditional phonics program. Whole words that are meaningful are usually easier for students to learn to read than words for which students have no basis of experience or knowledge. In the beginning stages of learning to read, it is critical to enable students to develop a sense of confidence.
While knowing the alphabet and knowing the sound symbol associations are usually regarded as prerequisite skills for learning to read, many students with ASD often have difficulty acquiring these prerequisite skills (Mirenda, 2003). Some students are able to recite alphabet letters and letter sounds by rote, but may be unable to apply this to decoding words in a fluent manner. The rate of reading fluency will affect a student’s ability to comprehend the message of the words. If a student needs to give more cognitive attention to a difficult decoding process, then it is likely that the student’s understanding of what the words are saying will decrease.

As the student acquires more words, it is essential to provide activities in which these words are used in meaningful contexts. Daily practice in sentence construction provides students with the opportunity to develop an understanding of grammar and to learn a framework for using language.

Many students with ASD have difficulty with the perception and understanding of sequences. This may lead to a significant challenge in the development of comprehension skills, as understanding causality and making inferences and predictions will be difficult. Activities such as using picture cards that can be sequenced to create a story or using if/then matching cards can help students.

**Writing**

While some students with ASD are proficient in printing and handwriting, many others have difficulty with written tasks because of difficulties with fine motor skills. The visual-motor coordination and fine motor movements that are required in written activities may be extremely frustrating and divert the student’s attention from the content of what he is writing to the physical process of print production. Difficulties with handwriting have been identified as one of the most significant barriers to academic participation for students with ASD in schools today (Simpson, 2007).

The use of keyboards, word processors, and writing software has facilitated the writing process for many students with ASD. Learning to use a keyboard is a valuable skill for students to acquire. For many students with ASD, using a computer is a highly preferred activity. Teach and encourage the student to learn to use the keyboard as a writing instrument.

In many cases, OTs is involved with students with ASD and provide assessments and information on a student’s fine motor and writing skills. OTs can provide recommendations about the strategies, resources, and accommodations that will be appropriate to assist students with fine motor and writing difficulties.

**Mathematics**

For many students with ASD, participation in mathematics can be a challenging aspect of the academic curriculum. There are several reasons for this:
Although many mathematical concepts can be demonstrated through visual examples, they are often accompanied by sophisticated verbal instruction.

- The language of mathematics instruction has its own vocabulary, and the precision of instruction and usage of terms can vary from one instructor to another.

- Mathematical terminology can be very challenging for students who struggle with processing the language of everyday interactions.

**Tips for Teachers**

- Fill-in-the-blanks and cloze exercises.
- Multiple-choice answers to questions (for example, students point to the correct answer).
- Scribing.
- Exemplars (for example, samples of work that demonstrate the expectations of the task)
- Reduction in the length or number of written responses.
- Division of written tasks into manageable components that focus on one section at a time.
- Visuals or graphic organizers to support the written task (for example, pictures of the sequence of a story).
- Word bank of key vocabulary or frequently used words.
- Rubric for task completion that specifies the essential components of a task in a clearly outlined format.

**Behavior Management**

The primary characteristics of ASD are Managing Challenging Behavior. Impairments in communication and social skills. These skills, in turn, are intertwined with behaviour. Severe problem behaviours that some students display – such as tantrums, aggression, destructiveness, and self-injurious behaviours – may be related to the difficulties they have with communication, adapting to change, understanding social situations, and their level of functioning. The communication, social, emotional, and behavioural difficulties experienced by students with ASD can vary.

Many of the challenging behaviours exhibited by students with ASD are methods used by the child to:

- Gain something (for example, desired object, attention).
- Make a change in the environment (for example, increase stimulation level, change to a more preferred activity).
- Escape the environment (for example, leave situation that is stressful).
Effectively managing behaviours requires that we consider not just the behaviour itself – what the student is doing – but also the underlying purpose of the behaviour. If we focus only on what the student is doing, and try to eliminate the behaviour, we may find that another behaviour arises in its place, because the underlying need has not been met. Behaviours have a communicative function. It is important to remember that inappropriate behaviours are usually in response to something in the student’s environment and are an attempt to communicate a need.

Thus, managing the behaviour of students with ASD requires that we recognize and address the message behind the behaviour.

**Successful Practices for Behaviour Management**

Effective behaviour management refers to an ongoing process with definable steps. It starts with a functional behaviour assessment (FBA), which is a systematic process designed to look beyond the student’s behaviour and focus on identifying its function or purpose. Based on the FBA, a behavioural support plan is developed to identify alternative behaviours for the student, and strategies for reducing or replacing ineffective behaviours. Finally, ongoing monitoring is used to review progress and identify any changes that need to be made.

**Completing Functional Behaviour Assessment (FBA) Step**

1. **Define:** Information needs to be collected to clearly identify and describe the problematic and challenging behaviours. Collecting data about a student’s behaviours helps to determine how frequently a targeted behaviour occurs and any changes that may take place over time. A variety of data-gathering methods should be considered, to ensure that a broad picture of the behaviour has been developed and that behaviours have been accurately observed, measured, and recorded.

2. **Analyzing Data:** Once data have been collected, the next step is to analyse all of the information to determine what may be causing the student to maintain the challenging behaviour, and the purpose or ‘function’ of the behaviour. Questions such as the following should be considered in analysing information about a student’s behaviours.

3. **Do a functional analysis to test the hypothesis:** A functional analysis is a systematic process through which antecedents and consequences are altered to develop or confirm the hypothesis about the function of the behaviour. • Provide John with other types of activities during this period.

4. **Develop a behaviour support plan:** Once a hypothesis about the purpose of behaviour is developed, a behaviour support plan can be designed to address the challenging behaviour of the student, on the basis of the earlier observation and analysis. The behaviour support plan should be individualized to the student and clearly set out what will be done to reduce the inappropriate behaviour.
5. **Monitor progress and identify alternative strategies:** It is necessary to continue monitoring the effectiveness of the interventions and behaviour support plan, and to establish a process for ongoing review and data collection to determine whether effective changes are occurring.

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<th>Check Your Progress</th>
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<tr>
<td>3. State any one use of visual aid.</td>
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<td>4. What is the aim of shaping?</td>
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<td>5. State the premise of applied behaviour analysis.</td>
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### 9.4 STRATEGIES TO DEVELOP AND ENHANCE COMMUNICATION SKILLS

Effective communication programs for students with ASD aim to develop functional communication skills to enhance or increase interactions with others. Student’s current communication abilities are assessed to determine the most effective communication system. The student’s expressive, receptive, and social communication skills are usually assessed by an SLP. It is essential that the program to develop communication skills is at the level of the student’s cognitive and linguistic development and includes methods, words, or concepts that are meaningful and functional to the child.

In order to learn, develop, and practice communication skills, students with ASD often require direct instruction, as well as opportunities for social interactions. It is often necessary to teach the student the verbal language and other communication methods that are required across a variety of communicative situations, such as the following: greetings (‘Hello’, wave hand), requests (‘Please help’, manual sign), and refusals (‘No, thank you’, shake head).

**Augmentative and Alternative Communication Methods**

Augmentative and Alternative Communication (AAC) makes use of services and devices, such as visual symbols, signs, or voice output devices, to supplement (augment) or replace (serve as an alternative to) a student’s current method of communication. There is a variety of AAC systems. They can be simply made, inexpensive, low-tech devices such as pictures and word cards. Others can also be more complex, expensive, high-tech systems such as computerized voice output devices with synthesized and digitized speech. In many cases, AAC systems are portable and can be used in different settings. They are reasonably easy for others to understand and use.
Counselling Strategies

The term ‘counselling’ has been defined by different people in various ways. For instance, Rogers (1952) describes ‘counselling’ as the process by which the structure of the self is relaxed in the safety of the client’s relationship with the therapist and previously denied experiences are perceived and then integrated into an altered self. But according to, psychologists, Pepinsky and Pepinsky (1954) counselling refers to an interaction which occurs between two individuals called the counsellor and the client that takes place in a professional setting and is initiated and maintained to facilitate changes in the behaviour of the client.

Whereas psychologist, Gustad (1953), sees counselling as a learning oriented process that is carried out in a simple one to one social environment, in which the counsellor (who is professionally competent in relevant psychological skills and knowledge) seeks to assist the client, by methods appropriate to the latter’s needs and within the context of the total personal programme to learn how to put, such understanding into effect, in relation to more clearly perceived, realistically defined goals to the end that the client may become a happier and more productive member of the society.

In 1992, psychologist, Gladding, stated that counselling is a relatively short term, interpersonal, theory based, professional activity guided by ethical and legal standards that focus on helping persons who are basically psychologically healthy to resolve developmental and situational problems. Unlike the above, Belkin (1975) believes that counselling cannot be specifically defined since it is a changing entity, but there are skills common to all such facilitative relationships.

All the mentioned definitions contain certain similarities. For instance all of them view counselling as a process which involves bringing about sequential changes over a period of time leading to a set goal. All these definitions stress upon the counsellor-counselee relationship as something that is not casual but is characterized by warmth, responsiveness and understanding.

Several misconceptions are also held by people about counselling. Some of the serious misconceptions held about counselling are as follows:

- Counselling is not all about giving information, although some information giving can be a part of counselling.
- Counselling is not about giving advice, making suggestions and recommendations.
- Counselling is not about influencing the client’s values, attitudes, beliefs, interests, decisions etc. With or without any threat.
- Counselling is not all about interviewing clients.

The major objective of all types of counselling is to help individuals become self-sufficient, self-dependent, self-directed and to adjust themselves efficiently to the demands of a better, happier and a meaningful life.
Rogers (1958) examined the process of counselling in terms of the stages of development by which personality change take place. He concluded that, in successful counselling, the client moves from fixity to changeableness; from rigid structures to flow; from stasis to process. He pinpointed seven crucial stages of the change process which are as follows:

- **First stage**: At the first stage, internal communication is blocked. There is no communication of self or personal meanings, no recognition of problems and usually no individual desire to change. At this stage, the client is closed, and communicative relationships are construed as dangerous as there is no desire to change.

- **Second stage**: When the client feels himself to be fully accepted as she or he is the second stage follows naturally. The second stage is characterized by a number of factors, both positive and negative. Expression begins to flow in regard to non-self topics; problems are perceived as external to self; there is no sense of personal responsibility in problems; feelings are described as un-owned, or sometimes as past objects; feeling may be exhibited, but are not recognized as such or owned; experiencing is bound by the structure of the past; personal constructs are rigid, and unrecognized as being constructs, but are thoughts of as facts; differentiation of personal meanings and feelings are very limited and contradictions may be expressed, but with little recognition of them as contradiction.

- **Third and fourth stage**: The third and fourth stages involve further loosening of symbolic expression in regard to feelings, constructs and self. These stages constitute an important moving forward in the process.

- **Fifth stage**: In the fifth stage, feelings are expressed freely as being in the present and are very close to being experienced. Feelings tend to ‘bubble up,’ or ‘seep through,’ in spite of the fear and distrust which the clients feels at experiencing them with fullness and immediacy. There is a beginning tendency to realize that experiencing a feeling involves a direct referent and there is an increasing ownership of self feeling, and a desire to be these, to be the real self.

- **Sixth stage**: The sixth stage continues this process of growth, self-discovery and a self-acceptance, congruence, and responsibility. This is a crucial stage as at this point, the client has become very close to an organic being that is always in the process of growth; he or she is in touch with the flow of feelings; his or her construction of experiences is free flowing and repeatedly being tested against referents and evidence within and without; experience is differentiated and thus internal communication is exact.

- **Seventh stage**: The client often enters the seventh and last stage without the need of the counsellor’s help. The client is now a continually changing
person, experiencing with freshness and immediacy each new situation, responding with real and accepted feelings, and showing ‘a growing and continuing sense of acceptant ownership of these changing feelings, a basic trust in his own process.’

This seven-stage conceptualization represents Roger’s clearest, most explicit description of the stages of personal growth, although these stages are implicit throughout his writings.

Since problems can arise at any time in life, therefore counselling must necessarily be a continuing process concerning persons of all age levels and placed in different life situations. The counsellor uses various counselling strategies with the following objectives:

- Facilitates behaviour change.
- Improves client’s ability to establish and maintain relationship.
- Enhances the client’s effectiveness and ability to cope.
- Promotes decisions making process.
- Facilitates client’s potential and development.

In addition, to the remedial services, the counselling services in an educational set up focus on prevention of various social, emotional, behavioural and psychological concerns. It also focuses on increasing the student’s self-esteem, reducing peer influence, providing drug information and suicide prevention programs.

To work effectively, the counsellor makes use of the following strategies:

- **Changing perceptions:** Through the process of reframing, the counsellor helps the clients to change distorted unrealistic objective and to move from functional fixity to a more appropriate and realistic objective by offering them opportunity to explore thoughts and desires within a safe, accepting and non-judgmental environment. Goals are refined or altered using cognitive, behaviour, or cognitive-behaviour strategies (Okun, 1987). Also reframing offers the client another probable viewpoint of why an event might have happened.

- **Leading:** Counsellors may use leads that vary in length and depends on the counsellor’s theoretical orientation and current phase of counselling to change the client’s perceptions (Robinson, 1950). Leads such as silence, acceptance, and paraphrasing may be more appropriate in the beginning of the counselling process, whereas, others such as persuasion may be more appropriate in the understanding and action phases of counselling (Patterson and Eisenberg, 1982).

- **Multi-focused responding:** Psychologists, Ivey (1983) and Lazarus (1981) think that tuning into the client’s major modes (visual, auditory, kinesthetic) of perceiving and learning is crucial in bringing about change. Baruth and Huber (1985), also point out the importance of the counsellor’s responding in the client’s language.
• **Accurate empathy:** Primary accurate empathy helps in the establishment of the counselling relationship, in data gathering and in problem clarification.

• **Self-disclosure:** To be effective, the counsellor’s self-disclosure should match the client’s needs (Hendrick, 1988). Selective and focussed self-disclosure serves to primary functions namely, modelling and developing a new perspective (Egan, 1990). Clients are more likely to trust counsellors who disclose personal information and are prone to make reciprocal disclosure if the client/counsellor relationship is strong (Curtis, 1981).

• **Immediacy:** Involves counsellor’s understanding and communication of the client’s feelings, impressions and expectations and the wants of the counsellor (Turock, 1980). Relationship immediacy is the counsellor’s ability to discuss with the client the quality of this relationship, whether it is strained, boring or productive. Here-and-now immediacy is the discussion of any given transaction as it is happening (Egan, 1990). Mis-interpretation of the counsellor’s message, unexpected outcome, influence on the client’s decision to terminate the counselling session are three main fears counsellor’s have with regard to immediacy (Turock, 1980). It is best used in a directionless relationship where there is question of trust, considerable social distance between counsellor and client, client dependency, counter-dependency and where there is an attraction between counsellor and client (Egan, 1990).

• **Reflection:** Empathic mirroring of feelings behind the words is called reflection.

• **Humour:** Requires both sensitivity and timing on the part of the counsellor, can circumvent client resistance, dispel tension and reduce psychological pain (Ness, 1989). Through an experience of ‘ha-ha’ often comes an awareness of ‘ah-ah’ and a clearer perception of a situation.

• **Confrontation:** It challenges clients to examine, modify and or control an aspect of behaviour. A good responsible caring and appropriate confrontation produces growth and encourages an honest examination of oneself. It should be used only when the relationship is strong.

• **Probing:** Refers to the use of closed ended or open ended questions to elicit information. Why question should be avoided as they make the client defensive.

• **Contracting:** There are two aspects of contracting—one focuses on the processes involved in reaching the goal; the other concentrates on the final outcome. While making contracts the counsellor must consider the background of the client, client’s motivational levels, the nature of the present problem and what resources are available to the client to assure the successful completion of the contract.
Rehearsal: Refers to practicing designated behavior overtly (verbalize or act out what is going to do) or covertly (imagine or reflect on the desired goals) (Cormier and Cormier, 1991). In rehearsal the feedback given by counseling helps the client recognize and correct any problem area (Geis an Chapman, 1971).

In addition to the specific skills involved, clients and counselors must work through any transference or counter transference issues that arise out of earlier situations or present circumstances (Gelso and Carter, 1985).

9.4.1 Therapeutic Services and Restorative Techniques

When dealing with people with disability, a mirage of intervention, therapeutic and restorative techniques are used such as psychotherapy, Special education and occupational therapy.

Details of psycho-medical, social approaches towards intervention have already been discussed at length in Unit-8. The details of special education are covered at length in Unit-14. Below we shall be discussing the important role played by occupational therapy in this regard.

Occupational Therapy for Special Needs Children

Occupational therapy (OT) may sound like it deals with finding a job or developing work skills, but it actually involves strengthening fine motor skills. These include tasks such as writing, cutting, shoe-tying, and using utensils. OT is commonly used in special education programs for children. OT may indeed include work-related skills, for adults recovering from an accident or stroke. For children, whose "occupation" is school and play; it will focus more sharply on developmental milestones and skills required for the playground and academic activities.

Techniques and routines that seem like play are used by occupational therapists who work with children. In reality, they are designed to target areas of delay and difficulty. With a sensory integration approach some occupational therapists are also trained in therapy. To help children better process and tolerate the information they get through their senses, this method uses play-like activities.

To help people increase their functional independence in daily life while preventing or minimizing disability, is the purpose of Occupational Therapy (OT). Often OT is combined with other treatments including Physical Therapy.

An important role is played by both occupational therapists (OT) and physical therapists (PT) for children with special needs, in helping children develop motor and life skills. Activities of Daily Living (ADLs), also known as self-help skills, such as brushing teeth.

Occupational Therapy in Early Intervention: Helping Children Succeed

Earliest years of a child are filled with new stimulations and novel experiences that drive his or her cognitive, social, and physical growth. The first 3 years of life are
Psychological Intervention

Early intervention is programs across the countries that are funded by federal, state, and local dollars. Early intervention is a collection of therapy and support services that provide children from birth to 3 years old who have disabilities, or who are at risk for developing them, the help they need to succeed later in life. One of several services is Occupational therapy that may be provided as part of early intervention. Children with many specific conditions are benefitted from it (for example, down syndrome, autism), in addition to children with no clear diagnosis.

Occupational therapy can help improve their motor, cognitive, sensory processing, communication, and play skills, for children with developmental delays or a known physical or mental condition associated with a high probability of delays. The goal is to enhance development, minimize the potential for developmental delay, and help families to meet the special needs of their infants and toddlers.

The Individuals with Disabilities Education Act (IDEA) mandates that early intervention programs provide services in the natural environment and within naturally occurring routines and activities of the family’s day. According to IDEA regulations, natural environments are those that are typical for the child’s peers who have no disabilities. Within the child and family situation occupational therapy practitioners have always worked.

Intervention

The intervention process consists of skilled services provided by occupational therapy practitioners (OTs and occupational therapy assistants) in collaboration with clients to facilitate engagement in occupations related to health, well-being, and participation. The intervention process includes a plan, implementation, and review. Through the implementation of techniques and procedures that are directed towards the client or towards his or her environment and/or activities the intervention’s aim is to improve the client’s desired and expected participation and performance in occupations. A unique aspect of the intervention process is the standard procedure of practitioners using the collective influence of the client’s context and environment, demands of the activity at hand, and the individual characteristics of the client. This procedure is formally characterized as a task analysis.

Sensory Processing Treatment Approaches

A common feature of ASD is difficulty in processing sensory information. Up to 96 per cent of children with ASD demonstrate difficulty in processing sensory information as a part of their daily routines. Restricted, Repetitive Patterns of
Behavior, Interest of Activities and that one of those 4 has something to do with ‘sensory features’. All areas of child development is impacted by the inability to accurately process sensory information, so approaches directed towards remediation of sensory processing deficits are often used by both occupational therapists.

**Physical Therapy**

A branch of rehabilitative health is Physical therapy (PT) that is considered one of the most important aspects of treating children with Cerebral Palsy. People with Cerebral Palsy experience mobility, function, posture and balance challenges of varying degrees, and physical therapy, which focuses on basic mobility such as standing, walking, climbing stairs, reaching or operating a wheelchair – is a key element in the multidisciplinary approach to increasing a child’s mobility.

The goal of physical therapy is to help individuals:

- Develop coordination
- Build strength
- Improve balance
- Maintain flexibility
- Optimize physical functioning levels
- Maximize independence

**The Importance of Physiotherapy for Disabled Children**

For children with physical disabilities they can often spend their day in the same position or positions that can have a variety ways that can affect their health even more that it is already. From higher risks for illnesses to the effects of a sedentary life, disabled children can benefit from the use of physiotherapy and other disabled services like massage therapy and acupuncture from qualified medical professionals.

You might ask why that is, well we’ve put together a short list of the ways that physiotherapy disabled services are so important to the continued health and mobility of disabled children. The following are the main advantages of physiotherapy:

- It keeps them fit.
- It helps to relax the body and reduce pain.
- It helps to promote overall health in the body.

**Physiotherapists for Children with Special Need**

Physios are probably the best known of the therapists who work with children with special needs. To help their patients gain and keep the best possible use of their bodies, they use exercises. They also try to improve breathing, to prevent the development of deformities and to slow down the deterioration caused by some progressive diseases.
The physio will assess your child’s problems and teach you exercises to do with him at home. The therapist may also show you ways to handle your child which will encourage good patterns of movement.

If your child receives physio at school, try to learn the exercises so you can continue with them during the holidays. Otherwise he may lose some of his hard won progress which will be very disappointing for everyone, especially him.

Physio therapists have a variety of ideas about the best way to treat some conditions, especially cerebral palsy. If you believe a different approach would be better for your child, ask your doctor to refer you to a clinic that uses it. Judging by the experience of other parents, you may need to be persistent in your request as doctors and physios are understandably resistant to suggestions that someone else can do better than they can.

**Physiotherapy techniques**

Physiotherapists use a wide range of techniques and approaches, including:

- Massage and manipulation, using the hands to relieve muscle pain and stiffness and encourage blood flow to an injured part of the body to help recovery.
- Remedial exercise (exercise that takes into account a person’s current level of health and any specific requirements they may have).
- Providing support to help patients manage chronic conditions.

**Speech therapy**

A treatment for speech and language disorders is known as speech therapy. A speech disorder involves a problem producing words and sounds, whereas a language disorder refers to a difficulty understanding words and putting together sentences and ideas for communication. Individuals gain the ability to communicate through speech and language, with the help of Speech therapy.

Speech therapists might use repetitive exercises and training as well as assistive devices for communication to assist with what is speech therapy. Called augmentive and assistive communication, or AAC, these devices produce speech or sound for those who are nonverbal.

A great deal of speech and language disorders is targeted by Speech therapy including the following:

- **Articulation disorders**: Difficulty producing sounds or syllables or saying words incorrectly.
- **Fluency disorders**: Including problems like stuttering, which is characterized by abnormal stoppages, repetitions, or prolonging sounds in words.
- **Dysphagia or feeding disorders**: Difficulties with eating and swallowing.
- **Receptive or expressive communication disorders**: Difficulties in understanding and processing language, or difficulty putting words together to form sentences, or trouble expressing or communicating in a socially acceptable way.

- **Complications from birth defects surgery**: Difficulty in speaking due to effects of conditions like cleft palate or surgery involving the throat and mouth.

  Speech therapy sessions involve modeling proper speech and using repetition exercises to improve speech and language. Use of play or books by speech therapists, to stimulate communication and increase chances to develop language skills. Therapists will model correct pronunciation, articulation, and expression during play activities and might actually physically show a child how to move their mouths or tongue to create what is speech properly.

  Speech and language therapy can ensure that your child will be better able to communicate and understand words.

**Methods Used in Speech Therapy for Special Needs Children**

Speech and language therapy needs of children with special needs encompass a variety of methods, depending upon each individual’s strengths and weaknesses.

To address the communication needs of students exhibiting various disorders and/or syndromes, there are a variety of methods, which include autism spectrum disorders, Down syndrome, Rett Syndrome, cerebral palsy, William’s Syndrome, Angelman Syndrome, developmental disabilities, and other rare genetic syndromes. To address all areas of speech and language, they have been trained to deliver services, including receptive language, auditory processing, expressive language, pragmatic language and social communication, articulation, voice, and fluency disorders as well as dysphagia, oral motor, and feeding needs.

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**Check Your Progress**

6. What is the overall objective of all types of counselling?

7. What are the main goals of physical therapy?

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**9.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS**

1. A comprehensive evaluation is conducted to determine the nature and severity of the problem and establish a child’s eligibility for special services, if screening results indicate a potential disability.

2. It makes use of a variety of techniques ranging from expressive insight-oriented, interpretive techniques to more supportive relationship-oriented techniques.
3. Visual aids help students to understand information as they provide a source that can be referred to as often as necessary and for the length of time that is required in order to process the content of the information.

4. Shaping aims to change behaviour gradually and systematically through the use of reinforcements.

5. The applied behaviour analysis is based on the assumption that the behaviour(s) to be changed are clearly defined and recorded, and the antecedents and reinforcers that might be maintaining an undesirable behaviour, or that could be used to help develop alternative or new behaviours, are analysed.

6. The overall objective of all types of counselling is to help individuals become self-sufficient, self-dependent, self-directed and to adjust themselves efficiently to the demands of a better, happier and a meaningful life.

7. The main goals of physical therapy are as follows:
   a) Develop coordination
   b) Build strength
   c) Improve balance
   d) Maintain flexibility
   e) Optimize physical functioning levels
   f) Maximize independence

9.6 SUMMARY

- In USA, Individuals with Disabilities Education Improvement Act (IDEA 2004) provides eligible children, starting at age 3, the right to special education services in public schools.
- IDEA diagnoses specific disability categories such as orthopedic and other health impairments, specific learning disabilities, autism, blindness and deafness, and mental retardation.
- Caregivers need to be familiar with expected ranges of development in order to know when a child might be showing signs of a significant delay or disability.
- The first step in identifying a young child’s disability is concern raised by someone familiar with the child, unless a medical diagnosis is made at birth or during a well-child visit.
- A comprehensive evaluation is conducted to determine the nature and severity of the problem and establish a child’s eligibility for special services, if screening results indicate a potential disability.
Self-Instructional Material

Psychological Intervention

- Specialized instruction and therapies are important components of special education but, first and foremost, young children thrive in settings with familiar adults who know them and provide loving care.
- The aim of psychoanalysis therapy is to release repressed emotions and experiences, i.e., make the unconscious conscious.
- The psychoanalytical psychotherapy deals with selected problems or highly focused conflict. In it, though the numbers of sessions are often decided in the beginning but the course of therapy can be altered as the patient’s needs and goals change.
- Psychoanalytical psychotherapy is regarded as the treatment of choice for neurotic disorders, narcissistic personality disorder, borderline personality disorder and non-psychotic character disorders.
- The approach to education of individuals who are deaf or blind has changed significantly since the rubella epidemic occurred in the United States and Western Europe in the early 1960s.
- The most widely recommended strategies for teaching students with ASD is the use of visual supports.
- Visual images help students to understand information as they provide a source that can be referred to as often as necessary and for the length of time that is required in order to process the content of the information.
- Both passive modeling and video modeling are viable tools in term of practice. Visual supports are usually simple and inexpensive.
- For students with Autism Spectrum Disorders (ASD), incorporating Methods of Applied Behaviour Analysis (ABA) into Programs is an effective approach to understanding and changing behaviour, and teaching new skills.
- A form of prompting is modelling. It tells students what is expected in a task by having students see the task being performed through a visual example.
- Through the use of reinforcement the target behaviour is encouraged. It is usually provided after the target behaviour to increase the likelihood that the behaviour will reoccur.
- Reinforcement can be provided for displaying positive behaviours – to encourage these behaviours to continue or for refraining from or reducing the occurrence of negative behaviours.
- The primary characteristics of ASD are Managing Challenging Behavior Impairments in communication and social skills.
- Effective behaviour management refers to an ongoing process with definable steps. It starts with a functional behaviour assessment (FBA), which is a systematic process designed to look beyond the student’s behaviour and focus on identifying its function or purpose.
Effective communication programs for students with ASD aim the development of functional communication skills to enhance or increase interactions with others.

9.7 KEY WORDS

- **Forward chaining**: It refers to a method in which steps within a task are identified through task analysis, and then the focus shifts to teach the first step or subtask that the student has not mastered, and then assist the student with the rest of the task.
- **Modelling**: It refers to a method of prompting which tells students what is expected in a task by having students see the task being performed through a visual example.
- **Psychoanalytic interventions**: It refers to interventions which bring together the academic and clinical worlds of psychoanalysis in works that are compelling, lucid, and accessible to a wide range of readers.
- **Task analysis**: It refers to a method in which tasks are broken down into smaller, teachable steps. In this method, the goals for each step are established, and task performance can then be taught according to these steps.

9.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

**Short Answer Questions**

1. What is the psychoanalytical approach?
2. List the main principles of educational programming of deaf/blind children.
3. What are the various types of instructional strategies?
4. Write a short note on the importance of visual support.
5. Why is predictable environment necessary for better functioning of children?
6. How is forward chaining different from backward chaining?

**Long Answer Questions**

1. What are the expected ranges of development in human beings? Discuss.
2. Why has psychoanalytical psychotherapy become a desirable and widely applicable form of treatment over psychoanalysis? Explain in detail.
3. Analyse the two main methods of visual support.
4. Describe the working of the applied behaviour analysis (ABA).
5. Interpret the steps involved in discrete trial training (DTT).
9.9 FURTHER READINGS


UNIT 10 DESIGNING TRAINING PROGRAMS FOR PROFESSIONALS

Structure
10.0 Introduction
10.1 Objectives
10.2 Training Need Analysis
10.3 Implementing an Effective Training Program
10.4 Answers to Check Your Progress Questions
10.5 Summary
10.6 Key Words
10.7 Self Assessment Questions and Exercises
10.8 Further Readings

10.0 INTRODUCTION

Training analysis is defined as a process in which identification of training gap takes and place and measures related to it are carried out. Training is described as a process in which skills or attitudes are acquired to improve the overall performance. Training analysis looks at each aspect in order to effectively identify the human elements of a system and required training to be given for the same.

The design training program was developed which proposed and developed tools for an integrated approach. It provides traceability between hazards and training and reviews the proposed training process.

In this unit, the concept of training analysis and its components have been discussed. The steps involved in the training process have been explained. The unit will also describe the steps involved in carrying out an effective training program.

10.1 OBJECTIVES

After going through this unit, you will be able to:
- Discuss the meaning and importance of training need analysis
- Analyse the concept of design integrated training analysis
- Identify the steps involved in the process of training analysis
- Explain the steps required to carry an effective training program
10.2 TRAINING NEED ANALYSIS

The formal process of identifying the training gap and its related training need is known as ‘training needs analysis’ (TNA).

The acquisition of skills, concept or attitude that improved performance within the job environment is known as training. Training analysis looks at each aspect as a result of an operational domain so that the initial skills, concepts and attitudes of the human elements of a system can be effectively identified and appropriate training can be specified.

Most of the times, training analysis is used as part of the system development process. Since, there is only a slight difference between the design of the system and the training required; in most cases it runs alongside the development to capture the training requirements. Training needs analysis looks at each aspect of an operational domain so that the initial skills concepts and attitudes of the human elements of a system can be effectively identified and appropriate training can be specified.

Design Integrated Training Analysis

Design integrated training analysis is a tool and method for an integrated approach which has been proposed and developed. The trade-offs between design and training is both assessed in light of the understanding of the operational tasks.

The model provides a systematic means of conducting a TNA at three levels:
1. Organizational
2. Operational (or task)
3. Individual (or person)

Training Analysis Process

The task of training can be broken down into a number of discrete components, each addressing a different part of the overall learning process. This breakdown is as follows:

- Psycho-motor skills
- Procedural skills
- Knowledge transfer
- Communication skills
- Colossal thinking
- Attitude learning
- Performance training
- Physiological stresses
The Ten-Step Process for Conducting a Training Needs Analysis

The basic process follows a series of steps which one can adapt to suit his or her own purposes.

1. **Strategic Objectives**: What is the organizational context and the ‘why’ behind any capabilities and learning?
2. **Operational Outcomes**: What do we need to be able to achieve, to meet our strategic objectives?
3. **Employee Behaviours**: What do people need to do, to generate the outcomes we want?
4. **Learnable Capabilities**: What are the capabilities that people need, so they will be able to do what we need them to do?
5. **Gap Assessment**: What are the current levels of capability, and what do we need to train, to get them to the desired level?
6. **Prioritize Learning and Training Needs**: What do we need people to learn? Based on the gap assessment.
7. **Learning Approaches**: To ensure people gain the right levels of capability. How will we transmit the knowledge, and secure the learning?
8. **Roll-out Plan**: How would we deliver the learning we have identified?
9. **Evaluation Criteria**: To train and educate our people, how will we evaluate the work we do?
10. **Cost Benefit Analysis**: How much will our learning programme cost, and how does that compare with its projected benefits?

**Tools for Training Needs Analysis**

The following tools are required to carry out the training need analysis:

- Direct observation
- Second-hand reports (to a lesser extent)
- Interviews
- Focus groups
- Questionnaires and surveys
- Assessments and psychometric tests
- Job descriptions and role profiles
- Performance appraisals and annual reviews
- Output from SWOT and PESTLE analysis
- Consultation with stakeholders
- Records, reports, and internal studies
- Work samples
Check Your Progress
1. State any one advantage of training need analysis.
2. What is design integrated training analysis?

10.3 IMPLEMENTING AN EFFECTIVE TRAINING PROGRAM

In this section we will discuss the steps required to implement an effective training program.

Program Description
The purpose of the rehabilitation training program is to ensure that skilled personnel are available to serve the rehabilitation needs of individuals with disabilities assisted through vocational rehabilitation, supported employment, and independent living programs. To that end, the program supports training and related activities designed to increase the number of qualified personnel trained in providing rehabilitation services.

Types of Projects
For example, in the USA, this program supports awards under the following categories:

- Rehabilitation Long-Term Training Program (CFDA Number 84.129)
- Rehabilitation Short-Term Training Program (CFDA Number 84.246)
- Training Interpreters for Individuals Who Are Deaf or Hard-of-Hearing and Individuals Who Are Deaf-Blind Program (CFDA Number 84.160)
- Rehabilitation Continuing Education Program (CFDA Number 84.264)
- General Training (CFDA Number 84.275)

Any of thirty rehabilitation long-term training fields awards can be made, in addition to awards made for innovative rehabilitation training, rehabilitation short-term training, and training of interpreters for individuals who are deaf or hard-of-hearing and individuals who are deaf-blind.

The recipients of grants under the rehabilitation long-term training program are required by the rehabilitation training program authority, to build closer relationships between training institutions and vocational rehabilitation (VR) state agencies promote careers in the public vocational rehabilitation program, identify potential employers who would meet the student’s payback requirements, and assure that data on the employment of students are accurate.

Since India is a signatory of UNCRPD, it has to provide the mandates present in that resolution. In India, Rehabilitation Council of India provides
educational and training facilities and qualifications for people working in the field. For such training a minimum of PG Diploma in Rehabilitation Psychologies is mandatory.

**Implementation of Training Programs and their Evaluation**

According to a rational consideration of training needs the training programs need to be implemented and moreover these training programs need to be evaluated for assessing their effectiveness. Here, the point is that training programs are conducted often without a clear articulation of training needs as well as not being implemented according to a set pattern.

First aspect, according to a careful consideration of training needs and the right training partners and the vendors have to be selected, training programs need to be implemented. This means that training programs have to be based according to the needs of the organization and not simply because there is a need for training to fill the mandatory number of hours.

Training programs are implemented without securing approvals from all the departments and divisions which mean that many potential participants would be unable to attend because they are busy with their work.

The evaluation of the effectiveness of the training programs is the second aspect that needs to be considered, this needs to be done based on how well the participants absorb the lessons and improve their skills. By conducting exit tests and other forms of assessment like presentation of case studies, this can be done.

Finally, in organizations training programs need to be conducted with a clear focus on linking them to organizational goals, selecting the right vendors, choosing a time that is convenient for all participants or at least a majority of them, publishing the training calendar in advance and most importantly, evaluating the effectiveness of the training programs by conducting exit tests and presentations to ensure that they have been well received.

**Monitoring, Outcome and Impact Studies**

Monitoring is a form of evaluation or assessment, though unlike outcome or impact evaluation, it takes place shortly after an intervention has begun (formative evaluation), throughout the course of an intervention (process evaluation) or midway through the intervention (mid-term evaluation).

Monitoring is not an end in itself. Monitoring allows programs to determine what is and is not working well, so that adjustments can be made along the way. It allows programs to assess what is actually happening versus what was planned.

Monitoring allows programs to:

- Remedial measures are implemented to get programs back on track and remain accountable to the expected results the programme is aiming to achieve.
• Determine how funds should be distributed across the programme activities.
• Collect information that can be used in the evaluation process.

The following are the examples of monitoring methods:
• Activity monitoring reports.
• Record reviews from service provision (for example, police reports, case records, health intake forms and records, others).
• Exit interviews with clients (survivors).
• Qualitative techniques to measure attitudes, knowledge, skills, behaviour and the experiences of survivors, service providers, perpetrators and others that might be targeted in the intervention.
• Statistical reviews from administrative databases (i.e. in the health, justice, interior sectors, shelters, social welfare offices and others).
• Other quantitative techniques.

Check Your Progress
3. State the purpose of the rehabilitation training program.
4. What are the main uses of monitoring?

10.4 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Training needs analysis looks at each aspect of an operational domain so that the initial skills concepts and attitudes of the human elements of a system can be effectively identified and appropriate training can be specified.
2. Design integrated training analysis is a tool and method for an integrated approach which has been proposed and developed.
3. The purpose of the rehabilitation training program is to ensure that skilled personnel are available to serve the rehabilitation needs of individuals with disabilities assisted through vocational rehabilitation, supported employment, and independent living programs.
4. The main uses of monitoring are as follows:
   a) Monitoring allows programs to determine what is and is not working well, so that adjustments can be made along the way.
   b) It allows programs to assess what is actually happening versus what was planned.
10.5 SUMMARY

- The formal process of identifying the training gap and its related training need is known as ‘training needs analysis’ (TNA).
- The acquisition of skills, concept or attitude that improved performance within the job environment is known as training.
- Training analysis looks at each aspect as a result of an operational domain so that the initial skills, concepts and attitudes of the human elements of a system can be effectively identified and appropriate training can be specified.
- Design integrated training analysis is a tool and method for an integrated approach which has been proposed and developed.
- The design integrated analysis is carried out on three levels which are Organizational, Operational (or task) and Individual (or person).
- The task of training can be broken down into a number of discrete components, each addressing a different part of the overall learning process.
- The purpose of the rehabilitation training program is to ensure that skilled personnel are available to serve the rehabilitation needs of individuals with disabilities assisted through vocational rehabilitation, supported employment, and independent living programs.
- The program supports training and related activities designed to increase the number of qualified personnel trained in providing rehabilitation services.
- According to a rational consideration of training needs the training programs need to be implemented and moreover these training programs need to be evaluated for assessing their effectiveness.
- The evaluation of the effectiveness of the training programs is the second aspect that needs to be considered, this needs to be done based on how well the participants absorb the lessons and improve their skills.
- Finally, in organizations training programs need to be conducted with a clear focus on linking them to organizational goals, selecting the right vendors and choosing a time that is convenient for all participants or at least a majority of them.
- Monitoring is a form of evaluation or assessment, though unlike outcome or impact evaluation, it takes place shortly after an intervention has begun (formative evaluation), throughout the course of an intervention (process evaluation) or midway through the intervention (mid-term evaluation).
- Monitoring allows programs to determine what is and is not working well, so that adjustments can be made along the way.
- Qualitative techniques to measure attitudes, knowledge, skills, behaviour and the experiences of survivors, service providers, perpetrators and others...
that might be targeted in the intervention.

- Statistical reviews from administrative databases (i.e. in the health, justice, interior sectors, shelters, social welfare offices and others).

### 10.6 KEY WORDS

- **Design integrated training analysis**: It refers to a tool and method for an integrated approach which has been proposed and developed.
- **Monitoring**: It refers to a form of evaluation or assessment, though unlike outcome or impact evaluation, it takes place shortly after an intervention has begun (formative evaluation), throughout the course of an intervention (process evaluation) or midway through the intervention (mid-term evaluation).
- **Rehabilitation training program**: It refers to a type of training program which ensures that skilled personnel are available to serve the rehabilitation needs of individuals with disabilities assisted through vocational rehabilitation, supported employment, and independent living programs.
- **Training need analysis**: It refers to the formal process of identifying the training gap and its related training need is known as ‘training needs analysis’ (TNA).

### 10.7 SELF ASSESSMENT QUESTIONS AND EXERCISES

**Short Answer Questions**

1. What are the various aspects of training need analysis?
2. Write a short note on the importance of program description.
3. What are the tools that help to carry training analysis?
4. List the types of modelling methods.
5. How are training programs evaluated?

**Long Answer Questions**

1. Explain the levels of the design integrated training analysis.
2. Describe the process of training analysis.
3. Identify the components of training analysis process.
4. Discuss the main types of projects in program designing.
5. Interpret the steps involved in the implementation of training program.
10.8 FURTHER READINGS


UNIT 11 ORGANIZATION AND MANAGEMENT

11.0 INTRODUCTION

During British rule when India’s traditional character started changing as a result of its contact with the west, voluntary organizations (VOs) came to be established. Since the traditional ties of family and kin groups did not weaken easily, there was no need for expressive groups. However, such organizations did come up, especially among the urban educated class, to satisfy their educational and intellectual needs. Since the British were colonial masters at the political level there was not much interaction between the rulers and the subjects. This and the need to win freedom from colonial masters gave rise to a number of voluntary associations with political goals. Among them, the Indian National Congress and the Servants of India Society were prominent. At the same time, people belonging to various caste groups, especially those who had received western education, started VOs of their own caste fellows to encourage education among them and also to eradicate some social customs (like death feast and bride and groom price), which they found outdated. Though such organizations opposed some customs of their caste groups, in an overall sense, they tended to strengthen the traditional structure of their castes. After Independence, education expanded to almost all sections of society. Voluntary organizations based on caste, religion, region and language proliferated, in turn strengthening the grip of these traditional institutions. However,
these organizations also could not escape the impact of modernization and became secularized to some extent. In this unit, you will learn about the evolution, characteristics and capacity building of non-governmental organizations.

### 11.1 OBJECTIVES
After going through this unit, you will be able to:

- Discuss the evolution of non-governmental organizations
- Explain the background characteristics of non-governmental organizations
- Describe capacity building of non-governmental organizations

### 11.2 EVOLUTION OF NON-GOVERNMENTAL ORGANIZATIONS

Alongside voluntary organizations (VOs) based on traditional institutions like caste, religion and sect, the democratic and welfare-oriented character of Indian polity also led to the establishment of many VOs which were non-sectarian and secular in nature. Later on, they came to be known as non-governmental organizations or NGOs. They emerged because of the limitations and inadequacies of governmental efforts, both at the political and economic levels, in providing basic services and facilities to all sections of society. It was found that the highly bureaucratic governmental machinery was not effective and fast enough to reach the poorest and those living in the remotest parts of the country. NGOs took up this task where the government had left it. Besides, NGOs also took up the problems of the people and started empowering them by creating awareness. In turn, vested interest groups among the non-dalits and the non-tribals also started feeling the pinch of the activities of the NGOs. This led to conflicts between the two opposite groups as well as harassment of the NGOs, who were serving the interests of deprived groups. Thus, at the grassroots level there was significant change, but this was largely localized and, therefore, not very effective.

Since many of the NGOs are run by charismatic leaders in the initial stages, the limited change that they bring about has a magnetic effect due to the leader’s charisma. But as these NGOs develop over the years, the old leadership changes, the charisma gets routinized and the social change gets circumscribed. Thus, by their very nature, VOs bring about only micro-level changes and the intensity of the changes gets diminished as these organizations grow in age. However, in view of the increasing corruption at the political and economic levels, VOs provide the only hope for the social transformation of society and if the social changes that they bring about are only fragmentary and piecemeal, this is an indication of worrisome trends.
Volunteers

The term ‘volunteer’ is normally used to denote someone who offers unpaid services for a good cause. However, this term has been used in a variety of ways and it has been observed that one may identify five main sources of voluntarism—religion, government, business, philanthropy and mutual aid. The missionary zeal of old religious organizations, the commitment of government organizations for public interest, the profit making urge in business, the altruism of ‘social superiors’ and the motive of self-help among fellow men all reflect voluntarism. Hence, there are a large variety of voluntary organizations which have different objectives. These may include business companies, political organizations, trade unions, residents’ welfare associations, professional organizations, voluntary action groups, autonomous boards, recreational clubs and voluntary welfare organizations. However, for the purposes of this unit, we are concerned only with voluntary social service organizations, which help in the development of weaker sections of society. Mutual aid and philanthropy are the two main sources from which voluntary social service organizations have developed. They spring from individual and social conscience respectively. Schemes based on these two motivating factors converge with each other and it is this mixture of the two elements which is peculiarly characteristic of VOs today.

Voluntary organizations in India are registered under the Societies Registration Act of 1860 and the Indian Trust Act of 1882 or the Cooperatives Societies Act. We first discuss the role of voluntary social welfare agencies in India in some detail and then of cooperative societies in brief.

11.2.1 Social Work in Ancient and Medieval Periods

As in other parts of the civilized world, social work in the form of mutual assistance, charity and philanthropy in India is an activity which serves the needy and helps one’s fellowmen. These are some of its many virtues which have been valued in Indian culture. All Indian religions emphasize charity. The responsibility for individuals in need of special assistance was shared by rulers, the rich, and also by individual members of the community. According to R.C. Majumdar (1961), in ancient and medieval periods ‘the kings, merchants, landlords and various corporate organizations vied with one another, according to their means for helping the cause of religion.’

11.2.2 Social Work during the British Period

Social work taken up by voluntary workers or the government during the British period passed through various phases:

The first phase from 1780 to 1880 was devoted to social reforms.

The second phase from 1880 to 1900 laid emphasis on establishing social welfare agencies for the socially handicapped.
The third phase from 1900 to 1920 had the formation of all-India organizations, especially for the welfare of Harijans, tribals and industrial workers.

The fourth phase from 1920 to 1937 emphasized on preventive aspects, that is, expansion of educational facilities, village uplift and development of industries, provision of recreational activities and protective legislations.

The fifth phase between 1937 and 1939 had the new short-lived Congress ministries in many states setting up rural development and/or women’s welfare departments for rural reconstruction and welfare of women respectively.

Social Reforms

Among the early social reformers the most prominent was Raja Ram Mohan Roy (1772-1833) who pleaded for the abolition of caste distinctions and the practice of sati. He was the founder of Brahmo Samaj, a sect against idolatry, which included social reforms as an integral part of its mission. In Bengal he was followed by Dwarkanath Tagore, Davendranath Tagore, Sesipada Bannernjee and Keshab Chandra Sen. In western India religious and social reforms on a similar pattern were initiated by the Paramhans Sabha and later on by the Prarthana Samaj. Its important leaders were Telang, Ranade and Chandavarkar, all from the Bombay judiciary. When the Indian National Congress was formed in 1885, Ranade was one of its leaders and he thought that it should principally deal with social reforms. But Hume who first thought of this all-India organization wanted to make it a political organization. Therefore, a separate organization for social reforms came into being in 1887 known as the Indian Social Conference. M.G. Ranade (1842-1901) was the moving spirit behind this. Social reforms’ associations were formed in various provinces under the guidance of the Indian Social Conference.

Among the other social reformers and social workers of this time was Swami Dayanand Saraswati (1824-1883) who formed the Arya Samaj in 1887. Swami set his face against caste, child marriages, widow’s celibacy and followed a closed-door policy towards converts who wished to return to the fold. He had a programme of national education. His programme worked well in Punjab. Swami Vivekananda (1862-1902) laid the foundation of Ramakrishna Mission. On return from America in 1897 he established the Ramakrishna Mission devoted to educational, social and medical relief work. In 1890, the Indian Social Reforms was founded in Madras. About the same time similar ideas on social reforms were popularized by Muslim reformer Sir Sayed Ahmad Khan. In 1875, he founded an educational institution, which later developed into Aligarh Muslim University. He also started the Muslim Educational Conference in 1888.

All-India Social Organizations

With Ranade’s death in 1901, Chandavarkar became the General Secretary of the Indian Social Conference. He was a very energetic man. The Conference declared the objective of social reforms to be a complete scheme of national
regeneration for India. The Indian Social Reforms was transferred from Madras to Bombay. A Central Social Reform Association was formed as a permanent organization of the Conference, which was to coordinate activities, publish literature and strengthen the provincial and district associations. In 1904, the Conference was attended by Muslims and Sikhs, Arya Samajists and Brahmno Samajists, theosophists and Buddhists from all over India. During the Conference it was resolved that a network of reform associations throughout the country would be formed. Later, social reform associations/conferences came up with alarming speed all over the country. In 1905, the Servant of India Society was formed by G.K. Gokhale. Though its primary purpose was political, it also laid emphasis on social, economic, educational aspects and activities for the depressed class. The Social Service League formed in 1911 in Bombay laid emphasis on improving the social condition of labourers. It organized night classes for mill workers, built travelling libraries and ran classes on sanitation and hygiene. There had been a separate ladies conference with the annual session of the Indian Social Conference since 1905, but in 1927 a separate organization known as All India Women’s Conference came into being.

**Gandhiji’s Constructive Programme**

Due to the growing influence of Gandhiji in the Congress and the emergence of independent organizations like the All India Women Conference, Depressed Classes Conference and Mission and the National Council of Women the social reform movement began to fade and there was no such conference on an all-India level after 1933. Gandhiji started his own programme for the removal of untouchability, temperance and some other constructive programmes. He set up appropriate national organizations with dedicated workers to solve specific problems like the Harijan Sewak Sangh and the All India Village Industries Association. However, the new social workers were reformers not because they had independent convictions but in submission to Gandhiji’s leadership and they drew their strength from the organization and its funds; political agitation also often affected their work.

**Social Work after Independence**

After Independence the Indian National Congress assumed power at the Centre and also in many states. Suddenly, the behaviour of many Congress leaders changed and Gandhiji was shocked by this change. In a speech at Hilsa he said that he had heard from various quarters that ever since the acceptance of office by the Congress it was abandoning its tradition of penance, sacrifice and service. Three days before his death he advised that the All India Congress Committee should resolve to disband the existing Congress organization and blossom into a Lok Sevak Sangh. It should become a body of servants. Each worker who became its member should be a habitual wearer of khadi and must be a teetotaler. However, his advice was not taken seriously by Congress leaders though some action was taken later on in this direction. The Bharat Sewak Samaj was floated by Gulzari Lal Nanda with
the blessings of Jawaharlal Nehru to take up social welfare activities in various fields. But it failed to do much work due to corruption prevalent at various levels. Even the Sarvodaya movement led by Vinobaji and Jai Prakash Narain failed due to various reasons; even those persons in power who were corrupt were not asked to leave their positions and do voluntary social work for the downtrodden.

Registering an NGO

In India a voluntary organization has to be registered and a procedure for starting a private non-profit limited organization or for starting a trust or society has to be followed. Section 28 of the Companies Act deals with the procedure for starting an NGO where the administration of an NGO is to be governed by a Board of Trustees or a Managing Committee Governing Council. Section 2(15) of the Income Tax Act is applicable uniformly throughout India for charitable purposes to provide adequate service relief to the poor, and for education and medical relief and the advancement of any other object of general public utility. The formation and registration of an NGO is based on Section 25 of the Company Rules and Additional Licensing Registration. Different legislations in India have different trust acts which are in force; these govern the trusts in the state, and are governed by the Indian Trusts Act 1882.

An application for registration is necessary for starting an NGO. The trustee's form has to be signed by the proprietor. Along with the form a copy of the trust deed along with an affidavit and a consent letter by the concerned person have to be submitted. After this the Societies Registration Act of 1860 (Section 20) has to be followed. The procedure varies from state to state. The application should be submitted together with a memorandum of association and rules and regulations, consent letters of all the members of the Managing Committee, authority letter duly signed by all the members of the Managing Committee and an affidavit sworn to by the President or Secretary of the society.

Today, there are many NGOs working in the area of Rehabilitation Psychology with disabilities including Uma Educational and Technical Society, Association of People with Disability India, Alzheimer and Related Disorders Society of India, etc.

Check Your Progress

1. Give the reasons for the emergence of NGOs in India.
2. Name the acts under which voluntary organizations in India are registered.
3. Who was the most prominent social reformer of the early period in India? What did he plead for?
4. Name the organization set up by Swami Dayanand Saraswati (1824-1883).
5. Name some of the leaders who worked in tackling the problem of destitution, drinking, exploitation of children and women and slums.
11.3 CHARACTERISTICS OF NON-GOVERNMENT ORGANIZATIONS

NGOs are classified differently. There are various types of NGOs:

(i) charity,
(ii) development, and
(iii) empowerment

In addition to these there are also other types of NGOs: (1) social welfarism, (2) radical nationalism, and (3) socialist orientation. It is in the third stage of development that action groups (NGOs) develop an alternative social order because of their radical socialist orientation.

Characteristics of NGO

The following are some of the characteristics associated with the word ‘NGO’:

- The generate and distribute profit is not the aim of NGOs. They are known as not-for-profit organizations. This is even valid when they are engaging in activities which seem revenue generating or in conditions where they give remuneration to the employees working for these organizations.
- Voluntary participation and organization is one of the chief characteristics of NGOs. They are formed voluntary by the will of their founders.
- NGOs are different from informal or ad hoc organizations in terms of their structure as well as rules and acts governing them. They have stated objectives, mission and vision. Additionally, they are answerable to their donors and members.
- NGOs display an independent existence, especially from government, public, political and commercial organizations.

There are several other characteristics of NGOs as expressed by many different authors, including:

- They get a legal status as granted by their registration with the Government.
- They are flexibility and distance from bureaucracy and red tapism.
- They are prompt in decision making as they are less hierarchies and structures.
- They are created by the promoters not for their benefit.
- The members of the NGOs generally carry a very high spirit and determination.
- The members have a greater degree of freedom in their work and it is not formally defined. And therefore, may promote leadership.
- They are value driven.
- They are people oriented.
11.4 CAPACITY BUILDING OF NON-GOVERNMENT ORGANIZATIONS

World Customs Organization defines capacity building as “activities which strengthens the knowledge, abilities, skills and behaviour of individuals and improve institutional structures and processes such that the organization can efficiently meet its mission and goals in a sustainable way.”

Therefore, capacity building of non-government organizations deal with the effective development and management of resources of the NGOs. It will not be unusual to liken the capacity building of NGOs to the concept of organizational development. In this section, you will learn about the capacity building of NGOs through their management and administration.

NGOs working in the field of rehabilitation psychology for the disabled are crucial on four counts: they assist with treatment and care, with prevention, with raising awareness as well as empowerment and advocacy. The following capacity building area of discussion pertains to all types of NGOs.

The term ‘administration’ has acquired many connotations, the most important is public administration. It began after Independence as a process of administering a district, a department or a ministry in the government. The initial emphasis, inherited from the British, was on maintaining law and order. To that was added the responsibility of ‘planning’ with the adoption of Five-Year Plans. With the introduction of the programme of community development and the institutions of Panchayati Raj as a system of development of grassroots village ‘communities’, the process of democratic decentralization was initiated. The introduction of technological developments put additional responsibilities on public administrators. The coming of computers helped in developing databanks and data analysis. These varied responsibilities and assistance put a heavy burden on bureaucrats although it made them ‘masters’ of all the areas of governmental influence. It is in this context that the concept and process of social welfare administration has to be viewed. The term ‘social’ implies ‘relationship’ and ‘welfare’ signifies ‘human aspects of development’.

Thus, human development and value orientation have to be the mainstay. In assuming this responsibility, a social welfare administrator has to face many constraints, the most difficult being the system of working under bureaucrats.

At this stage, it is necessary to explain the difference between social administration and social welfare administration, although both the terms are used interchangeably. Social administration deals with administration of social services of health, education, welfare and allied subjects, whereas social welfare administration per se deals with welfare services. The difference in the processes is subtle although the nature and content of services between the two differ widely.

In the context of administration for development, social administrators including welfare administrators have to take note of the historical process of
development and change. To begin with, the unitary trend in a federal system under the Constitution and the responsibilities of an administrator get divided between the demands of Central and state governments. Added to this are demands of democratic decentralization of development with the introduction of community development and Panchayati Raj although this trend prevails unevenly in different states. The programme of rural development still continues in forms different from those of community development and the importance of rural-urban continuum is overlooked many times. Instead, urban oriented technological developments are acquiring a central focus of development administration without recognizing the social aspects of technological change. All these areas of development have a vital impact on social administration.

The Department of Social Policy: With the adoption of the process of planning at the national level and its execution at the state and local levels, the responsibility for determining social policy was added to the scope. Although at present, this responsibility by and large rests with public administrators, it should really belong to social administrators. They have to prepare themselves through studies, research and reflection to shoulder the responsibilities for determining social policy.

Attitude and values are two important tools for a good social administrator. This is especially true under a democratic system. The emphasis on public participation requires belief, faith and commitment in the rights of individual citizens to question, and at the same time, to participate in promoting social and welfare services. The question that arises is whether an administrator is a partisan. This is true in the context of an egalitarian society as visualized in the Constitution.

Overall responsibilities of social administration: social administrators have manifold responsibilities:

- Determining new social policies and correcting existing ones.
- Planning social services including welfare at the macro and micro levels.
- Administering social services at the Central, state and local levels.
- Monitoring services systematically to know the progress of work and correcting them when found ineffective.
- Evaluating the performance every five years to provide correction in the next plan.
- Ensuring effectiveness and efficiency of services in terms of their impact in meeting the social needs of people and efficiency in terms of delivery of services ensuring social objectives and values.
- The general responsibilities of administrators should continue to be fulfilled, including
  - improving the efficiency of the administration
  - ensuring expeditious disposal of administrative responsibilities
  - ensuring full utilization of scarce resources
• delegation of responsibilities and decentralization of authority
• establishing and maintaining good public relations
• giving quick redress to citizens’ grievances

Social administration, including social welfare administration in the context of development thus has to draw its sources from general administration, public administration and economic administration to make its work effective. There is no one way of structuring development administration, especially if it is to be related to the requirements of the social environment.

11.4.1 Fund Raising Methods

Over time there have been changes in the work of voluntary organizations. The need for money has also increased with these changes. It is of vital importance that today the income of a voluntary organization should not only be adequate but it should also be regular and more than what it was earlier, so that the planning and performance of services remain effective.

Government Grants

The government releases grants from public funds. These are given to voluntary organizations in appreciation of their work in which the grant releasing authority is interested. They are evidence of cooperation between public authority and voluntary organizations. Grants from non-government or charitable trusts are incomes from investments derived from capital sums bequeathed to individual organizations. They are given for definite programmes of social work many of which are experimental and pioneering efforts. Many of these grants are also released for wider purposes rather than for definite work. Ad-hoc collections are made by voluntary bodies by organizing recreational programmes, melas, fairs, sales, etc. They contribute towards the funds of voluntary bodies, but not to a very large extent.

Community Chest

Community chest involves united fund raising for the benefit of voluntary organizations in a particular community. This is a new idea and is in practice in advanced countries such as America. For the continuance of their successful services, voluntary organizations must increase their income, for which they must be popular and must maintain good public relations. They must maintain a standard of their services and their accounts should be clear and properly audited.

Grants-in-Aid

Voluntary organizations engaged in social work have to face many problems, not the least of which is raising adequate funds to support and further the objectives that they have set for themselves. For organizations, other than those which are effectively supported by philanthropic trusts, this is a very real problem. Assistance from rich businesses and philanthropists is based on chance, often on a once-for-all basis and cannot be relied upon continuously on any permanent basis. Further,
there are limitations to the amount that can be raised through membership and by public collection drives. For their financial viability and sustained good work, such organizations have to depend a great deal on some single source of constant and substantial help, like the grants-in-aid that the government makes to such organizations. The question of grants-in-aid needs to be examined for the following aspects:

1. The nature of government schemes for grants-in-aid to voluntary welfare organizations, eligibility conditions and procedures for realization.
2. Present meager levels of utilization of this source of funds and the resources for it.
3. What voluntary organizations can do on their own part -by way of qualifying for more grants from the government and by way of better utilization of the available grants.

**Ad-hoc Collections**

Any voluntary organization running welfare services for the public needs money. The government does help such organizations by giving aid, but there are other sources also for collecting funds. Those voluntary organizations which have good contacts and a good reputation can arrange plays and dramas to raise money. However, the contribution to funds made by such programmes is not always sufficient. Dispensary contributions, nursery school fees, crafts classes fees, library memberships, creche fees, adult library membership fees and local clubs fees also contribute partly to the total budget of a programme.

The functions of the community chest may be summarized as:

1. To raise funds annually for local voluntary social welfare agencies through a community-wide appeal.
2. To distribute the funds thus collected among these agencies according to mutually agreed upon budget procedures.
3. To promote the social welfare of the community by coordinating existing programmes and improving standards of social work, preventing duplication, conducting research, administering common services and developing better public understanding and support.

The community chest works under a Board of Directors, which include the members of the community and representatives from participating agencies. The chest also has two committees: the Budget Committee and the Campaign Committee.

**Fund Collection**

No institution, whether voluntary or non-voluntary, can make its existence worthy of the cause unless it has sound financial backing. Empires have collapsed, armies have been defeated and trade has come to a standstill and closed down for want
Objectives and motives are essential for raising funds for any welfare institution. Fund raising mainly depends on its objectives and the motives for which the work is being started. The following constitute effective fund raising:

1. Objective
2. Appeal
3. Person
4. Accountability
5. Organized effort

A large number of members contributing less will ensure a bigger fund. Subscription raising gives wider scope to workers to go to the public to canvass for their institutions. Naturally, they have to explain about their working to the public. Public support is solicited and thus a true voluntary effort is created. Whether the funds collected are small or big, these give an opportunity to the workers to gain sympathy from the public.

The following categories of donors contribute to institutions and so they should have some place in the constitution of the respective institutions:

1. Donors
2. Life members
3. Sympathizers
4. Associate members

Donations may be collected from big trusts, firms, nidhis, etc. These trusts need a clear account which can be audited by chartered accountants and submitted to them regularly. However, while on the one hand voluntary workers have been facing many difficulties in raising funds to maintain a certain level of performance, on the other hand, there have been cases of individuals and agencies raising funds through unscrupulous means and not utilizing these for social welfare programmes. In many cases, where the funds are raised for genuine work, these are not utilized for the purpose for which they were raised. There have been certain cases of misrepresentation of so-called religious and social organizations. Sometimes though the funds are raised for genuine purposes, the expenses on fund raising as indicated earlier may be as high as 50 per cent of the total amount raised. Therefore, it is necessary to regulate and supervise fund raising and to lay down certain minimum conditions and procedures which should be followed in every fund raising process. This could be done by the local administration, preferably by a municipality. These conditions include:

(a) Minimum period of work.
(b) Service in a defined field of social welfare.
(c) Non-profit earning and charitable purpose of the agency.
(d) An active committee the bona fide of whose members is suitably established.

(e) Regular system of budgeting, accounting and auditing.

The following procedure can be adopted for exercising regulatory control over raising funds:

1. Submission of certain basic minimum information like the name and address of the organization, scope of its work, its age, budget estimates, statements of account, etc.
2. Inspection of the organization intending to raise funds and holding discussions about the purpose and plan for raising funds.
3. Granting permission for raising funds for a specific period, purpose, programme and its quantum.
4. Public announcement of the funds raised.
5. Depositing the funds collected in a scheduled bank (its accounts to be operated by at least two office bearers).
6. Accountability of the funds raised.

**Fund Raising Procedures**

Procedures for raising and distributing funds include:

1. Receipt of applications.
2. Preparing estimates of the financial requirements after scrutinizing budget estimates.
3. Fixing of targets for the year.
4. Publicity measures.
5. Forming campaign committees.
6. Raising funds.
7. Announcement of results.
8. Distributing funds.
9. Submission of accounts.
10. Arrangements for the next campaign.

**11.4.2 Planning**

Planning in the context of NGOs means working out in broad outlines the things that need to be done and the method to be adopted to accomplish the purpose set for the enterprise.

Organizing means building the structure of the authority through which the entire work is to be done; this has to be arranged and defined in order to achieve the desired goals.
Organization and Management

NOTES

Staffing means appointing suitable individuals to various posts in organizations. It covers the whole of personnel management. Directing means making decisions and issuing orders and instructions and embodying them for the guidance of the staff. Coordinating means inter-relating various parts of work and eliminating overlapping and conflict in different activities of an organization.

Reporting means keeping both the supervisors and subordinates informed of what is going on and arranging for the collection of such information through inspection, research and records. Budgeting means fiscal planning and accounting and control, that is, all activities related to financial management.

11.4.3 Training

The training scheme envisages establishing a training division in the association, which will concern itself with the following four-fold programme of activities: administration of a formalized three-month evening course for full-time paid workers, organizing workshops and seminars. Setting up a research cell in voluntary action for compilation of problems faced by voluntary workers and organizations on the basis of experiences of participants of courses (1) and (2). Such a compilation of problems will not only help in building the contents of the formalized course and also for the seminars and workshops, but it will also provide material for further study and research. A statement of the problems could be referred to various expert agencies for their opinion and the entire material published with suitable editing and noting in the form of small booklets or guide books for workers in the field of voluntary action.

Follow-up wing: The other activity of the training division would be initiating follow-up in the two categories of workers through correspondence and organization of informal study circles.

Each training course has to be organized for full-time paid voluntary workers which should concentrate on selected particularized -themes of study such as problems of institutional management, methods of working with people, research methodology, programme development, fund raising and so on. The courses may also similarly concentrate on various fields of social development like rural and urban, juvenile delinquency, relief and rehabilitation and women’s welfare.

Before each course is organized, a questionnaire will be issued to each participant as well as to his sponsoring agency seeking information regarding data, the needs of each participant and other areas in which help is sought for the training programme. While a syllabus committee will be formed to frame the curriculum of the three-month course of training, the syllabus thus framed will only be in broad outlines, the exact areas and content of each of the courses will be determined on the basis of a survey of the needs of each course. This could be done by members of the syllabus committee, of the faculty as well as by a few selected external experts and representatives of the voluntary agencies together. Training will have to be conducted in the evening for four days a week, one day being earmarked for institutional visits.
The training will consist of: (1) talks and discussions, (2) seminars and workshops on special problems, (3) visits to agencies and institutions, and (4) discussions with selected outstanding leaders in the field of voluntary action. The main emphasis of the theoretical aspects of the training will be discussions on selected problems faced by the workers, presented in the shape of case studies, previously prepared by the association. The members of the faculty will have to visit the various agencies and have preliminary discussions with their officials to select specific problems for preparing case studies.

**Evaluation and Follow-up of Training**

The training division of the organization will provide concurrent follow-up and evaluation of the results of training. This will be conducted on a systematic basis through application of modern techniques of evaluation and follow-up. The purpose of this activity will be to find out the impact of the training programme and of the workshops/seminars in the field of voluntary action in general and in the day-to-day working of the participants in particular. The results obtained from follow-up and evaluation will help in planning successive courses.

Supervision is no doubt a technical skill which can be acquired and developed by proper training. The personality of a successful supervisor is made up of a number of qualities which are made effective through the use of certain definite techniques.

An examination of the adequacy of contents of training in social welfare administration requires a detailed study by a group of social welfare administrators and social work educators in terms of the requirements in the field, availability of teaching staff, reading material and research findings.

**11.4.4 Coordination**

It is rightly said that a battle can be lost no matter how strong the force, if there is no coordination among the various wings, divisions and units of the force. As in battle so in administration. No organization, no matter how competent its staff members, can achieve its desired objective without coordination. The first principle of management states that an organization has to work well, no part of it should repeat what the other part does, no employee should work at cross-purposes and that there should be no conflict among various units inter-se. This is technically called ‘coordination’. Negatively, coordination means removing conflicts and overlapping in administration. Positively, it means securing cooperation and teamwork among the numerous employees of an organization. Newman defines coordination as ‘the orderly synchronization of efforts to provide the proper amount, timing and directing of execution resulting in harmonious and unified actions.’

Coordination is needed not only for securing work and cooperation but also to prevent conflicts that may arise in the working of an organization due to: (i) the ignorance of employees or units about each other’s activities, (ii) a tendency among men in charge of particular activities to regard their own deal as all-important.
unmindful of the needs of others and make encroachments on others’ sphere of activities, and (iii) a growing tendency towards empire building or greed for power among different units of an organization.

Coordination at the organizational level can be achieved through several devices such as establishing a special unit for coordination work commonly known as the ‘coordination’ or ‘establishment’ section or unit; through standardization of procedures and methods, through departmental meetings and conferences and through organization and methods staff.

Coordination at the inter-organizational level can be achieved through such devices as inter-departmental committees, meetings and conferences among officials of different departments and by appointing centralized staff, auxiliary and financial agencies like joint committees of inter-related departments from time to time like the Public Works Department, the Estate Office, the Directorate General of Supplies and Disposal, the Union Public Service Commission, the Comptroller and Auditor General of India and the Ministry of Finance and its various departments.

Coordination at the national level or at the inter-state level in India is achieved through the Planning Commission, the National Development Council, conferences and meetings, zonal councils and inter-state councils. The Cabinet Secretariat, the Cabinet headed by the Prime Minister and various Cabinet Committees effect major coordination between the Centre and the states. Conferences of governors, chief ministers and ministers are common and these help in coordination.

Besides the above bodies, certain other institutions and boards like the University Grants Commission, Interuniversity Boards, Association of Indian Universities and the Indian Historical Records Commission are also doing coordination work.

11.4.5 Monitoring, Evaluation and Public Relations

Additional provision should be made for developing local communities through community development centres for common activities like crèches, balwadis, tutorial classes for children, especially drop-outs, continuing education for women and men, vocational training of youth and adults and economic development activities for earning members of families, day-care centres for children of working women and day-care centres for the aged. The Board then ceases to be merely a post office for giving grants and acquires the responsibility of promoting development and welfare in the country.

11.4.6 Programme Activities

During the last thirty years, programme activities have been developed as per the needs. Therefore, they remain unrelated to each other. They need to be grouped together according to the common requirements of a family and the community. In place of the present ad-hoc approach of giving grants to agencies on the basis of
requests made for individual activities, efforts must be made to study the needs of local communities and grants offered for integrated activities of development and welfare. For example, all activities of children and women welfare, other than assistance for maintaining institutions, should be grouped together and aid given on the basis of families served and the local community developed. Thus, the regrouping of the present programme can take the following shape.

In revising programme activities, greater emphasis should be laid on preventive activities of economic development, skill training, vocational education, condensed courses and nursery schools. Support to other welfare activities should be treated as supplementary to the objective of making the family self-reliant and self-supportive.

With the merger of programmes of development, including rural development and family planning, the emphasis should shift to social development ensuring basic needs of employment, food, shelter, clothing, and health and education services, restricting the size of the family, recreation, cultural development and supportive emphasis on institutional services.

Check Your Progress

6. Give three functions of a community chest.
7. Give four categories of donors who contribute to institutions

11.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. NGOs emerged because of the limitations and inadequacies of governmental efforts, both at the political and economic levels, in providing basic services and facilities to all sections of society.
2. Societies Registration Act of 1860 and the Indian Trust Act of 1882 or the Cooperatives Societies Act are the acts under which voluntary organizations are registered.
4. The Arya Samaj was formed by Swami Dayanand Saraswati in 1887.
5. Bhandarkar, Kolkatkar, Chintamani, Karve, Chandavarkar, K. Veerasingam, Pantulu, Narendra Nath Sen, Baij Nath and Ram Kali Chowdhri are names of some of the leaders who worked for the betterment of society.
6. The three functions are:
   - To raise funds annually for local voluntary social welfare agencies through a community-wide appeal.
• To distribute the funds thus collected among these agencies according to mutually agreed upon budget procedures.
• To promote the social welfare of the community by coordinating existing programmes and improving standards of social work, preventing duplication, conducting research, administering common services and developing better public understanding and support.

7. The four categories are:
• Life members
• Donors
• Sympathizers
• Associate members

11.6 SUMMARY

• NGOs emerged because of the limitations and inadequacies of governmental efforts, both at the political and economic levels, in providing basic services and facilities to all sections of society.
• Voluntary organizations in India are registered under the Societies Registration Act of 1860 and the Indian Trust Act of 1882 or the Cooperatives Societies Act.
• There are various types of NGOs: (i) charity, (ii) development, and (iii) empowerment.
• The following are some of the characteristics associated with the word ‘NGO’: The generate and distribute profit is not the aim of NGOs, voluntary participation and organization NGOs have stated objectives, mission and vision, NGOs display an independent existence, especially from government, public, political and commercial organizations.
• World Customs Organization defines capacity building as "activities which strengthens the knowledge, abilities, skills and behaviour of individuals and improve institutional structures and processes such that the organization can efficiently meet its mission and goals in a sustainable way."
• Capacity building of non-government organizations deals with the effective development and management of resources of the NGOs. It will not be unusual to liken the capacity building of NGOs to the concept of organizational development. In this section, you will learn about the capacity building of NGOs through their management and administration.
• In the context of administration for development, social administrators including welfare administrators have to take note of the historical process of development and change. To begin with, the unitary trend in a federal system under the Constitution and the responsibilities of an administrator get divided between the demands of Central and state governments.
Over time there have been changes in the work of voluntary organizations. The need for money has also increased with these changes. It is of vital importance that today the income of a voluntary organization should not only be adequate but it should also be regular and more than what it was earlier, so that the planning and performance of services remain effective.

Planning in the context of NGOs means working out in broad outlines the things that need to be done and the method to be adopted to accomplish the purpose set for the enterprise.

Organizing means building the structure of the authority through which the entire work is to be done; this has to be arranged and defined in order to achieve the desired goals.

Staffing means appointing suitable individuals to various posts in organizations. It covers the whole of personnel management. Directing means making decisions and issuing orders and instructions and embodying them for the guidance of the staff. Coordinating means inter-relating various parts of work and eliminating overlapping and conflict in different activities of an organization.

Reporting means keeping both the supervisors and subordinates informed of what is going on and arranging for the collection of such information through inspection, research and records. Budgeting means fiscal planning and accounting and control, that is, all activities related to financial management.

The training scheme envisages establishing a training division in the association, which will concern itself with the following four-fold programme of activities: administration of a formalized three-month evening course for full-time paid workers, organizing workshops and seminars.

It is rightly said that a battle can be lost no matter how strong the force, if there is no coordination among the various wings, divisions and units of the force. As in battle so in administration. No organization, no matter how competent its staff members, can achieve its desired objective without coordination. The first principle of management states that an organization has to work well, no part of it should repeat what the other part does, no employee should work at cross-purposes and that there should be no conflict among various units inter-se. This is technically called 'coordination'.

11.7 KEY WORDS

- Volunteer: Someone who offers unpaid services for a good cause.
- Capacity building: It refers to activities which strengthens the knowledge, abilities, skills and behaviour of individuals and improve institutional structures and processes such that the organization can efficiently meet its mission and goals in a sustainable way.
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11.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short Answer Questions

1. What are the various forms that social work took in ancient and medieval times in India?
2. What are some of the important social activities that were taken up by social reformers in India before Independence?
3. Write a short note on the characteristics of NGOs.

Long Answer Questions

1. List the various responsibilities of a social administrator.
2. What are the various ways in which NGOs can raise funds? Discuss at least two of them in detail.
3. Discuss the various procedures for raising and distributing funds for a NGO.
4. What is the way in which an organization can provide training to its staff members?
5. Discuss some of the important areas of knowledge on social administration of training.

11.9 FURTHER READINGS


UNIT 12 PERSONALITY DEVELOPMENT OF DISABLED PERSONS AND INTERVENTIONS

Structure
12.0 Introduction
12.1 Objectives
12.2 Factors Influencing Personality Development of Disabled Individuals
   12.2.1 Lifespan Development of People with Disabilities
12.3 Assessment of Personality of Disabled Individuals
   12.3.1 Screening and Early Identification of People with Developmental Disabilities
12.4 Screening and Diagnosis of Autism Spectrum Disorder
12.5 Screening for Deafblind and Hearing Impairments
12.6 Screening for Developmental Delays and Multiple Disabilities
12.7 Screening for Orthopedic Impairment
12.8 Screening for Learning Disabilities
12.9 Screening for Traumatic Brain Injury
12.10 Screening for Vision Impairment
12.11 Screening for Intellectual Disability
12.12 Social Psychological Perspective in rehabilitation
12.13 Answers to Check Your Progress Questions
12.14 Summary
12.15 Key Words
12.16 Self Assessment Questions and Exercises
12.17 Further Readings

12.0 INTRODUCTION

You have already learnt in the previous units, especially in Unit 4, about the concept of lifespan development of persons with disabilities, specifically personality disorders. While understanding personality development as a complex process for people without disabilities, it gets even more difficult when some form of disability is involved. In this unit, you will recapitulate some of the basic concepts related to factors influencing personality development in disabled individuals. An assessment
Personality development of disabled persons and interventions

12.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the factors influencing personality development of disabled individuals
- Explain the life span development of people with disabilities
- Describe assessment, screening and early identification of people with development disabilities
- Explain social, psychological perspective in rehabilitation psychology

12.2 FACTORS INFLUENCING PERSONALITY DEVELOPMENT OF DISABLED INDIVIDUALS

The term ‘personality’ refers to enduring qualities of an individual that are shown in his ways of behaving in a wide variety of circumstances. It is a deeply ingrained pattern of behavior that includes modes of perception, relating to and thinking about oneself and the surrounding environment. This pattern of behavior seems to be different in each individual as different individuals have their own way of perceiving, thinking and behaving in different situations and circumstances.

As you have learnt before, personality traits are defined as normal, prominent aspects of personality. However, personality disorders result when these personality traits become abnormal, i.e., become inflexible and maladaptive and cause significant social or occupational impairment or significant distress.

Personality development is a complex process influenced by various factors such as

1. Biological Factors
2. Cultural Determinants of Personality
3. Family Influences on Personality Development.

These are the top three factors influencing personality development.

1. **Biological Factors**: Genetic, hereditary factors, physical appearance and physique and rate of maturation come under biological factors. Genetic endowment strongly influences personality development characteristics such as—aggressiveness, nervousness, timidity and sociability. A person’s personality characteristics and his/her personality development are influenced in an indirect way by heredity.
The physical appearance and physique-deficiency can be compensated by other achievements made in the individual’s life. The relationship shared by physical make-up and psychological characteristics is not very rigid and categorical. The relationship can be influenced by a vast number of complexes, interacting factors determining the individual’s personality structure.

2. **Cultural Determinants of Personality**: Social environment is the most significant aspect of the individual’s world. We all live in a society where we interact with a group of people and every society has a distinctive culture, a body of stored knowledge, characteristic way of thinking, feeling attitudes, goals, ideals and value system.

   The basic need leading to success in life, differ with respect to achievement motivation. In general, middle-class parents stress, achievement strongly, but lower-class parents do not. The sociological analysis suggests that the lower-class children develop little capacity to ‘delay gratification’, because, for them, the future is uncertain.

3. **Family Influences on Personality Development**: The development of social behavior in children is the ultimate aim of personality development. The process, by which the individual acquires the behavioural potentialities and, eventually, those behavior patterns that are customary and acceptable according to the standards of his family and the social group, is known as socialization.

   The first learning of the child occurs through social learning at home, and his earliest experiences with his family, particularly his mother, are critical in determining his attitude toward and his expectations of other individuals.

4. **Early Experience**: The personality of a person is influenced by one’s experience. In the early stages of life, the person faces some bitter experience and positive experiences that affect a person. The coordination of numerous relationships is improved by maturation.

12.2.1 **Lifespan Development of People with Disabilities**

As you have learnt earlier in Unit 4, the term lifespan development refers to age-related changes that occur from birth, throughout a person’s life, into and during old age. The study of how humans grow and change throughout their entire life is called life span development. Developmentalists have broken life span into the following nine stages:

1. **Prenatal Development**: Prenatal development takes place from the time of conception. Formation of the body begins and during this time proper nutrition and an environment free from teratogens such as lead, radiation etc.) needs to be provided to the child in order to avoid any difficulties or concerns during the time of birth. During prenatal developmental both the mother’s mental and physical health and adequate fetal development is of key concern to ensure smooth labor and delivery.
2. **Infancy and Toddlerhood:** The body goes through many changes during the first two years of life. The infant starts walking and talking within a short span of time. The caregivers see changes in their behaviours from erratic feeding and sleep schedules to be able to gain some control and move around as a mobile and energetic child.

3. **Early Childhood:** At the age of three to five years a child starts going to preschool followed by a formal school. He/she starts learning language, gaining a sense of self and greater independence. The child also gains a better understanding about the workings of the physical world.

4. **Middle Childhood:** At the age of six to eleven years children start learning about social relationships through interaction with friends and fellow students which are beyond their family environment. The children learn about their abilities, acquire academic skills and also how to compete with others. They tend to compare themselves with others and end up having a strong need for recognition. The rate of growth slows down and their motor skills get refined at this stage of life.

5. **Adolescence:** It is considered as a period of dramatic change marked by various physical, mental and socio-emotional changes that place during puberty. Puberty is marked by an overall physical growth spurt and sexual maturation. The adolescent also experiences cognitive changes as they start thinking about new possibilities and their understanding of abstract concept like love, fear and freedom improve. Children at this stage are quite impulsive, are high on risk taking behaviors, carry a sense of invisibility and are at a high risk of having sexually transmitted infections. They are high on sexual experimentation and promiscuous behavior.

6. **Early Adulthood:** The early twenties to thirties are considered as the early adulthood years. Love and work are the most important things at this stage of life. At this stage of life, one often tries to put in lot of effort to make a better future and to earn a good status in society for self. However, at this stage of life, there is always a high risk of people getting involved in violent crimes and substance abuse.

7. **Middle Adulthood:** The late thirties to the mid-sixties is considered as middle adulthood years. At this stage people become more productive and are at their peak in their love and work-related aspects of life. At this stage of life, people try to gain expertise in their fields and respective careers. They are also able to better understand a problem and find solutions for the same. An increase in their ability to think more rationally, logically and realistically is seen and they seem capable of making more informed decisions in life.

8. **Late Adulthood:** Late adulthood is sometimes subdivided into two or three categories such as the ‘young old’ and ‘old old’ or the ‘young old’, ‘old old’, and ‘oldest old’. Young old are the people between 65 and 79 and the ‘old old’ or those who are 80 and older. The main difference between these groups
is that 'young old' are similar to midlife adults who are working and are healthy, productive and active. But the 'old old' refers to people who remain active and productive and are largely living independently but due to old age always run the risk of developing various health problems like arteriosclerosis, cancer, cerebral vascular disease, dementia etc. to name a few.

9. Death and Dying: This stage is an inevitable part of one’s life, where one realizes that each one of us is a mortal being. Although the thought of death or dying leaves most uncomfortable and anxious but a deeper and a more meaningful understanding of death and dying can make one feel more confident, in control and it may enhance one’s acceptance to this stage of life. Death refers to the stage of one’s life, when the subtle consciousness leaves are body and according to Hindu Mythology goes to the next life, thus continuing the cycle of birth and death.

Lifespan development is a complex process where things can go wrong at any stage of development leading to a disability. The term developmental disability refers to a diverse group of chronic conditions that can occur to mental or physical impairments at any stage of one’s life span. When all areas of a child’s development get affected by developmental disability, it is termed as Global developmental Delay.

Various kinds of disabilities or impairments that can happen during one’s life span are largely categorized under the Right of Persons with Disabilities Act 2016 (RPWD Act 2016), as the following:

1. Blindness
2. Low-vision
3. Leprosy Cured persons
4. Hearing impairment (deaf and hard of hearing)
5. Locomotor Disability
6. Dwarfism
7. Intellectual Disability
8. Mental illness
9. Autism Spectrum Disorder
10. Cerebral Palsy
11. Muscular Dystrophy
12. Chronic Neurological conditions
13. Specific Learning Disability
14. Multiple Sclerosis
15. Speech and Language Disability
16. Thalassemia
17. Hemophilia
There are very many tests available for assessment of personality in individuals and the most popular among them are the psychometric tests and questionnaires. However, these methods are not appropriate and in fact are a barrier for assessing the personalities of disabled individuals. This limitation affects the person's position when applying for jobs or getting admissions. This is why it is important that assessment of personality of disabled individuals is fair and not one used for people without disabilities. While preparing appropriate tests for them several questions regarding the standard set, accommodations allowed, level of disabilities, types of disabilities and the interpretation of the scores, measures need to remove personal bias, balancing of quantitative, ecological and psychological perspectives, and many more. For example, the American Disabilities Act considers 4 core domains suitable to be tested for assessing personalities of people with disabilities: temperament, traits and character which are clustered; and motives/drives and of social competence on the 2 core domains: attachment style and interactional style.

Therefore, the assessment of personality of disabled individuals is a complex area of research where a number of factors need to be considered. In this section, you will learn about the screening of different developmental disabilities.

12.3.1 Screening and Early Identification of People with Developmental Disabilities

The limited ability of infant tests, whether intended for screening or definitive diagnosis of intellectual functioning, to predict future function has led to several controversies concerning their use.

As mentioned on the WHO website, screening is ‘the presumptive identification of unrecognized disease or defect by application of tests, examinations or procedures which can be applied rapidly.’
Screening sorts out apparently well persons who probably have a disease from those who probably do not. A screening test is not intended to be diagnostic. There have been many different definitions given for the process of screening. The following list enlists the components of the screening process, as given by Committee on Children with Disabilities (1994) of the American Academy of Pediatrics:

- Sensitive attention to parental concerns
- Thoughtful inquiry about parental observations
- Observation of a wide variety of the child's behaviors
- Examination of specific developmental attainments
- Use of all encounters for observing and recording developmental status
- Screening of vision and hearing to rule out sensory impairment as a cause of the delay
- Observation of parent-child interaction.

Among the screening process, early identification is the term used to refer to the evaluation and treatment provided to families and their children under 3 years old who have, or are at risk for having, a disability, or delay in speech, language or hearing.

The motivations for early identification programme are to recognize barriers, assist these children and manage as well as mitigate of the effects of disability.

Screening is the initial step for to identify those children who have or who are at risk of having or have developmental disabilities. This opportunity lies with the pediatricians who can incorporate screening examinations and refer the patients for confirmatory testing by an appropriate consultant, if indicated.

There are many developmental conditions which can be screened along with an understanding of their magnitude. Some of these developmental conditions include deafness, emotional behavioural disturbances like autism, mental retardation, cerebral palsy, blindness and language impairment.

### 12.4 SCREENING AND DIAGNOSIS OF AUTISM SPECTRUM DISORDER

The Centre for Disease Control states that there are certain features which characterizes ASD or Autism Spectrum Disorder including persistent, significant impairments in social interaction and communication as well as restrictive, repetitive behaviours and activities. Some of the Social communication and social interaction features include deficits in social-emotional reciprocity (e.g., deficits in joint attention, atypical social approach and response, conversational challenges, reduced sharing of interest, emotions, and affect), deficits in nonverbal communication (e.g., atypical...
eye contact, reduced gesture use, limited use of facial expressions in social interactions, challenges understanding nonverbal communication), and deficits in forming and maintaining relationships (e.g., diminished peer interest, challenges joining in play, difficulties adjusting behavior to social context).

It is important to know here that it is possible that these symptoms which cause impairment across many areas may not be prominent until environmental demands exceed children’s capacity. However, these are still very much present early in life. This disorder is related to the environmental, genetic and medical factors.

Assessment of Autism Spectrum Disorder

There are not any medical tests to diagnose autism spectrum disorder (ASD), therefore its identification might be difficult. Child’s behaviour and development are general precursors to make a diagnosis.

Centre for Disease Control says that ASD can be detected at 18 months or younger. By age 2, a diagnosis by an experienced professional can be considered very reliable. However, many children do not receive a final diagnosis until they are much older. This delay means that children with an ASD might not get the help they need.

Generally, diagnosing an ASD includes the following two steps:

i. Developmental Screening: This test is done to understand whether the children are learning basic skills when they should, or if they might have delays. During this test, the doctor might ask the parent some questions or talk and play with the child during an exam to see how she learns, speaks, behaves, and moves. Any observable delay could be a problematic sign.

It is recommended that such screening is done at child’s regular visits at 9 months, 18 months, 24 or 30 months. Problems like preterm birth, low birth weight or other reasons could warrant additional screening.

In addition, specific screened specifically for ASD at the child’s regular visit at 18 months, or 24 months. There is high risk for children have siblings or family members with ASD or if related behaviors are present.

ii. Comprehensive Diagnostic Evaluation: Centre for Disease Control says that thorough review in this evaluation may include looking at the child’s behavior and development and interviewing the parents. It may also include a hearing and vision screening, genetic testing, neurological testing, and other medical testing.

In some cases, the primary care doctor might choose to refer the child and family to a specialist for further assessment and diagnosis. Specialists who can do this type of evaluation include:

- Developmental Pediatricians (doctors who have special training in child development and children with special needs)
• Child Neurologists (doctors who work on the brain, spine, and nerves)
• Child Psychologists or Psychiatrists (doctors who know about the human mind)

Types of Screening Tools
As per CDS, there are many different developmental screening tools that may be administered by professionals, community service providers, and in some cases, parents. These include:

• Ages and Stages Questionnaires (ASQ)
• Communication and Symbolic Behavior Scales (CSBS)
• Parent’s Evaluation of Development Status (Peds)
• Modified Checklist for Autism in Toddlers (M-CHAT)
• Screening Tool for Autism in Toddlers and Young Children (STAT)
• Observation tools such as the Autism Diagnostic Observation Schedule (ADOS-G)
• The Childhood Autism Rating Scale (CARS)
• The Autism Diagnostic Interview – Revised (ADI-R)

12.5 SCREENING FOR DEAFBLIND AND HEARING IMPAIRMENTS
As per National Centre for Biological Information, ‘deafblindness’ is a condition presenting other difficulties than those caused by deafness and blindness. It is an ‘umbrella’ term, which can include both children and adults who are:

• Blind and profoundly deaf
• Blind and severely or partially hearing impaired
• Partially sighted and profoundly deaf
• Partially sighted and severely or partially hearing impaired

Further the NCBI says that the term, ‘children with deafblindness’, means children and youth having auditory and visual impairments, the combination of which creates such severe communication and other developmental and learning needs that they cannot be appropriately educated without special education and related services, beyond those that would be provided solely for children with hearing impairments, visual impairments, or severe disabilities to address their educational needs due to these concurrent disabilities.’

There is not yet one generally agreed definition of deafblindness, but most of the definitions include the following characteristics in the deafblind:

• Simultaneous presence of defective vision and hearing impairment which may vary in degrees.
NOTES

- Does not imply total loss of either vision or hearing.
- Communication is most severely affected.
- Highly individualized training is needed to cope with the condition.
- The world is much narrower as the distant senses are affected, and it is usually within the arm’s reach.
- Affects person in totality.
- Associated medical conditions with hearing and visual loss may be present.

Diagnostic Services

The ophthalmologist and the audiologist may detect visual and hearing problem at birth with the help of modern equipment and can refer the child for evaluation for additional disability, if they expect so. It is not uncommon to see identification by different schools for deaf, blind or mentally retarded children as in most of the cases there is misdiagnosis leading to the transfer of these children to special schools.

According to Rehabilitation Council of India, to detect deafblindness effectively, the screening must be done on specific populations such as children with one sensory disability in schools for the blind or in schools for the deaf and also in schools for the children with Learning Disability and Multiple Disabilities. In India, institutes like Blind People’s Association, Ahmedabad; L. V. Prasad Eye Institute at Hyderabad; Helen Keller Institute for the Deaf & Deafblind, Mumbai; Clarke School for the Deaf and Mentally Retarded, Chennai; National Association for the Blind, Delhi; Spastic Society of Tamil Nadu, Chennai; National Institute for the Mentally Handicapped (NIMH), Secunderabad; Ali Yavar Jung National Institute for Hearing Handicapped (AYJNIHH), Mumbai; National Institute for the Empowerment of Persons with Multiple Disabilities (NIEPMD), Chennai; Holy Cross Service Society, Trichy are some of the places equipped to do this kind of diagnosis. There are many other institutions and organizations in our country where early detection of this condition may take place.

Screening for Hearing Impairment

As per the World Health Organization, a person who is not able to hear as well as someone with normal hearing – hearing thresholds of 25 dB or better in both ears – is said to have hearing loss. Hearing loss may be mild, moderate, severe, or profound. It can affect one ear or both ears and leads to difficulty in hearing conversational speech or loud sounds.

People with hearing loss ranging from mild to severe are referred as ‘Hard of hearing’. They usually communicate through spoken language and can benefit from hearing aids, cochlear implants, and other assistive devices as well as captioning. People with more significant hearing losses may benefit from cochlear implants.

‘Deaf’ people mostly have profound hearing loss, which implies very little or no hearing. They often use sign language for communication.
Screening tools used are

Screening tools and their use vary in different countries. As per the Canadian Paediatric Society’s Caring for Kids, screening of newborns is recommended to help ensure early detection and management, whether treatment is medical, surgical or involves devices such as hearing aids, cochlear implants, bone-anchored hearing aids or other assistive devices. The screening programs aim to screen newborns by 1 month of age, confirm diagnosis by 3 months, and implement intervention, if required, by 6 months.

Children should have their hearing tested before they enter school or any time there is concern about a child’s hearing or language development.

The Canadian Paediatric Society’s Caring for Kids recommends the following tests for screening newborns and children:

- Otoacoustic emission (OAE): Used to check the response of the inner ear to sound.
- Automated auditory brainstem response (AABR): Used to check the brain’s response to sound.

12.6 SCREENING FOR DEVELOPMENTAL DELAYS AND MULTIPLE DISABILITIES

As per the National Centre for Biological Information, the qualitative and quantitative changes that occur in a child are known as development. Some examples of developmental milestones include social smiling, crawling, the first walking steps, grasping, and the first spoken word. Commonly studied developmental milestones include gross motor, fine motor, language, and social skills. These milestones act like scales based on which developmental delays are identified.

Early identification of such developmental milestones is first noticed by parents, followed by clinicians who recognize motor developmental delays in their clinical practices. Early identification is useful for timely referral for diagnosis, interventions, and treatment. Some of the common factors of developmental delays include early gestational age, twin status, nutrient intake, and low socioeconomic status.

Areas of a developmental delay

There are different areas of developmental delays, and children may experience one or more of these. These can be identified as:

- Cognitive Skills
- Self-help
- Fine motor development
- Communication
- Behaviour
Screening tests can identify children with developmental delay with reasonable accuracy, and, as noted, such children may benefit from early intervention.

Some authors and researchers in the area suggest that developmental screening instruments are of two types: those that require the direct elicitation of developmental skills from children in conjunction with parental report, and those that rely solely on parental report.

As per Sutton Hamilton (MD), who wrote the paper ‘Screening for developmental delay: Reliable, easy-to-use tools’ in the Journal of Family Practice, the following 2 screening instruments rely on parental input:

- **PEDS**: Parents’ Evaluation of Developmental Status consists of 2 open-ended questions and 8 yes/no questions. It takes approximately 5 minutes to administer if an interview is needed. It can even be completed by a parent. It uses fifth-grade reading level.

- **The Ages and Stages Questionnaires**: The Age and Stages Questionnaire (ASQ) system (formerly known as the Infant Monitoring Questionnaires) was developed by Bricker, Squires, and colleagues at the University of Oregon. It is a low-cost and easily administered screening instrument relying on parental report. Items are written at a fourth- to sixth-grade reading level; illustrations and examples are often provided. This self-administered assessment can be completed in 10 to 20 minutes and scored in 1 to 5 minutes.

Another popular screening tool among primary care providers include Guide for Monitoring Child Development (GMCD). GMCD is a practical, open-ended interview that catalyzes communication between clinicians and caregivers.

**Multiple Disabilities**

As per Rehabilitation Council of India, Multiple Disabilities means concomitant [simultaneous] impairments (such as intellectual disability-blindness, intellectual disability-orthopedic impairment, etc.), the combination of which causes such severe educational needs that they cannot be accommodated in a special education program solely for one of the impairments. The term does not include deaf-blindness.

**Characteristics of Students with Multiple Disabilities**

Combination, severity and age may reflect different characteristics. The common characteristics as compiled by American Academy of Special Education Professionals (AASEP) include:

- Limited speech or communication
- Difficulty in basic physical mobility
• Tendency to forget skills through disuse
• Trouble generalizing skills from one situation to another
• A need for support in major life activities (e.g., domestic, leisure, community use, vocational)

The AASEP further recommends the following procedures and measures of assessment to diagnose Multiple Disabilities. A student, meeting two or more standards of disabilities are considered positive for multiple disabilities. Their evaluation may include:

• An observation by a team member other than the student’s general education teacher of the student’s academic performance in a general classroom setting; or in the case of a student less than school age or out of school, an observation by a team member conducted in an age-appropriate environment
• A developmental history, if needed
• An assessment of intellectual ability
• Other assessments of the characteristics of speech and language impairments if the student exhibits impairments in any one or more of the following areas: cognition, fine motor, perceptual motor, communication, social or emotional, and perception or memory. These assessments shall be completed by specialists knowledgeable in the specific characteristics being assessed:
• A review of cumulative records, previous individualized education programs or individualized family service plans and teacher collected work samples
• If deemed necessary, a medical statement or health assessment statement indicating whether there are any physical factors that may be affecting the student’s educational performance;
• Assessments to determine the impact of the suspected disability:
  i. On the student’s educational performance when the student is at the age of eligibility for kindergarten through age 21
  ii. On the student’s developmental progress when the student is age three through the age of eligibility for kindergarten

Check Your Progress

4. Mention some of the developmental conditions which can be identified with the process of screening.
5. When can ASD be detected as per the CDC?
6. List what is included in ‘deafblindness’ as an umbrella term.
7. Who is said to have hearing loss as per WHO?
8. Mention the common areas of developmental delays.
12.7 SCREENING FOR ORTHOPEDIC IMPAIRMENT

As per Rehabilitation Council of India, Orthopedic Impairment 'means a severe orthopedic impairment that adversely affects a student's educational performance. The term includes impairments due to the effects of congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments due to the effects of disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures').

Characteristics of Students with Orthopedic Impairments

According to AASEP, orthopedic impairments are often divided into three main areas:

- Neuromotor impairments—An abnormality of, or damage to, the brain, spinal cord, or nerves that send impulses to the muscles of the body (Gargiulio).
- Degenerative diseases—These are diseases that affect motor movement (Gargiulio).
- Musculoskeletal disorders—Defects or diseases of the muscles or bones (Hallahan & Kauffman)

The AASEP further recommends the following evaluation:

- A medical statement or a health assessment statement indicating a diagnosis of orthopedic or neuromotor impairment or a description of the motor impairment;
- A standardized motor assessment, including the areas of fine motor, gross motor and self-help, when appropriate, by a specialist knowledgeable about orthopedic or neuromotor development;
- Assessments to determine the impact of the suspected disability:
  i. On the student’s educational performance when the student is at the age of eligibility for kindergarten through age 21, or
  ii. On the student’s developmental progress when the student is age three through the age of eligibility for kindergarten; and
- Additional evaluations or assessments that are necessary to identify the student’s educational needs.

12.8 SCREENING FOR LEARNING DISABILITIES

As per Rehabilitation Council of India, Learning Disorders (LD) are diagnosed when the individual’s achievement on individually administered, standardized tests in reading, mathematics or written expression is substantially below that expected for age, schooling and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living. As you have learnt earlier in Unit 6, learning disorders (LD) refer to a significant deficit in learning due
to a person’s inability to interpret what is seen and heard, or to link information from different parts of the brain (GEON, 2005). It can be classified into three major types: disorder of written expression (DWE); reading disorder (RD); and mathematics disorder (MD).

Various terms are used to describe specific learning disabilities. A person may exhibit one or more of them. Some of them are as follows:

- **Dysphasia/Aphasia - Speech and language disorders**
  i. Difficulty producing speech sounds (articulation disorder)
  ii. Difficulty putting ideas into spoken form (expressive disorder)
  iii. Difficulty perceiving or understanding what other people say (receptive disorder).

- **Dyslexia**: The general term for reading disability which involves difficulty in phonetic mapping, where sufferers have difficulty with matching various orthographic representations to specific sounds. Some claim that dyslexia involves a difficulty with sequential ordering such that a person can see a combination of letters but not perceive them in the correct order.

- **Dysgraphia**: The general term for a disability in physical writing, usually linked to problems with visual-motor integration or fine motor skills. (F81.2-3/315.1)

- **Dyscalculia**: The general term for disability in mathematics. (American Psychiatric Association, 1994).

**Screening and Assessment**

Before a specialized evaluation of a student is conducted, pre-referral discussions by teachers regarding the nature of the problem, and what possible modifications to instructions in the classroom might be made are important. The child must be assessed in all areas related to the suspected disability such as health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. (National Information Centre for Children and Youth with Disabilities, 2000).

An ideal assessment for LD is a long process requiring several sessions with a qualified educational psychologist. Apart from administering a battery of tests, the psychologist also gathers relevant information about the child from the teachers and school records.

The Rehabilitation Council of India has observed the following generally recognized assessment procedures for LD also mentioned in the AASEP:

- **Parental Consent and Parent Interview**
  i. Parents’ consent must be obtained before evaluating the child. The academic, developmental and medical history along with the linguistic usage and communications patterns of the child must be obtained from the parents.
ii. The parent must be involved in the planning of the intervention program such as attending a resource room, provision of accommodation and modifications to the child.

- **Gathering Information from the Teachers/School**
- **Looking at Student Workbooks**
  
  Unfortunately, in the present educational set up, very often the notebooks don’t reflect the learning difficulties faced by the child due to rote learning especially when the child can easily copy from the blackboard. The examination papers may give a clearer picture of the specific nature of difficulty. Only through collecting data through a variety of approaches (observations, interviews, tests, curriculum-based assessment, etc.) and from various sources such as parents, teachers, peers, adequate picture be obtained of the child’s strengths and weaknesses.
  
  A number of approaches being used recently include curriculum-based assessment, task analysis, dynamic assessment, and assessment of learning style.

- **Interview with the Child**
  
  ‘An Interview should be a conversation with a purpose’ (Wallace, Larsen, & Elksnin, 1992, p. 16), with questions designed to collect information that ‘relates to the observed or suspected disability of the child’. (National Information Centre for Children and Youth with Disabilities, 2000).
  
  A careful review of the student’s school records or work samples help the assessment team identify patterns or areas of specific concern which may be focused on at the time of interview. The student too, may have much to say to illuminate the problem (Hoy & Gregg, 1994, p. 44). (National Information Centre for Children and Youth with Disabilities, 2000).

### Psychological Assessments

The recommended Psycho-educational tests are discussed below under various heads:


- **Achievement**: Recommended tests include: Woodcock Johnson Psycho-166 Educational Battery-Revised, Nelson Denny Reading Test, SATA.

These tests would have to be modified and norms created for children who come from culturally and linguistically diverse backgrounds. SLD being a language-based disorder, it is imperative that tests for both receptive and expressive language be included in the assessment procedures.

The following are the other assessment procedures as discussed by the AASEP and mentioned by the Rehabilitation Council of India:

- **Curriculum Based Assessment**
  Direct assessment of academic skills (Curriculum Based Assessment) is one alternative that has recently gained popularity. ‘Tests’ of performance in this case come directly from the curriculum. For example, a child may be asked to read from his or her reading book for one minute. Information on the accuracy and the speed of reading can then be compared with other students in the class.

  The merits of a CBA however are lost in a system with a rigid curriculum based mainly on memorization as is true in India where CBA may not be the right option.

- **Dynamic Assessment**
  Dynamic assessment includes a dialogue or interaction between the examiner and the student. This interaction may include modeling the task for the student, giving the student prompts or cues as he/she tries to solve a given problem, asking what a student is thinking while working on the problem and giving praise or encouragement (Hoy & Gregg, 1994).

  Of course, dynamic assessment is not without its limitations or critics. One particular concern is the amount of training needed by the examiner to conduct both the assessment and interpret results. Another is a lack of operational procedures or ‘instruments’ for assessing a student’s performance or ability in the different content areas (Jitendra & Kameenui, 1993).

**Learning Styles**

All children have different learning styles. A learning style assessment, attempts to determine the elements that has an impact on a child’s learning.

Some of the common elements that may be included here would be the way in which the material is presented (i.e., visually, auditorily, tactiley) in the classroom, the environmental conditions of the classroom (hot, cold, noisy, light, dark) the child’s personality characteristics, the expectations for success that are held by the child and others, the response the child receives (for example, praise or criticism) and the type of thinking the child generally utilizes in solving problems (for example, trial and error, analyzing). Identifying the factors that positively impact the child’s learning are very valuable in developing effective intervention strategies.
Outcome-based Assessment

Outcome-based assessment involves considering, teaching and evaluating the skills that are important in real-life situations. For example it may start by identifying what outcomes are desired for the student (for example, being able to use public transportation). The team then determines what competencies are necessary for the outcomes (for example, the steps or sub skills the student needs to have mastered to achieve the outcome desired) and identifies which sub skills the student has mastered and which he/she needs to learn.

This type of assessment though generally used for the mentally challenged or autistic, may also be used for children in the general classroom with severe behavioural difficulties.

Assessment of the Culturally and Linguistically–Diverse

Because culture and language affect learning and behavior (Franklin, 1992) the school system may misinterpret what students know, how they behave, or how they learn. Students may appear less competent than they are, leading educators to inappropriately refer them for assessment. Once referred, inappropriate methods may then be used to assess the students, finally leading to inappropriate conclusions and placement into special education.

Assessments in India

As noted by the Rehabilitation Council of India, the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore has developed the index to assess children with LD (Hirisave U, et al., 2002).

There are two levels of this index. They are: Level I for children 5-7 years and Level II for 8-12 years. The index comprises of the following tests:

a. Attention test (Number cancellation).

b. Visuo-motor skills (the Bender Gestalt test and the Developmental test of Visuo – Motor integration).


d. Reading, writing, spelling and comprehension.

e. Speech and Language including Auditory behaviour (Receptive Language) and Verbal expression.


At the Lokamanya Tilak M.G Hospital, Sion, Mumbai, the procedure for assessment of Specific Learning Disability involves the following:

a. Neurological assessment.

b. Vision and Hearing tests.

c. Analysis of school progress report.
Most private institutions in India follow some, if not all of these procedures.

**Assessment facilities within School Setting**

The Rehabilitation Council of India further notes that in our country where numbers often determine procedures, it would be beneficial to provide basic facilities for assessments within the educational setting. The reasons are overwhelming:

- Children experiencing delays or learning problems may be screened at the first level, provided with timely help and only those requiring further assessment would need to undergo further testing.
- Ideal assessment procedures being very elaborate, cannot be completed in a single session.
- Attending clinics and hospitals would be difficult for the parents from a lower socioeconomic background.
- Information can be easily gathered from within the school. Observation of the child in the educational setting would be preferable to those made in a clinic.
- The assessment team could include a psychologist, special teacher/educator, class teacher which, with input from the parent and child, would facilitate a comprehensive assessment of the child.
- Assessment procedures would include instructional planning, placement and development of an Individualized Education Program (IEP) appropriate to the child’s special needs with a follow up evaluation of student progress.
- Eligibility for special education services/ classroom and accommodations/ modifications is best determined by a knowledgeable school team.

Given the lengthy assessment procedures, it is vital that proper pre-referral procedures are formulated for implementation. Teacher-training would avoid over-referral.

### Check Your Progress

9. What does the term Orthopedic Impairment include?
10. When are learning disorders diagnosed?
11. Define dysgraphia.
12.9 SCREENING FOR TRAUMATIC BRAIN INJURY

Traumatic Brain Injury (TBI) has been defined by the Centers for Disease Control and Prevention (CDC) as ‘a bump, blow or jolt to the head that disrupts the normal function of the brain’ that can result from external force to the head, including whiplash, blast exposure, or penetrating injury. There are 2 critical elements of this definition: (1) a blow to the head, resulting in (2) altered mental status, that is, loss of consciousness or a feeling of being dazed and confused. The consequences of TBI can range from mild symptoms (eg, headache, confusion) that quickly resolve to significant lifelong impairments in cognitive functioning, behavior and mood, and physical functioning (eg, fatigue, balance problems).

Screening Tools

The American Speech Language Hearing Association notes that screen for TBI is conducted by the speech-language pathologist, audiologist, or other professionals on the interdisciplinary care team. It is a precursor to more comprehensive evaluations. It mentions the use of following tools in this area:

- Sociodemographic and clinical data sheet: A semi-structured pro forma was prepared for the study covering relevant areas.
- Handedness scale: Based on this scale, dominant hemisphere is ascertained.
- Brief Psychiatric Rating Scale (BPRS): It is an 18-item scale measuring positive symptoms, general psychopathology, and affective symptoms.
- Head Injury Behaviour Scale (HIBS): It is a 4-point rating scale which assesses the behavioral excess and behavioral deficits after brain injury.
- Glasgow Coma Scale (GCS): This test is used to assess the severity of TBI. It assesses the performance of the patient in three areas, i.e., eye opening, best motor response, and verbal response.

Screening for Speech, Language, Cognitive-Communication, and Swallowing Screening

Screening is conducted in the language(s) used by the person, with sensitivity to cultural and linguistic variables.

Audio-logic Screening

Hearing screening and otoscopic inspection for impacted cerumen occur prior to screening for other deficits.
Assessment

Although Speech Language Pathologists and audiologists do not diagnose TBI, they need a clear understanding of the individual’s medical assessment, physical condition, course of recovery, and the nature/effects of the neurological damage, to guide development of an appropriate assessment plan (Hegde, 2006).

Comprehensive SLP Assessment

Individuals suspected of having communication-cognitive or swallowing deficits are referred for a more comprehensive assessment to the SLP.

As per the AASEP, Assessment of individuals with TBI is conducted to identify and describe: underlying strengths and weaknesses related to linguistic and cognitive processing, presence of dysphagia, identification of contextual barriers to communication and impact of speech, language, cognitive-communication, and swallowing impairments on quality of life and functional/participation.

Assessment Methods/Procedures

Assessment methods may include standardized and nonstandardized procedures. The decision to use standardized or nonstandardized assessment procedures is based upon a variety of factors, including the needs of the person with TBI, the complexity of impairment, payer rules, and facility policy.

• Standardized Assessment
  Standardized testing with a battery of assessments helps identify areas of weakness to be addressed in treatment and/or areas of strength that can be used to compensate for ongoing weaknesses. When appropriate, an entire standardized test battery is administered.

• Assessment Tools as suggested by AASEP include:
  i. Luria–Nebraska Neuropsychological Battery for Adults-Form I (LNNB-A)
  ii. Cognitive Symptoms Checklist (CSC): CSC is a tool to assist in the identification and treatment of problems in five basic cognitive areas: attention and concentration, memory, visual processes, language, and executive functions.
  iii. CIQ is a brief test to assess the degree to which an individual after TBI can perform appropriate roles within the home and community.

• Nonstandardized Assessment
  Nonstandardized procedures are used to systematically probe aspects of speech, language, and cognition. Functional nonstandardized assessment is particularly valuable in individuals with TBI, who often perform disproportionately better or worse in activities of daily living compared with abilities predicted by standardized test scores.
General Assessment Considerations

A comprehensive assessment addresses the components within the WHO International Classification of Functioning, Disability and Health (ICF) framework (ASHA, 2007; WHO, 2001), including body structures/functions, activities/participation, and personal/environmental factors, and is sensitive to cultural and linguistic diversity. Assessment considerations specific to TBI include the following.

- Interdisciplinary collaboration is necessary to ensure that the individual with TBI is not over-tested or exposed to practice effects consequent to repeated exposure to stimuli and to maximize the breadth and depth of skills assessed.
- Depression (which can be a consequence of neurological damage or a part of the post-traumatic stress disorder complex) can adversely affect test performance. If signs and symptoms of depression are present or suspected, the individual is referred to a neuropsychologist, clinical psychologist, or psychiatrist for further follow-up.
- The side effects of prescription drugs may impact the individual’s presentation and test performance (e.g., excessive drowsiness). Polypharmacy, or the concurrent use of several medications, is common among individuals who have multiple medical conditions, and some medications may exacerbate cognitive problems.

12.10 SCREENING FOR VISION IMPAIRMENT

World Health Organization, the International Classification of Diseases 11 (2018) classifies vision impairment into two groups, distance and near presenting vision impairment.

Distance vision impairment:
- Mild – presenting visual acuity worse than 6/12
- Moderate – presenting visual acuity worse than 6/18
- Severe – presenting visual acuity worse than 6/60
- Blindness – presenting visual acuity worse than 3/60

Near vision impairment:
- Presenting near visual acuity worse than N6 or M.08 with existing correction.

Assessments of Visually Impaired

Many different assessments are available for early identification of visual impairments. For instance, the American Association for the Blind’s run FamilyConnect website notes several measures of assessment. It is important for children with low vision, to undergo a functional vision assessment. This type of test tests the child’s use of the present vision in daily life and so is not applicable.
Test for visual impairment

- **Snellen test:** The Snellen test is also known as the visual acuity test. It uses a chart with successively shortening of random letters and numbers. The patients are asked to read the same with one eye at a time from a distance of 6 meters and then with both eyes. The test score contains two numbers. The first number represent how far away from the chart the patient was when he or she was able to successfully read the letters on the chart. The second number represents how far away a person with healthy vision should be able to read the chart.
  
  i. Healthy vision scores 6/6. If the score is 6/60, it means that the patient can only read something 6 metres away what a person with healthy eyesight can read 60 metres away.
  
  ii. Partial sight or sight impairment is defined as 3/60 to 6/60 vision or having a combination of moderate visual acuity (up to 6/24) and a reduced field of vision.
  
  iii. Blindness is defined as having poor visual acuity (less than 3/60) but having a full field of vision or having poor visual acuity (between 3/60 and 6/60) and a severe reduction in the vision field or having average visual acuity (6/60 or above) and an severely reduced field of vision.

- **Visual field test:** Visual field is the range of vision that a person can see without tilting or turning one’s head. This measures the peripheral vision of the eyes.

- **Tonometry test:** This test uses specialized instruments to determine fluid pressure inside the eye to evaluate for glaucoma.

- **Ocular Motility Assessment:** This tests if there is squint of other problems in the movement of the eyeballs.
Sometimes other tests like Visually evoked potential (VEP), Electroretinogram (ERG), Electro-oculogram (EOG) are sometimes prescribed to test if the signals from the eye are travelling adequately to the brain.

### 12.11 SCREENING FOR INTELLECTUAL DISABILITY

The following are some of the screening test used for intellectual disability:

- **Brigance Screens:** This is an easy to administer screening tool used to identify developmental delays and academic giftedness in children from age 0 to 7. The time taken to conduct this test is usually around 10-15 minutes. This test is known to be beneficial in developmental screening of different areas including maths, language development, literacy, physical health, etc. The results could be matched with standards to understand the performance. The cut-off scores resulting from this test puts children into three categories:
  i. Children with developmental delays and difficulties, they score below the cut-off, Usually, the child will receive the same result multiple times even with different examiners.
  ii. Children who are gifted or academically talented
  iii. Children who are performing adequately to their age.

- **Denver Developmental Screening Test – II:** This can be used as a first step screening for children between ages 0 to 6 to identify any developmental delay or risk thereof. Time taken for this screening is close to 30 minutes. The children get up to 3 trials before moving on. The test includes items that have sub-sample categories including race, less educated and place of residence. Based on core areas of functioning (fine motor adaptive, gross motor, personal-social, and language skills), it consists of 125 performance based and parent reported items. The scoring is composed of rating and percentile ranks. The rating consists of P: pass, F: fail, NO: no opportunity, R: refusal. The percentile ranks include: 25th, 50th, 75th, 90th. Falling short of the expected range by the number designates the normal, suspected and delayed interpretation. Rescreening might be recommended in 1-2 weeks if the child is suspected. The sensitivity is reported between 56-83% and the specificity is reports between 43-80%.

- **Battelle Developmental Inventory Screening Test:** For checking the motor, social cognitive and communication adaptive measures in children, this test is used. This test is recommended for children below the age of 8 and usually is completed within 60-90 minutes. The test then gives scores in three categories 0 denoting non-attempt, 1 point if the task is partially completed and 2 points are awarded if the task is fully completed. The test-retest and inter-rater reliability is 0.90-0.99 for both.
12.12 SOCIAL PSYCHOLOGICAL PERSPECTIVE IN REHABILITATION

The social model of disability has emerged from research conducted largely by people who have disabilities (Swain, Finkelstein, French and Oliver, 1993). This model assumes that a person with a disability may function differently from some other people, and his problems do not entirely result from the nature of disability rather from the unfounded stereotypes and prejudices toward those with disabilities (Funk, 1987). Such attitudes can reinforce incompetence and poor health that may limit social, vocational and recreational participation. As the person who has a disability recognizes and acknowledges the numerous barriers erected by society, feelings of hopelessness, passivity, or depression may merge and these may be interpreted by outsiders as a lack of adjustment and motivation.

A social model of disability sees the problem as rooted within society. Rather than attempting to fix or change the person with the disability, the focus should be on the removal or reforming of environmental and social barriers to full physical, social, career, and religious participation (French, 1993).

The idea of total societal accommodation to the presence of disability is not a new one. According to Nora Groce, residents of Martha’s Vineyard from the 17th to the early 20th century used social and linguistic adaptations. The island population contained a huge number of people with a hereditary form of profound deafness. Most of the people who can hear living in the island became bilingual in sign and in verbal language to be able to communicate effectively. Because people with and without hearing impairments were able to communicate, neither group the hearing ones nor deaf were regarded as being handicapped (Scheer and Groce, 1998).

In the field of disability research, most writers today recognize that the problems and barriers are not in the individual who has a disability but in the environment or society that erects barriers to participation. The social model of disability requires that society address barriers to inclusion rather than spending money on segregation of population (Finkelstein, 1991).

Check Your Progress

12. What are the consequences of Traumatic Brain Injury?
13. What is another name for Snellen test?
14. How does the social model of disability sees the problem?
1. The process, by which the individual acquires the behavioural potentialities and, eventually, those behavior patterns that are customary and acceptable according to the standards of his family and the social group, is known as socialization.

2. Middle Childhood: At the age of six to eleven years children start learning about social relationships through interaction with friends and fellow students which are beyond their family environment. The children learn about their abilities, acquire academic skills and also how to compete with others. They tend to compare themselves with others and end up having a strong need for recognition. The rate of growth slows down and their motor skills get refined at this stage of life.

3. When all areas of a child’s development get affected by developmental disability, it is termed as Global developmental Delay.

4. There are many developmental conditions which can be screened along with an understanding of their magnitude. Some of these developmental conditions include deafness, emotional behavioural disturbances like autism, mental retardation, cerebral palsy, blindness and language impairment.

5. Centre for Disease Control says that ASD can be detected at 18 months or younger. By age 2, a diagnosis by an experienced professional can be considered very reliable. However, many children do not receive a final diagnosis until they are much older. This delay means that children with an ASD might not get the help they need.

6. It is an ‘umbrella’ term, which can include both children and adults who are:
   - Blind and profoundly deaf
   - Blind and severely or partially hearing impaired
   - Partially sighted and profoundly deaf
   - Partially sighted and severely or partially hearing impaired

7. As per the World Health Organization, a person who is not able to hear as well as someone with normal hearing – hearing thresholds of 25 dB or better in both ears – is said to have hearing loss.

8. There are different areas of developmental delays, and children may experience one or more of these. These can be identified as:
   - Cognitive Skills
   - Selfhelp
   - Fine motor development
• Communication
• Behaviour
• Social and emotional development
• Gross motor development

9. The term includes orthopaedic impairments due to the effects of congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments due to the effects of disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

10. Learning Disorders (LD) are diagnosed when the individual’s achievement on individually administered, standardized tests in reading, mathematics or written expression is substantially below that expected for age, schooling and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living.

11. Dysgraphia is the general term for a disability in physical writing, usually linked to problems with visual-motor integration or fine motor skills.

12. The consequences of TBI can range from mild symptoms (e.g., headache, confusion) that quickly resolve to significant lifelong impairments in cognitive functioning, behavior and mood, and physical functioning (e.g., fatigue, balance problems).

13. The Snellen test is also known as the visual acuity test.

14. A social model of disability sees the problem as rooted within society. Rather than attempting to fix or change the person with the disability, the focus should be on the removal or reforming of environmental and social barriers to full physical, social, career, and religious participation (French, 1993).

12.14 SUMMARY

• Personality traits are defined as normal, prominent aspects of personality. However, personality disorders result when these personality traits become abnormal, i.e., become inflexible and maladaptive and cause significant social or occupational impairment or significant distress.

• Personality development is a complex process influenced by various factors such as Biological Factors, Cultural Determinants of Personality and Family Influences on Personality Development.

• The term lifespan development refers to age-related changes that occur from birth, throughout a person’s life, into and during old age. The study of how humans grow and change throughout their entire life is called life span development. Developmentalists have broken life span into the following nine stages.
Lifespan development is a complex process where things can go wrong at any stage of development leading to a disability. The term developmental disability refers to a diverse group of chronic conditions that can occur to mental or physical impairments at any stage of one's life span. When all areas of a child's development get affected by developmental disability, it is termed as Global developmental Delay.

There are very many tests available for assessment of personality in individuals and the most popular among them are the psychometric tests and questionnaires. However, these methods are not appropriate and in fact are a barrier for assessing the personalities of disabled individuals. This limitation affects the person's position when applying for jobs or getting admissions.

As mentioned on the WHO website, screening is 'the presumptive identification of unrecognized disease or defect by application of tests, examinations or procedures which can be applied rapidly.'

Screening sorts out apparently well persons who probably have a disease from those who probably do not. A screening test is not intended to be diagnostic.

Screening is the initial step for to identify those children who have or who are at risk of having or have developmental disabilities. This opportunity lies with the pediatricians who can incorporate screening examinations and refer the patients for confirmatory testing by an appropriate consultant, if indicated.

The Centre for Disease Control states that there are certain features which characterizes ASD or Autism Spectrum Disorder including persistent, significant impairments in social interaction and communication as well as restrictive, repetitive behaviours and activities. Generally, diagnosing an ASD includes the following two steps: Developmental Screening and Comprehensive Diagnostic Evaluations.

According to Rehabilitation Council of India, to detect deafblindness effectively, the screening must be done on specific populations such as children with one sensory disability in schools for the blind or in schools for the deaf and also in schools for the children with Learning Disability and Multiple Disabilities. As per National Centre for Biological Information, ‘deafblindness’ is a condition presenting other difficulties than those caused by deafness and blindness.

As per the World Health Organization, a person who is not able to hear as well as someone with normal hearing – hearing thresholds of 25 dB or better in both ears – is said to have hearing loss. Hearing loss may be mild, moderate, severe, or profound.

Early identification of such developmental milestones are first noticed by parents, followed by clinicians who recognize motor developmental delays.
in their clinical practices. Early identification is useful for timely referral for diagnosis, interventions, and treatment.

- As per Rehabilitation Council of India, Multiple Disabilities means concomitant (simultaneous) impairments (such as intellectual disability-blindness, intellectual disability-orthopedic impairment, etc.), the combination of which causes such severe educational needs that they cannot be accommodated in a special education program solely for one of the impairments. The term does not include deaf-blindness.

- Learning disorders (LD) refer to a significant deficit in learning due to a person’s inability to interpret what is seen and heard, or to link information from different parts of the brain (GEON, 2005). It can be classified into three major types: disorder of written expression (DWE); reading disorder (RD); and mathematics disorder (MD).

- An ideal assessment for LD is a long process requiring several sessions with a qualified educational psychologist. Apart from administering a battery of tests, the psychologist also gathers relevant information about the child from the teachers and school records.

- Traumatic Brain Injury (TBI) has been defined by the Centers for Disease Control and Prevention (CDC) as ‘a bump, blow or jolt to the head that disrupts the normal function of the brain’ that can result from external force to the head, including whiplash, blast exposure, or penetrating injury.

- World Health Organization, the International Classification of Diseases 11 (2018) classifies vision impairment into two groups, distance and near presenting vision impairment.

- A social model of disability sees the problem as rooted within society. Rather than attempting to fix or change the person with the disability, the focus should be on the removal or reforming of environmental and social barriers to full physical, social, career, and religious participation (French, 1993).

### 12.15 Key Words

- **Personality traits:** These are defined as normal, prominent aspects of personality.

- **Personality disorders:** It refers to the conditions when personality traits become abnormal, i.e., become inflexible and maladaptive and cause significant social or occupational impairment or significant distress.

- **Developmental disability:** It refers to a diverse group of chronic conditions that can occur to mental or physical impairments at any stage of one’s lifespan.
• **Screening**: It the presumptive identification of unrecognized disease or defect by application of tests, examinations or procedures which can be applied rapidly.

• **Multiple Disabilities**: It means concomitant [simultaneous] impairments (such as intellectual disability-blindness, intellectual disability-orthopedic impairment, etc.), the combination of which causes such severe educational needs that they cannot be accommodated in a special education program solely for one of the impairments.

### 12.16 SELF ASSESSMENT QUESTIONS AND EXERCISES

**Short Answer Questions**

1. List the various kinds of disabilities or impairments that can happen during one’s life span are largely categorized under the Right of Persons with Disabilities Act 2016 (RPWD Act 2016).

2. List the characteristics of children with deafblindness.

3. What are the three main areas in which orthopedic impairments are often divided?

4. ‘World Health Organization, the International Classification of Diseases 11 (2018) classifies vision impairment into two groups.’ Mention them.

5. Briefly mention some of the screening tools available for intellectual disability.

**Long Answer Questions**

1. Describe the various factors which affect personality development.

2. Discuss the stages in which developmentalists have broken life span into.

3. Explain diagnosis and assessment tools available for screening of autism spectrum disorder.

4. Describe the general assessment tools as well as assessment tools available in India for learning disabilities.

5. Examine the assessment tools recommended for identifying multiple disabilities.

6. Discuss the assessment tools for vision impairment.
12.17 FURTHER READINGS


Websites:

https://www.sciencedirect.com/topics/medicine-and-dentistry/snellen-chart
https://www.who.int/news-room/fact-sheets/detail/blindness-and-visual-impairment
https://www.asha.org/PRPSpecificTopic.aspx?folderid=858993337&section=Assessment#Screening
http://www.rehabcouncil.nic.in/writereaddata/ld.pdf
https://www.kidsnewtocanada.ca/screening/hearing
https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934680&section=Treatment
http://www.rehabcouncil.nic.in/writereaddata/deafblind.pdf
UNIT 13 EARLY INTERVENTION

Structure
13.0 Introduction
13.1 Objectives
13.2 Assessment for early Intervention
  13.2.1 Intervention Packages for Various Disabilities
  13.2.2 Strategies for Early Intervention
13.3 Services and Programmes for Disabled Individuals and Family in India
13.4 Answers to Check Your Progress Questions
13.5 Summary
13.6 Key Words
13.7 Self Assessment Questions and Exercises
13.8 Further Readings

13.0 INTRODUCTION

A system of services that helps babies and toddlers with developmental delays or disabilities is known as early intervention. The focus of early intervention is on helping eligible babies and toddlers learn the basic and brand-new skills that typically develop during the first three years of life. In precise, early intervention is doing things as early as possible to work on your child’s developmental, health and support needs.

Specialized support to children and families in the early years (from birth to school entry) is provided by early intervention services. Special education, therapy, counseling service planning and help getting universal services like kindergarten and child care are some of the entities that are included in the support.

13.1 OBJECTIVES

After going through this unit, you will be able to:

- Understand the concept of early intervention
- Discuss the assessment and strategies for intervention
- Describe the intervention packages for various disabilities
- Analyse the services and programmes for disabled individuals and their families
13.2 ASSESSMENT FOR EARLY INTERVENTION

During the assessment process, various strategies are used to evaluate child learning and development, including evaluation of the cultural, social and physical contexts within which undertakes learning and development. Let us discuss a few steps of assessment of the patient with a disability.

1. Recognize disability as identified by the patient: It is essential to address the patient’s disability in the health history and physical assessment. Be cautious while asking about patient’s disability; the patient is usually very much aware of the disability, and likely will be distressed if you don’t consider the disability when you obtain a health history and complete a physical assessment.

2. Assess patient’s ability to communicate and participate in health history and physical assessment: Assume that the patient is able to participate in conversation rather than assuming that he or she is unable to do so because of the disability. Communicate directly with the disabled person rather than to a family member or caregiver who is with the patient.

3. While assessing a person with a disability for health history identify accommodations and modifications (e.g., signing, large print, other, etc.) in case if needed: Identify what assistance is needed to transfer the patient safely from a wheelchair to an exam table so that a complete assessment, including pelvic or testicular and rectal exam can be conducted, if indicated.

4. Consider all aspects of physical assessment that would be included for every other normal patients: The health history and physical assessment should address the same issues that would be addressed with a person without a disability. For example, the health history should include sexuality, sexual function, reproductive health issues, preventive health care practices, and lifestyle behaviours. Assume that a person with a disability participates in the same activities and behaviours as those without a disability.

5. While interacting with disabled person use ‘person-first language’. Although some disability groups (e.g., the Deaf community) prefer to be identified by their disability ‘the Deaf person’, most prefer NOT to be identified by their disability. Language that refers to the person first ['person with a disability'] rather than their disability is more acceptable.

Disability-Specific Issues

1. Assess how patient’s disability will affect him to obtain health care. Assessment process should address the interaction of person’s disability and health care, manage self-care activities, follow health care recommendations, and obtain preventive health screening and follow-up care.
2. Assess patient for abuse or risk for abuse (physical, emotional, financial, and sexual) by others (family, paid care providers, strangers). Questions should be asked in a private setting, when no one else, including family and care providers, is in the room. Questions specific to abuse of persons with disability include: if they have been prevented from using wheelchair, cane, respirator, or other assistive device; been refused help for important personal needs etc. If abuse is detected, assess patient’s access to accessible information, resources, shelters, and hotlines.

3. Assess the patient for risk of falls: Ask about previous falls and injuries due to fall. Ask about impaired balance, muscle weakness, changes in gait, changes in vision, confusion.

4. Assess patient for depression: Do not assume that depression is ‘normal’ because he is a disabled person: depression, if present treatment should be offered just as any other patient would have offered treatment.

5. Assess patient for secondary conditions or risk for secondary conditions: Secondary conditions are those conditions which are a result of having a disability or result from treatment of a disability [e.g., pressure ulcers, injuries].

6. To encourage or permit self-care and independence, assess what accommodations the patient has at home or needs at home. These may range from use of assistive devices or simple rearrangement of the home to structural modifications to enable the person with a disability to remain in the home and to participate safely in preferred setting. Home care nurses and therapists [occupational or physical therapists] can be helpful in assessing the home environment and suggesting modifications that would increase the ability of individuals with a disability to function safely in their own home.

7. Determine what preparation and accommodations are needed during hospital stays, emergency room or clinic visits, acute illness or injury, and other health care encounters to enable a patient with disability to be as independent as he or she prefers. Determine if facility staff members are informed about the activities of daily living for which the patient will require assistance. Determine if accommodations are in place and readily available to enable the patient to use his or her assistive devices (hearing/visual aids, prostheses, limb support devices, ventilators, service animals).

8. Identify instructional materials (large print, Braille, visual materials, audiotapes, interpreter) needed by the patient with a disability.

9. Engage patient with disabilities in health promotion strategies and assess patient’s awareness of their potential benefits, accessible community-based facilities (e.g., health care facilities, imaging centers, public exercise settings, transportation).
Disability Impact Assessment

Disability impact assessment is the process used for carrying out disability proofing. It involves a comprehensive examination of how any proposed policy, legislation, programme or service impacts on a person with a disability. The analysis should consider all potential impacts, both positive and negative.

A disability impact assessment is the process of identifying, analysing and assessing the impact of existing or proposed services, policies and practices in relation to their consequences for equality for persons with a disability.

In simpler terms, a disability impact assessment will identify any difficulties or barriers that may exist or arise within a service delivery, policy or process that prevents someone from availing of that service, policy or process.

Timely identification of impairments, a secondary prevention, can reduce the impact of the impairment on the functional level of the individual and also in checking the impairments from becoming a disabling condition. Initially their need to be identified as soon as possible at home by the parents and outside (in the anganwadi centre’s/ schools/ sub - health centers/ through camps), and then they need to be assessed through a team of specialists to plan necessary interventions.

Home

Parents can observe and identify the children with disabilities by using the following checklist for early identification of disabilities:

13.2.1 Intervention Packages for Various Disabilities

Hearing Impairment

Screening New Born

- Is there anyone in the family with deafness since childhood?
- Did the mother take an abortificient drug or any other medicine in large doses during the first three months of pregnancy?
- Is the birth weight below 1500 gms.
- Did the child have a delayed cry after birth?
- Did the child have significant jaundice (yellowness of eyes) during the first 10 days after birth?
- Does the child have a cleft in the lip or palate, or a malformed pinna?

Screening Children in the age group of 6 months to 2 years:

- Does a child turn towards the source of sound which is located either at the back or towards one side of the body?
- Does he/she have discharge from the ear?
**Screening Children above 2 years age**

- Does he/she turn when called from behind?
- Uses gestures excessively
- The child does not speak or has a defective speech.
- The child does not understand the spoken language.
- The child has an ear discharge.

**Visual Impairment**

- The child does not follow an object moving before his eyes by 1 month’s age.
- The child does not reach for toys and things held in front of him by 3 months age.
- One eye moves differently from the other; including squint
- Eyes are either red or have a yellow discharge or the tears flow continuously.
- The child has tendency to bring pictures or books very near the eyes.

**Mental Retardation**

- Does the child respond to name/voice by 4th Month?
- Does the child smiles at others by 6th Month?
- Does the child hold the head steadily by 6th Month?
- Does the child sit without support by 12th Month?
- Can the child stand without support by 18th Month?
- Can the child walk well by 20th Month?
- Can the child talk 2-3 word sentences by 3rd Year?
- Can a child eat/drink by himself by 4th year?
- Can he tell his name by 4th year?
- Does he have toilet control by 4th year?
- Does he avoid simple hazards?
- Does he get fits?

**Loco Motor Disability**

- The child is not able to raise both the arms fully without any difficulties.
- The child is not able to grasp objects without any difficulty.
- The child has absence of any part of the limb.
- The child has a difficulty in walking.
Outside

In the rural and tribal areas as well as in the urban - slums, early identification is done through door to door surveys, screening children at the anganwadis, schools, health centres, sub-health centres, rehabilitation centres or through camps usually organized by the voluntary workers, or else.

Anganwadi Centre – ICDS

The Department of Women and Child Development under the Ministry of Human Resource Development, has been implementing the programme of Integrated Child Development Scheme (ICDS) since 1975. An anganwadi centre under the programme is located in each village and is run by an anganwadi worker. Some of the important objectives of the scheme include improvement of the nutritional status of the children in the age group of 0 - 6 years, providing nutrition and health education for every woman in the age group of 15 - 44 years and improving the capability of the mothers to look after the normal health and nutritional needs of their children. An anganwadi worker is required to do early detection of the disabilities in children present at their anganwadi centres.

Sub-Health Centres - Primary Health Centres

India has a well-established network of Primary Health Centres, each catering to a population of 30 to 40 thousand. These have sub-health centres at the field level. Each sub-health centre caters to a population of around 3,000 individuals and is managed by one female health worker. Under the programme of MCH (Mother & Child Health) the worker takes care of the children by providing immunization, and vitamin A supplementation to children below 6 years of age. She also identifies the health problems which may lead to disability and takes further preventive action.

School

Teachers in all the primary, upper primary and secondary government schools have a responsibility to identify children with disabilities.

Check list for identification of children with special needs: (School teachers and parents should use this check list).

Visual

- Watering of eyes
- Recurrent redness
- Often irritation
- Frequent blinking
- Squint
Early Intervention

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- Inappropriate stumbling over objects or bump into other people
- Tilting of the head or closure of one eye.
- Headache while doing fine work.
- Difficulty in counting the fingers of an outstretched hand at a distance of one meter.
- Moving head side to side while reading
- Difficulty in recognizing distant objects
- Difficulty in doing other fine work requiring perfect vision.
- Holding books too close or too far from the eyes.
- Frequently ask other children when taking down notes from the blackboard
- Exhibit difficulty in reading from the blackboard.
- Hitting against the objects on the side.

Note: If any of the above 4 responses are yes, then the child should be properly examined by a qualified ophthalmologist to see if the existing condition can be improved by medical treatment or by using spectacles.

Hearing

- Malformation of the ear
- Discharge from ear
- Pain in ear
- Irritation in ear
- Trying to listen from a closer distance
- Ask for the instructions repeatedly.
- Not able to write properly.
- Trying to listen to the echo reflection rather than from the speaker
- Make errors while copying from black board.
- Frequently ask a colleague to show his workbook.
- Problems in paying attention in the class
- Favour one ear for listening purposes.
- Problems when anyone speaks from behind.
- Child speaks loudly or too softly.
- Exhibit voice problem and mispronunciation
- Tune the TV/Radio too loud.
- Irrelevant answers.
• The child keeps away from his age mates.
• The child is unable to respond when you call from the other room.
• The child understands only after few repetitions.

**Note:** If any of the above 3-4 questions elicits response that indicates some kind of hearing/speech loss, then the child should be carefully examined by a qualified ENT specialist, an audiologist, and also by a speech therapist for complete evaluation. In case the child is below 4 - 5 years, a psychologist should also be consulted to address and identify any associated psychological problems which may not be overtly evident.

**Speech**

- Inappropriate sound in speech
- Stammering
- Baby speech
- Inability to learn correct sound and use incorrect speech
- Incomprehensible speech

**Physical Disabilities**

- Deformity in neck, hand, finger, waist, legs
- Difficulty in sitting, standing, walking
- Difficulty in lifting, holding, keeping things on floor
- Difficulty in moving or using any part of the body
- Difficulty in holding pen
- Using a stick to walk
- Jerks in walking
- Lack bodily coordination
- Epileptic behaviour/have tremors
- Joint pains
- Any part of the body is amputated.

**Note:** If answer to any of the above written statements is positive, the child should be carefully examined by a qualified orthopedic surgeon and referred to a physiotherapist &/or prosthetic/orthotic technician as needed.

**Mental Retardation**

- If the child does not sit unassisted even much after 12 - 15 months
- Or starts to walk even much after 2.5 years.
- Or starts to talk even much after 2.5 years.
Early Intervention

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- If a child has undue problems in eating, dressing or toilet activity independently by the age of 6 years
- Problems in holding a pencil/or using a scissors
- Unable to play with a ball; or play ‘guilli-danda’ with his peers.
- Frequent tantrums, while playing with the peers
- Usual inattentiveness to the spoken speech or addressal
- Requires too many repetitions to remember simple things
- Problems in naming even 5 fruits, vegetables or plants
- Problems in naming the days of the week
- Exhibit problems in expressing the needs in a clear language unlike the other peers
- Unable to concentrate on tasks even for a short period of time
- Inappropriate oral responses
- Difficulty in performing daily routine work
- Poor comprehension of lessons taught in the school class
- Difficulty in learning new things
- Difficulty in conceptualization
- Does not get well along with the children of same age group
- More efforts are required in learning or practicing as compared to the peers.
- Takes an unreasonable amount of time in perfecting any work
- Poor academic achievements
- Show an undue dependency on visual clues or material for learning.

Note: If the responses to any of the above 4 indicators is positive when compared to the average school going peers of same age group & class then the child should be properly assessed by a qualified psychologist or a teacher who is specially trained to take care of the mentally challenged children.

Learning Disabilities

- Difficulty in counting
- Lack of concentration or easily distraction by the surroundings, either at home or school
- Difficulty in sitting quietly in the classroom
- Does not write down the spoken words correctly
- In appropriate additions to the right word; e.g. ‘ischool’ in place of school
- Always confused between Right & Left
- Unreasonable difficulty in remembering the verbal instructions
• General difficulty in memorizing the things
• Extreme restlessness in a child which significantly interferes with the timely completion of various tasks
• Reverses letters or symbols too frequently while reading for example b as d, saw as was, etc.
• Reverses numbers too frequently while reading or writing for example 31 as 13, 6 as 9, etc.
• Excessive errors during reading like looses place or repeat / insert / substitute / omit words.
• Poor in mathematical calculations
• Problems in accurate copying from the common sources like a book or a blackboard, even though the vision is normal.
• Write letters or words either too close or too far (spacing problems).
• The child appears to comprehend satisfactorily but is not able to answer the questions.

Note:
• If the answer to any of the above 3-5 statements is positive, the child should be carefully examined by a qualified psychologist / paediatrician / or a special educator for initial screening & further consultations.
• One of the main characteristics children with learning disabilities is that their verbal skills are often much better than the writing skills. Therefore, they should be formally tested in order to elucidate their disability in detail.

Learning disabilities what to look for some first signs of trouble keeping up with the flow of expectations:

Table 13.1 Signs to look for Learning Disabilities

<table>
<thead>
<tr>
<th>Language</th>
<th>Memory</th>
<th>Attention</th>
<th>Fine motor skill</th>
<th>Other functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
<td>Pronunciation problem; Slow vocabulary growth; Lack of interest in story telling</td>
<td>Trouble learning numbers, alphabet, days of week, etc; poor memory for routines</td>
<td>Trouble sitting still; Extreme restlessness, in persistence at tasks</td>
<td>Trouble learning self-help skills (e.g. tying shoe laces); Clumsiness, Repeatability to draw or trace</td>
</tr>
<tr>
<td></td>
<td>Troubled decoding abilities for reading, Trouble following directions, Poor spelling</td>
<td>Slow recall of facts, Organizational problems, slow acquisition of new skills, Poor spelling</td>
<td>Impassivity, lack of planning, careless errors, Inability, Diffusability</td>
<td>Trouble learning about time (Temporal – sequential disorganization, Poor grasp of math concepts)</td>
</tr>
<tr>
<td>Lower Grades</td>
<td>Delayed decoding abilities for reading, Trouble following directions, Poor spelling</td>
<td>Slow recall of facts, Organizational problems, slow acquisition of new skills, Poor spelling</td>
<td>Impassivity, lack of planning, careless errors, Inability, Diffusability</td>
<td>Trouble learning about time (Temporal – sequential disorganization, Poor grasp of math concepts)</td>
</tr>
</tbody>
</table>
Middle Grades | Poor reading comprehension | Poor intelligible writing, slow or poor recall of math facts, Failure of automatic recall | Inconsistency, Poor self-monitoring, Great Knowledge of Trivia, Distant for fine detail | First - like or right pencil illegible, slow or inconsistent writing, Reluctance to write. | Poor learning strategies, Disorganization in time or space, peer rejection
---|---|---|---|---|---
Upper Grades | Weak grasp of explanations, foreign language problems, Poor written expression, Trouble summarizing. | Trouble studying for tests, Weak cumulative memory, Slow work pace. | Memory problems due to weak attention, Mental fatigue | (Assisting relevance of fine motor skills) | Poor grasp of abstract concepts, Failure to elaborate, Trouble taking tests, multiple choice (e.g. SAT's)

Note: These are guideposts for parents, teachers and other involved. They should not be used in isolation, but may lead you to seek further assessment. Many children will, from time to time, have difficulty with one or more of these items. They should always be reviewed in a broader content of understanding about a child.

13.2.2 Strategies for Early Intervention

The strategies for early intervention can be understood through its types.

Many children with a disability can benefit from some type of early intervention (or therapy). For example:

- **Occupational therapy** can help the children with fine motor skills, play and self-help skills like dressing and toileting.

- **Physiotherapy** can help with motor skills like balance, sitting, crawling and walking.

- **Speech therapy** can help with speech, language, eating and drinking skills.

Specialised support for specific disabilities like autism spectrum disorder, cerebral palsy, hearing impairment and vision impairment, these are some of the services provided by early intervention therapies.

The services and supports that are available to babies and young children with developmental delays and disabilities and their families are described as Early intervention.

Early intervention is for children from birth to age 3. To be eligible, your child must have either:

1. A developmental delay—be far behind other kids his age.
2. A specific health condition that will probably lead to a delay —this includes genetic disorders, birth defects and hearing loss, but typically not learning or attention issues like dyslexia and ADHD.

Three key additional ‘threats’ to a child’s development are the targets of Early intervention. It also targets which are strongly associated with adverse outcomes during adolescence and adulthood: child maltreatment, substance misuse and risky sexual behaviour.
All therapies and services for children with disability should be family focused, well-structured and evidence-based.

1. **Family centered:** This means that the intervention:
   - includes you and other members of the family, so you can work with the professionals and learn how to help your child.
   - is flexible – it can be offered in your home as well as in other settings such as kindergartens and early intervention centers.
   - Provides your family with support and guidance.

2. **Developmentally appropriate:** This means that the intervention:
   - is specially designed for children with disability
   - has staff who are specially trained in the intervention and services they provide
   - develops an individual plan for your child and reviews the plan regularly
   - Tracks your child’s progress with regular assessments.

3. **Child focused:** This means the intervention:
   - is on developing specific skills
   - includes strategies so that your child can learn new skills and use them in different settings.
   - helps the child prepare and supports them, to go to school.
   - helps find ways of getting your child with disability together with typically developing children (ideally of the same age).

4. **Supportive and structured:** This means the intervention:
   - It provides a supportive learning environment in which your child feels comfortable and supported
   - It is highly structured, well organised, regular and predictable.

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### Check Your Progress

1. What is early intervention?
2. What is the purpose of early intervention?
3. What is disability impact assessment?

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### 13.3 SERVICES AND PROGRAMMES FOR DISABLED INDIVIDUALS AND FAMILY IN INDIA

The National Policy identifies the Persons with Disabilities (PWD) as necessary and valuable assets of this country and the basic goal is to create an atmosphere for them in conjunction with the basic constitutional rights i.e. equality, freedom, justice and
dignity. This will also guarantee equal opportunities for the PWD thereby ensuring the protection of their rights and enabling their full participation in the society.

The primary objectives of the National Policy are:

1. Physical rehabilitation which includes medical treatment, counseling, providing aids and appliances.
2. Educational Rehabilitation which offers vocational and on-hand training.
3. Economic Rehabilitation ensuring a better and dignified life in society.

India implemented the CRPD (Convention on the Rights of Persons with Disabilities) act in 2008 which was enhanced by the National Center for promotion of Employment of Disabled People (NCPEDP) and Disabled Rights Group (DRG).

The Government has envisaged a number of schemes to promote the standard of life of the PWD in general.

Some of these schemes are:
1. Assistance to Disabled Persons for Purchase/Fitting of Aids/Appliances (ADIP) involving physical rehabilitation of the PWD by providing them with aids and appliances.
2. Deendayal Disabled Rehabilitation Scheme (DDRS) a multi-faceted scheme that addressing all the possible aspects of rehabilitation.
3. Scheme for Implementation of Persons with Disabilities Act aimed at providing funds for projects involving construction of public buildings, support the regional institutions that provide service to the PWD and creating awareness.

Some of the steps taken by the Ministry of Social Justice and Empowerment and Health and Family Welfare in India are:
1. District Rehabilitation Center (DRC) Project started in 1985.
2. Four Regional Rehabilitation Training Centers (RRTC) operative in Mumbai, Chennai, Cuttack and Lucknow under the supervision of the DRCs since 1985.
3. National Information Centre on Disability and Rehabilitation.
5. National Level Institutes- NIMH, NIH, NIV, NIOT and IPH.
6. The adoption of the National Policy for PWD in 2005.

It is evident that the government is sincerely putting in effort for the life enrichment of the PWD. But we, the able-bodied also have a certain duty towards the physically handicapped and the disabled other than reserving a seat for them in one corner of public vehicles.

The National Trust has also introduced a few schemes for the welfare of persons with Autism, Cerebral Palsy, Mental Retardation and multiple disabilities. The welfare schemes are stated as follows:
(a) **DISHA** - An early intervention and school readiness scheme for children upto 10 years.

(b) **VIKAAS** - A day care scheme for persons with autism, cerebral palsy, mental retardation and multiple disabilities.

(c) **SAMARTH** - A scheme to provide respite home for orphans, families in crisis, Persons with Disabilities (PwD).

(d) **Gharaunda** – A scheme that provides housing and care services throughout the life of the person with autism, cerebral palsy, mental retardation and multiple disabilities.

(e) **Nirmaya** – A scheme to provide affordable health insurance to persons with autism, cerebral palsy, mental retardation and multiple disabilities.

(f) **Sahyogi** – A scheme to set up caregiver cells (CGCs) for training and creating skilled workforce of caregivers to care for Person with Disabilities (PwD) and their families.

(g) **Gyan Prabha** – A scheme to encourage people with autism, cerebral palsy, mental retardation and multiple disabilities for pursuing educational/vocational courses.

(h) **Prerna** – A marketing scheme to create viable and widespread channels for sale of products and services produced by persons with autism, cerebral palsy, mental retardation and multiple disabilities.

(i) **Sambha V** – A scheme to set up additional resource centres in each city, to collate and collect the aids, software and other form of assistive devices.

(j) **Badhte Kadam** – A scheme that supports registered organizations (RO) of The National Trust to carry out activities for increasing the awareness of The National Trust disabilities.

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**Check Your Progress**

4. Give an overview of occupational therapy and speech therapy.

5. Mention a few schemes envisaged by government to promote the standard of life of the PWD.

**13.4 Answers to Check Your Progress Questions**

1. A system of services that helps babies and toddlers with developmental delays or disabilities is known as early intervention.

2. The focus of early intervention is on helping eligible babies and toddlers learn the basic and brand-new skills that typically develop during the first...
three years of life. In precise, early intervention is doing things as early as possible to work on your child’s developmental, health and support needs.

3. Disability impact assessment is the process used for carrying out disability proofing. It involves a comprehensive examination of how any proposed policy, legislation, programme or service impacts on a person with a disability. The analysis should consider all potential impacts, both positive and negative.

4. Occupational therapy can help the children with fine motor skills, play and self-help skills like dressing and toileting. While speech therapy can help with speech, language, eating and drinking skills.

5. Some of the schemes envisaged by government to promote the standard of life of the PWD are:
   1. Assistance to Disabled Persons for Purchase/Fitting of Aids/ Appliances (ADIP) involving physical rehabilitation of the PWD by providing them with aids and appliances.
   2. Deendayal Disabled Rehabilitation Scheme (DDRS) a multi-faceted scheme that addressing all the possible aspects of rehabilitation.
   3. Scheme for Implementation of Persons with Disabilities Act aimed at providing funds for projects involving construction of public buildings, support the regional institutions that provide service to the PWD and creating awareness.

13.5 SUMMARY

- A system of services that helps babies and toddlers with developmental delays or disabilities is known as early intervention. The focus of early intervention is on helping eligible babies and toddlers learn the basic and brand-new skills that typically develop during the first three years of life.

- Special education, therapy, counseling service planning and help getting universal services like kindergarten and child care are some of the entities that are included in the support.

- During the assessment process, various strategies are used to evaluate child learning and development, including evaluation of the cultural, social and physical contexts within which undertakes learning and development.

- Disability impact assessment is the process used for carrying out disability proofing. It involves a comprehensive examination of how any proposed policy, legislation, programme or service impacts on a person with a disability. The analysis should consider all potential impacts, both positive and negative.

- A disability impact assessment is the process of identifying, analysing and assessing the impact of existing or proposed services, policies and practices in relation to their consequences for equality for persons with a disability.
Parents can observe and identify the children with disabilities by using the following checklist for early identification of disabilities like hearing impairment, visual impairment, mental retardation, locomotor disability.

In the rural and tribal areas as well as in the urban - slums, early identification is done through door - to door surveys, screening children at the anganwadis, schools, health centres, sub-health centres, rehabilitation centres or through camps usually organized by the voluntary workers, or else.

Many children with a disability can benefit from some type of early intervention or therapy like occupational therapy, physiotherapy, and speech therapy.

Specialised support for specific disabilities like autism spectrum disorder, cerebral palsy, hearing impairment and vision impairment, these are some of the services provided by early intervention therapies.

The National Policy identifies the Persons with Disabilities (PWD) as necessary and valuable assets of this country and the basic goal is to create an atmosphere for them in conjunction with the basic constitutional rights i.e. equality, freedom, justice and dignity.

The Government has envisaged a number of schemes to promote the standard of life of the PWD in general like ADIP, DDRS, Scheme for Implementation of Persons with Disabilities Act.

The National Trust has also introduced a few schemes for the welfare of persons with Autism, Cerebral Palsy, Mental Retardation and multiple disabilities such as DISHA, VIKAA, SAMARTH, GHARAUNDA, NIRMAYA, SAHYOGI, GYAN PRABHA, PRERNA, SAMBHAV, and BADHTE KADAM.

13.6 KEY WORDS

- **Early Intervention**: It refers to a support and educational system for very young children who have been victims of developmental delays or disabilities.

- **Disability Impact Assessment**: It refers to the process of identifying, analysing and assessing the impact of existing or proposed services, policies and practices in relation to their consequences for equality for persons with a disability.

- **Mental Retardation**: It refers to a developmental disability that first appears in children under the age of 18. It is an intellectual functioning level that is well below average and significant limitations in daily living skills.

- **Dyslexia**: It refers to a learning disorder that involves difficulty reading due to problems identifying speech sounds and learning how they relate to letters and words (decoding).
13.7 SELF ASSESSMENT QUESTIONS AND EXERCISES

NOTES

Short Answer Questions
1. Write a short note on the assessment process of the disable patient.
2. Write a note on services provided at Anganwadi centres under ICDS.
3. What are the key elements of primary health centres?
4. List some of the common learning disabilities.
5. Write a brief note on the strategies for early intervention.
6. Prepare a note on key objectives of the National Policy.

Long Answer Questions
1. Explain the assessment process of the patient with a disability?
2. Discuss the disability-specific issues in detail.
3. Describe the sign and symptoms of children with special needs.
4. Analyse the important features that all therapies and services for children with disability.
5. Examine the schemes introduced by National Trust for the welfare of persons with Autism, Cerebral Palsy, Mental Retardation and multiple disabilities.

13.8 FURTHER READINGS

UNIT 14 SPECIAL EDUCATION

Structure
14.0 Introduction
14.1 Objectives
14.2 Aims, Objectives and Functions
14.3 Emerging Trends in Special Education
14.3.1 Trends in the Classroom
14.4 Educational Assessment and Evaluation for Persons with Disabilities
14.4.1 Special Education Interventions
14.5 Educational Technology for Disabled
14.6 Answers to Check Your Progress Questions
14.7 Summary
14.8 Key Words
14.9 Self Assessment Questions and Exercises
14.10 Further Readings

14.0 INTRODUCTION

In a rapidly changing world, it is pretty clear now that the feeling of oneness that we thought to be present among the people of a community, was forced. All individuals, young or old, are different in their nature, aspirations, skills, abilities, etc. Thus, the society should educate them in such a way that their individual talent is brought into focus. Special education attempts to do that very thing by addressing the needs and differences between individuals. In this unit, we will discuss special education, along with its aims and trends in it. Additionally, educational assessment of disabled people is also explained.

14.1 OBJECTIVES

After going through this unit, you will be able to:

- Explain the objectives and functions of special education
- Understand the emerging trends in special education
- Discuss the educational assessment and technology for disabled

14.2 AIMS, OBJECTIVES AND FUNCTIONS

The aim of special education is to ensure that all students’ educational needs are provided for and to ensure additional services, support, programs, specialised placements and environment.
Special education is the practice of educating students in such a way that they are able to address their individual differences and needs. This process involves the arrangement of teaching procedure, which is individually planned and systematically monitored, with adapted equipment and materials and accessible settings or 'Specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability.' Thus, special education can be defined as the form of learning provided to students with exceptional needs, such as students with learning disabilities or mental challenges, for example, a particular type of reading help that is provided to a student, who is dyslexic. The important aims of the special education are:

- To ensure that students with disabilities are provided with the environment that allows them to be educated effectively
- To include all type of physical, mental and behavioural disabilities
- To ‘ensure that all students with disabilities have available to them a free appropriate public education that emphasises special education and related services designed to meet their unique needs’.

The objectives of special education are:

- The objective of special education is to provide the children with special needs (SEN) a conducive learning environment, so as to facilitate their education.
- To provide appropriate educational program, related services to each child with a disability requiring special education, from age three to 21 years.
- To provide activities that foster social development and adjustment into the regular school and community activities.
- To identify disability among the preschool children.
- To provide an opportunity to participate in an approved preschool program within a reasonable distance from the child’s home.
- To provide and coordinate a comprehensive instructional program from kindergarten through high school.
- To motivate parents to be more involved and encourage them in understanding of special education programs.
- To provide appropriate vocational services to the students with disabilities.
- To provide healthy and friendly environment inside and outside of the school for each student with disability.

The function of special education can be encapsulated within the fact that it often require supports that goes beyond what is normally offered or received in the regular school/classroom setting.
There was one clearly defined goal in the early years of special education that is, appropriate education for students with disabilities. To attain this right, parents, professionals, and students with disabilities rallied together. The cases of autism spiked dramatically, in fact, quadrupled over the span of 10-years.

On combining these statistics with the way classroom technology has changed since the year 2000, it makes sense that special education is in an adjustment period. The initiatives in the special education are evolving the way that students are being served. Following are a few of the emerging trends in K-12 education in the US:

I. **LAMP**: LAMP or Language Acquisition through Motor Planning, is an approach that makes communication easier for students with autism and related disorders by connecting neurological and motor learning. These principles are proving especially helpful for those students who do not speak or have very limited verbal skills. The principles of LAMP paired with technology, has helped the growing student population with autism in communicating effectively and reaching higher academic achievements. From specially made computers to learning apps, LAMP is present in all of the technology.

II. **Assistive technology**: Students with any number of issues can be helped by Assistive technology. The technology being used can be as common as using an e-reader instead of a traditional book or as advanced as a computer that responds to the eye movements of the student as he/she commands. It can be argued that assistive technology gives a chance to learning that would not have existed without the technology. This tool is needed for academic success, when it comes to students with physical disabilities and learning disabilities, or a combination of both.

III. **Early detection**: Groups like Easter Seals are behind the cultural push to fund programs that specialise in early detection of developmental delays that can often be helped with intervention programs. It was reported by the Centre for Disease Control that 11 percent of the children end up not needing any special education in the school years, if they were admitted in the federally funded early intervention programs (before Kindergarten, as young as 24 months). The CDC also reported that the diagnosis for spectrum disorders like autism, the median age is older than 6. For kids to receive the help they need in early childhood and improve special education, it will take a change in thinking at all levels—from parents to lawmakers.
IV. Classroom integration: The time has gone when special education students were placed in separate classrooms, or even in completely different parts of a school. For at least part of the day, special education students are now sitting alongside their traditional student peers. The amount of time spent in a regular education classroom is determined by the particular disability, but more special education students are in regular classrooms than in the past, giving them the common school experience.

V. Student-led planning: When special education students reach high school, they are being called upon more and more to provide input for their individual education plans. This is done to prepare these students to be independent. When it comes to learning, the methods suggested by these students, give teachers more insight into the learning style of these students. Student-led input helps chart the course toward academic and life skills, instead of dictating what and how special education students should learn.

VI. Special education in the context of school reform: In the early years of the twenty-first century, two of the most prominent school reform agendas having significant effects on special education were standards-based education and school choice reform:

a) Standards-based education: Standards-based reforms enforce the standards to improve school performance and use accountability systems. With the amendment of the Individuals with Disabilities Education Act (IDEA) in 1997, the federal government mandated that district and state assessments should include students with disabilities.

b) School-choice reform: School-choice reform focuses on the freedom of students to choose from a variety of alternatives.

VII. Disability classifications: There is usually an agreement about what blindness actually means and whether the child qualifies for special education or other services for being blind. Disabilities categories like learning disability, mental retardation, emotional disturbance, autism, and giftedness require professional judgment and subjective analysis. Some of the disorders are:

- Learning disability
- Mental retardation
- Emotional disturbance
- Autism
- Attention deficit disorder and attention deficit hyperactivity disorder
- Gifts and talents
14.3.1 Trends in the Classroom

The three trends in special education that have significant influence on the classroom environment are:

I. Early intervention and prevention: Early intervention and prevention of disabilities are not new ideas, but they are being increasingly emphasised. Now, schools are realising that not only children benefit from early intervention and prevention but they can also save money by reducing the need for costly services required later.

II. Technology: With increasing intensity, technology has permeated into every part of our society and reached into classrooms. Technology has helped the students overcome their limitations previously placed on them by a disability. Keyboarding and navigation of the Internet by eye movements are made possible only by computer programs that is, technology. New prosthetics (artificial body parts) provide greater mobility and participation in education and society, while Cochlear implants allow deaf students to hear.

III. Transition: In 1997, amendments were made in IDEA, in which two mandates were added related to the transition from one school setting to another or from school to work. The requirement of the first amendment was the compulsory organisation of transition-planning conferences for children exiting early intervention programs, while the second one mandated the furnishing of a statement of needed services for the transition from high school to higher education or work in the Individualised Education Plan (IEP) for students age fourteen or older. Other forms of transition planning, such as from a self-contained or restrictive environment to a less restrictive environment or from middle school to high school are also becoming common.

Special education teachers

There is a critical teacher shortage in special education due to a shortage of people going through teacher training programs in special education and alarmingly high exit rates from the field.

More teachers in the classroom, can be placed with the help of the training programs. The quality of both the teacher education programs and the newly licensed teachers are questioned by some professionals. A trend in higher education is emerging to merge the special education teaching program with the general education program and doing away with special education altogether.

In India, Sarva Siksha Abhiyan has made provisions for ‘Special Educators’ in classroom and also the promotion of inclusiveness. In addition RCI is working at standardising teacher education (special education) along with pre-service and inservice training.
**Check Your Progress**

1. What is special education?
2. What was the report of the Centre for Disease Control with regards to early detection?
3. List some of the categories of disability.
4. Why is there a critical teacher shortage in special education?

### 14.4 EDUCATIONAL ASSESSMENT AND EVALUATION FOR PERSONS WITH DISABILITIES

The need for the educational assessment and evaluation cannot be emphasised enough. Without doubt, it is important in the education of regular students, but in case of special education students, it is vital. These tests help to recognise and work on the challenges faced by disabled students. They help to target the different individual problems of these students. There are various tests, which are often included in the assessments; these tests are both standardised and criterion-referenced. However, testing is not the only way that educators measure student’s aptitude. Assessments are evaluations and might consist of anything from simple observations that a teacher or aide jots down, while a student works on an assignment to the complex, multi-stage procedures such as a group of teachers assembling a large portfolio of a student’s work. Individual schools require assessments; they need districts or states to help them in determining whether or not a student qualifies for special education and, if so, the types and frequency of services that will best support a student’s success. Common assessments in special education include:

- **Developmental assessments**: Norm-referenced scales that assess infants, toddlers, and pre-schoolers
- Screening tests
- Intelligence Quotient (IQ) tests
- Academic achievement tests
- Adaptive behaviour scales
- Behaviour rating scales
- Curriculum-Based assessment
- End-of-Grade alternate assessments
**Individual intelligence tests**

As suggested by the name, individual intelligence tests are administered to a student on one on one basis. For example:

a) **Wechsler Intelligence Scale for Children (WISC):** This test is usually administered by the school psychologist, which measures, in variety of areas, a student’s (between the ages of 6 and 16) intelligence, which include linguistic and spatial intelligence. Some practitioners use it to diagnose attention-deficit hyperactivity disorder (ADHD) and learning disabilities.

b) **Stanford Binet intelligence scale (derived from the Binet-Simon test):**
   Like the WISC, this test is also designed in such a way that it helps the educators to differentiate between students performing below grade level because of cognitive disabilities and those who do so for other reasons.

**Group intelligence tests**

Tests that are often administered in the general education classroom are Group intelligence and achievement tests. Through these types of tests, the teachers can diagnose if a student has a learning disability. Measuring academic ability as well as a child’s cognitive level are the two functions of these tests.

**Skill evaluations**

Certain diagnostic measures are used by specialists such as the school speech pathologist and the child’s general practitioner for determining a child’s gross motor skills, fine manipulative skills and hearing, sight speech, and language abilities. Parents are typically referred to a paediatrician or specialist by the teachers as a part of the process of gathering the evidence necessary to develop a full physical evaluation for an individual education program (IEP).

**Developmental and social history**

Developmental and social history is a narrative assessment, which is formulated with the help of the child’s classroom teacher, parents, paediatrician, and school specialists. They may fill out checklists, answer questions, participate in an interview, or write a report addressing a child’s strengths, challenges and development (or lack thereof) over time. The child’s health history, developmental milestones, genetic factors, friendships, family relationships, hobbies, behavioural issues and academic performance are some of the issues that are focused on.

**Observational records**

The information about the child’s academic performance and behavioural issues can be provided by anyone who has worked with the child. Daily, weekly, and monthly observational records that show a child’s performance over time typically fall into
the domain of the general education teacher, as he or she is the individual working most closely with the child on a regular basis. The general education teacher typically has this firm notion about how is child’s work and behaviour compares to that of the other students of the same age and grade level.

Samples of student work
In this domain, general classroom teacher provides the most amount of the evidence. A snapshot of a child’s abilities and challenges in performing grade-level work is provided by a folder containing assignments, tests, homework and projects of a student. A more nuanced portfolio, which may include a research project, a writing assignment with several drafts or samples of work throughout a thematic unit, affords the materials for an in-depth investigation of a child’s learning style, thought process, and ability to engage in critical thinking tasks.

14.4.1 Special Education Interventions
Special education may be best described as a purposeful intervention designed to overcome or eliminate the obstacles that keep children with disabilities from learning. It is about providing individualised plans of instruction to help children with disabilities succeed. There are three, specific types of special education interventions:

a) Preventive Interventions: Preventive interventions are designed to prevent potential or existing problems from becoming a disability. In this form, special education seeks either to stop something from happening or reduce an identified condition.

b) Remedial Interventions: Remedial interventions are designed so that the effects of a disability can be reduced. Children with disabilities skills are taught by using these interventions, which allow them to function successfully and independently. They may aim at achieving academic, social, personal, and/or vocational goals.

c) Compensatory interventions: Compensatory interventions involve teaching special skills or using special devices to improve functioning. Compensatory intervention may be best identified as, in spite of a disability, teaching a child to perform a task or conquer a skill. It involves providing children with disabilities an asset that non-disabled children do not need.

Check Your Progress
5. Define Developmental assessments.
6. What are the functions of group intelligence tests?
14.5 EDUCATIONAL TECHNOLOGY FOR DISABLED

In order to efficiently provide the disabled students with learning skills, the technology plays a crucial role. Assistive technology refers to the devices and services that are used to improve the capabilities of a student with a disability. Assistive technology that helps students with learning disabilities includes computer programs and tablet applications that provide text-to-speech (like Kurzweil 3000), speech-to-text (like Dragon Naturally Speaking), word prediction capabilities (like WordQ), and graphic organisers (like Inspiration). Assistive technology helps in two ways:

- It can help the student learn how to complete the task.
- It can help to bypass an area of difficulty.

The different kinds of assistive technology are:

I. Laptop computers and computerised devices: For students with learning disabilities, laptop computers and tablet devices are beneficial because they are portable and lightweight. The quantity and quality of the notes can be improved for students with handwriting difficulties, with a laptop or computerised device (such as an iPad) on which they can take notes quickly and efficiently; using a word processor can help students to complete work that is more organised and includes less spelling errors than handwritten work.

II. Computer-assisted instruction: To provide instruction and practice opportunities on a wide range software and applications that have been designed is referred to as computer-assisted instruction. (For example, computer, laptop, iPad, mobile technology). It can help students practice spelling and multiplication drills. Students need to be taught how to use technology to support their learning in order to prevent the technology from being a distraction.

III. Software functions: Assistive technology can improve the writing skills of students with learning disabilities. Assistive technology can help students to bypass the mechanical aspects of writing. Features like spell check and grammar features can help students focus on communicating their ideas, knowing that they can easily make changes. It also helps them write with confidence. Four useful software functions for students who struggle with language-based learning disabilities are text-to-speech (Kurzweil 3000), speech-to-text (Dragon Naturally Speaking), word prediction (WordQ), and graphic organisers (Inspiration).
Fig. 14.1 Helping students with assistive technology

Text-to-speech software helps students to bypass the task of decoding words. Student’s sight may get improved, if the individual words highlighted as the text, are read aloud. Speech-to-text software bypasses the tasks of handwriting and spelling, allowing the student to concentrate on developing their ideas and planning their work.

IV. Mid-tech Devices: Mid-tech devices such as audio recorders, portable note takers, mp3 players, calculators, and pentop computers (such as LiveScribe smartpen) can be used without recurring the cost associated with high-tech devices. Concept organisers, whether completed electronically or by hand, may contribute to better writing in students with learning disabilities. Pentop computers can be used for reading (text-to-speech), writing (digitising written words), and math (strategy feedback). Calculators can help students with learning disabilities demonstrate their understanding of mathematical computations. Algebraic equations can be solved and graph shapes can be verified by using Graphing calculators.

Table 14.1 Examples of Assistive Technology by Domain

<table>
<thead>
<tr>
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<th>LOW-TO MID-TECH</th>
<th>MID-TO HIGH-TECH</th>
<th>APPS FOR MOBILE DEVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECEPTIVE</td>
<td>Notepad: These are used to record information. Students with learning disabilities (LDs) may prefer the information in colour-coding format, based on the purpose, topic, or function of the information.</td>
<td>Audio recorders: Audio recorders store hundreds of hours of audio and aren’t very costly.</td>
<td>Audiobooks: A simple way is provided by audiobooks to listen to many of the best classic books and modern titles.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Talking dictionary: Talking dictionaries can be used by students with LDs to verify definitions and spelling. Talking dictionaries can be carried in a pencil and are not as expensive as computers or tablets.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visuwords: Visuwords is a free online dictionary which allows students to look up words to find their meanings and associations with other words and concepts.</td>
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</table>
### SPEAKING
- **Cue cards:** Use cards provide helpful hints for the oral presentation of information. The process of composing cue cards can help organise the information.
- **Print:** A free 3D graphic organiser which can be used to create presentations. Print can be collaborative as students can comment and build upon other Print.
- **ShowMe Interactive Whiteboard:** In order to reduce anxiety, students may opt to record presentations on their iPad beforehand. Video recordings can be uploaded on YouTube or a more private domain.

### READING
- **Highlighter strips:** Translucent rectangles of colour can help eliminate extra visual clutter by blocking out the rest of the text.
- **Sticky notes:** Students with LDs may find it useful to summarise the main ideas of the text with sticky notes which can be stuck directly on the page.
- **Kurzweil 3000:** Text-to-speech software, such as Kurzweil 3000, can read aloud digital or printed text.
- **Storyline Online:** It is a free online streaming video program featuring books read aloud. Each book includes accompanying activities and lesson ideas.
- **Project Gutenberg:** It provides users with over 45,000 free e-books.
- **Wikipedia:** The Simple English function on Wikipedia allows content to be “translated” into plain English, which is easier to read.
- **Speak Selection:** Located in the accessibility features of Apple devices, Speak Selection can be used to read aloud electronic text.
- **Free Books:** This app contains more than 23,000 free books. Notes, highlight option, bookmark, and dictionary tools are also provided.
- **GaudyReader:** This PDF reader allows you to add sticky notes, highlight and take notes.

### WRITING
- **Pencil grips:** For students who struggle with handwriting, pencil grips can provide a surface that is easier to manipulate.
- **Computerised pens:** These pens can automatically transmit handwriting into digital text. Some computerised pens have audio-recording functions that allow the writer to listen to specific sections of the audio file by tapping on the written notes.
- **Word processing:** Functions such as spell check, dictionary options, synonym support, and word-prediction features are helpful for students with learning disabilities.
- **Pages:** It is an app, which allows you to compose, edit work, and share. It also includes word prediction, speech-to-text, and spell check functions.
- **iWordQ:** iWordQ provides reading assistance, word choice, and proof reading functions.
- **Dragon Dictation:** It is an easy-to-use voice recognition application, which allows you to speak and instantly see your text or e-mail messages. For this application to work you must be connected to the Internet.
<table>
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<tr>
<th>Physical Supports</th>
<th>Software/Tools</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graphic organizers: Organising ideas, visually, allows students with LDs to see the connections between ideas.</td>
<td>Inspiration: This software helps students to organise their ideas, visually, without the challenge of handwriting or spelling requirements. The content can be instantly translated into outlines for essays or compositions.</td>
<td>Simple/Mind: This app allows you to brainstorm and organise your ideas. Completed concept maps can be automatically converted to an outline.</td>
</tr>
<tr>
<td>Audio recorders: Many students with LD experience difficulty translating oral language into written text. Recording ideas early in the thinking process can provide a record for later recall and clarification.</td>
<td>Audacity: It is a free software program which allows you to record and edit sounds.</td>
<td></td>
</tr>
<tr>
<td>MATH 4-function calculator: Depending on the type of work being done, a 4-function calculator can be a great help, without providing disproportionate advantage to students with LDs.</td>
<td>Math Dictionary for Kids: It is an animated, interactive online math dictionary that explains over 600 common mathematical terms in simple language.</td>
<td>ShowMe and ScreenChomp: To solve problems, these apps provide an interactive whiteboard interface. The actions on the screen and audio can be recorded and shared as a video file.</td>
</tr>
<tr>
<td>Graphing calculator: Graphing computer can solve complex equations. The dynamic display screen allows the student to verify the results before solving on paper.</td>
<td>Brainy Camp: To assess students' understanding, animated lessons and interactive activities are used.</td>
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<tr>
<td>Math Practice Skills: IXL’s math practice skills are aligned with pre-K through Grade 8 provincial curricula and students’ performance is assessed on each objective.</td>
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### Special Education

**Check Your Progress**

7. How does assistive technology help?
8. What are the four useful software functions for students who struggle with language-based learning disabilities?
9. What is the use of Pentop computers?

### 14.6 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Special education is the practice of educating students in such a way that they are able to address their individual differences and needs.

2. It was reported by the Centre for Disease Control that 11 percent of the children end up not needing any special education in the school years, if they were admitted in the federally funded early intervention programs (before Kindergarten, as young as 24 months).

3. Some of the categories of disability are:
   a) Learning disability
   b) Mental retardation
   c) Emotional disturbance
   d) Autism
   e) Attention deficit disorder and attention deficit hyperactivity disorder
   f) Gifts and talents

**Sumdog:** Sumdog is a learning engine which adapts its math questions according to each student's ability. It covers a number of operations through simple algebra. It is designed for students aged 6 to 16.
4. There is a critical teacher shortage in special education due to a shortage of people going through teacher training programs in special education and alarmingly high exit rates from the field.

5. Developmental assessments are the norm-referenced scales that assess infants, toddlers, and pre-schoolers.

6. The functions of group intelligence tests are to measure academic ability as well as a child’s cognitive level.

7. Assistive technology helps in two ways:
   a) It can help the student learn how to complete the task.
   b) It can help to bypass an area of difficulty.

8. The four useful software functions for students, who struggle with language-based learning disabilities are text-to-speech (Kurzweil 3000), speech-to-text (Dragon Naturally Speaking), word prediction (WordQ), and graphic organisers (Inspiration).

9. Pentop computers can be used for reading (text-to-speech), writing (digitising written words), and math (strategy feedback).

14.7 SUMMARY

- In a rapidly changing world, it is pretty clear now that the feeling of oneness that we thought to be present among the people of a community, was forced. All individuals, young or old, are different in their nature, aspirations, skills, abilities, etc. Thus, the society should educate them in such a way that their individual talent is brought into focus.

- The aim of special education is to ensure that all students’ educational needs are provided for and to provide additional services, support, programs, specialised placements and environment. The initiatives in the special education are evolving the way that students are being served.

- The need for the educational assessment and evaluation cannot be emphasised enough. Without doubt, it is important in the education of regular students, but in case of special education students, it is vital. These tests help to recognise and work on the challenges faced by disabled students.
In order to efficiently provide the disabled students with learning skills, the technology plays a crucial role.

Assistive technology refers to the devices and services that are used to improve the capabilities of a student with a disability.

14.8 KEY WORDS

- **Giftedness**: Children are gifted when their ability is significantly above the norm for their age.
- **Autism**: A serious developmental disorder that impairs the ability to communicate and interact
- **Licensure**: The granting of a licence, especially to carry out a trade or profession

14.9 SELF ASSESSMENT QUESTIONS AND EXERCISES

**Short Answer Questions**

1. How does transition have a significant influence on the classroom environment?
2. Give two examples of individual intelligence tests.
3. What are the three specific types of special education interventions?

**Long Answer Questions**

1. Discuss the aims, objectives, and functions of special education.
2. Describe the emerging trends in K-12 special education.
3. Elucidate various examples of assistive technology by domain.

14.10 FURTHER READINGS


M.Sc. [Psychology]  
363 232  
ELECTIVE II: REHABILITATION PSYCHOLOGY  
II - Semester