CHAPTER I
INTRODUCTION
Introduction

Adjustment
✓ Meaning
✓ Theoretical Prepositions Of Adjustment
✓ Methods of Adjustment

Anxiety
✓ Meaning
✓ Diagnosis
✓ Types of anxiety disorders
✓ Treatment

Physical Disability
✓ Proposed changes on meaning of "disability"
✓ Removal of list of 'capacities'
✓ Legal definition of disability to be extended?
✓ Discrimination because of association or perceived disability?

Operational Definitions
1. Adjustment

In psychology, adjustment is studied especially in abnormal psychology and also in social psychology. In our daily life there has been a continuous struggle between the needs of the individual and the external forces, since time immemorial. According to Darwin's theory of evolution those species which adapted successfully to the demand of the living survived and multiplied while who did not died. Therefore adaptation or changing of oneself or one's surroundings according to the demands of external environment become the basic need for our survival. It is as true today with all of us as it was with Darwin's primitive species.

Adjustment generally refers to modification to compensate for to meet special conditions. In the dictionary the term adjustment means to fit, make suitable, adapt, arrange. Modify, harmonize or make correspondence. Whenever we make an adjustment between two things adapt or modify one of both to correspond to each other. For example wearing of cloths according to the requirement of the seasons is an example of the adjustment. Before understanding the adjustment as a process it is necessary to examine some of the definitions of adjustment given by the various researches;
Adjustment is the established of a satisfactory relationship as representing harmony, conformance, adaptation or the like. (Webster, 1951)

1.1 Meaning

Adjustment is the process by which a living organism maintains a balance between its needs and the circumstances that influence the satisfaction of these needs. (Shaffer, 1961)

Adjustment is the continuous process in which a person varies his behaviour to produce a more harmonious relationship between himself and his environment. (Gates and Jersild, 1948)

From these definitions it is clear that in every definition the needs are incorporated. One has to change one's mode of behavior to suit the changed situation so that a satisfactory and harmonious relationship can be maintained keeping in view in the individual and his needs on the one hand and the environment and its influence on the individual in the other hand. Even Shaffer's definition underlines one's need and their satisfaction. Shaffer tries to maintain a balance between his needs and his capacities of releasing these needs and as long as this balance is maintained he remains adjusted. As soon as this balance is disturbed he drifts towards maladjustment. Gates and Jersield (1948) mentioned that adjustment is a harmonious relationship between individual and his environment. In view of all these facts it could be stated that adjustment is a condition or state in
which the individual behavior conforms to the demands of the culture or society to which he belongs and he feels that his own needs have been or will be fulfilled. In this concern Arkoff (1968) had given an extensive definition of adjustment. He define adjustment is the interaction between a person and his environment. How one adjusts in a particular situation depends upon one's characteristics and also the circumstances of the situation. In other words, both personal and environmental factors work side by side in adjustment. An individual is adjusted if he is adjusted to himself and to his environment.

Examination of various definitions of adjustment reveals that adjustment can be interrelated as both process and the outcome of the process in the form of some attainment or achievement. When a poor child studies under the street light because he has no lighting arrangement at home he is said to be in the process of adjustment what he attain in term of success in his examination or the fulfillment of his ambition or pride in his achievement is nothing but the results of his adjustment to his self and his environment. In other words when adjustment is perceived as an achievement it means how the effectiveness with which an individual can function in changed circumstances and is, at such, related to his adequacy and regarded as an achievement that is accomplished as badly or well (Lazarus, 1976).

In some definitions of adjustment it was stated that the process of adjustment is continuous. If one observe that the process of
adjustment starts at one's birth and goes on without stop till one's death. In other words adjustment is something that is constantly achieved and re-achieved by us. Apparently, it appears that adjustment is a one way in process but in reality it is not. It is a two way process and it involves not only the process of fitting oneself in to available circumstances but also the process of changing circumstances to fit one's need. In this reference White (1956) commented excellently. White stated that the concept of adjustment implies a constant interaction between the person and the environment, each making demands on the other. Sometime adjustment is accomplished when the person yields and accepts conditions which are beyond his power to change. Sometimes it is achieved when the environment yield to the person activities. In most cases adjustment is a compromise between these two extremes and maladjustment is a failure to achieve a satisfactory compromise.

Researchers have made several attempts to measure the relationship between adjustment and other factors. For example the relationship between adequacy and social adjustment and adequacy of personal adjustment, has been investigated in the large number of studies. In Moreno's study it was observed that how choice status or high rejection status is evidence that the adjustment of the subject is not good. A large number of studies search the relationship between the socio metric status of the individuals and adjustment. In these studies it was observed that the subjects low in social status make more
unfavorable responses than the subjects high in social status (Baron, 1951)

In addition to the personal adjustment a number of other personality characteristics have been investigated as correlates of social status. In present study anxiety was one of the factors of which effect on the adjustment was examined while considering the personality variables the researchers found that the high anxiety affect the adjustment.

To get adjusted in life on has to be versatile individual for a simple reason that every individual has to face varied social situations which require different skills for satisfactory adjustment. Psychologist have pointed out and mentioned the characteristics of well adjusted person which denotes that these skills need to be developed and one has to learn to keep controls on the emotions. At the first place an individual must be aware of his own strengths and limitations. He must respects himself and other also. It is necessary that he should have an adequate level of aspiration, if the aspiration is very high which can not be achieved even by hard work then the adjustment is likely to be hampered.

To be adjusted satisfactory level it is necessary that the basic needs of the individual must be satisfied. Often it is seen that people develop critical or fault finding attitude, in fact one should learn to appreciate the goodness in objects, persons or activity. As far as
possible the observation should be scientific and objective not critical or punitive. There should be flexibility in behavior. Rigidity is likely to result in maladjustment. The individual must the capacities to deal with the other circumstances, in other words he must have courage to resist and fight odds. If the person is having a realistic perception of the world then there is possibility of satisfactory adjustment. In addition to this an individual must have a feeling of ease with his surroundings. Of course its very difficult to develop a balanced philosophy of the life but specially after maturation or during the late age one can have the established norms which could be treated as a balanced philosophy of life. No doubt one has to make special efforts in order to be well adjusted and successful in life.

1.2 Theoretical Prepositions of Adjustment

After studying the nature of adjustment and the factors that are related to successful adjustment it is necessary to consider theoretical prepositions related to adjustment. It is necessary because some people adjust to their environment successfully; many others could not it means that there are some factors that help in satisfactory adjustment and the other factors that hinder the satisfactory adjustment. In order to understand that, it is necessary to examine some of the theories of models of adjustment.
1.2.1. Psych-Analytic Model

One of the most famous views is related to psych-analytic theory. It was Sigmund Freud (1938) who proposed this view. According to Freud, human psyche consists of three layers: the conscious, the sub-conscious, and the unconscious. It is the unconscious that holds the key to our behavior; it is this unconscious level which decides the individual adjustment and maladjustment to his self and his environment. It contains all the repressed wishes, desires, feelings, drives, and motives many of which are related to sex and aggression. According to Freud, man wants to seek pleasure and avoid pain or anything which is not in keeping with his pleasure-loving nature. A person's behavior remains normal and in harmony with himself and his environment to the extent that his ego is able to maintain the balance between the evil designs of his id and the moral ethical standard detected by his super ego. Freud suggested that adjustment or maladjustment should not be viewed only in term of what the individual may be undergoing at present and what happened to him in his earlier childhood is even more important.

Adler disagreed with the view expressed by Freud. He proposed that there is an inherent strong urge in all human beings to seek power and attain superiority. However, as a child one is helpless and dependent which makes one feel inferior and in order to makeup for
the feeling of inferiority one takes recourse in compensatory behavior. Here there is a need of adjustment.

### 1.2.2. Moral Modal

This is one of the oldest view point about adjustment or maladjustment. According to this view adjustment should be judged in term of morality. Those who follow the norms are adjusted and those who violet or do not follow the norms are maladjusted. This view is not scientifically correct but in past it was respected much.

### 1.2.3. The Medico Biological Modal

According to this model genetic, physiological and biochemical factors are responsible for a person being adjusted or maladjusted to his self and his environment. Maladjustment according to this modal is the result of diseases in the tissues of the body, especially in the brain. Such diseases can be the result of heredity or damage acquired during the course of a persons life by injury, infection or hormonal disruptions arising from stress among other things. This model is still extant and enjoys credibility for rooting out the causes of adjustive failure in term of genetic influences, biochemical defect hypothesis, and disease in the tissues of the body.
1.2.4 Erich Fromms views

Fromm emphasized the need of security and felt that a child may feel the necessity for belonging to offset the fear of isolation and aloneness. The individual in his childhood may desire to live in his family, belonging to the members of the family and provided with love affection security. When he attains maturity he is impelled by an inner craving for freedom as a result he tries to escape from the very bonds which provided him his security he needed. In this kind of situation he may be confronted with the inner conflict of being dependent for the satisfaction of his needs. If the crisis dissolved the individual is satisfied and adequately adjusted but if the conflict retains then there is possibility of maladjustment.

1.2.5. The Socio Genic or Cultural Modal

This modal proposed that the society in general and culture in particular affects ones ways of behaving to such an extent that behavior takes the shape of adaptive or non-adaptive behavior turning one into an adjusted or mal adjusted personality. The society and culture to which one belongs does not only influence or shape ones behavior but also sets his standard for its adherents to behave in the way he desires. Individual, who behave in the manner that society desires are labeled as normal and adjusted individuals, while
deviation from social norms and violation of role expectancy is regarded as a sign of maladjusted and abnormality.

1.2.6. The Socio Psychological or Behavioral Model

According to this model behavior is not inherited. Competencies required for successful living are largely acquired or learnt through social experiences by the individual himself. The environmental influences provided by the cultural and the social institutes are important but in the interaction of ones psychological self with ones physical as well as social environment which plays a decisive role in determining adaptive success or failure. Behavior whether normal or abnormal, is learnt by obeying the same set of learning principles or laws. Generally every type of behavior is learnt or acquired as an after effect of its consequences. The behavior ones acquired if reinforced may be learnt by the individual as normal as a result one may learn to consider responses which are labeled normal as abnormal. Not only the normal or abnormal behavior is learnt but labeling of behavior as normal or abnormal is also learnt. In short the behaviorist model proposes that adjustment or maladjustment is acquired not inherent. Societal influences on the individual and vice versa should be taken into consideration for understanding adjustment or maladjustment of the individual with the self and environment.
1.3 Methods of Adjustment

In order to lead a healthy happy and satisfying life one has to learn the various ways of adjustment. The first, one being coping with ones environment as effectively as possible. The individual has to safeguard his self against turning into a mal adjusted and abnormal personality. Psychologists have suggested different ways and methods which could be grouped into two categories. The first one is called Direct Method and the second one is called indirect methods. In the direct methods increasing trials or improving efforts is an important one. The second one refers to adopting compromising means. At times one has to withdraw and to be submissive and finally he has to make proper choice and decisions. There are indirect methods of achieving adjustment; infact direct methods are those methods which a person tries to seek temporary adjustment to protect himself for the time being against a psychological danger. These are purely psyche or a mental device that is why they are called as defense mechanisms. In these indirect methods all the defense mechanism suggested by Freud are incorporated.
2. Anxiety

2.1 Meaning

Anxiety and fear are ubiquitous emotions. The terms anxiety and fear have specific scientific meanings, but common usage has made them interchangeable. For example, a phobia is a kind of anxiety that is also defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR) as a "persistent or irrational fear." Fear is defined as an emotional and physiological response to a recognized external threat (e.g., a runaway car or an impending crash in an airplane). Anxiety is an unpleasant emotional state, the sources of which are less readily identified. It is frequently accompanied by physiological symptoms that may lead to fatigue or even exhaustion. Because fear of recognized threats causes similar unpleasant mental and physical changes, patients use the terms fear and anxiety interchangeably. Thus, there is little need to strive to differentiate anxiety from fear. However, distinguishing among different anxiety disorders is important, since accurate diagnosis is more likely to result in effective treatment and a better prognosis.

2.2 Diagnosis

Anxiety disorders are often debilitating chronic conditions, which can be present from an early age or begin suddenly after a
triggering event. They are prone to flare up at times of high stress. A good assessment is essential for the initial diagnosis of an anxiety disorder, preferably using a standardized interview or questionnaire procedure alongside expert evaluation and the views of the affected person. There should be a medical examination in order to identify possible medical conditions that can cause the symptoms of anxiety. A family history of anxiety disorders is often suggestive of the possibility of an anxiety disorder. It is important to note that a patient with an anxiety disorder will often exhibit symptoms of Clinical Depression and vice-versa. Rarely does a patient exhibit symptoms of only one or the other.

2.3 Types of anxiety disorders

2.3.1 Generalized anxiety disorder

Generalized anxiety disorder is a common chronic disorder that affects twice as many women as men and can lead to considerable impairment (Brawman-Mintzer & Lydiard, 1996, 1997). As the name implies, generalized anxiety disorder is characterized by long-lasting anxiety that is not focused on any particular object or situation. In other words it is unspecific or free-floating. People with this disorder feel afraid of something but are unable to articulate the specific fear. They fret constantly and have a hard time controlling their worries. Because of persistent muscle tension and autonomic
fear reactions, they may develop headaches, heart palpitations, dizziness, and insomnia. These physical complaints, combined with the intense, long-term anxiety, make it difficult to cope with normal daily activities.

2.3.2 Panic disorder

Main article: Panic disorder

In panic disorder, a person suffers brief attacks of intense terror and apprehension that cause trembling and shaking, confusion, dizziness, nausea, difficulty breathing, and feelings of impending doom or a situation that would be embarrassing. One who is often plagued by sudden bouts of intense anxiety might be said to be afflicted by this disorder. The American Psychiatric Association (2000) defines a panic attack as fear or discomfort that arises abruptly and peaks in 10 minutes or less, and can occasionally last hours. Although panic attacks sometimes seem to occur out of nowhere, they generally happen after frightening experiences, prolonged stress, or even exercise. Many people who have panic attacks (especially their first one) think they are having a heart attack and often end up at the doctor or emergency room. Even if the tests all come back normal the person will still worry, with the physical manifestations of anxiety only reinforcing their fear that something is wrong with their body. Heightened awareness (hypervigilance) of any change in the normal function of the human body, will be noticed and interpreted as a
possible life threatening illness by an individual suffering from panic attacks. Normal changes in heartbeat, such as when climbing a flight of stairs will be noticed by a panic sufferer and lead them to think something is wrong with their heart or they are about to have another panic attack. Some begin to worry excessively and even quit jobs or refuse to leave home to avoid future attacks. Panic disorder can be diagnosed when several apparently spontaneous attacks lead to a persistent concern about future attacks.

2.3.3 Derealization

"Sufferers of Depersonalisation or Derealization feel divorced from both the world and from their own body. Often people who experience depersonalisation claim that life "feels like a dream", things seem unreal, or hazy; some say they feel detached from their own body. Another symptom of this condition can be the constant worrying or strange thoughts that people find hard to switch off." DP/DR builds up slowly with the underlying anxiety, but is noticed suddenly often after a panic attack, and difficult or impossible to ignore until recovery is made. This symptom of anxiety can be crippling to the sufferer and may lead to avoidance behaviour. Sufferers of DP/DR often see this strange phenomenon as being something catastrophic, and may become obsessed with an explanation they have come up with in their mind. It is often difficult to accept that such a disturbing symptom is
a result of anxiety, and the sufferer is often thinking it must be something more, or something worse.

### 2.3.4 Phobias

This category involves a strong, irrational fear and avoidance of an object or situation. The person knows the fear is irrational, yet the anxiety remains. Phobic disorders differ from generalized anxiety disorders and panic disorders because there is a specific stimulus or situation that elicits a strong fear response. A person suffering from a phobia of spiders might feel so frightened by a spider that he or she would try to jump out of a speeding car to get away from one.

People with phobias have especially powerful imaginations, so they vividly anticipate terrifying consequences from encountering such feared objects as knives, bridges, blood, enclosed places, certain animals or situations. These individuals generally recognize that their fears are excessive and unreasonable but are generally unable to control their anxiety.

### 2.3.5 Agoraphobia

A common complication of panic disorder is agoraphobia -- anxiety about being in a place or situation where escape is difficult or embarrassing (Craske, 2000; Gorman, 2000). It seems that the definition of the word has expanded to refer to avoidance behaviors
that sufferers often develop. If a sufferer of panic attacks seems to have them while driving, for example, then he or she may avoid driving, this relieves the anxiety and subsequently makes future driving more difficult, as a result of behavioral reinforcement.

2.3.6 Social anxiety disorder

Social anxiety disorder is also known as social phobia. Individuals with this disorder experience intense fear of being negatively evaluated by others or of being publicly embarrassed because of impulsive acts. Almost everyone experiences "stage fright" when speaking or performing in front of a group. Since occasionally there are artists or performers with social anxiety disorder who are able to perform publicly without significant anxiety, their love of performing and practicing their art may be diminishing their anxiety. Even such high-functioning phobic such as Glenn Gould experience anxiety in performance. But people with social phobias often become so anxious that performance, if they are not natural performers, such as children playing musical instruments from a young age, is out of the question. In fact, their fear of public scrutiny and potential humiliation becomes so pervasive that normal life can become impossible (den Boer 2000; Margolis & Swartz, 2001). Another social phobia is love-shyness, which most adversely affects certain men. Those afflicted find themselves unable to initiate intimate adult relationships (Gilmartin 1987).
2.3.7 Obsessive-compulsive disorder

Obsessive compulsive disorder is a type of anxiety disorder primarily characterized by obsessions and/or compulsions. Obsessions are distressing, repetitive, intrusive thoughts or images that the individual often realizes are senseless. Compulsions are repetitive behaviors that the person feels forced or compelled into doing, in order to relieve anxiety. The OCD thought pattern may be likened to superstitions: if X is done, Y won't happen—in spite of how unlikely it may be that doing X will actually prevent Y, if Y is even a real threat to begin with. A common example of this behavior would be obsessing that one's door is unlocked, which may lead to compulsive constant checking and rechecking of doors. Often the process seems much less logical. For example, the compulsion of walking in a certain pattern may be employed to alleviate the obsession that something bad is about to happen. Lights and other household items are also common objects of obsession.

2.3.8 Post-traumatic stress disorder

Post-traumatic stress disorder is an anxiety disorder which results from a traumatic experience. Post-traumatic stress can result from an extreme situation, such as being involved in warfare, rape, hostage situations, or involvement in a serious accident. It can also result from long term (chronic) exposure to a severe stressor, for example soldiers who endure individual battles but cannot cope with an
unceasing sequence of battles. The sufferer may experience flashbacks, avoidant behavior, and other symptoms.

2.3.9 Separation Anxiety

Separation Anxiety affects school aged children who struggle to socially engage or participate in the absence of their care-giver. It can also be difficult to distinguish separation anxiety from school phobia.

2.4 Treatment

The choices of treatment include behavioral therapy, lifestyle changes, and/or pharmaceutical therapy (medications). Sometimes a change in lifestyle is all that a person needs to treat the anxiety. With most, however, getting relief can be far more complex.

Mainstream treatment for anxiety consists of the prescription of anxiolytic agents and/or antidepressants and/or referral to a cognitive-behavioral therapist. Treatment controversy arises because, while some studies indicate that a combination of the medications and behavioral therapy can be more effective than either one alone, other studies have shown that the majority of anxiety disorder sufferers benefit most from pharmaceutical therapy (and not so much from behavioral therapy).

The right treatment may depend very much on the individual's
genetics and environmental factors. Therefore, to get the best treatment results, it is important to work closely with a psychiatrist, therapist or counselor who is familiar with anxiety disorders and current treatments.

3 Physical Disability

When many of us think of disabilities, the first image that may come to mind is that of someone using a wheelchair. Although an important segment of the disabled population, people who use a wheelchair for mobility represent only one segment of disabilities. There are a wide range of people who are covered by the Americans with Disabilities Act. A disability generally considered as a disadvantage or deficiency, especially a physical or mental impairment that prevents or restricts normal achievement.

The types of disabilities reported by the U. S. study are as follows:

- Physical Disability
- Developmental Disability
- Learning disabilities
- Mobility or orthopedic impairments
- Health impairments
- Mental illness or emotional disturbance
- Hearing impairments
- Blindness and visual impairments
Speech or language impairments

Other impairments

Various types of disabilities have been defined as follows;

**Physical disability** is a condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying.

**Developmental disability** a substantial handicap of indefinite duration, with onset before the age of 18 years, such as mental retardation, autism, cerebral palsy, epilepsy, or other neuropathy.

**Learning Disabilities** are documented disabilities that may affect reading, processing information, remembering, calculating, and spatial abilities.

**Mobility Impairments** may make walking, sitting, bending, carrying, or using fingers, hands or arms difficult or impossible. Mobility impairments result from many causes, including amputation, polio, club foot, scoliosis, spinal cord injury, and cerebral palsy.

**Health Impairments** affect daily living and involve the lungs, kidneys, heart, muscles, liver, intestines, immune systems, and other body parts (e.g., cancer, kidney failure, AIDS).

**Mental Illness** includes mental health and psychiatric disorders that affect daily living.
**Hearing Impairments** make it difficult or impossible to hear lecturers, access multimedia materials, and participate in discussions.

**Blindness** refers to the disability of students who cannot read printed text, even when enlarged.

**Low Vision** refers to students who have some usable vision, but cannot read standard-size text, have field deficits (for example, cannot see peripherally or centrally but can see well in other ranges), or other visual impairments.

**University of Minnesota (2007)** also described the various types of disabilities which have been as follow:

- Deaf and Hard of Hearing
- Vision Impairments
- Mobility Disabilities
- Psychiatric Disabilities
- Learning Disabilities
- Attention Deficit Disorder
- Systemic Disabilities
- Brain Injuries

**Deaf and Hard of Hearing**

Six to eight percent of the population has some type of hearing loss that affects their ability to hear speech or environmental sounds. A
person who is \textit{deaf} has a hearing loss of such severity that he or she depends primarily upon visual communication such as sign language, lip reading (also called speech-reading), writing or gestures. A person who is \textit{hard of hearing} has a functional hearing loss, but may not depend primarily on visual communication.

The causes and degrees of hearing loss vary across the deaf and hard of hearing community, as do methods of communication. There are two major types of hearing loss:

- \textbf{Conductive loss} affects the soundconducting paths of the outer and middle ear. The degree of loss can be accommodated through the use of a hearing aid or by surgery, but can rarely be corrected completely. People with conductive loss might speak softly, hear better in noisy surroundings than people with normal hearing, and might experience ringing in their ears or difficulties with balance and dizziness.

- \textbf{Sensorineural loss} affects the inner ear and the auditory nerve and can range from mild to profound. Hearing aids, surgery, and other devices may not be as effective in accommodating this type of hearing loss. People with sensorineural loss might speak loudly, experience greater high-frequency loss, have difficulty distinguishing consonant sounds, and not hear well in noisy environments.

The inability to hear does not affect an individual's native intelligence or the physical ability to produce sounds. However, given the close
relationship between oral language and hearing, students with hearing loss might also have speech impairments. Age at the time of the loss determines whether an individual is \textit{prelingually deaf} (hearing loss before oral language acquisition) or \textit{adventitiously deaf} (normal hearing during language acquisition). Those born deaf or who become deaf as very young children might have more limited speech development.

\textbf{Modes of Communication:}

Not all deaf students are fluent users of all communication modes used across the deaf community, just as users of spoken language are not fluent in all oral languages. For example, some deaf students are skilled lipreaders, but many are not. Many speech sounds have identical mouth movements, which can make lipreading particularly difficult. For example, "p," "b," and "m" look exactly alike on the lips, and many sounds such as vowels are produced without using clearly differentiated lip movements. Many deaf students use sign language, but there are several types of sign language systems. American Sign Language (ASL) is a natural, visual language having its own syntax and grammatical structure which closely resembles French. Fingerspelling is the use of the manual alphabet to form words. Students who use ASL often identify as culturally Deaf (with a capital "D") to indicate that ASL (not a spoken language) is their first language and they identify as members of the Deaf community, with its own
cultural norms, art, history, humor, etc. These students may also have difficulty with reading and writing English, because it is not their native language. Their grammar and literacy will be that of a student learning English as a second language. Some students who are more familiar with English may use Pidgin Sign English (PSE), which is also called "Contact Signing." It combines aspects of ASL and English and is used in educational situations.

**communicating with the deaf:** Make sure you have a deaf People's attention before speaking. A light touch on the shoulder, a small wave, or other visual signal will help. Look directly at a person with a hearing loss during a conversation, even when an interpreter is present. Speak clearly, at normal speed or slightly slower, without shouting or over-enunciating. If you have problems being understood, rephrase your thoughts, try different words, and avoid English idioms (e.g. "That's a Pandora's box" or "Let's push the envelope on this"). Writing is also a good way to clarify. Make sure that your face is clearly visible. Keep your hands away from your face and mouth while speaking. Try to make sure there is no light source (like a window) behind you. Back-lighting may cause shadows on your face and make it more difficult to see your face and non-verbal expressions which aid lip-reading.
Vision Impairments

Approximately 500,000 individuals have vision impairments to the extent that they are considered "legally blind." In general, a definition of legal blindness means a visual acuity of 20/200 or greater in the better eye with best correction; i.e., the legally blind person can see at 20 feet (6 meters) with the average person can see at 200 feet (61 meters). An individual may also be considered legally blind if there is significant loss in the field of vision (i.e., central or peripheral vision loss). Only two percent of people with vision impairments are totally blind; most blind people have some amount of usable vision.

Some considerations when working with the visually-impaired:

- Some with vision loss use canes or guide dogs for mobility purposes; however, many navigate without them.

- When talking with vision impairment, speak in a normal voice; most people with vision impairments are not hard of hearing.

- When entering a room, identify yourself to the person. Use the name when directing the conversation to him or her.

- When giving directions, use terms such as "left," "right," "step up" or "step down." Convert directions to the person's perspective. When guiding them offer your arm and let him or her take it rather than pulling the person's sleeve.
• If a blind person has a harnessed guide dog, it is working and should not be petted.

**Mobility Disabilities**

Mobility impairments refer to conditions that limit a person’s coordination or ability to move. Some mobility impairments are caused by conditions present at birth while others are the result of illness or physical injury. Injuries cause different types of mobility impairments, depending on what area of the spine is affected. *Quadriplegia*, paralysis of the extremities and trunk, is caused by a neck injury. Persons with quadriplegia have limited or no use of their arms and hands and often use electric wheelchairs. *Paraplegia*, paralysis of the lower extremities and the lower trunk, is caused by an injury to the mid-back. Person with this disability often use a manual wheelchair and have full movement of arms and hands. Other causes of mobility impairments are *muscular dystrophy, multiple sclerosis, cerebral palsy, amputation, arthritis, and back disorders*. A variety of symptoms may be present, including muscle weakness, decreased flexibility, and loss of balance, difficulty with dexterity and coordination, or limited ability to walk or climb stairs. Characteristics will vary from individual to individual.

**Some general considerations**

• When talking with a wheelchair user, attempt to converse at eye level as opposed to standing and looking down. If a person has
communication impairment as well as mobility impairment, take time to understand the person. Repeat what you understand, and when you don't understand, say so.

- Ask before giving assistance, and wait for a response. Listen to any instructions they may give; by virtue of experience, the person likely knows the safest and most efficient way to accomplish the task at hand.

- Be considerate of the extra time it might take a disabled person to speak or act. Allow the student to set the pace walking or talking.

- Wheelchairs are a source of freedom and mobility for people who can't walk or have difficulty with movement or endurance, so phrases such as "wheelchair-bound" or "confined to a wheelchair" are not appropriate.

- A wheelchair is part of a their personal space, so do not lean on or touch the chair without the user's permission. Do not push the chair unless asked to do so.

**Learning Disabilities**

The term learning disabilities (LD) refers to a heterogeneous group of neurologically-based conditions characterized by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities. The diagnosis of LD in an adult
requires documentation of at least average intellectual functioning along with a deficit in one or more of the following areas:

- Auditory processing
- Visual processing
- Information processing speed
- Abstract and general reasoning
- Spoken and written language skills
- Reading skills
- Mathematical skills
- Spatial skills
- Motor skills
- Executive functioning (planning ability)
- Memory (long-term, short-term, visual, and auditory)

It is estimated that 4-5% of the population has dyslexia, a specific learning disability that hinders the acquisition of literacy skills. This problem with managing verbal codes in memory is neurologically based and tends to run in families. Other symbolic systems, such as mathematics and musical notation, can also be affected. Dyslexia can occur at any level of intellectual ability.

**Attention Deficit Disorder (ADD)**

ADD is a persistent pattern of inattention or hyperactivity/impulsivity manifested in academic, employment, or social situations. It is marked by careless mistakes and disorganized work. Person with this
disability often have difficulty concentrating on and completing tasks, frequently shifting from one uncompleted activity to another. In social situations, inattention may be apparent by frequent shifts in conversation, poor listening comprehension, and not following the details or rules of games and other activities. Symptoms of hyperactivity may take the form of restlessness and difficulty with quiet activities. ADD arises during childhood and is attributed neither to gross neurological, sensory, language, or motor impairment nor to mental retardation or severe emotional disturbance.

**Psychiatric Disabilities**

Person with psychiatric disabilities have experienced significant emotional difficulty that has required treatment. With appropriate treatment, often combining medications, psychotherapy, and support, the majority of psychiatric disorders are cured or controlled. Below are brief descriptions of some common psychiatric disabilities.

**Depression** is a major disorder that can begin at any age. Major depression may be characterized by a depressed mood most of each day, a lack of pleasure in most activities, thoughts of suicide, insomnia, and feelings of worthlessness or guilt. The disorder is biochemical in nature and individuals with major depression cannot simply be "cheered up."

**Bipolar disorder** (manic depressive disorder) causes a person to experience alternating periods of mania and depression. In the manic
phase, a person might experience hyperactivity, talkativeness, inflated self-esteem and a decreased need to sleep, while the depressive phase is characterized by symptoms of depression such as withdrawal, feelings of helplessness, fatigue, and loss of appetite.

**Anxiety disorders** can disrupt a person's ability to concentrate and cause hyper-ventilation, a racing heart, chest pains, dizziness, panic, and extreme fear.

**Schizophrenia** can cause a person to experience delusions and hallucinations. It can often be controlled with antipsychotic medications.

Some general considerations regarding psychiatric disabilities:

- Trauma is not the sole cause of psychiatric disabilities; genetics may play a role.
- Psychiatric disabilities affect people of any age, gender, income group, and intellectual level.
- Disruptive behavior is not an attribute of most people with psychiatric disabilities.
- Eighty to ninety percent of people with depression experience relief from symptoms through medication, therapy, or a combination of the two. Depression is a variable condition that may fluctuate during a person's lifetime.
Systemic Disabilities

Systemic disabilities are conditions affecting one or more of the body's systems, including the respiratory, immunological, neurological, circulatory, or digestive systems. There are many kinds of systemic impairments, varying significantly in effects and symptoms. Persons with systemic disabilities differ from those with other disabilities because systemic disabilities are often unstable. This causes a person's condition to vary. Some common types of systemic disabilities are listed below.

*Diabetes mellitus* causes a person to lose the ability to regulate blood sugar. People with diabetes often need to follow a strict diet and may require insulin injections. During a diabetic reaction, a person may experience confusion, sudden personality changes, or loss of consciousness. In extreme cases, diabetes can also cause vision loss, *cardiovascular disease*, kidney failure, stroke, or necessitate the amputation of limbs.

*Epilepsy/Seizure disorder* causes a person to experience a loss of consciousness. Episodes, or seizures, vary from short absence or "petit mal" seizures to the less common "grand mal." Seizures are frequently controlled by medications and usually are not emergency situations.
*Epstein Barr virus/chronic fatigue syndrome* is an autoimmune disorder which causes extreme fatigue, loss of appetite, and depression. Physical or emotional stress may aggravate the condition.

*Lyme disease* is a multi-systematic condition which can cause paralysis, fatigue, fever, dermatitis, sleeping problems, memory dysfunction, cognitive difficulties, and depression.

*Lupus erythematosi* can cause inflammatory lesions, neurological problems, extreme fatigue, persistent flu-like symptoms, impaired cognitive ability, connective tissue dysfunction, and mobility impairments. Lupus most often affects young women.

*Multiple chemical sensitivity (MCS)* often results from prolonged exposure to chemicals. A person with MCS becomes increasingly sensitive to chemicals found in everyday environments. Reactions can be caused by cleaning products, pesticides, petroleum products, vehicle exhaust, tobacco smoke, room deodorizers, perfumes, and scented personal products. Though reactions vary, nausea, rashes, light-headedness, and respiratory distress are common to MCS.

*Multiple sclerosis (MS)* is a progressive neurological condition with a variety of symptoms, such as loss of strength, numbness, vision impairments, tremors, and depression. The intensity of MS symptoms can vary greatly; one day a person might be extremely fatigued and the next day feel strong. Extreme temperatures can also adversely affect a person with MS.
Brain Injuries

Though not always visible and sometimes seemingly minor, brain injury is complex. It can cause physical, cognitive, social, and vocational changes that can affect an individual for a short period of time or permanently. Depending on the extent and location of the brain injury, symptoms can vary widely. Some common results are seizures, loss of balance or coordination, difficulty with speech, limited concentration, memory loss, and loss of organizational and reasoning skills.

A traditional intelligence test is not an accurate assessment of cognitive recovery after a brain injury and bears little relationship to the mental processes required for everyday functioning. For example, individuals with brain injuries might perform well on brief, structured, artificial tasks but have such significant deficits in learning, memory, and executive functions that they are unable to otherwise cope. In addition, recovery from a brain injury can be inconsistent. A person with this disability might take one step forward, two back, plateau, and then unexpectedly make a series of gains.

General Considerations

Sometimes inexperience in interacting with someone with a disability leads to discomfort or uncertainty about how to act. The following considerations can be helpful in overcoming this uncertainty and
creating a comfortable environment for yourself and the person with a disability:

- Students with disabilities do not want pity, nor do they want to be unduly glorified for "courageously" coping with everyday life. A student is not defined by his/her disability.
- Like anyone, students with disabilities appreciate being asked if help is needed before it is given. It's always okay to ask; it's never okay to assume.
- Don't be overly self-conscious about using words and phrases that could be interpreted as disability-related puns, such as "See what I mean?" and "got to run." These are part of our common language and are not offensive.
- Be considerate of the extra time it might take a disabled student to speak or act. Allow the student to set the pace walking or talking.
- Speak directly to the student, not to a companion or interpreter.
- Most people with disabilities want to promote understanding. If you have questions about a student's disability, ask within polite boundaries and if your question is relevant to the conversation.
3.1 Proposed changes on meaning of "disability"

Removal of list of 'capacities'

Broadly, the **DDA** defines a disability as a physical or mental impairment which has a substantial and long-term adverse effect on one's ability to carry out normal day-to-day activities. It goes on to say that impairment can only be taken to affect normal day-to-day activities if it affects at least one of a number capacities, such as mobility, manual dexterity, speech etc. The Government proposes to remove this list of capacities from the definition of disability. It would no longer be necessary to show that the impairment affects mobility or speech etc.

Whether the list is there or not is not really relevant to stammering. The list of capacities includes 'speech', and so does not prevent stammering being treated as a 'disability'.

The **Disability Rights Commission** considered that the removal of the list will not help much. It favours a complete change in the definition of disability as discussed below. If the list is removed, according to DRC it is vital that detailed guidance is produced to provide a steer to courts and tribunals as to what is a 'normal day to day activity'. In particular, the Government needs to ensure that this proposed change
does not undermine existing case law, as this would be a recipe for renewed confusion.

3.2 Legal definition of disability to be extended?

The Disability Rights Commission recommended in July 2006 that the DDA definition of disability should be altered to cover any impairment, without having to show that its effects are substantial or long-term. The cross-party Parliamentary Scrutiny Committee on the Draft Disability Discrimination Bill had argued:

"If the Government are to achieve their aim of comprehensive, enforceable civil rights for disabled people against discrimination in society or at work then the current inadequacies in the DDA definition must be addressed. Many of the deficiencies...would, we believe, be overcome by focusing disability anti-discrimination legislation on the act of discrimination, and not the extent of the impairment."

At present the Government is not accepting this recommendation. The Government considers that disability discrimination law should only protect those people who are disabled in the generally recognized sense of the term

There is still a chance that things will change as a result of views expressed on the Green Paper - though the Government did not ask for views on the point. The DRC's full recommendation (Definition of
Disability within anti-discrimination law: Recommendation to Government') seems to have got deleted in handing over to the EHRC. However the DRC's views are also stated in their 2007.

The idea behind the DRC recommendation is that disability discrimination law should move away from protecting a group of 'disabled' people and instead protect anyone who experiences discrimination on the grounds of an impairment. If the definition is amended in this way, it would no longer normally be an issue whether the complainant has a disability. The focus would shift to such issues as whether there has been discrimination.

Under the extended definition, hopefully anyone with a stammer would be protected by the DDA, even if clinically the stammer's effect is only limited. Compare the current position. The recommendation says that help on interpretation of 'impairment' could be provided by statutory guidance and Ministerial statements in Parliament.

The DRC also recommended:

- considering the exclusion from the definition of a limited number of trivial conditions such as flu, for both policy and presentational reasons;
- considering steps to ensure that positive discrimination continues to be legal, with a new provision making it clear that employers and others can discriminate positively in favour of a narrowly defined targeted group of disabled people;
If the main DDA definition is changed, providing a more targeted definition of disability for the public sector duty, requiring public authorities to focus attention on those who are most excluded as a result of their impairment. There might be a requirement on them to promote equality for "people with impairments who are substantially excluded". Who is covered by this might vary according to the nature of the service.

The DRC's recommendation followed a consultation, to which the British Stammering Association contributed - Definition of disability consultation document. The recommendation was part of reviews taking place with a view to introducing a Single Equalities Act.

This proposal relates to a possible change in the legal definition, whereas the Northern Ireland guidance and the May 2006 guidance already applying to the rest of the UK - relate to how the existing legal definition should be interpreted.

Even if the DRC's recommendation is accepted by the Government, it would probably not take effect until 2010 or later.

3.4 Discrimination because of association or perceived disability?

In Coleman v Attridge Law, a UK employment tribunal has referred to the European Court of Justice (ECJ) the question of whether someone who experiences discrimination because of association with
a disabled person should be protected. An example is a career of a disabled person. The client in the case (who is not disabled) is arguing that her employers discriminated against her because of her son's disability. The ECJ case number is C-303/06. See the ECJ website for the questions referred to the court and, when available, the court judgment. A decision is expected in January 2008.

In its 2007 Green paper on proposals for a Single Equality Bill, the Government has said it is not persuaded that it would be a proportionate approach to extend DDA protection to those who are perceived to be disabled or who associate with disabled people. Subject to the outcome of the Green paper consultation and the Coleman case, no change in UK law is therefore likely.

The Disability Rights Commission, on the other hand, recommended that discrimination because of an association with a disabled person or because a person is mistakenly treated as disabled should be explicitly included in the DDA. The DRC argued that this change is required by the Framework Employment Directive. For cases of discrimination by association or perception there should be a right to equal treatment - but not to reasonable adjustments, because under the directive only disabled people have a right to adjustments. The DRC recommended the above.
Genetic discrimination?

The DRC considered there should be legislative protection from discrimination on the basis of genetic predisposition, and from requirements to undergo a genetic test or to disclose the results of one. This would not necessarily be part of the DDA. It pointed out that the Human Genetics Commission has said they think legislation is needed.

Is this relevant to stammering? Genetic make-up seems to make some people more disposed to have a stammer, but does not make it inevitable the person will stammer. However stammering, if it develops at all on a genetic basis, will normally be apparent from early childhood in any event.

Multiple discrimination?

The Government is asking for responses on whether special provisions are needed to deal with discrimination on multiple grounds - eg discrimination due to being an Asian who stammers. They ask for evidence of people who are losing or failing to bring cases because they involve more than one protected ground. Until they have that evidence, they are rejecting the proposal that combined multiple claims should be permitted.

The European and Human Rights Commission believes that a new equality act should include protection against discrimination and
harassment on multiple or intersectional grounds, reflecting the reality of many people’s experience. The EHRC gives an example of where an employer refuses to employ an older woman, and already employs a number of women and a number of older men. The discrimination cannot be said to be on grounds of age or on grounds of sex, but on the intersection of sex and age. For more, see pages 34-36 of the EHRC’s Discrimination Law Review response (link to Word doc on EHRC website).

The Disability Rights Commission also supported proposals for clear coverage of multiple discrimination and believed this would be straightforward to achieve.

4 OPERATIONAL DEFINITIONS

The operational definition of the various independent and dependent variable, which were used in present study, is as follow:

Adjustment: In this research adjustment has been defined on the basis of subjects’ score on Problem Behaviour CheckList (PBCL) developed by Veeraraghavan V. and Dogra A. (2000). Subject who scored higher on PBCL was defined low adjusted and vise-versa.

Study Habit: It means the attitude of study habit within the student which will be assessed by Study Habit Inventory by Palsane M.N. (1977)
**Anxiety**: In the present investigation anxiety defined as the level which measured by **Sinha Anxiety Scale SAS(1961)**

**Gender**: In this study Gender refers specifically to the biological characteristics, which indicate membership in one of two categories: Male or Female.

**Social Economic Status**: In the present study Social Economic Status will be determined on the basis of monthly family income (two categories i.e. High & Low Social Economic Status). Students whose family income is 5000 or below will be categorized into Low Social Economic Status while students whose family income are 25,000 or above will be category into High Social Economics Status.

**Physically Handicapped**: In the present investigation physically Handicapped has been defined for those people who is suffering from condition i.e. Orthopedic, Deaf & Dumb and Blind