Chapter - V

SOCIAL WORK
INTERVENTION
AND PHYSICALLY
CHALLENGED CHILDREN
5.1 Social Work Intervention:

Primary concern of social work profession being people-in-their-life situations where they have to constantly strike a delicate balance between compulsions of their social environment on one hand and their capacity to cope with on the other, Zastrow (1990) had defines social work principles, skills, techniques and values for helping individuals; groups, or communities to enhance or restore their capacity for psycho-social functioning and to create societal conditions favorable in their goals. The professionals and the scientific body of knowledge equip the social work practitioner with the right skills and attitudes towards physically challenged children in their situation and facilitate his/her helping role while working independently or in collaborative action working with and for the challenged children.

Social work intervention is often discharged through use of a single method or a combination of methods as found necessary. Following are the six widely recognized methods of social work profession:
i) *Social case work* is aimed at helping individuals, on a one to one basis, to enhance or restore their psycho-social functioning through application of professional principles, skills, techniques and values;

ii) *Group Work* is a process of social help in which the qualified social worker helps individuals in a group by providing a desirable group experience through various programmer media with a view to enabling members to move towards improved social relationships and their psycho-social functioning.

iii) *Community Organization* is the process of stimulating and assisting the local community to identify, evaluate, plan and co-ordinate its efforts to meet its own "felt" and "un-felt" needs and develop cooperative and collaborative spirit in working together.

iv) *Social work Administration* involves directing the overall programme of social service agency. Administrative functions include setting agency and programme objectives, analyzing social conditions in the community and making decisions about what services will be provided, employing and supervising staff members, setting up an organizational structure administering financial affairs and securing funds for the agency’s operations.

v) *Social Action* is concerned with changing the social environment to meet the recognized needs of individuals or
disadvantaged groups by application of tactics involving conflict, confrontation and negotiations.

vi) *Social work Research* may be defined as systematic investigation intended to add to available knowledge in a form that is communicable and verifiable.

Social work Research is applied research aims to contribute to the development of a dependable body of knowledge to serve the goals and means of social work in all its ramifications.

Thus, the present study, will look into the fact, whether any basic or necessary conditions are to be fulfilled for the physically challenged children if the intervention activity is to be impactful and fruitful.

### 5.2 Pre-conditions for Intervention:

Are there any basic or necessary conditions that must be fulfilled, if intervention activity is to be impactful is a question mark in front of the researcher. The answer for this would be –

One condition that seems so basic as to be considered axiomatic or determinative is the generation of valid information. Without valid information, it would be difficult for the client to learn and for the interventionist to help. This will be helpful to both social worker and the physically challenged children.

A second condition almost as basic is that interventions should be so designed and executed that the client system maintains its discreteness and autonomy. Thus, free informed choices is also a
necessary process in an effective intervention activity for physically challenged children.

Finally, if the client system is ongoing (existing over time), the clients require strengthening to maintain their autonomy not only vis-à-vis the interventionist but also vis-a-vis other systems. This means that their commitment to learning and change has to be more than temporary. It has to be so strong that it can be transferred to relationships other than those of the interventionist and can do so (eventually) without the help of the latter. The third basic process for any intervention activity is, therefore, the client’s internal commitment to the choice made and here such choice is helpful to the physically challenged children.

5.3 Levels of Intervention:

There are three levels of intervention, viz. primary prevention, crisis intervention and secondary intervention. More about each level follows.

Primary prevention:

This involves anticipating and forestalling the eruption of conflict, in an individual, family or community, especially that which could result in some sort of setback or violence. For instance, research indicates that the period around birth offers a unique opportunity for assessing parents and their babies for potential problems in their interaction with each other—Gray (1976); Schneider (1976) and Dean (1987). Similarly, if we could identify
violence prone couples at an early stage in their relationships, should we place them on At Risk Registers and what kind of supportive intervention be introduced? Supportive action could range from introducing more effective educational programmes to help people anticipate common problems in family life to counselling certain couples not to live together or get married – The open University (1980). In our local setting illustrations of Juvenile Guidance Centres or Schools for physically challenged children Programmes can be given as interventions for Primary Prevention of the related problems from the family side or from the relations and the problem could be prevented.

**Crisis Intervention:**

This may involve rescuing the victim or removing the perpetrator of abuse and further help restore some measure of equilibrium immediately after a crisis, providing relieved from conflict on a temporary basis or using a crisis for long term ends. The term is frequently misunderstood and misused especially in relation to situations of conflict and violence. For example, it is used indiscriminately to describe both family’s crisis and the professional’s or communities anxious response often in form of piecemeal, adhoc intervention. It must be noted that, crisis theory is about the family’s or community’s accessibility to change and not about the level of anxiety or urgency in the professionals or the community. Inter alia, crisis intervention theory suggests that during crisis often individual’s or family’s usual methods of coping
with problems prove inadequate and events which in themselves may seem trivial or unimportant become linked with earlier experiences and therefore trigger off unresolved or partly resolved conflicts from the past. By definition, the period of crisis does not last long and within a few weeks a new equilibrium is usually reached according to the kind of help received and the individuals or families adaptive capacities.

In Indian setting cases of pregnancy out of wedlock, rape, sudden deformity or disabilities resulting from accidents or illness, failure in love or board examinations, death of close relative or friend, natural or manmade disasters etc. could precipitate genuine crisis needing crisis intervention. Such crisis intervention will definitely solve the problems of physically challenged children to much extent.

Secondary intervention:

This may be short-term or long term intervention. It involves superficial monitoring of a situation to contain recurrence of violence or destruction and any further deteriorating trends. In this context, it may include affecting fundamental changes in individuals or whole families, their personality, behavior, patterns of interaction or environmental and social circumstances. To accomplish the aforesaid intervention goals any of the following techniques, alone or in a judicious combination may be used; case work; psychotherapy; psychoanalysis-in few cases; positive reinforcement; direct provision of material aid; affecting major or
minor structural change in local community or society through social action; resources to legal aid; teaching of social and communication skills; mobilizing resources for creation of services like housing, recreation, day care centres for children, schools for handicapped children, young, elderly handicapped or any other vulnerable group: catalyzing formation of self-help groups like tenants association, alcoholics anonymous; Dalit Kranti Sangh (Organization of the downtrodden); Wali Mandal (Parents’ Association) etc. The NGO’s working for the physically challenged children can adopt the Secondary Intervention to minimize the problem and to rehabilitate and develop physically challenged children.

5.4 Dimensions of Intervention:

Concept clarity of various dimensions of intervention considerably help in selection of specific intervention approaches. These dimensions as highlighted as below:

1. How causal factors are perceived and identified;
2. With relation to the aims and desired outcomes, whether the emphasis and level of intervention is on prevention, on dealing with utilizing crisis, on control and maintenance or on implementing change (e.g. by promoting growth, or relieving symptoms or problems of physically challenged children);
3. Whether the focus is on an individual, two people, an entire family or a wider network;
4. Whether the emphasis is on the past or the present, on experience or behavior, on utilizing apparent strengths or focusing on pathology;

5. Whether the emphasis is on offering professional help and support or an encouraging self-help to the children suffering from disability.

6. Whether statutory authority and responsibility exist;

7. How much time, knowledge, skill and other resources are available to those who intervene.

5.5 Objectives of Intervention or change Objectives:

Change objectives indicate the goals towards which the efforts of helping should be directed and can influence all components of the helping strategy / intervention design. Some of the principle objectives relevant to intervention design along with their brief description and relevant examples are summarized in Table 2.1.

While each objective with its own strengths and limitations has a legitimate place in social intervention, the objective of remediation is the most common and widespread problems calling for remediation are generally quite pressing and intervention methods directed towards remediation have been the best developed. More about each objective may be read from Table 2.1 Contemporary intervention has often been criticized because it does not focus sufficiently on the viral objectives of competence and prevention. However, fortunately of late, attitudes are changing for the better
and interventions focusing on competence and prevention are now beginning to receive the attention they deserve.

The researcher while doing the present research has framed a model intervention chart with selected and changed objectives for the welfare and rehabilitation of the physically challenged children, which is presented below:

**Table : Selected/Change Objectives with Examples**

<table>
<thead>
<tr>
<th>Change Objectives</th>
<th>What It is</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remediation</td>
<td>Intervention directed toward altering a problem that is a source of difficulty for the client</td>
<td>Providing social and psychological help to the Physically Challenged Children and asserting them for education.</td>
</tr>
<tr>
<td>Enhancement</td>
<td>Intervention directed towards improving functioning above an already satisfactory</td>
<td>The children who have severe handicap problem. Handle the problem through their satisfactory improving enhancement.</td>
</tr>
<tr>
<td>Competence</td>
<td>Intervention directed toward strengthening the client’s ability to handle not only an existing difficulty but also a variety of difficulties in a given area, including those that may rise in that area in the future.</td>
<td>To strengthen the ability of Physically Challenged Children training parents for child Management giving training to the Physically Challenged Children to overcome anxieties.</td>
</tr>
<tr>
<td>Education</td>
<td>The presentation of information to facilitate</td>
<td>Presenting information to the family and explaining its adverse effects and to</td>
</tr>
<tr>
<td>Understanding in an area of intervention.</td>
<td>Prevent in Rehabilitation of Physically Challenged Children.</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Prevention: Intervention directed toward eliminating potential difficulties before they arise or become sufficiently problematic to require remediation</td>
<td>Training the Physically Challenged Children in conflict resolution, communication and develop skills of Physically Challenged Children</td>
<td></td>
</tr>
<tr>
<td>Advocacy: Speaking up for and taking other actions on behalf of the client to protect the client; rights and to purpose client interests.</td>
<td>Assisting the Physically Challenged Children for getting the benefits of the various schemes of Government</td>
<td></td>
</tr>
<tr>
<td>Resource: Provision of such resources as food, clothing, shelter, money or medicine.</td>
<td>Provision of food, shelter and other facilities to the Physically Challenged Children.</td>
<td></td>
</tr>
<tr>
<td>Social Control: Interventions directed toward protection of the client and/or society generally through provision of special residential arrangements.</td>
<td>Establishing separate residential school and training centres for Physically Challenged Children.</td>
<td></td>
</tr>
</tbody>
</table>

5.6 Planning for Intervention:

The purpose of establishing an intervention plan in the first place is to know where we want to go and how we are going to get there. While such a plan does not guarantee that we will reach our destiny, it does improve our chances of getting there and reduces the probability of our getting lost on the way.
All the therapists, therefore, must formulate treatment plans that identify intervention methods appropriate for addressing particular client concerns. The fashioning of an intervention plan calls for consideration of suitable alternatives, given available methods, as well as new approaches that might be adopted to meet the problem in question and specially the problems of Physically Challenged Children.

5.7 Intervention Methods:

Intervention method are the backbone of the anatomy of the helping process and are generally central in intervention design. Further the methods are composed of none or more intervention techniques and a program format.

The intervention techniques is a recognized and distinctive sea of helping activities that relate to a particular interventional objective. Many intervention techniques are largely accelerative or declarative. The accelerative technique is used to increase desirable responding whereas the declarative technique is intended to decrease undesirable responding. Providing reinforcement in the form of praise to a child for doing his or her homework is illustrative of an accelerative technique. On the other hand, reducing pocket money (say, a days allowance) for incomplete homework would work as declarative technique. Few generalizations about the accelerative and decelerative techniques are as below:

1) All things considered, accelerative techniques are preferred over the decelerative. In the aforesaid example, if Chinky fails
to do her homework regularly, it would be more profitable to announce additional pocket allowance for the completion of homework by her rather than reducing the allowance for incomplete work.

2) There often negative effects of using a declarative technique for example, undesirable emotional reactions along with associating the therapist and the situation of intervention with unpleasant and aversive consequences.

3) Deceleration need not and often does not bring about a simultaneous increase in a desirable responding.

4) Accelerative techniques are not always powerful by themselves. There are difficult situations of behavior change in which even the strongest and best techniques may be ineffective. In such contexts both accelerative and declarative techniques can be used in combination. For instance, in addition to earning special pocket allowance for completion of homework Chinky could also lose her hours of TV viewing for failing to do it (homework).

5.8 Dilemmas of Intervention:

There is a fundamental dilemma of intervention with which all practitioners are confronted sometime or other. This dilemma may be expressed variously as whether the effect of their intervention can be deemed as positive or negative; whether the advantaged of their intervention outweigh the disadvantages; and whether, in fact, they are helping or hindering their clients. Inevitably such issues
involves value judgments as well as objective measurement which will be helpful for Physically Challenged Children.

5.9 Programme evaluation involves:

1. A process of making reasonable judgements about programme effort, effectiveness, efficiency and adequacy.
2. Based on Systematic data collection and analysis.
3. Designed for use in programme management; external accountability and future planning.
4. Focusses especially on accessibility, acceptability, awareness, availability, comprehensiveness, continuity, integration and cost of services.

5.10 Programme Efficiency:

Activities to assess the programme's economic efficiency include the measurement of the costs and the outcomes or the benefits of the programme. This evaluation builds on the impact evaluation and further assesses whether the programme uses resources efficiently.

Most agencies use one or these evaluations in the standard operations of their programmes. A comprehensive approach to evaluation would include a number of them.

5.11 Interventional Measures of Physical Disability:

The following are some of the interventional measures for the physically challenged children;
Medical Interventions:

Children with physical disabilities; both neurological and health impairments need medical supervision from time to time. Those with health impairments like seizures need to be given drugs at the specific rate per day while others may require rest even if they are in school. It is important for the parents and teachers to take doctor’s instructions carefully concerning the treatment of children with health impairment particularly concerning time to take the drugs, which is vital for diabetic and epileptic children.

Teachers need to be very keen to consult with the parents so as to keep up with the medical upkeep of the children with health impairment and be able to access the level of activity for those children. In order to prevent some disabilities, it is important for all children be immunized when they are young, to attend health care and be given improved or proper nutrition.

Physiotherapy:

Physiotherapy is a very important intervention which should be given to physically challenged children in any educational setting. The exercise is done by professionals called physiotherapists who are able to evaluate the motor functioning and limitations (Winzer, 1996). This exercise is designed to alleviate pain, correct or minimize muscular deformities, increase strength and mobility and improve health. Physiotherapist also offers advice to parents and teachers on the use of crutches, braces, prostheses and other
supportive devices and on how to monitor the progress of the child from time to time.

**Occupational Therapy:**

The occupational therapy aims at facilitating arm, head and mouth movements based on evaluation of the child's functioning development level. This therapy is to start early when the child is young and in pre-school programmes. This is where physiotherapy can also be done. This is supposed to prepare the child for self-care, work related activities like home management and employment as well as daily living activities.

**Self-care Skills:**

These are skills which help the physically challenged children to lead independent life later on. These include ability to feed, bathe, groom and clothe oneself. They need to be taught how to zip buttons, adjust braces, cut nails, brush teeth and many other skills. One of the main goals of pre-school is to train the children with disability to rest crutches, walking against sinks or desks, empty urine collection bags and manipulate braces and cutlery with moderate support. Teachers should help them to develop these skills slowly by themselves with minimal assistance in order to be able to take care of themselves after primary school.
Barrier- Free Access:

Since mobility is one of the major difficulties which physically challenged children encounter, then the house, pavements, classroom and other structural environment should be made accessible to them. The area around the school and the school compound should be free from architectural barriers which can cause mobility and emotional disturbances. They should be able to move freely with their wheelchairs, crutches and prostheses.

Adaptive and Assistive Devices:

For the physically challenged children to cope up with their expectation in classroom work, adaptive and assistive devices should be provided. These devices include; standing tables, mobile boards, head pointers, book turners, line readers, incontinence aids, adapted games, special scissors and many others which help them to work. All these will make them active even when the teacher is not around.

Education Programme:

Physically challenged children are capable of doing well in schools and so they need to be assisted to fit well in any educational programme. Those with mild disability should be integrated in public primary schools. Those with severe disabilities need to be given priority in special schools. Teachers should give these children some remedial classes especially when they miss school due some medical issues. These children may not move at same rate with their
classmates and so they need some emotional support from the teachers.

**Counseling Services:**

It is a known fact that disability always has some emotional problems tied to it. The children may see that they different from other children and so they may keep on nursing the trauma of disability as they are grow up. It is only through the interventions of psychological counsellor that these children will learn that disability is not inability. They need assurance to help them accept their disability and move on with their lives.

People with disabilities are primarily seen as dependents upon society, are not considered useful, and are therefore disvalued enormously by society. In the past people with disabilities have been shut away in back rooms, ostracised, regarded as evil, forced to beg, even used as fodder for medical experiments in Hitler's camps and then murdered in large numbers. Nowadays this mistreatment is cloaked in apparent sympathy and kindness, but nevertheless exists almost as strongly as ever. You may ask 'If you all know so clearly what the problem is, then why don't you just get up and do something about it, take control of your own destinies?'. It is because we have a hidden enemy which we call 'Internalised Oppression'.
5.12 The development of services under social work for the physically handicapped in seven directions as follows:

1. Services for the physically handicapped are in urgent need of development.

2. A reasonably accurate definition of the size and nature of the multiple and complex problems of physical disability will require extensive research.

3. The social service department should be responsible for social work with physically handicapped people and their families, the provision of occupational therapy, residential and day centres for them, holidays, home helps, meals on wheels, sitters-in service, help with adaptations to houses and flats.

4. Substantial development is particularly required in the services for handicapped school leavers, and more thought and experiment is required to determine the best timing and methods of giving guidance on careers to physically handicapped children and young people.

5. Co-ordination of services for physically handicapped people requires a major effort in teamwork. It is impracticable at present to specify a particular form of organization designed to achieve this everywhere.

6. The emphasis from the point of view of the social service department must be on helping the handicapped individual in the context of his family and community, and for this purpose a broadly based training and approach will be required.
7. It will be quite impossible for local authorities to run effective services for physically handicapped people without help from voluntary bodies."

At present it appears to be a matter of local organisation and resources available within each department as to which members of staff are working with the handicapped. Senior social workers, social workers and social work assistants may all be involved, as well as occupational therapists, craft instructors, craft assistants, and technical officers. Many handicapped clients never see a social worker, and occupational therapists are often 'holding' and supporting families who should be dealt with by a social worker, or other supervised team member.

Most social service departments are reluctant to attempt to identify the non-vocational needs of disabled people for fear of the expectations and increased demands.

People with handicaps need better trained workers.

"At the local level most of the organizations for the handicapped worked quite closely with the statutory services. Where they did not do so it seemed in the three towns more a result of statutory neglect than antagonism on the part of the voluntary organization within this kind of relationship the voluntary organizations were able to communicate needs, but seldom did they openly challenge the adequacy of existing provision by taking up an active pressure-group role"
5.13 The professionally trained social workers should be used:

(a) to provide personal social work help to the handicapped and their families on an individual, group or residential basis where, in addition to or arising from handicapping conditions, clients experience difficulties of a special nature (e.g. additional internal or external or environmental stress).

(b) to assess, with or without members of relevant other professions, the overall situation and specific needs of handicapped clients and their families.

(c) to provide, with or without the assistance of the remedial professionals and vocational guidance staff, care, support, advice and guidance; and to assist whenever possible in the process of rehabilitating those with handicaps.

(d) to advise, supervise and contribute to the training of social service staff on the social work aspects of services for those with handicaps and whenever possible to involve the client in the process.

(e) to plan and co-ordinate services either alone or with members of other disciplines, initiating plans based on where the client is living, include the domiciliary supportive services and take into account all relevant community aspects.

While this sounds fine in theory, in practice social workers (and especially qualified ones) have had a much more limited role.

There have been a number of studies which have discussed social work in relation to the physically handicapped -none of which are very complimentary to social work. For example Parsloe and
Stevenson (1978) found that the level and extent of social work intervention with the physically handicapped is relatively low. Occupational therapists or social work assistants in the main provide most input to the handicapped and their families. Goldberg and Warburton (1979.86) found that social work intervention both lacked depth and fared badly in comparison with work with other client groups.

5.14 The disabled people have been critical of social workers on the following dimensions which are as below:
- lack of status granted them by workers
- inadequate information
- ignorance about handicapping conditions
- lack of continuity of worker involvement
- failure to involve handicapped people in training process
- failure to recognize need for practical assistance as well as verbal advice.

While disabled people have therefore been critical of social workers, social workers have often been reluctant to throw themselves wholeheartedly into work with this particular group. There may be a number of reasons for this which may include the following. Firstly, low priority given to work with this group and hence low career prospects. Secondly, lack of understanding of potential of working with this group, for as Trieschmann (1980.XI) puts it
"Many people believe that work in the field of physical disability must be depressing because they have a vision of custodial care and of crippled lives filled with sadness and lost dreams. In actuality, rehabilitation of the physically disabled is especially rewarding because of the potential that exists in human beings in the face of stress, a potential that has seriously been underestimated."

The poor teaching about handicap on training courses may mean that workers feel inadequate or incompetent with this group. Finally, personal fears about handicap may mean that workers may be reluctant to get involved.

BUT the major criticism is that social workers, like all other professionals, have operated with inappropriate models or theories of disability, and it is in a sense perhaps fortunate that social work intervention has been so limited up to now. Before going on to consider an appropriate model of social work intervention it is necessary to discuss why the current model is inappropriate. For this purpose the inadequate model will be referred to as the 'individual model' of disability and this can be taken to include the medical model.

5.15 The Individual Model of Disability from social work perspective:

This individual model sees the problems that disabled people experience as being directly related to that disability. The major task of the professional is therefore to adjust the individual to his own particular disability. There are two aspects of this; firstly there is
physical adjustment through rehabilitation programmes designed to return the individual to as near normal a state as possible: and secondly there is psychological adjustment which helps the individual to come to terms with his physical limitations. It is possible to be critical of both of these aspects of adjustment and though I propose to concentrate on the latter, as it is of most relevance to social work, there has recently been a critique of the former also (Brechin and Liddiard 1981). In order to criticise the psychological adjustment the assumptions based on the individual model of disability, spinal cord injury will be the disabilities from which evidence will be drawn, though similar points can also be made about other disabilities.

"Patients must be allowed to come to terms, they must grieve and mourn for their lost limbs, lost abilities or lost looks and be helped to adjust their lost body-image."

5.16 A Social Model of Disability (from social work intervention):

Adjustment within the social model then, is a problem for society, not for disabled individuals. For some, however, it is not just a matter of society's willingness to adjust its patterns and expectations but to remove the social oppression which stems from this failure to adjust.

"In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. To understand this it is necessary to grasp the
distinction between the physical impairment and the social situation, called 'disability' of people with such impairment. Thus we define impairment as lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body: and disability as the disadvantage or restriction of activity caused by a set contemporary social organization which takes no or little amount of people who have physical impairments and thus excludes them in the mainstream of social activities. Physical disability is therefore a particular form of social oppression."

"The physically impaired person who vitally needs open access to specialist information frequently finds mystification instead of mater-of-factness; complexity instead of clarity; secrecy instead of salience or ignorance where there should be knowledge. These facts are deeply embedded in our social relations of social workers."

"The world of work (buildings, plant, machinery, processes and jobs, practices, rules, even social hierarchies) is geared to able-bodied people, with the objective of maximising profits. The growth of large-scale industry has isolated and excluded disabled people from the processes of production, in a society which is work centred"

This is crucial in present day society where the individual is judged upon what he does and appropriate social status thereby accorded. Hence it is not difficult to see that the dominant social perception of disabled people as dependent stems not from their inability to work because of their physical limitations but because of the way in which production is organised.
5.17 The Social Model and its Implications for Social Work:

The social work profession has failed to give sustained consideration to physical disability either in terms of theory or practice and evidence for this view can be sustained by comparing the number of books that have been written about the subject with say, the number written about children. There have been no books solely devoted to the topic of social work and physical disability at all, and while this is only one example of social work's lack of sustained interest, it is nonetheless a pretty powerful one when one considers that in recent years social workers have been very keen to write about a whole range of other topics from sex therapy to community work, from children and families to death and dying, from juvenile delinquents to the mentally ill and so on.

There has been this lack of sustained interest for social work has adopted the wrong model of disability any case. In attempting to outline a social model of disability before going on to now discuss some of the implications of this for social work practice, this goes against the current conventional wisdom which suggests the theory should be practice based rather than the other way round.

If consideration is given to the three main social work methods, it is nonetheless possible to make a number of statements relevant to practice. The switch from an individual to a social model of disability does not signify the death of casework for example. Rather it sees casework as one of a range of options for skilled intervention. It does not either deny that some people may grieve or mourn for their lost able-body but suggests that such a view should not
dominate the social worker's assessment of what the problem may be.

Similarly groupwork need not focus solely on the need to create a therapeutic environment in which individuals or families can come to terms with disability. Groups can also be used to pool information on particular benefits, knowledge on where and how to get particular services and even on a self-help basis to give individuals the confidence to assert that their disability does not stem from their physical impairments but from the way society often excludes them from everyday life. In addition the group can be used as the major means of giving disabled people back responsibility for their own lives.

The potential for intervention using community work methods is also exciting. There have already been a number of local access groups which focus on the way the physical environment disables people.

A few community workers can organised 'forum' meetings of all organizations of and for disabled people in a particular locality and these have prove useful in confronting local authorities about cut-backs, in ensuring that the needs of disabled people are taken into account in pedestrianisation schemes etc. And if the definition of 'community' is expanded beyond its strictly geographical meaning to take in the idea of moral communities (Abrams 1978) or psychic communities (Inkeles 1964) then it is possible to see community work methods being used in disability organizations.
In suggesting that theory should inform practice with regard to physical disability rather than vice versa a number of developments in social work practice compatible with the social model of disability have obviously been ignored. There have undoubtedly been initiatives by individual social workers or departments which are not based on the individual but social work as a profession has not given systematic attention to developing a theoretical perspective on disability.

5.18 The Disabled and Counselling:

In considering counselling approaches with the families of physically disabled children and adolescents, we are forced to rely mostly upon our own and others clinical views and observations. It is hoped that the discussion may stimulate further inquiry into promising ways to assist this challenging physically challenged children.

On first assumption is that physical disability occurs in a developmental context. There is no evidence to suggest that children with disabilities meet stages or crises which are fundamentally different from those encountered by nondisabled children, although there may be reliable differences of degree or timing. In fact it has been noted that disabled children frequently lag behind their nondisabled peers in affective or social development, but this does not lessen the importance of taking the total developmental status of the child into account in the clinical situation.
As with nondisabled children, the social work in the early years involves the parents centrally. There is near universal agreement that parental behaviors and attitudes affect the child's present and future methods of coping with the disability.

It is essential to treat the relationship between the child and his parents and the attitude of the latter towards the disability at the time of its occurrence, in order that the personality may not be crippled, as it is to treat the disease itself. Such a crippling of the personality is probably a more serious menace to the future happiness of the individual than a very marked physical disability.

Parents of disabled children face a variety of tasks not demanded of other parents. They are expected, for example (a) to care for the greater physical needs of the child, yet not overprotect; (b) to allow themselves to grieve about the disability without rejecting the child; (c) to treat the child as normal, yet not deny the disability; (d) to exert greater effort, often for less reward, than with other children; and (e) adjust expectations such that joy in the child's growth can be experienced even in the face of diminishing hopes. Not surprisingly, parents have been found to be imperfect at accomplishing these delicate adjustments; in addition, professionals have not always proven themselves useful in helping parents through the difficult first years of raising a disabled child.

Mothers anticipated little gratification from interacting with their children, found them unappealing and often reported having no time to play with them. Another negative factor was the shame felt at having a disabled child and the guilt at having such feelings,
which seemed to lead to a reticence to discuss concern openly with professional. According to researcher, the professional themselves tended to reinforce the preoccupation with the child’s physical needs. Mothers reported the professionals contacted within the first few months of the child’s life failed to provide either emotional support or practical suggestions which would enable them to face problems with a reasonably firm sense of direction.

Parents need reassurance that their efforts and attitudes makes a difference in the child’s life and that they can have a rewarding relationship with even a severely disabled child. In particular, during the first few months of the child’s life, families need psychological support as much as they need other practical help.

Unfortunately, we sometimes cultivate overdependence by teaching the children that their every move needs to be scrutinized and by encouraging parents to involve us in every decision concerning the child. In this sense we are in danger of reinforcing the idea that disabled children are assumed hopelessly deviant until proven otherwise.

As time goes by, the counselor’s focus being to move toward a more primary involvement with the disabled client. Many school-age children are articulate and psychologically minded enough to express a need for help coping with social situations. Others are anxious to discuss future educational or vocational plans, family problems, feelings of loneliness, etc. Often the socialworks who has gained the child’s trust can act as a mediator in decisions calling for
parent-child negotiation. Although counselling is not qualitatively different for disabled than for nondisabled children. The social workers must be sensitive to the special life situation of the disabled child, which may have resulted in a prolonged period of dependence on parents and to deficits in self-evaluative ability, social skills, and social awareness. A normally intelligent child as young as eight or nine years can benefit from direct intervention in these areas.

Finally, the counselor or social worker can work with the client on improving social skills and awareness. The counselor can render a valuable service in providing the disabled children with honest assessments of his/her social behaviour.
References:


• Albrecht, G. (Ed) 1976 The Sociology of Physical Disability and Rehabilitation. Un. of Pittsburgh Press
• Carroll, T. J. 1961 Blindness, What it is, What it does and How to Live with it. Little Brown, Boston and Toronto.
• CCETSW 1974 People with handicaps need better trained workers
• Clark, F. le Gros 1961 Blinded in War, A Model for the Welfare of all Handicapped People. Priory Press
• Cypher, J. (Ed) 1979 Seebohm Across Three Decades. BASW Publications
• Dartington, T., Miller, E.J. & Gwynne, G. V. 1981 A Life Together, Tavistock Publications
• Davis, K. & Woodward, J. Dial UK: Development of the National Association of Disablement & Advice Services
- Harris, A. with Cox, E. and Smith, C.R.W. 1971 *Handicapped and Impaired in Great Britain* HMSO, London
- Hatch, S. 1980 *Outside the State*, Croom Helm
- Inkeles, A. 1964 *What is Sociology?* Prentice Hall
- Kuhn, T. 1962 *The Structure of Scientific Revolutions* University of Chicago Press Ltd.
- Parsloe & Stevenson 1978 *Social Services Teams: The Practitioners View* HMSO
- Phelan, P. 1979 *Social Services for Physically Handicapped People*, in Seebohm Across Three Decades
- Seebohm Report 1968 Report of the Committee on Local Authority and Allied Personal Social Services Cmnd. 3703 HMSO
- UPIAS 1976 Fundamental Principles of Disability


• Glick, S. Emotional problems of 200 cerebral palsied adults. Cerebral Palsy Review, 1953, 14, 3-5.