Fall 2019

Intersections Between Health and Disability: A Case Study at Disha Centre, Jaipur, Rajasthan

Finnian Brokaw
SIT Study Abroad

Recommended Citation

Brokaw, Finnian, "Intersections Between Health and Disability: A Case Study at Disha Centre, Jaipur, Rajasthan" (2019). *Independent Study Project (ISP) Collection*. 3209.
https://digitalcollections.sit.edu/isp_collection/3209

INTERSECTIONS BETWEEN HEALTH AND DISABILITY: A CASE STUDY AT DISHA CENTRE, JAIPUR, RAJASTHAN

Finnian Brokaw
Academic Director: Dr. Azim Khan
ISP Advisor: Pooja Aggarwal: Disha- A Resource Centre for the Disabled
SIT Study Abroad
India: Public Health, Gender, and Community Action
Fall 2019

Table of Contents

Abstract

This study investigated intersections between health and disability by asking the question: how do community perceptions of disability at Disha: A Resource Centre for the Disabled in Jaipur, India relate to health and quality of life for a person with multiple disabilities? This study utilized a case study methodology. The researcher took qualitative interviews from six respondents in the immediate educational and familial support network of a 27-year-old man with multiple disabilities. An interview based, qualitative methodology was important for investigating the complexity of perceptions of multiple disabilities and health as intersecting identities. The responses were analyzed and reflected upon in this paper through the cross-cultural lens of the researcher. Upon analyses, many connections were found between the concepts of health and disability, particularly as they related to the social advancement of people with disabilities.

Acknowledgements

Gratitude and appreciation is extended to the Azim Ji, Abid Ji, Goutam Ji, Archna Ji, Bhavna Ji, Chris Ji, and the whole team at SIT for their support in preparing for and undertaking this project. Additionally, to Pooja Ma'am, Rainu Ma'am, Shivani Ma'am, Anil Sir, Dr. Lalit Kishore, Neha Ma'am, and everyone at Disha for hosting and supporting this study. None of this would have been possible without these people and organizations. The opportunity to come to India would not have been possible without the support of the researcher's friends and family, to whom she is also deeply grateful.

Glossary

ASD: Autism Spectrum Disorder

AYUSH: Ayurveda, Yoga, Unani, Siddha, and Homeopathy. These are traditional health practices acknowledged by the Indian government.

CP: Cerebral Palsy

Dalit: A low Indian caste, formally known as the “untouchable” caste.

Didi: Hindi word for “sister” or “older sister.”

DRM: Disability Rights Movement

ID: Intellectual Disability. The term “Mental Retardation” is no longer in use. The correct terminology to use instead is “Intellectual Disability.”

PWD: “Person/People with Disabilities.” This paper uses both person first (people with disabilities) and identity first (disabled person) language to describe disability. People with disabilities should always choose how they wish to be referred to and spoken about.

WHO: World Health Organization

Introduction

Objectives/motivations

Disability as an identity is discriminated against worldwide. For example, institutional segregation of people with disabilities is part of a dark history of discrimination in certain countries and remains as a reality in others. Particularly in a Western context, institutional and structural ableism is deeply ingrained ideologically and in practice. Even as discrimination is becoming more recognized, the identity of disability remains under-acknowledged within social justice movements and disabled people are not adequately supported societally. While acknowledging a lack of equitable access within academia itself, this study attempted to bring more attention to the identity of disability by asking the question: how do community perceptions of disability at Disha-A Resource Centre for the Disabled in Jaipur, India relate to health and quality of life for a person with multiple disabilities?

In her article "Disability rights movement in India: politics and practice," Nilika Mehrotra synthesizes the uniqueness of disability as identity. "Disability cuts across race, caste, and class division" (Mehrotra, 2011). Any person can have a disability or acquire a disability in addition to the other aspects of identity. No other social identity or grouping is "immune" to experiencing disability as it is thought of today. However, disabled people are not always allowed a full range of personhood. It is generally assumed that the experience of their disability can only have overwhelming yet polarized effect on their lives, rather than being just one aspect of a complete human existence. "There is an urgent need for researchers to recognize disability as an important marker of social inequality" (Mehrotra, 2011).

Mehrotra (2011) notes that even in early political and social activism for PWD in India, people with intellectual, development, or mental disabilities were largely left out of the discourse advancing social change. She explained how physical disabilities were the main focus of disability rights movements in India were until the 1990s, while mental and intellectual disabilities were seen as having their own “special issues” (Mehrotra, 2011). Learning this motivated the researcher to pursue a case study focused on intellectual or developmental disability at Disha in Jaipur. Upon arriving at Disha, the researcher learned that the organization specializes in multiple disabilities. This context provides an even more complex look at identity in that many of the students at Disha have both intellectual and physical disabilities, as does the subject of this case study. While intellectual disabilities may have been overlooked in social movements until more recently, physical disability has a long history of marginalization in India. Indian religious and spiritual traditions viewed physical disability as being punishment for the past sins of the disabled person or their family members. In the present study, investigating these multiple facets of disability identity proved to be complex in terms of interaction with the concepts of health.

This research aimed to investigate disability as a social determinant of health and the relationship between the concepts of health and disability in the Indian context. The intersecting aspects of identity between health and disability are fascinating, in terms of how the healthy lives of people with disabilities in India can be better supported societally in a way that also contradicts the discrimination that they face under the bounds of ableism.

Disability models

To contextualize this qualitative research regarding concepts of disability and health, information about disability models is provided here. Models are tools used within social sciences to describe identities as social phenomenon within society.

An overview of a few models of disability described by Disability World news platform:

Medical

The medical model focuses on biological health factors or physical trauma as being associated with disability. As it interacts with the concept of health, supports or interventions that the disabled person might seek out are viewed as functioning to "cure" or "partially cure" the person's condition, which is named as disability.

Biomedical

The biomedical model of disability is the most prominent model in Western ideology. It focuses exclusively on biological factors associated with disability. Its scope does not go beyond the impairment or limitation that the individual experiences. It is closely associated with the medical model but has more focuses than simply "curing" disability. Interventions can be conceptualized as support rather than a cure within this model.

Expert/Professional

Premised by the medical model, the expert model acknowledges that prevalent responses to the phenomenon of disability have been within a power dynamic of experts or professionals using the medical models to identify limitations and direct a course of action based in the medical models. The expert model acknowledges that this dynamic is not always empowering to disabled people themselves.

Empowering

In contrast to the expert model, the empowering model describes empowerment of a disabled person and their family to choose the needed supports/services/interactions that they will seek out, rather than the professional acting as the one who knows best and controls these outcomes.

Charity/Tragedy

Within the charity model, disability is viewed as a tragedy which deserves pity and acts of charity. It is not empowering to people with disabilities as it reinforces conceptions of helplessness and inability.

Religious/Moral

The religious model is the oldest model of disability. Within premodern religious conception of morality, the disabled person and their family were viewed as morally responsible for the experience of disability. Disability may be seen as a punishment from God or a higher power for sin or moral divergence. This model has bred discrimination against disability as it insinuates that the person or family committed some morally questionable act, and that they alone are to blame for the tragedy of disability. This model is observed in many traditions such as the Judeo-Christian tradition. It is also seen in the Indian spiritual context.

Social

The social model views disability as a socially constructed phenomenon. While it acknowledges differences and diversity within individuals and the human experience, it views the marginalization of people with disabilities as a lack of social and structural implementation to support disabled identities and lives. In this way, social factors, not inherent factors, are disabling. It views the problems associated with disability on a societal level and calls for necessary changes to be implemented in order to fully integrate people with disabilities into society at large.

Identity /Affirmation

The affirmation model of disability is closely related to the social model. It operates on the premise of the social model, viewing disability as a socially constructed societal problem. It goes beyond the social model in that it reclaims the identity of disability. This reclamation celebrates disability as a positive identity. Within deeply oppressive ableist structures, this model is revolutionary.

Minority

Another model premised by the social model, the minority model acknowledges all the ways that people with disabilities have been discriminated against, making them one of the world's largest minorities at around 15% of the world population (WHO, 2011).

Diversity

The diversity model acknowledges individual challenges within the social model. It specifies that blanket social changes could not be supportive to all identities and stresses a need to consider individual differences.

Spectrum

The spectrum model places all human functioning onto a spectrum and supports the idea that the identity of disability does not necessarily mean a reduced or lesser ability to function and contribute. Rather, it states that all people have varying abilities in different areas (Disability World, 2019).

History of disability in India

Mehrotra notes which models have traditionally been endorsed by the Indian government. "The attitude of the Indian state was clearly informed by the medical, charity, and religious models where PWD were construed as dependents and beneficiaries of state provisions" (Mehrotra, 2011). First, addressing the religious model: the religious model is in reference specifically to the theory of karma, conceptualizing disability as punishment for past sin. Anita Ghai, a disabled activist and author, has written extensively about her experiences with disability and health. Ghai is a polio survivor who has used a wheelchair for most all of her life. In her adulthood, she also experienced rheumatic heart disease and breast cancer. Ghai (2015) writes about religious violence incited against people with disabilities. As a child, Ghai saw people with physical disabilities shackled to a temple in chains. She was worried that the guards at the temple were going to shackle her, too. Second, the impetus for the charity model arose largely during

British colonization. Charity was used as a guise and mechanism of control by the British in colonial India. However, these “charitable” efforts ignored Indian indigenous beliefs and desires. Disability was largely ignored under the charity missionary efforts of the British (Mehrotra, 2011). The legitimacy and intentions of charitable efforts are dubious under the premise of colonization in the first place. However, in post-colonial India, a lasting sector of NGOs (non-governmental organizations) exists. Third, structures grounded in the medical model arose from the Indian state. The National Council for Handicap Welfare was established in post-colonial India to promote and implement policy serving people with disabilities. Most of this work was grounded in the medical model with an emphasis on curing. Its function could also be described by the expert model as professionals in this work held more social power than people with disabilities themselves.

Mehrotra herself conceptualizes disability as more grounded in the social model: “In India and much of south Asia, disability is largely seen as a product of cultural impediments like poverty, lack of development, illiteracy, unemployment and caste, class and gender barriers. PWDs are marginalized in education, employment, mobility and other significant life areas” (Mehrotra, 2011). More control over social movements was rightfully claimed by PWD in the 1980s (Mehrotra, 2011). Developmental disabilities were overlooked until the 1990s. In 1999, the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act was passed. It was enacted specifically for people with developmental and intellectual disabilities (Mehrotra, 2011). Globally, disability does not hold space as do other major social movements. “It is important to underscore the fact that disability has not been considered as a knowledge-base in the social sciences, arts and humanities in the same way that caste, gender, race, sexuality, and sexual orientation have established their broad significance” (Ghai, 2015). Without ranking experiences of inequality, disability as an identity has not established broad social justice attention in the ways that say, gender, has. For example, Ghai describes the indignation surrounding female feticide in India. Ghai contrasts this with a lack of a criminal label or even general social rejection of similar practices committed against disabled infants. The Persons with Disabilities (Equal Opportunities, Protection of Rights, and Full Participation) Act of 1995 was passed largely due to international pressure (Mehrotra, 2011). The Act emphasized protection of equal opportunity, and in 1995 acknowledged seven disabilities. It was expanded to include 21 disabilities in 2016. The Right to Free and Compulsory Education Act of 2009 promotes inclusion, mandating special education in all schools in India. However, there has been a lack of implementation to support actual inclusion, such as government schools limiting the number of students with disabilities that they accept (Teacher, personal communication). Mehrotra also notes that a lack of implementation of physical accessibility and opportunities for gainful employment have created massive barriers for people with disabilities in India.

Mehrotra details how various NGOs and federal initiatives such as the National Centre for Promotion of Employment for Disabled People have been working towards advancement in “social policy, identity, and citizenship” (Mehrotra, 2011) for people with disabilities. However, she goes on to cite Ghai to point out that cultural factors are still not considered in certain social service initiatives such as community-based rehabilitation centers. Most of the progress being made in regard to implementation of equitable structures for people with disabilities is occurring in Indian urban areas. Ghai writes how community-based rehabilitation centers have not been able to create any significant social change for people with disabilities in the rural Indian context.

With about 66% of India's 1.2 billion population living in rural areas at the 2011 census, this is overlooking a massive group of people (Chandramouli, 2011).

Literature regarding beliefs surrounding disability in India

Beyond models of disability, research on Indian peoples' perceptions of disability has shown that varying general beliefs about disability exist culturally. Beliefs surrounding cause of disability are diverse in India. In their study from Velore, South India, Edwardraj, Mumtaj, Prasad, Kuruvilla, and Jacob used a qualitative interview method with focus groups of teachers and mothers to explore perceptions of intellectual disability. Upon analysis, they found that the emerging themes for etiology (or cause) of ID were medical, followed by environmental, physiological and genetic-ranked most to least common. This alone confirms that various beliefs and attitudes regarding models of disability are present in Velore.

Kishore J., Gupta, Jiloha and Bantman used a cross-sectional method to assess myths and perceptions about mental disorders and health seeking behavior in Delhi, India. The researchers used a sample of 436 people from the Delhi area: both within the city, and in one rural area outside of Delhi. There sample consisted of both medical professionals and general population in hopes to be able to compare data between these two groups. The questionnaire gathered data on causes and treatments of mental health disorders, as well as on myths, cultural and religious belief systems. Kishore J. et al's results displayed various beliefs about cause of mental disorders in their sample:

Beliefs of causes of mental disorders found by Kishore J., et al:

Beliefs of cause	All Respondents	Medical professionals	Rural subjects
Higher education and IQ	33.3%		
Less sexual desire	23.6%	6.6%	
Loss of seminal or vaginal secretion		1.3%	34.7%
Punishment from God for past sins			39.4%
Air pollution		5.3%	52%

Additionally, there were responses detailing the influence that ghosts, witches, and devils could have on mental health conditions. Finally, biological and genetic reasons like an imbalance in neurotransmitters were also mentioned by respondents.

Disability & Health: Intersecting identities

Mehrotra notes that within the medical model, disability is viewed as a diseased state. Mehrotra goes on to assert that in the Indian context, the biomedical medical model still places emphasis on “curing” or “fixing” disability to make people with disabilities “normal” (Mehrotra, 2011). Considering the context of a long history of discrimination and deeply rooted global ableism, it is worth investigating which framings and perceptions of disability are productive to supporting holistic health and quality of life. Within this study, health was conceptualized more broadly. As an overall concept, “health” in this study related to social determinants of health and overall quality of life. The focus within biomedical models on “curing” disability (as Mehrotra mentions is the case in India), can be grounded in ableism. The negative connotations of needing to cure or change disability can be extremely devaluing to an identity which is a part of human diversity and should be celebrated. Ghai has valuable insights about this point: “I hope to establish that disabled people are fully human and do not need a cure from disability. Instead, they need empathy and support to be able to lead their lives” (2015). Ghai renounces the curative ideologies present in India. There is clearly progress to made towards supporting the health of people with disabilities while simultaneously combating ableist discrimination against them.

Curative ideologies were identified in the Indian context in Edwardraj et al's research. A theme supporting the idea that mothers hoped that children would be "alright" when they grew up emerged in Edwardraj et al study. This is in accordance with the idea that intellectual disability is something that needs to be cured. Other narratives along this thread included: distrust of social service intervention because they do not offer a "complete cure," and a hope that religious or spiritual involvement could offer a cure. This hope for a "complete" cure or change is a testimony that disability is profoundly stigmatized against in India.

The identification of these narratives in Edwardraj et al's study further demonstrate Indian perspectives that are rooted in stigma. Teachers interviewed blamed mothers as the cause for their children's disability. Mothers were blamed for "causing" disability in the context of prenatal etiology of disability, as well as through poor parenting. Themes of increased stress in parenting a child with ID were recorded from the mothers in the focus groups. A correlation between increased stress and mothers of lower socioeconomic status was noted. A lack of support from the greater community in raising their child was articulated by the mothers. Blame placed on mothers for their child's disability was also identified in the present study, and is further discussed in the findings section.

In Ghai's "Rethinking Disability in India" (2015), she contextualizes her experiences and identity of being a disabled woman in India in an intersectional way, making salient points about disability, gender and health. She identifies a connection between the religious and biomedical models in the context of secularism. "With advances in the 'scientific' understanding of the causes of impairment, the magic band shifted from religion, charity and human rights to medical science’s ability to rehabilitate and cure the disabled” (Ghai, 2015). Ghai writes about how the curative attitude in Indian society evaluates disability on the extent to which it is able to be normalized, and this is how people with disabilities are made to fit in. Ghai implies that it is not true inclusion or acceptance when normalization is valued over the diversity of the disabled identity. In “Rethinking Disability in India,” she describes her experiences with health and disability. Her experiences with polio, rheumatic heart disease, and breast cancer created multiple aspects to her disabled identity. Her heart surgery experiences became physically “invisible” once healed. However, a mastectomy as a result of breast cancer became another physical impairment. Ghai writes:

> *Just as I was beginning to find peace with the challenges of disability, another shock came along in the form of a rheumatic heart disease, followed over the years by several medical episodes that have not just challenged my own being but also raised many questions about the power and status of the medical profession as well as health care for the disabled…my whole experience left me with questions about the power and status of the medical profession and also about the social and political basis of any illness. I have come to believe that the position of medical professionals is itself a result of the socially institutionalized power to understand illness and consequent treatment, and needs to be interrogated* (2015).

She gracefully confronts the reality of her human struggle, while also advocating for social change regarding disability in India. Intersecting identities of disability and health are also related to the subject of the present study.

Methods:

In this study, research was conducted at Disha: A Resource Center for the Disabled. Disha is an NGO which runs a special school, along with various services such as therapeutic services like occupational therapy. A case study methodology was employed to collect the majority of the data. The subject of the case study was a student at Disha. The subject was a 27-year-old male with multiple disabilities, both physical and intellectual. As per the ethics of the study, the subject himself was not interviewed. Six people in the subject's support network at Disha were interviewed using a semi-structured interview methodology based on a uniform interview questionnaire. The individuals in this support network within Disha included: mother/teacher, former teacher, current classroom teacher, caretaker, communications administrator, and administrator. The subject's mother was working as a teacher at Disha. Interviews were conducted over a period of two weeks. Verbal consent from respondents was obtained before interviews were conducted. The questionnaire included background information seeking questions and open-ended questions regarding perceptions of the concepts of disability and health. The scale of the questions ranged from focusing on disability in India in general, to focusing on Disha, to focusing on the subject alone. Qualitative data was collected based on responses to the interviews. Voice recordings of the interviews were transcribed into a typed format. This data was analyzed by the researcher in a reflective way. Interview transcripts were reflected upon and emergent themes (discussed in results section) were identified by the researcher. Respondent's names are not used in the study to maintain confidentiality.

Observational methodology was also employed during time spent at Disha when interviews were not being conducted. While interviews only lasted two weeks, observations were taken over the period of one month. The researcher observed special school classes in 5th standard grade as well as in the vocational class program for students aged 18-24. The vocational class program was the subject's classroom. The researcher also observed occupational therapy, celebrations of holidays, and Disha's disability advocacy campaign at surrounding mainstream schools. During the time spent in the vocational classroom, the researcher recorded handwritten observations of the subject and how he spends his days at Disha. The time spent in other classrooms and doing other activities was used as observation of Disha in general as the setting of the case study.

Findings: Disability and Health

Background on the subject

The subject was a 27-year-old male with cerebral palsy and intellectual/developmental disability. His intellectual disability was described by his mother as multiple neurological disabilities. He had an Autism Spectrum Disorder diagnosis, but this was described by his mother as “99% cured.” Throughout her pregnancy with him, his mother had various complications. She described bleeding throughout the pregnancy. When he was born, he did not cry. He has had meningitis multiple times throughout his life, mostly as a baby and a young child. He has cerebral palsy and walks keeping his right foot turned “upside” (Mother, personal communication). At 7 years old, he fractured his right femur, which his mother believes could be due to his unique gait and the pressure on his right foot. His mother described significant strides throughout his life in social manners, fine and gross motor skills, daily routine, and ability to recognize family members and people in his life. Along with his ASD being “99% cured,” he has made lots of physical progress with his CP throughout his life. His mother described his unique developmental process: he did not walk until he was seven years old. Today, his mother said that he can move at a fast walk. He was described by multiple respondents as having no behavioral problems. He has a unique way of communicating. He is partially verbal and has specific words he can say. Many are in relation to family members and friends, such as “daddy” or “*didi*.” He loves holding and looking at magazines. Multiple respondents described him as a good, happy boy.

Disability & Health: the subject

In an interview with his mother, discussions of the subject’s story and his disabilities were health focused. Formalities of his disability diagnosis process were not explicitly explained by his mother. His mother shared details about his general health and his health as it related to or affected his disabilities. His mother described her own pregnancy complications, his absence of first cry, his meningitis and other illnesses such as malaria, and his femur breaking when the researcher asked her about his disabilities. In this way, his health and his disabilities were interlinked in the background story about his life that his mother told to the researcher. Health and disability are literally linked in the subject’s case because of his health complications which were causal factors in his etiology of disability. In this way, the two concepts are directly related. Beyond this connection, the concepts continue to overlap throughout findings of respondent’s perceptions of disability.

When the subject’s mother described some of his limitations, she described the progress he had made as he grew. He had learned routines and social manners for eating. She described how he recently had sat at a social gathering for four hours without yelling or moving around, which she was excited about in terms of his social progress. His ASD diagnosis, alternatively, was framed as being “99% cured.” All of these limitations which are conceptualized as a level of functioning are related to the subject completing daily tasks as we all do and being a part of a community as we all want to be. However, some are framed as overall progress, while another was framed as “being cured.” What is implied about disability when progress or change is described as a cure?

The subject’s mother described the ways that the subject’s experience of ASD diagnosis had shifted. She explained how they worked on three main points regarding the diagnosis: eye contact, socialization, and speech. In these areas, the subject had made progress such that his autism diagnosis is not used in current diagnostic descriptions any longer. His mother mentioned that his expression is limited, but that his understanding is very healthy. Health language was used about his past experiences with autism. The etiology of his disabilities was health based. However, his other current disabilities were framed by his mother as limitations. This language was not as health based.

The subject's mother described various therapies that the subject has participated in throughout his lifetime. She said he received so many therapies that most all of his time during the developmental period in his life was spent in therapy. "I worked- a lot of work- with him. Physical exercises, as well as acupressure, acupuncture, ayurvedic medicines, massage, massage therapy. I used to apply a lot of massage therapy. As well as rice milk, oil massage, masala massage, sheep milk massage. I have given him camel milk also" (Mother, personal communication). She described these as having the purpose of making the subject's body feel better in general. She also described how he would stand in mud daily. The occupational therapist at Disha later described how this is a tactile therapy for standing on different surfaces. Prior to this clarification, the researcher had drawn a parallel between this mud therapy and Ghai's description of religious therapies that she received throughout her life:

> *My first recollection is when, as a child, I was buried neck-deep in such a 'curative' mud at the tender age of eight during a solar eclipse. I clearly recollected how my mother sat next to me reading from the Hindu scripture the Bhagavad Gita, oblivious of my discomfort and anguish with throngs of people watching this peculiar state of affairs. My trauma remained suppressed for a long time and it was only in later years through psychoanalysis that some of the traumatic memories resurfaced. My story finds resonance in the lives of many other children. The stories of belief in miracle cures were seen again when the longest solar eclipse of this century occurred on 22 July 2009* (2015).

While the subject's experience of mud therapy was not religious, the therapies were included within a holistic view of health. Inclusion of AYUSH and traditional health practices within disability therapies shows a holistic perspective of health. Disha’s methodology of support for students was educational, and mainly within the biomedical model of disability. Disha’s education style was described as teaching the children how they needed to be taught based on their diagnoses (Administrator, personal communication). However, the children at Disha did receive Pranic healing, a modern form of energy healing meant to unblock energy associated with the student’s limitations. The Pranic healers would ask the teachers which areas they thought that the energy healing should focus on, and then conduct the healing on the students. For example, one student received Pranic energy healing to help support her body in gaining the fine motor skills necessary for her to write with a pencil. Additionally, the research team at Disha led by Dr. Lalit Kishore conducted a focus-group based study about how to integrate Spiritual Intelligence into classroom curriculum at Disha (Kishore L.). From an American perspective, traditional healing practices may be viewed as separate from mainstream healthcare practices. However, AYUSH and other traditional healing methods are very integrated into the Indian healthcare system and into Indian cultural concepts of health.

Disability & Health: General perceptions and findings

Key emerging themes based on data:

Interview Question	Themes identified / endorsed
How do you think disability is caused?	Congenital, prenatal/neonatal complications, accidents, disease, lack of awareness/lifestyle (mainly mothers specified as being at fault for unhealthy lifestyles causing disability).
What does the word “disability” mean to you?	Social & spectrum models endorsed; some details consistent with biomedical model.
Has your perspective on disability changed over time?	All respondents mentioned a lack of awareness about disability before choosing to work at Disha. Two respondents mentioned fears or phobias surrounding disability before working at Disha.
What are some of the student’s strengths?	Five respondents described institutional strengths of Disha, attributing the student’s personal strengths to Disha’s support of them. Four subjects eventually acknowledged the individual student’s strengths in their answers after first acknowledging Disha.

What is your relationship with the students like?	Four respondents reported having familial like relationships with the students and feeling like the students were their own children. Three respondents said they prefer spending time at Disha to spending time at home. All respondents reported positive, meaningful relationships with the students.
Do you think that the subject is healthy?	All respondents felt that the subject is currently healthy. Three respondents included disability as a measure of health, saying disability means inherent unhealthiness, or including changes to limitations as health progress. On the contrary, one respondent dis-equated disability with health. One respondent included the support of family within the concept of health.
What do you think is the single most important change that must be made to help support people with disabilities in India?	All respondents unanimously identified a need for greater awareness/sensitivity towards disability in India, or a need for structural change of implementation of physical and social support systems. Social change, be it structural or conceptual, was identified as the single most important change that must be made to better support people with disabilities unanimously by respondents.

An interaction between the concepts of disability and health were identified in the data collected regarding beliefs about the causation of disability. Different beliefs about the root cause of disability were endorsed by respondents. All respondents except for one listed more than one root cause of disability. Congenital was the prevailing answer, as five respondents included it in their answer. Other causes included: accidents/trauma, prenatal or neonatal complications, disease, lack of awareness, and lifestyle. All of these causes except for one are grounded firmly in the biomedical model. The answers about lifestyle were largely grounded in the biomedical model, as they were descriptions of lifestyle effects on bodily health, such as drinking alcohol or smoking. Some respondents had beliefs that people of lower socioeconomic status, lower caste, or people living in rural areas were more likely to lead unhealthy lifestyles relating to root cause of disability. Two respondents specifically mentioned women of lower caste or women who lived in rural areas as women who were likely to drink or smoke. Answers about lifestyle also included other holistic health factors, such as spirituality as a measure of a healthy lifestyle.

(These references to spirituality were in a general sense. No respondents endorsed theory of karma beliefs regarding cause of disability being related to past sin.) Four respondents who spoke about lifestyle in their answers only spoke about the mother's lifestyle. In this way, the cause of disability seemed to be inherently linked to the mother.

This is a phenomenon that the mother of the subject mentioned explicitly: mothers being blamed for their child's disability. Particularly in regard to the perceived health of the mother's lifestyle during pregnancy. (She also mentioned mothers being blamed for other aspects of their children's identities, such as the sex of their baby. There is a misogynistic preference for male children in India.) The mother of the subject was the one respondent to include men in her answer regarding lifestyle as it is perceived to be connected to disability. "I don't know about other countries, but India is man dominated. Though I have read about other countries also, not only India in other countries also it happens: female suffers hypertension" (Mother, personal communication). Here, the mother of the subject attributes hypertension that women suffer to their societal role in a patriarchal country like India. She went on to explain hypertension during pregnancy as another causative factor in disability. She spoke about her hope that all couples looking to get pregnant could receive social and genetic counseling as a preventative factor against disability and to ensure the general health of the child. Within this statement, too, she specified that it is important for both the woman and the man within a heteronormative couple to receive this counseling.

Additionally, an administrator was the only respondent who acknowledged that lifestyle might not always be a factor in causing disability. She acknowledged that disability can occur without an unhealthy lifestyle being a causal factor. While other respondents had framed lifestyle as a personal choice, two respondents spoke about lack of access to social services to support health and awareness for women in rural areas or women of lower caste or class. Lack of access to support was the disability-causing factor identified that is most closely related to the social model of disability, as it acknowledges that lack of social support can be a disabling factor in a disabled person's life.

When asked if the subject was healthy, the respondents answered in a variety of ways. Many of the answers used the concept of health interchangeably with presence of disability. Perhaps in this particular case, where health and disability were so interlinked in his story of disability etiology, this makes sense. However, his current state and his disabilities were also considered in this question about health. His mother described him as 99% healthy today. The researcher interpreted this answer as being in a general sense, regarding both his absence of disease, and his improvements in aspects of his disabilities. An administrator also responded to this question with an explicit example of change in social behavior. She said that the subject stands during the daily prayer nowadays, something that he had not done in the past. In this way, his social progression was equated with improvements in his overall health. The subject's limitations were described in the answer to this question as lost "potential" by an administrator. This lack of "progress" was viewed as unhealthy.

Another teacher answered the question in a general way, responding about all the students rather than just the subject. This teacher made a statement that all the students attending a special school could never be fully healthy. "(They are) not healthy… not to come to a special school" (Teacher, personal communication). In this answer, the teacher seemed to be referencing disability as a health issue of its own. She went on to describe how the children are also susceptible to general sicknesses like seasonal colds. In contrast, an administrator responded by saying that the children with disabilities at Disha seem to be more prone to small infections, but that besides this they are “just like every other person.” In this way, the administrator intentionally did not associate disability with an idea of being unhealthy. However, it is unclear why the administrator also felt that the children were more prone to typical infections and illnesses. These two differing answers of the teacher and the administrator are in conflict with one another pertaining concepts of disability and health. The teacher confounded disability with health, while the administrator intentionally separated the two concepts. The administrator and the teacher were in agreement with one another pertaining to Disha students being susceptible to the common cold. It is unclear why these two respondents’ beliefs were different on a conceptual level, but in agreement regarding the specific example of their students being more susceptible to typical illness.

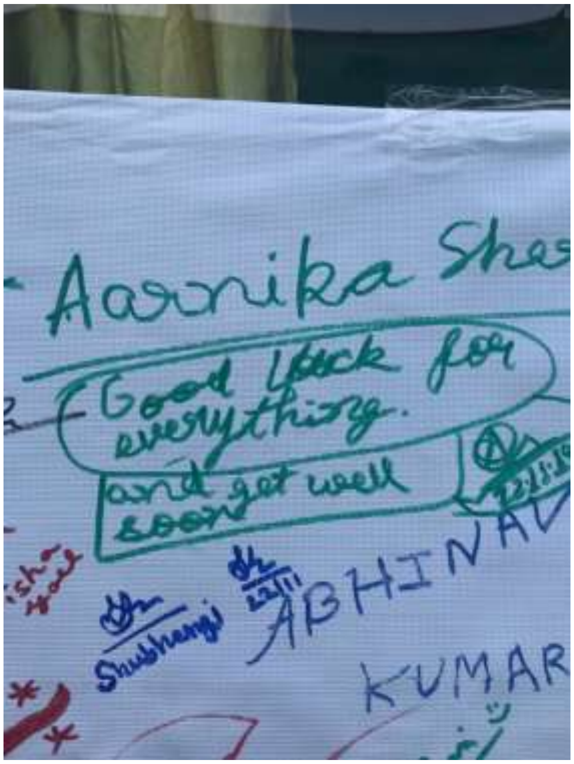
The support of general health practices for the children at Disha was positive in some ways and negative in others. During the morning assembly, the children would stretch and do physical exercises, sing, pray, and sit in meditation all together. Through this ritual, the physical and spiritual health of the students was being supported each day. In contrast, the researcher observed that not all the bathrooms at Disha had soap in them, and that healthy toileting practices like proper handwashing and a change of soiled clothes were not always supported by Disha staff. It seemed to the researcher that teachers and therapists did not support toileting within the distribution of work at Disha. Only the caretakers would engage in this type of support for the students. The organization did not have enough caretakers to thoroughly support all the student’s toileting needs in a healthy way. This is one way that the student’s health should be more supported.

Three respondents gave answers about the subject’s supportive family throughout the interviews. This thread also came up as an answer within the question about the subject’s health.

This shows that not only was the role of familial support highly valued within general perceptions by respondents, it was even included within the idea of having a healthy life. Multiple respondents referred to the subject as a “boy” or “child” despite how he was 27 years old at the time of study. Infantilization of adults with disabilities can be counterproductive to supporting them in accessing equitable adult rights. This relates to the idea of lifelong familial support being healthy. However, a key difference should be noted between familial support of limitations and infantilization. Additionally, a caretaker responded that she believes that the subject is healthy and powerful, but that he should take care not to go outside alone. In this way, general support of him was also included in concepts of his health.

Community perceptions

The researcher observed one example of community perceptions of disability and health during Disha’s disability advocacy campaign leading up to International Day of Persons with Disabilities on December 3, 2019. This was a campaign were Disha students and staff members traveled to local mainstream schools in Jaipur to spread awareness about disability and inclusion and collect signatures of solidarity and donations for Disha. As mentioned in the introduction, inclusion is severely lacking in most Indian mainstream schools. The signatures for this campaign were collected from mainstream school children. Some of the children included messages of support with their signatures. These messages included the sentiment “get well soon” more than once. The researcher acknowledges that there could be a language barrier/cultural difference present in terms of intended meaning with this wish. However, from the researcher’s perspective, this is a direct confoundment between disability and health within a charity/pity model of feeling sorry for people with disabilities. This speaks to a lack of general awareness regarding disability, as described by respondents in this study.



A mainstream student's wish that the children at Disha would "get well soon."

Findings: Social Action

Responses grounded in the social model of disability were recorded when the researcher asked: "What does the word disability mean to you?" These important responses regarding social advancement frame disability as a social determinant of health and quality of life. The mother of the subject said that she does not like how the label of disability is connected to a separate sector of institutions. She wishes that being labeled as disabled did not create segregation. Another teacher also spoke about segregation as being inherently linked to disability in India and called for integration and inclusion. She said that she has noticed India gaining awareness surrounding disability: she said that when she started teaching in 2006, many of her student's parents did not want to accept their child's disability diagnosis. She felt that today, parents are increasingly accepting of their children's diagnoses. Still another teacher said that he does not like the negative connotations of disability as a label. He said that he prefers to think of it as a condition, because he feels that the children all have strengths from which he can learn. A caretaker acknowledged that disability simply means that the children have specific limitations. An administrator said that disability means that the children and the family face problems which are largely due to the lack of overall access in India. Another administrator said that she does not like to use the term disability, as we all have differences. "They are just differences: some people wear glasses" (Administrator, personal communication). She said that Disha's job is to highlight the ability in disability, and to teach the children in the ways that they learn.

Respondents were asked: "What do you think is the single most important change that must be made in India to support people with disabilities?" The answers to this question were unanimously about social and physical supports- grounded in the social model. Five respondents spoke about the need for greater implementation of social supports, whether they be physical or otherwise. A caretaker spoke about a greater need for assistive devices for people with disabilities at Disha. A teacher and administrator spoke about a need for an increase in all types of supports in rural areas. Another administrator spoke about the implementation of a greater range of social programs. She specifically identified a need for legitimate implementation of special education in mainstream and government schools, as well as other absent programs, like daycares. Another teacher spoke about accountability for implementation and execution of laws designed to support people with disabilities. The other aspect of social supports that multiple respondents answered about was increased awareness and sensitivity about disability. Four respondents used the word "awareness" in their answer, and one used the word "sensitivity." Respondents spoke about the need for the general public in India to become more educated about disability. "No segregation, no isolation, we are walking together, we are working together, according to his or her potential, according to their strength… They should work together. Then no limitations, no disability in the world" (Mother, personal communication). Here, the subject's mother describes her outlook, which is grounded in community and the social model, calling for an end to the segregation and isolation of people with disabilities. A lack of access and awareness were the major themes identified from answers to questions regarding social framing of disability.

An intriguing theme emerged when respondents were asked about their student's strengths and capabilities. Five respondents attributed the student's strengths to the support of Disha. Two respondents said that they saw strengths in the student's progress over time based on the support of Disha. An administrator described seeing children go from "severe condition" to being much more similar to typical children. A teacher had a similar sentiment, acknowledging strengths within the children's evolution at Disha. She also highlighted parental support as important to their progress, saying that it makes her happy when parents also believe in their children. She said that many students are capable of working outside Disha once they graduate. She expressed hope that mainstream education institutions would become more accessible and inclusive in a legitimate way, saying that current inclusion is not the answer because institutions include people with disabilities on paper, without structures in place to actually support them. Another teacher's answer about the student's strengths was Disha's vocational training for them, which he said provides them with skills that are transferable outside of Disha. Still another teacher attributed the student's strengths to her work creating personalized plans for them.

An administrator responded to the question initially by highlighting the institution's strengths, such as its accessible architecture, range of programs, and devoted staff. She went on to say that the student's favorite subjects are music and sports. The researcher observed the benefits of these two programs during holiday celebrations observed at Disha. Student's participated in friendly games and races during holidays and gave wonderful dance performances as a form of celebration. It is clear to the researcher that the music, dance and crafts programs at Disha foster creativity in the students. These performances are of great value in the way that they represent Disha and highlight the student's strengths. The administrator finally arrived at speaking about the student's strengths in sports, describing certain student's achievements at the level of Special Olympics World Games competitions. She said that before Disha was represented at domestic and international Special Olympics competitions, parents did not see the value in their children participating in sports. Eventually, the children's strengths in sports were recognized based on their successes. After that, more parents started allowing their children to participate. This shows the importance of institutional support in giving people with disabilities a chance to be included in the first place. However, strengths of the students without the context of Disha were barely acknowledged in the answers to this question. This is evidence of a segregated institute for disability functioning within the charity model. The respondents attributed the student's worth to the institution. This has elements of a charity or savior model. Although the student's strengths were not highlighted without the context of the institution, it is important to acknowledge that societal support is a key aspect of the social model. The researcher simply interpreted potential connections to the expert and charity models in these answers, in that Disha and its staff were attributed for the student's strengths, rather than any of the student's inherent abilities.

However, respondents spoke about their student's inherent worth within their community and of the love that they have for the children who attend Disha in other ways. Two respondents said that they prefer spending time at Disha to spending time at home. Two other respondents said that when they go home or when school is closed, they miss the children. When describing their relationships with the children at Disha, four respondents said that the children are like members of their families. An administrator said that she feels that the students are like her own children. The relationships present within Disha's community are clearly incredibly valuable to the respondents. Respondents identified inherent value in their students and in their work at Disha. One teacher said: "(Students are) my friends, my family… Without my students, is not life. Have learned so many things. Before this field, life is not life. I am selfish: me me me. Without children, life is not life." The mother of the subject said that her life is dedicated to her students. She said that she feels that it was meant to be that she had her son and that he led her to work in this field. This is an important framing of these students with disabilities, as it shows that they are absolutely capable of contributing valuably to their community and their relationships.

Limitations

For ethical reasons, this study did not include the perspectives of the children at Disha under 18 years of age. While the subject was 27 years old, the researcher was unable to conduct a verbal interview with him due to the nature of his communication limitations. This study does not include the direct perspectives of people with disabilities themselves. Perhaps it goes without saying, but it cannot be stressed enough that the perspectives collected from teachers and family members within the support network of the subject are not representative of the subject's direct experiences. The researcher would like to acknowledge that perspectives from the disability community, particularly of people with intellectual or developmental disabilities are often overlooked or undervalued. More direct perspectives are desperately needed. Additionally, the researcher acknowledges her own position of privilege in getting the opportunity to come into this organization to observe and make commentary on the experience. The prevailing, singular narrative that people with disabilities are helpless and need to be stood up for allows non-disabled people to feel that they can speak for people with disabilities. Further, it allows them to feel that, in doing so, they are doing the right thing. Skotch notes "...a distinction often made by disability rights activists is between organizations *of* disabled people and organizations *for* disabled people" (Skotch, 1989). The researcher is in a position of power by getting to make her perspectives heard in a way that some of the children at Disha currently may never experience due to how they are treated and perceived by the world. This is recognized not with pity, but rather as a call to action to work collectively towards the empowerment of people with disabilities.

A language barrier was present within this study. Findings are subject to miscommunication, as the researcher speaks little functional Hindi, and interview subjects individually spoke varying levels of English. While translators were used when appropriate, the language barrier still subjects the findings to potential miscommunication. Beyond language barrier, cultural miscommunication was also present at times. The researcher humbly acknowledges the cross-cultural perspective within which this research was conducted. This research represents the perspective of an American student visiting India. The researcher in no way claims any expertise on the Indian cultural context. Much of this research experience included pondering the cross-cultural nature of the context and the researcher consciously attempting to remain open and objective towards cultural differences. Nonetheless, the researcher would like to acknowledge inherent biases (particularly in the cross-cultural context) that no doubt permeated the research process and product.

Social dynamics at Disha occasionally affected data collection such that they should be mentioned under the limitations section. In considering the background of the social fabric at Disha, reflections on sociocultural dynamics regarding disability must be intersectional. "In charting the history of the disability rights movement (DRM) one needs to examine the rise of other similar movements in postcolonial India, especially the women's movements, environmental movements, and more recently *dalit* movements." (Mehrotra, 2011.) The researcher observed a social hierarchy within the division of work at Disha. Some of this she interpreted as being attributed to caste and class, and other aspects of it seemed to be a part of a social hierarchy specific to Disha. For example, the caretakers at the school were all women who completed the cooking, cleaning, and personal care work (toileting, meal support) for the students at Disha. They were described to the researcher as less educated and of lower socioeconomic status than other workers at Disha. Additionally, people who were in Disha's vocational skills program were trained as assistants to administrators or therapists at Disha.

The dynamic of social hierarchies created a limitation in this research when it arose in translation situations. In one interview with a caretaker, because of her nervous body language it was clear to the researcher that the caretaker was worried about giving a wrong answer or giving the answer "I don't know" in the presence of the translator and the researcher. The translator used a condescending tone with the caretaker and pushed the caretaker to give more information in her answers, potentially influencing the information gained in this interview. After the interview, the translator described the caretaker as less educated and professional. This bias within the power dynamic of the social hierarchy was evident throughout the interview process and affected the data obtained. Additionally, when a researcher at Disha helped translate an interview with a teacher, he kept adding his own opinions to the translated answers. The researcher interpreted this as being a matter of seniority of the researcher over the teacher. In one interview with a teacher, the mother of the subject was also present at the interview, and she answered certain questions instead of the intended respondent. This also seemed to be due to a position of seniority as the subject's mother. The researcher felt it important to explain this social dynamic as in pertained to the information collected in this project, as in all of these situations, information from the intended respondents was compromised or unobtainable.

Conclusions

The findings of this study support the conclusion that the concepts of disability and health intersect in various ways based on perceptions of people in disability support network at Disha Centre. In this case, a history of health issues were causal factors in the subject's disabilities. This was a direct connection between disability and health. Aspects of the subject's current day disabilities themselves were also viewed as health issues by some respondents. The subject had multiple disabilities, and certain disabilities were spoken about biomedically using health languages, while others were described using non-health based language. The subject was viewed as healthy largely because of changes or improvements throughout his life with his diseases, disabilities, and his supportive family. These finding were consistent with other trends showing that disability was mainly conceptualized by respondents at Disha biomedically (in both curing and non-curing model), and socially considering factors of social change needed to support people with disabilities. Beyond the family unit of support, respondents spoke about social change that is needed to support people with disabilities in India, mainly physical access and general awareness. Further investigations are needed to fully assess how the complexities of health and disability can be framed to help empower people with disabilities in India to access the equality that they deserve. There is also a need for further research regarding intersections of other identities disabled people might have that could also prevent them from access to health or quality of life, such as culture, class, caste, gender, sexuality, race, or religion.

Recommendations for further study:

Additional recommendations for further study include more trauma research in the Indian context and integration of trauma informed practices. Through observations collected at Disha regarding the social hierarchy, the researcher found herself wondering if the social advancement for people with disabilities that people at Disha spoke about was in line with certain aspects of their methodology, particularly their disciplinary methods. The researcher wondered if strict discipline within the social hierarchy at Disha might cause the children with disabilities to adhere to the current social position that they occupy. A shift in this structure and methodology might better prepare them to feel empowered to seek equality, advancement, and equitable treatment once in the real world.

For example, the researcher found a cross cultural difference in the physical and verbal disciplinary methods at Disha. The type of disciplining at Disha was different from experiences the researcher has had with both general and special education in the U.S. The children's behavior is highly valued by Disha. In an interview, an administrator had described the children as just as, if not more, disciplined than children in other Indian schools. The types of disciplinary methods observed by the researcher included raised voices with commanding tones, and occasional threats and physical touch. The researcher observed one child flinching as his teacher came close to him shouting a command, an indication that the child may have experienced physical abuse before. Another child was forced to complete therapy sessions with a pin held up to her as a threat. The researcher aimed to frame these observations as a cross cultural difference, but at times had a hard time remaining objective and became emotional about these situations. Further, corporal punishment is banned under Indian legislation. The Right to Free and Compulsory Education Act of 2009 bans physical and mental harassment in schools under Section 17 parts 1&2 of Chapter IV: "(1) No child shall be subjected to physical punishment or mental harassment.(2) Whoever contravenes the provisions of sub-section (1) shall be liable to disciplinary action under the service rules applicable to such person" (The Right to Free and Compulsory Education Act, 2009). The researcher questioned the degree of disciplinary methods used. The researcher was concerned about how harsh discipline might be affecting the children.

The researcher wondered if this discipline might be traumatic for the children. Significant strides have been made within the last 40 years in regard to our understanding of trauma. Advancements in the field of neuroscience have allowed greater insights into the continued somatized and psychological effects of trauma. Bessel van der Kolk is a psychiatrist who specializes in trauma. Van der Kolk's work included some of the first MRI brain scans in relation to traumatic experiences. Among other key discoveries, these first MRIs demonstrated a lack of communication between the left and right brain hemispheres when in a traumatized state, indicating an inability in the brain to process trauma in a way that would be comparable to "normal" or baseline brain function. These MRI scans found that the left hemisphere is disabled as it processes trauma, inhibiting executive brain function such as memory and ability to form a chronological narrative (Van der Kolk, 2014). Most of van der Kolk's work surrounding trauma was done with patients in therapy, long after the traumatic events had occurred in his patient's lives. This new understanding of trauma as an agent that deeply affects psychological and physiological capability during and even long after the trauma has occurred, has initiated a whole new discourse surrounding trauma.

Historical trauma frameworks were developed and born into public consciousness after this shift in the study of trauma occurred, where trauma's *continued* effects were more understood and accepted. Some trauma frameworks and models are in contrast with one another. The current debate central to the framework proposed by Kirmayer, Gone, and Moses is the difference between historical trauma, and continued structural violence. Some models are deeply grounded in past trauma, with one model even proposing an idea that past trauma could renew with each generation, without taking into account the possibility of current trauma (Hüseyinzade Şimşek, 2017). This concept is challenged in the model by Kirmayer et al which identifies a key difference between the trauma of the German Holocaust and the holocaust of indigenous peoples of America: this model acknowledges the difference between mass trauma which has a clear ending, and trauma which is continued in present day. This model proposes the idea that too much causal emphasis is placed on the historical trauma concept, taking weight away from trauma inflicted by current day structural oppression (Kirmayer et al 2014). Both of these models would be relevant to consider in the case of structural oppression against people with disabilities and the continued effects of trauma.

However, these models were not developed in the context of disability. Research regarding trauma responses specifically in people with intellectual disabilities is lacking. According to a systematic review by Wiggam, Hatton, and Taylor, there is no trauma research using measures of life events and trauma specific to the population of people with intellectual disabilities. The main trauma research for this population is regarding sexual abuse (Wiggam, Hatton, & Taylor, 2011). It is incredibly important that sexual trauma is being acknowledged for this population, as people with disabilities in the United States face rates of sexual abuse seven times higher than their non-disabled counterparts (Gustafson & Herman, 2018). In general, trauma research for people with disabilities desperately needs more attention, as current trauma research has shown that trauma has significant effects on the brain and nervous systems. As such, brains with atypical function should also be included in this research. Further, this population is vulnerable to trauma due to the systematic oppression that they face.

Beyond disability, trauma research for all populations has yet to be addressed in the Indian context. Issues of trauma beyond physical accidents such as car crashes have been largely unresearched in India. New and emerging discourses in the U.S. have identified a number of experiences as having the potential to cause traumatic effects in individuals. The most current research has found that trauma's effects on the brain and the body can be ample and long lasting. These findings (Van der Kolk, 2014) have been the impetus for movements such as integrating trauma informed practices into the social services sector in the American context. For example, in March 2016 the Springer Journal of School Mental Health published a whole issue on piloting the implementation of trauma-informed practices in American schools (Overstreet & Chafouleas, 2016). Research suggests that traumatic events can cause psychopathological effects in people with disabilities (Wiggam, Hatton, & Taylor, 2011). Because of this, the researcher implores Disha to re-examine verbal and physical disciplinary methods. Trauma informed research and practice is incredibly important, especially for socially vulnerable populations. It is the opinion of the researcher that more extensive trauma research is needed in the Indian context. This research is incredibly important as it is connected human rights issues and can support pathways towards healing. However, in this context it must also be coupled with social change to end human rights abuses.

Bibliography: References

Primary Sources

Teacher/Mother. Personal Communication. November 2019.

Former Teacher. Personal Communication. November 2019.

Classroom Teacher. Personal Communication. November 2019.

Caretaker. Personal Communication. November 2019.

Communications Administrator. Personal Communication. 2019.

Administrator. Personal Communication. 2019.

Secondary Sources

Chandramouli, C. Census of India 2011: Provisional population totals. (2011.) Paper 2, Volume 1. http://censusindia.gov.in/2011-prov-results/paper2/data_files/india/paper2_1.pdf

Disabled World News. Models of disability: types and definition. (2019.) DW#66-5297. https://www.disabled-world.com/definitions/disability-models.php

Edwardraj, S., Mumtaj, K. , Prasad, J. H., Kuruvilla, A. and Jacob, K. S. Perceptions about intellectual disability: a qualitative study from Vellore, South India. (2010.) Journal of Intellectual Disability Research, 54: 736-748. doi:10.1111/j.1365-2788.2010.01301.x https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2788.2010.01301.x

Ghai, A. *Rethinking disability in India.* (2015.) Routledge.

Gustafson, M. Herman, T. Abused and Betrayed. (2018.) National Public Radio. https://www.npr.org/series/575502633/abused-and-betrayed

Hüseyinzade Şimşek, A. (2017). Post-Memory: Family as a Space of Historical Trauma Transmission. *Current Debates in Philosophy & Psychology*, *11*.

Kishore J., Gupta A., Jiloha R.C., Bantman P. Myths, beliefs, and perceptions about mental disorders and health-seeking behavior in Delhi, India. (2011.) Indian J Psychiatry. Oct-Dec; 53(4): 324–329. doi: 10.4103/0019-5545.91906 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3267344/

Kishore, L. Interfacing spirituality and pedagogy with elements of positive psychology. Disha- A Resource Centre for the Disabled. Print.

Kirmayer, L. J., Gone, J. P., & Moses, J. (2014). Rethinking Historical Trauma. *Transcultural Psychiatry, 51*(3). https://doi.org/10.1177/1363461514536358

Mehrotra, N. Disability rights movement in India: politics and practice. (2011.) Economic & Political Weekly, XL VI (06), 65-72.

Overstreet, S. Chafouleas, S.M. School Mental Health: Trauma Informed Practices. (2016.) Springer Journals. Vol. 8 Issue 1.

The Right to Free and Compulsory Education Act 2009. (Ministry of Law and Justice.) S. 17.1, 17.2. (India.)

Scotch, R.K. Politics and Policy in the History of the Disability Rights Movement. (1989.) *The Milbank Quarterly* Vol. 67, Supplement 2 (Part 2). Disability Policy: Restoring Socioeconomic Independence pp. 380-400. Wiley on behalf of Milbank Memorial Fund . https://www.researchgate.net/profile/Timothy_Elliott/publication/16977705_Media_and_disability/links/ 0deec519b856c15c15000000/Media-and-disability

van der Kolk, B. (2014). T*he Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma.* New York, NY: Penguin Books.

WHO. World report on disability (2011.) ISBN 978 92 4 068521 5 https://www.who.int/disabilities/world_report/2011/report.pdf

Wigham, S., Hatton C., & Taylor J.L. The effects of traumatizing life events on people with intellectual disabilities: A Systematic Review, Journal of Mental Health Research in Intellectual Disabilities. (2011.) 4:1, 19-39, DOI:10.1080/19315864.2010.534576