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RESEARCH AND DOCTORAL TRAINING

DISCRIMINATION AT WORK AND COPING STRATEGIES OF SOME EMPLOYEES WITH DISABILITY: CASE STUDY IN THE CITY OF YAOUNDE

A Dissertation Submitted in Partial Fulfilment of the Requirements for the Award of a Master’s Degree in Specialized Education

Option: **Social Handicap**

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SUMMARY

DEDICATION

To my beloved parents

Mr **EGOH Mathias** and Madam **EGOH Margaret**.

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This work would never have been a success if not for a certain number of people to whom we show a lot of gratitude for their great contributions.

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My greatest thanks goes to the essence of life for Grace and sustaince.

LIST OF ACCRONYMS AND ABBREVIATIONS

ASD:	Autism Spectrum Disorder
BDD:	Body Dysmorphic Disorder
CF:	Cystic Fibrosis
CISS:	Community Integrated Service System
CRPD:	Convention on the Rights of Persons with Disabilities
DNA :	Deoxyribonucleic Acid
EAP:	Employees Assistance Program
EEO:	Equal Employment Opportunity
EFC:	Expected Family Contributions
FASD:	Fetal Alcohol Spectrum Disorder
FNE:	National Fund of Employees
GDP:	Gross Domestic Product
ICD:	Impulse Control Disorder
ICF:	International Classification of Functioning, Disability and Health
ILO:	International Labour office
IQ :	Intelligence Quotient
MINAS:	« Ministry of Social Affairs »
MS:	Multiple Sclerosis
NGO:	Non-Governmental Organization
NSSF:	National Social Security Fund
OCD:	Obsessive Compulsive Disorder
PFC:	Power Factor Correction
PTSD:	Post Traumatic Stress Disorder
PWD:	Persons with Disabilities
PWS:	Prader-Willi Syndrome
SCI:	Spinal Cord Injury
UK:	United Kingdom
UN:	United Nations
UNCRPD:	United Nations Convention on the Rights of Persons with Disabilities
USA:	United States of America
WHO:	World Health Organization

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ABSTRACT

Understanding the relationship between discrimination at work and coping strategies of employees with disabilities in the city of Yaoundé is the centre point of this study. The study engages the transactional theory, the medical and the social model of disability in understanding and explaining how discrimination at work affects the life of employees with disability. Medical model conceptualizes the "normality" and excludes people who do not fit to the conceptualization of "normal" that set a ground for marginalization of disabled people. The researcher seeks to know the different types of discrimination employees with disability are faced with, the different coping strategies these employees use so as to cope at work. In another term looking for those strategies that would help them cope. Given that lack of good coping strategies, employees with disability will not be very productive at their job side. The research engaged a survey research approach which used a semi structured interview guide for the collection of relevant data. We interviewed seven employees with disability. The study carries one main research objective/Question and one specific objectives/Questions were used to guide this study. The study discovered discrimination like: stereotype, prejudice, harassment, social avoidance, victimization, stigmatization and hard labour. The thematic content approach was used to analyse the data collected from the field. Generally, the study found out that coping strategies greatly influence or reduces the feelings of discrimination at work of employees with disabilities. Specifically, the study found out that stigmatization and social avoidance significantly influence the performance of employees with disability. The study concludes that discrimination at work affects the life of employees with disability. Therefore, the study recommends that the government and non-governmental organizations take appropriate measures to educate the society on the how to treat employees with disability.

The study ended by giving suggestions for further studies.

Key words: **Discrimination at work; Coping strategies; Employees with disability; Yaoundé**

RÉSUMÉ

Comprendre la relation entre la discrimination au travail et les stratégies d'adaptation des employés handicapés dans la ville de Yaoundé est le point central de cette étude. L'étude s'appuie sur la théorie transactionnelle, le modèle médical et le modèle social du handicap pour comprendre et expliquer comment la discrimination au travail affecte la vie des employés handicapés. Le modèle médical conceptualise la "normalité" et exclut les personnes qui ne correspondent pas à la conceptualisation de la "normale", ce qui crée un terrain propice à la marginalisation des personnes handicapées. Le chercheur cherche à connaître les différents types de discrimination auxquels les employés handicapés sont confrontés, les différentes stratégies d'adaptation que ces employés utilisent pour une intégration professionnelle réussie. En d'autres termes, il s'agit de trouver les stratégies qui les aideraient à s'en sortir. En l'absence de bonnes stratégies d'adaptation, les employés handicapés ne seront pas très productifs dans leur travail. La recherche a adopté une approche de recherche par enquête qui a utilisé un guide d'entretien semi-structuré pour la collecte de données pertinentes. L'étude comporte un objectif/une question de recherche principal(e) et un objectif/une question spécifique qui ont été utilisés pour guider cette étude. L'étude a découvert des discriminations telles que : les stéréotypes, les préjugés, le harcèlement, l'évitement social, la victimisation, la stigmatisation et les travaux forcés. L'approche du contenu thématique a été utilisée pour analyser les données recueillies sur le terrain. En général, l'étude a révélé que les stratégies d'adaptation influencent grandement ou réduisent les sentiments de discrimination au travail des employés handicapés. Plus précisément, l'étude a révélé que la stigmatisation et l'évitement social influencent de manière significative la performance des employés handicapés. L'étude conclut que la discrimination au travail affecte la vie des employés handicapés. Par conséquent, l'étude recommande que le gouvernement et les organisations non gouvernementales prennent des mesures appropriées pour éduquer la société sur la façon de traiter les employés handicapés.

L'étude se termine par des suggestions pour des études ultérieures.

Mots clés : Discrimination au travail ; Stratégies d'adaptation ; Employés handicapés ; Yaoundé

0. GENERAL INTRODUCTION

Disability is part of the human condition. Almost everyone will be temporally or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulty in functioning. Furthermore, most extended families have a disabled member and many non-disabled people take responsibility. This issue will become more acute as the demographics of society change and more people live to and old age. Worth noting here is the fact that disability prevalence would likely increase in the future. This is due to increasing natural disasters, armed conflicts, diseases and an ever aging population. According to the World Health Organization (WHO) 2001 disability has three dimensions. Impairment in a person's body structure or function, or mental functioning; examples of impairments include loss of limb, loss of vision or memory loss. Activity limitation, such as difficulties seeing, hearing talking. (WHO) updated copy 2022 defines disability as a condition or function judged to be significantly impaired relative to the usual standard of an individual or group.

In this section our study we shall come out with the context and justification, statement of the problem, the various research questions, the objectives of the study, significant of the study, delimitation or scope of the study and presentation of the work.

0.1 Context and justifications

Discrimination of disabled employees is becoming more and more important recently. Employment of disabled employees has become a crucial topic of discussion for many countries, international organizations, political agendas, non-governmental organizations, etc. Fighting against discrimination made against employees with disability is one of the major interest of these actors. The contextual background looks at reactions towards disability and disabled people in historical and current terms in Cameroon. Cameroon is a culturally diverse nation and thus the ideas towards people living with disabilities are multifaceted. There is a long history of killing, abandonment, discrimination and many other forms of mistreatment of people living with disabilities in Cameroon. However, the situation is gradually changing for the better. Crisis and war are known to cause injuries and trauma that can result in disabilities. For the injured, the situation is often exaggerated by delays in obtaining emergency health care and longer-term rehabilitation. Conflicts are estimated to account for 1.4% of people living with disability (WHO & World Bank 2011). Within the context of Cameroon, the ongoing arms conflict between the Northwest and Southwest regions and the Government of Cameroon has greatly increased the rate of people living with social disabilities. The fight between the government of Cameroon and Boko haram, coupled with increased road accidents due to extreme bad roads have been a contributing factor to a steady rise in the number of people living with social disabilities. Prior to the boko haram insurgency and the Anglophone crisis, there have been many intertribal conflicts that have rendered many people socially disabled. Disability rights are not new rights, rather, they bring poignancy to human rights that already exist but have been historically denied or discriminated. The challenges and impediments faced by PWD's in Cameroon are significant and should therefore not be treated with laxity. Consequently, the Cameroonian legislator has hitherto enacted a plethora of laws and set up commendable institutional mechanisms for the protection of persons living with disabilities. However, a critical examination of these laws and their actual fulfillment shows a significant gap between legal theory and practical reality. There exists a plethora of laws for the protection of the rights of PWD's in Cameroon. These laws encompass International Ratified Conventions, Regional Norms and Domestic Statutes. An analysis of these laws will help provide a better grasp of the legal framework both at the international, regional and national levels. The principal international texts that have been established to protect the rights of PWD's include the 1948 Universal Declaration of Human Rights and the 2006 Convention on the Rights of Persons with Disabilities. The Cameroonian Ministry of Social Affairs is the main ministry responsible for protecting the rights of PWD's. The Ministry is made up of several units. Its department of Social Protection of PWD's is one of its core Department charged with the duty to elaborate, enforcement and follow up the socio-economic reintegration policy of PWD's, the implementation of Government's policy of special education, health assistance, equipment and professional training of PWD's. It further helps PWD's by providing subventions to private institutions delivering care to these persons, promotion of development programs and capacity to mobilize and manage resources of target populations, enter technical relationships with national and international organisms of promotion of PWD's and collection of statistical data on target populations, in conjunction with the technical structures concerned (Ministry of Social Affairs Minas, Available at www.minas.gov.cm). The ministry has hitherto implemented various schemes for the betterment of PWD's. In 2006, the Ministry of Social Affairs took the following steps for the betterment of the rights of PWD's.

On **22 March 2006**, the Minister of Social Affairs and the Director of CNPS signed an agreement aimed at improving assistance to disabled persons and victims of industrial accidents. The agreement was also implemented within CNPS, which provided its disabled staff members with special vehicles to facilitate their transportation to work. On **4 September 2006**, a partnership agreement was signed between the Minister of Social Affairs and the National Director of national fund for employees (FNE) on facilitating the integration of vulnerable persons into training programs and gainful employment to help PWD's to economic and social independence. A meeting between the Ministers of Higher Education and Social Affairs on **13 March 2006** led to the signature of a joint circular letter aimed at ameliorating the conditions of disabled and vulnerable students by providing them with accommodations, integrating them into University "work-study programs" and finding vacation internships for them. On 10 April

2006, a meeting was held between the Ministers of Social Affairs and Public Works to ensure the effective application of the **1983**Act on disabled persons' access to public buildings and of the related implementation Decree No. **90/1516 of 26 November 1990;** Looking at the adequacy of the initiatives and/or action plans formulated by the government of Cameroon to protect the rights of PWD's, it might be tempting to establish that these fundamental initiatives have been successful in accomplishing significant Human Right improvements in the arena of the fight for the protection of the rights of PWD's. Such an establishment would be fundamentally flawed. PWD's in Cameroon face the difficulty of moving from one place to another. Many roads are not paved and muddy. The terrains are hilly and most regions are mountainous. This means that those with mobility impairments face the challenge of moving their bodies on these landscapes.

0.2. Statement of the problem

Folkman and Lazarus (1966), established that the manner in which we face difficult situations depends on the diverse forms of reasonable adjustments made. There exists a link between the different strategies that help to cope at difficult situations like discrimination and stressor events. This theory presents different mechanisms of coping called determinants of coping as: Sociobiographic factors, contextual factors, cognitive factors and personality factors. Many people face this difficult situation at work, especially the case of discrimination made against employees with disability. Although there are mechanisms of coping, we realize in the field that there are a lot of discrimination made against disabled employees. How then can we overcome this situation? Should coping strategies be the ideal solution to discrimination at work? To overcome come this situation, we made inventory according to the types of discrimination at work: stereotype, victimization, harassment, prejudice, social avoidance and many others.

Many governments especially in developed countries have adopted social policies which aims to penetrate disabled persons into the economy, in order to fight against discrimination (Robertson, Lewis, et Hiila, 2004). But this is not the case with many African countries. More emphasis is to be put in to see that Africans can conveniently fight against discrimination made against employees with disability. In a great context, it is of paramount interest to study the different types of discrimination employees with disabilities are faced with. This will go a long way to help Africans fight this ultimate battle. Inasmuch as we put in the interest to prevent discrimination against employees with disability, it is important too to study the various coping strategies these employees have develop over the years. A good study of these strategies will go a long way to remedy the situation of employees with disability and to give us an idea of the pain they go through at their work place. It is evident that most people living with disabilities in Cameroon still witness negative attitudes like discrimination, stigmatization, stereotype, victimization, prejudice and harassment from their respective workplace that affects their ability to work effectively at their various workplace. Hence high cases of work difficulties and inefficiency amongst people living with disability. Individuals with disability typically have a more complex career development process than their peers and are more susceptible to lots of difficulties in performing their work effectively (Enright, 1996; Luzzo, Hitchings, Restish, 1999; Ochs & Roessler, 2001). Career decision making difficulties are related to impaired decision making skills, unclear goals, lack of employment information, perceived barriers and value conflicts (Germeijs & Deboech, 2003; Holland et al, 1980; Ladany, Melincoft, Constantine & love 1997; Osipow, 1999) are significant obstacles to efficiency at work for many people with disability. However, while the study of discrimination and employees with disability have been an increasing field in recently, researchers in this area have been too slow to integrate the discrimination processes in the workplace. Again researchers have not distinguished the different sectors of work in their analysis. To analyze the theoretical and practical tension on ground, between disabled employees and discrimination, it is important to open the medical and social models of disability. Working conditions are greatly influenced by disability models adopted y service providers (Gottlieb, Myhill, et Blanck, 2021) Research further suggests that discrimination made against employees with disability by their employers, colleagues or coworkers and clients is the principal cause of inefficiency, thus rendering their workplace inhabitable and work very difficult. There also exists behaviors of the society and individuals that renders disabled employees ineffective. Individual factors include cultural background (Enright et al., 1996; Szymanski & Hershenson, 1998), socioeconomic status (Blustein, Juntunen, & Worthington, 2000), self-esteem (Munson, 1992), and disability status. Environmental factors such as family involvement (Hitchings, Luzzo, Ristow, Horvath, Retish, & Tanners, 2001). In 1983, the Cameroonian Government passed the first PWDs Act. This Act has been follow by Decree of 1990 and in 2011 by the Act on the Protection and Promotion of the Disabled which foresees a punishment for all discriminating employers. According to this law, disability is a limitation of opportunities for full participation of a person with impairment in an activity in a given environment. However, this Act has no provisions on the non-discrimination in the built environment and it removes the quota imposed by the 1990 decree making it difficult to demonstrate any deviations of employers Understanding that discrimination against employees with disabilities is almost an inevitable act, disabled employees have over the years adopt coping strategies to ameliorate the unfavorable conditions at their workplace. These strategies though not a final solution to the problems they face at work, it subsides anger. Therefore, finding out better coping strategies for employees with disability will go a long way to help adapt at their workplace. Based on the above, this study sets out to find the different types of discrimination made against employees with disability at work and the various coping strategies that disabled employees can use to better their conditions in the city of Yaoundé.

0.3 Research questions.

Research questions basically reflect the purpose or objectives of the study (Schloss & Smith, 1999) as quoted in Amin (2005). Muhammad (2003), there is no doubt that the strength of any society lies on the power of everyone. By maintaining values and morals, religious heritage and above all live a Life without discrimination. In this light, if discrimination at work of disabled workers are not checked, or coping strategies are not put in place, then the future will be catastrophic because there will be more bed ridding amongst employees with disabilities thus a fall in the work force and the economy of the country. From the problem of this study, it leads us to the following research questions.

0.3.1 Main Question

In order to render this research remarkable, the main research question was based on; what are the different types of discrimination employees with disability face at work and the coping strategies in the city of Yaoundé?

0.3.2 Specific research questions

How do employees with disability cope at their workplace in the city of Yaoundé?

0.4. Objective of the study

This study aims at contributing more information to enrich literature review, specialized educators, employees with disabilities and psychological understanding of discrimination at work and coping strategies of employees with disabilities.

0.4.1 Main objectives

The main objective of this study is to identify the various types of discrimination employees with disability face at their work place.

0.4.1.1. Specific Objectives

To explain how employees with disability cope at their workplace.

0.5 Significance of the study

This study will help the researcher to prevent discrimination at work of employees with disability. It will again help the researcher as a handicapologist to be able to provide psychosocial support to employees with disability.

Socially, this study will help sensitize the society of a silence act of discrimination at work of disabled employees, the society will also be re-educated on how to value and treat employees with disabilities. This will equally change the mindset of the society on disabled workers.

Scientifically, this work will enable researchers, specialized educators, psychologists to create awareness campaigns for employees with disabilities. It will also help disabled employees to be strong and cope at their various workplace.

0.6 Delimitation or scope of study.

This work will be centered towards companies, governmental and non-governmental organizations (NGOs). The target will be employees with disabilities in all forms of work in the city of Yaoundé. We shall set a pace for these employees to enjoy working and being void of any form of discrimination at their various workplace.

0.7. Presentation of work

This work in made up of two parts. The first comprises of two chapters that is chapter one, which deals with discrimination at work of employees with disabilities, chapter two which deals with coping strategies of employees with disabilities and related theories. Part two which is equally made up of two chapters dealing with Research methodology and Presentation of results. Each chapter starts with an Introduction and ends with a brief summary.

Summarily, this part of the work has given us an insight of what discrimination at work is and why and why the researchers decided to work on this topic. We have also seen the formulated research questions laid down from the objectives, and also the research problems that the researcher wants to solve with the help of this research work.

PART ONE:

CONCEPTUAL, EMPIRICAL AND THEORETICAL BACKGROUND.

CHAPTER 1:

DISCRIMINATION AT WORK OF SOME EMPLOYEES WITH DISABILITY

Introduction

This section of the research will outline literature examining the experiences of some employees working with disability. The controversial issue of defining disability will be addressed, allowing input from a variety of authors. Discrimination at work, types of discrimination at work, the overview of disability, disability and work, types of discrimination made against employees with disability will equally be outlined. Important models of disability like the medical and social model of disability will be put forward and a critical comparism of the two models will be made. For the purpose of this study, the researcher will limit to employees with disability.

The Greek achievements in philosophy, the arts, and in architecture have had a profound effect on the culture of the entire western world (Devonport, 1995; Risbero, 1975). This influence includes how they perceived and treated people living with disabilities. The Greek Empire was obsessed with human perfection. They believed beauty and intelligence wereintertwined. This belief laid the ground work for future beliefsrelated to people living with disabilities. The Greek obsession with bodily perfection, which can be traced back to 700-675 BC. (Dutton, 1996), found expression in prescribed infanticide for children with perceived imperfections (disability). Infanticide in the form of exposure to the elements for sickly or weak infants was widespread and in some states mandatory (Tooley, 1983). The now familiar association between impairment, exclusion and impotency is clear. Moreover, the Western link between impairment as a punishment for sin also has its roots in Greek culture

Following their conquest of Greece, the Romans absorbed and passed on the Greek legacy to the rest of the known world as their empire expanded. The Romans too were enthusiastic advocates of infanticide for `sickly' or `weak' children drowning them in the river Tiber. Like the Greeks, they treated harshly anyone whose impairments were not visible at birth. People of short stature and deaf people were considered objects of curiosity or ridicule. In the infamous Roman games `dwarfs' and `blind men' fought women and animals for the amusement of the Roman people. Even the disabled Emperor Claudius, who escaped death at birth only because he was from the highest echelon of Roman society, was subject to abuse from both the Roman nobility and Roman Guards prior to his ascendancy to the imperial throne. Even his mother, Antonia, treated him with contempt and referred to him as `a monster of a man, not finished by nature and only half done' (Garland, 1995, p. 41). According to the Disability History Exhibit web site: "Greek response to disability was Abandonment, Exposure, Mutilation." (Alaskan D.H. & S.S. 2011)

Influenced by Greek society since, at least, the time of Alexander the Great (Douglas, 1966) the Jewish culture of the ancient world perceived impairments as un-Godly and the consequence of wrongdoing. Biblical text is replete with references to impairment as the consequences wrongdoing. The Old Testament, for instance, states that if humans are immoral then they will be blinded by God (Deuteronomy, 27-27). These traditions are continued in the New Testament too. In the book of Matthew, for example, Jesus cures a man with palsy after proclaiming that his sins a forgiven (9-2).

Unlike other major religions of the period the Jewish faith prohibited infanticide. This became a key feature of subsequent derivatives, Christianity and Islam, as did the custom of `caring' for the `sick' and the `less fortunate’ either through alms giving or the provision of `direct care' (Davis, 1989). However, the opposition to infanticide and the institutionalization of charity is probably related to the fact that Jewish society was not a particularly wealthy society. It was predominantly a pastoral economy dependent upon the rearing of herds of cattle, goats and sheep, as well as on commercial trade. In addition, unlike their neighbors, the Jewish people were a relatively peaceful race, prone to oppression themselves rather than the oppression of others. In such a society people with impairments would almost certainly have been able to make some kind of contribution to the economy and the well-being of the community (Albrecht, 1992). Furthermore, in its infancy Christianity was a religion of the underprivileged; notably, `slaves and women', charity, therefore, was fundamental to its appeal and, indeed, it’s very survival. Nonetheless, being presented as objects of charity effectively robbed disabled people of the claim to individuality and full human status. Consequently, they became the perfect vehicle for the overt sentimentality and benevolence of others - usually the priesthood, the great and the good.

Following the fall of Rome in the fifth century AD Western Europe was engulfed by turmoil, conflict and pillage. Throughout `the Dark Ages' the British Isles were made up of a myriad of ever-changing kingdoms and allegiances in which the only unifying force was the Christian Church. Given the violent character of this period it is likely that social responses to people with impairments were equally harsh (Barton L.& Mike, O., 1997). But by the thirteenth century, and in contrast to much of the rest of Europe, a degree of stability had been established in the British Isles. An indication of English society's attitude to dependence, and by implication impairment, is evident in the property transfer agreements of the period (Macfarlane, 1979). Until the seventeenth century, people rejected by their families and without resources relied exclusively on the haphazard and often ineffectual tradition of Christian charity for subsistence. People with `severe' impairments were usually admitted to one of the very small medieval

hospitals in which were gathered `the poor, the sick and the bedridden'. The ethos of these establishments was ecclesiastical rather than medical (Scull, 1984).
There was also a steady growth in the numbers of people dependent on charity in the 18th century. This was the result of a growing population following depletion due to plagues, successive poor harvests, and an influx of immigrants from Ireland and Wales (Stone, 1984). Hence, the fear of `bands of sturdy beggars' prompted local magistrates to demand an appropriate response from the central authority; the Crown (Trevelyan, 1948). To secure allegiance the Tudor monarchs made economic provision for those hitherto dependent upon the Church. The Poor Law of 1601, therefore, is the first official recognition of the need for state intervention in the lives of people with perceived impairments. But a general suspicion of people dependent on charity had already been established by the statute of 1388 which mandated local officials to discriminate between the `deserving' and the `undeserving' poor (Stone, 1984).

Moreover, although `English individualism' was well entrenched by the thirteenth century the Church remained a formidable force in English and European culture. Besides offering forgiveness and a democratic afterlife in a frequently hostile world where for many lives could be `nasty, brutish and short' (Hobbes, 1983) the Christian Church asserted and retained its authority by propagating and perpetuating fear - fear of the Devil and of his influence. The biblical link between impairment, impurity and sin was central to this process Indeed, St Augustine, the man credited with bringing Christianity to mainland Britain at the end of the sixth century AD, claimed that impairment was `a punishment for the fall of Adam and other sins' (Ryan and Thomas, 1987, p. 87).

Disabled people provided living proof of Satan's existence and of his power over humans. Thus, visibly impaired children were seen as `changelings' - the Devil's substitutes for human children. The Malleus Maleficarum of 1487 declared that such children were the product of the mother's involvement with sorcery and witchcraft. The religious leader and scholar accredited with the formation of the Protestant Reformation, Martin Luther (1485 - 1546) proclaimed he saw the Devil in a disabled child; he recommended killing them (Haffter, 1968).

As in the ancient world, people with impairments were also primary targets for amusement and ridicule during the middleAges. Analysis of the joke books of Tudor and Stuart England show the extent of this practice. Besides references to the other mainstays of `popular' humour such as foreigners, women, and the clergy, every impairment `from idiocy to insanity to diabetes and bad breath was a welcome source of amusement (Thomas, 1977, pp. 80-81). Children and adults with physical abnormalities were often put on display at village fairs (Nicholli 1990) visits to Bedlam were a common source of amusement, and the practice of keeping `idiots' as objects of entertainment was prevalent among the wealthy (Ryan and Thomas, 1987).

Taken together these developments provided a new found legitimacy for already well-established myths and practices from earlier `less enlightened' times. Thus, the nineteenth century is synonymous with the emergence of `disability' in its present, form. This includes the systematic individualization and medicalisation of the body and the mind (Armstrong, 1983; Foucault 1975), the exclusion of people with apparent impairments from the mainstream of community life into all manner of institutional settings (Scull, 1984) and, with the emergence of `Social Darwinism', the `Eugenics Movement', and, later, `social hygiene' `scientific' reification of the age old myth that, in one way or another, people with any form of physical and or intellectual imperfections pose a serious threat to western society. The `logical' outcome of this was the proliferation of Eugenic ideals throughout the western world during the first half of the twentieth century (Jones, 1987; Kevles 1985), and the systematic murder of thousands of disabled people in the Nazi death camps of the 1930s and 40s (Burleigh, 1995; Gallagher, 1990). It is important to remember too that Marxist Communism also has its roots firmly planted in the material and ideological developments which characterized eighteenth- and nineteenth-century Europe, and that many of its principal protagonists, both in Britain and overseas, embraced eugenic ideals as an essential corollary of the `Utopian' hope for a better society.

The concept of disability has been examined from various cultural perspectives across the continent of Africa and found that the perception of disability is not uniform (Eskay M., Onu V. C., Igbo J. N., Obiyo N. 2012). As we grow in our knowledge of the dynamics surrounding the concepts of culture and disability, we begin to realize that individual perceptions and languages play a vital role in our understanding of who we are as a people and as a culture. According to Wright (1960), language is not merely an instrument for voicing ideas, but also plays a role in shaping ideas by guiding the experience of those who use it. Scheer and Groce(1988) pointed out that when different cultures used positive language to describe individuals with disabilities, these individuals with disability ended up integrating well into the society.

A study conducted among the Tonga People revealed that both positive and negative attitudes and behaviour towards children with disabilities. The complexities of these attitudes were influenced by their historical background, life experiences, social, cultural and economic factors (Muderedzi. J., Arne H. E., Stine H. B. &Babill S. 2017).In most traditional African cultures, including Cameroon and Zimbabwe, there is a strong belief that people's lives are controlled by ancestral spirits and that disability is of spiritual origin (Pepra O., Mckenzie, Mprah W., &Nsaidzedze S.B., 2016; Marongwe & Mate, 2007; Mpofu& Harley, 2002; Shoko, 2007). Disability stigma (discrimination) as well as curtesy stigma (discrimination acquired as a result of being related to a person with a stigma) has been noted to be present in Zimbabwe (Khupe, 2010; Lang &Charowa, 2007).

On the other hand, studies from other African communities such as the Xhosa in South Africa (Mckenzie& Swartz, 2011), BaTswana in Botswana (Ingstad, 1997), and Maasai in Kenya (Talle, 1995) have found that children born with anomalies were seen as "a gift from God" and remained valued members of the community. In Zimbabwe, Dengu (1977) found that it was through the introduction of Christianity that disabled children started to be seen as gifts from God, although in some cases feelings of shame persisted, leading to cases of hiding.

Perceptions and beliefs about disability as a punishment, the result of ancestral anger or retribution by divine forces, have been found in many cultures (Braathen&Ingstad, 2006; Coleridge, 1993; Devlieger, 2005; Talle, 1995). There are several beliefs for the negative attitudes revolving aroundchildren with disabilities in Nigeria. These beliefs cut across the Nigerian society and hence have asimilar impact on the citizens' attitudes on learners with disabilities. According to Onwuegbu (1977), Abang(1985) and Ozoji (1990) and later supported by Marten (1990) and Eskay (2009), the causes of such negative perceptions on learners with disabilities were related to: (1) a curse from God (due to gross disobedience to God's commandments); (2) ancestral violation of societal norms (e.g., due to stealing); (3) offenses against gods of the land (e.g., fighting within the society); (4) breaking laws and family sins (e.g., stealing and denying); (5) misfortune (e.g., due to marriage incest); (6) witches and wizards (e.g., society saw them as witches and wizards); (7) adultery (a major abomination); (8) a warning from the gods of the land (due to pollution of water and the land); (9) arguing and fighting with the elders (a societal taboo); (10) misdeed in a previous life (such as stealing); (11) illegal or unapproved marriage by the societal elders (arguing and fighting against the elderly advice in marriage); (12) possession by evil spirits (due to gross societal disobedience); and many others.

A study from Ghana, (Wright, 1960) found that children with disabilities were seen as protected by supernatural forces, were the reincarnation of a deity and were always treated with kindness, gentleness and patience. Studies among the Shona and Kalanga of Zimbabwe, (Khupe, 2010; Lang &Charowa, 2007) have highlighted negative attitudes such as disabled people constitute a burden to society and that disability is associated with evil. A study by Jackson and Mupedziswa (1988) among the Karanga in Zimbabwe found that beliefs and attitudes expressed by informants toward persons with disability often seemed to be in contradiction with how they acted towards them.

It is important to note that while in Western societies impairment is primarily seen as an individual affair and functionally limiting at the bodily or cognitive level, in many non-Western societies what is perceived to be the cause and/or consequences of impairment may be dysfunctional social relations or the transgressing of social order (Shuttleworth & Kasnitz, 2005). In non-Western societies one's disability and culture are central to determine the position or the status that the individual is given in a specific society. Often, one's disability conforming to social expectations frequently is rewarded for that behavior; the culture tends to accept those who are willing to conform to given values, standards of behavior and ethical concerns. Cultural understanding is also shaped by the meanings attached to various behaviors by the social and economic organization of a given society, or by other internal and external cultural dynamics, or imposed standards upon all citizens of that given culture. Murphy (1990) indicated that disability had been defined by society and was given meaning by a culture; therefore, there were various cultural perspectives of what disability was and how disability in people was perceived and treated in various cultures.

From the cultural perspective, large- and small- scale societies perceive disability differently. Insmall-scale societies, close interactions between individual members are the norm; each individual may have extended and multi-strand relationships with other members of that society (Scheer&Groce, 1988). Individuals may interact in the course of economic production, during leisure time, or while participating in the arts or ceremonies. The social identity in these small-scale societies is based on family clan and other characteristics
but not on the individual's physical characteristics.

Despite the emergence of the social model and the rights approach to disability, culture and religion still influence the understanding of disability substantially in many societies (Reinders, 2011; Trescher, 2017). Attitudes and perceptions are socially as well as culturally constructed and dynamic in nature and may vary with the social situation in which they are acted upon (Edgerton, 1970; Ingstad, 1997). Ingstad and Sommerschild (1983) found that previous life experiences are another important source of influence on people's attitudes and behaviour toward disabled persons. They found that previous positive experiences in handling other types of crises became a source from which parents could draw when they got a disabled child. They identified two types of reactions to the experience of having a disabled child; those who said that they got a terrible shock which it took them sometime to overcome, and those who saw it as just one of those things that happen in life. Differences in attitudes towards a disability depended on whether or not it is perceived as a troubling disability in thatit causes problems for others and takes the mother away from carrying out chores necessary for the survival and daily life of the family. Each family would have their own constructed notions of disability that might influence the treatment of and relationship with the disabled child (Ingstad, 1995). The diversity of disability experiences across the world needs to be acknowledged in order to understand attitudes towards disability especially in the developing world like Cameroon where there is scarce information due to lack of research

1.1. Discrimination

Discrimination is the unfair or prejudicial treatment of people and groups based on characteristics such as race, gender, age or sexual orientation. But explaining why it happens is more complicated. For many people, discrimination is an everyday reality. Discrimination is a public health issue. American Stress Survey (2015), people who say they have faced discrimination rate their stress levels higher, on average, than those who say they have not experienced discrimination. That's true across racial and ethnic groups. The Civil Rights Act, the Age Discrimination in Employment Act, and the Americans with Disabilities Act prohibit discrimination in employment on the basis of race, color, sex, ethnic origin, age and disabilities. Discrimination can be classified into two different types, they include direct and indirect discrimination. Direct discrimination takes place when individuals or groups are treated unequally because of their ethnic background. Indirect discrimination, by contrast, refers to situations in which individuals or groups are treated equally according to a set of seemingly neutral rules or procedures, but when put into practice these rules favor members of one group over members of another. Internationally there has been an increasing focus on non-discrimination protection in the workplace and human rights for disabled people (Halvorsen & Hvinden, 2011). While discrimination in the workplace issue has been partially ignored, the general tendency on discrimination issue is majored on employers and non-disabled colleagues' negative attitudes, labeling and negation of human capital that are assigned as the main discrimination sources in employment arena (Shier, Graham, & Jones, 2009). However, discrimination experienced by disabled people is not just a result of prejudice of employer, colleagues or society but discrimination has an institutionalized form especially in public sector. While employers' and non-disabled employees' negative assumptions regarding disabled employees could be partly explained by social and cultural infrastructure, it is more related with organization of modern industrial society.

1.2.1 Discrimination at Work

Discrimination in the workplace happens when a person or a group of people is treated unfairly or unequally because of specific characteristics. These characteristics include race, ethnicity, gender identity, age, disability, sexual orientation, religious beliefs or national origin. The Equality at Work Law of 1988 forbids discrimination by employers between employees or those seeking employment on the basis of gender, sexual orientation, attitude, whether they have children, age, race, religion, nationality, country of origin, viewpoint, political party or length of service in the reserves, in each of the following: application for employment, working conditions, promotion, training or professional courses, previous dismissals or compensation payment, career changes or payment given to an employee on leaving previous employment.

1.2.1.1. Types of discrimination at work

1.2.1.1.1. Direct discrimination at work

Direct discrimination is where somebody has been treated differently or worse than another employee due to an underlying reason. These underlying reasons may be someone's age, race, religion or beliefs. An example is if an older employee is not allowed to work as part of a social media marketing team because the company feels they're too old to understand the concepts, despite having the same level of expertise as younger employees. This example is a direct form of discrimination against this more senior employee due to their age. Direct discrimination falls into three separate categories. The categories include:

- **Ordinary direct discrimination**. This type of discrimination is where somebody is treated differently because of a protected characteristic someone possesses. Ordinary direct discrimination is the only type of direct discrimination which may be lawful, but only if it is 'objectively justifiable'.
- **Direct discrimination by association**. This type of discrimination is where somebody is treated differently because of a protected characteristic possessed by someone they're associated with. An example of this type of discrimination is someone being uninvited from work social activities because they're friends with a colleague who possesses a protected characteristic.
- **Direct discrimination by perception**. This type of discrimination is where someone is treated differently because of a protected characteristic other people think they possess, regardless of whether the perception is correct. Direct discrimination can be an intentional or unintentional act. However, regardless of whether there was an intention to discriminate, you can still make a claim against the perpetrator. In discrimination cases, the most important focus is how the victim feels rather than whether the perpetrator meant it in that way.

1.2.1.1.2. Indirect discrimination at work

Indirect discrimination is a less obvious type of discrimination than direct discrimination and is usually unintentional. This type of discrimination in the workplace occurs when a company puts a plan or rule in place, which isn't discriminatory but puts people with specific characteristics at a disadvantage. An example may be setting a minimum height requirement for a job where height is not relevant. This example discriminates against women (and some specific ethnic groups) who are generally shorter.

1.2.1.1.3. Harassment

Harassment is when somebody is conveying negative behavior towards a fellow employee, which humiliates, intimidates or excludes them. This type of discrimination in the workplace is a violation of somebody's dignity and creates a toxic working environment for that person.

Common examples of harassment include: Bullying, stereotype, Unpleasant nicknames, social avoidance, Gossiping and spreading rumors about someone, Asking inappropriate questions.

It's not a defense for the harasser to say that they didn't mean their behavior to upset the victim. With harassment, the victim's feelings towards the action are more important than how the harasser saw the conduct.

1.2.1.1.4. Victimization.

Victimization is where somebody becomes a victim of harmful behavior because they have done (or because it's suspected that they have done or may do) one of the following things in good faith:

- Made an allegation of discrimination
- Supported a complaint of discrimination
- Gave evidence relating to a complaint about discrimination
- Raised a grievance concerning equality or discrimination
- Did anything else for (or in connection with) the Equality Act, such as bringing an employment tribunal claim of discrimination. By reporting this type of behavior, you could be a victim to victimization through being labelled a 'troublemaker', being left out and ignored, being denied a promotion, or being made redundant.

1.2.1.2. Types of discrimination against employees with disability at work.

1.2.1.2.1. Failure to make reasonable adjustment.

This is one of the most common types of disability discrimination. Changes to policy or the working environment which are designed to minimize or negate the effects of an employee's impairment are known as 'reasonable adjustments'. Such alterations might include use of an ergonomic keyboard, assistive computer software or a desk chair with additional back support. Employers are legally required to make these reasonable adjustments for their disabled staff members wherever possible. Failure to do so can qualify as discrimination. The employer's duty to make reasonable adjustments applies from the recruitment process onwards. This could include enquiring whether job candidates require reasonable adjustments and allowing candidates to complete any written test using a computer. What is considered reasonable in the context of ‘reasonable adjustments’ will depend on the circumstances of each case. Relevant factors can include whether an adjustment is practical, the cost of the adjustment, what resources are available to the employer and how effective the adjustment is likely to be. Further, there may be instances where a proposed adjustment is not reasonable and, as such, the organization can lawfully refuse to comply with the request.

1.2.1.2.2. Harassment and victimization

As a type of disability discrimination, harassment covers any unwelcome conduct in the workplace which relates to the person’s disability. This may include written, verbal or physical conduct, which is embarrassing, upsetting, intimidating, hostile or otherwise offensive in any way. Any person who witnesses harassment in the workplace can make a harassment claim; they do not need to be disabled or share a common disability with the person being harassed. Victimization refers to a situation in which an employee is subject to mental, emotional or physical harm, loss or damage, because they have done any of the following:

- Made a discrimination complaint
- Supported another person’s discrimination complaint
- Raised a grievance which relates to discrimination or equality

A person can also be victimized if they are believed to have done one of these things, or if someone suspects that they intend to.

1.2.1.2.3. Discrimination arising from disability

This type of disability discrimination covers situations in which a person is subject to poor or “unfavorable” treatment due to something associated with their disability, rather than the disability itself. The issue associated with the disability could be something like absence from work due to ill health, poor eyesight, mobility issues or difficulty paying attention. To prove discrimination arising from disability, the victim does not have to show that they have been treated less favorably than their colleagues; they simply need to demonstrate that they themselves were treated unfavorably no comparison is necessary. For example, an employee with dyslexia takes longer to complete written reports, due to the issues they have with reading and writing. This results in disciplinary action against the employee, which prevents them being eligible for an annual bonus.

1.3. Over view of disability.

1.3.1. Definitions

1.3.1.1. Disability

The term ‘disability’ has been somewhat hard and controversial to define. The meaning of ‘disability’ has evolved and changed over the years. A wide range of approaches have been discussed throughout disability related literature. The one thing that is certain however, is that in order to develop effective programs and policies that ensure the rights of disabled people are being met, a shared definition or understanding of ‘disability’ should be agreed upon (Department of Education and Training, 2005). Indeed, existing literature narrows the scope of defining disability into two major classification systems: ‘the medical model’ and ‘the social model’ and further suggests that in recent years there has been a shift from the ‘medical’ to the ‘social model’. In other words, people with disabilities are perceived as being disabled by society, rather than by their bodies (WHO, 2011). This is an important perspective as it not only affects how we define disability but has an impact on social planning and programs design, as well as on employment strategies (Department of Education and Training, 2005).

United Kingdom Government (2010) suggests that a person is disabled if they have a mental or physical impairment that causes them substantial and long-term adverse effects when carrying out their daily activities. Additionally, the Employment Equality Act 1998 – 2015, offer a detailed description of the term ‘disability’:

“The total or partial absence of a person’s bodily or mental functions, including the absence of a part of a person’s body. The presence in the body of organisms causing, or likely to cause, chronic disease or illness. The malfunction, malformation or disfigurement of a part of a person’s body. A condition of malfunction which results in a person learning differently from a person without the condition or malfunction. A condition, illness or disease which affects a person’s thought processes, perception of reality, emotions or judgement or which results in disturbed behavior”

The result is social exclusion, less favorable treatment of and discrimination against people with impairments. Hence, people with ‘disabilities’ are people with impairments who are disabled by barriers in society. The key point being made is the notion that disability is external to the individual and is a result of environmental and social factors. Before moving on, it is important to look at the term invisible disabilities; these are disabilities that are not immediately apparent to another person. The Invisible Disabilities Association (2017) offer the following explanation; invisible disabilities are physical, mental or neurological conditions that restrict a person’s mobility, senses or activities and are undistinguishable to the onlooker. As a result, people with invisible disabilities are subject to judgment, misunderstandings and false perceptions (The Invisible Disabilities Association, 2017). An example of an invisible disability is someone with a level of hearing loss in one or both ears, but because they choose not to wear a hearing aid, their disability is not immediately evident. It is not hard to imagine how this can cause difficulties not only for the person themselves but even for those around them who are unaware of their level of ability. In the workplace, workers with invisible disabilities encounter unique challenges compared to workers with visible disabilities. Workers with invisible disabilities can choose whether to disclose their disability to their employer and/or co-workers. Disclosing this kind of information can have implications on the individual worker's health, social relationships and work performances (Santuzzi, Waltz, Finkelstein and Rupp, 2014).

According to the Webster Miriam's dictionary disability is a physical, mental, cognitive, or developmental condition that impairs, interferes with, or limits a person's ability to engage in certain tasks or actions or participate in typical daily activities and interactions**.** Disability is further defined as any impairment of the body or mind that limits a person's ability to partake in typical activities and social interactions in their environment (Scheer&Groce, 1988). The United Nation's Conventions on the rights of Persons with Disabilities (UNRPD) (2011) recognizes disability as an evolving concept and states that "persons with Disabilities include those who have long term physical, mental, intellectual and sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on equal basis with others". The American Disability Act (ADA)defines disability, with respect to an individual, as 'a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment (ADA Act of 1990).According to the social model of disability which appeared in the 1960s, disability is considered as a social product, as a result of society's inadequacy to the specificities of its members. The model identifies the presence of physical and social barriers which makes it difficult for people with disabilities to exercise their rights and freedoms in all aspects of life. In this same light WHO (2011) says disability is thus not just health problems. It is a complex phenomenon, reflecting the interactions between features of person's body and features of society in which he/she lives. From the above definitions of disability, it obvious that disability is a deviation from normal functioning but the difficulties which the individuals face are exacerbated by community perception and social interactions.

Disability is not just a health problem or attribute of individuals, but it reflects difficulties individuals may experience in interaction with society and physical movements. For disabled persons and their families, the situation becomes doubly difficult due to general health problem and unique social stigma attached to various types of disability. Disabled people experience various barriers due to restriction of participation and their lives are affected with poor health outcomes, low education, lack of social and economic participation, higher rates of poverty and increased dependency.

In general, Disability studies are an academic discipline that examines and theorizes about the social, political, cultural, and economic factors that define disability. The disability rights movement, scholars, activists and practitioners construct debates around two distinctly different models of understanding of disability - the social and medical models of disability (Disabled-World.com). However, there are many other models that are used in disability studies. Disability scholars use the models to identify the different factors that are implicated in the proper comprehension of disabilities.

Hence, Disability is not just a health problem or attribute of individuals, but it reflects difficulties individuals may experience in interaction with society and physical movements. Evidently the term "disability" has many different meanings; the global burden of disease (GBD) however, uses the term disability to refer to loss of health, where health is conceptualized in terms of functioning capacity in a set of health domains such as mobility, cognition, hearing, and vision. Disability studies are an academic discipline that examines and theorizes about the social, political, cultural, and economic factors that define disability. Disability scholars use models to identify the different factors that are implicated in disabilities. Disability scholars also classify disability in to different Categories. These categories may include: social, mental, psychological, intellectual, physical disability etc.

Social Disability: A social disability can refer to any disorder that leads to the inability to make progress socially and emotionally meaning the impact of the disorder degrades a person's quality of life. Some social disabilities are recognized federally under the IDEA- they can include autism, other health impairment, intellectual disability, emotional disturbance, among others. When the impact is so great, an individual might qualify for services through a school district if they are school age, or if they are an adult, they may qualify for federal or state disability insurance to support any services they need to treat their disability and lead a productive life(https://www.quora.com/What-does-a-social-disability-mean).Examples include Post Traumatic Stress Disorder (PTSD), Major Depressive Episode (MDE). Depression etc.

Mental Disability: According to the WHO mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in important areas of functioning. There are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm. Some examples include Anxiety Disorders, Depression, Personality Disorders, Eating Disorders, and psychotic Disorders etc

Psychological disability: According to the APA (2013), a psychological disorder is a condition that is said to consist of the following:

- There are significant disturbances in thoughts, feelings, and behaviors. A person must experience inner states (e.g., thoughts and/or feelings) and exhibit behaviors that are clearly disturbed—that is, unusual, but in a negative, self-defeating way. Often, such disturbances are troubling to those around the individual who experiences them.
- The disturbances reflect some kind of biological, psychological, or developmental dysfunction. Disturbed patterns of inner experiences and behaviors should reflect some flaw (dysfunction) in the internal biological, psychological, and developmental mechanisms that lead to normal, healthy psychological functioning.
- The disturbances lead to significant distress or disability in one's life. A person's inner experiences and behaviors are considered to reflect a psychological disorder if they cause the person considerable distress, or greatly impair his ability to function as a normal individual (often referred to as functional impairment, or occupational and social impairment).
- The disturbances do not reflect expected or culturally approved responses to certain events. Disturbances in thoughts, feelings, and behaviors must be socially unacceptable responses to certain events that often happen in life. Some believe that there is no essential criterion or set of criteria that can definitively distinguish all cases of disorder from no disorder (Lilien feld & Marino, 1999). Examples of psychological disabilities include manic depression, bi-polar disorder, schizophrenia, personality disorders, post-traumatic stress disorders, anxiety disorders, delusional disorders, and eating disorders. Psychological disabilities can create barriers to education in different ways.

Physical disability

A physical disability is identified as a disability associated with a physical impairment. Physical activity limitations may also be used to identify physical disability, but should be defined as limitations in performing simple activities that are clearly associated with physical (rather than intellectual, etc.) abilities (Wen &Nicola, 1999). Therefore, a physical disability is a substantial and long-term condition affecting a part of a person's body that impairs and limits their physical functioning, mobility, stamina or dexterity. The loss of physical capacity results in the person was having a reduced ability, or inability, to perform body movements such as walking, moving their hands and arms, sitting and standing as well as controlling their muscles. A physical disability does not necessarily stop you from performing specific tasks but makes them more challenging. This includes daily tasks taking longer to complete, such as getting dressed or difficulty gripping and carrying things. It is important to note that defining physical disability is not about the physical condition itself but how it impacts daily life, such as the ability to carry out work activities. A person may be born with a physical disability or acquire it in life due to an accident, injury, illness or as a side effect of a medical condition.

Physical disability may also constitute any physiological disorder or condition, cosmetic disfigurement, or anatomic loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine systems' (Americans with Disabilities Act of 1990).Examples of physical disability include cerebral palsy, multiple sclerosis, epilepsy, amputations, spinal cord injuries, deaf, dumb, blindness, learning disabilities (dysgraphia, dyslexia, dyspraxia, dyscalculia, dysorthography and attention deficit hyperactive syndrome (carehome.com). Just as types of physical abilities and how they impact a person's daily life are all different, causes of physical disabilities also vary.

1.3.2. Disability and work.

The right of people with disabilities to decent work, however, is frequently denied. People with disabilities, particularly women with disabilities, face enormous attitudinal, physical and informational barriers to equal opportunities in the world of work. Compared to non-disabled persons, they experience higher rates of unemployment and economic inactivity and are at greater risk of insufficient social protection that is a key to reducing extreme poverty. However, many authors have narrowed the scope of employment barriers for disabled people down to three: physical, attitudinal and organizational. Physical barriers that affect disabled people at work come in the form of obstructions that make movement within the workplace difficult, in other words the issue is with a lack of access due to poor planning (Hales, 1996). Modarressy-Tehrani (2016) concur, with disability advocates maintaining problems with access remain widespread. Physical barriers can also include a lack of appropriate tools or equipment, as well as reasonable adjustments - these barriers cement fear in the minds of both employed people with disabilities, as well as unemployed people seeking work (Bengisu, Izbirak and Mackieh, 2008). An analysis of The National Disability Survey reported that unmet needs for services and devices presented a barrier to employment for people with disabilities. The most identified unmet needs included; flexible work arrangements (46%), modified job tasks (29%) and accessibility modifications (32%) (Watson et al., 2015). S4ome employers expressed concerns around the potential costs to the organization for employing someone with a disability. This is in direct relation to making reasonable accommodations for a person who is disabled, as a way of better enabling them to carry out their duties. Houtenville and Kalargyrou (2011) indicate that particularly in small organizations there exists a fear of the cost of adjustments to better equip someone who is disabled. However, the authors do state that under the Americans with Disabilities Act the provision of making reasonable adjustments, the record shows that most such adjustments are not exceptionally high. In a similar way, (Jayasooria, Krishnan and Ooi, 1997) agree that employers showed reluctance to adopt or make changes to modify facilities and equipment, more than likely due to potential costs of such adjustments.

Attitudinal barriers can be described as the negative attitudes disabled workers experience through the people around them, including employers and co-workers (Bengisu et al. 2008). A large number of authors reported the attitudes of employers as one of the major challenges facing people with disabilities – employers and fellow workers tend to create greater barriers than any physical barrier (Department of Educational and Training, 2005). As previously mentioned there is a collective agreement that in recent years there has been a shift from ‘the medical model’ to ‘the social model’ of disability. The development of the social model has challenged traditional concepts of disability. Many sources agree that it’s this mindset that has played a key role in the employment disadvantage of people with disabilities. Hanley (2014) argues that despite anti-discrimination legislation and government support schemes disabled people remain at a disadvantage in terms of employment. Hanley blames the discriminatory attitudes of both employers and staff for this. His findings suggest that staff rationality over disability and work is conflicted. On the one hand, he found that people view work as competitive at both organizational and individual level. On the other hand, although workers seem generally sympathetic towards the idea of having disabled people in their workplace, they had anxiety over the actuality of it. Hanley indicates that people rationalize this way of thinking by conceptualizing disabled workers as different to disabled people. The competitive drive that exists today as well as perceptions of what is fair, require disabled people to ‘fit’ into work and to not be treated differently to their co-workers. The unfortunate result of this reality Hanley claims is that staff attitudes towards what is reasonable are a key driver in regard organizational and managerial approaches to what is reasonable. Not unlike Hanley, Butler and Parr (1999) proposes that more and more employers are expecting employees to be able to do everything, to be flexible, to self-manage their time, to see something and fix it, to be adaptable and to perform and become their employment. This attitude coincides with the increasing competitive nature of corporate society.

Some employers expressed fears around the ability of employees with disabilities to adequately carry out the work allocated to them. The concern is that an employee with a disability would not have the requisite skills necessary for the job and would not be as productive as employees who did not have a disability (Houtenville et al. 2011). Of course, in certain countries there is an obvious issue with existing prejudices regarding disability, which deters employers from considering applications made by employees with disabilities (Jayasooria et al. 1997).

1.3.2.1. Employment Arena vs. Disabled People

Historical development of employment arena for disabled people could serve to establish the historical continuity of the approaches. Moreover, it attempts to provide an evolutionary perspective. The historical development of employment arena for disabled people could be distinguished into three famous phases introduced by Finkelstein (1980).

The first phase corresponds to feudal society, before the industrial revolution, that the economic base did not prevent disabled people from participating in the production process; however, they had no full contribution. So they were not segregated from the society completely (Oliver, 1990; Gleeson, 1999).

The second phase started with the creation of new productive technology. Rising of the factory system let disabled people stand outside of the production process. Institutions have provided physical base to segregate them from rest of the society. The dominant

view of suffering personal tragedy and unable to care themselves have brought care and protection: “In this era disabled people were regarded as individually unfortune and not segregated from rest of society” (Oliver, 1990).

With the phase II, by the emergence of capitalism, institutions have begun to segregate disabled people. Prior to industrialization most disabled people were economically productive, however with the coming of the urban factory based system, nature of the work has changed and they have labeled as economically unproductive (Barnes, 1991). According to Oliver (1990) the rise of capitalism has brought profound effects on organization of work and social relations that should be controlled by the institutions. Institutions have become major mechanisms to provide social control. Proliferation of hospital, prisons, asylums, workhouse etc. has served new guide to impose social order. “Economically unproductive” people are controlled by institutions that growing gradually. In other words, the rise of institutions as a mechanism of social provision and social control has played crucial role for systematic exclusion of disabled people from the mainstream economic and social life (Oliver & Barnes, 2012). In this respect, the rise of the capitalism facilitates the development of professionals (social workers, occupational therapists, physiotherapists, teachers etc.) and for segregating disabled people in the mainstream activities of the society.

In respect of provision to meet the changing needs of disabled people with the development of capitalism, this was done through the elaboration of ever more detailed systems of bureaucratic organizations and administration (Oliver, 1990, p.40).

By the help of detailed systems of bureaucratic organizations and administration, non- disabled people are allocated to the work-based system; disabled people are allocated to needs-based system of distribution. In other words, the paid workplace is the force of marginalization where the devalorisation of disabled people is practiced (Gleeson, 1999). While it is claimed and partially true that majority of disabled people were integrated into the community with the emergence of capitalism, oppression and prejudice was widespread with it (Oliver & Barnes, 2012).

When phase I and phase II are compared, disabled people are socially active and seen as responsible for their actions in phase I, however, in phase II disabled people are socially passive and subjected to be protected and cared. In this way, rising of capitalism excluded disabled people from the workforce. Moreover, rising of capitalism associates disability with absence from labour market (Barnes, 2000). Also Barnes (1991) claimed that most disabled people were able to make an economic contribution before industrial revolution, in other words, by industrial revolution economically productive people have been turned to economically unproductive. Since nature of work and the way it was organized has been constructed for non-disabled, disabled people have been excluded from the workplace. With the coming of this era, disabled people have been seen as a burden since many were unable to take on heavy physical labour required in factories and were thus unable to make a contribution to economy (Stalker, Baron, Riddell, & Wilkinson, 1999). For these reasons, centrality of work causes emerging “useless” label for disabled people since they are not able to contribute to the “economic good of the community” (Barnes, 1996). Disabled people have been thought with “dependent” or more precisely “dependent culture” paradigm with the rise of capitalism (Jolly, 2000). Dependency basically refers “the inability to do things for oneself and consequently the reliance upon others to carry out some or all of the tasks of everyday life” (Oliver, 1999: 9) Capitalism’s social construction of disability reflects dependency as a social problem and an inevitable consequence of the social construction of disability that prevail in industrial societies.

According to Finkelstein (1980), utilisation of new technologies will bring liberation of disabled people in phase III that emphasizes on the beginning of struggle to reintegrate disabled people into economic side of the society. However, the new technology paradigm has been served as “magic wand” and “magic way” for liberation of disabled people in an economic manner. While the new technology paradigm promises new employment opportunities for disadvantage categories, the requirements of the new mode of production (access to technology etc.) simply has created new divisions. Parallel to this, Priestly (2003) argued that technologies are not independent units from the prevailing relations of production, so technology could not guarantee successful employment by itself. New technologies may offer new pathways for employment of disabled people, however technical assistance will not guarantee social inclusion Stevens, 2002). In this respect, we could argue that employment of disabled people is governed by phase II is still valid.

In disability literature of Turkey, majority of the study focused on private sector and ignored the experiences of disabled worker in public sector. Also majority of those dealt with employers’ perception towards disabled workers. By doing so, medical perspective is run and the employability issue is discussed just around employers’ agenda.

As an example of those, the study of Gökbay, Ergen and Özdemir (2011) suggest that gaining self-confidence of (potential) disabled employees offers successful employment. Öztürk (2011) points the strategical attitude of private sector towards disabled employees as employing disabled people for 3-4 months before auditing of İŞKUR in order to not to pay fine, then fire them. One the hand the study displays one of the crucial invisible barriers in the employment arena, on the other hand, parallel with medical view, it suggested to educate disabled employees as if “the problems” are caused by disabled people. One of the study claims that there are no disabled employees who have high disability percentage in the workplace that suggests invisible disability is very common in the private sector (Yılmaz, 2004).

1.3.3. Institutional Discrimination

Discrimination is one of the crucial terms in understanding social problem related with diversity. In this study, I separated discrimination towards disabled people in the employment arena into two: (1) institutional discrimination and (2) disability harassment. The former is a vehicle underpinned by dominant ideology to express the restriction of minority group members’ socioeconomic status in the society through specific institutions within political economy. The latter refers to discriminatory attitudes and practices among employers, colleagues and labor markets, which is differentiated from individual discrimination, due to the social settings of the workplace. These discrimination types are not mutually exclusive but dependent on each other. Institutional discrimination has a higher abstracted level and disability harassment is meaningful under it. So they have no equal level to be categorized. In this section, I will focus on institutional discrimination. The notion of institutional discrimination has been used in several subfield of social sciences; educational studies (Solmon, 1973), migration studies (Bathnitzky & McDowell, 2011; Teixeira, Lo, & Truelove, 2007), poverty studies (Rodenborg, 2004), racial studies (Stainback & Irvin, 2012; Miller & Garran, 2007; Henkel, Dovidio, & Gaertner, 2006), gerontology (Ayalon, & Gum, 2011), feminist studies (Colander & Woos, 1997), health studies (Dubois-Arber & Haour-Knipe, 2001) and disability studies (Barnes, 1992a; Barnes, 1994a; Barnes 1994b; Pincus, 1996; Wolfensberger, 1989; French & Swain, 2012). In this study, institutional discrimination is held as to deny minority group, being outside of the "social norms", to access upper socioeconomic status.

The terms of individual discrimination and institutional discrimination are varied. According to Pincus (1996) individual discrimination refers to the attitudes of group of people that is intended to have a harmful effect on the members of another group. However, institutional discrimination refers to policies of the dominant group institutions and the attitudes of individuals who control these institutions that are intended to have a harmful effect on minority groups. In other words, discriminatory attitudes are embedded in the institutions and institutional discrimination corresponds to more than the sum of all elements of individual discrimination. Even if attitudes of all individuals are positive, social and political settings of the institution does not allow for inclusion. Many barriers to employment realize at individual employer or workplace level, however barriers to employment are governed at the macro level (Arthur & Zarb, 1995).

Institutional discrimination is carried out by dominant group against minority group since by definition dominant group control the institutions, institutional discrimination is carried out by non-disabled people against disabled people. How people behave within institutions and how entire institutions behave people are the two component dynamics of institutional discrimination (Wolfensberger, 1989). Institutional discrimination determines who deserves a job and who does not. Discrimination experienced by disabled people is not just an outcome of individual negative attitudes. It has much more complex structure. For Barnes (1992a: 5), "institutional discrimination is complex form of discrimination which operates throughout society and is supported by history and culture".

Institutional discrimination claims that inequalities are woven into very structure of the organizations, indeed society.

Institutional discrimination is founded on the social divisions in society and, in particular, hierarchical power relations between groups (for example disabled and non-disabled people). Inequalities in the distribution of resources particularly economic, underpin hierarchical power relations, with many disabled people being marginalized from open employment and condemned to poverty (French & Swain, 2010, p.53).

Institutional discrimination underpinned by dominant ideology operates in three ways: (1) establishing normal/abnormal dualism, (2) legitimizing social inequalities and power relations (French & Swain, 2012) and (3) governing eugenism principles. When problem is located in disabled people by the help of medical model, the ideology of normal/abnormality works properly. The employment arena is greatly influenced by disability models adopted by institutions. Since models are tool for approaching disability issue, they determine the lines to build relationships in the work force. Institutional discrimination towards disabled people rests on the assumptions of medical view of disability. This view offers that disability has a traumatic physical and psychological effect on disabled people that legitimizes the discrimination they faced (Barnes, 1994b). Moreover, medical certification of disability has become one of the major tools for social policies (Stone, 1984).

As a second ideology, patterns of discrimination are gathered within institutional context and these patterns become institutionalized, discrimination becomes “natural” and “as should be” (Wood & Ragar, 2012). The dominant ideologies and assumptions are deeply embedded in social consciousness that they become “facts”, common sense and they are naturalized (Oliver, 1999). Institutional discrimination in the employment arena serves to increase inequalities between minority group and majority group that lead to disproportionate number of minority group in positions of lower socioeconomic status (Henkel et al., 2006). By the help of institutional discrimination, lower socioeconomic status of disability and discrimination within employment become “natural” and “as should be”:

The labeling of a condition as disabling by both the medical profession and state bureaucracies educates the public to believe the condition is actually disabling (Stone, 1984, p.190).

The final dominant ideology underpins institutional discrimination is that eugenism principles. Institutions, both private and public sector, in modern era have adopted Spencer's social Darwinism and the “survival of the fittest” principle. At this point, related with social Darwinism, it is a need to mention eugenic movement as a science of biologically improve human race, is one of the effective tool of modernization ideal. Eugenism was developed around progressivism, developmentalism, scientism, nationalism and racism in the aim of improving the quality of human species. Eugenic movement is assumed to guide social progress and national development. Also it is believed that eugenic movement serves to increase economic, military and governmental efficiency. Modern eugenism has been constructed around Darwin’s theory of evolution, Spencer’s theory of survival of the fittest and social Darwinism by Galton (1972). He dreamed healthier human species by the attempts of explaining human biology based on scientific knowledge. However, modern eugenism used its own methods for survival of the fittest rather than let survival of the fittest naturally realized. For this reason, eugenism could be characterized as social and political program rather than scientific. While eugenism referred to “science”, over the years it is evolved to “social movement”. The thinking system of social Darwinism has eliminated people who were genetically weak and dependent of others’ care. In this respect, disabled children were killed, disabled adults are excluded from the economic area and disabled older were left to die (Barnes, 1996). Eugenism sees society as a biological organism. It is assumed that people who have physical and mental differences bring both economic and social burden, and racial degeneration (Alemdaroğlu, 2006). Since abnormality causes a burden of the society, eugenic movement has a motivation to save the public by displaying “winners” and “losers”. (Kemp, 1946). In this respect, disabled employees are assigned as the “losers” of the workplace. The disabled are evaluated within eugenism perspective and “the best” disabled workers those who are better able to adapt to the environment and conditions are preferred by this continuous circulation.

Social policies try to find the source of unemployment in discriminatory attitudes of employers and physical barriers in the workplace, however, political economy with three dominant ideology mentioned above is much more crucial to understand unemployment and discrimination in workplace faced by disabled people.

The political economy perspective suggests that disabled people are excluded from the workforce not because of their personal or functional limitations, nor simply because of discriminatory attitudes and practices among employers and labour markets but because of the way in which work is organized within capitalist economy itself (Oliver, 1996a, p.34).

Many governments have adopted social policies which aim to penetrate disabled people into economic mainstream however; there are hidden assumptions and ideologies underpinned by medical view of disability.

Under industrial capitalism that is precisely what happened, and disability became individual pathology; people with impairments could not meet the demands of wage labour and so became controlled through exclusion (Oliver & Barnes, 2012, p.82).

Discriminatory attitudes of employers and physical barriers in the work place could not be denied in the process of employment of disabled people, but these are just outcomes of political economy. For instance employer’s attitudes stem from the expectation of maximization of profit, avoiding costs of environmental modification and health care coverage, not totally due to their prejudices towards disabled people. Russell (2002) stated with economic determinism that root cause of the institutional discrimination could be found in comparison between present costs of production with the potential contribution of employed who will make future profits.

However, this comparison still embraces some kind of prejudices (not individual but within capitalist understanding) that cause disability harassment that I will open in the following section. 3.4 Disability Harassment

All type of barriers could be evaluated as discrimination. However discriminatory barriers are underpinned by approaches that attempt to eliminate and disqualify groups of people, perceived as a “threat”, from mainstream activities. In other words, discriminatory barriers have a constricting effect on the opportunities of disabled people to achive mainstream activities (Chan, McMahon, Cheing, Rosenthal, & Bezyak, 2005).

Harassment is a manifestation of the attitudinal barriers (Weber, 2007). Not just physical workplace barriers prevent people with disabilities from obtaining meaningful employment but also discrimination and negative attitudes towards them are also the other barriers (Wehman, 1996).

Disabled people have experienced harassment related to their disability status just as experienced harassment on the basis of gender, race or other characteristics.

Disability harassment is defined as unwelcome bothering, tormenting, troubling, or coercing of another person related to the disability of that person and is composed of verbal behavior or gestures as distinguished from physical violence or force. The harassing behavior is typically repeated and often takes place in a social context, with the harasser attempting to gain power over the individual being harassed. The determination of the occurrence of harassment belongs with the recipient, not with the harasser (Holzbauer & Berven, 1996, p.478).

Disability harassment has two forms. Firstly, if disability harassment needed social interaction, it exists as visible discrimination. Secondly, disability harassment underpinned by ideologies has latent feature that gives an assumption that all people have equal chances in the mainstream activities. Also disability harassment takes a variety of forms coming from variety of subjects. It may come from employers, colleagues or institution itself. No matter what its form, it deprives disabled people of equal access to employment arena (Weber, 2002). Disability harassment is not mere thoughtlessness or failure to accommodate the needs of disabled people (Weber, 2007).

People are disabled by the physical, organisational and attitudinal barriers within the society. Disability identity became meaningful within the context of work. The search for work and workplace itself need interactions and through these interactions disabled people made a distinction between themselves and those who are not disabled (Brown, Hamner, Foley, & Woodring, 2008). Charlton (2006) argued that disabled people have been socially oppressed since they have not been considered as economically productive members of the society. Since medical model associates disability with inability, disabled people are identified as worker who cannot perform certain tasks (Woodhams & Corby, 2003). In general, perceived inabilities of disability cause exclusion from workforce. Furthermore, the motive force of competitive capitalism is to exclude “slow” or “incapable” workers (Gleeson, 1999). Capitalism as an economic and social system undervalues disabled people, regarding them as inevitably “less productive” (Foster, 2007). Disabled employees are assumed as incompetent that brings incapability of performing same tasks at the same level of colleagues without disability. According to Robert and Harlan (2006), disabled workers were automatically considered as “slow, incapable of keeping up”, “slow learners”, “stupid”, “of low or limited intelligence”, or “not mentally capable”. Moreover, regardless of their actual abilities, talents and skills, they are put in the same category as “just disabled”.

Disabling attitudes of employers, unequal access to education and training, an absence of appropriate support, and disabling barriers in the workplace are the major reason of discrimination faced by disabled people in the workplace (Priestly, 2003). Educational level is one of the fundamental indicators for activity in the labour market. However, discrimination in the education system functions to minimize the expectations of disabled people from the labour market. In other words, they are prepared to expect less for mainstream activities through practicing education system. The perception of disability limits employment opportunities however, it is the lack of skills among disabled people that sets legitimate ground for employer to discriminate them (Roggero, Tarricone, Nicoli, & Mangiaterra, 2006) Indeed, while system claims to need qualifications, it is evident that education does not much matter for employment of disabled people. Even if a person with a disability is well educated and well qualified to perform a job, employers seek for people with invisible disability if they have to employ.

1.3.4. Types of Disability.

Disability groups are a broad categorization of disabilities in terms of underlying health condition, impairment, activity limitations, participation restrictions and environmental factors. The primary disability is the disability that most clearly expresses the experience of disability by a person. It can also be considered as the disability group causing the most difficulty to the person (overall difficulty in daily life, not just within the context of the support offered). A person’s functioning or disability is conceived as a dynamic interaction between a person with a health condition(s) and environmental and personal factors (WHO 2001). Functioning and disability are both multidimensional concepts. Disability is the umbrella term for any or all of an impairment of body structure or function, a limitation in activities (the tasks a person does), or a restriction in participation (the involvement of a person in life situations). The International

Classification of Functioning, Disability and Health (ICF) recognizes two main components of functioning and disability: a body component comprising classifications of Body Function and Body Structure; and an Activities and Participation component providing a complete set of domains for aspects of functioning from both an individual and societal perspective. Environmental factors represent an important new component of the ICF in recognition of their influence on functioning and disability. Personal factors are also recognized but are not classified. There exist many types of disabilities which has been classified into specific groups depending on the impairment. Below are the various types and their specificity:

1.3.4.1. Physical disability.

Physical disabilities may affect, either temporarily or permanently, a person's physical capacity and/or mobility. There are many different causes of physical disabilities but they can include inherited or genetic disorders, serious illnesses, and injury.

1.3.4.2. Acquired brain injury.

Acquired brain injuries are due to damage that happens to the brain after birth. They can be caused through a wide range of factors including a blow to the head, stroke, alcohol or drugs, infection, disease such as AIDs or cancer, or a lack of oxygen. It is common for many people with a brain injury to have trouble processing information, planning, and solving problems. They may also experience changes to their behavior and personality, physical and sensory abilities, or thinking and learning. The effects of brain injuries and the disabilities they cause can be temporary or permanent.

1.3.4.3. Spinal cord injury (SCI)

The spinal cord can become injured if too much pressure is applied and/or if the blood and oxygen supply to the spinal cord is cut. When the spinal cord has been damaged, it leads to a loss of function such as mobility or feeling. For some people, a spinal cord injury results in paraplegia (loss of function below the chest), for others it leads to quadriplegia (loss of function below the neck). Accidents account for 79% of spinal cord injuries in Australia – mostly caused by motor vehicle accidents and falls. Other causes include cancer, arthritis, infections, blood clots, and degenerative spinal conditions. As well as affecting the ability to move through paralysis, it may affect many areas of a person's body – such as the cardiovascular and respiratory systems, bladder and bowel function, temperature, and sensory abilities.

1.3.4.4. Spina bifida

Spina bifida is the incomplete formation of the spine and spinal cord in utero. It can cause the spinal cord and nerves to be exposed on the surface of the back, instead of being inside a canal of bone surrounded by muscle. People with spina bifida experience a range of mild to severe physical disabilities including paralysis or weakness in the legs, bowel and bladder incontinence, hydrocephalus (too much fluid in the brain cavities), deformities of the spine, and learning difficulties. The cause of spina bifida is not well understood, but it is likely caused by genetic and environmental factors. Adequate intake of folate by the mother in early pregnancy has been found to be a significant factor in preventing a child developing spina bifida.

1.3.4.5. Cerebral palsy

Cerebral palsy is typically due to an injury to the developing brain before or during birth, caused by a reduced blood supply and lack of oxygen to the brain**.** Illnesses during pregnancy such as rubella (the German measles), accidental injury to the brain, meningitis in young children, and premature birth can all be causes. In Australia, over 90% of cerebral palsy was due to a brain injury while the mother was pregnant, or before one month of age, however, 10% of people develop the disability later in life, usually as a result of infections such as meningitis or encephalitis, stroke, or a severe head injury (Cerebral Palsy Alliance). People with Cerebral palsy may experience weakness, difficulty walking, lack of muscle control, problems with coordination, involuntary movements, and other symptoms.

1.3.4.6. Cystic fibrosis (CF).

Cystic fibrosis (CF) is an inherited genetic condition, which affects the body’s respiratory, digestive, and reproductive systems. It specifically affects the mucus and sweat glands in the body, causing mucus to be thick and sticky. In the case of the lungs, this can clog the air passages and trap bacteria causing lung damage and recurrent infection. A range of other symptoms are caused by the effects of CF on other parts of the body, including sinus infections, liver damage, diabetes, poor growth, diarrhea, and infertility. People with CF can also have low salt levels in the body which causes problems such as fatigue, cramps and dehydration.

1.3.4.7. Epilepsy

Epilepsy is a neurological condition where a person has a tendency to have recurring seizures due to a sudden burst of electrical activity in the brain. Seizures can cause unusual movements, odd feelings or sensations, a change in a person’s behavior, or cause them to lose consciousness.

The causes of epilepsy are not always known, however, brain injuries, strokes, cancer, brain infection, structural abnormalities of the brain, and other genetic factors can all cause epilepsy. There are many different types of epilepsy and the nature and severity of seizures experienced by people can vary widely. Some people can control their seizures with medication and the condition is not lifelong for every person.

1.3.4.8. Multiple sclerosis (MS).

MS occurs when the myelin sheath protective tissue around nerve fibers in the body becomes damaged, causing random patches or scars. The scars can interfere with messages sent through the central nervous system, affecting the brain, optic nerves, and spinal cord. The symptoms of MS are very varied but can include fatigue, loss of motor control, tingling, numbness, visual disturbances, memory loss, depression, and cognitive difficulties. The progress and severity of MS can be difficult to predict. it may progress very slowly for one person, but develop quickly in another.

1.3.4.9. Muscular dystrophy.

Muscular dystrophy is a group of genetic disorders that lead to progressive and irreversible weakness and loss of muscle mass. There are more than 30 different types of muscular dystrophy, and each has a separate cause. Signs and symptoms can be very varied however can include difficulty walking, trouble breathing or swallowing, restriction in joint motion, and heart and other organ problems. Symptoms of the most common type of the disease appear in childhood, however, others do not become apparent until middle age or older.

1.3.4.10. Dwarfism.

Dwarfism is short stature (abnormal skeletal growth) which can be caused by over 300 genetic or medical conditions. It is generally defined as an adult height of 4 feet 10 inches or less, with the average height of someone with dwarfism being 4 feet. In general, there are two categories for dwarfism:

- Disproportionate dwarfism: where some parts of the body are smaller, whilst other parts are average or above-average.
- Proportionate dwarfism where the body is averagely proportioned, and all parts of the body are small to the same degree.

Children with dwarfism may experience a delay on developing motor skills, however, dwarfism does not have a link to any intellectual disability.

1.3.5. Types of mental illness

Different types of mental illness affect a person's thinking, emotional state and behaviors.

1.3.5.1. Bipolar disorder

Bipolar disorder (formerly known as manic depression), causes extreme mood swings including emotional highs (mania) as well as extreme lows (depression). These mood swings come in ‘cycles’ which can last days, weeks or even months. When episodes are extreme, some people may experience suicidal thoughts and symptoms of psychosis. A person may be affected so much that they are unable to distinguish reality from fantas. The causes of bipolar disorder are not fully understood but are likely to be a combination of genetics and other causes.

1.3.5.2. Depression

Depression is a mental illness which significantly affects the way someone feels, causing a persistent lowering of their mood and feelings of dejection and loss. Depression has a variety of symptoms and will affect everyone in different ways. Some of the symptoms may include feeling extremely sad, disturbed sleep, loss of interest and motivation, feeling worthless, loss of pleasure in activities, anxiety, changes in appetite or weight, physical aches and pains, and impaired concentration. While the exact cause of depression isn’t known, it is generally due to a combination of recent events, personal factors, family history, drug and alcohol use, as well as changes within the brain itself.

1.3.5.3. Anxiety disorders

People with anxiety disorders frequently have intense, excessive, and persistent worry and fear about everyday situations. These feelings interfere with daily activities, are difficult to control, are out of proportion to the actual danger, and can last a long time. Examples of anxiety disorders include generalized anxiety disorder, social anxiety disorder (social phobia) and specific phobias. Other symptoms of anxiety disorders can include panic attacks, trembling, sweating, difficulty breathing, feeling faint, rapid heartbeat, nausea, or avoiding certain situations. Some of the causes or triggers of anxiety include the environment, stressful situations, trauma, family history, and substance abuse.

1.3.5.4. Schizophrenia

Schizophrenia is a mental illness which influences the way a person thinks, feels, and acts, often distorting their perception of reality. If not receiving treatment, people with schizophrenia may experience persistent symptoms of psychosis. They can have hallucinations such as seeing things, hearing voices, smelling odors, and feeling sensations on the skin. They can also have delusions which are false beliefs that strongly persist in their mind, and refuse to go away. Other signs and symptoms can include low motivation, dulled emotions, rambling and disorganized speech, lack of desire to form social relationships, and a lack of ability to express emotion.

1.3.5.5. Anorexia nervosa

Anorexia nervosa is an eating disorder characterized by an abnormally low body weight, an extreme fear of gaining weight, and a distorted perception of body weight. It can affect both men and women. People who have anorexia can restrict their eating, compulsively exercise, and misuse laxatives or diet aids. It’s important to know that this behavior is not connected to vanity or a lifestyle choice in any way. Anorexia has one of the highest mortality rates of all mental illnesses, with 10-20% of people dying within 20 years from complications or suicide.

1.3.6. Types of intellectual disabilities

An intellectual disability may mean difficulty communicating, learning, and retaining information.

1.3.6.1. Fragile X syndrome

Fragile X syndrome is the most common known cause of an inherited intellectual disability worldwide. It is a genetic condition caused by a mutation (a change in the DNA structure) in the X chromosome. People born with Fragile X syndrome may experience a wide range of physical, developmental, behavioral, and emotional difficulties, however, the severity can be very varied. Some common signs include a developmental delay, intellectual disability, communication difficulties, anxiety, and behaviors similar to autism such as hand flapping, difficulty with social interactions, difficulty processing sensory information, and poor eye contact. Boys are usually more affected than girls – it affects around 1 in 3,600 boys and between 1 in 4,000 – 6,000 girls.

1.3.6.2. Down syndrome

Down syndrome is not a disease or illness, it is a genetic disorder which occurs when someone is born with a full, or partial, extra copy of chromosome 21 in their DNA. Down syndrome is the most common genetic chromosomal disorder and cause of learning disabilities in children. In Australia, approximately 270 children, or one in 1,100, are born with Down syndrome each year. People with Down syndrome can have a range of common physical and developmental characteristics as well as a higher than normal incidence of respiratory and heart conditions. Physical characteristics associated with Down syndrome can include a slight upward slant of the eyes, a rounded face, and a short stature. People may also have some level of intellectual and learning disabilities, but this can be quite different from person to another.

1.3.6.3. Developmental delay

When a child develops at a slower rate compared to other children of the same age, they may have a developmental delay. One or more areas of development may be affected including their ability to move, communicate, learn, understand, or interact with other children. Sometimes children with a developmental delay may not talk, move or behave in a way that's appropriate for their age but can progress more quickly as they grow. For others, their developmental delay may become more significant over time and can affect their learning and education.

1.3.6.4. Prader-Willi Syndrome (PWS)

Prader-Willi syndrome (PWS) is a rare genetic disorder which affects around 1 in 10,000 – 20,000 people. This disability is quite complex and it's caused by an abnormality in the genes of chromosome 15. One of the most common symptoms of PWS is a constant and insatiable hunger which typically begins at two years of age. People with PWS have an urge to eat because their brain (specifically their hypothalamus) won't tell them that they are full, so they are forever feeling hungry. The symptoms of PWS can be quite varied, but poor muscle tone and a short stature are common. A level of intellectual disability is also common, and children can find language, problem solving, and math's difficult. Someone with PWS may also be born with distinct facial features including almond-shaped eyes, a narrowing of the head, a thin upper-lip, light skin and hair, and a turned-down mouth.

1.3.6.5. Fetal alcohol spectrum disorder (FASD)

FASD refers to a number of conditions that are caused when an unborn fetus is exposed to alcohol. When a mother is pregnant, alcohol crosses the placenta from the mother's bloodstream into the baby’s, exposing the baby to similar concentrations as the mother. The symptoms can vary however can include distinctive facial features, deformities of joints, damage to organs such as the heart and kidneys, slow physical growth, learning difficulties, poor memory and judgement, behavioral problems, and poor social skills. Many cases are also often misdiagnosed as autism. The World Health Organization recommends that mothers-to-be, or those planning on conceiving, should completely abstain from alcohol.

1.3.7. Types of sensory disabilities

Different types of sensory disabilities affect one or more senses; sight, hearing, smell, touch, taste or spatial awareness.

1.3.7.1. Autism spectrum disorder (ASD)

Autism spectrum disorders are a lifelong developmental disability. They affect the way someone interacts with the world around them, as well as with other people. Around 1 in 200 Aussies have autism (ABS, 2012), and boys are four times more likely to have autism than girls. The effects of autism are wide ranging and can include difficulties in social interaction and communication, restricted and repetitive interests and behaviors, and sensitivity to sensory experiences – noise, light, touch etc. As autism can be very variable, the word ‘spectrum’ describes the range of difficulties that someone with autism may experience. Autism is a complex disability and cause is not well understood. As far as we know there’s no single cause. Instead, it’s likely to be due to a combination of environmental and genetic factors.

1.3.7.2. Blindness and low vision

A person is considered legally blind if they cannot see at six meters what someone with normal vision can see at 60 meters or if their field of vision is less than 20 degrees in diameter. A person is said to have low vision when they have permanent vision loss which affects their day to day and cannot be corrected with glasses. Blindness and low vision can occur as a result of a number of different diseases, conditions, or accidents. Some eye conditions are congenital (present at or near birth), while others are caused later in life. Some specific causes of vision loss can include an injury to the eye, eye defects, albinism, macular degeneration, diabetes, glaucoma, cataracts, and tumors. Whilst some forms of vision loss can be prevented and even reversed, others may develop as people age. it is more common in those over the age of 65.

1.3.7.3. Hearing loss and deafness

Hearing loss, also known as a hearing impairment, is the partial or total inability to hear. If someone has very little or no hearing, the term 'deaf' may be used. Damage to any part of the external, middle, or inner ear can cause hearing loss which can range from being mild to profound. Causes of hearing loss can be quite varied and can include problems with the bones within the ear, damage to the cochlear nerve, exposure to noise, genetic disorders, exposure to diseases in utero, age, trauma, and other diseases.

1.3.8. Perception of Disability

People are constantly evaluating and making judgments about other people and events. We react to people and situations on the basis of our perception i.e how we evaluate and judge them. Perception of disability is an important construct affecting not only the well-being of individuals with disabilities, but also the moral compass of the society. Negative attitudes toward disability disempowered individuals with disabilities and lead to their social exclusion and isolation. By contrast, a healthy society encourages positive attitudes toward individuals with disabilities and promotes social inclusion (Babik& Gardner, 2021).

Despite the obvious benefits of inclusive education and social inclusion, children with disabilities are not always accepted by their typically developing peers. Across cultures, children with disabilities encounter negative attitudes, bullying, social exclusion, and isolation (Ochs et al., 2001; Hanvey, 2002; Nowicki and Sandieson, 2002; Cummins and Lau, 2003; Kelly, 2005; Laws and Kelly, 2005; Odom et al., 2006; Guralnick et al., 2007; Shah, 2007; Vreeman and Carroll, 2007; Nugent, 2008; Gannon and McGilloway, 2009; Koster et al., 2010; de Boer et al., 2012a; Lindsay and McPherson, 2012; Snowdon, 2012; Kayama and Haight, 2014). Socially excluded children may have unsatisfying peer relationships, low self-esteem, and lack of achievement motivation, which affect their social and academic aspects of life, mental health, and general well-being (Juvonen and Graham, 2001; Brown and Bigler, 2005; Murray and Greenberg, 2006; Pijl and Frostad, 2010; Lindsay and McPherson, 2012; Mâsse et al., 2012).

Attitudes toward individuals with disabilities vary with the type of disability. For example, children with emotional or behavioral disabilities and those with multiple disabilities are perceived more negatively by their typically developing peers than children with a specific physical disability (McCoy and Banks, 2012). Moreover, children with intellectual disability are perceived more negatively than children with a physical disability (Nowicki, 2006; de Laat et al., 2013), with level of social inclusion being positively related to the mental age of the child with disability (Carvalho et al., 2014). In the school context, with its high expectations to learn and negative future consequences of failing to do so, intellectual disability may have greater salience to typically developing children than physical disability.

Children with positive attitudes toward peers having disabilities may be more willing to interact with them compared to children with negative attitudes (Diamond, 1993; Okagaki et al., 1998; Roberts, 1999; Roberts and Smith, 1999; Favazza et al., 2000; Gaad, 2004). As a result, more exposure to individuals with disabilities may lead to better understanding of disability and higher levels of acceptance (Hong et al., 2014). Thus, attitudes drive behavior, which, in turn, affects the individual's knowledge, beliefs, and attitudes. Interventions improving children's knowledge about disabilities and providing exposure to those with disabilities is the most successful technique of changing children's attitudes toward peers with disabilities (Diamond and Carpenter, 2000; Nikolaraizi et al., 2005; Nowicki, 2006; Rillotta and Nettelbeck, 2007; Siperstein et al., 2007; Feddes et al., 2009; Kalyva and Agaliotis, 2009; Gasser et al., 2014; Armstrong et al., 2016).

Developmental psychologists suggest that early childhood is the best time to intervene against the formation of negative attitudes toward disability, before these attitudes and behavior patterns become fully established and difficult-to-change (Killen et al., 2011; Lee et al., 2017).Family plays a significant role in shaping children's beliefs and attitudes toward others: parenting styles and children's attachment styles may determine the child's future attitudes toward individuals with disabilities. Importantly, there is an intricate interplay between parental factors and children's personality factors. Being the primary agents integrating children into society, parents may significantly influence their children's attitudes toward out-groups in general and individuals with disabilities in particular (Hellmich and Loeper, 2019).Importantly, parents may communicate their beliefs and attitudes to children explicitly through discussions or explicit teaching, or implicitly by modeling their values in daily interactions with other people or by providing their children opportunities to interact with out-group peers (Dunn, 1993; Castelli et al., 2007; Hellmich and Loeper, 2019).

People with disabilities have been stigmatized throughout history as a function of negative perceptions. In many cultures, disability has been associated with curses, diseases, dependence, and helplessness. Disability stigma can play out in a number of ways including; not get married to a normal person, not being enrolled in particular jobs like the military, farming, and sports etc. overall negative perceptions may lead to the following:

1.3.8.1. Social avoidances

People with disability may be left out of social activities orthey may find their friends become more distant after they develop a disability. People may be hesitant to make eye contacts or start a conversation with someone who has a visible disability. When children with disabilities are constantly avoided, they too learn to isolate themselves. Social avoidance is a distinct subtype of social withdrawal that involves a desire to avoid social interaction due to anxiety and a preference to spend time alone (Asendorpf, 1990). These two components, social anxiety and preference for solitude, jointly increase the likelihood of social maladjustment among children with disabilities. For example, feelings of social anxiety inhibit positive social interactions and reduce social opportunities, further contributing to problems in interpersonal relations (La Greca, 2001; Russell et al., 2011). Moreover, because socially avoidant children seek out more solitude, they might miss out on important opportunities to practice and develop new cognitive and social skills (Coplan et al., 2009; Jones et al., 2015). Indeed, past research has shown that compared to their more sociable counterparts, socially avoidant children experience more peer difficulties and internalizing problems. For example, Coplan et al. (2006) found that compared with other children, avoidant children reported the highest levels of negative affect and depressive symptoms and the lowest levels of positive affect and overall well-being. Similarly, Nelson (2013) reported that social avoidance was related to peer difficulties among young adults. Bowker and Raja (2011) also found that social avoidance was associated with peer-exclusion.

1.3.8.2. Discrimination

People with disabilities may be denied jobs, housing or other opportunities due to false assumptions or stereotype about disabilities. It is unlawful to discriminate against an individual by reason of disability. Discrimination issues typically relate to flawed or inconsistent organizational policies, procedures or practices that have failed to accommodate people’s physical or mental impairments as required by law. Understanding and recognizing different types of disability discrimination can help the society to take a proactive approach to prevent discrimination and avoid people with disabilities suffering less favorable treatment because of their condition.

There are four main types of discrimination recognized by the Advisory, Conciliation and Arbitration Service (ACAS) which include, Direct discrimination, indirect discrimination, Harassment and Victimization **(**Morris, 2019**).** Article 5 of the Convention of the rights of people living with disabilities emphasize on the equality and non-discrimination of people living with disabilities. It states that everyone is equal before and under the law. Everyone is entitled to the equal protection and benefit of the law without discrimination.

1.3.8.3. Condescension (Over protection)

People living with disabilities may be coddled or overprotected due to perceptions of their helplessness. Lowered expectations and over-protection of the individual with a disability can cause lowered self-esteem which can result in a life time of underachievement and failure to reach their full potential (Sanders k.J., 2006). Over-protection and lowered expectations of persons with disabilities may result in several unwanted and unintended consequences which can have lifelong impact. The prejudicial attitudes of those around a child with a disability often include overt acts of sympathy and pity. This discomfort may cause the person with a disability to be segregated and may exaggerate the sense of inequality. Adolescents with disabilities may not be prepared to make decisions for themselves because of their subjection to low expectations and because they are micromanaged by parents and educators. This negative feedback keeps the individual in an inferior and dependent position, often giving up on him/her-self (Nakamura C.Y., 1959). Parents unknowingly cause their child to become powerless by failing to allow the child the opportunities to advocate for them self. Parents who over-protect their children can deprive them of their independence as they transition into adulthood and inadvertently promote dependence on others. Physical disabilities significantly impact development of the child's personality in that they may lack a sense of belonging. Parents who over-protect the child with a disability will continue to over- protect as the child enters adolescence and young adulthood. Another consequence of over-protection may be hostility of the child toward the parents (Sanders, K.J., 2006).

> *"For all parents…who have a child (with a disability), the diagnosis represents a loss which must be grieved. The loss for which the parent grieves is of the dream that all parents have of how their child and how their life would turn out. Their dream does not include a child with disabilities… The grief engendered by the death of a family member is acute and terminal…The grief experienced by the parent of a child with special needs is chronic. There is usually minimal emotional support carrying a fetus for 9 months and delivering a healthy child. When the child has a disability, the mother feels she has failed in some way…Grief very often translates into…behavior that is not helpful for the child. Guilt-ridden parents tend to over-protect their child ('I let something bad happen to you once. I am not going to let that happen again… I am going to make it up to you." (Laterman D. (2004)*

Negative effects of over-protection and lowered expectations have far- reaching consequences. All that lack of belief can have an effect on one's self. Individuals with disabilities are not expected to do more, so they do not. In some reviews, the responses by over-protected college students included: "I was restricted at home; was prohibited to go on trips; rarely allowed to leave home; I could never go where I wanted; they balked against my independence." (Nakamura C.Y., 1959). A consequence of lowered expectations can lead the individual to believe that the disability is the root cause of all his/her futility and uselessness. The over-protected child with a disability is often not challenged to strive for excellence; they are allowed to settle for less (Yura T., 1983).

Children with disabilities may have developmental delays or physical limitations which could have an impact on the individual and how they are perceived by others. These differences may cause the child to develop perceptions about him/her which may be based on actual functional limitations. "Parents must be aware of the child's perceptions concerning her/himself so that child's perception of the disability does not negatively affect the child's ability to reach their full potential." (Yura T., 1983) One of the tasks of effective parenting is to teach their child appropriate behavior. Society and culture have different expectations about persons with disabilities, which may influence the parent's role as a parent of child with disabilities (Woolfsen L., 2oo4). This task can become even more essential and complicated. In the past, all too often, individuals with disabilities were hidden in institutions and in backrooms of homes. In today's world, youngsters with disabilities are in public and private schools (not segregated in classrooms for individuals with special needs); as adults, they are involved in all forms of employment, entertainment and just about all settings for everyday activities. This requires that they be given the opportunity to develop their full potentials to become functional members of their respective communities and contribute to the development of their communities

1.3.8.4. Internalization

People with disabilities may themselves adopt negative believes about their disabilities and feel ashamed or embarrassed about it. In sociology and other social sciences, internalization means an individual's acceptance of a set of norms and values (established by others) through socialization. John Finley Scott (1994) described internalization as a metaphor in which something (i.e. an idea, concept, and action) moves from outside the mind or personality to a place inside of it. The structure and the happenings of society shape one's inner self and it can also be reversed. To internalize is defined by the Oxford American Dictionary as to "make (attitudes or behavior) part of one's nature by learning or unconscious assimilation: people learn gender stereotypes and internalize them. "Through internalization individuals accept a set of norms and values that are established by other individuals, groups, or society as a whole. Lev Vygotsky, a pioneer of psychological studies, introduced the idea of internalization in his extensive studies of child development research. Vygotsky provides an alternative definition for internalization, the internal reconstruction of an external operation. He explains three stages of internalization (Vygotsky, 1978):

1. An operation that initially represents an external activity is reconstructed and begins to occur internally.
2. An interpersonal process is transformed into an intrapersonal one.
3. The transformation of an interpersonal process into an intrapersonal one is the result of a long series of developmental events.

In this study we consider internalization as the non-conscious mental processes by which the stereotypes (beliefs, feelings etc) or negative attitudes of the "so called normal "individuals are assimilated into the self and adopted by people living with a disability.

Causes of social Disabilities

Scientists are not sure of the exact causes of disabilities. However, recent studies link the cause to hereditary, congenital and acquired.

Hereditary: A person with a hereditary disability has had the condition since birth or developed the condition because of inherited genetic problems (Berg V., 2020). Some disabilities are known to be inherited, such as spinal muscular atrophy and muscular dystrophy (diseases of the muscles and nerves). Women who already have one or more children with an inherited disability are more likely to give birth to another child with the same problem. Other disabilities can result when close blood relatives (such as brothers and sisters, first cousins, or parents and children) have children together. Children born to mothers 40 years of age or older are more likely to have Down syndrome. However, most disabilities are not inherited.

Congenital: Congenital disability means that the disorder developed before or during the birth of a child. Congenital disorders (birth defects) are an abnormality of body structure, function or chemistry present at birth that results in physical or mental disabilities. While all the causes of congenital disorders are not known, some disorders can be prevented. Actions you take can help prevent congenital disorders and make a better life for your baby. These disorders are caused by factors such as alcohol or chemicals that come from outside the developing child's body. The parents can control exposure to some of these factors, such as alcohol and tobacco smoke (Centre for Disease Control and protection, 2021). Many disabilities in babies are caused by harmful conditions of women's lives. If women can get enough nutritious food to eat, can protect themselves from work with toxic chemicals, and can get good health care, including care at the time of childbirth, then many disabilities could be prevented.

Acquired: A person can acquire a physical disability due to a number of reasons. These can be severe accidents, brain injuries, infections, diseases and as a side effect of disorders and other medical conditions, such as a stroke and dementia. Good health care can prevent many disabilities. Difficult labor and birth can cause a baby to be born with a disability such as cerebral palsy. Trained birth attendants who can identify risks and handle emergencies can prevent babies from being born with many disabilities. Immunization can also prevent many disabilities. But many times vaccines are not available, or people who are poor or live far from cities cannot afford them, or there are not enough for everyone. If a woman gets German measles (rubella) during the first 3 months of pregnancy, her child may be born deaf. Some illnesses a pregnant woman may get can cause physical or learning problems when her baby is born. Illnesses that can cause birth defects include German measles (rubella), which is a common cause of deafness in newborn babies. There is a vaccine that gives protection against rubella, but a woman who gets an immunization of the rubella vaccine should not get pregnant for one month afterward

Effects of Disabilities

The impact of disability may take many forms. The first effects are often physical pain, limitation of mobility, disorientation, confusion, uncertainty and a disruption of roles and patterns of social interaction. The first effects are often physical pain, limitation of mobility, disorientation, confusion, uncertainty and a disruption of roles and patterns of social interaction. Disabled people are minority groups, starved of services and mostly ignored by society, live in isolation, segregation, poverty, charity and even pity. Due to discrimination they do not go to public places and not free to get those rights which a non-disabled person gets. They are deprived of education and employment.

Effects on the disabled person

The course of the child's physical, psychological, and social development will forever be altered by the disability. Since development proceeds sequentially, and since relative success at mastering the tasks of one stage is a prerequisite for facing the challenges of the next stage, one could anticipate that the earlier the onset, the greater the adverse impact on development (Eisenberg, Sutkin, and Jansen 1984). There are many ways in which the accomplishment of development tasks is complicated for persons with disabilities. This, in turn, has an effect on their families as well as on which family roles can be assumed by the person with disability (Perrin and Gerrity 1984).

Parents, fearing injury or more damage to their young child, may restrict their child's efforts to explore and learn, or they may overindulge the child out of sympathy or guilt. If other people react negatively to the child's disability, parents may try to compensate by being overly protective or overly solicitous. These parent behaviors further compromise the child's development of autonomy and self-control.

As children with disabilities move into school environments where they interact with teachers and peers, they may experience difficulties mastering tasks and developing social skills and competencies. Although schools are mandated to provide special education programs for children in the least restrictive environment and to maximize integration, there is still considerable variability in how effectively schools do this. Barriers include inadequate financing for special education; inadequately trained school personnel; and, very often, attitudinal barriers of other children and staff that compromise full inclusion for students with disabilities.

Developmental tasks of adolescence, developing an identity and developing greater autonomy are particularly difficult when the adolescent has a disability. Part of this process for most adolescents generally involves some risk-taking behaviors, such as smoking and drinking. Adolescents with disabilities take risks too, sometimes defying treatment and procedures related to their condition, such as skipping medications or changing a prescribed diet. Issues related to sexuality may be particularly difficult because the person with disability has fears about his or her desirability to a partner, sexual performance, and worries about ever getting married or having children (Coupey and Cohen 1984). There is some evidence that girls may be at greater risk for pregnancy because of their desire to disavow their disability and prove their normalcy (Holmes 1986). Teens with mental impairment may be subjected to sexual exploitation by others.

When disability has its onset in young adulthood, the person's personal, family, and vocational plans for the future may be altered significantly. If the young adult has a partner where there is a long-term commitment, this relationship may be in jeopardy, particularly if the ability to enact adult roles as a sexual partner, parent, financial provider, or leisure partner are affected (Ireys and Burr 1984). When a couple has just begun to plan a future based on the assumption that both partners would be fully functional, they may find the adjustment to the disability too great to handle. The development of a relationship with a significant other after the disability is already present is more likely to lead to positive adjustment. Young adulthood is that critical transition from one's family of origin to creating a new family unit with a partner and possibly children. When disability occurs at this stage, the young adult's parents may become the primary caregivers, encouraging or bringing the young person home again. The risk is that the developmental course for the young adult and his or her parents may never get back on track. This is influenced in part by the extent to which there are independent living options for persons with disabilities to make use of in the community.

When the onset of disability occurs to adults in their middle years, it is often associated with major disruption to career and family roles. Those roles are affected for the person with the disability as well as for other family members who have come to depend on him or her to fulfill those roles. Some kind of family reorganization of roles, rules, and routines is usually required. If the person has been employed, he or she may have to give up work and career entirely or perhaps make dramatic changes in amount and type of work. The family may face a major loss of income as well as a loss in health and other employee benefits. If the person is a parent, childrearing responsibilities may be altered significantly.

The adult may have to switch from being the nurturer to being the nurtured. This may leave a major void in the family for someone to fill the nurturing role. If the person is a spouse, the dynamics of this relationship will change as one person is unable to perform as independently as before. The partner with the disability may be treated like another child. The sexual relationship may change, plans for having more children may be abandoned, lifestyle and leisure may be altered. Some spouses feel that their marital contract has been violated, and they are unwilling to make the necessary adjustments

Children of a middle-aged adult with a disability also experience role shifts. Their own dependency and nurturing needs may be neglected. They may be expected to take on some adult roles, such as caring for younger children, doing household chores, or maybe even providing some income. How well the family's efforts at reorganization work depend ultimately on the family's ability to accommodate age-appropriate developmental needs. In families where there is more flexibility among the adults in assuming the different family roles, adjustment is easier.

The onset of disability in old age is more expectable as bodily functions deteriorate. This decline in physical function is often associated with more depression. An older person may live for many years needing assistance in daily living, and the choices of where to get that assistance are not always easily made. Spouses may be unable to meet the extra caretaking needs indefinitely as their own health and stamina decline (Blackburn 1988). Adult children are often in a position of deciding where their elderly parent or parents should live when they can no longer care for themselves. Having their parents move in with them or having them moves to a nursing home or seniors' residence are the most common options. However, each of these choices carries with it emotional, financial and social costs to the elderly person as well as to his/her adult children.

Effects of Disabilities on Families

Disability places a set of extra demands or challenges on the family system; most of these demands last for a long time (Murphy 1982). Many of these challenges cut across disability type, age of the person with the disability, and type of family in which the person lives. There is the financial burden associated with getting health, education, and social services; buying or renting equipment and devices; making accommodations to the home; transportation; and medications and special food. For many of these financial items, the person or family may be eligible for payment or reimbursement from an insurance company and/or a publicly funded program. However, knowing what services and programs one is eligible for and then working with a bureaucracy to certify that eligibility (often repeatedly) is another major challenge faced by families. Coordination of services among different providers (such as a physician, physical therapist, occupational therapist, dietician, social worker, teacher, and counselor) who often are not aware of what the other is doing and may provide discrepant information is another challenge faced by families (Sloper and Turner 1992). While care coordination or case management is often the stated goal of service programs, there are many flaws in implementation. Families experience the burden of this lack of coordination.

The day-to-day strain of providing care and assistance leads to exhaustion and fatigue, taxing the physical and emotional energy of family members. There are a whole set of issues that create emotional strain, including worry, guilt, anxiety, anger, and uncertainty about the cause of the disability, about the future, about the needs of other family members, about whether one is providing enough assistance, and so on. Grieving over the loss of function of the person with the disability is experienced at the time of onset, and often repeatedly at other stages in the person's life.

The disability can consume a disproportionate share of a family's resources of time, energy, and money, so that other individual and family needs go unmet. Families often talk about living "one day at a time." The family's lifestyle and leisure activities are altered. A family's dreams and plans for the future may be given up. Social roles are disrupted because often there is not enough time, money, or energy to devote to them (Singhi et al. 1990).

Friends, neighbors, and people in the community may react negatively to the disability by avoidance, disparaging remarks or looks, or overt efforts to exclude people with disabilities and their families. Families often report that the person with the disability is not a major burden for them. The burden comes from dealing with people in the community whose attitudes and behaviors are judgmental, stigmatizing, and rejecting of the disabled individual and his or her family (Knoll 1992; Turnbull et al. 1993). Family members report that these negative attitudes and behaviors often are characteristic of their friends, relatives, and service providers as well as strangers (Patterson and Leonard 1994).

People with disabilities (PWD) face physical and attitudinal barriers to participation in employment opportunities, education and development processes in general. The Social model of disability views this exclusion as 'disabling' and as caused by the way in which society is organized, making PWD more vulnerable to poverty and exclusion from the labour market. Exclusion from employment is also linked to exclusion from education and training opportunities, often due to the same barriers (accessibility and negative attitudes of parents, teachers and children).

Even where PWD are employed, exclusion may be evident. In surveys of work arrangements in Australia, Canada, the UK and the USA, it was found that PWD may be under-employed relative to their level of training, have lower income levels, have less promotion prospects, are at greater risk to become unemployed and are more often in non-standard work arrangements (Elwan 1999; Emmett, 2006). Exclusion of PWD is also evident in the fact that disability is closely related to poverty, both a cause and a consequence. Poverty increases the risk of disability, for example through lack of healthcare, poor nutrition, greater exposure to injuries or lack of knowledge about prevention. Disability also adds to the risk of poverty, for example due to the costs associated with the disability, discrimination in the labour market or exclusion from education. This means that PWD are more likely to experience discrimination that leads to financial difficulties and social and economic deprivation. PWD can be caught in a vicious cycle of poverty and disability, each being both a cause and a consequence of the other (Elwan, 1999; ILO, 2000; DFID, 2000; Yeo, 2001; Yeo and Moore, 2003; Mitra, 2005; Yeo, 2005; Emmett, 2006; Nagata, 2007).

Effects of Disability on the society

Although in principle workers, their families and employers ought to carry out some financial burden of disability, the society as a whole must bear the rest. This additional burden is reflected in the costs of auto insurance, social security payments, social services, and health care. Here are examples of the costs associated with disability incurred by Canadian society (Canadian Society of Professionals in Disability Management (CSPDM) 2022)

- Each person with a disability who exhausts sick leave/disability benefits and must go on social assistance moves from being a benefit contributor to a benefit recipient. Canadian society also loses the contributions these individuals make as a result of their education, hard work and creativity.
- A single person, who becomes disabled and goes on a disability pension at age 35, will require a capitalized pension of $220,940 in order to pay an annual pension of $9,252 until age 65 or $980,410 if the eligible pension amount is $48,000.
- Between 1996 and 1997, $3 billion was paid in Canada/Quebec Pension Plan Disability Benefits.
- $400 million was paid in Employment Insurance Sickness Benefits during that same period.
- Auto insurers paid $1.8 billion to persons with disabilities.
- The Insurance Corporation of BC spends approximately $300 million per year on wage replacement for those injured in automobile accidents.

Even though the above cites the particular case of Canada, it equally indicates that every society is affected to some extent by the presence of people with disabilities and can go through the same or similar challenges.

Persons with disabilities in Cameroon continue to face diverse barriers that prevent them from enjoying their full civil, political, economic, social, cultural and developmental rights. This is largely due to lack of awareness, ignorance and prejudice in our society. It is also because some legislation fails to protect the rights of persons with disabilities and inclusive education in Cameroon.

1.4. Models of disability.

Disability models are fundamentally interested in the process of how welfare conditions could be provided for disabled. Shakespeare (2006) stated that all of the models include political thought of increasing life quality of disabled, providing social inclusion and removing social barriers experienced by disabled. Models could not be evaluated in a manner of theory, “a model is a standard, example, image, simplified representation, style, design, or pattern, often executed in miniature so that its components all are easy to discern” (Silvers, 2010: 22). On the one hand models are shaped by thoughts; on the other hand, thoughts are shaped by them. In other words, models compile theories and ideas and limit the alternative way of thinking practices (Hammell, 2006). Disability studies has own variables, problems to be studies and methodologies to be used like all disciplines. However, since it is hesitated to call disability studies as a discipline in an academic community, disability studies fit the conceptualization of paradigm as Kuhn (1961) theorized. According to Pfeiffer (2002) the terms model and paradigm could be used interchangeably due to their inclusive features of variables in the field and their relationships. Also Finkelstein (2004) prefers the concept of "interpretation" rather than "model" or "paradigm" since the thoughts which are named as "model" have not exceed the level of theory. But, models could be thought as wider framework which consists of similar paradigms and interpretation.

1.4.1. Medical Model

The medical model on the agenda of a lot of disability studies has two main features. The first one is that "problems" are seen as a result of disabled people. The second is the assumption that disability causes psychological disorders. In this respect, medical model has moved to personal pathological problems (Hedlung, 2000). While it is observed that medical model and individual model are used in the same meaning, at the same time different conceptualizations could be seen. For instance, Oliver thinks that medical approach is just a part of individual model: In short, for me, there is no such thing as the medical model of disability, there is instead, an individual model of disability of which medicalization is one significant component (Oliver, 1996a, p.31) Bury (1982) who is one of the most crucial representatives of medical approach, takes the issue of chronic illness and disability as a "disruptive event" that is woven with risks and uncertainties in everyday life.

Chronic illness involves a recognition of the worlds of pain and suffering, possibly even of death, which are normally only seen as distant possibilities or the plight of others. In addition, it brings individuals, their families, and wider social networks face to face with the character of their relationships in stark form, disrupting normal rules of reciprocity and mutual support. The growing dependency involved in chronic illness is a major issue here (Bury, 182, p.169).

Bury suggests the terms of "coping", "strategy" and "style" in struggling for chronic diseases and disability. Coping trains people to tolerate or put up with the effects of illness. In other words, coping turns to "sense of coherence" and crucial buffer against the stress when confronting with a "disruption". He uses the term of coping with normalization in a parallel meaning. By the help of normalization, patients could save their personal identity and public self. In contrast coping, strategy concerns the actions people take rather than the attitudes people develop. Strategy refers actions taken to "mobilize resources and maximize favorable outcomes" (Bury, 1991: 462). Lastly, "style" expresses how people manage and present their diseases. Depending on "cultural repertoires", people fashion in presenting their altered physical appearance and social circumstances. According to Bury (1991), development of style could be possible only after the successful development of coping and strategy. Bury takes the issue of struggle of diseases and disability around normalization and inherent acceptance. At this one-way relationship between disabled-barriers point of view, disabled people will “cope” with “themselves”, constitute their activities by “strategies” and establish their own “barriers gallery” by symbolic “styles”.

Cultural symbols are supported by medical community’s military metaphors – fighting against disability and disease (such as the war on cancer). These metaphors envisage disabled as an enemy, disabled becomes a category that should be struggled and kept away from. Developed methods against the disease are not only used by medical community but spirit of society. For this reason, phenomenon of treatment and its methods are executed by defensive and warrior spirit in both social and individual levels (Peters, 1996). For this view, disability is a status of body that should be fight by medical intervention, defeated and replaced immediately. In addition, medical model does not complete the fight against disability but fed up by this “war”. Forasmuch, medical professionals alike the society and the state as powerful groups design the lives of disabled people as a powerless group.

Medical model defines disability as “outside of the health conditions”. Furthermore, disabled as a client of the medical industry in line with technological developments, should be rehabilitated and “reintegrated” into society. Medical and rehabilitation services make up a principle to treat one’s physiological “deficiencies” and make one seem “normal” as possible. However, in this process disabled people should collaborate with experts by face with their “deficiencies” in a psychological sense (Hammell, 2006). Forasmuch, if disability is a “personal tragedy”, rather than take a position towards physiological status, accept the “reality” and limit the expectations of daily life by this acceptance would be much more appropriate.

It could be claimed that all “problems” related with disability are seen as a result of impaired body for medical model. Also assumption of disability brings psychological disorders constitutes social barriers limit disabled people to participate to the mainstream activities. Since disability is conceptualized around “outside of the health conditions”, disabled people are forced to be rehabilitated. Rehabilitation should not be understood as just a medical technique. Rehabilitation reflects the spirit of the society, social institutions and system. Society, social institutions and system perceive disability how rehabilitation system conceptualizes. So medical view becomes the component of attitudes shown towards disabled. Medical meanings of disability shape public and institutional discourses and present a ground for the construction of medical view.

1.4.2. Social Model

Social model has emerged as a critique of medical model. From 1960s to the present, disability literature has developed by the contention between these two models. While medical model sees impairment as a cause of social inequalities and disadvantages the

disabled experience, social model which constructed as an alternative of medical model criticizes it to ignore the role of social structures in their oppression and marginalization (Abberley, 1987). The main difference between medical and social model lies in the causal logic of disability. Medical model refers individual, social model refers social structure as a cause of disability (Bampi et al., 2010). Theoretical analysis has shifted from body to disabling environments, negative social attitudes and discriminatory barriers (Barnes, 1996).

Oliver (1990) criticizes both the perception of disability as a personal problem and disability as a “bad luck” that can be happen to everyone; therefore, he asserts the “personal tragedy theory”. Personal tragedy theory is operated through media representations, language, cultural beliefs, research, policy and professional practice (Swain & French, 2004). This view is so dominant today that moves disability to hegemonies rhetoric by the codes of “sufferer”, “helpless”, “pathetic” and “luckless”.

Social model reacts to causal logic established between disease / impairment with disability. For Oliver (1996c), medical model misses the point of what aspect of lives of disabled people need medical or therapeutic intervention, which aspects require policy developments and which aspects require political action. Failure to distinguish these aspects has resulted in the medicalization of disability and the colonization of disabled people by medical professional’s army. Instead, we are increasingly demanding acceptance from society as we are, not as society thinks we should be. It is society that has to change not individuals and this change will come about as part of a process of political empowerment of disabled people as a group not through social policies and programs delivered by establishment politicians and policy makers nor through individualized treatments and interventions provided by the medical and para-medical professions (Oliver, 1996c,p.37). In this respect, Finkelstein (2001) establishes individual-society dualism conjecturally and adds individual to the society which has made visible by social model. Moreover, parallel to Oliver, he offers to be organized for the freedom of disability: The agreed UPIAS interpretation was that, although it may be a tragedy to have impairment, it is oppression that characterizes the way our society is organized so that we are prevented from functioning. In other words, at thee. personal level we may talk about acquiring an impairment being a personal tragedy, but at the social level we should talk about the restrictions that we face are, and should be interpreted as, a crime. It is society that disables us and disabled people are an oppressed social group. The central issue in our campaigns for a better life, therefore, ought to be concerned with issues around emancipation and this requires struggles for social change rather than concentrating on individual experiences, ‘rehabilitation’, etc. (Finkelstein, 2001, p.2). Pfeiffer (2002) expands the disability studies issue into nine paradigms corresponds to nine models. The first one is “the social constructionist version” as found in the US that includes the paradigm of carrying out social roles and tasks produces discrimination. It is assumed that disabled people have different physical appearance, so they have no capacity to carry out their roles. The second is “the social model version as found in UK” that includes the paradigm of organization of society also produces discrimination. In contrast to US perspective, this model has a class perspective that adopts Marxist interpretation. Organization of the society produces barriers and social restrictions that prevent disabled people from participation in society. The third is “the impairment version” carries the paradigm of that

impairment in no way signifies tragedy and a low quality of life and to assume so discriminatory. It is assumed that pain of impairment and personal experiences are overlooked. According to this model, the impairment distinguishes disabled from the other people. The forth is “the oppressed minority (political) version” that includes the paradigm of that people with disabilities are an oppressed minority. Since there are architectural, sensory, attitudinal, cognitive, economic barriers etc. disabled people are treated as second class citizens. The fifth is “the independent living version” that includes the paradigm of that all people need various services in order to live independently. This model emphasizes on self- advocacy, system advocacy, and elimination of barriers, equal rights, equal opportunities, self-respect and self-determination to get free of care of others as a favor. The sixth is “the post-modern, post-structuralism, humanistic, experimental, existentialist version” that includes the paradigm of that all people have agendas most of which result in discrimination, but especially discrimination based on disability.

1.5. Conceptualization of Impairment and Disability by Medical and Social Model

In this section, I will explain the conceptualization of impairment and disability through mainly UPIAS’, WHO’s ICIDH and ICF and Nagi’s (1965) definitions. While medical model emphasizes on the differentiation from “ideal body”, social model suggests that disability is constituted by social barriers and oppressions. Therefore, interests of subjects and forms of producing knowledge are different in two definitions of disability. In addition, there is a trend that synthesized the two definitions. For Shakespeare (2006), neither there is a disability without the society, nor a society without disability. Impairment is a prerequisite to experience social barriers. In addition to this, culture, value and expectations are three of the main parameters on the definitions of disability. For instance, dyslexia were not a “problem” until states demand literacy of their citizens. The demand of literacy has assigned dyslexia as impairment; not making necessary arrangements for dyslexia have been identified as disability. Moreover, according to Morris (1991), impairment is as painful and difficult as could not be explained only by factors of social barriers. She also claimed that disability interpretations have denied individual impairment experiences and have trivialized these experiences.

The definition of disability of UPIAS, founded in 1972, is based on clear cut separation of impairment and disability. The most determinant point of separation is that impairment was no longer the cause of disability; in contrast, discrimination mechanisms produced in society are the cause of disability (Thomas, 2007). This definition model transfers disability from individual pathology to social barriers and power relations. Beyond, the demand of the maximum independent living, mobility, productive work and life control where and how disabled people wanted by necessary financial, medical, technical, educational and other regulations that should be applied by the state include the level of social policy. The definition of impairment and disability are shown on the table below (UPIAS, 1976: 14):

Table 1. The Classification of Disability (UPIAS)

Impairment	Impairment as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body.
Disability	Disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities.

In medical model sense, WHO (World Health Organization) offered three classifications as impairments, disabilities and handicaps in ICIDH (International Classification of Impairments, Disabilities and Handicaps). According to Masala and Petretto (2008: 1235), “This model was aimed at analyzing, describing and classifying the consequences of diseases, such consequences being distinguished between impairments, disabilities and handicaps”. The model of ICIDH is shown on the table below (WHO, 1980: 47).

Table 2. The Classification of Disability (WHO - ICIDH)

Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function.
Disability	Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
Handicap	A disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

In contrast to UPIAS, WHO establishes a casual relation between impairment and disability. WHO designs disability as a limitation to perform daily activities as a result of impairment.

Handicap is conceptualized as a limitation to perform social roles as a result of impairment and disability. UPIAS members criticized ICIDH model due to its medical-based individualistic approach and attitude that holds individual responsible by establishing link between impairment, disability and handicap (Masala & Petretto, 2008). This medical route that travel from disease to impairment, from impairment to disability and from disability to handicap did not address social and environmental factors (Bampi et al., 2010). Barnes and Mercer (2003) criticized ICIDH model of WHO in three points. The first is that the approach of WHO is based on medical definitions and "normality" that stems from bio-physiology. Moreover, the definition of handicap ignores the relativity of roles in social and cultural manner. The second is that impairment is conceptualized as the source of both disability and handicap. The medical intervention is legitimated by struggling with handicap, diminishing the effects of impairment and disability. In the aim of decreasing the social and economic disadvantages, medical services, rehabilitation and educational intervention become available to apply. Lastly, as an extension of the second criticism, this classification assumes environment as "neutral" and ignores the effects of social, economic and cultural barriers on the social exclusion of people with impairment. For Barnes and Mercer (2003) there is no doubt that medical services have many positive outcomes for disabled people and they could increase their life quality. However, ICIDH emphasized on "abnormal" physiological structure of disabled people by diagnosing and treating the individuals rather than experienced social exclusion. Furthermore, according to Boorse (2010: 55), impairment that ICIDH model conceptualized means "clinically evident pathological condition".

In accordance with the criticisms towards ICIDH model, WHO published ICF (International Classification of Functioning, Disability and Health) report that define impairment as the deviation from the generally accepted standards in population in respect to biomedical aspects of body and functions of it (WHO, 2001). “Activity” that is preferred rather than “disability”, emphasizes on performing tasks or work and “participation” that is preferred rather than “handicap”, emphasizes on participating in daily life, by doing so ICF highlights to understand disability within the society rather than exclusionary side of society (Tesio, 2011). For this reason, ICF still does not include social context. “Performance” and “capacity” are the major components to understand “activity” and “participation”. “The performance qualifier describes what an individual does in his or her current environment... The capacity qualifier describes an individual’s ability to execute a task or an action” (WHO, 2001: 15). While “performance” is associated with the environment, “capacity” depends on the “ability” to perform physical functions that is far from environment context. According to WHO (2001), to determine the full ability of the individual, there should be neutralized the effects of different environments on the individual to standardize the environment.

> *Capacity reflects the environmentally adjusted ability of the individual. This adjustment has to be the same for all persons in all countries to allow for international comparisons... The gap between capacity and performance reflects the difference between the impacts of current and uniform environments (WHO, 2001, p.15).*

Although ICF touched upon the context of social model in a descriptive way, insisted on medical model within the perspective of “management of disability”. In this sense, ICF acknowledged that disability should be managed and disabled people should be rehabilitated as “web of problems”. Nordenfelt (2006) offers concept of “ability” for ICF’s “performance” and “opportunity” for ICF’s “capacity”. The measurement of reel performance establishes a link between one’s own body structure – biochemical, physiological and psychological conditions – with one’s own performance. According to Nordenfelt, (2006) “performance” should be replaced with “ability” what one’s inner resources permit him or her to do. Opportunity refers to external possibilities that should be understood as the outer of the individual. The concept of “capacity” of ICF included “individual’s ability to execute a task or an action” that lacks of social context. In this regard, Nordenfelt’s “opportunity” fits the social model due to its environmental arrangements and political approach over environmental arrangements.

Barnes (2003) explains the definitions of disability in terms of three typologies: “orthodox individualistic” medical definition, “liberal inter-relational” account and “radical socio-political” interpretation. While “orthodox individualistic” stems from Western culture of nineteenth century, it is related with WHO’s ICIDH. The ICIDH is not independent from medical view that employs three definitions as “impairment”, “disability” and “handicap”. Three definitions have also static contexts and recall mental and physical “normality”. For Barnes (2003: 7), Beside the ICIDH model has a “set of euro-centric values about what is and what is not biologically socially acceptable, the ICIDH presents impairment as the primary cause of disability and handicap”. Euro-centric view conceptualizes rehabilitation as a philosophy and plans to reduce or eliminate the impairment. In other words, disabled people as objects of correction, treatment, discipline and change, are tried to be normalized by euro-centric values. Secondly, “liberal inter-rational approach” could be expressed in WHO’s ICF. WHO declared ICF, after the great criticisms towards ICIDH. ICF relates impairment with “abnormality” of body functions and structure in a biomedical perspective like ICIDH. Also ICF revised disability as refers to “activity” and handicap as refers to “participation”. Although ICF asserted that definitions were effected and constructed by social and physical environment, disability remains a health rather than political concern. Liberalized social policy for disabled people has been transferred from institutional to community care which is assumed to serve to integrate disabled into social activities. Disabled people who are stigmatized as “sick” in “orthodox individualistic” medical definition, even are evolved to “citizenship” in “liberal interrational approach”, still rehabilitation system is not questionable since in its “ideal” form it preserves itself to be precondition of disabled people’s integration. Lastly, “radical socio-political” interpretation was born with the criticisms towards medical model.

UPIAS makes a clear distinction between disability and impairment and argues that disability is imposed and constructed by social barriers. For this perspective, dominant definition of disability can be seen as little more than a “sick” joke.

> *It is a concerted attempt to politicize disability in order to provide a clear and unambiguous focus on the very real and multiple deprivations that are imposed on people whose biological conditions are deemed socially unacceptable in order to bring about radical structural and cultural change (Barnes, 2003, p.19).*

For both “orthodox individualistic” medical definition and “liberal inter-relational” account, on the basis of institutional or community care, solution is repairing or correcting the body. In this sense, the metaphor of "sick" joke characterizes the individual oriented view of rehabilitation and lack of political content.

Also Nagi (1965: 101-103) constituted four type of classifications as active pathology, impairment, functional limitation and disability shown on the table below.

Table 3. The Classification of Disability (NAGI)

Active Pathology	Interruption of or interference with normal processes, and the simultaneous efforts of the organism to regain a normal state.
Impairment	A loss or abnormality of an anatomical, physiological, mental, or emotional nature.
Functional Limitation	Limitation in performance at the level of the whole organism or person.
Disability	*Disability* refers to social rather than to organismic functioning.

The first two categories are related with tissues, organs, body systems; functional limitation is related with the individual and finally disability is related with social level. Active pathology is resulted from infection, trauma, metabolic imbalance, degenerative disease processes, or other etiology. This category refers to "fight against diseases"
through modern medicine: "In modern health practices, the organism is aided by surgical intervention, medication, and other forms of therapy to help regain equilibrium" (Nagi, 1991: 322). While impairment, defined as anatomical, physiological, mental, or emotional nature abnormality, focuses on tissues, organs or organ systems, functional limitation, defined as limitation in performance at the level of the whole organism or person, focuses on the whole organism. So, active pathology is not based on functionality but impairment and functional limitation emphasizes functionality in different levels. In this respect, functional limitation establishes a bridge between impairment and disability. The last category of Nagi's model as disability transfers functionality from the body to the social level.

> *[Disability] is an inability or limitation in performing socially defined roles and tasks expected of an individual within a sociocultural and physical environment. These roles and tasks are organized in spheres of life activities such as those of the family or other interpersonal relations; work, employment, and other economic pursuits; and education, recreation, and self-care (Nagi, 1991, p.322).*

According to Boorse (2010), Nagi's functional limitation and disability concepts are both performance measures. While functional limitation is "organismic", disability is "social" performance. Due to the social nature of disability, it is a “relational” concept; however, the other three are pure “attributes” of the individual. Boorse clarified Nagi’s classification with an example:

> *Imagine that an office worker suffers a back wound that severs his spinal cord at his tenth thoracic vertebra. The wound is active pathology; the blockage of neural transmission to his lower spinal cord is impairment; his resulting inability to walk or run is functional limitation; and his inability to reach his job in a wheelchair-inaccessible office building, or to keep playing tennis with his wife, is disability (Boorse, 2010, p.58).*

Thomas (1999) utilized the understanding of disability by the help of social-relational perspective. In social-relational perspective, disability only comes into play when social barriers experienced by impaired people are socially imposed. Then, non-socially imposed of barriers do not constitute disability. Thomas’s (1999) definition of disability, modernized formulation of UPIAS is that:

> *Disability is a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional wellbeing (Thomas, 1999, p.60).*

Thomas (1999) did not deny the existence of impairment when mention disability in social imposed field of social-relational interpretation. Thomas’s “impairment effects” is a source of inspiration in this respect. “Impairment effects” refers to physiological feelings as pain or hurt. For this reason, impairment is non-socially imposed restrictions of activity. However, aim of Thomas (2004) is to display the debates of whether impairment and chronic diseases constitute restrictions of activity or not is unnecessary. Since social-relationity should be interested in social context.

> *Yes, of course impairment causes some restrictions of activity—but these are not what is of interest in studying and combating disability. Disability is a form of social oppression on a par with other forms of oppression in our society associated with gender, race, class, and sexuality (Thomas, 2004, p.581)*

To conclude, as it is displayed above, there has been a great conflict in definition of disability / impairment. Since definitions, based on models, are translated into social policies; understanding social and ideological barriers of disabled people requires deeper analysis of definitions and thinking system behind them.

1.6. A comparism of medical and social model of disability.

Two competing conceptual models of disability have been used to define the origins of the abnormal physiological and psychological functioning (Lo Bianco and Sheppard-Jones, 2008). , The medical model considers disability a feature of the person, directly caused by diseases, disorders, traumas, or other health conditions, which would require medical treatment or intervention with the primary goal to “correct” the problem within the individual (Johnston, 1996; Marks, 2000; Mitra, 2006; Forhan, 2009; Nind et al., 2010; Brandon and Pritchard, 2011; Palmer and Harley, 2012; Bingham et al., 2013). By contrast, the social model does not consider the disability an attribute of the individual, but rather a socially created problem (Hutchison, 1995; Mitra, 2006; Purdue, 2009; Barney, 2012). In this case, the problem that needs to be corrected lies not within the individual, but within the unaccommodating social environment (Brandon and Pritchard, 2011; Roush and Sharby, 2011; Barney, 2012; Palmer and Harley, 2012; Bingham et al., 2013).

According to the social model, disability could be imposed by society on individuals with impairments through isolation and exclusion from everyday activities (Brandon and Pritchard, 2011; Bingham et al., 2013). Such isolation and exclusion may stem from society’s unfavorable perceptions of people with disabilities and unwillingness to remove environmental barriers impeding full participation (LoBianco and Sheppard-Jones, 2008; Forhan, 2009; Palmer and Harley, 2012). However, neither medical nor social model acknowledge the complex nature of disability. Therefore, a comprehensive integration of the two approaches produced the biopsychosocial model, which considers disability in the context of an interaction between biological, psychological, and societal factors, each limiting the individual’s functioning to some extent (Engel, 1980; Borrell-Carrió et al., 2004; Thomas, 2004; Shakespeare, 2006; Le Boutillier and Croucher, 2010). However, considering the nature of this study it is the social model of disability that is relevant.

1.7. Conclusion.

This chapter outlines a clear view on discrimination at work. It elaborates how employees with disability are treated at work. We have equally defined disability and how it affects those working with it. To make the work more efficient, we have analyzed two models of disability, that is the medical and social model. A comparism of both models was made.

CHAPTER 2

COPING STRATEGIES OF SOME EMPLOYEES WITH DISABILITY

2.1. Introduction

Disabled employees should not be denied the ability to engage in strategies and mechanisms which help to cope with the effects of their condition simply because they inconvenience other staff (Paul Burton 2021). However, it is often required for an employer of employees with disabilities to make reasonable adjustments in the workplace. A reasonable adjustment is a change to ensure that an employee with a disability is not disadvantaged within the workplace. Employers have a duty to make such adjustments, failure to do so could be considered discrimination. In this chapter we shall focus more on the coping strategies employees with disability have developed over the years in different types of work. This chapter equally lay down some theories of coping where these workers can grab from it and e more useful at their workplace.

2.2. Coping strategies.

Coping is defined as constantly changing cognitive and behavioural efforts to manage specific external and /or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). Thus coping process is intended to reduce threat and that depends on cognitive activity.

Coping strategies are as numerous and varied as the stressors that precede them. From Folkman and Lazarus' *Ways of Coping Questionnaire* and Charles Carver and colleagues' *Coping Orientation of Problem Experience* , some common strategies or categories for coping responses are accepting the situation or one's role in it, active/confrontive coping to remove the stressor or oneself from the stressor, anticipatory coping aimed toward an expected but uncontrollable event, avoiding the stressor or associated feelings of distress, denying the problem or feelings, disengaging mentally or behaviourally (giving up), distancing from the situation or minimizing its significance, planning the steps to solve the problem, reinterpreting the stressor as a positive or growth-oriented experience, seeking social support, controlling one's emotions or waiting for an appropriate time to act, using substances to dull feelings, suppressing competing activities until the problem subsides, turning to religion, using humour, and venting emotions.

Individuals also engage in proactive coping. These future and action oriented behaviours can prepare a person not only for particular stressors, but also for those that are likely to arise in the normal course of life. Proactive coping includes building and strengthening all resources (e.g., from practical and academic knowledge, experiences, and enough numbers and varied kinds of social contacts; see also direct effects hypothesis of social support). As well, proactive coping involves gaining skills and abilities to assess the changing environment more accurately, from signs of a possible stressor, to appropriate strategies and resource use, to feedback on a given situation. Though it is impossible to make causal claims, future-oriented coping tends to be associated with positive outcomes such as goal achievement and lower levels of distress. However, too great an emphasis on the future may be a sign of hypervigilance, which has been linked to negative outcomes such as anxiety and poor information processing.

As with the other components of coping, research classifies strategies by type, such as problem focused coping or emotional focused coping. One needs to bear in mind, however, that people's thoughts, feelings, and behaviours seldom fit into black-or-white categories such as those required for quantitative analytics. For example, a man responds to being laid off by networking with friends to learn of other job opportunities. Networking is active coping and planning, both of which are problem-focused. Networking with friends, however, likely adds the benefit of support from others to decrease his anxiety, which is emotion-focused. This illustration also shows that often the best method of coping is a combination of problem-focused and emotion-focused strategies. Whether it is a single strategy or a few enacted together, this approach can both reduce the impact of the stressor and the negative emotions it may evoke. Yet, there is no one universal coping strategy that will be effective in all situations. Coping strategies that lessen distress in one situation may be ineffective or even detrimental to the individual in another.

Similarly, one must keep in mind that strict labelling of most strategies and other coping behaviours can result in erroneous interpretations. This is especially true when attempting to categorize responses as effective or ineffective. Seldom is a coping response all good or all bad, and one must well consider the many specifics of the situation and the goals of the individual prior to drawing firm conclusions. For example, considering the time frame during which the strategy is employed (e.g., the duration of the stressor) may be helpful in assessing its efficacy. Denial or substance use (not to be mistaken with abuse or use of illicit drugs) may be adaptive in the immediate aftermath of a traumatic event. However, these strategies rapidly deteriorate as wise choices for coping over time and should be replaced with responses that are more appropriate as time progresses. So, when the laid-off man goes home, he may have a few beers to wash down his sorrows, but continuing this behaviour would no doubt exacerbate the problem.

2.3. Strategies to overcome negative attitudes

To overcome negative attitudes, stigmatization, and discrimination, it is necessary to develop a framework for disability that allows for generalization and examine how people understand disability. Furthermore, organizational members need to be educated about disability and its consequences for a person in a work environment. Broadening this conclusion to the societal level, a generally enhanced awareness of people with disabilities as a substantial part of the workforce in organizations might counteract psychological barriers also within work teams. Political stakeholders can contribute to this process by underpinning the urgency of workplace integration in times of an ageing workforce and skill shortages so that prospective employers recognize the profit they can gain. This process can be supported by the publication of best practice examples and the allocation of supportive structures (Niehaus & Bauer, 2013). Furthermore, meta-analyses of the psychiatric disability literature on stigma change have demonstrated that contact is even superior to other approaches, such as education. It can be argued that exposure is the cure of stigma (Corbière, 2014).

2.4. Important tips for disabled employees

2.4.1. Start your day off right

After scrambling to get the kids fed and off to school, dodging traffic and combating road rage, and gulping down coffee in lieu of a healthy breakfast, many people arrive to work already stressed. This makes them more reactive to stress in the workplace. You might be surprised by how affected by workplace stress you are when you have a stressful morning. When you start off the day with planning, good nutrition, and a positive attitude, you might find that the stress of your job rolls off your back more easily.

2.4.2. Be Clear on Requirements

A factor known is unclear requirements for employees. If you don’t know exactly what is expected of you, or if the requirements for your role keep changing with little notice, you might become extremely stressed. If you find yourself never knowing if what you are doing is enough, it may help to have a talk with your supervisor. You can take the time to go over expectations and discuss strategies for meeting them. This can relieve stress for both of you!

2.4.3. Stay away from conflict

Interpersonal conflict takes a toll on your physical and emotional health. Conflict among co-workers can be difficult to escape, so it’s a good idea to avoid conflict at work as much as you can. Don’t gossip, don’t share too many of your personal opinions about religion and politics, and steer clear of "colorful" office humor. When possible, try to avoid people who don’t work well with others. If conflict finds you anyway, make sure you know how to handle it appropriately. Even if you’re a naturally disorganized person, planning ahead to stay organized can greatly decrease your stress at work. Being organized with your time means less rushing in the morning to avoid being late as well as less hustling to get out at the end of the day. Keeping yourself organized can also mean avoiding the negative effects of clutter, and being more efficient with your work.

2.4.4. Be comfortable

Another surprising stressor at work is physical discomfort, often related to where you perform most of your daily tasks (such as your desk). You might not notice you're stressed if you're sitting in an uncomfortable chair for just a few minutes, but if you practically live in that chair when you're at work, you might have a sore back *and* be more reactive to stress because of it. Even small things like office noise can be distracting and cause feelings of low-grade frustration. Do what you can to create a quiet, comfortable, and soothing workspace.

2.4.5. Forget Multitasking.

Taking many task at the same time was once heralded as a fantastic way to maximize one's time and get more done in a day. However, people eventually began to realize that if they had a phone to their ear and were making calculations at the same time, their speed and accuracy (not to mention sanity) often suffered. There is a certain "frazzled" feeling that comes from splitting your focus and it doesn't work well for most people. Instead of multitasking to stay on top of your tasks, try another cognitive strategy like chunks.

2.4.6. Walk at Lunch

Many people feel the ill effects of leading a sedentary lifestyle. You can combat the physical *and* mental effects of work stress by getting some exercise on your lunch break. If your schedule allows for it, you might try taking short exercise breaks throughout the day. This can help you blow off steam, lift your mood, and get into better shape.

2.4.7. Keep Perfectionism in Check

Being a high achiever might make you feel good about yourself and help you excel at work, but being a perfectionist can create problems for you (and those around you). You might not be able to do everything perfectly, every time especially in a busy, fast-paced job. A good strategy to avoid the perfectionism trap is always striving to just do your best and making time to congratulate yourself on your efforts. You may find that your results are better and you'll be much less stressed at work.

2.4.8. Listen to Music on the Drive Home

Listening to music offers many benefits and can be an effective way to relieve stress before, during, and after work. Playing an uplifting song while you make breakfast can help you start the day off feeling better prepared to interact with the people in your life. Likewise, combating the stress of a long day with your favorite music on the drive home can help you wind down and feel less stressed when you get there.

2.4.9. Make recovery your top priority.

Work is important, but it is only one aspect of your life. Even on busy days, remember that recovery is your top priority. Continue to focus on your treatment plan and self-care strategies throughout the day.

2.4.10. Remember what's important about work.

It is rare to find a job that doesn't involve challenging people, deadlines, difficult assignments and other stressors. At times when work feels overwhelming, try to focus on the positive reasons why you work, including financial independence and security, personal satisfaction and the sense of community or belonging that comes from contributing to a team effort.

2.4.11. Don't expect perfection.

You will face disappointments, make mistakes, and have challenges at work – everyone does. Adjust your attitude and expectations about yourself and your work, knowing that problems and interpersonal conflict happen in any job.

2.4.12. Don't let the past define today or tomorrow.

Realize that problems caused by your symptoms in the past will not necessarily repeat themselves, especially if you have a working treatment plan in place. Just because a lack of energy once caused you to miss a crucial deadline doesn't mean you are unreliable. Give yourself credit for the progress you are making, and permission to start over.

2.4.13. Develop symptom-specific strategies.

Make sure to learn all you can about your illness and your specific symptoms. Take a close look at the symptoms that have tripped you up in the past, and develop specific strategies for countering each of them. For example, if your depression can make it hard to concentrate or if you feel overwhelmed when beginning a project, it might be helpful to break work assignments into smaller, more manageable steps that can be completed in shorter timeframes.

2.4.14. Get support.

Involving co-workers in shared responsibilities, asking family members to help with chores, or reaching out to a friend to listen to your ideas and concerns are all good strategies for accomplishing your goals without sacrificing your emotional health and recovery. Many employers also offer an Employee Assistance Program (EAP) to assist employees with personal and work-related issues. EAPs typically provide free short-term counseling, referrals and follow-up services.

2.4.15. Be your own advocate.

You are your own best advocate as you negotiate the challenges of life with a disability, including at work and in the healthcare system. Knowledge is power, so educate yourself about your rights and the resources available to you. As you take charge, you'll also start to feel less helpless and more empowered.

2.4.16. Take advantage of the things you can do.

While you may not be able to change your disability, you can reduce its impact on your daily life by seeking out and embracing whatever adaptive technologies and tools are available. If you need a device such as a prosthetic, a white cane, or a wheelchair to make your life easier, then use it. Try to let go of any embarrassment or fear of stigma. You are not defined by the aids you use.

2.4.17. Set realistic goals and be patient.

A disability forces you to learn new skills and strategies. You may also have to relearn simple things you used to take for granted. It can be a frustrating process, and it's only natural to want to rush things and get back to functioning as quickly as possible. But it's important to stay realistic. Setting overly aggressive goals can actually lead to setbacks and discouragement. Be patient with yourself. Every small step forward counts. Eventually, you'll get there.

2.4.18. Nurture the important relationships in your life.

Now, more than ever, staying connected is important. Spending time with family and friends will help you stay positive, healthy, and hopeful. Sometimes, you may need a shoulder to cry on or someone to vent to. But don't discount the importance of setting aside your disability from time to time and simply fun.

2.4.19. Joining a disability support group.

One of the best ways to fight loneliness and isolation is to participate in a support group for people dealing with similar challenges. You'll quickly realize you're not alone. Just that realization goes a long way. You'll also benefit from the collective wisdom of the group. Support groups are a great place to share struggles, solutions, and encouragement.

2.4.20. Accepting help doesn't make you weak.

Refusing to seek out needed assistance can delay your progress or make you worse, either physically or emotionally. Let go of the fear that asking for support will inspire pity. Allow the people who care about you to pitch in. Not only will you benefit, it will also make them feel better.

2.4.21. Consider talking to a mental health professional.

Having someone to talk to about what you’re going through can make a huge difference. While loved ones can provide great support in this way, you may also want to consider talking to a therapist. The correct therapist can help you process the changes you’re facing, work through your grief, and reframe your outlook in a more positive, realistic way.

2.4.22. Listen to your body.

Exercise should never hurt or make you feel lousy. Stop exercising immediately and call your doctor if you feel dizzy, short of breath, develop chest pain or pressure, break out in a cold sweat, or experience pain.

2.4.23. Don’t compare yourself to others (or to your past self).

Avoid the trap of comparing your exercise efforts to those of others even others with similar disabilities. And don’t discourage yourself by comparing where you are today to where you were pre-disability.

2.5. Theories on coping

2.5.1. The transactional theory

From Lazarus and Folkman’s transactional theory of stress and coping, individuals are constantly appraising stimuli within their environment. This appraisal process generates emotions, and when stimuli are appraised as threatening, challenging, or harmful (i.e., stressors), the resultant distress initiates coping strategies to manage emotions or attempt to directly address the stressor itself. Coping processes produce an outcome (i.e., a change to the person environment relationship), which is reappraised as favorable, unfavorable, or unresolved. Favorable resolution of stressors elicits positive emotions, while unresolved or unfavorable resolutions elicit distress, provoking the individual to consider further coping options to attempt to resolve the stressor (Folkman, 1997; Folkman and Lazarus, 1985; Folkman and Lazarus, 1988; Lazarus, 1990; Lazarus, DeLongis, Folkman, and Gruen, 1985; Lazarus and Folkman, 1984). According to this perspective, stress is defined as exposure to stimuli appraised as harmful, threatening, or challenging, that exceeds the individual’s capacity to cope (Lazarus and Folkman, 1984). A frequent discussion within the coping literature is the comparative effectiveness of two PFC and EFC strategies. Most broadly, EFC is regarded as maladaptive and ineffective, with research associating EFC with negative outcomes, while less consistent, albeit generally positive effects have been associated with PFC (Folkman and Moskowitz, 2004; O’Driscoll, Brough, and Kalliath, 2009; Taylor and Stanton, 2007). For example, Graven et al. (2014) con- ducted a systematic review of the relationships between coping and health-related outcomes for cardiac patients. PFC was generally associated with improved psychological well-being, self-care, and health-related quality of life, while EFC was associated with poorer psychological well-being and health-related quality of life, and a higher risk of mortality. Boyd et al. (2009) also demonstrated that EFC was associated with adverse outcomes such as increased anxiety, emotional exhaustion, and dissatisfaction, while PFC was associated with lower levels of emotional exhaustion.

While EFC is often cited as a maladaptive coping strategy, many researchers have argued against generalizing the effects of PFC and EFC in this simplistic way (e.g., Dewe and Guest, 1990). The persistent notion that EFC strategies are maladaptive is due in part to the negative labeling of EFC reactions (e.g., escape and avoidance; Dewe and Cooper, 2007), as well as the tendency for EFC to be significantly associated with adverse outcomes (Folkman and Moskowitz, 2004). However, Lazarus and Folkman's (1984) transactional theory of stress and coping suggested that neither coping strategy is inherently effective or ineffective. Instead, the effectiveness of a given coping strategy is dependent on how well the coping strategy corresponds with appraisals and situational conditions (Cummings and Cooper, 1998; Dewe and Cooper, 2007; Folkman and Moskowitz, 2004). Therefore, the crucial components determining coping effectiveness are fit and context. For example, EFC is generally described as exerting short-term adaptive effects when appraisals generate intense emotional distress, when stressors are appraised as being uncontrollable, and when existing resources are insufficient to support PFC strategies. According to Folkman and Moskowitz (2004), the need for coping arises in intensely emotional environments, and an initial function of coping "is to down-regulate negative emotions that are stressful in and of themselves and may be interfering with instrumental forms of coping" (p. 747). The short-term adoption of EFC may, therefore, be adaptive when stressors are appraised as being uncontrollable and when insufficient resources exist, allowing individuals to amalgamate the resources required to engage in future PFC strategies (Ben-Zur, 2009; Terry, 1994).

Nonetheless, the sole and persistent reliance on EFC or avoidance strategies over long periods of time is not considered to be beneficial. EFC behaviors encourage individuals to dis- connect from the problem, and this in turn prevents further attempts to cope and contributes minimally to directly addressing the stressor (Ben-Zur, 2009; Semmer, 2006). Avoidance coping, for example, has been associated with lower adherence to treatment regimens (Taylor and Stanton, 2007). A training simulation study investigating the effect of different coping styles in relation to post traumatic stress disorder (PTSD) symptoms, stress responses (anxiety, heartrate, and salivary cortisol levels), and performance within a sample of police recruits found that avoidance coping was related to positive short-term effects (lowered anxiety) but adverse long-term effects (e.g., increased salivary cortisol and PTSD symptoms; LeBlanc, Regehr, Jelley, and Barath, 2008). Thus, EFC and avoidance coping strategies may initially be adaptive because they enable individuals to avoid intensely emotional reactions to their work situations, but continual reliance on these strategies is maladaptive. Unfortunately, few studies allow for genuine evaluations of coping effectiveness as they fail to simultaneously consider situational characteristics, personal characteristics, and out- comes (Boyd et al., 2009; Dewe and Cooper, 2007). Studies adopting a longitudinal research design are scarce, despite recognition of the necessity for these designs in order to accurately assess the evolving stress process, including the extent to which multiple coping strategies are implemented and interchanged (Brough et al., 2005a; Semmer, 2006). Additionally, coping effectiveness has primarily been evaluated in relation to negative outcomes: EFC behaviors have more consistently been related to these outcomes (e.g., psychological strain), while mixed findings have generally been produced for PFC (Folkman and Moskowitz, 2004; Taylor and Stanton, 2007). Taylor and Stanton argued that PFC is likely to have more persistent effects on positive outcomes (e.g., well-being), which are generally less frequently studied. Coping effectiveness can, therefore, be usefully conceptualized as strategies that reduces negative outcomes and increases positive outcomes (Dewe and Cooper, 2007). The theoretical distinction between PFC and EFC "provides a useful way of talking about many kinds of coping in broad brushstrokes" (Folkman and Moskowitz, 2004, p. 751) and, as noted above, this coping dichotomy has been highly influential within the broader coping literature. Nonetheless, this dual coping taxonomy has been criticized primarily for both its theoretical and its methodological flaws (Brough et al., 2005a). One common criticism is that the PFC and EFC dichotomy provides only a surface explanation of coping and fails to adequately differentiate between the conceptual complexities of these coping responses (Dewe and Guest, 1990; Folkman and Moskowitz, 2004; Skinner, Edge, Altman, and Sherwood, 2003). For example, Latack and Havlovic (1992) observed that the PFC and EFC taxonomy is "insufficiently spe- cific to capture the various sub-dimensions that have emerged in coping research" (Latack and Havlovic, 1992, p. 492). More specifically, the PFC–EFC dichotomy provides an inadequate categorization for the subdivisions of coping strategies; masks important differences within categories; and is neither mutually exclusive nor exhaustive, given that some strategies can be classified as both PFC and EFC (e.g., support seeking; Folkman and Moskowitz, 2004; Latack and Havlovic, 1992). Skinner et al. (2003) emphasized that coping taxonomies need to be conceptually clear, mutually exclusive, and exhaustive. As we will discuss, the PFC and EFC taxonomy generally does not meet these conceptual characteristics.

Conceptually clear taxonomies are those in which coping behaviors and strategies clearly align with a higher-order category of coping and can be precisely and unambiguously assigned (Skinner et al., 2003). For example, seeking information about the problem, brainstorming solutions, and making plans to address the problem are behaviors or strategies that are focused on the problem, and could, therefore, be categorized as “approach” coping. However, in terms of the PFC and EFC taxonomy, the inclusion of behaviors and strategies is less clear. Emotion-focused coping in particular is an ambiguous construct and is defined in research investigations by an extraordinarily wide variety of coping behaviors, including active attempts to calm one-self, venting and panic, exercise, positive reinterpretation, and acceptance (Jerusalem, 1993; Stanton, Danoff-Burg, Cameron, and Ellis, 1994). This ambiguity of what exactly constitutes EFC, in particular, is cited as evidence that this categorization is not at all conceptually clear. Mutually exclusive taxonomies include coping reactions that are described in one single category (Skinner et al., 2003). For example, a coping response such as “making a plan” directly contributes to problem-solving but can also calm emotions, thereby enabling it to be classified as both a PFC and an EFC response. Similarly, seeking social support may be classified as a PFC strategy if it relates to seeking support about the problem; alternatively, seeking social support can also be described as EFC if the purpose is venting emotions (Pargament, Koenig, Tarakeshwar, and Hahn, 2004; Stanton et al., 2000). Hence the conceptual overlap between the PFC and EFC classifications is evident and weakens empirical evidence supporting the stress and coping theory.

Exhaustive or comprehensive taxonomies are those in which the core coping methods are fully included within the described categories (Skinner et al., 2003). This is unfortunately not the case for PFC and EFC behaviors because they do not encompass all coping behaviors. For example, the use of avoidance coping is not fully encompassed by the PFC and EFC taxonomy because avoidance coping (e.g., denial, escapism) does not purely focus on the problem or the emotions. Consequentially, avoidance coping is commonly included as an additional category in coping assessments based on the EFC–PFC taxonomy (Folkman and Moskowitz, 2004; Williams, Hundt, and Nelson-Gray, 2014). The categorical assessment of behaviors as either PFC or EFC is, therefore, highly problematic. Lazarus (1996) acknowledged this issue and suggested that “any coping thought or act can serve both or perhaps many other functions” (p. 293). Despite this theoretical limitation, coping research has, in the vast majority of cases, overlooked the limitations of the EFC–PFC taxonomy and descriptions of coping responses as a dual dichotomy using this taxonomy remain prolific.

2.5.1.1. Alternative Coping Taxonomies

As an alternative to the PFC–EFC dichotomy, other coping taxonomies have been proposed that purport to explain coping responses more accurately. One such multifaceted coping taxonomy, for example, was developed by Edwards and Baglioni (1993; 2000) and is based on cybernetic theory. The cybernetic theory (Edwards, 1992) defines coping as a reaction to minimize symptoms of strain, modify perceptions of desired and actual mental states, and resolve discrepancies between perceived and desired states via five coping mechanisms. Consistent with the PFC strategies, direct coping actions may be made to actively change the situation. Alternatively, if the situation is perceived as being uncontrollable, or if previous coping efforts have failed, indirect attempts to minimize the symptoms of ill-health may be enacted (symptom reduction). An individual may repress undesirable aspects of a stressor (avoidance), adjust their own desires so they are better aligned with the perceived situation (accommodation), or minimize the importance of the discrepancy (devaluation; Edwards and Baglioni, 1993; 2000). One of the strengths of this cybernetic theory of coping is that it contains multiple forms of EFC strategies (Dewe and Guest, 1990). An empirical evaluation of this cybernetic coping taxonomy has been conducted and evidence noted for the strength of its psychometric properties a point on which the Ways of Coping instrument commonly used to assess Lazarus and Folkman's (1984) EFC–PFC coping taxonomy has been criticized (e.g., Brough et al., 2005a; 2005b; Guppy et al., 2004).

Another classification of coping behaviors was suggested by Skinner et al. (2003), who classified coping into three categories according to its adaptive function. That is, adaptive processes that coordinate an individual's actions with the contingencies in the environment (competence); adaptive processes that coordinate the individual's reliance on others with the social resources in the environment (relatedness); and adaptive processes that coordinate an individual's preferences with the options available in the environment (autonomy). Each adaptive process is made up of four types or "families" of coping (i.e., 12 coping dimensions in total) that represent a higher-order category of coping, such as problem-solving or information seeking. Each coping family describes specific coping behaviors or strategies, such as planning or asking others. By first asking what the adaptive process is, and then asking what the function is within that adaptive process, Skinner et al. (2003) suggested that it is possible to categorize specific coping behaviors. Duhachek and Oakley (2007) empirically assessed Skinner et al.'s (2003) three-stage coping taxonomy by developing items to assess the 12 dimensions. Their results across two studies supported the validity of the 12 coping dimensions. Support for Skinner et al.'s model was also produced by Webster, Brough, and Daly (2014), who used the framework to classify qualita- tive data on the ways of coping with toxic leadership, and by Didymus and Fletcher (2014), who also found support for these 12 coping dimensions' system in a sample of athletes. These studies provide promising support for this classification of coping across different contexts, and further research utilizing this will be valuable for increasing our understanding of the taxonomy coping.

The vast majority of coping research has focused on how people cope with past stressors and/ or stressors occurring in the present. However, the experiences of coping with potential future stressors, known broadly as future-oriented coping, has increasingly been acknowledged (Folkman and Moskowitz, 2004). Thus, some stressors are anticipated before they occur (e.g., birth of a new baby, intensive workload, bereavement), and the consequent coping behaviors can also be planned in advance to varying extents. Schwarzer (2000) proposed four categories of coping depending on the temporal location of the (potential) stressor and the degree of certainty with which it would occur: reactive, anticipatory, preventive, and proactive coping. Greenglass, Schwarzer, and colleagues also developed an empirical instrument to assess both future-oriented coping and avoidance coping, the Proactive Coping Inventory (PCI; Greenglass, Schwarzer, Jakubiec, Fiksenbaum, and Taubert, 1999a; Greenglass, Schwarzer and Taubert, 1999b). This measure, therefore, assesses future-oriented coping from a trait perspective.

Reactive coping is undertaken to deal with the harm or loss that has already been experi- enced, thereby situating it in the past and as having certainly occurred. The majority of coping research to date, including that described by Lazarus and Folkman's (1984) transactional the- ory of stress and coping, consists of reactive coping. Anticipatory coping is enacted in response to a recognized upcoming event of likely certainty in the short-term future. An example is preparing for an upcoming exam or performance appraisal assessment occurring within the next few weeks. The focus, therefore, is on managing known risks and utilizing resources to reduce the stressor or maximize anticipated benefits (Schwarzer and Taubert, 2002). Preventive coping is utilized to deal with potential future stressors that are possible, although their eventual occurrence is uncertain, and reflects efforts aimed at accumulating resources to assist in reducing the severity of the stressor. An example might be preparing a survival kit and emergency plan in case of a house fire or a severe weather event sometime in the future. It is akin to risk management in a broad sense of preparing resources "just in case." Due to its emphasis on preventing or reducing the impact of negative outcomes, preventive coping is primarily driven by threat appraisals. Finally, proactive coping focuses on the accumulation of resources to enhance one's poten- tial and opportunities for personal growth (Schwarzer, 2000). It is typically enacted for events that are highly likely to occur in the future. An example of proactive coping is actively attend- ing professional development workshops to enhance one's chances of a job promotion due to increased knowledge, skills, and performance. It is, therefore, akin to goal management rather than risk management, and is primarily driven by challenge appraisals (Schwarzer and Knoll, 2003).

Of these four types of coping, proactive coping has received the most research attention, followed by preventive coping. Research has supported the mediating role of proactive coping between stressors and a variety of health and work-related outcomes. For example, Angelo and Chambel (2012) demonstrated that proactive coping significantly mediated the relationships between job demands and both psychological burnout and work engagement for a sample of firefighters. That is, when proactive coping was enacted the subsequent health and work outcomes for the firefighters were improved. Similarly, Nizielski, Hallum, Schu¨tz, and Lopes (2013) reported that proactive coping significantly mediated the relationship between emotion-appraisal and psychological burnout, such that levels of burnout were again reduced when proactive coping occurred. The mediating impacts of both preventive and proactive coping were also demonstrated between stressors and student engagement by Gan, Yang, Zhou, and Zhang (2007), supporting the beneficial effects of these types of coping on individual well- being outcomes.

2.5.2. Future-oriented coping and the transactional theory

Research has employed the theoretical framework of the transactional theory of stress and coping, to assess relationships between future oriented coping with research variables such as cognitive appraisal, personality, support, and outcomes (e.g., Drummond, 2014). This research revealed that future-oriented coping demonstrated significant relationships with cognitive appraisal, work-related support, personality, and psychological strain, in accordance with the propositions of the transactional theory. Further support that proactive coping operates as a mediator of personality and support in predicting health and work-related outcomes was demonstrated by Drummond and Brough (2016a), who found support for proactive coping as a mediator between personality (optimism, goal orientation, and future and past orientation) and psychological strain. Similarly, Angelo and Chambel (2012) also demonstrated that both colleague support and supervisor support predicted work engagement through proactive coping. More research, however, is needed to understand the role of preventive coping as a mediator between personality and support on health and work-related outcomes. Preventive coping has been investigated in terms of its application to interventions aimed at improving health. For example, Thoolen, de Ridder, Bensing, Gorter, and Rutten (2009) implemented an intervention based on preventive coping and self-regulation principles to improve self-care behaviors in adults with newly diagnosed type 2 diabetes, showing that the intervention was successful in improving health-related behaviors and reducing weight over 12 months. Similarly, Vinkers, Adriaanse, Kroese, and de Ridder (2014) conducted an intervention for weight control in overweight and obese adults using preventive coping principles, and found the experimental groups reduced their body mass index compared to a control group who did not. These researchers also developed a tool to assess situation-specific (i.e., state-based) preventive coping, referring to it as the Proactive Competence Scale (PCS; Bode, de Ridder,

2.5.3. Classification of approaches

The Lazarus model outlined above represents a specific type of coping theory. These theories may be classified according to two independent parameters: (a) trait-oriented versus state-oriented, and (b) micro analytic versus macro analytic approaches (cf. Krohne 1996). Trait-oriented and state-oriented research strategies have different objectives: The trait-oriented (or dispositional) strategy aims at early identification of individuals whose coping resources and tendencies are inadequate for the demands of a specific stressful encounter. An early identification of these persons will offer the opportunity for establishing a selection (or placement) procedure or a successful primary prevention program. Research that is state-oriented, i.e., which centres around actual coping, has a more general objective. This research investigates the relationships between coping strategies employed by an individual and outcome variable such as self-reported or objectively registered coping efficiency, emotional reactions accompanying and following certain coping efforts, or variables of adaptation outcome (e.g., health status or test performance). This research strategy intends to lay the foundation for a general modificatory program to improve coping efficacy. Micro analytic approaches focus on a large number of specific coping strategies, whereas macro analytic analysis operates at a higher level of abstraction, thus concentrating on more fundamental constructs. S. Freud's (1926) `classic' defence mechanisms conception is an example of a state-oriented, macro analytic approach. Although Freud distinguished a multitude of defence mechanisms, in the end, he related these mechanisms to two basic forms: repression and intellectualization (see also A. Freud 1936). The trait-oriented correspondence of these basic defences is the personality dimension repression–sensitization (Byrne 1964, Eriksen 1966). The distinction of the two basic functions of emotion-focused and problem- focused coping proposed by Lazarus and Folkman (1984) represents another macro analytic state approach. In its actual research strategy, however, the Lazarus group extended this macro analytic approach to a micro analytic strategy. In their `Ways of Coping Questionnaire' (WOCQ; cf. Folkman and Lazarus 1988, Lazarus 1991), Lazarus and co-workers distinguish eight groups of coping strategies: confrontative coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem- solving, and positive reappraisal. The problem with this conception and, as a consequence, the measurement of coping is that these categories are only loosely related to the two basic coping functions. Unlike the macro analytic, trait- oriented approach that generated a multitude of theoretical conceptions, the micro analytic, trait-oriented strategy is mostly concerned with constructing multidimensional inventories (overviews in Schwarzer and Schwarzer 1996). Almost all of these measurement approaches, however, lack a solid theoretical foundation (cf. Krohne 1996).

Task-Oriented, Emotion-Oriented, and Avoidance-Oriented Coping by Parker and Endler (1992) Parker and Endler (1992) observed that many coping measures are characterized by methodological shortcomings which preclude generalization of results from one population to another. Their goal was to change this situation by introducing a new instrument based on three coping styles. The first two referred to problem- vs. emotion-focused coping (Lazarus and Folkman, 1984). Parker and Endler (1992) noted that problem-focused coping strategies are associated with a task-orientation, whereas emotion-focused ones reflect a person-orientation: “task-orientation refers to strategies used to solve a problem, reconceptualise it (cognitively), or minimize its effects” (Parker and Endler, 1992, p. 325) and “person-orientation refers to strategies that may include emotional responses, self-preoccupation, and fantasizing reactions” (Parker and Endler, 1992, p. 325). According to Parker and Endler (1992), many coping models distinguished a third basic dimension–avoidance-oriented coping, involving both task-oriented, and person-oriented strategies. Task-oriented avoidance is conceptualized as distraction, while person-oriented avoidance takes the form of social diversion. A person may avoid a stressful situation by engaging in substitute activities (distraction e.g., watching TV) or seeking out other people (social diversion). “In task-oriented coping, the person is confronting the stressful task. In distraction coping, the person is substituting an alternative task of his or her choosing” (Parker and Endler, 1992, p. 326). On the other hand, social diversion is “person-oriented in that the individual tries to “lose himself or herself” by being with other persons rather than confronting the stressful situational task” (p. 326). To measure the three coping styles, Endler and Parker (1999)developed the Coping Inventory for Stressful Situations (CISS).

In contrast to most coping inventories, the CISS has revealed satisfactory psychometric properties and a stable factor structure confirmed across different cultures (e.g., Furukawa et al., 1993; Strelau et al., 2005; Rafnsson et al., 2006; Boysan, 2012). The most significant limitation of the model is that it encompasses only three coping categories and cannot explain a plethora of coping responses (cf. Schwarzer and Schwarzer, 1996).

2.6. Coping strategy inventory

The original coping strategy inventory (CSI) was developed to categories coping responses based on coping target and directionality of response. With this system individual are classified using a 2X2 matrix that quantifies the degree to which each strategy is generally employed. Coping efforts are first categorized as to whether they represent an engagement strategy involving approach related actions that result in confronting hazards, often viewed as a crucial factor in limiting the long term psychological and physiological sequel ace of environmental stressors, or disengagement strategy (avoidance) seeking to limit exposure to noxious stimuli often producing desirable short term effects, but leading to long term problems including depressive symptoms. (Levine, Warrenburg, Kerns, & Schwartz, 1987)). Within these categories the target of coping effort is either problem-focused or emotion –focused. (Suls & Fletcher, 1985) (Laux & Weber, 1993). Emotion focused coping emphasizes the regulation of one′s effective response, whereas problem focused coping emphasizes the management of the hazard producing situation. The CSI was selected because it was believed to adequately address the questions of coping it, addressed factors that were crucial to the model. The CSI was originally constructed as a 78-item questionnaire. (Tobin, Holroyd, Reynolds, & Wigul, 1989). A seven-point Likert scale was used to record the participant′s responses. When individuals face events which are stressful that can be controlled by them Lazarus and Folkman pointed out that then these individuals adopt problem focused strategies. Whereas when these individuals cannot control the stressful events they adopt emotion focused strategies. (Lazarus R. a., 1984). The coping methods were divided into eight types by Stone and Neale. These eight types were distraction, situation re- definition, direct action, catharsis, acceptance, seeking social support, relaxation and religion (Stone, 1984). A revised version Ways of Coping Checklist (WCC) was developed by Folkman and Lazarus using problem and emotion-focused coping methods as the basis. This WCC was used to test university students. The test results showed eight inventories like direct coping, alienation, self-control, search for social support, accept responsibilities, prevention/avoidance, plan for solving problems and positive appraisal coping (Folkman, 1985). Scheier, Weintraub and Carver have done huge researches on the coping strategies. The results of these researches revealed that denial/aloofness, centre of the problem, self-accusation, acceptance/abandonment, active re-interpretation, evasion through delusions, and social support are the main stress coping strategies (Scheier, 1986).

Coping strategies were divided into direct and indirect strategies by Pine and Aroson. They categorized the concepts into action and non-action. These divisions and categorizations were mutually combined to form four categories, these four categories are direct/action, direct/non-action, indirect/action, and indirect/non-action. The findings of this research shows, that the most active strategy that is beneficial for as individual′s growth is direct/action. This emphasizes facing hazardous situations with courage. However, the most passive strategy that is harmful for physical and mental health of any individual is direct/non-action. This is when an individual takes the help of harmful alcohol or drug to flee from reality. This may cause irrecoverable harm (Pine, 1988).

Coping Matrix which is a table that can be used to explain coping strategies and coping resources was pointed out by Justice. This Coping Matrix splits the coping behaviour into problem-focused and emotion-focused. In problem-focused coping an individual try to change the strongest source of the problems which including both the external and internal environment. In emotion-focused coping an individual try to points at moderate the negative impact or the difficulties brought on by problems, including both the physical and emotional perspective. Justice even claims that the coping strategies used by an individual normally include three methods like direct action, indirect action, or controlled action, these are irrespective of whether the resources for coping exist or not. They hinder individual from adjustment of factors of their success (Justice, 1988).

A cope inventory was developed by Carver, Weintraub and Scheier′s, when they were researching on university students. This cope inventory is a multidimensional inventory. It integrates the similar coping methods into two types (Carver C. W., 1989). These two types are: problem-focused coping which includes the adoption of active coping actions, suspension of competitive activities, suspension of coping behaviours and search for tools of social support and emotion-focused coping includes denial, acceptance, search for religion, positive interpretation and search for emotional social support.

A multidimensional coping inventory (MCI) was developed by Endler and Parker. This MCI includes three methods i.e. mission-focused coping (which is similar to problem-focused), emotion-focused coping and evasion-focused coping (Endler, 1990). The stress coping methods of young people were divided into four categories by Halstead, Johnson and Cunningham. These four categories are problem-focused coping, search for social support, positive thinking and evasion coping (Halstead, 1993). On investigation of the university students revealed when exams were the source of stress, this stress was estimated as threatening and harmful stress by

Carver and Scheier. These results also showed the frequent usage of problem-focused coping, search for social support and positive appraisals. (Carver C. a., 1994) . Thoits′ pointed out in his research that people who continuously have higher self-esteem and control power, often tend to use the problem-focused coping strategies method with imitativeness. Whereas people, who have lower self-esteem or lack control, tend to passively use the emotion-focused coping strategies method (Thoits, 1995). The source of stress experienced by 110 university students of the nursing department was investigated by Timmins and Kaliszer. The result of their investigation showed that the main coping strategies are like schools arranging education for clinical internship, or guiding students to face stress recognition, and also incorporating counseling from direct internship professors (Timmins, 2002). 113 university students were examined for their psychological and physiological aspects of adjustment by Kim and Seidlitz. Their investigations showed that stress coping methods can be categorized into problem solving, search for support, rejection, sense of humor and physiological situations (Kim, 2002) . University students were investigated by Misra and Castillo using the questionnaire investigation method. The findings of their investigation showed that the stress coping attitudes of these students include frustrations, disputes, changes and taking up responsibilities (Misra, 2004). The same questionnaire investigation method was used by Karademas and Kalantzi-Azizi to investigate university students. The investigation results emphasized that when an individual faces stress, they choose different stress estimations to cope with stress (Karademas, 2004). Investigation of 235 university students for their adoption of stress coping methods was done by Twamley, Hami and Stein. The results of this investigation showed that the coping methods were divided into three types. These are current experience mode, evasion and negative strategic modes. The negative strategic modes include usage of alcohol and drug (Twamley, 2004). An investigation based on the optimists and pessimists was done by Iwanaga, Yokoyama and Seiwa. The results of this investigation showed that the coping methods were divided into problem management, problem estimation, re-establishment of appraisals, and evasion (Iwanaga, 2004). Another research on the university students of the nursing department done by Steele, Lauder, Caperchione and Anastasi showed that when students faced clinical care, interpersonal relationships and financial problems, then to cope with them effectively they use effective management experiences, such as a support Web site, sequential handling, active anticipation and attitude (Steele, 2005). Research in cyber bullying indicates that it could be very problematic for classifying strategies into known general categories. This may depend on the construction of the measuring tool (Riebel, 2009). In another article on cyber bullying, the coping mechanisms are like leaving a website, deleting threatening messages etc. In the context of cyber bullying, some studies include technical coping or directly addressing the bully in this model (Parris, 2011). Veronika Slegolova used the coping strategies like technical coping, avoiding, defensive coping and social support in her article on coping on cyber bullying among adolescent victims. (Veronika Šléglová, 2011). There are few researches which spoke of the factors influencing the coping strategies of an individual. Conner in his study of finding the relationship of personality type with coping strategy claimed that personality may directly facilitate or constrain coping. (Jennifer K. Connor-Smith, 2007). In his study he found out that personality most strongly predicted coping in his samples. In another study the researcher tried to investigate the relationship of personality profile and the coping strategies adapted by military pilots. (Maja Meško1, 2009). The results of this study revealed that certain personality characteristics were differently and significantly related to specific stress coping strategies adopted by military pilots. In another research personality and coping play both independent and interactive roles in influencing physical and mental health. (Connor-Smith2, 2010). The results of this study reveal personality is strongly associated with the coping skills of the individual. Another study on factors influencing the coping strategies among nursing personnel revealed that strategies focused on the problem were adapted to a greater extent more by postgraduate nurses, head nurse and nurses with greater work experience. Intensive care unit nurses mainly adapted the strategy of denial. While strategy focused on emotions were most adapted by female nurses. (Zyga, 2016).

2.7. Conclusion

This chapter as required has put forward enormous coping strategies for employees with disabilities. Theories link to coping has equally gain grounds in this chapter given the fact that they are essential for the effectiveness of employees with disabilities. Employees are often being pressured in multiple ways, often in combination with numerous pressures that may include relationships, money, parental expectations, and experimenting with drugs and alcohol.

PART TWO:

METHODOLOGICAL AND EMPIRICAL FRAMEWORK OF THE STUDY

CHAPTER 3 : RESEARCH METHODOLOGY

3.0 Methodology of the study

In this chapter the researcher will describe particular procedures and methods that were used to carry out this research. This part of the study will present and justify the site of the study, the respondents, the method of research, collection of data techniques, the instruments of data collection and techniques of results analysis. First and foremost, the researcher shall review the problem this study is trying to solve.

3.1. Brief review of the problem

In this sub-section, the researcher shall recall the problem and objectives of the study.

3.1.1 Summary of the problem.

Occupational researchers and practitioners are well aware of the stubborn gap in employment rates between disabled and non-disabled people in countries. They may be less aware that many of the causes of this gap can be found in the workplace.

To understand the mechanisms involved we need to know more about those aspects of work, such as problems with employment rights and forms of ill-treatment, which may be more common among disabled employees. Research has demonstrated that people with disabilities encounter difficulties which are not caused by their impairments or long-term health problems but can be traced to the behaviour of employers, managers and other employees. Even though they have lower expectations, disabled employees have lower job satisfaction and feel they have less influence in, and commitment to, their workplaces.

The question remains, however, as to what connection there might be between these subjective experiences of the workplace and the behaviour of employers.

The most recent data on unfair treatment in the workplace comes from the Fair Treatment at Work Survey, carried out in 2008. Around one in four disabled people in Great Britain said they had experienced some form of unfair treatment, discrimination, bullying or harassment at work in the previous two years (27 per cent), compared with 17 per cent for non-disabled people.

Specifically, 19 per cent of disabled people said they had experienced unfair treatment, 12 per cent discrimination, two per cent sex-based harassment and 14 per cent other bullying or harassment. Negative experiences at work with colleagues or clients that could constitute harassment or bullying were reported by more than half of disabled people (53 per cent) compared with less than two–fifths (38 per cent) of non-disabled respondents. More than a third of disabled people (37 per cent) said they had been treated in a disrespectful or rude way, 23 per cent that they had been insulted or had offensive remarks made about them and 14 per cent that they had been humiliated or ridiculed in connection with their work. Nine per cent had experienced actual physical violence at work.

In the 2010 Citizenship Survey, 15 per cent of disabled people in England and Wales who had looked for work in the previous five years said they had been discriminated against when they had been refused or turned down for a job. This is higher than the proportion for non-disabled people (seven per cent). The 2010 Equality Act was brought into practice partly to prevent discrimination against disabled people in the workplace. Yet disabled workers are often still unfairly treated. So what more must be done to ensure best practice? People with disabilities are a largely untapped employment resource in many countries. About 48.5% of people with disabilities are employed in the European Union (EU), compared with only 24.4% in Latvia. Although there has been some progress on employing disabled people in Latvia, as the statistical facts and figures show, the problem still remains.

One of the most significant barriers that workers with disabilities face when entering the workforce are co-workers' and supervisors' attitudes and stereotypes (Colella & Bruyère, 2011). Several studies that investigate the attitudes of the general population towards people with disabilities report that people often feel a high degree of social distance towards people with disabilities (Angermeyer & Dietrich, 2006; Aromaa, Tolvanen, Tuulari, & Wahlbeck, 2011; Tanaka, Inadomi, Kikuchi, & Ohta, 2004). In the work environment, this perception of a social distance can translate into a biased view about the capacities of employees with disabilities (Burge, Ouellette-Kuntz, & Lysaght, 2007; Ross, 2004; Scheid, 2005) in a way that persons with disabilities are perceived as helpless, having no capacities to develop (Prins, 2013), and being unable to effect a similar level of performance as their colleagues. The performance of a colleague with disability seems to be one of the biggest concerns of employees in an organization. Individuals who believe that a co-worker with a disability is responsible for an increased job-difficulty and a higher workload, have lower expectations towards this co-worker and more negative reactions and attitudes concerning employees with disabilities in general (Burge et al., 2007; Scherbaum, Scherbaum, & Popovich, 2005; Vornholt, Uitdewilligen, & Nijhuis, 2013). Commonly, people seem to rely on stereotypes they have about people with disabilities when predicting future work performance (Colella & Varma, 1999). This even accounts for high-qualified university graduates with a disability, regardless of their obvious qualification (Niehaus & Bauer, 2013). Such negative biases were also found to be prevalent under conditions in which the performance of the employee with a disability had direct (positive) consequences for the ratter (e.g., for receiving a reward) (Colella, DeNisi, & Varma, 1998).

Negative attitudes towards people with disabilities are often accompanied by a misunderstanding of disability, such as distrust and fear of co-workers or managers concerning the disability. Individuals with mental disorders are especially vulnerable to experience such mistrust and belong to one of the most stigmatized groups in our society because their disability is invisible and their skills and handicaps not immediately ascertainable (Bos, Kanner, Muris, Janssen, & Mayer, 2009). This can result in several (negative) consequences in the workplace, such as the denial of necessary workplace accommodations (Toth & Dewa, 2014). People with mental disorders are attributed as being dangerous, deviant, and aggressive, which evokes fear and irritation in others (Bos et al., 2009). The higher the level of stigmatization of the disease, the more likely it is that the affected person will experience discrimination (Beatty & Kirby, 2006). Stigma comprises stereotyping, prejudice, and discrimination, whereas discrimination is the behaviour that results from negative stereotypes (Dijker & Koomem, 2003). For persons with mental disorders, fear of stigmatization is a particular concern (Toth & Dewa, 2014), as well as a need for active coping (Muschalla, Fay, & Seemann, 2016). All these made the researcher want to quickly lay hands on some of the discriminations at work and some strategies disabled employees can use to cope in this situation.

3.1.2 Review of the objective of the study

The objective of this study is to find out how coping strategies can influence or reduce discrimination at work of employees with disabilities.

3.2. Site of the study

The site for the study is the spatial context where the research work is done (Amin, 2005). It is also the space where the research is enclosed or a precise place where the data is collected for analysis. This study took place at the City of Yaoundé.

3.2.1. Justification of the choice of site of study.

To make this work reliable, the researcher we chose the City of Yaoundé since it has many workers with disabilities.

3.2.2. Presentation of the site

We shall present the site base on its historical background, it’s geographical location.

3.2.2.1 Historical background of Yaoundé

We can say that **Yaoundé**, also spelled **Yaoundé**, city and capital of Cameroon. It is situated on a hilly, forested plateau between the Nyong and Sanaga rivers in the south-central part of the country. Founded in 1888 during the period of the German protectorate, Yaoundé was occupied by Belgian troops in 1915 and was declared the capital of French Cameroun in 1922. From 1940 to 1946 it was replaced as the capital by Douala, but after independence it became the seat of the government of Cameroun in 1960, of the federal government in 1961, and of the united republic in 1972. The city has grown as an administrative, service, and commercial centre and a communications hub for road, rail, and air transport. Yaoundé contains several small manufacturing and processing industries (a cigarette factory, a brewery, sawmills, and printing presses) and is also the market for one of the richest agricultural areas in the country.

The University of Yaoundé was founded in 1962; the city also has schools of education, agriculture, health, engineering, journalism, administration, and international relations. The Pasteur Centre of Cameroon, which conducts biomedical research, is among Yaoundé's many research institutes, and the national library and archives are located in the city. Natural features in the vicinity include Nachtigal Falls and a chain of grottoes known as Akok-Bekoe (Grottoes of the Pygmies).

3.2.2.2. Geographical location of Yaoundé.

It is situated on a hilly, forested plateau between the Nyong and Sanaga rivers in the south-central part of the country.

3.3. Procedures and criteria's used in the selection of respondents

3.3.1. Criteria for selections

We shall use two criteria to select respondents whom will answer our interview questions and questionnaires, they include inclusion and exclusion.

3.3.1.1 Criteria for inclusion

Inclusion criteria for this study are as follows:

- Willingness to participate in the study
- Disabled employee
- Ability to speak, read and write English or French

3.3.1.2 Criteria for exclusion

Exclusion criteria is as follow:

- Unwillingness to participate in the study

3.4. Types of research

In clinical psychology and specialized education, there exists four different types of research (Fernandez & Pendicilli, 2006). These types of research include; quantitative and objective research and qualitative non objective research. Research methodology consists of a practical activity whose aim is to identify and name some psychological states, attitudes and behaviors of an individuals. Methodology helps in the collection of information from individuals with the use of instruments like observations, questionnaires, interviews, scale and test, which gives us a rich knowledge about the concern (Fernandez & Pediniclli, 2006). Our study is based on clinical psychology that special need education which uses quantitative and qualitative research, but on the basis of this study, we shall limit ourselves to qualitative research. Qualitative research studies human phenomenon with the aim to understand, explain, exploit and evaluate individual performance. It's procedures and analyses descriptive data such as questions answered by respondents. Speech written or spoken from the observable behavior or reactions.

This type of research is intensive and interested in indepth studies of the social phenomenon in its natural environment or in its real self. It also permits us to understand the meaning and consequences of human action as a social being.

The qualitative research is pertinent to this work because it agrees points of view of the researcher. This will allow us do a thoroughly check and analysis on discrimination at work a coping strategies of employees with disabilities.

3.5. Sampling techniques

The study employed purposive sampling techniques in identifying the respondent in this case employees with disabilities. In the purposive sampling the researcher has selected the respondents base on their knowledge, commendable experience and vital information presumed important for the study (Trochin, 2006). Some of the techniques commonly used in sampling include;

- **Probability sampling** which involves a random selection of a population, allowing you to make strong inferences from the statistics about the whole group studied.

- **Non probability sampling** which a non-random selection of the population and taking into consideration the convenience or other criteria, this allows the researcher collects data easily.

The sample period was 2021-2022, this sample represent the population of employees with disabilities and was considered good enough to provide a general view of the entire population and serve as a good base for valid and reliable conclusion.

3.6. Demographic Characteristics.

Demographic characteristics of participants in this study include the general aspects of the participants in the study. The work constituted seven respondents of different types of handicaps in the city of Yaoundé.

Table 4 : Identification

GENDER	AGE	STATUS	PROFESSION	HANDICAP TYPE
Female	41	Married	Cook	Dwarf
Female	46	Single	Teacher	Left leg infirmity
Male	32	Single	Sales agent	Amputated right leg
Male	46	Married	Lawyer	Left leg infirmity
Female	29	Single	Sales agent	Albinos
Male	36	Married	Accountant	Left arm infirmity
Male	49	Married	Moto mechanic	Amputated right leg

Table 4 identifies each respondent with the gender, age, status, profession and the type of handicap.

Table 5 : History of handicap

By birth
By birth
I had a small wound on my leg the age of 25. The wound kept increasing. Medical report shows that I was diabetic. Two years later, the situation got worse doctors advices that the leg should be amputated. Finally, my family accepted the doctor’s proposals. That is why I am handicap today.
By birth

By birth
By birth
Eleven years ago, I had an accident at my job site. The car I was repairing fell on my right leg and injured me seriously. There was no other option than to amputate my right leg

Table 5 tells us the history of handicap for each of the 7 respondents. It explains weather the handicap is acquired y birth or some accidents or what so ever may be the case. 4 respondents had their handicaps through birth and 2 through accident as it is clearly explained.

Table 6: Family situation

MARITAL STATUS	NUMBER OF CHILDREN	FAMILY HISTORY
Married	01	Married 12 years now
Single	00	Never got married
Single	00	Never got married
Married	03	Married 16 years now
Single	00	Never got married
Married	02	Married 10 years now
Married	04	Married 16 years now. I have lost a child

Table 6 verifies marital status, number of children, and the family history of respondents. It tells us that 4 of the respondents are married and 3 single. 4 equally have children ranging from 1 to 4 while 3 of the respondents do not have children. Many have given the number of years they have been into marriage.

3.7. Interview Guide

This is an in-depth interview conducting to try to learn more from the discrimination made against employees with disabilities in the city of Yaoundé - Cameroon, your coping strategies, and how you manage Stressors like discrimination experience based on the treatment you receive in this job side. Before we begin, do you have any questions?

A. Identification

- Gender
- Age
- Status
- Nationality
- Profession

B. History of handicap

1. How did you become handicapped?

C. Family situation

1. Marital Status:
    - Married and living together?
    - Married but living separately?
    - Divorced/ separated (legally)?
    - Single
    - Other, specify
2. Number and ages of children (if dead, age and cause of death)
3. Can you talk to me briefly about your family?
    - Children? Spouse/partner?
    - Who are does considered as part of your family?

D. Job and working situation

1. What is your job here?
    - How long have you been working here? Months/years?
    - How long have you been working in this center?
    - Why did you choose to work here?
2. Can you tell me more about your life in this center?
    - When did you come here?
3. Have you work in other places?
4. What are your major difficulties as a worker in this center?
5. What are your main successes since you started working?
6. Has this center made some reasonable adjustments for you?
7. Do you know there have to be some reasonable adjustments for you as a handicap?
8. Have you in one way or the other experience discrimination at work? Yes/No?
    - If yes can you explain a bit?

- How do you cope in this situation?

9. Can you describe your work task?
10. Do you always finish your daily task? Yes/No?
    - If yes, how do you go about it?
    - If No what is the problem
11. What kind of work do you do daily?
12. What part of your daily work do you enjoy most or least?
13. How many times do experience discrimination a day?
    - Do you report your case?
    - Are your problems of discrimination treated?
    - Who do you report your case to?
    - Are you always satisfied when you report your case?

E. Coping strategies

1. Our research is on discrimination at work and coping strategies of employees with disabilities in this center.
    - What would you say are your coping strategies?
    - How does one achieve these coping strategies?
    - How do these strategies help?
2. How do you manage the different coping strategies you are dealing with?
    - Does ILO provide support? Others?
    - Family support?
3. Can you tell me any other support link to coping with discrimination at work of disabled employees of this center?
4. What are the main barriers to dealing with coping strategies faced with discrimination?
5. What degrees do you currently hold?
    - None:
    - High School:
    - BA/BS, field:
    - Masters, field:
    - PhD, field:
    - MD, field:
    - Other degree, field:
6. Are you a student?
    - What degree(s) are you currently seeking?

3.8. Data collection tools and designs

The main data collection tools for this study was the secondary are semi structured interview guides. The design included questions. The questions were clearly simplified and structured in a manner void of ambiguity and technical details. These questions were administered using drop and pick method. The interview guide was use to allow respondents give their responses in a free environment and help the researcher gather information. The interview guides were being done through a close follow up of respondent's base on their experience and problems face during work, possible solutions will be checked and noted for verification.

3.9. Tools for data analysis

The data was thoroughly checked to avoid errors in responses, exaggerations, omissions and coherence. All analysis was done using thematic content approach. For easy management and longevity of data, it was captured in Microsoft excel 2016 windows. All data was entered and verified after effective coding. Data was then scrutinized in relation to the objectives of the study, otherwise with a potential abundance data.

Summarily, this chapter has brought out the method used in gathering from the different respondents, the manner in which the information was analyzed. This chapter made it clear that the qualitative research technique is best for this study and will help us acquire reliable and authentic information from our respondents as shown in the next chapter below.

CHAPTER 4:

PRESENTATION OF RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the research findings and analysis. The study investigate discrimination at work made against employees with disabilities and the possible coping strategies these disabled employees have adopted in the city of Yaoundé. This chapter will also interpret and analyze primary data from qualitative interviews of employees with disabilities in the city of Yaoundé. Findings were presented to respond to the objectives of this study. The study sought to provide answers to the objectives;

- The main objective of this study was to investigate the various types of discrimination employees with disability face at their work place.
- To explain how employees with disability cope at their workplace

4.2. Presentation of findings.

4.2.1. Responses from the interview guide

Respondent 1.

I am a Cameroonian that originates from the north west region. I am 42 years old and a professional cook. I have work in the city of Yaoundé for 15 years and 2 years in my present workplace. I am a dwarf so am a handicap from birth. My present work is so tedious; I don't have a resting time at all. I work well and makes sure I finish my daily task though my hard work is not appreciated. Yes, I face a lot of difficulties since am too short, the kitchen is constructed such that I have to stretch too much to use the equipment's. Yes, in this place I face a lot of discrimination every working day. My colleagues avoid me all the time, they do not want me to always work closer to them. They prefer sending me to the market all the time and that is so difficult for me. My colleagues usually go home with excess food while I go home with almost nothing. Usually I report my case of discrimination and boss does nothing about it so I have learned to cope with it. I don't know what you mean reasonable adjustment. I know of organizations that help handicaps but I have received no support from any of such organizations. My boss discriminates me, I say so in the sense that he will always pay me last, I don't know if it's because of my situation. Yes, I have developed some strategies to cope at my workplace. I don't talk too much; I don't answer my colleagues each time they insult me. I try as much to remain a lone in my working space. I have never met a psychologist to explain my situation. My best time of the day is when we are closing. My highest certificate is first school leaving certificate.

Respondent 2

I am a Cameroonian that originates from the Center region. I am 46 years old and a teacher by profession. Am presently teaching in an evening school where I have thought for 4 years now. I have been in the teaching job for over 20 years now. No I was not born handicap I only acquired this left leg infinity when I was 11 years old in a motor accident between Bafia and Yaoundé. Many doctors tried all they could to see my leg stands straight but it was not possible. So I just had to leave with this infirmity. I choses to work in this school because it is closer to my house and so less expensive for transportation to school. In the beginning I was treated well here but as time passes I have been discriminated all the time. My boss first started by reducing my salary with no justification, when I walk up to him he said I don't deserve a good salary that I am a disabled person and have nothing much to do with money. The reply of my boss made me sick for a very long time. I have no husband and no child, people I consider my family are my siblings. Yes, I face discrimination in school like 10 times a day. My colleagues will always accuse me wrongly. They will send me to teach up stairs knowing fully well that I face difficulties in climbing. Most of the time am given over period to teach with no compensation. My happiness in school comes when my students perform well especially in public exams. Yes, I know there have to be some reasonable adjustments for handicaps like me but it has never come. Yes, I have adopted strategies to cope with the treatment I received from my job. I employ good morals, ignore side comments, I always program myself well and keep to time. I don't have a psychologist I talk to but I seek advice from my pastor and some friends. I have not received support from any organization. Yes, I once took my formal school to court when I was discriminated upon. The court asked the school to pay me 800000 francs' cash, but since then I have received just 300000 francs. I am a university drop out, my highest certificate is Cameroon Baccalaureate.

Respondent 3

I am a Cameroonian that originates from the Center region of Cameroon, I live and work in Yaoundé as a sales agent in a super market. I am 32 years old and I have work here for 4 years. Yes, I am a handicap with an amputated right leg. I had a smell wound on my leg that could not heal since I was also diagnosed of diabetes. After several years of suffering my family accepted the doctor's proposal to cut my leg. This was when I became handicap. I decided to sell eggs in this company because I was I had no other job to do. I dropped out of the university due to the fact that I could not help myself financially. I have a good relationship with my boss. He pays my salary early every month. My colleagues are not good to me. We have problems all the times but am not afraid of them. Yes, I am being discriminated upon, my colleagues do not want me to benefit the same from the privileges of the company like them. Lost at times the boss will ask us to take broken eggs to our homes but my colleagues won't allow me take some. I do not have a wife but I have a child. Yes, I face discrimination here because of my situation, my colleagues do not respect me at all. I don't know about any reasonable adjustments for handicaps. Yes, I have some strategies which I use to cope with my situation. They include: patience, hard work, perseverance, listening to music. I am discriminated at least 8 times a day. I use to report any case of discrimination to my boss but not anymore because nothing is always done to my complaints. My highest certificate is Baccalaureate.

Respondent 4.

I am a Cameroonian that originates from the southwest region of Cameroon. I am 46 years old, married with 3 children. I am a lawyer by profession. I was born with this infirmity so I consider myself handicap. I have a lovely family that respects me in fact my wife is the best. My extended family members are not really good to me because of my situation, they think I am a disgrace to them. Yes, I face discrimination in my place of work. My colleagues who are lawyers still discriminate me even they know it's a crime. I have been working in this court for 9 years, defending my clients and have never fail a case. Yes, my life in this court is fairly good. I have difficulties in going around the court and claiming up stairs. There are no reasonable adjustments made for me. Am always given less time to express myself the way I feel. Yes, I have developed strategies to cope, they include: hard work, stay away from trouble, stereotype, prejudice. And the fact that there are reasonable adjustments. I have no support from any an organization

Respondent 5

I am a Cameroonian from the northwest region of Cameroon. Am 29 years old and a sales agent in a super market in Yaoundé. I am an albino so I was born handicap. I am single no child too. I belongs to a complicated family not everyone loves me but I am fine with it. I have been selling in this job side for two years. I chose to work here in order to raise money for myself. My major difficulty is that I don't see clearly in order to better do my job. Yes, I face a lot of discrimination job. I being stigmatize, stereotype and my colleagues always avoid me. I am being discriminated upon like 20 times in one day. Yes, my salary is always paid here and on time. No I don't know about any reasonable adjustments for disabled employees. Yes, each time I face discrimination i report to my boss but no concrete decision is always taken. Yes, I have some strategies that helps me to cope here. These strategies are about 60% effective. The strategies are hard work, stay away from problems, listening more and talk less. No I don't have a psychologist. I receive small support from my family but not from any organization. My highest certificate is Baccalaureate.

Respondent 6

I am a Cameroonian that originates from the west region. I am 36 years old and an accountant in a small micro finance. I was born handicap I have a wife and 2 children. I have a good family and we live together in harmony. I consider anyone close to me as my family. I work in order to raise income for myself and my family. Yes, I have been working here for a period of 5 years and I have learned to like the place despite the difficulties. I have difficulties in doing my job accurately because of my this my handicap. The job is a difficult one too. Over work and over time. Yes I receive my salary all the time. Yes, there has been a lot of discrimination from my boss and colleagues. My colleagues disrespect me at will. There avoid me socially and stigmatize me. There are no reasonable adjustments for my handicap. My boss gives over work all the time and specifically for me. I am subjected to work more than everyone despite my condition. Yes, I have adopted good coping strategies for myself and they are about 75% effective. They are listening to music, avoid over talking, isolation. I have no support from anyone I do my self.

Respondent 7

I am a Cameroonian from the northwest region. Am 49 years old and a professional mechanic. I am married with 4 children. I became handicap at the age of 37. It all happened when the jack of a car I was repairing fell on me and created a deep wound. It was resolved weeks later that the leg should be amputated. We tried every other means but we ended up cutting my leg. This is how I became handicap and I regretted ever being a mechanic so I cannot advise anyone to become a mechanic. Yes, I have a good family I am proud of. My difficulty is that I cannot move easily so I cannot do my job easily. I have made money from this job for my family. Yes, my colleagues will always discriminate me in all aspects. They don’t want me to make money like them but God is always on my side. There are no reasonable adjustments made for me. Yes, a lot of strategies to come I avoid problems by all costs I don’t talk when it’s not necessary.

The data was presented on a tabular form for easy understanding.

Table 7: Job and working situation

JOB	DURATION OF PRESENT JOB	REASON FOR WORKING	WORK PLACE DISCRIMINATION EXPERIENCE	DAILY DISCRIMINATION FREQUENCY	DO YOU REPORT YOUR CASE OF DISCRIMINATION?	IF NO WHY	DO YOU FEEL YOUR SUGGESTIONS ARE TAKEN INTO CONSIDERATION
Cooking for clients in a hotel in Acacia Yaoundé	Two years of working	To raise income for myself	Yes. Discrimination from my boss and colleague	Often discrimination like 10 times a day	Yes I always report my case of discrimination but usually no response	-	My suggestion does not count at my job site
A teacher in an evening school	08 years of teaching in this school	I was recommended to the school and I also love teaching	Yes I am discriminated by the entire staff	Like 5 times on my working days	Yes, I once took the school to court and won a case of discrimination against me. I was to be given a sum of 600 000 thousand francs but I had receive just 400 000 hundred for the moment	/	My suggestion does not count at my job site
Sales agent	06 years of selling in this company	To raise income for myself	Yes my boss and my colleague discriminate me often	Like 15 times daily	No	My boss is too strict. I am afraid to lose my job	My suggestion are taken into consideration but not all the times
To defend the right of people and accelerate judicial	09 years of working at the	I love the job. I also like justice. To	Yes from the administration, colleague at job	03 times daily	Yes, I have won four cases of discrimination against me	/	Yes my suggestion are always taken into considerations

procedures	Court (military tribunal	raise income for myself	site				
Sales agent	Two years of selling	To raise income to myself	Yes every one discriminates me at my job site	Like twenty times daily	No	, I don’t want to lose my job	my suggestion are not taken into considerations
Accountant	04 years accounting in this company	I love the job. I also want to raise income for myself	Yes, from my boss only	Once daily	Yes I report anytime my boss discriminate against me but usually no response	/	my suggestion are not always taken into considerations
Repairing buses	09 years of working with this company	I like the job	Yes, there is discrimination from my colleagues	Six times daily	No	I am afraid to lose my job	my suggestion are not taken into considerations

Table 7 presents the results on how the seven respondents to the interview guide go about their job and the conditions which surrounds it. We realize that many of them have been working for long with the main reason of raising income for themselves. The table also tells us of the discrimination they go through at work and equally the discrimination frequency. Most of them confessed that the discrimination comes from their employers, colleagues and even some clients. It equally explains the feelings of these employees at work and if their various suggestions are taken into consideration or not. Just one amongst the seven respondents have report a case of discrimination, others fear to lose their work and so prefer to stay quiet and cope with the condition. There is clear evidence of discrimination of employees with disability on the table.

Table 8 : Coping strategies

STRATEGIES ADOPTED TO FIGHT DISCRIMINATION AT WORK PLACE	ARE/IS YOUR STRATEGIES EFFECTIVES	DO YOU RECEIVE ANY FAMILY SUPPORT	DOES YOUR CENTER HOLDS MEETING TO RESOLVE DISCRIMINATION ISSUES	DO YOU RECEIVE SUPPORT FROM EXTERNAL NGOs LIKE International labour office (ILO)	WHAT ARE THE MEAN BARRIERS DEALING WITH COPING STRATEGIES
- Hard work - Perseverance - Report my problems of discrimination	Yes like 18% effective	Yes very little	No	No	Ignorance or lack of knowledge
- Talk less at work - No complains - Ignore site comments - Pray all the time	Yes very effective	Yes I receive some support	No	No	Laziness
- Patience - isolation - listening to music - Prayers	Yes they are effective	Yes enough support	No	No	Lack of knowledge
- Offenly visit a psychologist - avoid too much talking	Yes they are 100% effective	No family support	Yes	No	Failure to accept your condition and learn how to cope

- Hardwork - Time conscious - Lot of exercise					
- Forgiveness - Hardwork - listen to music - Ignore discrimination	Yes they are effective	Yes there is family support	No	No	Ignorance
- listen more and talk less - Application of ethic - Hardwork - Ask questions	Yes they are effective	No family support	No	No	Ignorance ad laziness
- isolation - avoid evil colleagues - Time conscious - Forgiveness - Ignore site comment	Very much effective	No family support	No		

Table 8 is basically on coping strategies it verifies weather or not the respondents have developed strategies to cope. It has been stated clearly that all respondents have developed strategies to cope. The effectiveness of these strategies has also been demonstrated. They have also declear that no support is given to them.

4.3. Analysis of findings.

The data was analyzed in a tabular form taking into consideration all the themes in the semi structured interview guide. For reasons of proper understanding we analyzed using the two objectives of the study.

Table 9 : Respondent 1.

Discrimination at work	Coping strategies
Respondent 10 is a 41-year-old woman who is married with a daughter. She cooks in a hotel in the city of Yaoundé. She faces discrimination at work at least 10 times a day. she is being discrimination upon by her boss, colleagues and clients. She faces discriminations like: social avoidance, harassment, victimization, stereotype, stigmatization and prejudice. There is no reasonable adjustment made for given that she is a dwarf. She has no support from any organization.	Over the years she has developed strategies to cope with her job, given that she faces a lot of discrimination. She confesses these strategies are 80% effective. She has been using strategies like: • Being comfortable • Listening to music • Non compares • Perseverance • Hard work.

Table 9 is gives the detailed explanation of respondent 1. The woman says she is being discriminated upon gives the number of times she face's discrimination daily. equally states the types of discrimination she faces. The coping strategies she develops over the years are also listed above.

Table 10 : Respondent 2

Discrimination at work	Coping strategies
Respondent 2 is a 46 years old woman with a left leg infirmity and teacher by profession. She is single with no child. She is being discriminated by the administration where	She has equally adopted strategies which has been of great help to her over the years she has been teaching. Below are some of her strategies to cope:

she teaches and the entire staff of her school. She faces discrimination like 5 times on her working days. The types of discrimination she faces daily includes: victimization, stereotype, prejudice, and the fact that there are no reasonable adjustments for her.	• Talk less and listen more • Ignore side comments • Listening to music • Hard work and prayers.

Table 10 is gives the detailed explanation of respondent 2. The woman says she is being discriminated upon gives the number of times she face's discrimination daily. equally states the types of discrimination she faces. The coping strategies she develops over the years are also listed above.

Table 11 : Respondent 3.

Discrimination at work	**Coping strategies**
Respondent 3 is a 32 years old man with an amputated leg. He is a sales agent that originates from the center region of Cameroon. He is being discriminated upon by his boss, colleagues and clients. He faces discrimination approximately 15 times daily. He faces discrimination like stereotype, social avoidance, victimization and the non-provision of reasonable adjustments for his disability.	He also testified that in order to cope he has developed strategies that keeps him going at his job side. They include: • Listening to music • Patience • Good programing of time • Avoiding confrontation • Isolation

Table 11 is gives the detailed explanation of respondent 3. The man says he is being discriminated upon gives the number of times he face's discrimination daily. equally states the types of discrimination he faces. The coping strategies he develops over the years are also listed above.

Table 12 : Respondent 4

Discrimination at work	Coping strategies
Respondent 4 is a male lawyer with a left leg infirmity. He is married with 3 children. He is discriminated like 3 times daily. He faces discrimination from his boss and colleagues and the entire court. He faces prejudice, stereotype, victimization and stigmatization. There have made no reasonable adjustments for me.	The respondent has equally developed strategies to cope at work. Below are some strategies he developed: Taking advantage of everything I can do • Ignoring side comments • Do not expect perfection • Hard work and prayers • Stay away from evil colleagues

Table 12 is gives the detailed explanation of respondent 4. The man says he is being discriminated upon gives the number of times he face's discrimination daily. equally states the types of discrimination he faces. The coping strategies he develops over the years are also listed above.

Table 13 : Respondent 5

Discrimination at work	Coping strategies
Respondent 5 is an albino's girl. She is sales girl agent in a popular supper market in Yaoundé. She is discriminated upon by her boss and colleagues. she faces discrimination like 9 times daily. She faces discrimination like: social avoidance, stereotype, stigmatization, victimization. There is no reasonable adjustments made for her condition.	She has over the years of her working life developed good coping strategies that keeps her going almost smoothly. They include: • Talk less and listening more • Time conscious and programing • Listening to music • Ignore side comments • Hard work

Table 13 is gives the detailed explanation of respondent 5. The girl says she is being discriminated upon gives the number of times she face's discrimination daily. equally states the types of discrimination she faces. The coping strategies she develops over the years are also listed above.

Table 14 : Respondent 6

Discrimination at work	Coping strategies
Respondent 6 is a man with a left arm infirmity. He is an accountant in micro finance. He is married with two children. He faces discrimination from his colleagues and clients. He approximates his discrimination to 5 times daily. he faces prejudice, stereotype harassment. There are no reasonable adjustments for his condition. Support from no organization.	His coping strategies include: • Listening to music • Time consciousness • Isolation • Avoiding problems and evil colleagues • Hard work

Table 14 is gives the detailed explanation of respondent 6. The man says he is being discriminated upon gives the number of times he face's discrimination daily. equally states the types of discrimination he faces. The coping strategies he develops over the years are also listed above.

Table 15 : Respondent 7

Discrimination at work	Coping strategies
Respondent 7 is an old man with an amputated right leg. He is married, having children and is a professional mechanic. He equally faces discrimination at work due to his condition. The types of discrimination he faces are: stereotype, social avoidance, prejudice, harassment and victimization. There is no reasonable adjustment for his condition.	His strategies to cope include: • Hard work • Quietness • Avoid too much talking • Prayers.

Table 15 is gives the detailed explanation of respondent 7. The man says he is being discriminated upon gives the number of times he face's discrimination daily. equally states the types of discrimination he faces. The coping strategies he develops over the years are also listed above.

4.3.1. Summary of analysis.

The data of this study was collected from a sample of seven (07) employees with disabilities in the city of Yaoundé. Four (4) of which are males making 57.14% of the sample and (3) of which are females making 42.85% of the sample. The ages of the respondents ranges from 29 - 49, with an average age of 39. Amongst these respondents, 57.14% are married and living with their families while 42.85% are unmarried and living on their own. It is being also seen that 71.43% of the respondents were handicaps from birth while 28.57% became handicaps through an accident. The data showed that those who were handicaps from birth have a high capacity to deal with discrimination than the other 28.57% who became handicaps through accident. 57.14% were married with children ranging from 1 - 4 and 42.85% where unmarried with no children. 42.85% of the respondents work just to raise income for themselves while 57.14% of the respondents really love the job there do. 100% said there were being discriminated at their workplace. 57.14% always report their problems of discrimination to their bosses or to competent authorities while 42.85% do not report their problems of discrimination for fear that they could lose their job. 71.43% of the respondents said their suggestions were never taken into consideration at workplace while 28.57% said their suggestions were always taken into consideration at their workplace. 100% respondents have gradually developed strategies that helped them cope at their workplace despite the high frequency of discrimination. 100% respondents have also proposed possible ways of fighting workplace discrimination of employees with disabilities.

71.43% of the respondents propose that listening to music can be and essential strategy to cope with workplace discrimination of employees with disabilities. 57.14% of the respondents proposed that hard work is a good strategy to cope with workplace discrimination of employees with disabilities. 28.57% said self-education through a psychologist is an effective strategy to cope with workplace discrimination of employees with disabilities. 28.57% said ignoring negative comment against you at work is a good strategy to cope with workplace discrimination of employees with disabilities. 57.14% of the respondents testify that their coping strategies developed were very effective, 42.85% said their strategies are effective. 85.71% of the respondents said their centre do not organize meetings to solve problems of discrimination while 14.28% affirmed that special majors are being taken to solve their problems of discrimination. In a concise manner what we can say about our research can be seen as follows.

4.4. Interpretation of findings.

Arriving at the end of our research work which had as main objective to investigate the rate at which coping strategies influence or reduces discrimination at work of employees with disabilities. We discovered that; a greater percentage (57.14%) of the respondents were males and the minority percentage (42.85%) were females. We observed that majority of the respondents were married and living with their families (husband, wife, and children) and a smaller percentage of them are single and living on their own. We equally observe most of the respondents became handicapped by birth, and these respondents could easily deal with problems of discrimination at workplace rather than a few of them that became handicap through accidents and were so weak in dealing with problems of discrimination at workplace. Most of the respondents affirmed that there love the jobs there are into while a few are just working to raise income for themselves. All the respondents testified that there were frequently discriminated at their workplace. 57.14% of the respondents will always report to the competent authorities each time there are discriminated but usually no good response will come from the report. A few of them usually do not report discrimination against them for fear that they might lose their job. All of them have developed various strategies to cope with workplace discrimination but none of them could boast of the fact that the strategies were effective. Resilience, hard work, self-education through psychologist, resistance and good moral were affirmed as very good coping strategies for many of the respondents. A greater part of them (57.14) received family support while others do not get support from family. None of them receive support from local NGOs.

Coping strategies have direct effects on variables. Materazo defined health as a biological, psychological and social wellbeing of an individual. Basically on discrimination at work, our topic insisted on the social well-being of workers with disability. Here we see clear link between colleagues and the work area. It significantly implies that the feelings of workers are based on the kind of treatment they receive at work. It also deals with social avoidance in the workplace, that is why you see employees with disability develop mechanisms of defense like, distraction, some others use prayers to overcome such situations. As subjects to victimization, they live in isolation. This life style has enormous consequences on the workers: - drug addiction, violence, succeed and many others.

Coping strategies also have indirect effects on change in behavior of employees with disability. This implies that discrimination at work is link to some benefits of workers like salary increment, career increase, advantages, awards of medals, attestation of service and appointments at work. These employees cannot ameliorate their leaving conditions if these advantages are not given to them. As a professional psychologist in social disability, I share the idea that we can take measures to overcome this situation: distraction, positive interpretation in brief coping, acceptance of their situation will go a long way. Coping strategies also regulate and reduces stress link to problems of disability. According to Parker and Endler, this regulation or reduction is based on mental health and are felt on social events. Lazarus and Folkman distinguished ways of coping checklist amongst colleagues (1996) and brief cope with Lazarus and al (1989). As the domain difficulties we realized some types of coping do not work in all situations. With brief scale cope, the items are positive interpretation, acceptance and distraction. The principal items of discrimination are stereotype, victimization, social avoidance, harassment and prejudice. Five out of the Seven (7) respondents insisted on social avoidance, this means employees with disability are avoided by their colleagues. That is why disabled workers are interested in new measures to fight their situation. Colleagues do not like close work positions with disabled workers and as time passes, they face discrimination all the time.

4.5. Discussion of findings.

From the above explanation and statistics of this study, we discovered the different types of discrimination employees with disability face at their workplace. We have equally seen the various strategies these employees have developed over the years to cope at work. The effects of discrimination, stigmatization, social avoidance, stereotype, victimization, harassment, prejudice has greatly affected the life of employees with disabilities in the city of Yaoundé. We also observe that a Majority of handicaps are males as compared to women in the city of Yaoundé. This can be justified by the fact that men are involve in risky jobs which exposed them to accidents. Also a majority of our sample were married and lived in families where they feel supported and esteemed, while a minority are unmarried and received little or no support due to their handicap situation. Furthermore, from our sample data we discovered that many handicaps love their jobs and are willing to impact the society positively despite their conditions while a minority just work to sustain a living. This justifies the fact that more importance should be given to handicap persons to ensure better and equal opportunities for them in the society. Moreover, the stigmatization faced by handicaps in our society is very high as all of them face discrimination at their workplace and society, but received no support neither from their hierarchy at work nor from civil society organizations in charge of human rights. The medical model considers disability a feature of the person, directly caused by diseases, disorders, traumas, or other health conditions, which would require medical treatment or intervention with the primary goal to “correct” the problem within the individual (Johnston, 1996; Marks, 2000; Mitra, 2006; Forhan, 2009; Nind et al., 2010; Brandon and Pritchard, 2011; Palmer and Harley, 2012; Bingham et al., 2013). By contrast, the social model does not consider the disability an attribute of the individual, but rather a socially created problem (Hutchison, 1995; Mitra, 2006; Purdue, 2009; Barney, 2012). In this case, the problem that needs to be corrected lies not within the individual, but within the unaccommodating social environment (Brandon and Pritchard, 2011; Roush and Sharby, 2011; Barney, 2012; Palmer and Harley, 2012; Bingham et al., 2013).

According to the social model, disability could be imposed by society on individuals with impairments through isolation and exclusion from everyday activities (Brandon and Pritchard, 2011; Bingham et al., 2013). Such isolation and exclusion may stem from society’s unfavourable perceptions of people with disabilities and unwillingness to remove environmental barriers impeding full participation (LoBianco and Sheppard-Jones, 2008; Forhan, 2009; Palmer and Harley, 2012). However, neither medical nor social model acknowledge the complex nature of disability. Therefore, a comprehensive integration of the two approaches produced the biopsychosocial model, which considers disability in the context of an interaction between biological, psychological, and societal factors, each limiting the individual’s functioning to some extent (Engel, 1980; Borrell-Carrió et al., 2004; Thomas, 2004; Shakespeare, 2006; Le Boutillier and Croucher, 2010). However, considering the nature of this study it is the social model of disability that is relevant. From this discussion of Findings, we realized that handicaps persons are confronted to so many discriminations in their daily lives thus the aim of our research which aims at bringing up suggestions and recommendations to reduce or completely eradicate all forms of discrimination faced by handicap persons in our societies and even around the globe.

4.6. Recommendations.

- All employers should make it clear to everyone who works for them, or uses their services, that disability discrimination is against the law (Equality Act 2010) and they will not tolerate it.
- Employers should train their staff on recognizing disability discrimination and encourage them to report it.
- Employers should recruit and retain staff who often have more resilience and problem-solving skills through developing ways of living with a disability

- Employers should be prepared to make all reasonable adjustments to policies, procedures and practices and to physical features of premises, in order to accommodate the needs of a particular disabled employee or job applicant.
- As an employee, in case a violation has occurred, inform your manager or your company. Most discrimination cases are caused by ignorance on the side of the offender, so it’s essential to educate them on the subject. Having an open discussion about your disability can help others reassess behaviours and prevent future incidents from happening.
- If your employer refuses to take action or engage in dialogue, then this is a sign that you need to file a formal complaint. Getting in touch with the relevant authorities will help you address this and make it easier to resolve the issue
- All employees with disability should frequently visit their psychologist for proper check-ups and updated ideas on how to improve on their working conditions.
- Worker should be educated on how to treat co-workers especially those with disabilities.
- Non-Governmental Organizations in the field of special needs education should complement the efforts of the government to organize seminars or conferences to educate and counselling sessions for employees with disabilities
- Creating awareness generally to the entire society about disability discrimination and sensitize the society how to coexist with disabled people.
- Sensitization campaigns should be organized by all educational stake holders of good will using different social media and communication channels.
- Everyone should encourage inclusion in all aspects of life.

This research work could not be very accurate because of some difficulties encountered during the research. Below are major difficulties faced.

GENERAL CONCLUSION

Understanding the relationship between discrimination at work and coping strategies of employees with disabilities in the city of Yaoundé was the centre point of this study. The study engaged the transactional theory, the medical and the social model of disability in understanding and explaining how discrimination at work affects the life of employees with disability. Medical model conceptualized the "normality" and excluded people who do not fit to the conceptualization of "normal" that set a ground for marginalization of disabled people. The researcher seeks to know the different types of discrimination employees with disability were faced with, the different coping strategies these employees used so as to cope at work. In another term looking for those strategies that would help them cope. Given that lack of good coping strategies, employees with disability will not be very productive at their job side. The research engaged a survey research approach which used a semi structured interview guide for the collection of relevant data. We interviewed seven employees with disability. The study carries one main research objective/Question and one specific objectives/Questions were used to guide this study. The study discovered discrimination like: stereotype, prejudice, harassment, social avoidance, victimization, stigmatization and hard labour. The thematic content approach was used to analyse the data collected from the field. Generally, the study found out that coping strategies greatly influence or reduces the feelings of discrimination at work of employees with disabilities. Specifically, the study found out that stigmatization and social avoidance significantly influence the performance of employees with disability. The study concluded that discrimination at work affects the life of employees with disability. Therefore, the study recommends that the government and non-governmental organizations take appropriate measures to educate the society on the how to treat employees with disability. The study ended by giving suggestions for further studies. The research work also concluded that there exist different types of discrimination at work affecting employees with disabilities. The research equally concluded that the effective use of coping strategies by disabled employees will go a long way to remedy the discrimination Borden on them. In many companies, enterprises and institutions, disability has been associated with curses, diseases, dependence, and helplessness. The way employers, colleagues and clients perceives people with disability, greatly influences their activities in general and life as a whole beginning from their workplace to social interactions and livelihood or empowerment in many societies there exist a host of negative attitudes towards the people living with disabilities. These negative attitudes create social barriers that interfere with the normal functioning of the individuals leaving with disabilities. It is therefore not the disability that constitute the problem but the social barriers. This makes it necessary for every company, enterprise and institutions to look for ways to combat these negative attitudes. If we can fight against these negative attitudes, we will be doing good and solving the problems of employees with disabilities and ensuring inclusion. For this reason, the fight for the rights of people living with disabilities should be the concern of everyone in the society. The medical model of disability can be justified that even those who are so called normal may become disabled tomorrow. Workers, employers and clients with positive attitudes toward employees with disabilities may be more willing to interact with them compared to people with negative attitudes. As a result, more exposure to individuals with disabilities may lead to better understanding of disability and higher levels of acceptance. Thus, attitudes drive behaviour, which, in turn, affects the individual's knowledge, beliefs, and attitudes. Interventions improving the society's knowledge about disabilities and providing exposure to those with disabilities is the most successful technique of changing society's attitudes toward employees with disabilities. Developmental psychologists suggest that early childhood is the best time to intervene against the formation of negative attitudes toward disability, before these attitudes and behaviour patterns become fully established and difficult-to-change. Family plays a significant role in shaping children' beliefs and attitudes toward others: parenting styles and children's attachment styles may determine the child's future attitudes toward individuals with disabilities. Importantly, parents may communicate their beliefs and attitudes to children explicitly through discussions or explicit teaching, or implicitly by modelling their values in daily interactions with other people or by providing their children opportunities to interact with out-group peers. Therefore, effective strategies to fight against discrimination at work of employees with disabilities will be more successful if we target the government, non-governmental organization, social workers, communities, families, companies, enterprises and institutions.

Social care has an impact on a patient's health according to two modalities: the direct and indirect effects. There can also be some moderations depending on the type of social care. These types are based on mental or physical health. The direct effects of social well-being design the important positive or negative impact no matter the intensity of stress even an individual undergoes. lack of or a weak social care contributes to a risk factor. Research done on social care of persons with disability confirms the direct impact on psychosocial and physical health of that individual. "Support is a helping hand given to an individual by others ". We have two kinds of care: objective help brought about by someone: receive help and the quality of comfort presented by the person, perceived help. Emotional support: the express of his affection for someone. It constitutes a help in a bad situation from the comfort and reconciliation that there give the individual. Care esteem: which consist of giving back confidence to someone in his own value and on his own capacity. Informative Care: which comprise a set of suggestions and advices which permits an individual to face situation. Material care: which is expressed by concrete and practical help; and amongst these different types of care, emotional care is that which is seen as the most important and efficient.

5.1. Suggestion for further studies

- This current study can be replicated using a larger sample size
- A comparative study of this nature can be carried out using two ethnic groups with different cultures to assess the impact of culture on the perception of people living with disabilities

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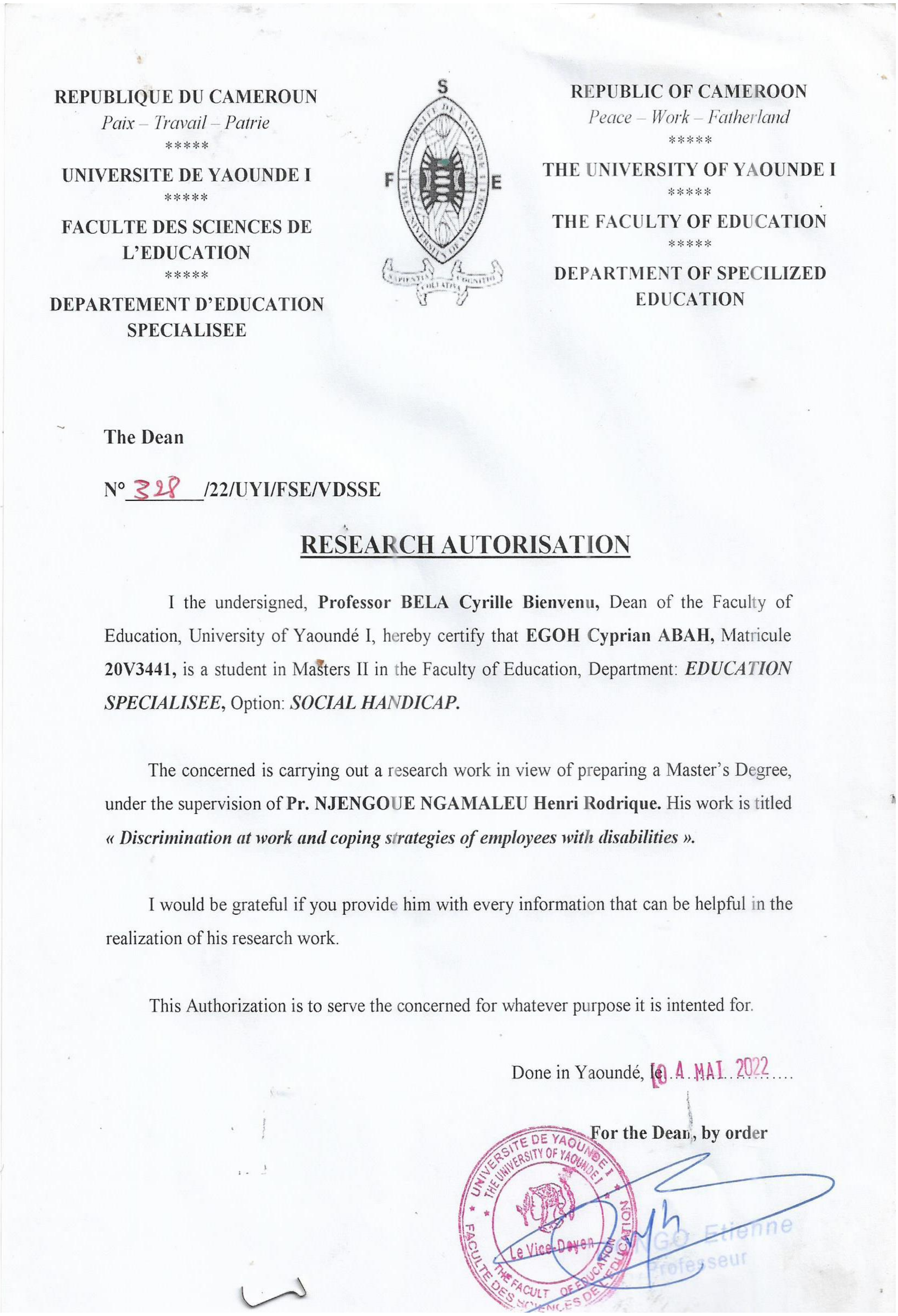
ANNEXES



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The Dean

N°328/22/UYI/FSE/VDSSE

RESEARCH AUTORISATION

I the undersigned, **Professor BELA Cyrille Bienvenu,** Dean of the Faculty of Education, University of Yaoundé I, hereby certify that **EGOH Cyprian ABAH,** Matricule **20V3441,** is a student in Masters II in the Faculty of Education, Department: ***EDUCATION SPECIALISEE,*** Option: ***SOCIAL HANDICAP.***

The concerned is carrying out a research work in view of preparing a Master's Degree, under the supervision of **Pr. NJENGOUE NGAMALEU Henri Rodrique.** His work is titled ***« Discrimination at work and coping strategies of employees with disabilities ».***

I would be grateful if you provide him with every information that can be helpful in the realization of his research work.

This Authorization is to serve the concerned for whatever purpose it is intented for.

Done in Yaoundé, le 0 4 MAI 2022

For the Dean, by order

Le Vice-Doyen
NGO Etienne
Professeur

TABLE OF CONTENT

APPENDICES.

Respondent 1.

I am a Cameroonian that originates from the north west region. I am 42 years old and a professional cook. I have work in the city of Yaoundé for 15 years and 2 years in my present workplace. I am a dwarf so am a handicap from birth. My present work is so tedious; I don't have a resting time at all. I work well and makes sure I finish my daily task though my hard work is not appreciated. Yes, I face a lot of difficulties since am too short, the kitchen is constructed such that I have to stretch too much to use the equipment. Yes, in this place I face a lot of discrimination every working day. My colleagues avoid me all the time, they do not want me to always work closer to them. They prefer sending me to the market all the time and that is so difficult for me. My colleagues usually go home with excess food while I go home with almost nothing. Usually I report my case of discrimination and boss does nothing about it so I have learned to cope with it. I don't know what you mean reasonable adjustment. I know of organizations that help handicaps but I have received no support from any of such organizations. My boss discriminates me, I say so in the sense that he will always pay me last, I don't know if it's because of my situation. Yes, I have developed some strategies to cope at my workplace. I don't talk too much; I don't answer my colleagues each time they insult me. I try as much to remain a lone in my working space. I have never met a psychologist to explain my situation. My best time of the day is when we are closing. My highest certificate is first school leaving certificate.

Respondent 2

I am a Cameroonian that originates from the Centre region. I am 46 years old and a teacher by profession. Am presently teaching in an evening school where I have thought for 4 years now. I have been in the teaching job for over 20 years now. No I was not born handicap I only acquired this left leg infinity when I was 11 years old in a motor accident between Bafia and Yaoundé. Many doctors tried all they could to see my leg stands straight but it was not possible. So I just had to to leave with this infirmity. I choses to work in this school because it is closer to my house and so less expensive for transportation to school. In the beginning I was treated well here but as time passes I have been discriminated all the time. My boss first started by reducing my salary with no justification, when I walk up to him he said I don't deserve a good salary that I am a disabled person and have nothing much to do with money. The reply of my boss made me sick for a very long time. I have no husband and no child, people I consider my family are my siblings. Yes, I face discrimination in school like 10 times a day. My colleagues will always accuse me wrongly. They will send me to teach up stairs knowing fully well that I face difficulties in climbing. Most of the time am given over period to teach with no compensation. My happiness in school comes when my students perform well especially in public exams.

Yes, I know there have to be some reasonable adjustments for handicaps like me but it has never come. Yes, I have adopted strategies to cope with the treatment I received from my job.

I employ good morals, ignore side comments, I always program myself well and keep to time. I don't have a psychologist I talk to but I seek advice from my pastor and some friends. I have not received support from any organization. Yes, I once took my formal school to court when I was discriminated upon. The court asked the school to pay me 800000 francs' cash, but since then I have received just 300000 francs. I am a university drop out, my highest certificate is Cameroon Baccalaureate.

Respondent 3

I am a Cameroonian that originates from the Centre region of Cameroon, I live and work in Yaoundé as a sales agent in a super market. I am 32 years old and I have work here for 4 years. Yes, I am a handicap with an amputated right leg. I had a smell wound on my leg that could not heal since I was also diagnosed of diabetes. After several years of suffering my family accepted the doctor's proposal to cut my leg. This was when I became handicap. I decided to sell eggs in this company because I was I had no other job to do. I dropped out of the university due to the fact that I could not help myself financially. I have a good relationship with my boss. He pays my salary early every month. My colleagues are not good to me. We have problems all the times but am not afraid of them. Yes, I am being discriminated upon, my colleagues do not want me to benefit the same from the privileges of the company like them.

Lost at times the boss will ask us to take broken eggs to our homes but my colleagues won't allow me take some. I do not have a wife but I have a child. Yes, I face discrimination here because of my situation, my colleagues do not respect me at all. I don't know about any reasonable adjustments for handicaps. Yes, I have some strategies which I use to cope with my situation. They include: patience, hard work, perseverance, listening to music. I am discriminated at least 8 times a day. I use to report any case of discrimination to my boss but not anymore because nothing is always done to my complaints. My highest certificates are Baccalaureate.

Respondent 4.

I am a Cameroonian that originates from the southwest region of Cameroon. I am 46 years old, married with 3 children. I am a lawyer by profession. I was born with this infirmity so I consider myself handicap. I have a lovely family that respects me in fact my wife is the best. My extended family members are not really good to me because of my situation, they think I am a disgrace to them. Yes, I face discrimination in my place of work. My colleagues who are lawyers still discriminate me even they know it's a crime. I have been working in this court for 9 years, defending my clients and have never fail a case. Yes, my life in this court is fairly good. I have difficulties in going around the court and claiming up stairs. There are no reasonable adjustments made for me. Am always given less time to express myself the way I feel. Yes, I have developed strategies to cope, they include: hard work, stay away from trouble, stereotype, prejudice. And the fact that there are reasonable adjustments. I have no support from any an organization

Respondent 5

I am a Cameroonian from the northwest region of Cameroon. Am 29 years old and a sales agent in a super market in Yaoundé. I am an albino so I was born handicap. I am single no child too. I belongs to a complicated family not everyone loves me but I am fine with it. I have been selling in this job side for two years. I chose to work here in order to raise money for myself. My major difficulty is that I don't see clearly in order to better do my job. Yes, I face a lot of discrimination job. I being stigmatize, stereotype and my colleagues always avoid me. I am being discriminated upon like 20 times in one day. Yes, my salary is always paid here and on time. No I don't know about any reasonable adjustments for disabled employees. Yes, each time I face discrimination i report to my boss but no concrete decision is always taken. Yes, I have some strategies that helps me to cope here. These strategies are about 60% effective. The strategies are hard work, stay away from problems, listening more and talk less. No I don't have a psychologist. I receive small support from my family but not from any organization. My highest certificate is Baccalaureate.

Respondent 6

I am a Cameroonian that originates from the west region. I am 36 years old and an accountant in a small micro finance. I was born handicap I have a wife and 2 children. I have a good family and we live together in harmony. I consider anyone close to me as my family. I work in order to raise income for myself and my family. Yes, I have been working here for a period of 5 years and I have learned to like the place despite the difficulties. I have difficulties in doing my job accurately because of my this my handicap. The job is a difficult one too. Over work and over time. Yes I receive my salary all the time. Yes, there has been a lot of discrimination from my boss and colleagues. My colleagues disrespect me at will. There avoid me socially and stigmatize me. There are no reasonable adjustments for my handicap. My boss gives over work all the time and specifically for me. I am subjected to work more than everyone despite my condition. Yes, I have adopted good coping strategies for myself and they are about 75% effective. They are listening to music, avoid over talking, isolation. I have no support from anyone I do my self.

Respondent 7

I am a Cameroonian from the northwest region. Am 49 years old and a professional mechanic. I am married with 4 children. I became handicap at the age of 37. It all happened when the jack of a car I was repairing fell on me and created a deep wound. It was resolved weeks later that the leg should be amputated. We tried every other means but we ended up cutting my leg. This is how I became handicap and I regretted ever being a mechanic so I cannot advise anyone to become a mechanic. Yes, I have a good family I am proud of. My difficulty is that I cannot move easily so I cannot do my job easily. I have made money from this job for my family. Yes, my colleagues will always discriminate me in all aspects. They don’t want me to make money like them but God is always on my side. There are no reasonable adjustments made for me. Yes, a lot of strategies to come I avoid problems by all costs I don’t talk when it’s not necessary.