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KVS – PRT

Special Educator

Kendriya Vidyalaya Sangathan (KVS)

Volume - 1

Section A (Compulsory)

Understanding Disability

SIERRA INNOVATIONS

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1 CHAPTER

Understanding Disability

Historical Perspectives of Disability

1. Introduction to Historical Understanding of Disability

Disability is not merely a biological or physical state; it is a **concept shaped by time, society, economic conditions, culture, and political systems**. To understand contemporary disability education, inclusive practices, and rights-based policies, we must understand how societies historically viewed disability.

Historically, responses to disability have ranged from **fear, exclusion, segregation, charity**, to **rehabilitation, empowerment, and rights-based inclusion**. The journey from "care and cure" to "rights, dignity, participation, accessibility, empowerment, and inclusion" has taken many centuries.

For exam purposes, understanding historical evolution helps explain **why current laws, inclusive education systems, early intervention models, and cross-disability approaches** exist.

2. Ancient Civilizations and Disability

2.1 Early Tribal Societies

Anthropological evidence shows that early tribal communities often had dual attitudes:

- Some considered disability a **curse, sin, or bad omen**.
- Others saw people with disabilities as having **special spiritual powers**, especially those with epilepsy, mental illness, or atypical behaviours.

  Support depended heavily on **collective living**, meaning families and tribes sometimes protected persons with disabilities.

2.2 Ancient Egypt

Evidence from mummies and tomb carvings shows that people with disabilities:

- Were accepted in community life
- Performed occupations (scribes, priests, artists)
- Received medical treatment (Egyptians had advanced orthopaedic practices)

  The "Edwin Smith Surgical Papyrus" documents early treatments for fractures, head injuries, paralysis etc.

2.3 Ancient Greece

Greece gave contradictory models:

A. Negative Views

- **Sparta**: Practiced abandonment of infants with physical impairments (eugenic practice).
- Physical perfection was idealised.

B. Humanistic Views

- **Hippocrates** rejected supernatural explanations.
- He explained epilepsy and mental conditions as diseases of the brain.

  Thus, Greek society influenced **medical and moral models**.

2.4 Ancient Rome

Rome followed a legalistic and eugenic orientation:

- The Roman Law (Twelve Tables) permitted **infanticide of deformed infants**.
- However, adults with disabilities could:
  - Vote (depending on status)
  - Own property
  - Work in crafts and trade
  - Receive military pensions for injuries

  Roman systems laid foundation for **state welfare**, including early pensions and care for injured soldiers.

2.5 Ancient India

Indian history portrays a complex mixture of spiritual, medical, and social responses.

A. Vedic and Post-Vedic Period

- Disabilities often interpreted through **karma and rebirth theories**.
- Buddhism promoted compassion-based views-establishing rest houses and shelters.

B. Medical Traditions

Ayurvedic texts like Charaka Samhita and Sushruta Samhita describe:

- Mental illness
- Epilepsy
- Mobility impairments
- Treatments including herbal therapy, surgery, and behavioural approaches

C. Social Roles

Some with disabilities served as:

- Court jesters
- Musicians
- Craftsmen
- Advisors (blind poets, scholars)

  Overall, attitudes depended on caste, economic class, and local customs.

3. Medieval Period: Superstitions, Religious Views & Institutionalization

Between 5th-15th century:

3.1 Europe

- Disability equated with **possession, witchcraft, sin**.
- Many with mental illness or epilepsy were executed or isolated.
- Church established “almshouses”, monasteries, and asylums offering basic shelter.

  Medical understanding declined during this period.

3.2 Middle East

Islamic scholarship advanced:

- Hospitals (Bimaristans) provided care.
- Scholars like **Avicenna (Ibn Sina)** wrote about mental illness, speech disorders, and neurological conditions.

3.3 India

- Bhakti and Sufi movements promoted compassion.
- However, social stigma persisted.
- Lepers, blind people, and mentally ill were often segregated but also provided alms and charity.

4. The Renaissance & Enlightenment Period (14th-18th Century)

This era marks a historical transformation.

4.1 Scientific Exploration

- Revival of anatomical studies.
- Disabilities viewed increasingly through **medical explanations**, not supernatural ones.

4.2 First Systematic Teaching Approaches

Teachers who pioneered education of persons with disabilities:

A. For Deaf Education

- **Pedro Ponce de León** (Spain) taught deaf students using sign, reading, writing.
- **Charles Michel de l'Epée** (France) founded the first free public school for the deaf.

B. For Blind Education

- Advances in tactile reading led to development of early systems (later inspiring Braille).

C. For Intellectual Disability

- **Jean-Marc Itard** attempted systematic training with Victor, the "wild boy of Aveyron".
- Itard emphasised sensory training, behaviour shaping-foundation of modern special education.
  Renaissance marks the beginning of **organized special education**.

5. Industrial Revolution & Institutional Era (18th-19th Century)

5.1 Industrialization and Social Problems

Urbanization brought:

- Poverty
- Injuries
- Accidents
- Occupational hazards
  This increased the population of persons with disabilities.

5.2 Growth of Asylums and Large Institutions

People with disabilities (PWDs), especially those with mental illness or intellectual disability, were placed in:

- Asylums
- Workhouses
- Orphanages
  These institutions focused on **custodial care**, not education.

5.3 Special Schools and Training Institutes

Parallel to institutionalization, specialized education grew:

- Schools for the blind
- Schools for the deaf
- Institutions for intellectual disability

Key Figures:

- **Louis Braille** (developed Braille in 1824)
- **Samuel Gridley Howe** (first school for blind in US)
- **Alexander Graham Bell** (oral method for deaf students)

6. Early 20th Century: Medical Model Dominance

The early 1900s saw two major developments:

1. **Rise of medical model:** Disability seen as a problem within the individual → to be fixed or cured.
2. **Eugenics movement:** Many countries sterilized persons with intellectual disability, epilepsy, mental illness.

This era also introduced:

- IQ testing
- Classification systems
- Scientific diagnosis
- Psychology-based interventions

Special education expanded but was **segregated**.

7. Post-World War Era: Shift toward Rehabilitation & Rights

The two world wars (especially WWII) changed global attitudes dramatically.

7.1 Rehabilitation Movement

Large numbers of soldiers returned with:

- Amputations
- Blindness
- Hearing loss
- Neurological injuries
- PTSD

Governments invested in:

- Prosthetics
- Vocational rehabilitation
- Physical therapy
- Social inclusion
- Welfare schemes

Rehabilitation became a formal profession.

7.2 United Nations & Global Human Rights

Post-war development included:

- Universal Declaration of Human Rights (1948)
- Emergence of global disability rights movements
- WHO establishing ICD classifications
- Concept of social determinants of disability

8. Late 20th Century: From Segregation to Integration to Inclusion

8.1 Deinstitutionalization (1960s-1970s)

Movements in Europe and the U.S. closed many abusive institutions. People with disabilities began living in:

- Group homes
- Family environments
- Community services

8.2 Integration Movement

Schools started allowing children with disabilities to study in:

- Regular classrooms
- With resource rooms
- Part-time inclusion

However, the child had to "fit" the regular system.

8.3 Inclusive Education (1990s onwards)

A major shift occurred:

- Instead of children adjusting to school
- Schools must adjust to children

Inclusive education is the backbone of modern disability policy.

9. Indian Historical Evolution of Disability Services

9.1 Pre-Independence India

- Missionary schools for the deaf and blind emerged in the 19th century (Bombay School for the Deaf, 1885).
- Custodial asylums were common for mental illness.

9.2 Post-Independence (1947-1980s)

- Government established **National Institutes** for blindness, hearing, locomotor, intellectual disabilities.
- 1974: Integrated Education for Disabled Children (IEDC).
- 1980: Training of special educators through RCI-supported institutes.

9.3 Rights-Based Era (1990s onward)

Key milestones:

- **1995:** Persons with Disabilities Act
- **1999:** RCI Act (professional regulation)
- **2009:** Right to Education (RTE) Act
- **2016:** Rights of Persons with Disabilities (RPwD) Act (benchmark disabilities = 21 categories)
- **2020:** NEP emphasises inclusion, UDL, teacher training

  India moved from **welfare → medical → educational → rights-based** perspectives.

10. Models of Disability (Exam-Critical)

Understanding models clarifies conceptual evolution.

10.1 Moral/Religious Model

- Disability seen as punishment, sin, evil spirit.
- Leads to stigma, exclusion.
- Dominant in ancient and medieval periods.

10.2 Charity Model

- Disability = object of pity.
- Institutions, donations.
- Passive role of PWDs.

10.3 Medical Model

- Disability = defect in the individual.
- Requires cure, correction, rehabilitation.
- Dominant from 19th to mid-20th century.

10.4 Social Model

- Disability is created by society's barriers.
- Barriers = physical, attitudinal, communication.
- Solution = accessibility, inclusion, rights.
- Basis of UNCRPD, RPwD Act 2016.

10.5 Biopsychosocial Model

- Combination of both individual factors and social factors.
- Used in WHO's ICF framework (2001).

10.6 Rights-Based Model

- Person with disability = rights-holder.
- Accessibility, empowerment, participation.
- Enshrined in UNCRPD (2006).

11. Summary of Historical Evolution (High-Yield)

Era	Dominant View	Key Features
Ancient	Supernatural, medical	Mixed approaches, early medical texts
Medieval	Sin, possession	Asylums, exclusion
Renaissance	Humanistic, scientific	Birth of special education
Industrial	Institutionalization	Asylums, segregated schools
Early 20th	Medical model	IQ tests, therapy, eugenics
Post-WW	Rehabilitation	Social welfare, therapy
Late 20th	Integration	Resource rooms
21st Century	Inclusion & rights	UNCRPD, RPwD, NEP

12. Why Historical Perspective Matters for PRT Special Educators

- Helps understand **why inclusive education evolved**
- Explains resistance, barriers, stigma still present
- Guides modern teaching practices
- Helps educators adopt a **progressive, rights-oriented mindset**
- Connects policy provisions with historical injustices

Concepts, Definitions & Categories of Disability

1. Introduction to Conceptual Understanding of Disability

Understanding disability requires clarity about **core conceptual terms** used across laws, psychology, rehabilitation, and education. These concepts form the foundation of inclusive education, early identification, intervention, and cross-disability approaches.

Historically, disability per se was seen as a characteristic of the person. However, contemporary frameworks see disability as an **interaction between an individual's functional differences AND environmental, attitudinal, institutional, and communication barriers**.

Before diving into categories, an educator must understand:

- Concept of disability
- Key definitions
- Variations in definitions across laws & disciplines
- Distinction among impairment, disability, and handicap
- How these concepts are used (diagnosis, assessment, eligibility, accommodations)

These are repeatedly asked in recruitment exams like KVS, NVS, DSSSB, RCI exams, CTET, etc.

2. Definitions of Disability (Classical & Modern)

Different agencies (WHO, UN, legislatures) have given definitions that reflect shifts in understanding.

2.1 WHO (World Health Organization) - ICIDH (1980)

The International Classification of Impairment, Disability and Handicap (ICIDH, 1980) provided three key distinctions that remain foundational:

Impairment

Any loss or abnormality of psychological, physiological, or anatomical structure or function.

Examples:

- Loss of limb, blindness, hearing loss
- Cognitive deficits
- Organ system dysfunction

Disability

A restriction or lack of ability to perform an activity in a manner considered normal for a human being. This is activity-level limitation.

Examples:

- Inability to walk, speak, see letters
- Difficulty in learning, calculation, daily living skills

Handicap

A disadvantage experienced due to impairment or disability that limits fulfillment of a role considered normal.

This is a **social-level disadvantage**.

Example:

- Being rejected for admission because the school is inaccessible
- Being prevented from working due to stigma
- Social exclusion or attitudinal barriers

Why this framework matters

It formed the basis for:

- Rehabilitation classification
- Special education categories
- Early intervention and therapy planning

  Even though replaced by newer frameworks, exam bodies still ask ICIDH.

2.2 WHO ICF Framework (2001)

Replaced ICIDH with the International Classification of Functioning, Disability & Health (ICF).

ICF shifts from medical model → biopsychosocial model.

Key Components:

1. **Body functions and structures** (replaces 'impairment')
2. **Activities** (replaces 'disability')
3. **Participation** (replaces 'handicap')
4. **Environmental factors** (barriers/facilitators)
5. **Personal factors** (age, gender, coping, education, community)

Conceptual meaning

- Disability = **outcome of interaction**
- Not located "inside" the person
- Focus on functioning, not limitations only

WHO ICF is crucial to inclusive education because:

- It emphasizes participation
- Encourages environmental modifications
- Aligns with rights-based and cross-disability framework

2.3 UNCRPD Definition (2006)

The UN Convention on the Rights of Persons with Disabilities defines persons with disabilities as:

Individuals with long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder full and effective participation in society on an equal basis with others.

Key points:

- Disability is not only impairment
- Barriers create disability
- Rights, dignity, autonomy, equality are core
- Long-term, not temporary conditions

  This is the **globally accepted rights-based definition** that India follows.

2.4 Indian Definition: Rights of Persons with Disabilities Act (2016)

RPwD Act defines:

A person with disability means a person with long-term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders full and effective participation in society.

It also defines:

"Person with benchmark disability" as a person with at least **40% disability**.

This is crucial for:

- Reservation
- Employment
- Examinations
- Certification
- Entitlement to schemes

3. Differences Between Impairment, Disability, Handicap (High-Depth Explanation)

Though modern definitions move away from these distinctions, exams often test them.

Impairment

- Refers strictly to **body-level problem**
- Can be structural or functional
- Medical assessment identifies impairments
- Examples: visual impairment, hearing impairment, neurological impairment

Disability

- Refers to **activity limitation**
- Occurs when impairment affects performance
- Measured through functional assessments
- Examples: inability to read print, difficulty walking, speech inability

Handicap (social disadvantage)

- Refers to **participation restriction** caused by societal barriers
- It is NOT inherent to the person
- Examples: inaccessible schools, stigma, exclusion from games

Summary explanation

A person may have an impairment but no disability
(E.g., a person with one kidney can still function normally)
A person may have a disability but the handicap can be removed
(E.g., providing ramps removes mobility handicap)
Hence, educators focus on **reducing barriers** to eliminate handicaps.

4. Concept of Disability: A Deep Theoretical Understanding

The concept evolved from being an individual problem → social problem → rights issue.

4.1 Medical / Individual Concept

Disability resides within the person:

Cause → Disease or deficiency → Cure
Educational Implication:

- Therapy
- Remediation
- Correction
- Labeling for special education

4.2 Social Concept

Disability arises due to barriers:

Cause → Environment + attitudes → Inclusion
Educational Implication:

- Curriculum adaptation
- Infrastructure changes
- Social acceptance
- Peer sensitization
- Universal Design for Learning (UDL)

4.3 Biopsychosocial Concept

Combines both: disability as interaction.

4.4 Rights-Based Concept

Emphasis on:

- Dignity
- Equality
- Non-discrimination
- Accessibility
- Participation
- Independent living
- Individual rights

This is the current global standard and basis of inclusive education.

5. Need for Classification and Categorization of Disabilities

Why classify disabilities?

1. **Educational Planning**
   - Curriculum modifications
   - Specific teaching strategies
   - Individualized Education Plans (IEPs)
2. **Eligibility Determination**
   - For concessions, support services
   - Resource allocations
3. **Assessment & Intervention**
   - Early identification
   - Referral services
4. **Policy & Legislation**
   - Reservation
   - Certification
5. **Professional Communication**
   - Teachers, therapists, medical staff coordinate based on classification

Classification is not labeling; it is a system for support.

6. Broad Categories of Disability (International Framework)

According to international educational and rehabilitation systems, disabilities fall under:

1. **Sensory Disabilities**

- Visual impairment
- Hearing impairment
- Deafblindness

2. **Physical / Locomotor Disabilities**

- Cerebral palsy
- Spinal cord injuries
- Musculoskeletal disorders
- Amputations

3. **Intellectual Disabilities**

- Mild, moderate, severe, profound
- Global developmental delay
- Down syndrome
- Other genetic conditions

4. Developmental Disabilities

- Autism Spectrum Disorder
- Specific Learning Disabilities (reading, writing, math)
- Intellectual disability
- ADHD (behavioural disorder)

5. Neurological Disabilities

- Epilepsy
- Multiple sclerosis
- Parkinson's
- Traumatic brain injury

6. Mental / Psychosocial Disabilities

- Depression
- Bipolar disorder
- Schizophrenia
- Anxiety disorders

7. Speech & Language Disabilities

- Expressive/receptive language disorders
- Speech articulation problems
- Stuttering
- Voice disorders

8. Multiple Disabilities

More than one primary disability (e.g., deaf-blind).

These categories are important because exams often ask for **broad classifications vs. Indian legal classifications**.

7. Benchmark Disabilities Under RPwD Act, 2016 (INDIA)

This is extremely important for KVS/NVS/CTET.

The Act recognizes 21 benchmark disabilities grouped into categories:

A. Physical Disabilities

1. Locomotor Disability

Includes:

- Orthopaedic disabilities
- Amputations
- Cerebral palsy
- Muscular dystrophy
- Leprosy cured persons
- Dwarfism
- Acid attack victims

2. Visual Impairment

- Blindness
- Low vision

3. Hearing Impairment

- Deaf
- Hard of hearing

4. Speech and Language Disability

Long-term speech-related issues (not temporary)

B. Intellectual Disabilities

Includes:

- Specific learning disabilities
- Intellectual disability
- Autism spectrum disorder

Specific Learning Disabilities subdivided into:

- Dyslexia (reading)
- Dysgraphia (writing)
- Dyscalculia (math)
- Dyspraxia (motor planning)

C. Mental / Psychosocial Disabilities

- Mental illness (schizophrenia, bipolar disorder, etc.)

D. Neurological Disabilities

- Cerebral palsy
- Parkinson's disease
- Multiple sclerosis
- Chronic neurological conditions

E. Blood Disorders

- Hemophilia
- Thalassemia
- Sickle-cell disease

F. Multiple Disabilities including Deaf-Blindness

Multiple disabilities category recognizes complex conditions needing specialized support.

8. Educational Classification of Disabilities (Teacher-Oriented Approach)

Schools and educators classify disabilities based on **teaching and support requirements**, not medical diagnosis.

A. Based on Learning Needs

1. Sensory (vision, hearing)
2. Cognitive/intellectual
3. Learning (SLD)
4. Communication
5. Emotional/behavioral
6. Physical/orthopaedic
7. Multiple

B. Based on Impact on School Performance

1. Those affecting academic learning
2. Those affecting communication
3. Those affecting mobility
4. Those affecting behaviour/emotional regulation
5. Those requiring medical monitoring

Why this matters?

Teachers plan interventions according to **functional needs**, not labels.

9. Factors Influencing Classification

1. Severity

- Mild
- Moderate
- Severe
- Profound

2. Onset

- Congenital
- Acquired (injury, accident, illness)

3. Duration

- Temporary
- Long-term
- Permanent

4. Progression

- Stable
- Degenerative

5. Nature of Impact

- Neurodevelopmental
- Medical
- Behavioural
- Sensory

Exams often test severity levels for intellectual disabilities and autism.

10. Cross-Disability Concept in Classification

Understanding disability categories is not enough; modern education uses cross-disability approach:

- All disabilities share common needs such as accessibility, acceptance, assistive devices, inclusive pedagogy.
- Services (like counselling, therapy, IEP, support rooms) must accommodate all types.
- Teacher training must be multi-category, not limited to one disability.

This concept connects classification to inclusive, universal support systems.

11. Myths and Misconceptions About Categories

Many misconceptions influence classification:

Myths:

- Disability = illness
- All disabilities are visible
- Only specialists can teach children with disabilities
- One disability excludes another
- Slow learners = disabled
- SLD = intellectual disability

Realities:

- Many disabilities are invisible (SLD, autism, mental illness)
- Students can have co-occurring disabilities
- Teachers with proper training can handle diverse needs
- Disability is not a disease

Breaking myths is essential for inclusion.

12. Practical Importance of Understanding Disability Categories for PRT Teachers

Understanding categories helps PRT Special Educators:

1. **Plan Classroom Instructions**
   Adapt teaching methods for reading, writing, communication, mobility.
2. **Develop IEPs**
   Tailor objectives, strategies, assessments.
3. **Provide Interventions**
   Know when to use remedial teaching, therapy referrals, behaviour management, assistive technology.
4. **Work in Inclusive Settings**
   Understand accommodations required (scribe, large print, extra time).
5. **Collaborate with Parents & Professionals**
   Knowing categories helps explain children's difficulties with sensitivity.
6. **Conduct Early Screening**
   Identifying signs of sensory, developmental, behavioural, cognitive issues early.

13. Summary & Takeaways

This chapter establishes the conceptual foundation:

- Disability = interaction between impairment and barriers
- Difference between impairment-disability-handicap
- Evolution from medical → social → rights-based model
- WHO ICF framework emphasises functioning
- RPwD Act lists **21 benchmark disabilities**
- Educational categories based on learning needs
- Classification essential for planning, assessment, inclusion
- Cross-disability perspective ensures holistic support
- Foundation for upcoming detailed chapters on each disability type

Categories of Disability (Detailed & in-Depth)

1. Introduction: Why Categorizing Disabilities is Essential

Categorizing disabilities is foundational for special and inclusive education because:

- It helps teachers understand **functional limitations** and **educational needs**.
- It supports creation of **IEPs (Individualized Education Plans)**.
- It ensures **legal clarity**, particularly under RPwD Act 2016.
- It guides **screening, assessment & early intervention**.
- It trains educators in **disability-specific and cross-disability pedagogies**.
- It forms the basis for **accommodations**, e.g., extra time, scribes, assistive devices.

  Without systematic categorization, support services become more generalized and less effective. KVS/NVS PRT Special Educators must thoroughly understand all categories-both **broad global categories** and **India's legally recognized benchmark disabilities**.

2. Broad Global Categories of Disabilities (Educational & Functional Perspective)

Internationally, disabilities are grouped functionally according to how they affect learning, development, mobility, communication, and behaviour.

These categories help teachers understand **what difficulties to expect** and **what teaching adaptations** will be required.

2.1 Sensory Disabilities

These affect the senses-vision, hearing, and sometimes tactile perception.

A. Visual Impairment

Includes:

- Blindness
- Low vision
- Conditions like albinism, retinitis pigmentosa, congenital cataract

Functional difficulties include:

- Reading print text
- Orientation & mobility
- Recognizing visual symbols
- Participation in visual-based classroom tasks

B. Hearing Impairment

Includes:

- Deafness
- Hard of hearing
- Sensorineural/conductive/mixed types
- Prelingual or postlingual hearing loss

Functional difficulties:

- Speech development
- Listening comprehension
- Oral communication
- Language learning

C. Deafblindness

Combination of visual and hearing impairment causing severe communication and learning difficulties.

Teachers must use:

- Tactile communication
- Multisensory strategies
- Environmental modifications

2.2 Physical / Locomotor Disabilities

These affect the **musculoskeletal**, **neurological**, or **motor systems**.

Includes:

- Cerebral palsy
- Amputations
- Muscular dystrophy
- Poliomyelitis sequelae
- Spina bifida
- Spinal cord injuries
- Orthopaedic deformities

Functional difficulties:

- Sitting, standing, walking
- Writing, fine motor tasks
- Self-help (feeding, dressing)
- Physical fatigue

Educational planning must focus on assistive devices, accessibility, alternative formats.

2.3 Intellectual Disabilities (Cognitive Disabilities)

These affect global cognitive functioning and adaptive behaviour.

Types by severity:

- Mild
- Moderate
- Severe
- Profound

Functional difficulties:

- Generalized learning delay
- Concept formation
- Problem-solving
- Social skills
- Self-help skills

This category includes:

- Down Syndrome
- Intellectual Developmental Disorder (IDD)
- Global Developmental Delay (GDD)

2.4 Developmental Disabilities

Neurodevelopmental conditions appearing in early childhood:

Includes:

- Autism Spectrum Disorder (ASD)
- Intellectual Disability
- Specific Learning Disabilities (SLD)
- ADHD
- Communication disorders
- Developmental coordination disorder
- Social communication disorder

  Functional difficulties vary widely across language, behaviour, cognition, sensory processing, and communication.

2.5 Specific Learning Disabilities (SLDs)

SLDs affect academic skills, not intelligence.

Includes:

- Dyslexia
- Dysgraphia
- Dyscalculia
- Dysorthographia
- Dyspraxia

Functional difficulties:

- Reading accuracy & fluency
- Spelling
- Writing expression
- Mathematical calculations & reasoning

SLD students often show:

- Average or above-average intelligence
- Specific deficits in one academic domain

2.6 Psychosocial / Mental Health Disabilities

Relate to emotional regulation, behaviour, cognition and perception.

Includes:

- Depression
- Anxiety disorders
- Bipolar disorder
- Schizophrenia
- Psychosis

Functional difficulties may include:

- Concentration problems
- Mood instability
- Social interaction difficulties
- Hallucinations/delusions (in severe cases)
- Irregular school attendance

2.7 Neurological Disabilities

Affect brain, spinal cord, or nervous system.

Includes:

- Cerebral palsy
- Traumatic brain injury
- Epilepsy
- Multiple sclerosis
- Parkinson's disease
- Neuromuscular disorders

Functional effects depend on location and severity of neurological damage.

2.8 Speech & Language Disabilities

Affect communication expression, comprehension, speech production.

Includes:

- Articulation disorders
- Fluency disorders (stuttering)
- Voice disorders
- Aphasia
- Expressive/Receptive language disorders
- Childhood apraxia of speech

Functional difficulties:

- Difficulty expressing needs
- Social communication barriers
- Literacy delays
- Classroom participation challenges

2.9 Multiple Disabilities

Presence of two or more significant disabilities, e.g.:

- Deafblindness
- Intellectual disability + cerebral palsy
- Visual impairment + autism
- Hearing impairment + SLD

Functional difficulties are compounded, requiring integrated multi-disciplinary support.

3. Categories of Disabilities According to RPwD Act, 2016 (INDIA)

This is the most exam-sensitive portion. India legally recognizes 21 benchmark disabilities under 7 major groups:

3.1 Group A - Physical Disabilities

1. Locomotor Disability

A disability of bones, joints, muscles leading to restricted movement.

Includes:

- Cerebral palsy
- Leprosy cured
- Dwarfism
- Muscular dystrophy
- Acid attack victims
- Amputation
- Paralysis
- Post-polio residual paralysis
- Spinal cord injury
- Osteogenesis imperfecta
- Scoliosis

Key features:

- Difficulty in mobility
- Difficulty with fine motor tasks
- Need for orthoses/prostheses
- Adaptive equipment

2. Visual Impairment

Includes:

Blindness

- Total lack of vision
- Very limited light perception

Low Vision

- Can see partially even with corrective measures
- Uses adaptive devices for reading, mobility

Functional issues:

- Reading/writing
- Navigation
- Participation in visual learning

3. Hearing Impairment

Two subcategories:

- **Deaf**: 70+ dB loss in better ear
- **Hard of hearing**: 60-70 dB loss

Functional effects:

- Delayed speech
- Communication difficulties
- Social participation challenges

4. Speech and Language Disability

Long-term speech problems including:

- Stuttering
- Dysarthria
- Voice disorders
- Apraxia
- Cleft palate-related speech deficits
- Aphasia
  Not temporary speech loss.

3.2 Group B - Intellectual Disabilities

Includes:

1. Specific Learning Disability

A neurodevelopmental disorder with deficits in one or more of:

- Reading
- Writing
- Spelling
- Arithmetic
  Not due to low intelligence or lack of schooling.

2. Intellectual Disability (ID)

Significantly below-average intellectual functioning with deficits in adaptive behaviour.

Severity levels:

- Mild
- Moderate
- Severe
- Profound

3. Autism Spectrum Disorder

Characterized by:

- Social communication difficulties
- Restricted, repetitive behaviours
- Sensory processing issues
  Severity ranges widely (Level 1 to Level 3 support needs).

3.3 Group C - Mental / Psychosocial Disabilities

Mental Illness

Includes:

- Schizophrenia
- Bipolar disorder
- Severe depression
- OCD
- Anxiety disorders
- Psychotic disorders
  Requires long-term treatment.

3.4 Group D - Neurological Disabilities

1. Cerebral Palsy

Non-progressive brain injury affecting movement, posture, muscle tone.

Types:

- Spastic
- Athetoid
- Ataxic
- Mixed