

Clinical Psychological Analysis of the Handicapped/Disabled

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Abstract

Handicap/Disability remains a debilitating condition for the disabled/ handicapped and the caregivers, as they have to live and manage the condition in their life time (handicapped/disabled). The condition that affects motor ability, communicating ability, vision, thoughts, cognition, understanding, self-care, social interactions, education, usage of community amenities, self hygiene has both biological and environmental causes. Being a lifetime condition makes the management of this disability quite expensive, demanding the need for Government at various levels to take charge (management) of cases diagnosed as handicap/disability. This study x-rayed the etiology of major developmental crisis that mostly results in handicaps/disabilities, clinical psychological management and expected Government roles in the education, prevention, and management of the debilitating condition.

Key Words: Handicap, Disability, Clinical psychology, Government roles, x-tray.

Introduction

Clinical Psychology is the branch of psychology that is involved in the management of human abnormality, using all the basic principles of psychology in understanding the etiology of human abnormality. Thus the emphasis of clinical psychology is on abnormal psychology: the application of psychological science to understanding and treating mental disorders including

the handicaps, this is very germane, given the fact that clinical psychologists are more involved in the diagnosis and treatment of psychological disorders than in any other branch psychology (Stangor, 2010). It has been reported that about one in every four Americans (or over 78million people) are affected by a psychological disorder during any one year and at least half a billion people are affected worldwide (Kessler, Chiu, Demler, & Walters, 2005). The impacts of psychological disorder (mental illness & Handicaps) are particularly strong on people who are poorer, of lower socioeconomic class, and from disadvantaged groups (Stangor, 2010).

Clinical psychologists have been involved in the psychological management of people who are challenged with psychological disorders including the handicaps, in the bid for clinical psychologists to perform their duties efficiently they embrace the principles of psychology, they are concerned with the understanding of covert, overt behaviors and physiological changes. In the cause of studying human behavior and the mental process clinical psychologists have three major aims: observation of human and animal behavior, clinical psychologists attempt to study human behavior by observing, measuring and quantifying human behavior. The second aim is that of understanding and explanation which is appreciating factors that cause and maintain behavior, while the third is to predict/control and modify behavior which is the application of the other two aims. Thus, clinical psychology is not only a science but a profession with his view points, and ethical standard of profession.

Clinical psychology embraces so many concepts in the bid to delivering it duties, among these include clinical assessment: systematic collection, organization and interpretation of information about a person and his/her situation, and the prediction of his/her behavior in a new situation (Gathercole, 2009). The purpose of assessing clients/patients is to provide information on which decision about their future can be based, on the type of treatment/care whether to treat as out-patient or as in-patient, when they should be discharged, and what job to take. As a matter of fact clinical assessment is a significant tool as it aids the clinician in understanding the client and decision making. Until recently ideas about the psychology of handicap/disability have been exclusively created by non-handicapped/disabled people and almost always in rehabilitation or medical settings. Generally these interpreters of psychology of the handicapped/disability have been able-bodied practitioners (Doctors or clinical psychologists). Perception of the professionals working with the handicaps have significant impact in the management of these people. Handicap is said to be situation that makes progress difficult, a disadvantage, a serious usually permanent, physical, or mental condition that affects one's ability to walk, speak, see, think, understand etc.(Oxford Advanced Learners Dictionary, 2001).

The term disability has replaced the older designation spastic, handicapped, and crippled. An individual with a physical or intellectual disability, then, is said to be "handicapped" by the lowered expectations of society. A disabled person is one who has a condition called a disability that interferes with his or her ability to perform one or more activities of everyday living. For example locomotion (indoors and going outside), getting dressed, communicating with others. Disability refers to any impairment, activity limitations, or participation restrictions, or the outcome, or result of a complex relationship between an individual's health

condition and personal factors and of the external factors that represent the circumstances in which the individual lives. (WHO, 2001).

Disabilities are an umbrella term, covering impairments, activity limitations, and participation restrictions. Impairment is a problem in body function or structure, an activity limitation is a difficulty encountered by an individual in executing a task or action, while a participation restriction is a problem experienced by an individual involvement in life situations. Thus disability/handicap is a complex phenomenon reflecting an interaction between features of a person's body and features of the society in which he or she lives. (Wikipedia, 2013). Also the National Joint Committee on Learning Disabilities (NJCLD) defines the term learning disabilities as a heterogeneous group of disorders manifested by significant acquisition in the use of listening, speaking, reading, writing, reasoning, or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to Central Nervous System dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g. sensory impairment, mental retardation, social and emotional disturbance) or environmental influences (e.g. cultural differences, insufficient/inappropriate instructions, psychogenic factors) it is not the direct influence of those conditions or influences. (NRCLD, 2010).

For most professionals (therapists or clinical psychologists) handicapped or disabled experience rejection, when they walk into a hospital (rehabilitation) ward and stand next to a bed, or enter physiotherapy or occupational therapy room and turn their attention unto the complaints of the client. Alternatively they might be sitting at their work desk and there is knock on the door. A disabled/handicapped person or a parent with a handicapped person child comes into the room and set of problems are presented, in this experience of handicap/disability the problem only appear when the handicap appears, the workers, therapists, clinical psychologists naturally associate the problem with the person for this is the way it is experienced.

The clinical psychologist begins to ask the patient questions that the handicap may have with dressing, walking, eating, learning, hygiene, memory, social interaction etc. In the cause of assessment the clinical psychologist may substitute observation for questions but focus of attention by the clinical psychologist remains on what the person cannot do, or his having difficulty in doing. The attention is not on a functioning handicapped/disabled person living in their home, at work, or school but on the contrary on a non-functioning person in a medical setting.

Contemporary ideas about the psychology of handicapped have developed on the basis of three assumptions (1) Handicap/disability means you cannot function you have problems (that is why the handicap person is in the medical setting) (2) Handicap is something that the individual has or possesses it is part of you (you are a person with disability/handicap. (3) The psychological reactions of the individual are all interpreted in terms of reactions to personal dysfunction.

Psychology of Disability/Handicap

How the handicaps are perceived have significant influence on both the assessment and management of the handicaps, since handicaps are experienced by the worker fundamentally as negative personal attribute of a patient, or someone in need of help (that's why practitioners are employed by health or welfare services). The core of psychology of the handicapped is basically the relationship between the clinical psychologist and the handicapped with the view to alleviating the problems suffered by the handicapped and the inability of the patient to solve these problems unaided (for example physiotherapist who only see physically deformed children needing treatment can start to believe that all disabled children need treatment). Under these circumstances psychological reactions of handicapped people are interpreted as reactions to basic pathology. Hence the mythology those spinal injured patients have to go through a mourning process before they can adjust to disability, in clinical psychological practice similar professional experiences or observations in rehabilitation settings with disabled patients can lead practitioners to interpret most behavior of the handicapped people in terms compensations for disability (Nuhu., & Ade, 2012).

Failure to get patients to see their problems in the predefined ways of the professional (i.e. in rehabilitation programs) it's often interpreted as failure in the disabled individual (lacking in motivation). The words disability, disabled, disablement and handicapped are themselves showing changes in use, the word cripple and incurable are in respectful use. Now professionals are beginning to use the terms impairment and handicapped to indicate the abnormality and the disadvantage of being disable. The vast majorities of handicapped problems are mainly social, educational, employment, architectural, and care character. Doctors, clinical psychologists and other professionals contribute constructively when they abandon, doctor/patient, therapist/patient relationship and simply offer rehabilitation. Biology and Environmental factors have significant influence on causes of handicaps, it affects male, female, young, old, lower socio-economic status, high socio-economic status, presents in all cultures, races, all religions, etc.

As earlier mentioned that Handicaps are among children and the developmental psychologists have opined that most developmental crisis that are not detected between the age 0-3yrs are always difficult to manage for both the child and the caregiver, most developmental crisis/disorder result in handicaps: Developmental disorder is any condition that appears at some stage in a child's development and delays the development of one or more psychological functions, such as language skill, cognitive skills, social skills (Segen, 2006). Developmental disorders include psychological and physical disorders, and represent impairment in the normal development of motor or cognitive skills that are developed before age 22. Examples of developmental disorders are Mental retardation, Learning disabilities, Pervasive developmental disorders, Communication disorders, Attention-deficit hyperactivity disorder, Conduct disorder, Functional disconnection, Enuresis, Encopresis, and several others.

Mental Retardation

Mental retardation (MR) is defined as the arrest of intellectual development in children. According to DSM-IV-TR, MR is defined as significantly sub-average intellectual functioning paired with deficits in adaptive functioning (such as self-care, home living, interpersonal skills,

use of community resources, functional academic skills, safety, occupational activities, etc.) appearing prior to age 18. Mental retardation has been classified in various ways; one approach is to examine individuals based on their scores on traditional IQ test. Usually, an IQ score of 70 and below is indicative of MR. While the American Psychiatric Association (APA, 2000.) categorizes MR as mild, moderate, severe and profound.

The American Association for Mental Retardation (AAMR) based their categorization on the levels of support the individual requires (intermittent, limited, extensive and pervasive). Another approach is to categorize mentally retarded individuals based, using educational yardsticks of educable, trainable, severe and life support. Mental retardation has a chronic course and the prognosis is poor, although varying considerably among individuals. Given appropriate training, however, individuals with mild/moderate MR can live relatively independent and productive lives. Mild MR is observed more among males, with a male-to-female ratio of 6:1 no gender differences are found among people with severe MR (Durand & Barlow, 2002).

Management of Mental Retardation

Direct biological treatment of MR is not a viable option, as such has not been shown to yield encouraging results. Generally, treatment of people with MR parallels that of people with pervasive developmental disorders (PDDs), which involves teaching them the skills to become more productive, more independent, more able to participate in community life, attend school and later hold a job and have the opportunity for meaningful social relationships. Also, part of the roles clinical psychologists play include empathizing with the care givers of mentally retard and ensure that they teach them skills in managing their wards.

Pervasive Developmental Disorders

Pervasive developmental disorders are group of disorders marked by impaired social interaction, unusual communication, and inappropriate responses to stimulus in the environment, pervasive developmental disorders are wide ranging, significant and long lasting dysfunctions that appear before the age of 18. The group includes Autistic Disorder, Asperger's Disorder/syndrome, Rett's Disorder/syndrome, pervasive developmental not-otherwise specified. The commonest of the PDDs is autistic disorder, because its initially received more attention than the others, these disorders is often referred to as autistic-spectrum disorders. Although the patterns are similar in many ways, they do differ significantly in the degree of social impairment, sufferers experience and in the time of onset (Kobot et al., 2003).

Given the low prevalence of Rett's disorder and childhood disintegrative disorder among the major cases seen in the hospitals and rehabilitation centers, emphasis will be on Autistic disorder and Asperger's disorder.

Autistic Disorder (Case Presentation)

In retrospect (Master, 'A', His, Mother.) she can recall some things that appeared odd to her, for example she remembers that 'A' as she usually call him, never seemed to anticipate being picked up when she approached him, in addition, despite A's attachment to a pacifier (he would complain if it were misled), he showed little interest in toys, as a matter of fact, 'A' seemed to lack interest in anything, he rarely pointed to things and seemed oblivious to sounds.... 'A' spent much of his time repetitively tapping on tables, seeming to be lost in his own world.

After his 2nd birthday, A's behavior began to trouble his parents..... 'A', they said, would "look through" people or pass them, but rarely look at them. He could say a few words but didn't seem to understand speech. In fact, he did not even respond to his own name. A's time was occupied examining familiar objects, which he would in front of his eyes twist and turned them. Particularly troublesome to the parents were A's odd movements –he would jump, flap his arms, twist his hands and fingers, and perform all sorts of facial grimaces, particularly when he was excited, these Alhaji B, (A's Father) described as A's rigidity in the cause of history taking.

'A', would line things up in rows and scream if they were disturbed, he insisted on keeping objects in their place and would become upset whenever his mother or any member of the family attempted to rearrange the living room furniture..... slowly.

'A', was displaying autistic disorder or autism, a pattern first identified by the American psychiatrist Leo Kanner in 1943. Children with this disorder are extremely unresponsive to others, uncommunicative, repetitive, and rigid. Their symptoms appear early in life, typically before 3 years of age. Just a decade ago, autism seemed to affect around one out of every 2,000 children (APA, 2000). Having documented the history of A's condition, part of the clinical psychological analysis of A's condition include empathizing with the parents, cognitive restructuring of the parents (accepting their child's condition) and measures the child needed to cope with the condition.

However, in recent years there has been a steady increase in the number of children diagnosed with autism, and it now appears that at least one in 600 and perhaps as many as one in 200 children display the disorder (Fombonne, 2003; Wing & Potter, 2002).

Around 80% of all cases of autism occur in boys, as many as 90 percent of children with the disorder remain severely disabled into adulthood. They have enormous difficulty maintaining employment, performing household tasks, and living independent lives (Siegel & Ficcaglia, 2006). More over even the highest-functioning adults with autism typically have problems displaying closeness, empathy, and support in their social interaction and communication and have restricted interests and activities (Baro-Cohen & Wheelwright, 2003).

Part of clinical psychological assistance to Master 'A' includes objective assessment, understanding/explanation of the his condition so as to control his condition, the parent were not left out in the management, following basic behavioral modification pattern, months after Master A's condition has improved significantly, can pronounce words averagely, home hygiene improves, and most importantly the social support improved significant wish is a very vital factor in the management of Autism, for research has shown that most autistics' care givers abandon their wards. But in the case of Master A', contrary is the case however the parents were also counseled to ensure that they attend clinic as scheduled.

What Are the Features of Autism

The individual's lack of responsiveness- including extreme aloofness, lack of interest in other people, low empathy, and inability to share attention with others has long been considered the central feature of autism (Sigel & Ficcaglia, 2006). Like master 'A', children with this disorder typically do not attach to their parents during infancy, instead they may arch their backs when they are held and appear not to recognize or care about those around them. Language and communication problems take various forms in autism, approximately half of all sufferers fail to speak or develop language skills (Dawson & Castelleo, 1992). Those who do talk may show peculiarities in their speech.

One of the most common speech problems is *echolalia*, the act echoing of phrases spoken by others. The individuals repeat the words with the same accent or inflection, but with no sign of understanding or intent communicating. Some even repeat a sentence days after they have heard it (*delayed echolalia*). Because they have difficulty empathizing and sharing a frame of reference with others, individuals with autism may also display other speech oddities, such as *pronominal reversal* or confusion of pronouns the use of you instead of I when A', was hungry, he would say Do you want dinner? In addition individuals may have problems naming objects, using abstracts language, employing a proper tone when talking, speaking spontaneously, using language for conversational purposes or understanding speech.

Autism is also marked by limited imaginative or abstract play and by very repetitive and rigid behavior. Children with the disorder may be unable to play in a varied, spontaneous way. Unlike other individuals of the same age, the children may fail to include others in their play or represent social experiences when they playing in fact they often fail to see themselves as others see them and have no desire to imitate or be like others (Siegel & Ficcaglia, 2006). Typically they become very upset at minor changes of objects, persons, or routines and resist any efforts to change their own repetitive behaviors. 'A', for example, line things up and screamed if they were disturbed.

Similarly, children with autism may react with tantrums if a parent wears an unfamiliar pair of glasses, a chair is moved to a different part of the room, or a word in a song is changed. Leo Kanner (1943) labeled such reactions *a perseveration of sameness*; furthermore, many sufferers become strongly attached to some particular objects like plastics lids, rubber bands, buttons, and water. They may collect these objects, carry them or play with them constantly; some are

fascinated by movement and may watch spinning objects, such as fans, for hours. The motor movement of people with autism may also be unusual, as in the case of master A', he would jump, flap his arms, twist his hands and fingers, rock, walk on his toes, spin, and make faces. These acts are called *self-stimulatory behaviors*; some individuals also perform *self-injurious behaviors*, such as repeatedly lunging into or banging their head against a wall pulling their hair, or biting themselves.

The symptoms of this disorder suggest a very disturbed and contradictory pattern of action to stimuli; sometimes individuals with autism seem over stimulated by sights and sounds and to be crying to block them out, while at other times they seem under stimulated and to be performing self-stimulatory actions. They may for example fail to react to loud noises, yet turn around when they hear soda being poured. (Dawson, et al, 1998). Similarly, they may fail to recognize that they have reached the edge of a dangerous high place, yet immediately spot a small object that is out of position in their room

DSM Checklist for Autistic Disorder

A total of at least six items from the following groups of symptoms:

- A. Impairment in social interaction, as manifested by at least two of the followings:
 - a. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.
 - b. Failure to develop peer relationship appropriately.
 - c. Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people.
 - d. Lack of social or emotional reciprocity.
- B. Impairment in communication, as manifested by at least one of the following:
 - a. Delay in or total lack of the development of spoken language.
 - b. In individuals with adequate speech, marked impairment in the ability to start or sustain a conversation with others.
 - c. Stereotype and repetitive use of language, or idiosyncratic language.
 - d. Lack of varied, spontaneous make-believe play or social imitative play.
- C. Restricted repetitive and stereotyped patterns of behavior, interests, and activities as manifested by at least one of the following:
 - a. Abnormal preoccupation with one or more stereotyped and restricted patterns of interest.
 - b. Inflexible adherence to specific to specific nonfunctional routines or rituals.
 - c. Stereotyped and repetitive motor mannerism (e.g. hand or finger flapping or twisting).
 - d. Persistent preoccupation with parts of objects.

Prior to 3 years of age, delay or abnormal functioning in social interaction, language, symbolic or imaginative play, however emphasis is more on autism reason being that, among major developmental crisis that lead to handicap/disability among children autism is more prominent compared to others mentioned in this study.

Asperger's Disorder

Around the time that Kanner first identified autism, a Viennese physician began to note a syndrome in which children display significant social impairment yet manage to maintain relatively high levels of cognitive function and language. Those with ASPERGER'S disorder, or Asperger's syndrome, experience the kinds of social deficits, impairments in expressiveness, idiosyncratic interests, and restricted and repetitive behaviors that characterize individuals with autism, but at the same time they often have normal or near normal intellectual, adaptive, and language skills (Siegel & Ficcaglia, 2006; Ozonoff et al., 2002).

Many individuals with this disorder want to fit in and interact with others but their impaired social functioning makes it hard for them to do so. They wind up appearing awkward and unaware of conventional social rules. (ASA, 2006). Clinical research suggests there may be several subtypes of Asperger's disorder, each having a particular set of symptoms; a team of researchers has distinguished three subtypes.

Namely: rule boys, logic boys, and emotion boys (Sohn & Grayson, 2005). *Rule boys* are Asperger sufferers who need to have a set of rules that govern their lives. They are extremely stubborn about following these rules, and they may typically be able to respect authority figures and structure. *Logic boys* are primarily interested in the reasons behind rules; rules alone are not sufficient. They want to know how the world works, often question the logic of other's reasoning, and may have their own reasons why things are happening.

In, Logic boys' types of Asperger's disorder are often typically unwilling to accept illogical events and often become overly analytical. *Emotion boys* tend to be run by their feelings, they have more tantrums than others with Asperger's disorder and seem less available to others, and it is hard to sway them with rules or reason and they often act out. Asperger's disorder appears to be more prevalent than autism; approximately one in 250 individuals displays this pattern, again 80 percent of them boys (CADDRE, 2004). It is important to diagnose and treat Asperger's disorder early in life so that the individual has a better chance of being successful at school and living independently, although Asperger individuals must contend with deficits throughout their lives, many are able to complete a high level of education, such as college or trade school.

This is typical of the opinion of the developmental psychologists that every abnormalities of children when detected usually as early as three years usually have positive prognosis, similarly Asperger's disorders apart from the fact that they are manageable following the principles of developmental psychologists they can also successfully hold jobs, particularly ones that require a focus on details and limited social interactions (ASA, 2005). Despite their social deficits, some people with Asperger's disorder further manage to have romantic- even- marital- relationship, particularly with others who display the same disorder.

What Are the Causes of Paversive Developmental Disorders

Due to clinical assessment and frequent diagnosis research is more on autism than Asperger's disorder or other pervasive developmental disorders. Currently many clinicians and researchers believe that the other pervasive developmental disorders are caused by factors similar to those responsible for autism and that people with the other disorders can often be helped by interventions similar to ones that bring positive change in cases of autism. It is quite possible however that in the coming years as Asperger's disorders receive more and more study, clear differences in the causes and treatments of various disorders will emerge.

A variety of explanations have been offered for autism, this is one disorder for which socio-cultural explanations have probably been overemphasized, in fact such explanations initially led investigators in the wrong direction, more recent work in psychological and biological spheres has persuaded clinical theorists that cognitive limitations and brain abnormalities are the primary causes of autism.

Socio-Cultural Causes

At first, theorists thought that family dysfunction and social stress were the primary causes of autism. When he first identified autism for example Leo Kanner (1954) argued that *particular personality characteristics of the parents* created an unfavorable climate for development and contributed to the child's disorder, he saw these parents as very intelligent yet cold – "refrigerator parents", these claims had enormous influence on the public and on the self – image of the parents themselves, but research has totally failed to support a picture of rigid, cold, rejecting, or disturbed parents (Roazen, 1992). Similarly some clinical theorists have proposed that a high degree of *social and environmental stress* is a factor in autism. One again, however research has not supported this notion, investigators who have compared children with autism to children without the disorder have found no differences in the rate of parental death, divorce, separation, financial problems, or environmental stimulation (Cox et al.2008).

Psychological Causes

According to certain theorists people with autism have central perceptual or cognitive disturbances that makes normal communication and interactions impossible, one influential explanation holds that individuals with the disorder fail to develop a theory of mind, an awareness that other people base their behaviors on their own beliefs, intentions, and other mental states, not on information that they have no way of knowing (Hale & Tager-Flusberg, 2005; Frith, 2000). By 3-5 years of age most children can take the perspective of another person into account and use it to anticipate what the person will do. In a way learn to read others' minds. For example let's say we watch Tope place a marble in a container and then we observe

Jide move the marble to a nearby room while Tope is taking a nap, we know that later Tope will search first in the container for the marble because he is not aware that Jide has moved it. We know because we take Tope's perspective into account.

A normal child would also anticipate Tope's search correctly, a person with autism would not he or she would expect Tope to look in the nearby room because that is where the marble actually is. Tope's own mental process would be unimportant to the person. Studies have shown that people with autism do have this kind of mind-blindness although they are not necessarily the only kids of individuals with this limitation (Dahlgren et al., 2003). They thus have great difficulty taking part in make-believe play, using language in ways that include the perspectives of others, developing relationships, or participating in human interactions, why do people with autism have this and other cognitive limitations? Some theorists believe that they suffered early biological problems that prevented proper cognitive development.

Biological Causes

For years researches have tried to determine what biological abnormalities might cause theory-of-mind deficits and other features of autism. They have not yet developed a detailed biological explanation but they have uncovered some promising leads (Volkmar, 2001; Rodier, 2000). First examinations of the relative of people with autism keep suggesting a *genetic factor* in this disorder. The prevalence of autism among their siblings is as high as 6 to 8 percent (Piven et al., 1997), a rate much higher than the population's. Moreover identical twins of people with autism display the highest risk of all (Treffert, 1999). In addition chromosomal abnormalities have been discovered in 10 to 12 percent of people with the disorder (Sudhalter et al., 1990). Some people have also linked autism to *prenatal difficulties or birth complications* (Rodier, 2000; Simon; 2000).

The chances of developing the disorder are higher when the mother has rubella (German measles) during pregnancy, was exposed to toxic chemicals before or during pregnancy or had complications during labor or delivery. In 1998 one team of investigators proposed that a *postnatal event* the vaccine for measles, mumps, and rubella might produce autism in some children, alarming many parents of toddlers. However to date research has not confirmed a link between the vaccine and the disorder. (Institute of Medicine, 2004; Taylor et al., 1999).

Finally researchers have identified specific *biological abnormalities* that may contribute to autism, some recent studies have pointed to the *cerebellum* (DeLong, 2005; Pierce & Courchesene, 2002, 2001). Brain scans and autopsies reveal abnormal development in this brain area occurring early in the life of people with autism, scientists have long known that the cerebellum coordinates movement in the body, but they now suspect that it also helps control a person's ability to shift attention rapidly. It may be that people whose cerebellum develops abnormally will have great difficulty adjusting their level of attention, following verbal and facial cue, and making sense of social information all key features of autism. In a similar vein neuroimaging studies indicate that many children with autism have increased brain volume and

white matter (Filipek, 1999) and structural abnormalities in the brain's limbic system, brain stem nuclei, and amygdale (Newschaffer, Fallin, & Lee, 2002).

Many individuals with the disorder also experience reduced activity in the brain's temporal and frontal lobes when they perform language and motor initiation tasks- tasks that normally require activity by the brain's left hemisphere (Escalante, Minshew, & Sweeny, 2003). Many researchers believe that autism may have multiple biological causes (Mueller & Courchesne, 2000). Perhaps all relevant biological factors (genetic, prenatal, birth, and post natal) eventually lead to a common problem in the brain a final common pathway such as neurotransmitter abnormalities, that produces the cognitive problems and other features of the disorder.

Conclusion and Recommendation

Clinical psychological analysis of the handicapped involves the use of basic knowledge in psychology to understanding the etiology of handicaps in so doing clinical psychologists embrace the principles of observation/assessment, understanding/explanation and prediction/control/modification of the said behavior, thus in the bid to managing handicaps the clinical psychological analysis of the handicaps equally put into management plan caregivers of the handicaps, for research has shown that most caregivers of the handicaps also experience psychological problems like anxiety, depression, insomnia, stress related illness, poor social support, etc., a case was reported in a psychiatric hospital where a caregiver abandoned her son who was a disabled due to chronic condition of the boy. (Nuhu & Ade, 2012). For this reason considering the debilitating, frustrating and depressing condition of the disabled, Government are expected to be put into consideration when formulating health care policy.

Clinical psychologists in the bid to discharging their duties to the handicaps embrace principles of clinical psychological practice, they do not judge their clients (handicaps) and their care givers for they believe most of the causes of the handicaps are not under the control of the handicaps even though there are evidences to show that parents of the handicaps played significant role in the cause of their becoming victims of handicap, clinical psychologists do not judge the caregivers, as in the case of consuming alcohol during pregnancy, did not attend antenatal clinic during the pregnancy, missed expected immunization during pregnancy, clinical psychologists only empathize with the client and the care giver.

Also clinical psychologists discharge their duties genuinely without fear or favor they attend to all clients (handicaps) on the same platform, they also treat all clients same regardless of your sex, race, religion, tribe, etc (non-possessive warmth). All these factors significantly influence the clinical psychological analysis of the handicaps.

Research and experiments are continuous, in understanding the etiology of handicaps not only for the management but also for possible prevention as research has shown that most developmental problems that results to handicaps/disabilities are preventable for example autism has been linked to prenatal difficulties or birth complications (Rodier, 2000; Simon, 2000), pregnant women are advised to visit antenatal regularly and avoid quark health centers

when they are to deliver. For now most handicaps cases do not have cure but continuous management of the situation, making the position of clinical psychologists more relevant, in the developed countries most cases of the handicaps are being taken care by the Federal, State or Local Government, but contrary is the case in the developing countries.

Part of the advocate of the Nigerian Association of Clinical Psychologists (NACP), Nigerian Psychological Association (NPA) other relevant bodies is to ensure that Federal Government takes over the management of all cases of the handicaps, for these cases are lifetime cases and the management is quite expensive, though Government is making significant impact in the area of prevention, for example the Nationwide campaign that every child below 5 be immunized against measles is a remarkable effort towards preventing handicap in Nigeria, currently another face of the immunization is on that every child below the age of 5 must be immunized against measles as research has shown that polio constitute significant rate of handicaps in the country. (FMH, 2013).

Likewise the need for Federal Government to integrate the services of clinical psychologists in the policy formulation, most especially in the areas of health is very essential, for Government needs to be more involved in the areas of prevention as most causes of handicaps are preventable.

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