

Getting to Know the World of a Person with a Disability
Help Begins with Understanding

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Foreword

The world we live in is marked in all its spheres with one common feature: a desire for perfection. The media incessantly advertise perfection. Perfect image, perfect body, perfect laundry detergent. A feeling arises as if anything that fails to achieve this perfection did not belong to this world. As if anyone who fails to achieve this perfection did not belong to this world.

Yet the truth is the life of an individual seldom matches this perfect vision. Everybody lives their personal, not always perfect life.

There is also another view of the world. There is also another world. A world seemingly not perfect in its image, but the contrary is true of its essence. It is a world of people who, without their fault, were born into this world with a disability. These people find themselves in a situation they can not affect or change, which nevertheless limits them and in many respects keeps them from living their life the way other people do. The expectations these people have reflect their desire to live a full-fledged life. They also want to be useful for their environment. I dare express an opinion that questions of considerable relevance remain open in our society in this respect. The crux of these questions lies in a mutual relationship of those who meet the perfection criteria on the outside and those with a disability. In their mutual understanding, expectations and possibilities of mutual help.

Such mutual interplay can occur only if they know each other. Often there is a chasm between the world of people with disabilities and that of the people who do not have any, or even as it were a wild river preventing both to cross it to the other bank. Is it possible to build a bridge so that these two worlds can meet? I would be glad if some of the ideas from this book contributed to this.

I dedicate this book to my best friend Edita, a woman who lives all her life on the other bank and helps me build the bridge.

Mária Šmidová

1 New starting points

At the beginning of the third millennium the international community took a step that can be called historic. For the first time it signed a multilateral universal international treaty of human-right nature. This treaty commits the states to guarantee particular rights of 650 million persons with disabilities all over the world. A move from the general and as a rule not legally binding form of guaranteeing the rights of these persons to an integral, complex and binding document may be considered a new quality of this guarantee.

Convention on the Rights of Persons with Disabilities (henceforth “the Convention”) and *Optional Protocol to the Convention on the Rights of Persons with Disabilities* (henceforth “the Protocol”) are new multilateral international United Nations treaties adopted by the UN General Assembly resolution 61/106 of 13 December 2006 at its 61st session. The Convention became binding in Slovakia the following year in March 2007, when the President of the Slovak Republic signed the treaty of accession.

The basic conceptual bases of the Convention include:

1. Full and effective participation of the persons with special needs in society is currently being hindered by both environmental and attitudinal barriers.
2. Emphasis on the interaction of the measures for equalizing opportunities on the national, regional and international levels.
3. Mainstreaming the issues of the people with special needs is an integral part of strategies of sustainable development.
4. Discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person.
5. Recognition of individual differences among the people with special needs and emphasis on severe disabilities.
6. Special attention is called to the importance of international cooperation for improving the living conditions of persons with special needs in every country, particularly in developing countries.
7. The valued existing and potential contributions made by persons with special needs to the overall well-being of their communities is recognized.
8. It is taken into account that the promotion of the full enjoyment by persons with special needs of their human rights and fundamental freedoms results in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty.

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9. The importance of individual autonomy and independence for persons with special needs, including the freedom to make their own choices is considered.
10. It is recognized that persons with special needs should have the opportunity to be actively involved in decision-making processes about policies and programmes, especially those directly concerning them.
11. Attention is drawn to the particularly difficult conditions of girls, women and children, people in conflicts and poor people with special needs.
12. Gender equality in the area of exercising the rights of the people with special needs is emphasized.
13. The importance of people with special needs having access to healthcare services, information, communication and education as well as to the physical, social, cultural and economic environment is recognized.
14. Family is the natural and fundamental group unit of society and is entitled to protection by society and the State. Thus persons with disabilities and their family members are entitled to receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities

Definition of the terms disability, person with a disability, discrimination on the basis of disability

In defining disability, we are building upon the new approaches taken in the Convention. The progressive element of the Convention's concept is the definition of disability and of a person with a disability. For comparison – new terms are also taking root in Slovakia, such as “special needs” and “person with special needs”.

Pursuant to Article 2 the purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The term “Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

This includes all forms of discrimination hindering persons with disabilities from living a full-fledged life, without imposing unnecessary burdens in relation to the equality principle.

In this respect, the Convention clearly addresses the issue of persons with disabilities in a very accurate and complex manner, taking into account the greatest range of interrelated conditions and circumstances possible. Thus it operates in connection with the facts that condition their lives in practice.

The basic principle in the approach to persons with disabilities rests in the recognition that disability consists in society, not in the person with a disability.

In this respect, certain conceptual development can be seen as compared to the “UN Standard rules” which use the terms “impairment,” “disability” and “handicap” to express any disability. Such terminology was superseded by a new structure of “impairments” and “disabilities.”

Disabled is such person with impairment who is in a certain way discriminated by society which fails to equalize his or her opportunities adequately.

Examples:

A child with an intellectual impairment is disabled by the fact that the school is unable to adapt to pupils with decreased learning ability.

A child with extreme myopia. Persons with myopia in two different countries: where such person has access to corrective lenses, he is not considered a person with a disability according to the Convention; on the contrary in a country without such access such deficiency of the society causes his disability.

These examples clearly show the relation of a disability to society, not to the person in question. According to the philosophy of the Convention, a handicap is not a question of status but a cause of disability. Such disadvantage affects persons with impairment by placing them to the category of persons with disabilities.

This conception could be in harmony with the Slovak conception of “persons with disabilities” in the sense that it is one side of the dichotomy:

A person with impairment has consequently special needs. If society does not enable such person to fulfil his needs, one can talk about a person with a disability.

It needs to be emphasized that it is incorrect to use the term “disabled person”. It accentuates the relationship of the disability to the person, not to society. The same applies to the formerly used terms “invalid person”, “mentally retarded person”, “wheelchair-bound person” and the like.

It can be concluded that the term “person with a disability” establishes an important principle of approaching the persons with long-term physical, mental, intellectual or sensory impairments. The term refers to a person with a disability which is disadvantaged in society by his life conditions, be they the same or different from those enjoyed by a person without such impairment. In this sense, disability is related to society, not to the person in question, and according to the international law, the condition of disability is discriminating.

2 Classification of Disabilities

In both theory and practice, a shift to interactive theories and theories of systems has occurred and the social dimension of disability is becoming increasingly important.

This has also become evident in various documents of the international community which has achieved a historic step. The WHO has corrected its original definition of disability and suggested such account of the concepts of impairment and disability that contains new social aspects.

The new WHO definition introduces three levels of disability:

- biological disability;
- somatomental functional impairments;
- interpersonal, social level.¹

The classification of impairments is primarily based on medical diagnostics identifying organ or functional deficiencies. At the same time, many diagnosed impairments can not be removed by medicine and thus disability can not be precluded.

In terms of type, such impairments may be of organ or functional nature. In terms of intensity mild, moderate and severe disabilities. In terms of time of origin congenital or acquired.

The following basic classes of disabilities are discerned:

- mental disability,
- vision impairment,
- hearing impairment,
- physical disability,
- impairment of communication abilities,
- psychosocial impairment (behavioural disorders),
- learning impairment.

2.1 Mental Disability

Mental disability occurs when the development of intellect is arrested or incomplete. It manifests during the developmental phase and is characterized mainly by the impairment of abilities constituting the overall level of intelligence, i.e. cognitive, language, motor and social abilities.

¹ Cf. ZÁSZKALICZKY, P.: Proměny paradigmatu – od segregace k inkluzi. In: LECHTA, V.: *Základy inkluzivní pedagogiky*. Praha : Portál, 2010.

This terse definition raises many questions related to the very living of one's life. Biologically, this disability is caused by a severe permanent organ or functional brain impairment. Socially, this disability is characterized by disorientation in the world and society, limiting the ability to handle one's own social existence independently, without outside assistance. Pedagogically, such people have reduced learning ability; legally, their competence to perform legal acts is reduced.

But what does this disability mean in terms of psychology? A glimpse primarily suggests a decreased level of intellectual abilities measurable by the standardized IQ tests, as compared to the norm in the population.

The difference between mental retardation and demency needs to be emphasized. Although symptomatically very similar, the cause, or aetiology, of these diseases is different.

Mental disability is a congenital disease originating in the prenatal or perinatal period, or most frequently prior to the first year of the child's life.

Demency is characterized by the reduction of already acquired mental capabilities of an individual manifested in degenerative brain diseases, e.g. Alzheimer's disease.

In the case of this disability the main cause is brain impairment, either *functional* or *organ*.

Aetiological diversity is also related to the temporal factor which has a substantial impact on the origination of a mental disability. On this basis, the factors which may result in a mental disability may be divided into three groups.

Substantial prenatal factors comprise virus infections, x-rays, diabetes mellitus or insufficient nutrition in the mother, bleeding during pregnancy, anaemia, pre- or postmaturity, alcohol, cigarette or drug use. Perinatal factors related to the time of delivery are mainly hazardous childbirths. Postnatal factors can be determined more precisely in the case of syndromes caused by genetic disorders. The causes may also be extrinsic, especially genetic mutations or chromosomal abnormalities (Down syndrome, Turner syndrome), metabolic disorders (phenylketonuria), intoxication (fetal alcohol syndrome), traumas (hypoxia, asphyxia), multifactor aetiology, injuries, diseases (encephalitis), surgeries (tumour-removing operations), brain diseases, social factors (child neglect).

Diagnostics of each illness is a complicated process. The process requires great effort particularly if such severe disease is in question. From collecting the descriptions and features of the condition, careful capturing of aberrancies from the healthy condition in every respect, to ascertaining the developmental aberrancies in terms of the child's lagging behind, one can achieve differential diagnostics resulting in a diagnosis. Individual diagnostic procedures need to be coordinated. A team of specialists should include a physician, a paediatrician, a psychiatrist, a neurologist,

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a psychologist, a special educationist and a social worker. However, the most important role in this team belongs to the parents.

If we want to answer this question, we need to take into account individual characteristics of volitive processes, emotions, motivations, levels of aspiration and self-appraisal. In the case of people with mental disabilities these characteristics are marked with certain peculiarities.²

Yet another view needs to be added to this one. An important feature of these people is their ability to take and give love. The very reduction of their ability to perceive life in all its complexity protects them from pride, suspicion, being judgmental. Boldly perhaps, I would express an opinion that they bring a model of love to this world. Love capable of giving and taking absolutely.

A story of Paľko, 28 years

Born to older parents, his primary diagnosis is infantile cerebral palsy, quadruparetic form, which is the reason he uses wheelchair. Secondary disability is reduced intellectual ability to the level of moderate mental disability.

In kindergarten he attended the sorting class; after diagnostic tests he entered the special school. He attended the primary school for six years. After finishing it his parents worked hard to have him further educated. Due to his limited ability in the area of both fine and gross motor skills he could not continue in further education. That is why his mother had to quit her job, stay at home and look after him 24 hours a day. Paľko likes shopping in shopping centres. That is why one can often meet him in the company of his mother in a shopping centre near their flat. He likes observing everything. He remembers well the people they meet and so he talks to everyone he has already met and reminds them of the situations when they first met. His prospects include life with his mum whom she loves dearly. His father is a model for him. Watching Paľko's family we find ourselves as it were in a different world.

2.2 Physical Disability

The term *physical disability* encompasses three types of disabilities: physical disability in the narrow sense, disease and debilitation.

Physically disabled is an individual with a defect of the locomotive and skeletal systems, as well as one with a defect of the nervous system, if such defect is manifested by hypokinesia.³ Included are also all aberrations from the normal shape of the body and limbs, i.e. deformities, as well as abnormalities, i.e. anomalies.

Physical disability may be: 1. congenital, 2. acquired during the life.

² Cf. POŽÁR, L.: *Psychológia osobnosti postihnutých*. Bratislava : UK, 1996, p. 44.

³ Cf. KOLLÁROVÁ, E.: *Základy somatopédie*. Bratislava : UK, 1993.

Congenital disabilities are caused by developmental defects of the fetus usually in the first weeks of pregnancy.

Acquired impairments may be caused by e.g. an injury, hormonal activity, various inflammatory and degenerative diseases of the brain or cerebral cord and the like.⁴

Two tendencies may be noticed in the terminology used abroad:

- an individual is called physically disabled, defective, handicapped (handicape physique),
- an individual is referred to as having a motor disability, defect, handicap (mit Bewegungstörungen); or an equivalent of this term is used.

Physical disability is usually externally visible. More or less conspicuous differences may most frequently include disproportion of individual body parts, differences in the shape of the trunk and limbs, a missing limb or its part.

Physical disability also influences the mental wellbeing of the person and may be reflected in the area of cognitive processes, will, emotionality and social relationships.

An individual has contracted a disease when he possesses a pathological condition commonly defined as a misbalance of the organism and the environment.

In this context, various anatomical and functional changes are brought about in the organism. The important thing here is not to call someone ill, but the ill person himself who requires particular care due to the contracted illness.

The category of the diseased is differentiated into several groups according to the affected respiratory, skeletal and muscular, nervous, cardiovascular, digestive, urinary, reproductive, integumentary, endocrine and other systems.

It is important whether health is fully restored or the diseases result in physical deformity, while other permanently limit an individual in certain areas. This is further reflected in the approach to these individuals.⁵

Debilitated is a recuperating or immuno-compromised individual, an individual susceptible to relapse or with threatened health as a result of inadequate environment, lifestyle or nourishment.

Special categories of the debilitated include asthenic and obese individuals.

Multiple disability affects an individual with more than one disability (e.g. scoliosis and a blood disease), especially one having a sensory, speech or mental disability in addition to a physical disability. Alternatively, such individuals are referred to as disabled by multiple diseases.

⁴ Cf. KRAUS, I., ŠANDERA, O.: *Tělesně postižené dítě*. Praha : SPN, 1964.

⁵ Cf. ŠMIDOVÁ, M.: *Přístup k deťom s telesným postihnutím*. Trnava : SAP, 2005.

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In general, due to the degradation of the environment and the quality of life caused by stress and loss of values, the number of people with physical disability is on the rise.

The most precise way to the understanding of individual kinds of physical disability is to follow their neurological classification. Individual kinds are introduced in their main characteristics.⁶

Infantile cerebral palsy

This disease is considered to be the most frequent aetiology of a physical disability. It is a disease of civilisation. Recently, the number of cases of infant cerebral palsy has been on the rise. One needs to get acquainted with it.

The cause of infantile cerebral palsy is a damage of the brain and cerebellum before the growth and development of the brain is completed.⁷

It is a syndrome of non-progressive brain damage caused by factors affecting immature nervous system during the childbirth or in the early postnatal life manifested mainly by a motor defect, often associated with an intellectual, seizure, emotional and specifically behavioural disability.

The period when the developing brain tissues are not mature has not yet been clearly defined. It ranges from 28 days after the delivery (from the paediatric point of view) to 6 months through one year after the delivery (from the neurological point of view), up to 3 years after the delivery. Some authors argue that the possibility of the occurrence of a perinatal disease extends up to seven years.

The name of the disease is also an important question. Formerly, two names were used: the Anglo-Saxon – “cerebral palsy” or “infantile cerebral palsy” and the French – “encéphalopathies infantiles” (infantile encephalopathy).

The Anglo-Saxon term has been accepted as the official name of the diagnosis. It has been translated into most languages of the world, often with the complementary term “infantile”. Thus the following terms have come into use:

- in the English literature „cerebral palsy“ (CP),
- in the French literature „infirmité motrice“,
- in the German literature „zerebral Kinderlähmung“.

⁶ Cf. SLOWÍK, J.: *Speciální pedagogika*.

⁷ Cf. VAJDA, R: *Špeciálna neurológia pre somatopédov*. Bratislava, 1992.

Craniocerebral injuries in children

The consequences of craniocerebral injuries in children depend on their age. They include birth injuries, brain concussion, post commotion syndrome, brain contusion and laceration and posttraumatic epilepsy.

Mild brain dysfunction

Mild brain dysfunction is caused by an early disability of an immature brain or by a minimum damage of the central nervous system. Such damages are obscure and little is known about them. Yet their significance is great, due to the increasing number of children with this diagnosis. Currently, it is associated with the ADHD diagnosis.

Neurocutaneous syndromes

Neurocutaneous syndromes are genetically conditioned progressive diseases. A characteristic feature of the neurocutaneous syndromes are dysplastic skin modifications combined with modifications of the central nervous system.

Neurological syndromes associated with chromosomal abnormalities

Chromosomal aberrations include damages of autosomal or sex chromosomes, either in their count or structure. Out of the great number of different syndromes the most frequent include Down syndrome, also known as trisomy 21, anti mongolism or Lejeune syndrome, trisomy 18 or Edward syndrome, etc.

Neurological syndromes associated with chromosomal abnormalities are manifested in somatic stigmatisation, psychological retardation, spasms, abnormal movement, structural brain modifications and behavioural disorders.

Degenerative nervous system disorders in child age

Degenerative nervous system disorders are systemic diseases anatomically manifested in degenerative changes of the white or grey brain matter. In the case of these conditions, syndromes where entire cell and neural pathway systems are degenerated are distinguished from those where the process affects only cell structures. Degenerations begin at an early age and progress rapidly. Most of them have familial occurrence with dominant or recessive heredity.

Demyelinating diseases of the nervous system in child age

Demyelinating diseases of the nervous system belong to the group of diseases whose common feature is histiotropy, i.e. they are related to a particular tissue, to the white matter of the brain and spinal cord, causing the decay of myelin. Their de-

velopment is very rapid. Demyelinating diseases may be roughly divided into focal and diffuse. The most frequent focal demyelinating diseases are Morbus–Pelizeaus–Merzbacher and sclerosis multiplex. The most frequent diffuse demyelinating disease is encephalitis periaxialis Schilder.

Sclerosis multiplex is the most frequent disease to be encountered in social care institutions. Typical symptoms prevalently include parasthesias on the lower extremities, urination difficulties, hypokinesia in terms of parapareses or even plegias of the lower extremities. Speech is ataxic, affected with severe pareses of the orofacial system. Nystagmus and intention tremor are symptomatic.

Metabolic disorders of the central nervous system

Metabolic disorders of the central nervous system are diseases where a metabolic defect prevails in the clinical picture or is the main pathogenic factor. It is a wide group of conditions where absence of enzymes causes permanent and as a rule progressive condition of the central nervous system. Defects in metabolism of proteins, lipids and saccharides are distinguished.

Metabolic disorders of the central nervous system are manifested either by general symptoms or also by affected organs other than the brain, complications in basic metabolic processes.

Epileptic seizures

Epileptic seizure is an abrupt transient pathological brain condition manifested by sensory and motor symptoms. Pathogenetically, epileptic seizures are divided in two large groups – partial (focal) and generalised seizures.

Inflammatory conditions of the central nervous system

Brain inflammations caused by infections and affecting organism as a whole are concerned. According to the affected site, inflammatory diseases of the central nervous system may be divided into brain conditions (encephalitides), spinal cord conditions (myelitides) and conditions of their protective membranes (meningitides).

The symptoms include neck pain during movement, headache, fever and vomiting up to the damage of the nervous system.

Muscular conditions in the child age

Along with the conditions of other parts of the motor system (motor cells of the ventral spinal cord horns, nerve roots), the muscular conditions of the motor system are referred to as neuromuscular conditions. Muscle fibre conditions, so-called myopathies, include damage of the striated muscles.

The symptoms include gradual loss of muscular strength and mass, gradual immobilisation and inability of autonomous movement.

Vascular brain conditions

These conditions originate abruptly. Abrupt cerebrovascular stroke, brain haemorrhage and subarachnoid haemorrhage are discerned.

The cause of hypoxia, oxygen deficiency, is asphyxia during birth. Severe ischemias cause damage of brain vessels with subsequent haemorrhage into the brain tissue. These damages are the most common causes of infantile palsy, mental retardation and epileptic seizures.

Amputations

Amputations are performed when traumatic or pathological changes of the extremities deteriorate or threaten the life of the affected person.

Spine curvature disorders

Spine curvature disorders include lordosis (spine bending forward), kyphosis (spine bending backwards) and scoliosis (pathological spine bending to the side).

This disability is manifested by wrong stature and backache.

Congenital developmental disorders

Some developmental disorders are caused by a defect in the closure of the medullary tube, most often at its upper or lower end, most frequently diastematomyelia, the spina bifida and spina bifida occulta, congenital muscular atrophy – Oppenheim's disease, congenital deformations of extremities.

In the case of a physical disability, not only its severity but also the fact that people with the disability are fully aware of their situation needs to be considered. The manner an individual perceives her disability depends on his personal features, but to a degree also reflects the relationship of the society towards him.

The process of integration and inclusion of people with disabilities is in progress in our society. All types of schools are improving conditions for the education of students with physical disabilities, mainly by removing barriers, preparing individual educational forms, and the like.

Despite that, such students are not frequently encountered, mainly at universities. The cause lies in concerns lingering in these young people as well as in teachers who are underprepared and unwilling to accept specific procedures and needs required from their part by a specific disability.

Any young person answers the question of what he longs for most as follows:
1. to find a good life partner. 2. own self-realisation and a good job "I would enjoy."

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If we ask the same question any young person with special needs, the answer is: 1. to find a good life partner. 2. own self-realisation and a good job “I would enjoy.” The answer is always the same. The difference is in the actual possibilities such young people have.

The possibilities of young people do not differ in the material sense, something else is in question: several remarkable and simple facts related to young people with disabilities. For the most part, education as a part of their normal development is concerned, the process of forming their personality, the degree of their independence, their self-realisation, their real usefulness in professional terms, their attitude to culture, their social contacts, awareness of their own dignity.

The possibilities of young people with disabilities form their experience which in turn shapes their convictions about the perspective of their own life. Lack of education affects their prospects much more significantly than lack of education in the young people in general. Their chance to succeed is, as a rule, multiple times lower, yet at the same time proportioned to their education.

A story of Klára, 29 years

I met Klára when she was a ten-year-old girl. As a result of her infantile palsy, she had a severe physical disability and was confined to a wheelchair. She was very pretty. She studied well. She was responsible. Her classmates liked her because she always cared for others and helped everyone who needed her help. It was hard to notice the grief she had inside. After some time, we became closer and she told me. Her parents had just got divorced. The mother stayed with her and the father had found another family. He showed no interest in them. Asked, if she knew, why it was so, she told me: “That’s what worries me the most. It’s because of me.”

She finished her secondary school. For some time she lived with her mother but she was not satisfied with such life.

After a long deliberation she applied to study at a university. The best student in her year, she was still unable to accept herself. She lived in incessant doubt about herself, about the meaning of life.

After three years of study, questions without answers led her to the termination of her life.

A story of Jana, 50 years

Another story is that of Jana whom I met twenty years ago. Jana had gone through infantile palsy. As a result she found herself in a wheelchair. Every time I met this girl and her family I felt marvellous peace and serenity from their part. I would reflect on how it was possible that a young pretty person could live so happily and fully, although her world was confined to the dimensions of one house, where she, sitting in a wheelchair, accepts loving help from her mother and father. Whence these elder parents have this strength – to be joyous every day, to plan nice things,

to talk well about others, wishing them all the best, to be happy about other peoples' success. Acceptance I experienced in this family led me to searching for the answer to the question about the source of this positive strength that accepts everyone without any reservation despite a person's difficult health condition. It is not easy to accept a disability of one's own child, to come to terms with the fact that this child will never live the life of any other child in the neighbourhood, never will be able to choose a school she likes, travel and feel free, which is what every young person longs for. She will never be able to put on a beautiful dress and go dancing. In a parent, this must instil at least a feeling of anger or disappointment, which, however, I definitely did not perceive during my visits to them. Quite on the contrary, I could freely talk about my success or maybe complain about a perceived injustice and every time I left the place accepted and understood.

2.3 Visual Disability

Visual impairment is one of the damages called sensory disability. It affects 1.5 % of the entire population.

Definition of the visual disability

From the viewpoint of typhlopedics, a person with a visual disability is considered one who even after optimum correction (pharmaceutical, surgical, by means of dioptric spectacles, and the like) has problems in real life to collect and process information by means of sight.⁸

Visual acuity (the rate of sight sharpness) represents accurateness of visual differentiation. Both far and near acuity are measured.

For instance, the far acuity of 1/20 means that a person with a visual disability distinguishes at the distance of one metre what a healthy person does at the distance of twenty.

Near acuity is evaluated by numbers representing the letters in the diagnostic chart an individual is able to read.

According to the WHO, persons with a visual disability may be classified into the following four basic groups:

- *blind persons*, i.e. persons with complete loss of vision or persons able to perceive light without being able to determine its source;

⁸ Cf. VITÁSKOVÁ, K., LUDÍKOVÁ, L., SOURALOVÁ, E.: *Zefektivnění studia a profesního uplatnění handicapovaných studentů na vysokých školách*. Olomouc : Univerzita Palackého, 2003.

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- *virtually blind persons*, i.e. persons with some remaining vision able to perceive light or shapes of objects, but unable to use their sight in normal life, despite correction;
- *low vision persons*, i.e. persons with a severe visual impairment, but able to perform common actions with the remaining vision. They are not able to perform visual work;
- *persons with defective binocular vision*, i.e. persons with a visual defect causing problems with spatial perception. It is a defect in functional balance and physiological cooperation of the right and left eye.

The life of persons having a visual disability is aggravated by the problems resulting from their disability. The limitations are perceived with regard to the level and type of the visual disability. The main obstacles are twofold. First there are (physical) barriers precluding independent movement and orientation (no sound at pedestrian-crossing lights, insufficient designation of dangerous obstacles, absent leading lines and embossed markings and the like). Perhaps more relevant are the barriers in obtaining information (unavailability of common information in suitable format, being, for the persons with a visual disability, Braille, sound recordings or electronic versions of texts, or font size and type used in printed documents, signs, information tables, and the like).

In evaluating the level of a disability, an important criterion is whether the disability is congenital or acquired.

With congenital visual disability one adapts to different life conditions from childhood. Congenital visual disability means that other senses aiding in the perception of the world develop from one's birth. In a way, inability to compare the way of life with common visual control makes the acceptance of the disability easier. On the other hand, it is demanding on learning. From childhood, the social learning of the sightless people is hindered. A sightless person is dependent on the help of another person. That is why intervention aims rather at the family, close community. Integration into common society presupposes education aiming at the development of independence in everyday life. Such independence is a condition of independence in making decisions.

In the case of the acquired visual disability the situation is different. The main emphasis is on helping the person with the disability to cope with her new situation. The age the disability is acquired is also crucial. Acquired knowledge, experience, notions of life and of the environment one has lived in may be helpful in coping with the disability and integrating into society.

A story of Ján – 40 years

An ordinary boy from the country, taken far from the family by his visual disability, as he was able to study only at a special school. Afraid of the new environment, he would search for some certainty to help him. In a chance meeting,

he got acquainted with a group of young people who invited him to their circle. Together, they would talk about values, how nice it is to live for others and about the responsibility for those who are worse off than us. He thought it incomprehensible that someone could have a harder life than himself. Yet at other meetings he got acquainted with people with much graver problems than he had known. Young people without meaning of life. He met one of them who told him how desperately he lived. He listened carefully and felt very sorry for him in the inside. He would search for a way to help him. Unsuccessful, he found the courage to ask. His friend simply replied: you have already helped me, at last have I found someone to talk to who cares for me. You are more perceptive than anyone I have met yet, because I can see in your eyes you want to help me. Ján was surprised because he of course had barely any sight.

From that time on he has helped many people, quietly, discreetly. In his profession of a massager he listens to life stories of seemingly healthy people.

2.4 Hearing Disability

In terms of graveness, the hearing disability is ranked second by the World Health Organisation (WHO). In Slovakia, 5–7% of population is registered as deaf or hard of hearing. According to unofficial statistics, 90% of children with a hearing disability are born into a hearing family.⁹

Hearing disability is a result of an organ or functional defect in any part of the acoustic analyser, auditory pathway and auditory cortical centres, or of functional perception defects.¹⁰

Grades of hearing loss according to the WHO:

- mild hearing loss up to 26–40 dB;
- moderate hearing loss 41–44 dB;
- moderately severe hearing loss 56–70 dB;
- severe hearing loss 71–90 dB;
- deafness above 91 dB.¹¹

The disability is characterised by defects in the ability to hear speech. The grade of hearing impairment is not the only indicator of the graveness of the hearing disability.

⁹ Cf. ROMANČÍKOVÁ, M., SCHMIDTOVÁ, M.: Sluchové postižení. In: LECHTA, V.: *Základy inkluзивní pedagogiky*. Praha : Portál, 2010.

¹⁰ Cf. SLOWÍK, J.: *Speciální pedagogika*.

¹¹ Cf. FREEMAN, R., CARBIN, F. C., BOESE, J. R.: *Tvé dítě neslyší – pro všechny, kteří pečují o neslyšící děti*. Praha : FRPSP, 1992.

Getting to Know the World of a Person with a Disability

Hearing disability imposes limitations to the life of an individual. Those may be of different manner and level.

The primary and most important one appears to be the communication barrier which may impact the development of speech and limit the ability to understand others. A grave deficit is in the orientation abilities, such as spatial orientation, limited to the visual range. A mental load, called by some experts life in the “prison of silence.” A limited network of social relationships is predominantly caused by the problem with communication. Thought development is also severely limited, as a result of failure to develop the internal speech. The loss of the safety function of the hearing is a limitation which may expose a deaf person to a life-threatening risk. Sounds coming from the outside often alert to danger one needs to react to immediately, which imposes limitation in deaf persons due to the hearing loss.

A story of Šaňo – 12 years

Šano was born with a severe hearing disability. He attended a school for deaf children. He was a good student. He was also extraordinarily gifted to paint beautifully. He would hide this gift from his schoolmates. He did not belong to the posse of boys because he was could not adapt to their rough ways. Most of the time, he was diffident, watching everybody and everything. Often he was mocked and attacked by boys.

During one hike into a nearby forest directly crossed by a railway, Šaňo got lost. After a while of searching, he was spotted right on the track. A swift intervention of the attending nurse saved his life.

After this affair he confessed he decided to end his life because he felt alone. He longed for friends, but when he approached them, most of the time they would mock him that he was fat and could not run. The nurse reminded him of his gift of painting, but he saw even greater handicap in this, because the schoolmates would mock him even for that.

Hours of conversation between the nurse and the schoolmates ensued, resulting in their understanding of how they had hurt him. The nurse, who was able to understand Šaňo’s world and explain his feelings to his schoolmates in a suitable manner, built a bridge over which they approached each other. In a short time they made their schoolmate enter a young artist competition; and when Šaňo won a prestigious painting prize, he also lost the feeling of inferiority. Today, he works as a graphic designer.

2.5 Impairment of Communication Abilities

Communication ability of a person is impaired when any level of his language expression (or several levels at the same time) interferes with the communicative intent of the person.¹²

Damaged communication abilities may be manifested as a speech defect that is either congenital or acquired. In terms of speech therapy, the following kinds of communication ability damages are defined.

Damaged speech development

Damaged speech development means speech absence from two aspects. Either a developmental speech absence as an accessory symptom (most often as a result of a hearing damage, mental retardation or as a result of a central damage) or a developmental speech absence as the main symptom (caused by the pathology of the social environment).

Dyslalia

Dyslalia is an inability to use individual speech sounds or groups of them in the communication process. It is manifested by wrong pronunciation.¹³

Rhinolalia

Rhinolalia is manifested by a change in the resonance of the speech sounds. Closed rhinolalia is characteristic by pathologically reduced nasality and open rhinolalia is characteristic by pathologically increased nasality.

Mutism

Mutism is an inability to speak on the neurotic or mental basis. If mutism is confined to a particular person or situation, it is called selective mutism. If the neurotic inability spreads also to the area of hearing, it is referred to as surdomutism.

Stammering

Stammering is considered a syndrome of complex damage to the coordination of the organs which take part in speech. It is most conspicuously manifested by typical tonical or clonical disruptions of the flow of speech.

¹² Cf. LECHTA, V., a i.: *Diagnostika narušenej komunikačnej schopnosti*. Martin : Osveta, 1995; LECHTA, V., MATUŠKA, O., ZÁSZKALICZKY, R: *Nové cesty k postihnutým ľuďom*. Bratislava : Liečreh Gúth, 1997.

¹³ Cf. *Defektologický slovník*. Praha, 1984, p. 98.

Voice damage

The damage is manifested by pathological change in the structure of the voice – change of its acoustic qualities, the manner of producing and using voice, with accessory bruits or other sounds that may appear in the voice and reduce its quality, such as wheezing.

Aphasia

Aphasia is a speech damage affecting one or more components of the production and understanding of speech, caused by a local brain damage.

Developmental dysarthria

“*Dysarthria* is a complex pronunciation disorder (as opposed to dyslalia where damage only affects pronunciation of some speech sounds). Dysarthria occurs on various levels, from mild articulation damage, acoustically manifested only in some speech rounds (e.g. fricatives or trills), to severe damage where the speech is completely incomprehensible. Dysarthria is caused by a damage of the innervation of the articulation motor organs.”¹⁴

Dysarthria is not only the characteristic speech damage in the children suffering from the infantile palsy, it is also one of the most complicated and hardest to remove speech disorders known by the speech therapy. It is understandable if we remember that it is caused by the damage of innervation of the speech organs as a result of an organ damage of the central nervous system.

Dysarthria may be distinguished from various aspects, the most important being the site of the lesion. The level of localisation of individual dysarthrias depends on the range of the lesion in the central nervous system which may affect the motor systems to the point of complete inability to articulate which is referred to as *anarthria*.¹⁵

Communication – a Road to Mutual Understanding

The human spirit (transcendentality) is realised through language. It means, however, that a dialogue of at least two people is always concerned. Cooperation, social relationship of people is always necessarily preceded by communication.

Philosophy accepts the opinion that a human being becomes human only among people who address each other. In order to become a person, a human being necessarily needs to establish communication between Me and You. Individuals become persons if accepted by other people, encouraged to self-realisation, educated and

¹⁴ *Defektologický slovník*, p. 97.

¹⁵ Cf. LECHTA, V.: *Logopedické repetitórium*. Bratislava : SPN, 1990, p. 211.

expressed love. This is how people, consciously or not, are co-creators of human beings, including themselves.¹⁶

From the position of personal ontology it can be said that being has a personal profile and that as a consequence it can only be understood through dialogue, communication. Being is manifested in the attitudes of a person, or rather of a personality.¹⁷

A person with a disability able to express his feelings, to speak about the mistakes of others and defend himself through communication, achieves self-esteem on his own. Self esteem makes him confident about his perception and judgement. He believes he can achieve something. He believes in his truth and has the courage to express his opinions. He is willing to take on an active role. He is less anxious, less exposed to doubt. He has more possibilities to concentrate on good things and is eager to achieve them. This completes a beneficial circle which tends to maintain itself.

How can I help these people? By teaching them to communicate.

On the one hand it means to achieve technical mastery of speech. On the other, to teach them communicate in terms of “being able to tell,” to name their feelings correctly, not to be ashamed for them and not to be afraid to use their voice, so that other know how they feel. Finally, it means to teach them how to react to the problems of others, not to be afraid to speak their mind, join in a discussion even with a different opinion, to have one’s opinion. Such communication seems to be natural. Yet, the people working with persons with disabilities can tell that it is a complicated problem and an extremely important task to accomplish.

¹⁶ Cf. ANZENBACHER, A.: *Úvod do filozofie*. Praha, 1987, p. 205.

¹⁷ Cf. LETZ, J.: *Metafyzika a ontológia*. Bratislava : ÚSKI, 1993, p. 139.

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Approach to a Person with a Disability

“Once you notice a child is improving her self-perception, you will see he is also getting more successful. And more importantly, you will see a child that enjoys his life more and more.”¹⁸ This is how a well-known American author of popular psychological short stories has described the essence of one way of forming personality.

Why a Person Has Great Value

Both in the self-valuation of a person with a disability and in his valuation by the people around him, the perennial crucial question is the general reason for human value and dignity. Does this reason consist, totally or partially, in any fact related to the pre-eminence or advantages of a non-disabled person to the disabled one?

“Christ Jesus, Who, though he was in the form of God, did not regard equality with God something to be grasped. Rather, he emptied himself, taking the form of a slave, coming in human likeness; and found human in appearance” (Philippians 2:5-7, NAB)

This quote, in my opinion, contains the depth and essence of human value. The idea that God deemed human beings worthy that His Son should be like them, or in other words, that human beings should have the likeness of God as created in His image instils a deep and justified feeling of human worth. This entitles every human being not to have any doubts about his dignity, either on the objective or subjective side, manifested in a person’s self-esteem.

The entire spiritual evolution of a human being may be said to aim at the goal of his life through his participation in Christ who has already gone through such evolution process and reached its victorious end.¹⁹

Moreover, the fundamental meaning of the Incarnation is related to the Redemption of every human being without exception, not to mention the fact that particular attention is paid to those who have less opportunities to assert themselves.

Hence, the worth and dignity of a person are essentially not derived from any particular features or abilities of that person. Remaining on the positions offered by the Christian value system, the worth and dignity of a human being does not need

¹⁸ The author of the quote is Dayne Wayer, the author of popular short stories with the title *Chicken Soup for the Soul*, popular also in Slovakia. WAYER, D: *Slepačia polievka pre dušu*. Bratislava, 1994.

¹⁹ Cf. LETZ, J.: *Život v hľadani pravdy*. Bratislava, 1996, p. 181.

any further fundamental argument. In other words, we need to accept the idea that addition of some other criteria for such argument may often be an inadvisable social habit.

Personality of a Person with a Disability

In the previous section we approached the notion of a human person and the essence of his worth. Every human being has the same worth and chance to grow into a unique personality. On these grounds we will find the following considerations about a person born with a disability.

Due to a disability, a person is in a different situation. His personality is formed under unusual conditions.

Be one born with a disability or acquire it in the course of one's life, in any case, such person is confronted with a difficult life situation. Such situation often produces crises one needs to tackle.

In terms of psychology, life crises may be viewed differently. Life crises signify important life events, both positive and negative. They are usually understood either as something pathological or, on the positive side, as potential sources of progress in the development.

The former understanding examines stressful life situations as related to an illness or pathological manifestation. This school understands life crises only as something pathological and pointless. Since Freud, traumatic life events have been prevalently considered in terms of their negative impact on the development of a human being. As viewed by the psychoanalytical theories based on the homeostatic model, after a traumatizing experience an individual psyche returns to the previous tranquil state or a traumatic neurosis arises. Anxiety and intrusive thoughts related to the event persist, with the result of deterioration of personal mental wellbeing.²⁰

The latter understanding examines life events as related to further individual development. "Whenever we are confronted with a situation we cannot avoid, whenever we have to face an inexorable fate such as an incurable disease, we get an opportunity to realise the highest value and fulfil the deepest meaning hidden in suffering."²¹ According to this school, even in life crises one can find a positive potential to stimulate personal growth. Experience of a life crisis may result in a metamorphosis of the personality, its rebirth, adoption of new goals, new values, new life strategy and new self-knowledge.

Difficult life situations at certain stage of individual development include circumstances or tasks that require mobilisation and exertion of mental strength or

²⁰ Cf. JAFFE, D. T.: Self-Renewal : Personal Transformation Following Extreme Trauma. In: *Journal of Humanistic Psychology*, 25, 1985, pp. 99–124.

²¹ TAROČKOVÁ, T.: Životné udalosti ako aktuálna premenná v celoživotnej vývinovej psychológii. In: *Československá psychologie*, 34, 1990, 3, pp. 251–258.

adoption of certain knowledge, experience, skills and creativity to overcome, tackle or solve them.²²

In a person with a disability, this above all requires that he accepts his disability, realizes the difference resulting from his handicap and limited possibilities in society resulting from the unprepared environment he lives in. These and other facts have also negative effects on the person but at the same time they make a positive contribution to the formation of his personality. After all, the features of a personality are formed in rather difficult situations and circumstances that are often more suitable for the development of resilience. It is known that precisely persons with disabilities can stand difficult situations despite poorer biological conditions.²³

Overcoming difficulties requires much strength. Yet the strength necessary to overcome these difficulties is at the same time new energy forming a person and changing him in a different, more valuable personality. This fact is empirically undeniable. In this direction point the words of Pope John Paul II who addresses the people with disabilities: "We need you to teach the whole world what love is."²⁴

Characteristic features of people with disabilities are listed in many psychological and pedagogical studies. The most frequently mentioned feature is the inferiority complex. Then follow the feelings of isolation, loneliness and being different, manifestations of passivity and pessimism, inappropriate fear, reduced adaptability, great emotional swings and rather critical than friendly attitude towards others; emotionally „colder“ and critical distance from others.²⁵

It is very important to know all the problems and manifestations affecting the personality of a person with a disability. Still, only to a minimum extent does the literature define the positive features of people with disabilities. This conveys an impression that a person with a disability is automatically a rather problematic person.

Based on our experience, some of the positive features typical for people with disabilities include.

1. Reduced self-esteem caused by the disability. Yet with success achieved, their self-esteem rises significantly.
2. Feelings are manifested less, yet often experienced very deeply on the inside.
3. Joy of little things and of little gestures of attention.
4. Gratitude for slightest attention.
5. Reservedness in first contacts and problems making friends. However, if they trust someone, they are capable of having very close and lasting friendships and relationships.

²² KOŠČO, J.: Teoretické otázky systému poradenstva a psychológia v poradenstve. In: KOŠČO, J., et al.: *Poradenská psychológia*. Bratislava, 1987, pp. 7–73.

²³ Cf. KUBÍČOVÁ, Z.: Obtížné životní situace zdravotně a zejména tělesně postižených dětí a mladistvých. In: *Kritické životní situace dětí a mladistvých s tělesným a zdravotním postižením*. Zborník z konferencie Somatopedickej spoločnosti. Brno, 1995, pp. 7–16.

²⁴ JOHN PAUL II: *Christifideles laici*. Post-synodal Apostolic Exhortation of 30 December 1988, chap. IV.

²⁵ Cf. POŽÁR, L.: *Psychológia osobnosti postihnutých*, pp. 50–53.

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6. Solidarity with others and willingness to help.
7. Little activity in searching for possibilities and opportunities, such as job or social opportunities. Yet if given an opportunity, they are diligent and thorough in what they do.
8. A problem is they do not express their opinion. This is caused by their dependence on others which hinders them from expressing their opinions for fear of breaking the relationships with those on which they depend.
9. A significant positive feature of their personality is an ability to understand others and sympathize with their problems. This often translates into an extraordinary sensitivity and ability to express love.

In helping professions for the benefit of people with disabilities, one needs to take into account the entire personality of a human being. Physical as well as mental problems can be overcome only if one respects the entire personality.

4 Fundamental Principles of Helping Persons with Disabilities in Helping Professions

4.1 The Principle of the Therapist's Self-knowledge as a Fundamental Precondition of his Work

Every person has certain personal presuppositions to develop and realise. One has to discover them, get to know them and decide to use them. Observing the behaviour of a person in time we conclude that these presuppositions, their essence cannot be taken only in the static but also in the dynamic manner as a source of activities leading to self-realisation. Encountering in this activity equal spiritual and personal beings, one's development is conditioned by being addressed by another human being and by an ability to return such address. Only in a personal relationship one matures into full development.²⁶ One needs to keep in mind that such relationship is in a context of other relationships within a community where it acquires distinctive quality and that a relationship with an individual is a way to a broader community which in turn mediates relationships with individuals.

Healthy self-realisation in a relationship with another human being requires free acceptance of the other for his own sake. This is only possible if we do not resign from our freedom, personal presuppositions and the essence of our personality, but on the contrary, we develop them. Otherwise it would not be mediation but abolition of the moral value of self-realisation. It is a space where everybody decides for themselves and no one else is allowed to deny or constrain the possibility to do so. Nobody can resign from this possibility.²⁷

Based on these fundamental conditions of self-realisation in a community, the most important principle in helping others is that of the self-knowledge of the therapist.

A decision to work in a helping profession is really bold and very responsible. The work of this kind is a vocation with a deep meaning and great value for both the helped and the helper.

In a well-known biblical story a king counted the strength of his forces before going to war. Such counting of one's strength before every serious task indicates a responsible approach. Those who wish to help others need to weigh their ability to

²⁶ Cf. CORETH, E.: *Co je člověk?* Praha : Zvon, 1994, p. 159.

²⁷ Cf. CORETH, E.: *Co je člověk?*, p. 165.

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pursue the vocation in a helping profession. Several aspects need to be considered in the process.

Above all good self-knowledge. Such knowledge requires prolonged time and silence where one can find his hidden qualities, gifts and talents, but also fears. Confrontation of one's own self-perception with the view of another trusted person is very useful.

What can lead a person to the desire to work in a helping profession?

To give meaning to life, to do something that is considered praiseworthy, pity, desire to help the weaker, but also the necessity to find a job.

A genuine healthy relationship in a helping profession, especially in the work with people with disabilities, must be grounded on the utmost respect for the personality of a person with a disability. Every human being, including persons with disabilities, has a personality that is unparalleled and unique. The only difference is a physical inability to perform some activities.

What is the condition for a good preparation for helping people with disabilities? One needs to have solid knowledge about their diagnosis, their actual possibilities, where they need help but also what a therapist should not be doing for them. Where they need to be left independent and where they need to be directed and assisted.

It is important for a therapist to know the environment where one will work. This environment is specific in its aim and in many cases does not correspond to the ideal expectations of both the clients and those who work with them.

Every therapist should weigh all his personal gifts. He should bring his expectations in line with reality and make a decision on this ground.

The main motive for a decision to pursue a vocation in the field of care for people with disabilities should be the effort to be close to a person who needs it. A therapist should be helpful in the matters that persons with disabilities cannot handle on their own as a result of their disability. However, sufficient distance is necessary so that a client has the freedom to develop independently.

Everyone who works beneficially in this area is an example of a person who wants to "give", marking a sharp contrast to society based only on "having". Thus a therapist is becoming a bearer of the "quality of being", of new culture, the "culture of life" that embraces and respects every human being, lending him, as far as possible, a hand in solidarity.²⁸

²⁸ Cf. ĎAČOK, J., ŠOLTĚS, L., KLEPANEC, J.: *Etické aspekty práce s telesne postihnutými deťmi*. Bratislava : Ústav medicínskej etiky a bioetiky, 1997.

4.2 The Principle of Developing the Right Approach to One's Disability

Only rarely and reluctantly do people with disabilities talk about the way they perceive their disabilities. It is related to the fact that such people talk very little about themselves and their feelings in general, as indicated in the section about communication. It is too bold to define the problem of the relationship to one's own disability without consulting the people in question. Although these people are unwilling to talk about their disabilities, in close personal contacts one can learn about their feelings and maybe also help to direct them.

Story No. 1 – Janka. As a result of infantile palsy, little Janka has a severe physical disability. All her four limbs are affected so that she has to use a wheelchair and has a problem with the mobility of arms. Her best friend Jožka has a similar disability. However, Jožka has undergone operations that improved her condition and she began to walk with a support. Janka was offered the operation, too.

With joy she went through the operation, although it constituted a intensely painful surgery. Yet, the result was not good and Janka's condition after the operation deteriorated.

Prior to the surgery we would talk a lot together about how much she was looking forward to walking. (This is what she would like to experience in her life, to stand on her own two feet.) After an unsuccessful operation I was anxious to hear Janka's reaction: "Never mind it's gone wrong, maybe next time it'll work out fine."

Story No. 2 – Anna. Anna lives in the country with her parents. She uses wheelchair. She does not have any friends. She is very discontent. She blames her parents for insufficient care, relatives for not visiting her, but she does not do anything for that. Most of her time she spends reading magazines and listening to the radio. She does not like going out of her house. She "infests" the environment around her with nervousness and many people around her have already been affected by her pessimism.

Story No. 3 – Edita. Edita is a young woman. She lives at home with her family. She uses a wheelchair. She has many friends she likes to spend her time with. She attends various seminars; she educates herself and tries to affect her environment. If she cannot handle something by herself, she asks for help without hesitation. She is also able to accept such help as is sometimes offered insensitively or forcibly by tactless people. She says she understands them and is happy there is "good in people". And her disability? She only notices it when she realises she cannot go to the cinema because the lift is out of order.

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These life stories provide only a sketchy picture of the way children approach their disability. Yet they offer a more realistic perspective on this very complicated problem.

The attitude of a person to his disability can be characterized as a relatively stable manner the person knows and judges certain physical or sensory defect, how he lives it out emotionally and how he acts according to it.²⁹

In the past, the basic approach to this problem was direct: two extremes of an interval expressing the coping with the loss would be sought in the psyche of an individual – acceptance and non-acceptance.

Acceptance of a disability means cognitive, emotional and conative mastering of all life's possibilities and limitations related to the disability. It means adoption of all remaining possibilities and their realisation with regard to all the related limitations. Acceptance is understood as a condition of thorough healthy and active adaptation in the life of a person with a disability. The emphasis is on the active overcoming and coping with the defect and its consequences for life.

The line between the possibility and impossibility is always very fluid and many limitations can be avoided by creating alternative possibilities using personal creativity and compensational tools. There are many individual differences. From this aspect, the acceptance of a disability is understood as “sustained and internalised readiness of a person with a disability to continuously overcome the consequences of the defect and to produce motivation for related external activity.”³⁰

Non-acceptance is the opposite pole to the acceptance. Its manifestations are much more complex and diverse than those of relatively unambiguous acceptance. It is understood as “failure to accept and recognize life possibilities and limitations brought along by a disability”³¹.

- a) One refuses the disability, still struggling with its manifestations, not giving up, hoping for a change, for recovery.
- b) One accepts the disability resignedly, as a fact about which nothing can be done.
- c) One accepts the disability trying to cope with it in a positive manner, using one's strengths and knowledge as much as they are available.

Like everything in life, these views of the relationships to one's disability of course develop and change during life. The cause of their dynamics is maturing of a personality, changes in attitudes both of a person to society and of society to the person. However, the relationship to one's disability is to a great extent influenced by the child's parents and those in contact with him.

²⁹ *Akceptace vady jako produktu sociálních vztahů postiženého jedince*. Zborník z konferencie tyflogologickej spoločnosti. Praha, 1976, pp. 5–47.

³⁰ TAROČKOVÁ, T.: Smútkové poradenstvo ako vynárajúca sa oblasť psychologického poradenstva. In: *Československá psychologie*, 39, 1995, 3, pp. 229–240.

³¹ TAROČKOVÁ, T.: Smútkové poradenstvo ako vynárajúca sa oblasť psychologického poradenstva. In: *Československá psychologie*, 39, 1995, 3, pp. 229–240.

4.3 The Principle of Correct Acceptance of a Person with a Disability by his Environment

The closest people to everyone are their parents. Their attitude to the child in early infancy predestines much in the child's life. This attitude is particularly determining for a child with a disability since such child is, due to the disability, reliant upon the help of others, above all his parents.

Beyond dispute, the role of parents and family has a priority in the healthy development of every child. Even more important role plays the approach of the parents to their child who has a disability. From the beginning, such child lives a different life from his peers. He experiences less acceptance from the close and other people. Such child is less cuddled. Rarely does he experience spontaneous praise. Pity and acts of solidarity are something he encounters more often than admiration and expectations of activity.

The only fundamental compensation for this negative feature of their life can be a good harmonious family.

In our society there is a network of social institutions designed to serve children with disabilities. At the same time a network of new modern rehabilitation institutions is growing. Although their role is crucial, the fundamental condition for healthy development of a child is to be an outpatient in such facilities. In other words, the main setting the child should grow in is his family.

Yet the attitude of the parents to a child with a disability may vary, from excessive love to rejection of the child. The attitudes encountered are as follows:

- a) natural parental attitude (healthy support of the self-development of the child, ability to let the child go into the world),
- b) the attitude of excessive care (overprotective upbringing resulting from the feeling of guilt),
- c) first the attitude of excessive care, but, after failures, loss of interest in the child and his disability,
- d) the attitude of hate towards the child arising from the failure to handle one's own feeling of guilt,
- e) the attempt to use the disability of the child for the benefit of the parent,
- f) complete rejection of the child, resignation from parental rights.

These attitudes of parents to their own child result from the acceptance or non-acceptance of the fact that their child has a disability. These attitudes are also further affected by the feelings of guilt from which the parents suffer all their lives.

A serious problem needs to be emphasized here, one that appears in the attitude of a parent to the disability of his child. When a parent learns his child has a disability, a protective mechanism is triggered in him that drives him to use all available medical and rehabilitation means to remove the disability. In many cases, this effort may be partially successful after a long time. In the case of many diagnoses of total

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collapse of the mobility, e.g. infantile cerebral palsy, the disorder is only very rarely recovered from. If there is any improvement, it is only partial. That is why it is very important for parents to really know the disability of their child and accept his real prospect of recovery. If recovery is not medically possible, they should concentrate on the development of those capabilities that may be a way to the self-realisation of the child.

There is still a lot to be done in this respect. Society helps children with disabilities but it forgets those who provide security to the child, those who can best guide him, encourage him and make him ready for life. It is a very demanding task that lies on the shoulders of the parents of children with disabilities. As a rule, parents are ready to help their child. Still, it needs to be kept in mind that they also need help themselves. Above all to accept the disability of their child, to understand their role in the life of their child and to cope with themselves. Such help to parents should form a basis for helping their children who have disabilities. Working with parents may be often more useful for the child than many other social services, even those above standard. In other words, such services can make a positive and actual difference in the life of a child with a disability only if he feels security in the family which has accepted him correctly.

What is the relationship of the broader environment to a child with a disability? The answer to this question needs to be sought in the past, when society literally “sterilised” itself in this area by establishing special centres for the treatment, education and “disposal” of the people with disabilities. As a result, most people did not have a contact with people with disabilities, and when such contact occurred by chance, the reaction was usually excessively negative.³²

As a result of the isolation of people with disabilities from society, the attitude of broader environment to them has developed into:

- a) tolerance of people with disabilities,
- b) pity for their disability,
- c) self-realisation at the expense of the people with disabilities,
- d) rejection of the people with disabilities.

The healthy attitude we need to strive to achieve is that of partnership. We should take as a model those countries where a person with a disability lives a full fledged life. For instance, in Canada people with disabilities feel the state cares for them significantly. In addition, the way people with disabilities are referred to in this country is interesting: “physically challenged”. This also speaks about sensitivity and shared responsibility of the society for its people with disabilities. Both society and they actually feel the relationship to disability is a challenge. This challenge can

³² Cf. GÚTH, A.: *Etika vzťahov na rehabilitačnom pracovisku*. In: LECHTA, V., MATUŠKA, O., ZÁSZKALICZKY, R.: *Nové cesty k postihnutým ľuďom*, p. 85.

be seen everywhere but mainly in the attitude of non-disabled people to those with disabilities. They are accepted in a natural way and without restrictions.³³

One example for many speaks about an attitude of a society to its citizens with disabilities. In academic year 1994/1995 I met a fourth-year law student at the Ottawa University. His only difference was he had no arms and legs. He was tied to a wheelchair controlling it with his mouth and shoulders. During exams he worked with a computer which was his only advantage in the study. Otherwise his life was not any different from that of a common student. He would live in the dormitory, attend student events and drive his wheelchair through the university corridors without problems. He would laugh at the jokes of his colleagues and also entertain them himself. Everybody treated him in a normal way. He also acted confidently. He worked in the university radio studio preparing a program for his colleagues with disabilities of which there was a considerable percentage at the university.

What was the source of his self-esteem and normal attitude of his colleagues? The attitude to the people with disabilities based on the idea that every person has both assets and liabilities, which is not a reason for one-sided valuation for any human being. The environment in the school breathed this. At the university, everything is adjusted so that every student with a physical disability gets wherever a student without one does. No stairs; lift and corridor doors equipped with photocells, libraries adjusted for being used as simply as possible. Disability was taken into account everywhere and everybody accepted it in a natural way.

4.4 The Partnership Principle

In the work with a child with a disability one needs to take into account the child's physical possibilities and both intellectual and moral capabilities, being aware of his human dignity and the child's share in responsibility for the outcome of such work.

The above idea may be called the general definition of the term *partnership principle*. In this context we once more emphasize the insight of D. Wayer at the beginning of Chapter 3: „Once you notice a child is improving her self-perception, you will see he is also getting more successful. And more importantly, you will see a child that enjoys his life more and more.”

I have met a young man recently. He has a severe physical disability. His day starts with him waking up and having a breakfast; then he turns on the radio or a video. He has graduated from the secondary school and in my opinion his intellect is above average. When we talked about what he thought about his life he told me: “Life is no good.” He gave me a list of people who had not understood him in his life and had not given him an opportunity. Asked why he had not told them, he answered

³³ Cf. ŠMIDOVÁ, M.: Filozofia výchovy a vzdelávania v špeciálnych školách v Kanade. In: *Efeta* 6, 1996, 2, pp. 19–20.

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no one would have listened to him and understood him all the same. At the end he declared: "I do not want to live".

Thinking about this and similar young people I reached a conclusion, a principle that, in my opinion, is of crucial importance when working with children with a physical disability. *The integrity of a person is based on his awareness of his dignity.*

The environment always treats a person with a disability differently from his peers. He constantly needs to be subjected to various examinations. He accepts care from other people regardless of whether he likes it or not. Often he views many things differently than those who take care of him. Naturally, these people are interested in things they consider important. However, a person with a disability may not necessarily deem those things crucial. The fact he does not have the courage to talk about these things may be considered a serious problem.

Hardly anybody expects or requires help from such people. They are getting used to that help is provided only one-sidedly to them. Yet there might be someone else who may need help from them and persons with disabilities are actually able to provide such help. Logically, such people often suffer from feeling useless and this is a source of their lack of self-esteem. They need to be led to solidarity with other people either with similar or different fate. "It takes some time before a feeling of fellowship is born... Often we strongly resist to believing that we are invited to living for others. To belong somewhere means to forget one's self, one's independence..."³⁴

If little is expected from persons with disabilities in relation to other people, as little is expected from them in relation to themselves. They are not expected to struggle with their own problems. For society, the simplest solution is to provide them professional "full service". More effort would require drawing their attention to their capabilities to overcome obstacles, to have their plans and goals, to search for the solutions to achieve them; in brief, how to penetrate deeper into their capabilities and possibilities. For society, a task would automatically follow to make some room for them to overcome obstacles which clashes with insufficient patience in people and their unwillingness. In the case of people with disabilities, this problem is not addressed, partly because they are not the only concerned. It is a general problem of the entire human society. "All of us experience firsthand the sad effects of blind submission to pure consumerism: in the first place a crass materialism, and at the same time a radical dissatisfaction... deeper aspirations remain unsatisfied and perhaps even stifled."³⁵

Especially for people with disabilities it is of crucial importance to learn to help themselves to the greatest extent possible.

³⁴ VANIER, J.: *Porušené telo*. Bratislava, 1994, p. 64.

³⁵ JOHN PAUL II.: Encyclical *Sollicitudo rei socialis*. 30 December 1987, chap. IV.

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Based on my encounters with such people I have come to realize that if we look closer and deeper at these people, in addition to a disability that defines their problem, they always possess something extraordinary, exceeding the average. It can be a particular ability or quality.

The conviction of *exceptional gift* is true. People with disabilities do not live in a whirlwind of many events which may be a disadvantage for them. In any case, they are not overwhelmed by many sensations that, either by themselves or due to thinking about them, cause “exhaustion” of a human organism and trigger some protective mechanisms.

The simplest example may be a human face that affects the relationship among people in personal contact. Yet, as a result of his disability, a sightless person is able to sense the interior life of another person more deeply.

The space that is not filled with a lot of sensations and information can be used to the advantage of the people with disabilities. The ancient and Christian thought recognizes a person with a disability as one who, as a result of his disability, is unique and thus esteemed in a certain field. In general, a person with a disability has an exceptional ability to listen, understand, make decisions and see things in their simplicity. I remember how my friend with a physical disability, who has never studied psychology, in one case discovered certain causes of the behaviour of my children, only with the depth of her insight, and helped me in their upbringing.

Help to the people with a disability should consist in that we help them discover such exceptional gift in themselves. Awareness of such gift means awareness of one's value. Thus a person with a disability gains at least some level of confidence that he possesses something what both he and the people around him can admire, something that is admirable. What is important here, awareness of a certain discovered capability helps discover further capabilities and possibilities and to actually count on them. One is encouraged to exercise such capability, to be responsible for oneself. As a result, one also has a reason to cooperate, seeing that one is capable of affecting the quality of one's life.

The essence of the partnership principle: A therapist, knowing what a person with a disability needs to have corrected, identifies his resources and capabilities. A person with a disability, feeling responsible for himself and for others, understands where he can help himself and others and searches himself for the means to achieve this goal and tries to use them.

5 Complex Rehabilitation – a Condition of Comprehensive Assistance to People with Disabilities

Purpose and Content of the Complex Rehabilitation Care

The *purpose* of the complex rehabilitation care is social integration or re-integration of a person with a disability to society, to a life acceptable for him.

It depends on several factors, mainly on the type and level of disability as well as on the fact, whether a congenital or acquired disability is in question. These criteria affect the means and methods selected for the assistance.

The *content* of complex rehabilitation care is made up of four basic components and in Slovakia it can be carried out in Community centres.

Complex rehabilitation should include medical rehabilitation, educational rehabilitation, vocational rehabilitation and social rehabilitation.

Medical Rehabilitation

The term medical rehabilitation has two meanings: medical rehabilitation in a broader and narrower sense.

Medical rehabilitation in the broader sense is understood as the entire health care for disabled and debilitated persons. Its aim is to cure the disease or to improve health condition, to remove or alleviate an organ or functional defect and to establish favourable physical conditions for social inclusion of an individual.³⁶

It is represented by diagnostic activities encompassing the procedures related to establishing correct diagnosis, treatment program, priorities and procedures in neurological, surgical, orthopaedic, prosthetic, diet, physical, motility and psychotherapeutic treatment.

Complex rehabilitation in this field is provided by physicians specialised according to medical branches, nurses, rehabilitation nurses, laboratory personnel and allied health professionals.

In this context the fundamental bioethical principles should be mentioned that need to be adhered to by all health personnel.

³⁶ Cf. KOLLÁROVÁ, E.: *Základy somatopédie*, pp. 21–25.

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The fundamental principle is that of autonomy, being the right of the patient for self-realisation and his own identity. Other principles include beneficence, i.e. the duty to work for the wellbeing of the patient; non-maleficence, the duty not to harm the patient; truth-telling, i.e. duty to tell the truth; confidentiality, the right of a patient to manage information about himself; and justice, meaning justice in the distribution of goods and services and quality control.

In many situations, the application of these principles is not conflicting and ethical decision-making is straightforward. However, there are situations where a conflict between two or more principles arises, giving rise to ethical dilemmas. Ethical dilemmas may occur when a health professional should strike a balance between the moral responsibility towards his patients and the conflicting responsibility towards society.³⁷

On 28 October 1993, The Standard Rules on the Equalization of Opportunities for Persons with Disabilities Standard Rules were adopted by the UN General Assembly. According to these Rules the term “complex rehabilitation” was replaced by the term “rehabilitation”. Specifying this term further, the Rules define the rehabilitation process as not involving initial medical care. It should include a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.³⁸

Medical rehabilitation in the narrower sense entails a complex of medical procedures in the field of rehabilitation.

Rehabilitation physician assesses the condition of a patient and establishes a rehabilitation plan containing rehabilitation procedures. Such specific rehabilitation procedures are performed at workplaces with special equipment. Those include either rehabilitation facilities in healthcare and social care facilities or rehabilitation institutions, spas and convalescent homes.

The most elaborated medical procedures include physiotherapy, kineziotherapy and ergotherapy.

Physiotherapy, also called physical therapy, represents a set of procedures using natural agents for medical or curative purposes. Physiotherapy is also understood as a general term embracing kinesiotherapy and ergotherapy, as well as one including such kinds of procedures using agents such as electricity, heat, water, radiation, air and others. These are called electrotherapy, acoustotherapy, thermotherapy, hydrotherapy, balneotherapy, phytotherapy, climatotherapy.

Kinesiotherapy (gr. kinesis – movement) is a therapy based on movement. It is important not only from the aspect of development of mobility but also from the aspect of the influence on other organs.

³⁷ Cf. PULLMANN, R., ŠOLTÉS, L.: Etické aspekty skríningu Alzheimerovej choroby. In: *Medicínska etika a bioetika*, 1996, 3, pp. 1–3.

³⁸ Cf. *Štandardné pravidlá pre vyrovnávanie príležitostí pre osoby so zdravotným postihnutím*. Schválilo Valné zhromaždenie OSN 28. októbra 1993. Praha, 1993, p. 12.

This group also includes curative physical education and hippotherapy. It is a curative rehabilitation, relaxing and educational method based on a neurophysiological principle. This method rests upon the symbiosis of the movement of an animal and of a human being. It helps children with physical disabilities to internalise perceptions resulting from movement since early childhood and to gain reflections supporting further curative process.³⁹

Ergotherapy (gr. ergon – work) uses work or some activity as a means of therapy. It may be aimed at fitness – fitness ergotherapy, ergotherapy targeted at an affected area, ergotherapy targeted at finding a job and ergotherapy targeted at education to self-sufficiency.

In this context it needs to be noted that it is necessary, at least for the persons with a physical disability, to undergo treatment in rehabilitation spas at least once in a year. It also needs to be realised that teachers at schools do not understand this matter correctly and often deem the absence from school during the treatment (although substitution education is provided) as a cause for taking off the marks of the child with a physical disability. It is a preconception regarding the quality of the substitution education during treatments.

Educational Rehabilitation

This component of the complex rehabilitation care includes the field of education of children with disabilities in their early life. Education in this period is provided by special pedagogues. These specialists make use of specific pedagogical procedures, methods and techniques aiming at the support of treatment.

According to their specialisation, individual educational fields are called as follows:

Somatopedics or pedagogy for people with physical disabilities is a branch of special pedagogy dealing with education of people with a physical disability, diseased and debilitated patients. In a broader sense, it addresses the issues of education of children and youth in all age groups as well as adults in need of special care as a result of their physical disorder, disease or debilitation. It forms a theoretical basis for special education of the three categories of people with disabilities. Somatopaedics deals with the people with disabilities in all the three categories, i.e. people with physical disabilities, diseased and debilitated people.⁴⁰

Psychopedics or pedagogy for people with a mental disability is a branch of special pedagogy dealing with education of the people with mental disabilities.

Typhlopedics or pedagogy for the people with visual impairment is a branch of special pedagogy dealing with education of the people with visual impairment.

³⁹ Cf. BOSKOVIČOVÁ, K.: Nadácia Hipoterapia Hipológ. In: *Rehabilitácia*, 3, Bratislava, 1993, p. 158.

⁴⁰ Cf. KOLLÁROVÁ, E.: *Základy somatopédie*, p. 7.

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Surdopedics or pedagogy for the people with hearing disability is a branch of special pedagogy dealing with education of the people with hearing impairment and hearing loss.

Speech therapy deals with all kinds of impaired communication ability and at the same time impaired communication ability as a result of another primary disability.

Previously, education of children with disabilities would take place exclusively in special schools established for the purpose. These were special facilities providing complex care to those children. In most cases the facilities were boarding schools. They were attended on a daylong, weeklong or yearlong basis.

Special schools represented a considerable investment into professional staff, obtaining professional knowledge, educational materials, premises and equipment. In fact, many special schools became centres of professional knowledge, specialisation and basic equipment of which there is shortage in common schools. Yet, a negative feature of these facilities was their low effectiveness in the field of education aiming at the development of non-cognitive functions and processes of personality due to a great number of children.

Recently, the idea of integration has been gaining momentum in our country. It consists in education of people with disabilities in common local schools. At the same time, there is a trend of supporting young people with disabilities to attend secondary and higher schools. This requires creating possibilities for their education.

In Slovakia, this process is represented by the initiative of the Ministry of Education of the Slovak Republic to establish Council of the Ministry of Education for the Support of the Study of Students with Specific Needs. It is a new impulse towards integration. This trend has been supported by many national and international movements.⁴¹ The Convention also defines the term “people with specific needs”. This term is also used in the development of legal documents.

Young people with specific needs have limited possibilities to establish themselves in professional or personal life. One way to help them to the full development is study at a higher education institution. Legal conditions established by the Slovak republic for the students with specific needs regarding the possibility of their higher education. The measures taken by the state should help young talented people with specific needs to receive appropriate education in order to be able to use their potential to their benefit and that of society. A disability is a limitation of possibilities the state is obliged to remove and thus equalize opportunities and conditions. It is obliged to do this also by a complex universal international legal instrument for the protection of the human rights of people with disabilities, the *UN Convention on the Rights of Persons with Disabilities*. Its actual fulfilment can help people with

⁴¹ Cf. HEGARTY, S.: Špeciálna pedagogika v Európe. In: LECHTA, V., MATUŠKA, O., ZÁSZKALICZKY, R.: *Nové cesty k postihnutým ľuďom*, pp. 27–30.

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specific needs to live a meaningful life, develop their gifts for others and strengthen a feeling of their own dignity.

Along with other documents and political decisions, including signals from the organisations of people with specific needs, the process of implementation of the Convention in Slovakia has supported public discussion about helping people with specific needs. In the area of education in Slovakia, preparations have been made by means of § 100 of Act No 131/2002 Coll. on Higher Education and Regulation No. 458/2012 Coll. on Minimum Claims of a Student with Specific Needs for real support of a students and applicants for study with specific needs. In order to fulfil their needs, consistent implementation of the above norms needs to be ensured by their further specification in the internal arrangements of individual higher education institutions. Such arrangements should establish admission conditions for applicants with specific needs as well as study conditions for students with specific needs.

The underlying assumption of the above conception is that in compliance with the legal principle of equality in the access to education, higher education institutions should provide generally accessible academic environment by creating adequate admission conditions for applicants with specific needs and adequate study conditions for students with specific needs without relaxing requirements for their performance during admission or study.⁴²

For comparison, pursuant to the Convention Article 3, the Convention is based on several principles that include chiefly *respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons, non-discrimination, full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women; respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities*. Particularly the Convention Article 24 on education gives this conception a more concrete shape, which forms a basis for the wording of both Act § 100 and the Regulation.⁴³

⁴² §100 sect. 1 Act. No. 131/2002 Coll. on Higher Education and on Alterations and Amendments to some Acts.

⁴³ The Convention Article 24 reads: *1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and life long learning directed to: a) the full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity; b) the development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential; c) enabling persons with disabilities to participate effectively in a free society. 2. In realizing this right, States Parties shall ensure that: a) persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability; b) persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live; c) reasonable accommodation of the individual's requirements is provided;*

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From the Act § 100 one can make a picture of the requirements for internal arrangements of a higher education institution about the status, duties and rights of applicants and students with specific needs.

Internal arrangements of higher education institutions establishing the status, rights and duties of applicants and students should be binding for all students and employers of every type of higher education institution. Definition of an applicant or a student with specific needs is a fundamental norm. Pursuant to the Act, such applicant or student is considered a person with a physical, sensory or multiple disability, with a chronic disease, debility, mental disorder, autism or other pervasive developmental disorder or learning impairments applying for a study or studying at a higher education institution who agrees with evaluation of his specific needs and has provided for this purpose a medical certificate, not older than three months, which may be predominantly a medical finding, report on the course and development of a disease and disability or an extract from the medical records or a statement of a psychologist, speech therapist, school psychologist, school speech therapist or a special education teacher.

Pursuant to the second sentence of the Convention Article 1, *Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.* Although not identical with the definition in § 100 of the Act, this conception is not at variance with it.

Every higher education institution should keep records of all students with specific needs. Such records should be kept by the university coordinator; individual faculties should keep their own records by respective faculty coordinators. The re-

d) persons with disabilities receive the support required, within the general education system, to facilitate their effective education; e) effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion. 3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including: a) facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring; b) facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community; c) ensuring that the education of persons, and in particular children, who are blind, deaf or deafblind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development. 4. In order to help ensure the realization of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities. 5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

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cards need to include the following student-related information: name and surname, surname at birth, date of birth, personal number, place of birth, permanent address, correspondence address, faculty, field of study, year of study, grade of study, form of study, type and extent of the disability, disease, debilitation or impairment and specific needs, provided supportive services, data of the assistant, data of the person who is informed in case of necessity and the telephone contact at the student and her assistant.

Arrangements related to the supportive services for students with specific needs should be provided by a higher education institution according to the extent and type of the specific need of the student, at least to the measure established in the Regulation. Application for supportive services should be filed exclusively by students with specific needs. They can use these services but without relaxing the requirements for study performance.

Another requirement is to ensure accessibility of all the academic premises. Educational process should heed future possibilities of a student with specific needs to establish himself in her vocation. In addition, an institution should also provide counselling to applicants with specific needs so that they can make a responsible decision related also to the job outlook after finishing the studies. All these matters should be made public through an easily accessible web site of the institution.

All the rights of students with specific needs should be established in the internal arrangements of respective higher education institution. Accessible and goal-oriented electronic tools (adjusted hardware and software) should be provided to the students by their schools. A student with specific needs also needs to be awarded social scholarship even after standard study time is exceeded provided that it is caused by the disability. A higher education institution should also ensure that students with specific needs have representation in its academic bodies and associations.

A higher education institution should employ a coordinator for students with specific needs appointed and removed by its statutory body. A condition for the appointment of the coordinator for students with specific needs should be adequate education (a diploma in the field of special pedagogy, psychology, social work) and experience in the field. According to the law it would be appropriate if each faculty had a coordinator for students with specific needs.

The coordinator should take an active part in identifying students with specific needs at the school, evaluating their specific needs, the extent of adequate supporting services and should participate in their provision. His duties should also entail ensuring cooperation with individual bodies of the educational institution, with its

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employees and students, mainly to educate them in this area and to provide them information and counselling related to specific needs of students. In addition, he should suggest and implement educational activities at the university leading to the understanding of the approach to students with specific needs based on their worth which is not defined by their abilities but flows from the assumption of the objective value of a human being; in this sense, he should initiate scientific events, issue publications and practical clinical activities. In drafting the budget of the institution he should submit proposals for using financial means to support the study of students with specific needs, chiefly material supplies and equipment. Pursuant to the law, an annual report on the conditions of using supportive services should be also submitted to the management of the educational institution by the coordinator and mutual interconnectedness and information with other higher education institutions, universities, the ministry and non-governmental organisations ensured within his competency for the benefit of care for students with specific needs.

Students with specific needs that result from all kinds of disability, disease, debilitation or impairment should be granted and ensured by the higher education institution all spatial, material and study rights enacted by the Regulation. Arrangements related to the content, form and the manner of ensuring these rights should be in the competency of the coordinator. All the decisions of this kind should be also recorded and reported to the management of the educational institution that should ensure the implementation of the decisions made. In addition, a student with specific needs should have a right to apply for reassessment (change) of his status and the scope and content of provided supportive services. A suitable time for such reassessment is the period prior to the beginning of a semester, yet in justified cases a student with specific needs should have the right to use such possibility also during a semester.

A student with specific needs should have the right to borrow publications from the university library for an extended period of time. According to its managerial and technical possibilities, a higher education institution should ensure lodging in preference for students with specific needs at their request in a suitable location accessible according to the type of the specific needs, furnished in compliance with the applicable standards for the lodging and movement of persons with limited mobility and orientation. A higher education institution should also ensure that students with specific needs have free access to boarding and reserve parking places at the request of a student with specific needs.

Implementation of the Convention is but the first step on the road to the acceptance of the people with specific needs. The barriers present are not merely physical. Overcoming them is a task that requires understanding and acceptance.

As a part of complex rehabilitation in every age, from childhood to adulthood, from the grammar school to the graduation from the secondary or higher school, educational rehabilitation represents one of the fundamental conditions of fulfilling the duties of society towards these people. At the same time, society can benefit from a strong potential of the people who might have disabilities, but their gifts and talents are exceptional.

Vocational Rehabilitation

This part of complex care for people with disabilities includes their finding a job. The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the UN General Assembly read: “States should recognize the principle that persons with disabilities must be empowered to exercise their human rights, particularly in the field of employment.”⁴⁴ In the spirit of these rules every society is obliged to create favourable circumstances for vocational integration of people with disabilities. It presupposes vocational preparation in the form of education, training and mediating appropriate job offers.

To make jobs suitable for people with disabilities, appropriate preparation and designing of job offers and working conditions is required.

Employers should make use of the offer of the state to employ people with disabilities under advantageous financial conditions. This offer is rarely accepted by the employers due to a negative attitude and prejudice about people with disabilities.

In many cases it is desirable that people with a disability which is significant and does not allow them to commute could work in the domestic environment, if possible.

In the developed countries, special attention is paid to the vocational rehabilitation of such people. Above all preparation for a suitable or substitution job of a person who wants to use his strength for the benefit of himself and that of society is concerned. In Slovakia, we are also approaching this model. New specialised centres with this aim have been created recently. Those include sheltered workshops that are supposed to be a preparation for a real employment.

Similar in nature are new social-rehabilitation centres. The goal of this integration model is to make use of the gifts and talents possessed by a young person with a disability giving him an opportunity to develop them. Examples include improving one’s computer skills or intensive language courses. If a person with a disability wants to assert himself on the labour market, he has to be better than the others in some respect. In addition to demonstrating his professional skills in the given field,

⁴⁴ *Štandardné pravidlá pre vyrovnávanie príležitostí pre osoby so zdravotným postihnutím The Standard Rules on the Equalization of Opportunities for Persons with Disabilities.* Schválilo Valné zhromaždenie OSN 28. októbra 1993. Praha, 1993, p. 24.

he also has to dispel the doubts of the environment. To do this, he needs to exhibit superior skills to those of the people without disabilities.

Solving the problem of vocational self-realisation of people with disabilities would make a significant contribution to the increase of their self-valuation and confidence which would be, in a way, a compensation for their disability.

Social Rehabilitation

Social rehabilitation includes a range of areas in the life of a person with a disability within the society he lives in.

The most fundamental desire of most people with disabilities, both children and adults, is to achieve the highest level of independence possible. This desire can be fulfilled only in the circle of people who understand it, try to support it and create conditions for their realisation.

At the time when a child is growing up, a young person with a disability has his own ideas of independence, much like any young person. These include mainly the possibility of separate lodging. That requires building of suitable premises by society – accessible flats under reasonable conditions.

An interesting form of help towards independence is the project of “Personal assistance”⁴⁵. Its broad implementation is a suitable means of achieving independence as it provides possibilities for greater participation in the life of society.

Recently, a possibility has emerged mainly for the people with physical and sensory disabilities to use special taxis, payment for which can be made by means of coupons obtained in a certain foreign aid program.

After finishing compulsory education there are situations in the lives of the people with disabilities that they are not able to use their time in a useful way. A solution proposed by a Children’s club Slniečko in Košice, opened on 22 August 1996, built and furnished from gifts, may serve as a model. In this club, younger people with a physical disability are offered a possibility of education, requalification, social contact and rehabilitation outside the time spent at school. The same applies to other people with physical disabilities at any time.

Early Intervention

Early intervention is an important element of the complex care. It represents an independent field of care for children with various developmental disorders and

⁴⁵ Personal assistance is a project brought into Slovakia from Sweden. It is a system of helping people with disabilities to integrate into society. Personal assistants, selected by the people with disabilities themselves, perform services according to their wishes. It is experience of the author, gained in the contact with the people using such services.

disabilities as well as for their families, in the period of the first years of their lives prior to their attending a pre-school or school facility. It is an interdisciplinary care consisting in diagnostics, rehabilitation, counselling and therapy.⁴⁶

The term early intervention is used globally (frühförderung, rane intervencije, raná péče) for therapeutic, educational and socialisation measures and programs aimed at the above category of children and their families. Their purpose is to integrate the family and to minimize the consequences of a disability on the development of a child. Early intervention is characteristic by having the entire family for its client and being provided predominantly in the natural environment in cooperation with the health care system.⁴⁷

A summary study *Early Childhood Intervention*⁴⁸ speaks about the importance of the ecological-systematic approach which is currently widespread and can be considered a referential framework also in the early intervention. It is also a foundation for definitions that emphasize the key role of the family as a crucial factor for the success of early intervention. A group of professionals contributing to this study stresses that the goal of early intervention is to ensure and support development of a child, strengthen the competence of the family and support the inclusion of the family and the child to society, with the services provided in the natural environment of the child, on the local level, if possible, and the work is performed in a team, on several levels with focus on family.

Most European Union countries have not only acknowledged the need for early intervention, but have also taken necessary steps to perform it by creating a supportive set of services for its functioning. In some European countries the services related to the care for a child with a disability and her family are financed by the state and provided in an ambulant and outpatient form in early intervention centres from the birth of a child. An interdisciplinary team in such centres is chiefly made up of a medic, a psychologist, a social worker and a pedagogue and this system ensures good exchange of information among the professionals.

The amended Act No. 448/2008 Coll., effective since 1 April 2014, in paragraph 33 defines early intervention services that are provided to a child until the seventh year of life if his life is threatened as a result of a disability.

Many European states realize the effectiveness of the early intervention programme which is very important on all the levels of prevention, primary, secondary and tertiary.

⁴⁶ HORŇÁKOVÁ, M. 2010. *Včasná intervencia orientovaná na rodinu*. Bratislava: Univerzita Komenského, 2010. 260 p. ISBN 978-80-223-2915-6.

⁴⁷ HRADILKOVÁ, T. et al. 2012. *Naše cesta. Metody práce s rodinou v rané péči*. České Budějovice: Středisko rané péče SPRP, 2012. 55 p. ISBN 978-80-87510-20-9.

⁴⁸ EUROPEAN AGENCY FOR SPECIAL NEEDS AND INCLUSIVE EDUCATION. 2005. *Early Childhood Intervention: Analysis of Situations in Europe - Key Aspects and Recommendations*. [online]. [accessed 2013-06-22]. Available online: <<http://www.european-agency.org/publications/ereports/early-childhood-intervention/early-childhood-intervention-analysis-of-situations-in-europe-key-aspects-and-recommendations>>.

In the Slovak Republic, the 2008 – 2015 National Programme of Children and Youth Care informed that no particular programme for the support of community care for mother and child had been adopted. Although early intervention has legislative support in our country as a result of the adoption of the amendment to Act No. 448/2008, it is not systematic and sufficiently staffed. Currently, it is rather supported by a system of counselling centres associated with special schools and educational institutions. First outpatient facilities for early diagnostics and therapy are cropping up, being professionally oriented mainly on impairments and training of parents in individual particular therapeutic techniques. Our facilities lack services of professional teams and the ambulant forms of care are nearly totally absent.⁴⁹ Psychological and spiritual support of families is even less developed.

Functioning early intervention centres in Slovakia are created only with the support of predominantly non-profit organizations. The Act on social services does not include the complex form of care for the family of a child with a disability. Such assistance to a child with a disability in his natural environment should be provided in our social care system in the form of ambulant social service. Such service may provide assistance to parents as early as from the birth of the child. In reality, however, the ambulant form of social services of the family of a child with a disability is not being provided in Slovakia. Research conducted in the territory of Slovakia has shown urgent need for such service in the families where a child with a disability is born.⁵⁰

An important part of the early intervention service needs to be its provision in home environment, the environment of the child, and its client to be the entire family. Consultation in the family allows individual approach and is important for both parents and the child.⁵¹

According to the European Agency for Special Needs and Inclusive Education⁵² the common features of early intervention services include availability to ensure that families in need are reached as early as possible, not only in cities but also in the country. Proximity in the sense of the provision of services either within the community or directly at home and proximity in the sense of understanding and respecting the needs of the family. Affordability of the service to families. In most countries financed from the funds of the Ministry of Health, Social Affairs and Education, or insurance companies and non-profit organisations. Interdisciplinary working, which

⁴⁹ HORŇÁKOVÁ, M. 2010. *Včasná intervencia orientovaná na rodinu*. Bratislava: Univerzita Komenského, 2010. 260 p. ISBN 978-80-223-2915-6.

⁵⁰ GREGOROVÁ, M.: *Sociálna práca zameraná na podporu rodiny s dieťaťom so zdravotným postihnutím. Diplomová práca. VŠ sv. Alžbety, 2013.*

⁵¹ HRADILKOVÁ, T. et al. 2012. *Naše cesta. Metódy práce s rodinou v rané péči*. České Budějovice: Středisko rané péče SPRP, 2012. 55 p. ISBN 978-80-87510-20-9.

⁵² EUROPEAN AGENCY FOR SPECIAL NEEDS AND INCLUSIVE EDUCATION. 2005. *Early Childhood Intervention: Analysis of Situations in Europe - Key Aspects and Recommendations*. [online]. [accessed 2013-06-22]. Available online: <<http://www.european-agency.org/publications/ereports/early-childhood-intervention/early-childhood-intervention-analysis-of-situations-in-europe-key-aspects-and-recommendations>>.

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means that professionals providing support to the families work in various professions and thus interdisciplinary cooperation facilitates sharing information among the team members. Diversity of services results from the involvement of three areas: health, social services and education.

Taking into account the results of the analysis in the above study conducted in several European countries the following recommendations follow:

In the area of availability it is recommended to establish a systematic early intervention conception on local, regional and national levels with the support of policy measurements, ensure availability of information and clearly define the target groups.

To ensure proximity of services, information needs to be obtained about the conditions of the family and its social environment directly in the natural environment of the family with respect to the needs of the family and the child.

Affordability regardless of the socio-economical background of the family which implies that all early intervention services should be financed from public funds.

Cooperation of the professionals with families should be ensured, the families being their main partner. Such cooperation should be initiated by the professionals. The professionals should be able to work in team; the transfer of information must be functional and smooth, common further on in-service training needs to be organized.

In order to ensure quality services, the stability of team members is necessary. Diversity in the sectors ensuring early care should not exclude a certain measure of responsibility of the health, social and education sectors.

When parents obtain information about the opportunity of early care assistance, an adviser will be assigned to them in an early care centre to guide the family and mediate contact with other professionals.

Another form is walking a parent to a physician or other institutions and compiling reports and supportive statements for the family. Centres organize both individual consultations and common activities, seminars with professionals, meetings of parents or week-long courses for families. They may also lend special toys and aids children may try out or adults get inspiration from. Aids, toys and literature are brought by the adviser both for consultations and to the family.

Early intervention provides information, professional care and counselling in managing care for a child with a disability. The best way to help a child is to empower the entire family. The professionals meet the needs of both individual family members and the family as a whole. They need to know well how to engage the parents and how to work with them, how to plan the services, set and time goals. Then need to pay attention also to both parents and siblings or other family members and to know how to work with them. To coordinate care for the family with other institutions or services, mediate contact with other parents with similar problems, help parents to gain informal support in the municipality or in the close neighbour-

hood.⁵³ This poses a serious challenge to the Church which can play a vital part in the process.

As many as 6% of pre-school children in the EU are affected by grave developmental threats due to health and social disadvantage (ECI 2.0, 2010).⁵⁴

Early intervention is important both from the professional and social aspects. It aims at supporting and strengthening the child, family and the services that mediate help. It has its share in creating an open and well-knit society aware of the rights of children and their families. After a discussion going on for several years and involving the entire society some changes managed to be put into the Act on Social Services that are related to the legal support of early intervention.

Trying to understand the problems of the family, its life, living out and relationships, one needs to focus on the specific problems one of which undoubtedly is a disability in a family.

The contemporary modern times brings many new, not always positive views of life and family. On the one hand, it has liberated people from the ties to the extended family and community, but on the other it has compartmentalised human life to areas controlled by bureaucratic apparatus that weakens the competence of contemporary family. The features of today's family include increased dependence on the state, increased independence on the circle of relatives and increased independence of the spouses on the family.⁵⁵

A birth of a child with a disability makes a family different from other families. This difference involves all its members. It takes on a different social identity, the lifestyle of a family changes, as well as the behaviour both within the family and outwards towards society.⁵⁶

The birth of a child with a disability as an unsuspected and unexpected event in a family represents an extraordinary burden for the parents of the child. The family goes through a life crisis associated with a painful feeling of unsatisfied expectation of a birth of a healthy child. For the parents it is one of the gravest life crises because it immediately involves their child, the most vulnerable aspect of their life. It is a disappointment for them, associated with anxious and hopeless feelings. They go through a crisis of parental identity and they face a task to accept their child the way he is.⁵⁷

⁵³ HRADILKOVÁ, T. et al. 2012. *Naše cesta. Metody práce s rodinou v rané péči*. České Budějovice: Středisko rané péče SPRP, 2012. 55 p. ISBN 978-80-87510-20-9.

⁵⁴ ECI 2.0. Európska iniciatíva za kompetentnosť vo včasnej intervencii. Tréning zručností na podporu pedagógov, zdravotníckych odborníkov a sociálnych pracovníkov. [online]. [accessed: 2013-07-07]. Available online: <<http://www.earlyintervention.eu/index.php?menupos=4>>.

⁵⁵ KRAVÁROVÁ, M. 2010. *Problémy a zmeny v súčasnej rodine*. [online]. Prohuman. [accessed 2013-10-2]. Available online: <<http://www.prohuman.sk/socialnapraca/problemy-a-zmeny-v-sucasnej-rodine>>.

⁵⁶ VÁGNEROVÁ, M. 2008. *Psychopatologie pro pomáhající profese*. 4. ed. Praha: Portál, 2008. 872 p. ISBN 978-80-7367-414-4.

⁵⁷ BINAROVÁ, M. – SOBOTKOVÁ, I. 2007. Životní spokojenost a fungování rodin tělesně postiženým dítětem. In: *Psychológia a patopsychológia dieťaťa*. 42, 2007, 4, pp. 307-322.

Coping with this stress in family depends on multiple factors. It depends on the parents' experience, the features of their personalities, age, health condition, the quality of the partner relationship, number of children, kind and cause of the disability. Approaches to the coping with this stress may be twofold – active and passive. The active approach is manifested in the effort to struggle with the unacceptable situation, ask physicians and healers for help and focus on the rehabilitation of the child.

The passive way of coping with the stress limits the ability to find an acceptable solution, often is manifested in the form of escape from a situation the parents can not cope with. An extreme solution is placing the child into an institutional care or leaving the family by one of the parents, most often the father. One way of escaping the situation may be its denial, when the parents act as if the child was healthy or his problems were only temporary. It is their most frequent manner of defence from other people. One of the ways may also be an ersatz solution, by which a parent compensates for his failure to assume the parenting role. They may resign from the possibility the child's condition may improve and start to pay attention to something else, e.g. a professional carrier, which however may be a cause of stagnation for the child even in those areas, where he would otherwise make progress.⁵⁸

Every family has individual strengths and capabilities on which it can build and by which it can cope with various stressful situations. A complex of these factors or the strong sides of the family help them handle stressful situations and cope with them without a significant disturbance in its balance. Under favourable circumstances even a traumatizing situation may be at least in part a positive experience, since it may activate and act as a challenge. In this respect, it can be said it is useful to adopt the attitude of acceptance considering such situation as a trial or a task in life. This attitude will enhance the confidence of the parents and develop their capabilities and personality.

Another possibility is to find something one can affect or control in a situation which otherwise can not be substantially changed. This involves several meaningful activities parents do for their child with a disability.

Another possibility is purposefully going through positive experiences, experiencing something enjoyable, having a good time, relaxing. This involves sports, physical work, hobbies, meeting friends and many others.

Several physical, psychological and social factors are involved in coping with stress. These may facilitate handling the situation but also increase the risk of a crisis and subsequent failure. Physical health and strength, related to the ability to deal with fatigue and insufficient rest are important because care for a child with a disability is a long-term matter with a frequent deteriorative effect on the health of the caretaker.

⁵⁸ VÁGNEROVÁ, M. 2008. *Psychopatologie pro pomáhající profese*. 4. ed. Praha: Portál, 2008. 872 p. ISBN 978-80-7367-414-4.

Getting to Know the World of a Person with a Disability

To a great extent, the experiencing and handling of difficult life situation is also affected by personal features of the parents. An important role is played by their openness, ability to make social contacts, whether they are able to formulate the need for assistance clearly, whether they are able to accept help. Emotional stability and balance contributes to the ability to assess the problem in a broader context, to be on the top of things, it helps winning and keeping around people who may be helpful, if necessary. Optimism and tendency to see rather the positive aspects helps to manage not only the present stress, but also to ponder on the future with hope. Characteristics such as friendliness, helpfulness and empathy in the relations with people help to put oneself in the place of the child, even if he is different, help and protect him. A person with such disposition is able to perceive also the manifestations of love and gratitude bestowed on him by the child.

A very important characteristic of the parents of children with disabilities is self-control with its positive manifestations in responsibility, hard will and systematic approach. This helps parents establish an effective system for the work with the child, even certain stereotype, meticulous planning of every day, regular activities with the child. The choice of an attitude to the stress resulting from the care for a child with a disability by a parent depends also on the level of his confidence and assuredness. A healthy measure of confidence helps choose more active solutions; helps obtain information, professional help or spiritual support.

In the context of handling stress one needs resilience, which is defined as an ability of an individual, group or community to resist or recover from a grave adversity, to adapt to changing conditions and to prosper.⁵⁹

Family resilience is an ability of a family to handle problems constructively and start again. It is an important protective factor of a family which helps parents to find assistance, support, resources and possibilities to manage problems in life.

Every family has certain presuppositions, strengths and possibilities for better handling of particular problems or obstacles. A family may discover such strengths and presuppositions also with the assistance of professionals who are helpful in their identification and development.

Sources of resilience are internal and external. The internal resources of a family spring from the familial environment itself that characterises it. It includes the way individual family members communicate with each other, whether they are open to each other, whether they are able to hold together, search for possible solutions, also the flexibility of the family system, the ability of a family to abandon usual stereotypes, adapt to new situations and tasks.

Other internal resources of resilience of a family include the ability of a family and its individual members to distinguish and respect status and personal possibilities in distributing tasks and responsibilities without putting excessive burden on

⁵⁹ HORŇÁKOVÁ, M. 2010. *Včasná intervencia orientovaná na rodinu*. Bratislava: Univerzita Komenského, 2010. 260 p. ISBN 978-80-223-2915-6.

individuals. Time spent together and family rituals help to hold the family together, create stability and achieve harmony.

An important source of resilience for a family with a child with a disability is its spirituality, religious conviction and priorities in its hierarchy of values.⁶⁰

In a well-functioning family, the spouses support each other. Confidence in the partner that he would provide support is also one of the most important social factors affecting the handling of the stress related to the birth of a child with a disability. Yet, the way such stress is experienced and handled may be different in men and women. Men do not manifest their emotions on the outside, they do not talk about their feelings and in the case they withdraw and close up they may convey an impression of lack of interest in their partners. Women expect emotional support from men, they need their partner to sense their feelings and to show it, while men usually do not manifest this way, they are rather dispassionate and more realistic. They both need to handle the change in their lives, adapt to new conditions and cope with them.⁶¹

Differences can be also seen in fulfilling the parenting roles. It is also reflected in the relationship of the father to their child with a disability which is different from that of the mother. It also results from the difficulties in coping with his feelings; men are more affected by bothersome reactions of the environment or a change in the relationship with the partner. In a family with a child with a disability, the father may become insecure in his parenting role, a passive father, who escapes to the role of the “sponsor”, or a refusing father, because the child is not as he imagined.

If unable to handle the situation, he tends to close up or leave the family. In most cases the father provides financial support to the family, in better ones he helps the mother with the chores. It is all too clear, however, that care for a child with a disability falls predominantly on one parent, usually the mother. As the glue of the family, the mother can establish a positive emotional framework along with other family members; she has ways to create an atmosphere of satisfaction and mutual solidarity. She is better at handling adversity and stress. Biologically, she is better equipped for her maternal role.

In many families the relationship of the parents is affected by long-term division of roles. The mother usually takes on responsibility for further development of the child and as a result she loses the freedom to make decisions about herself, her job, hobbies and free time. She becomes financially dependent on her partner, extended family or social benefits. Without any contact with friends and other people she may feel isolated and misunderstood. In general, men are not as open as women; they

⁶⁰ SOBOTKOVÁ, D. – DITTRICHOVÁ, J. et al. 2009. *Narodilo se s problémy, a co bude dál?* Praha: Triton, 2009. 107 p. ISBN 978-807287-141-3.

⁶¹ VÁGNEROVÁ, M. – STRNADOVÁ, I. – KREJČOVÁ, L. 2009. *Náročné mateřství.* Praha: Karolinum, 2009. 333 p. ISBN 978-80-246-1616-2.

tend to keep their feelings for themselves and are worried more than they show on the outside.

Care for a child with a disability brings a family many duties and limitations in several areas. For instance, the mother stays at home to care for the child which situation instils a feeling of isolation in her; the family has only one income, reduced financial means and increased expenses, with resulting overall dissatisfaction which may adversely affect the relationship of the child's parents.

Due to the problems with the child, the marital relationship often gets under pressure. In the case of some parents communication between them may fail also because they conceal their real feelings and stay quiet. Conflicts may also arise from insufficient understanding of the way the marital partner copes with the fact of the child's disability which may be very different in both parents.

The marital relationship is usually affected by the fact that parents pay maximum attention to the child with a disability and hence push their partner role into the background. Accusations of the partner may persist in parents. The change of the running and management of the household requires increased ability to cooperate and management skills from the spouses. If one of the partners neglects the family life, gradual alienation may occur. More often than in common relationships, problems related to the care for and upbringing of a child with a disability get partners into exceedingly difficult situations and may cause marital conflicts. Weariness, long-term stress, mental fatigue and physical load significantly affect the way the partners communicate and interact.⁶²

Disease or disability of a child puts the parents into a new situation, tests their mental resilience, stability of mutual family ties, management skills, help of their social environment as well as the ability to bear the financial costs of treatment and rehabilitation.

It is true that the presence of a child with a disability in a family poses a test for the cohesion and cooperation of the partners. It affects their relationship in any case: it may either strengthen or corrupt it. Willingness to solve problems together, openness towards the partner, mutual help and support contributes to the improvement and strengthening of their relationship.⁶³

Mothers, who often bear greater mental load, say what they appreciate the most about their partner:

1. Help and support the father provided to the mother. Some mothers understood as help even the fact that the partner had not left the family leaving them alone with

⁶² SVIČEKOVÁ, G. 2008. *Život rodiny s dieťaťom postihnutým NSO*. [online]. Interdisciplinárna starostlivosť o deti s nervosvalovými ochoreniami. [accessed 2013-2-9]. Available online: www.parentproject.cz/onas/2008/ppt_08_sk/ppt-12.pdf.

⁶³ VÁGNEROVÁ, M. – STRNADOVÁ, I. – KREJČOVÁ, L. 2009. *Náročné mateřství*. Praha: Karolinum, 2009. 333 p. ISBN 978-80-246-1616-2.

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the child. They appreciated their mental support and providing security. Going through problems together was a real support for the mothers.

2. The relationship of the father to his child with a disability. Perhaps the most important thing for a mother is a positive relationship of the father to the child that he accepts the child the way he is. Mothers emphasized help with disability-compensating activities, e.g. doing the exercises with the child, accompanying him to the doctor, staying with him at a health resort and the like. They also found helpful when the father was able to take care of the child, to attend to his needs, feed him and go for a walk with him. Thus he showed he cared for the wife and the children.
3. Economical security of the family. Financial security is appreciated by those mothers who stay at home without any other help from the father of the child, or if the father has left the family.

In order to provide mutual support in such difficult situation, parents need to focus on some realities that may be helpful to them.

Above all, the parents should know as much as possible about their child. If the parents know what the disability of the child consists in, they are able to help and understand him better. Such knowledge should not be limited to the diagnosis, i.e. the medical aspect, but should also extend to the psychological living out which the child herself will have to handle.

Birth of a child with a disability needs to be accepted correctly. If the parents accept such situation as a task, a healthy environment for upbringing and living together can be created. This fact also needs to be accepted as a trial, an opportunity to activate and mobilise one's strengths. On the contrary, if the parents perceive the disability of their child as a disaster, it leads to passivity and closing up which is not beneficent for the child and the family.

Selflessness, not self-sacrifice. A child with a disability needs help, understanding and support from the parents. Care for him should be distributed in the family; it should not be a prerogative of one person, most often the mother of the child.

To accept the truth – about the prospects. A parent should have a realistic view of the child, he should not expect a miraculous development of his condition or compare him to his healthy peers, but he should concentrate on the child's advances.

It is important for the parents to accept the truth that the child does not suffer. A child with a disability lives his child's life corresponding to his mental maturity and does not live out his disability the way we see it with our grown-up eyes.

The parents of a child with a disability make a mistake when they try to accelerate the development of the child, not respecting the pattern of his individual development. Energy and finance expended a wrong way may become an obstacle for his further development. The child may develop wrong habits or defence mechanisms are triggered in him.

Getting to Know the World of a Person with a Disability

The feeling they are not alone is helpful for the parents. Overcoming many obstacles, disappointments and failures may lead the family to social isolation and closing up. The parents need to keep on saying to themselves that they are not alone with such fate. Today, in the age of developed communication technologies, there is no problem to find families with a similar fate willing to share their experience and feeling regarding their child with a disability.

Similarly, the parents need to know they are not in danger. The parents of a child with a disability may be overly sensitive to the attention of other people, curious looks, and uneasy behaviour of the environment. Nevertheless, this tension is natural because the assurance of the parents has been shaken and the pain they feel makes them oversensitive. It is rather a defence mechanism that wanes after some time.

The most important part of the life of the parents is the ability to protect their relationship, their marriage and family. Because of problems with the child, their relationship is often under pressure. The marital relationship may be easily corrupted by fatigue and stress. The ability to talk and listen to each other, as well as to the children, is necessary for good relationships in a family. In any case, things do not need to be let gone too far and one should never give up.

Related to this principle is openness and thinking about the future. Parents should be able to assess themselves realistically, as to what extent they are able to meet the needs of their child or what help they can expect from their relatives. The prospects also include assessing the possibility of having another child who in most cases brings only positives and heals the entire environment.

Recently, the need to support families has been mentioned with ever greater seriousness. Especially those facing a serious problem which definitely includes a birth of a child with a disability. At the same time, new initiatives arise urging the authorities to build the system of early support. It is a service that should build a bridge between a hurt family and the ways of its treatment, in parallel with the medical diagnostics and therapy. Early diagnostics and intervention require experts who are prepared both as professionals and as human beings to see the problems of the family dispassionately. To be close to such family means to provide it assistance in the search for possible diagnostic, treatment and therapeutic procedures as well as orientation in the social assistance network. This is more than just a professional form of help. However, the people working in this network should also in parallel work with the family of the child with a disability.

In addition to this basic issue it is necessary to assess the real needs and possible ways of helping such families not only in solving the problem of the disease itself but also in that of searching for the answer to the question of where a source of a positive strength to handle it might be. The role of the father in such families is crucial.

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Help to be provided should have some characteristic features, mainly directness, i.e. individual adjustment to the needs of a given person. Other features include flexibility, i.e. adjustment to the situation and its changes, effectiveness in spending the financial resources from social benefits are used for the needs necessary for quality life. Last but not least, professionalism in the provision of medical and other services is required.

6 Law Serving the Assistance to People with Disabilities

The generally binding legal regulations in the Slovak Republic that regulate the rights and duties of people with disabilities are based and should be in accordance with the principles and norms adopted by the regional and universal international and a supranational communities.

The documents related to the legal issues of the persons with disabilities may be divided into three groups:

1. Non-legal documents which form a basis and guidelines for the creation of legal norms.
2. International treaties and the European Union legislature.
3. Generally binding legal regulations in the Slovak Republic.

6.1 Non-legal Documents

Regarding the philosophical basis for the protection of individual rights of people with disabilities, the social documents of the Catholic Church, mainly papal encyclicals, are both of historical and current value. It may be said that many UN documents and other systems of protection of the rights of people with disabilities are grounded on the documents of the Catholic Church and are related to them.

The most complex non-legal document unambiguously declaring the priority of the idea of providing for people with disabilities by reducing their handicap and integrating them into society to the idea of charity and institutionalised keeping people with disabilities away from society is the document adopted by the United Nations General Assembly on 28 October 1993 under the title *The Standard Rules on the Equalization of Opportunities for Persons with Disabilities* (henceforth “the Rules”). What is the main idea of the equalization of opportunities? The equalization of opportunities is defined by the Rules as a process through which various systems of society and environment, such as services, information and documentation, are made available to all, particularly persons with disabilities. It is a principle of equal rights for all members of society. As a result, people with disabilities have the right to live in their local communities (not in isolation) and they still must have full responsibility, i.e. such measure of responsibility that is identical or, as much as the circumstances allow, similar to that of the people without disabilities.

People with physical and sensory disabilities are further addressed in the *Declaration on the Rights of Disabled Persons*, adopted by the UN GA on 9 December 1975, and in the *Declaration on Social Progress and Development*.

Many international organisations in Europe and over the world, as well as the European Union, adopt political documents addressing the protection of the rights of people with disabilities. In order to implement real measures in the field of life of people with disabilities several plans and programs are adopted both by the UN and regional organisations. One of the most important ones is e.g. *Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015*. In Slovakia it is being implemented mainly by the Ministry of Labour, Social Affairs and Family of the Slovak Republic, as well as by the Offices of Labour, Social Affairs and Family on local levels. The Offices of Labour, Social Affairs and Family are accompanied by Counselling and Information Centres for the citizens with disabilities (CIC for CD).

Charter of the Rights of Physically Disabled Persons is based on the Declaration of the Rights of Man and of the Citizen, General Declaration of Human Rights, European Convention of Human Rights and General Legislation on Physically Disabled Persons issued in Paris in 1975 (by the Association of the Paralysed France). According to these documents every person with a disability has the same rights and duties as anybody else. Thus every economic and social policy related to the rights and duties of people with disabilities needs to be upheld.

Disability leads to limited motor activity and such person is increasingly dependent on the environment, close people and the entire society. Thus the society is obliged to help such fellow citizens to integrate into normal life. People with disabilities are fully entitled to live their life independently, in the way they choose. They have the right to incorporate into social life; they have the right to have all their wishes and desires fulfilled. Those willing to live in homes with nursing service should be enabled to choose a quality facility where their personality would be fully respected. People with physical disabilities can also use private houses or flats and society must give them an opportunity to adjust them for comfortable, independent and safe life.

Those responsible for making decisions on building houses and flats as well as public communications are obliged to create as favourable conditions as possible for self-realisation, safety and confidence of people with disabilities.

Article 1

Way of life: Every person with a physical disability has the right for independent choice of his way of life and the place he wants to live.

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Article 2

Family and environment: Like every human being, a person with a physical disability also wants to love and be loved. He is fully entitled to establish, develop and sustain his own family and to exert influence on the development of familial and amicable relationships.

Article 3

Right for quality and qualified assistance: Every person with a physical disability has the right for quality and qualified assistance. Amicable relationship between the person who provides and the one who accepts such assistance must be based on mutual respect, trust and respect.

Article 4

Right for medical care: A person with a disability has the right to choose his physician to look after his health. He has the right for regular information about his personal health situation and for participation in all decisions about himself.

Article 5

Housing and environment: A person with a disability is fully entitled to make his own decision to live in a place corresponding to his requirements and needs.

Article 6

Right for technical assistance: A person with a physical disability has the right for full financing of the technical equipment and assistance necessary for independent life.

Article 7

Participation in social life: People with physical disabilities must be mediated communication, mobility and access to society, education, authorities, economic, occupational and leisure activities and sport.

Article 8

Every person with a physical disability has the right for sufficient income to ensure his comfortable and peaceful life.

Conclusion

People with physical disabilities, associations, fellowships and unions should unite in their effort to improve mutual understanding and to better safeguard the exercise of their basic human rights, including:

- right to be different,
- right for a dignified and appropriate way of life,

- right for integration to society,
- right for one’s own opinion and its fulfilment,
- right for equal citizenship and independent choice of way of life and place to live.

6.2 International Treaties and European Union Legislature

The fundamental legal documents in the area of protection of the rights of people with physical and sensory disabilities are international treaties and legally binding documents of universal nature adopted by the United Nations. These include mainly:

- *Charter of the United Nations* and *Statutes of the International Court of Justice* (San Francisco 26 June 1945); published in the SR under No. 30/1947 Coll.

- *General Declaration of Human Rights*, adopted by the UN GA in 1948.

- *International Covenant on Civil and Political Rights* (New York, 16 December 1966); published in the SR under No. 120/1976 Coll., it establishes in art. 26 that all persons are equal before the law and without any discrimination are entitled to the equal protection of the law.

- *Optional Protocol to the International Covenant on Civil and Political Rights* (New York, 16 December 1966); published in the SR under No. 169/1991 Coll., it establishes the mechanism of the implementation of the Covenant.

- *International Covenant on Economic, Social and Cultural Rights* (New York, 16 December 1966); published in the SR under No. 120/1976 Coll., it is based on the same anti-discrimination principles as the International Covenant on Civil and Political Rights. In art. 12 it establishes that the Parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In art. 13 it establishes that education shall be directed to the full development of the human personality and shall enable all persons to participate effectively in a free society.

- *Convention on the Rights of a Child* (New York, 20 November 1989); published in the SR under No. 104/1991 Coll., it particularly establishes the rights of a child with a disability in art. 23. Suggestive are those parts of the document where the parties recognize that “a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community.”

- *Convention on the Elimination of All Forms of Discrimination against Women* (New York, 18 December 1979); published in the SR under No. 62/1987 Coll., it establishes among other things also the rights of girls and women with disabilities.

Thus within the UN, human rights are regulated by political documents and universal treaties on human rights, as well as by treaties aimed at certain groups of people, such as women, children or migrating persons. Since 2008, the rights

of the people with disabilities have also been regulated by a specialised universal international treaty. One should remember that it is the largest group of people in the world: according to the World Health Organization (WHO) there are about 650 million people over the world with various kinds of disability, which represents roughly 10% of the world population. At the same time, 80% of these persons (400 million people) live in poor countries which can not provide people with disabilities with decent life and as a result they have much lower life standard. Needless to say, disability also affects the families of the people with disabilities, which means we are talking about approximately one billion people. Even in Europe the situation is not under control. Every sixth person in the European Union has a disability which makes about 80 million of its citizens. More than one third of the people above 75 years have health issues and with the progressive aging of the population in the member states of the Union, this number will only rise.

The above political and legal documents adopted by the UN addressing the people with disabilities have not become obsolete but are still forming a valid basis for the first complex universal international legal instrument for the protection of the human rights of persons with disabilities, the *Convention on the Rights of Persons with Disabilities* (henceforth “the Convention”), which was along with its *Optional Protocol* adopted by the UN GA on 13 December 2006. The Convention has been open for signature by states since 30 March 2007. The President of the Slovak Republic signed the Convention and the Optional Protocol on 26 September 2007, by which the Slovak Republic expressed its will to ratify both documents. Pursuant to the final provisions, the Convention and the Optional Protocol entered into force on 3 May 2008 (more at the UN website: <http://www.un.org/disabilities>). On 26 May 2010, both the Convention and the Optional Protocol were ratified by the Slovak Republic where they entered into force on that day and imposed a duty to commence the process of implementation of the Convention to our domestic legislation. The Convention is published in the Collection of laws under No. 217/2010 Coll.

According to the Convention, the fundamental basis for the approach to the persons with special needs is the idea that disability consists in society, not in the person with special needs. In this sense, following the Convention Article 1, persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.⁶⁴ An obvious example is a situation of an extremely myopic (short-sighted) person in two different countries. Where such person has access to corrective lenses he is not considered a person with a disability following the Convention; on the contrary in a country

⁶⁴ Cf. ŠMIDOVÁ, M.: K dohovoru o právach osôb so špeciálnymi potrebami : Východiská. I. časť. In: *Integrácia*, 13, 2006, 3; ŠMIDOVÁ, M.: K dohovoru o právach osôb so špeciálnymi potrebami : Aktuálny stav, nástroje implementácie a hodnotenia základnej koncepcie. II. časť. In: *Integrácia*, 14, 2007, 3.

without such access such deficiency of the society causes his disability. This example clearly shows the relation of a disability to society, not to the person in question.

The European Union as a whole has also become a party to the Convention. Hence all the policies, legal regulations and programs within its cognizance should be in accordance with the provisions of the Convention. This applies e.g. to the areas of access to education, employment, transportation, infrastructure and buildings open to the public, voting rights, participation in the political life and ensuring full legal capacity for the people with disabilities.

Within the UN system, the rights of people with disabilities, particularly in the areas of labour, education and health care, are addressed also by other international treaties, mainly those entered into within the International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO) and the World Health Organization (WHO).

One needs to be bear in mind that not only the UN but also various continental or regional systems have their own structures in the social field, including the regulation of the rights and duties of persons with disabilities. Varying in content and extent, such regulations have been adopted by the EU, the Council of Europe, the OBSE as well as within continental regional legal regulations, e.g. social and other human right protection systems on the African and American continents. In the region of Europe, the key documents are deemed to be the *European Social Charter* and *Convention for the Protection of Human Rights and Fundamental Freedoms*.

The revised *European Social Charter* (Strasbourg, 3 May 1996), published in the SR as 273/2009 Coll., provides particular protection to children. In addition to the anti-discrimination provisions, the Charter explicitly establishes the right of the people with disabilities to professional education, right to social help, right to vocational training and to professional and social readaptation.

Convention for the Protection of Human Rights and Fundamental Freedoms (Rome, 4 November 1950); published in the SR as 79/1994 Coll., it establishes in art. 14 that the enjoyment of the rights and freedoms set forth in the Convention shall be secured without discrimination on any ground such as sex, race... or other status.

In the European Union, in relation to the Treaty of Lisbon, i.e. the Treaty on European Union and the Treaty on the Functioning of the European Union of 1 December 2009, published in the Official Journal of the EU under No. 2008/C 115/01, the *Charter of Fundamental Rights of the European Union*, published in the OJ EU under No. 2007/C 303/01, also became legally binding based on the Treaty on European Union art. 6, and is applied within the jurisdiction of the Union. Pursuant to the Charter art. 21 par. 1 any discrimination including that on the ground of disability is prohibited. At the same time, the Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life. Pursuant to art. 26 the Union recognises and respects the right of persons

with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community.

6.3 Generally Binding Legal Regulations in the Slovak Republic

The Constitution of the Slovak Republic, adopted on 1 September 1992 and published under the No. 460/1992 Coll., stipulates in art. 12 par. 2 that basic rights and freedoms on the territory of the Slovak Republic are guaranteed to “everyone regardless of their sex, race ... or *any other status*.” The Constitution of the Slovak Republic thus established a principle that people with disabilities should have the same rights (but also duties) as those without disabilities. “Other status” may also be interpreted as the status of a person with a disability. In other words, pursuant to the Constitution of the Slovak Republic and in accordance with the Standard rules on the Equalization of Opportunities for Persons with Disabilities, a person with a disability should not be disadvantaged or handicapped in any basic human right-related area.

The above constitutional principles form a basis for several legal norms in the Slovak national legislature.

Act No. 448/2008 Coll. on social services regulates the legal relationships in providing social services, financing social services and in the supervision of providing social services.

Act No. 447/2008 Coll. on monetary allowances for the compensation of a severe disability regulates legal relationships in providing financial allowances for the compensation of the social consequences of a severe disability, legal relationships in the issuance of a card for a natural person with a severe disability, issuance of a card for a natural person with a severe disability with an attendant, a parking card for a natural person with a disability and legal relationships for the purpose of the assessment of the need for particular care provided pursuant to a special regulation. The purpose of the regulation of the legal relationships is to support social integration of a natural person with a severe disability into society with his active participation preserving his human dignity, under conditions and in the areas delineated by the Act.

Act No. 461/2003 Coll. on social insurance defines social insurance, provides for its scope, performance, organisation, financing, state supervision and proceedings in the matters of social insurance.

Act No. 5/2004 Coll. on employment services regulates, among other things, the area of employing people with disabilities.

Act No. 601/2003 Coll. on subsistence minimum establishes subsistence minimum as a socially accepted minimum borderline of the income of a natural person, under which he incurs poverty.

Act No. 305/2005 Coll. on social and legal protection of children and on social guardianship regulates social and legal protection of children and social guardianship in order to prevent crisis situations in families, to protect the rights and interests of children protected by law, to prevent the deepening and repeating of disorders in mental development, physical development and social development of children and natural persons of age and in order to prevent the rise of socio-pathological phenomena.

Act No. 245/2008 Coll. on education (the school act) establishes principles, goals, conditions, range, content, forms and organisation of education at schools and educational institutions. Thus it deeply impacts the dignity of life of people with disabilities.

Act No. 576/2004 Coll. on health care and services related to the provision of health care regulates the provision of health care and services related to the provision of health care, rights and duties of natural and legal persons in the provision of health care, course of action in the case of death and the scope of actions performed by the state administration in the area of health care.

Act No. 578/2004 Coll. on health care providers, health care workers and health care professional organizations establishes, among other things, conditions for providing health care and related services by natural and legal persons and duties of a health care provider and duties of a health care worker.

Act No. 580/2004 Coll. on health insurance.

Act No. 581/2004 Coll. on health insurance companies establishes, among other things, the supervision of the provision of health care and regulates the conditions, procedures and range of free access to information.

Act No. 355/2007 Coll. on the protection, support and development of public health establishes, among other things, the performance of the prevention of diseases and other health issues, requirements for healthy life conditions and healthy working conditions and the duties of natural and legal persons in the protection, support and development of public health.

Act No. 211/2000 Coll. on free access to information establishes the conditions, procedures and scope of free access to information; the persons required to make information available pursuant to this act being the state bodies, municipalities, regional authorities, in the scope of their decision-making authority, as well as those legal and natural persons, invested with the legal authority to decide about the rights and duties of natural or legal persons in the area of public administration, as well as legal persons established by the law and legal persons established by a state authority, regional authority or a municipality pursuant to a special act.

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Act No. 365/2004 Coll., anti-discrimination act regulates the application of the equal treatment principle and establishes the means of legal protection in the case of failure to comply with the principle; under the compliance with the equal treatment principle is also meant non-discrimination based on a disability. The Act also implements the EU Council Directive 2000/78/ES of 27 November 2000 establishing a general framework for equal treatment in employment and occupation. In implementing the equal treatment principle this directive also establishes a general framework for combating discrimination based on disability. It is established that in the relationship with persons with disabilities reasonable accommodations should be made, particularly in the form of appropriate measures taken by employers (unless such measures would impose a disproportionate burden on the employer) to enable persons with disabilities to establish themselves on the labour market.

Act no. 9/2010 Coll. on complaints establishing the manner of filing and handling complaints.

Act no. 213/1997 Coll. on the non-profit organisations providing universally beneficial services regulates establishment, formation, termination, dissolution, the status of the administrative bodies and financial management of non-profit organisations. The universally beneficial services are considered providing health care, social and humanitarian aid, protection of public health, services supporting regional development and employment and provision for housing, administration, maintenance and renewal of the stock of flats, as regards the possibility of association of persons with disabilities. The legislation on the establishment and operations of foundations can be found in Act No. 34/2002 Coll. on foundations.

A practical and important decree is the Ministry of Environment mandate No. 532/2002 Coll. establishing details of general technical requirements for construction and general technical requirements for the buildings used by persons with limited movement and orientation abilities.

7 Concluding remarks on relationship and knowledge

Based on the principle encompassing the idea that a human being is above all a being that addresses and is addressed one can also ask a question what the mutual knowledge of the two “worlds” would bring. The one of the people with disabilities and the one populated by the people without apparent disabilities.

Knowledge shows the way to understanding, understanding to relationship, relationship to fulfilment. Both the therapist and the one reliant upon his assistance have a great treasure they can impart to each other. The greatness of this treasure lies in the ability to discover a value in the other person.

Relationship can be built in everyday contacts. A human person, which is in each moment of his life an integration of multiple dimensions, with a human being as a microcosm, a synthesis of the sensory and supersensory world.⁶⁵ Somatic, mental, interpersonal⁶⁶ and spiritual dimensions, they all are seeds of an interpersonal relationship enriching both sides. The meaning of life consists in lasting and complete human happiness, although it may be difficult to define in individual cases.

The exact opposite is human suffering understood as the absence of happiness. Darkness as the absence of light. Suffering as the absence of happiness. Suffering as the absence of a satisfying condition of the somatic, mental and social dimensions. Suffering that can hardly be treated by exclusive concentration on one of the above human dimensions, because it is an indivisible inability to be happy, to experience happiness. All human dimensions are inseparable, at the same time and always mutually interconnected and conditioned. Human suffering and happiness are categories that have obtained their content and value in the ideally integrated personality of Christ. Taken on by Christ, some light is shed on their meaning which can be accessed by both sides.

This fact allows us to sense a new dimension in their mutual relationship. A human being as a being addressed and addressing is not only an instrument which can be mended by grinding. Something more is at stake: a relationship between two concrete persons, a reason for their encounter as two people with multidimensional integrated personality.

One does not need to hesitate to formulate the questions of the value of a human being, of his mission, help, the meaning of life. They need to be answered not only academically; above all, they need to be based on one's personal attitude.

Help begins with understanding

⁶⁵ This idea is further developed in the first part of the monograph ŠKODA, R: *Základy katolíckej sociálnej náuky*. Košice : HKR, 1991.

⁶⁶ In general, the existence of a human being is characterised by philosophy as Being-with. A human being as self-purpose can be realized only with other people. A human being is realized in a mutual human personal relationship, in an interpersonal relationship. Cf. ANZENBACHER, A.: *Úvod do filozofie*, p. 204nn.

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